

RELATING FOLLOWING AGGRESSION
WOMEN'S MEDIUM SECURE SERVICES

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RESEARCH SUMMARY

Background: Women in medium secure services can present with aggressive behaviours and a high level of risk to self and others. Research suggests frontline staff are frequently the victims of, or witness to aggression by forensic inpatients. The therapeutic relationship is proposed as central to therapeutic outcome, but may be jeopardised by inpatient aggression. Staff perceptions of the therapeutic relationship and aggression have not been explored in women's medium secure services. The study aimed to develop a theoretical model grounded in frontline staff perceptions of the therapeutic alliance and aggression in a women's medium secure services.

Method: The data from 13 semi-structured interviews conducted with frontline staff was analysed using Constructivist Grounded Theory methods.

Results: The tentative descriptive theoretical model "Relating Following Aggression" emerged from the interview data. Contextual information supports five core categories, and the related sub-categories. The findings propose the therapeutic relationship is intrinsically linked to boundaries, and boundary violations could result in relational deterioration. Aggression affected the emotional and psychological wellbeing of the participants, and compromised the staff-patient relationship. The participants were fearful of aggression occurring in their workplace which resulted in them spending less time with the women and withdrawing from the therapeutic relationship.

Conclusion: The findings reveal the complexity of the frontline staff-patient relationship in women's services. Aggression occurring between frontline staff and women can seriously compromise the therapeutic relationship through a crossing of the boundary line and a perceived

breach of trust. Greater support for both the frontline staff and women is required. Future research is recommended.

Keywords: *Frontline staff, women, aggression, forensic, therapeutic relationship, Constructivist Grounded Theory.*

STATEMENT OF TERMS

Aggression and violence. Multiple interchangeable definitions of violence and aggression are provided in healthcare research. This study uses the National Institute of Clinical Excellence (NICE, 2015) definition which subsumes violence and aggression:

“Violence and aggression refer to a range of behaviours or actions that can result in harm, hurt or injury to another person, regardless of whether the violence or aggression is physically or verbally expressed, physical harm is sustained or the intention is clear” (NICE, 2015, p.15)

Frontline staff: The term frontline staff refers to staff working, on shift, in direct contact with the women. This includes registered nurses of differing grades and support staff including support workers and healthcare assistants.

Female forensic Inpatient: Throughout this thesis I refer to the female inpatients as ‘inpatients’ ‘patients’ or ‘women’. The terms patient, client and service user were used interchangeably by other researchers, and by the participants.

Forensic Service: The terms ‘forensic’ and ‘secure’ are used interchangeably to refer to the secure and forensic service throughout the document.

CONFIDENTIALITY

In accordance with British Psychological Society (2010) guidelines, all names of individuals and services where the research was undertaken have been replaced with pseudonyms in order to protect the identity of those who participated in this thesis. I have also ensured that any identifiers in the data were removed, to ensure the findings are not traceable back to staff members.

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Chapter One: Introduction

Chapter Overview

This chapter incorporates two parts.

Part 1: Places the study in the current context of research and clinical practice. I present a review of research and theory relating to the therapeutic alliance and aggression, and focus on its application to women's forensic inpatient services.

Part 2: Presents a meta-synthesis of qualitative research relating to frontline staff experiences of aggression occurring in secure inpatient services. Included is an overview of the synthesised interpretations and key concepts.

Part 1: Current Context of Research and Clinical Practice

This study focuses on frontline staff perceptions of the therapeutic relationship and aggression in women's medium secure services. The study was conducted in a women's medium secure service. This chapter presents an argument for research in this area.

In 2006 the College Centre for Quality Improvement established the Quality Network for Forensic Mental Health Services to ensure the 'sharing of best practice' for high quality mental health care in forensic services (Royal College of Psychiatrists, 2014). The care and risk management of forensic inpatients, particularly aggression to self and others, is central to healthcare initiatives raising awareness of the safety and security, and the wellbeing and integrity of staff and service users (Department of Health (DoH), 2010; National Institute of Clinical Excellence (NICE), 2015).

The 'Zero Tolerance' campaign (DoH, 1999) set out to tackle violence and aggression towards healthcare professionals in the workplace, by prosecuting and withholding treatment from aggressive patients. However, forensic inpatients by definition show higher levels of violence, than patients in other healthcare sectors (NICE, 2015). Furthermore, in the forensic sector withholding treatment would unlikely be a disincentive for aggression, given most patients are detained against their will. The campaign's focus on the management of aggression rather than the prevention and treatment of aggression was challenged, and the campaign risked criminalising mental illness, for "ill patients whose responsibility for their actions was at least grossly impaired" because of their mental illness (Madon, 2008, p. 126). The campaign was revised and in 2003 became the National Health Service (NHS) Security Management Service (SMS) (NHS, SMS, 2003). Since the launch of the campaign, violence reporting has significantly increased, with two thirds of reported incidents occurring in mental health and learning disability sectors (NHS Counter Fraud and Security Management Service,

2009). However, this may represent an increase in incident reporting, rather than aggression prevalence.

Admissions to women's medium secure services have increased (Jamieson, Butwell, Taylor & Leese, 2000), alongside this is a reported increase in referrals of violent female offenders with higher risk behaviours (Long, Dolley, Barron & Hollin, 2012). Janicki (2009) explored staff and patient perceptions of prosecuting inpatient violence in a women's medium secure ward and showed that both staff and patients valued criminal justice system intervention as it boosted staff morale and acted as a deterrent to aggressive patients. However, they found the police and courts rarely supported prosecution. This finding is important when considering staff responses towards aggression, and particularly how women's aggression in the forensic context is conceptualised by the criminal justice system.

The current political context and austerity measures have resulted in the NHS being required to provide more for less (Hurst & Williams, 2012). Forensic inpatient staff can struggle to maintain safe therapeutic environments in the face of service user aggression and limited resources and staffing. Facing aggression in the workplace is frightening and stressful for frontline staff. It is therefore important to consider frontline staff responses to aggression in forensic services. This study aims to contribute to the literature on aggression and the therapeutic relationship in women's forensic inpatient care.

Current Provision of Forensic Services

Adult forensic mental health services provide multi-disciplinary specialist assessment and treatment for males and females with complex and severe mental health problems and offending behaviours which are typically violent in nature. In the main, forensic service users have criminal justice system restrictions placed upon them, and are detained under the Mental Health Act (DoH, 1983 amended 2007) "against their will and experience a significant

limitation on their rights and autonomy” (Carr & Havers, 2012, p. 115). Whilst aiming to provide treatment and patient recovery, detainment is deemed for the “safety and protection of the public” (Centre for Mental Health, (CMH) 2013, p.3).

There are presently three levels of security (high, medium, low) within forensic services. The women’s forensic service model provides one additional level, Women’s Enhanced Medium Secure Services (WEMSS) (Edge, 2006). These are commissioned by the NHS England who commission both NHS providers (65%) and the independent providers (35%) in England (CMH, 2013). In 2009/10 a substantial amount of public spending on the NHS mental health budget (18.9%) was allocated to forensic services (CMH, 2011).

Medium secure services. Forensic services were reformed in the 1980s following the Glancy (DoH and Social Services, 1974) and Butler (Home Office, 1975) reports which highlighted a gap in the provision of psychiatric care for offenders. The reform led to the introduction of the medium secure forensic service. In 2009 there were 27 women-only medium secure services in the UK, and women represented around 15% of the total population of service users in secure care (Parry-Crooke & Stafford, 2009).

Lengthy admissions are commonplace in medium secure care, with over 50% lasting over 5 years. In comparison, lengths of stay in non-secure inpatient services are typically up to 1 year for 50% of inpatients (CMH, 2011). A number of factors contribute to the high cost of forensic service provision, because of the ‘complexity of patient need’ (CMH, 2013). The daily cost of a medium secure bed for women (£979) is much higher than that for their male counterparts (£483) (CMH, 2013). The reasons for this are unclear.

Women's Secure Services

Characteristics of women in forensic services. In regards to their offending, women tend to commit less violent crimes (Pfafflin & Adshead, 2004), have fewer previous convictions (Coid, Kahtan, Gault & Jarman, 1999), and are more likely to have a history of 'fire setting and criminal damage' than men (Lambert & Turcan, 2004, p.156). Bartlett, Somers, Fiander, & Harty (2014) found that 28% of women admitted to medium secure services were admitted under criminal sections, 6% were transferred from prison and 49% are admitted to medium secure care on civil sections as alternative psychiatric settings are unable to safely manage their serious risk to self. However, Long, Dolley and Hollin (2011) found only 13% of women admitted to an independent sector medium secure service in the United Kingdom had no criminal history. This could reflect a difference in referrals between public and independent services.

Pfafflin & Adshead (2004) propose the combination of high risk to self and 'disturbed behaviour', differentiate women in secure services from women in alternative inpatient services. Women are more likely to have been transferred from other NHS settings (Lambert & Turcan, 2004), and are more likely to have multiple readmissions and be detained for longer periods than men (Parry-Crooke & Strafford, 2009; Aitken & Logan, 2004). The most prevalent primary diagnoses of women in low and medium secure services are psychosis (43%) and personality disorder (38%), with a high representation of emotionally unstable personality disorder, and 53% having a comorbid diagnosis (Bartlett et al. 2014). Whereas, male patients are more likely to have a diagnosis of antisocial personality disorder (Coid, Kahtan, Gault & Jarman, 1999).

The Corston Report (Home Office, 2007) reported that women admitted to secure care are more likely than male patients to have children in care; and to have been 'victims' themselves; they are also more likely to have experienced domestic violence than male patients

(DoH, 1999b). Women and men in secure care often have low socio economic statuses influenced by “a combination of poverty, educational and social exclusion, poor housing, homelessness, unemployment, [and] poor parenting and a childhood in care” (DoH, 1999b, p. 8). The prevalence of childhood sexual abuse (CSA) in women in secure care is thought to be between 60 - 80% (Lart, Payne, Beaumont, MacDonald & Mistry, 1999, p.2). The experience of CSA is particularly high in women with a diagnosis of personality disorder (Keulen-de-Vos et al. 2011).

Need for gender specific services. The DoH policy documents ‘Women’s Mental Health: Into the Mainstream’ (DoH, 2002) and ‘The Corston Report’ (Home Office, 2007) highlighted the need for strategic development of psychiatric services to provide holistic approaches to risk management and ‘gender specific’ care for women with complex psychological needs. Baroness Corston (2007) raised concerns about the standard of care for women, stating “women have been marginalised within a system largely designed by men for men for far too long and there is a need for a ‘champion’ to ensure that their needs are properly recognised and met” (Home Office, p. 2).

Women in secure care have often experienced disempowerment relating to gender, abuse and early deprivation. It was felt that without gender specific services the psychiatric system was at risk of re-enacting experiences of violence and re-traumatising women through ‘invasive institutional practices’ (Long, Fulton & Hollin, 2008). Motz (2012) proposes that women without a strong sense of self often hide away from staff and other patients in mixed wards, or alternatively establish abusive relationships with male service users, thus ‘re-enacting their previous exploitative and abusive relationships’ (p.116). Despite the push for gender specific care, Motz argues gender specific services can be paternalistic and deny female service users the opportunity to ‘process their traumatic experiences’ in a healthy way (p. 116).

Harm to self and others. Female forensic inpatients can be both the victims of violence, and perpetrators of violence (Aiyegbusi & Kelly, 2012), directing violence inwards as well as outwards. Bartlett & Hassel (2001) propose that the nature of risk women present to themselves or others is different to that posed by their male counterparts (in secure care), where women present a greater risk to themselves. However, Loper (2000) reported an increasing occurrence of violence towards staff within women's secure services, with the likelihood of an under report of the true prevalence of incidents. It is therefore important to consider how frontline staff can contain and manage the risk women pose to their own safety, but also the safety of others including the staff team themselves.

Tripartite Care

The 'Best Practice Guidance' (DoH, 2007) document encapsulates the DoH's strategy for risk management within secure care (Barker, 2012). The guidance stipulates three core integrated elements of security; procedural, physical and relational security. At a foundational level the three elements define boundaries between staff and patients which are considered paramount to maintaining safety, security and a therapeutic milieu. When the appropriate boundaries are in place staff can begin to support the therapeutic rehabilitation of service users (DoH). All forensic mental health staff should receive training on all three elements of security which are described below:

Physical security. 'Physical security relates to the secure physical environment (both internal and external) of the secure service and is based on the design, structure and tangible features of the service (p. 10).

Procedural security. ‘Procedural security relates to staff maintaining boundaries and effectively applying operational policies and procedures aimed at providing consistency of care (p. 11).

Relational security. ‘The ‘See Think Act’ (DoH, 2010) document provides guidance on relational security principles for staff working in secure mental health services. Relational security is based on Attachment Theory (Bowlby, 1969; Lawday, 2010) and facilitates security through staff/patient relationships. Integral to relational security is a cohesive staff team, working together with a shared responsibility and focus of the task of providing quality of care and a safe therapeutic milieu (DoH, 2007, p. 11). Parry-Crooke and Stafford (2009) describe relational security as “Embodying high staff-to-patient ratios, time spent in face-to-face contact, a balance between intrusiveness and openness and working towards high levels of trust between patients and professionals” (p. 42).

Within medium secure services the levels of both procedural and physical security are similar between male and female services. However, relational security is more heavily emphasised within women’s medium secure services (Long, Fulton & Hollin, 2008) and features as a central theme within the ‘National Women’s Mental Health (MH) Strategy’ (DoH, 2002). This is because women forensic inpatients’ early experiences are typically abusive, neglectful, abandoning and disempowering. Furthermore, women’s emotional, psychological and social development tends to emphasise the relational (Jeffcote & Travers, 2004).

Relating Theory and women’s secure services. Women tend to develop larger social networks than men, and these relational networks, when functioning healthily can act as psychological protective factors (Jeffcote & Travers, 2004). In her ‘Relational Theory’ Miller (1976) describes how women develop their sense of self and self-worth through relationships

and connections with others. This differs from men who tend to differentiate themselves in relationships.

Women in medium secure services have often experienced multiple dysfunctional relationships. They are often separated from their functional but also negative social and familial relational networks on which they may depend for some form of stability. Furthermore, many women have experienced early deprivation and neglect, and trauma in both relational and non-relational contexts, in childhood and adulthood (Drennan & Wooldridge, 2014). These multiple experiences of violence and relational abuse often make it harder for women to draw upon sound relational experiences, whilst in and out of secure care, particularly for women with a diagnosis of personality disorder.

I will now present aspects of Attachment Theory (Bowlby, 1969) as one of the main theoretical underpinnings of this study. This is because Attachment Theory provides one perspective on the function of anger and aggression and forms the basis of relational security, which is considered paramount in the therapeutic care of women.

Attachment Theory

Attachment Theory (Bowlby, 1969) considers the early relationships between children and their primary care givers, mainly their parents, who offer a 'secure base' (Ainsworth, 1967). Attachment security is achieved through childhood experiences of protection, safety and physical responsiveness of the primary care-giver, as well as active and structured encouragement of exploration of novel environments and experiences (Bowlby, 1969). These relationships determine the child's 'internal working model' which may be regarded as a template for future relationships. Early relational experiences can determine whether someone has a secure, insecure or disorganised attachment style. The attachment style is adaptive and activated when the individual is under threat (Crittenden & Landini, 2011), but also when the

attachment figure is ‘inaccessible’ (Bowlby, 1969). It modulates anxiety, and is thought to remain stable over the course of a person’s life, although attachment ‘behaviours’ may change in relation to interpersonal experiences (Fonagy et al., 1996) and therapeutic interventions (see section below). Insecure and disorganised attachments, and attachment disorders can arise from early traumatic experiences of neglect, abuse and violence. In some circumstances attachment relationships are paradoxical, where the adult providing the secure base can also be the source of the abuse. This can lead to an ‘increasing dependency on the abuser’ (Holmes, 2001, p. 96), ‘incompatible working models’ (Bowlby) and a propensity to engage in abusive relationships later in life. This is particularly important for staff to consider when supporting women in medium secure services, with a high prevalence of insecure and disorganised attachment styles, who also may have a diagnosis of personality disorder.

Critique of Attachment Theory. Despite much support, Attachment Theory has not been free from critique. Attachment to the primary care giver in infancy may be supported by evolutionary psychology (to keep the child safe, and to provide social learning opportunities). However, some critics state Bowlby’s ideas regarding attachment are culture specific, referring to how the concept was formulated within Western contexts on children where the mother was often the primary care giver in an “atomized” family. The attachment model may therefore not fit all cultures such as where multiple members of a community take responsibility for the child (Burman, 2008). Furthermore, Winnicott (1960) felt that Attachment theory could be parent blaming, and whilst he agreed it was important for parents to show intimacy and consistency, he felt this was unrealistic to expect this all of the time and so proposed the concept of the “good enough” mother. Therefore, Attachment theory could be considered a social construction of the culture and dominant ideologies from which it was born.

Some developmental and social theorists have questioned the evidence for internal working models, and have challenged whether attachment styles are consistent through to adulthood thus determining adult behaviour (Mikulincer & Shaver, 2007). Research suggests attachment style can change in adulthood. This goes against Bowlby's proposition that early relationships determine later relational experiences, although it is important to state Bowlby was open to later protective good relationships, and did not see working models as fully and wholly deterministic of later working models. Other research has shown the consistency of attachment styles over the lifespan (Hazan and Shaver, 1994).

Harris (1998), a social psychologist, believes Attachment theory overemphasises primary caregiver relationships. Harris questions the validity of Attachment theory, referring to how the model of attachment is based on evidence gathered from 'momentary stressful situations' between the parent and infant, rather than routine everyday non stressful situations. Harris believes the environment and relationships encountered throughout an individual's life have equal, if not more bearing on the person's relational and personality development. Harris further suggests social behaviour is learned, she uses the example of how despite some individuals growing up in supportive and sensitive care giving environments they can be influenced by their peer relationships to make risky unwise decisions and form unhealthy relationships to others. Furthermore, Harris states that people may experience more influential relationships in their life than just their primary caregivers, such as friends, friends parents, and intimate partners for instance, which may all go on to influence an individual's relational style throughout their lives.

Bronfenbrenners (1979) Ecological Transactional Model of human development supports Harris's (1998) critique of Attachment theory. He considers how an individual's social and emotional development, their personality, and relationships are influenced by complex interweaving factors that form the context of the child's world, such as different environmental

systems and risk factors. This model suggests that it is not only the early caregiving relationship (parental values and beliefs) which is important for the developing child, but that relational and cultural influences continue and change across the lifespan. Both social models help explain how relationally adaptive some individuals become because of their social circumstances.

In women's secure care it will be important to consider whether the relationships patients have with each other, and staff have attachment related functions, and to consider whether their early relational experiences of attachment to their primary caregivers are predictive of attachment behaviours or whether relational adapting, learning and experiences can change relational patterns in later life. This to some extent would suggest that experiencing a supportive and consistent relationship in later life could create relational adjustment. Whilst it is important to remain open minded to these alternative theories I believe attachment theory offers a sound foundation of the importance of early attachment relationships, and relational patterns over an individual's life. Whilst Attachment theory is the main theoretical influence for this thesis, I hold other theories in mind. I now go on to explain how attachment theory is applicable to women's secure care.

Attachment theory in relation to women's secure care. In women's forensic services Attachment Theory is considered in relation to relationship disturbances and repair, care-seeking behaviour, and the importance of staff forming less dysfunctional attachments to those which women have come to know. Relational security puts forward that for women to develop, and recover, they need a safe and secure relationship. The staff member must offer a new relational experience, and help the women work through and repair therapeutic relational ruptures, thus contributing to the foundations of the secure base (Bowlby, 1969). This relational experience is then internalised into a securer sense of self. The staff/patient

relationship is used as a tool to provide psychological and emotional ‘containment’ (Bion, 1962), and to support the development of new relational templates and a ‘care-giver icon’ (Kraemer, 1992). Holmes (2001) suggests that in mental health services the secure base becomes a trusted member of staff, or the mental health service itself. The secure base offers a responsive and sensitive safe haven, where the patient can receive/seek support in times of mental distress.

Holmes (2001) notes “for people to form a trusting relationship- an external secure base - and then to internalise it so that they feel secure in themselves is a developmental as well as a cognitive process and, inevitably, takes time” (p. 6). The longer nature of admissions in women’s secure services means there is greater opportunity for the relationship to develop. However, because of previous abandonments and betrayals of trust, women may believe staff will be unable to meet their emotional needs, like others have failed to in the past. Alternatively women may test out the staff members ability to tolerate their ‘badness’ (Aiyegbusi, 2001), and reject staff attempts to interact, or feel unworthy of care and support (Clarke-Moore & Barber, 2009). Bowlby (1969) suggests that when an individual with an insecure attachment feels rejected they may attempt to avoid the ‘rejecter’, but also experience an intense desire for ‘proximity and care’ (p. 82). Furthermore insecure attachment styles, emotional dysregulation, and problems mentalizing often coexist (Fonagy et al. 2010). Aiyegbusi proposes that women “experience an intense desire for care, but at the same time fear care because psychic pain originating from earlier rejection and loss is associated with it” (p. 142). This may be indicative of the women’s attachment styles, which make it harder for women to develop and sustain therapeutic relationships with forensic staff. This is further complicated by the reactions of staff (Hinshelwood, 1999).

Like Holmes (2001), Adshead (1998) proposes that the forensic institution can act as a ‘positive attachment to patients and provide a secure base’ (p. 67). The ‘brick mother’ (Rey,

1994) provides a metaphor for the physical and psychological ‘containment’ provided by the forensic service. Despite this, admission to, or discharge from secure services may result in severe separation anxiety and stress for women (Bowlby, 1973). Particularly after long institutionalisation, where anxiety manifests in leaving the stable relationships women build up with staff, but also, because of lengthy admissions women become de-skilled and the transition to the ‘real world’ is frightening (P. Beazley, personal communication, 22nd July 2015). This anxiety may manifest as anger and aggression (Adshead, 1998), and an activation of insecure attachment styles, which can challenge the staff/patient therapeutic relationship. I will now go on to describe the concept of the therapeutic relationship.

The Therapeutic Alliance

A number of theorists have proposed different conceptions of the therapeutic alliance. With its foundation in psychoanalysis, the concept of the alliance was first referred to by Freud (1913). The most widely adopted concept of the alliance in psychotherapy is that of Bordin (1979) who re-constructed Greenson’s (1965) concept of the ‘working alliance’, which Bordin proposed as an ‘ingredient’ to the therapeutic alliance (Hovarth & Luborsky, 1993). Bordin’s tripartite model details how a therapist’s collaborative approach enhances the ‘attachment bond’ (relationship) between the client and therapist and strengthens ‘goal’ and ‘task’ attainment. For a more comprehensive understanding of the history of the development of the concept of the therapeutic alliance in psychotherapy see: Hovarth & Luborsky (1993); Safran & Muran (2000).

Despite the theory, the concept of the therapeutic alliance has been critiqued. For instance, Brenner (1979) challenges the concept of an alliance and instead proposes that the interactions between patient and therapist are based on ‘transference phenomena’. Omer (2000) challenges attempts to quantify or qualify the therapeutic relationship, or capture the

processes involved, instead proposing that there can be no one general conceptualisation. Safran & Muran (2006) propose that attempts to distinguish between the alliance and transference are unhelpful, and instead propose research should focus on how the therapeutic alliance contributes to 'change processes'. Despite the multiple constructions of the therapeutic alliance, the therapist/client relationship is key to most psychological approaches to therapy and is considered by some as the most contributory factor to therapeutic outcome (Charura, 2014). Most of the research into the therapeutic alliance is focused on the psychotherapist/client relationship, but more recently the focus has moved to include relationships in psychiatric services (MacInnes, Courtney, Flanagan, Bressington & Beer, 2014).

Therapeutic relationships in psychiatric services. The therapeutic relationship between staff and patients in psychiatric settings is different from that of the therapy room. For instance, the length of treatment is undetermined, staff spend more face to face time with patients because of their long shifts, and the patient will experience multiple relationships because of staff changes. Furthermore, frontline staff will support practical matters, tend to personal care needs, administer medication and spend more time 'socialising' with patients on the ward. Because of the debilitating nature of many mental health difficulties and the vulnerability that ensues, a service user's capacity, ability to protect themselves, and manage their mental health is compromised. It is therefore necessary for the staff member to assure the service user they are entering into a safe relationship where trust, confidentiality, predictability, reliability and consistency of care is present and maintained (Safran & Muran, 2000). As such frontline staff utilise the therapeutic relationship as a therapeutic tool (Aiyegbusi, 2004, Scanlon, 2006).

The health outcomes of the therapeutic relationship in psychiatric services have been supported in a number of research studies (Hovarth & Symonds, 1991; Martin, Garske &

Davis, 2000). In a grounded theory study on psychiatric nurses' perceptions of the therapeutic alliance, Scanlon (2006) found it was important for nursing staff to maintain a 'professional boundary' and "bracket opinions or biases formulated in their own lives" (p. 325). Dziopa and Ahern (2008) completed a literature review on 'quality therapeutic relationships' in mental health nursing. They found nine therapeutic relational constructs: "understanding and empathy, being genuine, being there, demonstrating respect, promoting equality, support, self-awareness and maintaining boundaries". They suggest nurses must hold in mind the potential for boundary crossings or violations, and recognise that an overly professional stance can act as a barrier to relationship formation. It is important to consider boundaries when working with women in forensic care, particularly those with a diagnosis of personality disorder whose early years have been marked with boundary violations (Norton, 2012).

Therapeutic relationships in forensic services. The Best Practice Guidance (DoH 2007) stipulates that the therapeutic relationship is fundamental to the treatment of patients in secure settings. Recent literature draws attention to the therapeutic relationship in reference to recovery models in secure care (Aiyegbusi & Clarke-Moore, 2009; Drennan & Alred, 2012), and supports the promotion of therapeutic relationships, which guide and facilitate relational security within secure women's services (Long, Fulton & Hollin, 2008; Birch, 2012). This is particularly important as the most common diagnosis of women in medium secure service is emotionally unstable personality disorder (Long, Hall, Craig, Mochty, & Hollin, 2011b).

Jeffcote & Travers (2004) propose that an understanding of women's relationships, both literal, and internalised representations, is crucial for staff to understand women in secure care. This understanding will ensure the staff team can function under the 'emotional demands' of the work. They further propose that women in secure settings don't necessarily have experiences of 'belonging' because of their experiences of 'abuse, deprivation and neglect'

(p.21). This can make it difficult for women to trust staff and can act as a barrier to the nursing task and therapeutic relationships. Furthermore, the nursing task involves frontline staff being aware of patients “conscious and unconscious communications of distress” whilst maintaining “boundaries in the face of pressure to transgress” (McMillon & Aiyegbusi, 2009, p.180). Moreover, frontline staff are expected to maintain high levels of professionalism, often when faced with women’s shocking aggressive acts towards self and others. As the literature reveals, the therapeutic relationship is believed to be imperative to women’s services, where recovery is enabled through the relational context.

The revised theory of the therapeutic alliance (RTTA). Ross, Polaschek and Ward (2008) (see Appendix A for diagram) propose a revised theory of the therapeutic alliance between client and therapist in secure populations. The model elaborates Bordin’s (1979) concept of the ‘working alliance’. The revision takes into account factors which may act as barriers to the formation of the therapeutic alliance in secure services.

Like Bordin (1979), Ross et al. (2008) suggest that goals and tasks are established collaboratively between the therapist and patient, and that therapist technique enables the development of the therapeutic bond. They extend the model to offending populations by incorporating systemic ‘external factors’ which can rupture or facilitate the relationship. Despite relating to forensic services, the RTTA model has limitations; it is ‘untested’, and relates specifically to the therapist/client relationship. The model also suggests the therapist uses their skills and professional knowledge to manage relational ruptures. However, as previously described the alliance between a therapist and patient is different to that between frontline staff and patients. Frontline staff, such as nurses and support workers, often do not have training on managing therapeutic ruptures to the same level as psychotherapists or psychologists. Moreover, forensic frontline staff are in close proximity to service users for

many hours a day; therefore ruptures are not contained within the confines of the therapy room. Furthermore, the relationship between frontline staff and forensic inpatients is often involuntary, and further complicated by the dual role of caring whilst maintaining safety, which can hinder collaboration.

Care/control dichotomy. Care is considered central to the role of healthcare staff and is often the reason staff enter the profession (Jackson & Borbasi, 2000). Frontline staff in women's secure services encounter conflicting roles described as the 'care control dichotomy', where they must balance the invasiveness of risk management whilst developing trusting relationships with patients (Aiyegbusi & Clarke-Moore, 2009). The requirement to maintain ward safety can prevent staff from offering their 'ideal' caring role, and can lead to relational breakdown (Clarke, 1996). Adshead (2012) highlights the power imbalance between psychiatric inpatients and psychiatric staff, where treatment is provided without consent. This can lead to "power disparities between psychiatric patients and professionals that can be exploited by either party" (p. 17).

Addressing relational ruptures. Bowlby (1988) proposed therapeutic ruptures and repair are necessary to develop a secure base. Safran, Crocker, Mcmain and Murray (1990) suggest that therapy that involves ruptures, which are subsequently worked through, is more effective than therapy without ruptures. However, forensic frontline staff, particularly support staff, may not have the knowledge and skills to manage the interpersonal challenges presented to them by the female forensic inpatients (Allen & Beech, 2010). Needham et al. (2005) refer to how psychiatric staff are faced with a double ethical dilemma of care and control, but also maintaining relationships to patients who pose a risk to the staff member's personal safety, or who have perpetrated aggression towards them.

Aggression in Healthcare

Multiple interchangeable definitions of violence and aggression are provided in healthcare research. Rather than differentiating the two, the definition used in this study is:

“Violence and aggression refer to a range of behaviours or actions that can result in harm, hurt or injury to another person, regardless of whether the violence or aggression is physically or verbally expressed, physical harm is sustained or the intention is clear” (NICE, 2015, p.15)

NICE (2015) recommends staff “establish a close working relationship with service users at the earliest opportunity and sensitively monitor changes in their mood or composure that may lead to aggression or violence” (p.15). Patient aggression towards frontline staff is a common occupational hazard, and can have significant and long term effects on staff and service users’ wellbeing, hospital milieu and quality of service user care (Arnetz & Arnetz, 2001; Hamrin, Iennaco & Olsen, 2009). Bowers, Nijman, Simpson & Jones (2011) completed a comprehensive literature review of aggression in inpatient services. The report included 424 studies on inpatient violence and highlighted the extent to which frontline staff, particularly forensic staff, are vulnerable to inpatient aggression at work. This could suggest that the therapeutic relationship is more vulnerable to impasses within forensic services.

Aggression in forensic settings. Forensic services can be frightening places to work (Adlam, Aiyegbusi, Kleinot, Motz & Scanlon, 2012). One of the more challenging tasks of forensic staff is to manage and prevent aggression and violence. This can set forensic nursing apart from general psychiatric nursing (Dickens, Piccirillo & Alderman 2013). In their cross-sectional study of staff experiences of aggression in a large forensic hospital Kelly et al. (2015) found over a period of one year 70% of staff were physically assaulted by patients. Broderick,

Azizian, Kornbluh & Warburton (2015) recorded aggression prevalence in a forensic psychiatric hospital between 2011 -2013, they found one third of patients were aggressive towards staff. However, 28.7% of assaults were perpetrated by only 1% of patients.

Interestingly, aggressive patients had longer admissions than non-aggressive patients, although the reasons for this were unclear. Knowles, Coyne and Brown (2008) carried out a study in both male and female secure wards in the United Kingdom. They found patients were more frequently aggressive to staff of the same gender, regardless of the gender ratio of staff present on the ward. These findings are important when considering staffing women's secure wards, where there is a high ratio of female staff.

Aggression in women's forensic services. Women forensic inpatients are not only the victims of violence but also sometimes the perpetrators. Kuivalainen, Vehvilainen-julkenen, Putkonene, Louheranta and Tiihonen (2014) reviewed incident reports of violence in a Finnish forensic hospital. A total 840 incidents were perpetrated by one fifth of the patients, with one patient being responsible for 181 incidents. One in four incidents were perpetrated by women inpatients. In contrast to this Nicholls, Brink, Greaves, Lussier & Verdun-Jones (2009) found women were just as likely as men to perpetrate aggression towards staff, and also have the same index offences. However, Sarkar and di Lustro (2011) suggest that women's violence is commonly interpersonal, where aggression is often directed at potential attachment figures, such as frontline staff. These findings suggest that when considering research on inpatient aggression it is imperative to consider whether the sample is skewed by a sub sample of more aggressive patients. However, the authors do not refer to a theoretical framework for establishing attachments. I will now present an overview of theories relating to aggression.

Theories on Aggression

To understand the impact of aggression on the therapeutic alliance it is important to consider psychological theories of aggression. The following psychological theories are not exhaustive, but those which I feel help to shed light on why women in medium secure services may be aggressive. Theories of aggression vary in their distinction between the precipitants, the origins of aggression, and how aggression is maintained. These theories help understand how the staff team may react to aggressive acts.

Attachment theory. Bowlby (1969) incorporates evolutionary and psychoanalytic theory into his understanding of anger and aggression. Proposing that anger in securely attached individuals is a functional reaction, and aggression is ‘distorted functional behaviour’. Bowlby proposes that violence is inter-generational, where ‘abused and rejected’ children go on to repeat the cycles of abuse they experienced. Bowlby (1973) proposed that the function of anger is to increase intimacy. It could be that women’s aggression is aimed to increase intimacy with certain staff by keeping others at a distance. However, sometimes aggression may alienate the staff member, despite this not being the intention. Adshead (1998) proposes that anger and violence can be triggered when the psychiatric inpatient feels the relationship to their attachment figure or care-giver is threatened. This can arise where “attacks may be made on offered care, either indirectly by sabotaging treatment plans, or directly by assaults on staff. This can lead to a rejection by staff and a termination of care” (p. 66).

Psychoanalytic/psychodynamic theory. There are a number of psychoanalytic and psychodynamic theories on aggression. I will briefly present the two theorists I feel are most relevant to this research; Sigmund Freud and Melanie Klein. Freud (1920) described aggression as a death instinct (Thanatos) or drive. Freud proposed every person has the

capacity to become aggressive to self and others, but aggression only occurs when an individual's threshold for anger, frustration or pain has been breached. Self-destruction is prevented through ego defences such as sublimation and displacement, where anger towards the self gets directed to others (Hartman, Kris, & Loewenstein, 1949). Because of their early abusive and violent experiences, the women's violent interactions could be representative of their abusive internalised objects (Klein, 1932). In her Object Relations Theory Klein proposed that life and death instincts were first experienced through the infants relationship to mother. Later relationships are based on the infants internal object (other) relations which determine the healthy mental health of an individual. Klein proposed aggression is an innate instinct, where the baby projects their loving or hating instincts as aggressive phantasies through attacking the 'breast' as the primary object. Through this the baby learns to internalise the loving nurturing object, and begins to manage its destructive impulses. If integration of 'good' and 'bad' objects is not achieved, the individual forms damaged internal objects which can result in disintegrated personality disorganization, such as in Emotional Unstable Personality Disorder. When this occurs the individual projects these 'bad' parts of themselves onto others. Although widely respected psychoanalytic explanations are difficult to test empirically.

Social cognitive theory. Social Learning Theory (Bandura, 1977) is a cognitive approach to understanding aggression. Bandura challenged the psychodynamic view on instinctual drives proposing instead that aggressive behaviour is learned through modelled aggression perpetrated by others. The theory suggests that people learn to be aggressive through reinforcing and punishing contingencies (Mason & Chandley, 1999). In certain groups, such as in forensic services women may modify their behaviour and 'acquire' aggression, to meet the social standards of the other patients, and aggression can maintain an individual's status.

Following aggression the perpetrator may experience “cognitive distortions such as blaming or dehumanizing the victim” (Gunn & Walker, p.212). This approach is not specific to women. However, women in secure care may have experienced and witnessed violence in their childhoods, and may have relied upon aggression to survive. The theory suggests that women can learn to be aggressive throughout their lives, including in forensic services. This results in women becoming desensitised to aggression, and viewing it as ‘normal’ behaviour. This theory places aggression in the social context, and supports social cognitive theories proposing aggression is functional and reactive to environmental factors. This theory suggests learning is facilitated through modelling, therefore, modelling non aggressive behaviour could modify the aggressive behaviour of women in secure care.

Impact of Aggression.

Aggression can have a myriad of impacts, including fear and hopelessness (Whittington & Sykes 1994), emotional exhaustion, post-traumatic stress disorder, burnout, and physical, emotional and psychological harm for staff, and demoralisation and trauma for both staff and service users (Bowers et al. 2009; Allen & Beech. 2010). In addition to the psychological, emotional and physical consequences of aggression, incidents of violence and self-destructive behaviours have been shown to compromise relationships in psychiatric nursing (McCabe & Priebe, 2004; Dziopa & Ahern, 2009). Cookson, Daffern & Foley (2012) found male patients with a “hostile-dominant interpersonal style” (p.26) had poor therapeutic relationships with staff. Compromised relationships can result in staff becoming critical and responding anti-therapeutically to the women, and believing patient’s actions are attention seeking and ‘manipulative’ (Bowers, 2003). The concept ‘malignant alienation’ (Watts & Morgan, 1994) describes how the therapeutic relationship is compromised with patients that are considered ‘manipulative’ and ‘hard to like’. In these situations staff can lose empathy with patients which

can result in patient alienation. Furthermore patient aggression can result in staff members questioning their competency as carers (Whittington & Sykes) resulting in cognitive dissonance and self-doubt. Cognitive dissonance may occur when staff attempt to avoid situations in conflict with their belief systems (Festinger, 1957), resulting in a motivational drive to alleviate the discomfort by changing their attitude and behaviour, towards patients, colleagues and their work in general. If these cognitive biases and relational changes are not addressed they may further exacerbate negative interactional patterns with patients, and staff burnout.

Nathan, Brown, Redhead, Holt and Hill (2007) compared levels of burnout in staff working in male and female medium secure wards. Over an 18 month period they found significantly higher levels of emotional exhaustion and burnout for staff on the women's, than the male ward. However, the wards were mainly staffed with staff of the same gender as patients, which could have confounded the findings. Terry (2014) completed a systematic review scoping 'educational interventions' aimed at reducing burnout in nursing and support care staff in secure services. The review found that when nurses begin to encounter burnout their attitudes towards patients including the therapeutic relationship suffer. Interestingly the review found psychosocial interventions were beneficial for nurses but increased emotional exhaustion in support care staff, suggesting that the supervisory and learning needs vary between the two groups of professionals. It will be important to consider this difference within the current study, which explores frontline staff perceptions of aggression and the therapeutic alliance.

Salias & Fenton (2000) found nurses in stressful situations tended to use restrictive strategies such as restraint, seclusion and medication rather than collaborative relational strategies. Meehan, Bergen, & Fjeldsoe (2004) reported service users perceive restrictive strategies as an unnecessary exertion of power and control with very little therapeutic worth. Interestingly Bonner, Gwen, Rawcliffe, Lowe & Wellman (2002) found both staff and patients

found restraint traumatic. Hinshelwood (2002) noted that when faced with high levels of distress in the workplace nurses can become task focused and risk averse, mechanical and uncaring in their interactions. A loss of empathy resulted in a limited understanding of the patients presenting problems, which in turn left patients feeling dissatisfied with their nursing experiences. This finding can be considered in light of social defence's theory (Menzies Lyth, 1960).

Social Defences Theory. Menzies Lyth (1960) describes how healthcare staff can struggle to work therapeutically with patients. In her seminal paper Menzies Lyth suggested that nursing staff develop a number of unconscious psychological defences in order to cope with the intolerable feelings of anxiety experienced when working in stressful healthcare settings. One of the defences Menzies Lyth reported on was how nurses limit contact with patients through avoidance strategies such as becoming task orientated. Adshead (2012) has written about social defences in forensic institutions. The defences entail nurses maintaining an emotional distance from patients to defend against “feelings of disgust, fear, hatred and excitement” (Adshead). Furthermore anxiety is defended against through the use of ‘immature’ psychological defences including ‘denial, splitting and projection’ (Menzies Lyth). Menzies Lyth felt that nurses and the healthcare organisation incorporated these defences into their practice to avoid the “conscious experience of guilt [and] uncertainty” (Adshead, p.103). However, the strategies are ineffective and result in nursing teams feeling unable to express the feelings arising in their work. This is important to consider when exploring the impact of women inpatient aggression which can create negative feelings in the frontline staff team. One further point to consider is that Menzies Lyth wrote about social defence's theory over 50 years ago. Healthcare has changed significantly since then and has become much more technologically and target driven. Furthermore, Menzies Lyth talks about nursing staff

defending against anxiety by being moved from ward to ward thus limiting contact with patients. This is fundamentally different to the experience of staff working in women's forensic services, where staff often work with the same women in the same ward for a number of years (Whittle, 1997).

Summary

It is important to consider aggression from a frontline staff perspective to understand how the forensic organisation can support staff and women forensic inpatients in the context of aggressive incidents. Attachment and Psychodynamic theories can provide understanding on the developmental trajectory of aggression for the individual, based on their relationships throughout childhood and adulthood. Social Learning Theory can enable a better understanding of how aggressive behaviours develop, and are maintained within the forensic organisation. Social Defence's Theory gives insight into how staff anxiety induced through working with women's challenging complex needs, including aggression, is defended against by frontline staff. In order to better understand the complex interpersonal processes occurring between forensic staff and women it will be necessary to further develop theory. Particularly in the field of women's medium secure services where very little research has been conducted.

Part 2: An Exploration of Staff Perceptions of Forensic Inpatient Aggression

This part presents a meta-ethnographic 'lines of argument' synthesis of qualitative research exploring frontline staff understanding and perceptions of forensic in-patient aggression.

Rationale for meta-synthesis. It is already known that forensic service models differ from alternative mental health inpatient services such as; in length of patient admission, the

complexity of presenting disturbance and mental health issues, and the level and history of violence. The presented literature details how the characteristics of women in secure care are different from their male counterparts.

A number of literature reviews have extensively examined staff experiences of patient aggression in a number of healthcare settings (Jansen, Dassen & Jebbink, 2005; Cornaggia, Beghi, Pavone & Barale, 2011). However this research is predominantly quantitative in design and not related specifically to the forensic setting. Finfgeld-Connett (2009) completed a qualitative meta-synthesis on aggression management in mental health settings. Only two out of 15 articles explored aggression in forensic services, and these were male services. The author recommends replication and further qualitative meta-synthesis to explore aggression in alternative healthcare settings. As far as I am aware this review is the first to synthesize qualitative literature which scopes the ways in which aggression in the forensic context is understood by forensic staff. Because of the paucity of literature relating to aggression in women's secure services, the review aimed to scope qualitative literature exploring staff perceptions and understanding of aggression in male or female forensic services.

Meta-synthesis. Qualitative meta-synthesis is attracting increased attention within nursing research (Bridges et al. 2013). It is utilised in the decision making processes on healthcare provision and can aid policy makers “to gain new insight into relevant patient and/or organisational aspects” (Ring, Ritchie, Mandava, Jepson, 2010, p. 5).

The underpinning tenet of meta-synthesis is to develop a ‘comparative understanding’ of the research (Noblit & Hare, 1988). One approach to meta-synthesis, amongst others, is the meta-ethnographic ‘lines-of argument’ approach (for other approaches see: Noblit & Hare). This approach adopts a holistic, inferential approach to analysis through constant comparative analysis of the articles, similar to that used in grounded theory (Strauss & Corbin, 1998). This

is aligned with the Interpretivist and Constructivist assumptions (Pound et al. 2005) which underpin this study. Noblit & Hare, propose a seven phase approach to meta-ethnography which I follow in this study (see Appendix B for details).

Aim. Through a meta-ethnographic synthesis I aim to produce a tentative explanatory model on forensic frontline staff perceptions and understanding of forensic inpatient aggression.

Search Strategy.

An advanced electronic database search took place between December 2014 and January 2015. The electronic resource EBSCOHost was accessed through the Tavistock and Portman NHS Foundation Trust Library. All inter library loans were requested through the University of Essex Albert Solomon Library. The databases searched included: CINAHL plus, PsycARTICLES, MEDLINE and PsycINFO.

The PICO method (Needleman, 2002) was initially used to complete a search of the literature. However, the PICO search retrieved around 7000 articles. To narrow the search the SPIDER tool (Cooke, Smith & Booth, 2012) was used, as it has been shown to have greater specificity than PICO (Methley, Campbell, Chew-Graham, McNally & Cheraghi-Sohi, 2014). The tool structured the search strategy, six concepts (broadened using related synonyms) were entered into the search:

SPIDER Search terms:

Sample (S): Forensic and frontline staff

Phenomenon of Interest (P of I): Experiences of patient aggression/violence.

Design (D): Interview or focus group

Evaluation (E): Lived experience

Research type (R): Qualitative

A number of key terms and synonyms related to the six concepts were combined using Boolean operators AND OR. Truncations and wildcards were employed to optimise and expand the search (See Table 1). Limiters extracted peer reviewed English articles, published 1980–2015 (inclusive).

Search results and extracted data. The search strategy located 708 (See Table 1) relevant qualitative articles relating to the review question. All 708 titles and abstracts were reviewed and read for relevance and suitability for inclusion. The inclusion and exclusion criteria (detailed below) were applied to filter and further extract articles from the 708 articles. The rationale for decisions relating to inclusion and exclusion criteria can be found in Appendix C.

Inclusion criteria: a) Peer reviewed articles, b) qualitative research published between 1980 and 2015, c) articles exploring forensic staff experiences of physical and non-physical inpatient aggression, d) forensic staff working in forensic adult (18-65) inpatient settings, e) all papers were included regardless of methodological limitations.

Exclusion criteria: a) research in non-forensic inpatient settings (e.g. general hospital, emergency room, PICU), b) research primarily exploring restraint and seclusion, c) patient aggression related to self-harm, para-suicide or suicide, d) horizontal workplace aggression, e) articles specific to older adult/ elderly and child or adolescent services, f) aggression specifically related to alcohol and drug use, g) articles not written in English, h) retrospective incident/patient file review, I) grey literature, literature reviews, dissertations and theses.

Application of the inclusion and exclusion criteria resulted in the selection of 35 related articles. From these 35 articles, ten were requested through the inter-library loan service as they were unavailable through the electronic library. After the inter library loan articles were made available the total 35 articles were read in full. Reference lists were checked using a snow-balling technique to source additional articles not retrieved through the database search; one further article was identified and included.

Since the review aimed to extract all relevant articles relating to forensic frontline staff experiences of patient aggression, a hand search was completed on a number of reputable journals; *Journal of Psychiatric and Mental Health Nursing* (1997-2015), *Journal of Advanced Nursing* (1928-2015), *The Archives of Psychiatric Nursing* (1990-2003), *Aggression & Behaviour*, *The Journal of Forensic Psychiatry and Psychology* (1990-2015), *Journal of Forensic Psychology Practice* (2000-2014), *International Journal of Forensic Mental Health* (2002-2015). This search failed to identify any further articles.

From the total 36 articles, a total of 27 articles were rejected. This left nine qualitative articles (see Figure 1: Flow chart of article selection process) exploring forensic inpatient aggression from a staff perspective. I contacted the authors of the nine extracted articles, authors of relevant literature reviews and other experts in the field were consulted by email. Communication with Professor Deborah Kindy identified one further article (see Appendix D).

The final ten articles exploring staff experiences of aggression in forensic inpatient services are arranged in chronological order in the literature matrix (Table 2).

Quality Appraisal.

The critical appraisal process involves “systematically examining research evidence to assess its validity, results and relevance before using it to inform a decision” (Hill & Spittlehouse, 2001, p.1). With over one hundred qualitative appraisal tools, there is no common consensus regarding quality appraisal of qualitative research (Noyes, Popay, Pearson, Hannes & Booth, 2008). However, in meta-synthesis it is considered best practice to include ‘all’ relevant studies, where the synthesis filters out methodologically weaker research (Sherwood, 1997).

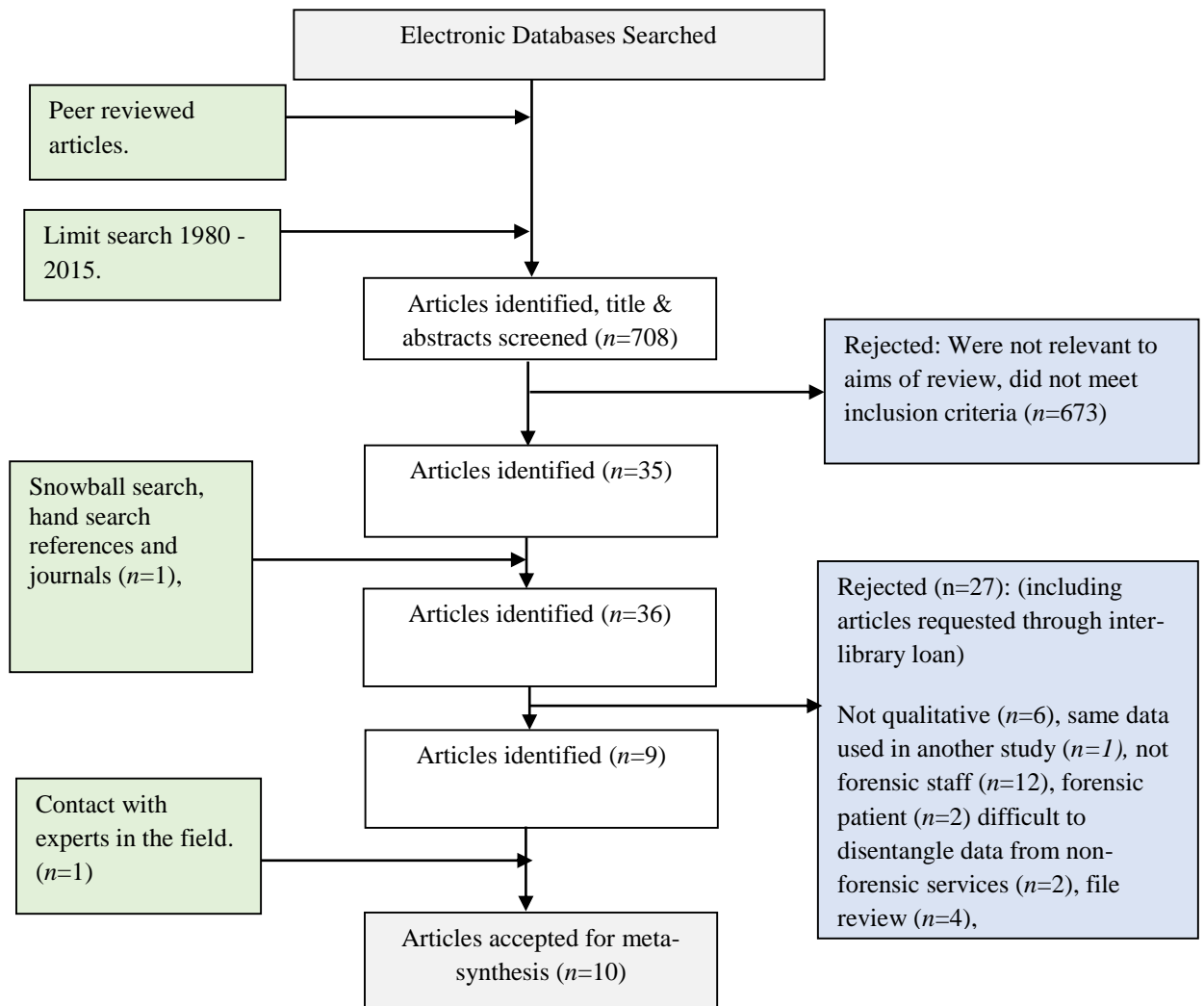
All included articles were peer reviewed and appraised using the Critical Appraisal Skills Programme (CASP) tool (2010) (See Appendix E). A colleague and I appraised five articles to address inter-rater reliability. I completed the appraisal of the remaining articles independently. The quality appraisal was completed to benefit the reader’s interpretation of the final synthesis.

Table 1: Key Terms for SPIDER Search Strategy

Search	Search terms	Total Search results	MEDLINE & CINAHL Plus*	PsycINFO & PsycARTICLES*
S(P)	RMN OR RMHN OR RPN OR mental health nurs* OR staff* OR nurs* OR psychiatric nurs* OR MHN OR mental health prof* OR support worker* OR healthcare assistant* OR inpatient nurse* OR inpatient staff OR forensic nurs*	639572	503542	136030
S(P)	in-patient* OR acute* OR forensic* OR inpatient* OR ward* OR psychiatri* OR secure* OR medium secur* OR low secur* OR high secur*	913230	287556	625674
Pof I (I)	Hostil* OR aggress* OR violen* OR incident* OR physical a* OR aggress* beh* OR attack* OR verbal a* OR intimid* OR assault* OR threat* OR safety	359572	151983	207589
D	interview* OR focus group* OR case study OR observ*	711629	274146	437483
E (O)	view* OR perce* OR understand* OR experience* OR OR attitude* OR feel* OR belie* OR opinion* OR thought* OR expos*	1304499	353692	950807
R	Qualitative OR mixed method*	136198	66407	69791
#	S AND S AND PofI AND D AND E AND R	708	365	343

= Limiters: Peer reviewed literature; published 1980–2015.

Figure 1: Flow Chart of Article Selection Process in Metasynthesis.



Flow chart adapted from PRISMA (Moher, Liberati, Tetzlaff & Altman, 2009)

Table 2: Summary of Final Articles Selected for the Meta-Synthesis.

	First author	Location	Aim	Participants	Setting	Data Collection	Method of Analysis
1	Trenoweth, (2003)	United Kingdom	To explore “how mental health nurses make risk assessments in clinical crisis situations where there is a perceived likelihood of imminent violence.”	10 senior clinical mental health nurses	Secure mental health environment	SSI	Grounded Theory
2	Hinsby (2004)	Outer London, United Kingdom	To explore “how patients and nurses describe violent incidents? What categories of analysis may be observed in their accounts?”	4 M nurses (and 4 M patients)	Forensic MSU	SSI	Triangulation: Grounded Theory and Discursive Approach
3	Kindy (2005)	Canada	To explore “the lived experience of registered nurses working in an environment where assault is a continual threat?”	10 registered nurses (4M, 6F)	State Forensic Hospital	Open ended interviews	Phenomenological analysis
4	Duperouzel (2008)	United Kingdom	To explore “staff management of imminent aggression”.	1 nurse, 5 support workers (3M, 3F)	MSU ID	SSI	Grounded Theory
5	Allen (2010)	United Kingdom	To explore “nursing staff judgements about female patients’ violence risk level”.	14 inpatients 17 nursing key-workers	30-bed MSU women	SSI	Template Analysis Approach

Personality Disorder Unit(PDU); Medium Secure Unit (MSU); Intellectual Disabilities=ID;M=male; F=female; Semi-structured Interview=SSI
 Summary of Final Articles Selected for the Meta-Synthesis.

	First author	Location	Aim	Participants	Setting	Data Collection	Method of Analysis
6	Jacob (2011)	Canada	To explore “how fear influences nurse-patient interactions”.	14 Registered nurses, 4 Registered Practical nurses (5M, 13F)	Forensic inpatient MSU	SSI	Grounded Theory in a sequential fashion
7	Kurtz (2011)	United Kingdom	The “exploration of staff experiences on MSU and PDU”.	13 nurse, other (5M, 8F) 12 PDU nurse, other (5M, 7F)	MSU & PDU in MSU	In-depth interview	Grounded theory
8	Tema (2011)	South Africa	To explore “psychiatric nurses lived experiences of hostile behaviour of patients in a forensic ward?”	9 Psychiatric nurses (2M,7F)	Male forensic ward	In-depth phenomenological interviews	Tesch’s open coding method
9	Wright (2014)	England and Wales	To identify “nursing staff and patients attitudes to the management of violence and aggression”.	8 M patients 10 staff (7M,3F)	Three forensic high security facilities	SSI	Thematic Analysis
10	Maguire (2014)	Victoria, Australia	To explore “the practice of limit setting for management of aggression”.	12 nurses (5M,7F) 12 patients	116-bed forensic hospital	SSI	Thematic analysis

Personality Disorder Unit (PDU), Medium Secure Unit (MSU); Intellectual Disabilities ID; M=male; F=female; Semi-structured Interview=SSI

The Process of Synthesis.

Synthesis was achieved through a ‘lines-of-argument’ analysis. The themes detailed in each of the articles were extracted into a table (See Appendix F). I extracted codes (metaphors, common themes and concepts) from each of the articles into a bespoke template in a word document. I took notice of any patterns and themes, but also discrepancies, and inconsistencies in the studies.

In meta-synthesis the focus is not on reinterpreting the first order constructs such as the data taken from interviews (participant quotes) (Weed, 2005). Instead second order constructs (the author’s interpretations of the participants’ quotes) extracted from the results and discussion sections are treated as the raw data. This process involved going back to the articles and the code table to identify ‘heterogeneity and contrasting findings’ (Noblitt & Hare, 1988) within and between the second order constructs. This constant comparison between the studies resulted in concept development (see Appendix G).

Results of Synthesis.

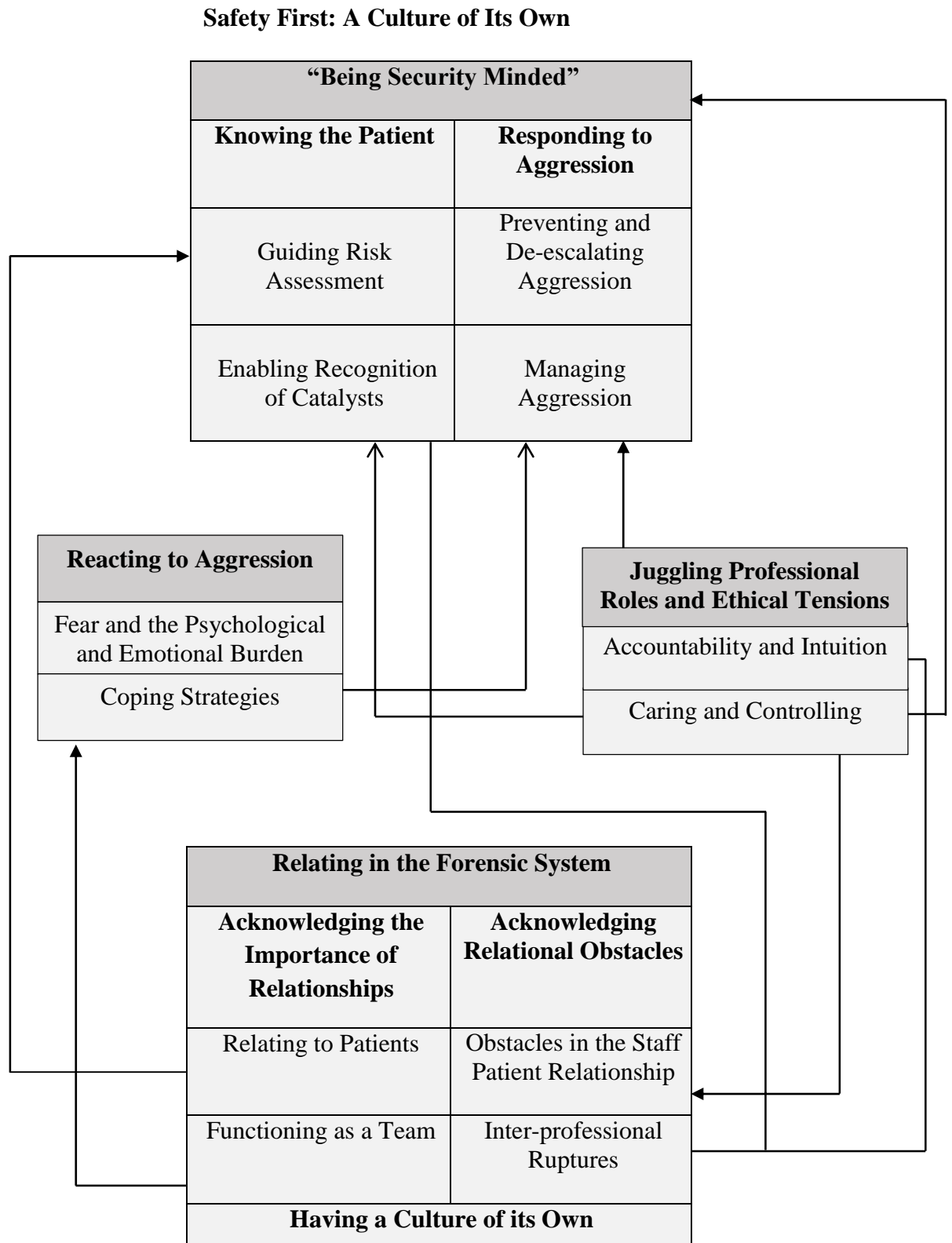
Ten qualitative articles of differing quality, objectives, methods and analysis were included (See Figure 1 and Table 2). The data analysis techniques included: Grounded Theory ($n=5$), Thematic Analysis ($n=2$), Phenomenological Analysis ($n=1$), Template Analysis ($n=1$) and Open Coding ($n=1$). Six of the studies were conducted in the United Kingdom, the remainder were conducted in Canada ($n=2$), South Africa ($n=1$) and Australia ($n=1$). A total of 121 staff members took part as research participants, including nurses ($n=75$), support workers ($n=5$), keyworkers ($n=17$) and unspecified staff ($n=24$). Six of the studies interviewed nurses only. Six of the studies detailed length of experience of frontline staff, this ranged from 2-34 years. Four studies reported the age of participants, this ranged from 20-60 years. Four of the studies explored both staff and patient perspectives, although only the staff perspective was

carefully extracted and included in the synthesis. The research was conducted in different levels of forensic services (see Table 2). This included medium secure units ($n=5$), a high secure unit ($n=1$) and other forensic units ($n=4$). The services were gender were predominantly male services ($n=9$). All of the articles refer to the service users as patients ($n=10$). Only one article, Kindy (2005), provides a definition of aggression for the purposes of the research.

Safety First: A Culture of Its Own.

The overarching model encapsulating the second and third order interpretations is titled 'Safety First: A Culture of Its Own'. This reflects the interlinking constructs relating to the management of risk and relationships in the forensic system. Four dominant third-order constructs: 1) Being Security Minded; 2) Relating in the Forensic System; 3) Reacting to Aggression; 4) Juggling Professional Roles and Ethical Tensions, and second order interpretations are summarised below. Throughout the results I will refer to each article in the name of the first author only.

Figure 2: Diagrammatic Depiction of Overarching Model.



Being Security Minded

Knowing the patient

Guiding risk assessment. Eight of the articles emphasised the importance of staff gathering information on the patient to inform working practice and decisions about risk of aggression (Allen, 2010; Duperouzel, 2008; Hinsby 2004; Jacob, 2011; Kindy, 2005; Kurtz, 2011; Trenoweth, 2003; Wright, 2014).

Nurses sought to understand their patient's psycho-social and offending histories to facilitate violence risk assessment (Allen, 2010; Trenoweth, 2003). Past history of violence and substance misuse (Allen, 2010), "prior to or proceeding their admission" (Trenoweth, 2003) and aggression occurring in hospital (verbal, physical and property damage), including previous incidents witnessed by staff, were considered predictors of current risk of aggression. Some staff found it difficult to comprehend the duality of both patient vulnerability and their aggressive potential (Kurtz, 2011), and others found knowledge of a patient's history 'contaminated' their opinion of the patient (Jacob, 2011). In some cases violence was described as internal to the patients, related to personality traits (Allen, 2010) or the "patient's identity" (Wright, 2014).

Some of the articles referred to how staff choice of intervention was influenced by patient diagnosis (Allen, 2010; Trenoweth, 2003); predicted patient behaviour, and facilitated understanding of patients past and current risk history, and their pathway into forensic services (Trenoweth, 2003). Staff conceptualised mental illness and personality disorder as distinct (Allen, 2010; Hinsby, 2004; Jacob, 2011; Trenoweth, 2003), where mental illness required 'compliant' treatment with medication to reduce violence risk (Allen, 2010). Patients presenting with psychosis (Wright, 2014), 'particularly with paranoid overtones' were considered a higher risk of violence, than patients with a diagnosis of personality disorders (Allen, 2010; Trenoweth, 2003). 'Out of control' behaviour (Hinsby, 2004), emotional

instability, and impulsivity were thought to elevate risk of aggression (Allen, 2010; Kindy, 2005). Mental illness was associated with ‘out of control’ behaviour and personality disorder with ‘in control’ behaviour. The aggressive tendencies of patients ‘in control’ were “described as premeditated, selective, purposeful, and manipulative”, and those ‘out of control’ required controlling (Hinsby, 2004).

Enabling recognition of catalysts. The recognition of catalysts of aggression was mentioned in seven of the articles. Knowing the patient enabled staff to notice the ‘catalysts’ for aggression (Allen, 2010; Hinsby, 2004; Kindy, 2005; Trenoweth, 2003; Wright, 2014). There was no single easily identifiable trigger but a combination of internal and external contributing factors (Hinsby, 2004; Kindy, 2005; Trenoweth, 2003). Allen (2010) found nursing key workers felt patient “extroversion and optimism” acted as protective factors. Some felt aggression was ‘unpredictable’, which hindered prevention and staff understanding (Hinsby, 2004; Tema, 2011). Whereas Wright (2014) reported staff attitudes could trigger aggression. Hinsby, (2004) found nurses struggled to mentalize with or ‘understand the patient’s perspective’ or their motivations for their aggressive behaviour. At times staff members appeared responsible for instigating aggression. Kindy, (2005) reported staff antagonising patients. In contrast to this Duperouzel (2008) found staff attempts to understand the “reasons for the client’s behaviour, in order to appreciate the problem and to try to help the person to calm down”. However, this study included participants identified as “superior in the management of violent and aggressive individuals”.

Restrictive practices increased the likelihood of aggression occurring on the wards (Allen, 2010; Hinsby, 2004; Kindy, 2005). Nurses believed that a loss of autonomy through forensic detainment contributed to aggression including; reactions to authoritarian care

(Maguire, 2014) and “anger at involuntary detention...the mental health or legal system, enforcement of medication or refusing permission to leave the ward” (Trenoweth, 2003).

Responding to Aggression

Preventing and de-escalating aggression. Prevention of and de-escalation of aggression was mentioned in eight of the articles. Aggression prevention measures were widely understood to protect staff and patient wellbeing (Duperouzel, 2008). Prevention involved providing ward activities to alleviate boredom (Wright, 2014), ‘tuning in’ to the more subtle cues related to changes in patient presentation, non-verbal communication and the wishes and needs of their patients (Trenoweth, 2003), which is related to ‘knowing the patient’. This occurred once the staff team felt they had developed a ‘good relationship’ with the patient, and a patient’s compliance with medication were thought to reduce the risk of incidents (Allen, 2010). However, Hinsby (2004) felt “nurses’ accounts lacked any talk about prevention” and were highly dependent on policy and procedure which directed their responses to aggression. Having ‘knowledge’ (of a patient) was thought to be a “protective factor”, and increased staff ‘confidence’ to “undertake nonphysical interventions” (Allen, 2010).

Staff paid attention to their proximity to patients and monitored them “from a safe distance” (Jacob, 2011). A particular style of verbal communication was incorporated to deescalate aggression. Humour was sometimes used by “the nurses to negotiate when discussing difficult topics” (Duperouzel, 2008). Staff attempted to empower patients by offering a ‘get out clause’ where patients could consider an alternative outcome involving diffusion of the situation. Furthermore, patient’s knowledge and insight into their mental health, developed through psycho-education (Allen, 2010), and working as a team (Kindy, 2005; Tema, 2011; Trenoweth, 2003) were seen as a protective factor preventing aggression.

Gender contributed to ward safety and Wright (2014) suggested that female staff were more effective in reducing aggression than male staff. Despite this Tema (2011) found that young female staff were more often the victims of 'sexual harassment' from male patients. Wards were more unsettled when male staff were not working, suggesting that a gender balance amongst staff was a significant factor in reducing aggression, where a male staff authoritative approach, and female staff soft/maternal presence complimented each other (Jacob, 2011; Tema, 2011).

Managing aggression. The management of aggression was mentioned in nine of the articles. Jacob (2011) found nurses managed aggression risk through ensuring security measures were in place; "being security minded" was the main focus of their forensic nursing practice. A number of strategies were used to manage aggression, including physical security (Jacob, 2011), working as a team (Kindy, 2005; Trenoweth, 2003), staff/ patient relationships (Allen, 2011), surveillance (Hinsby, 2004; Jacob, 2011), patient restraint, seclusion, medication and limit setting (Maguire, 2014), and use of intuition (Duperouzel, 2008).

Successful management of a threatening situation depended on professional knowledge and experience (Kindy, 2005) and staff gender (Wright, 2014). Despite aggression resulting in staff feeling shaken and afraid, they presented a 'façade' of calm competence and confidence, which was crucial in managing aggression, and influencing the patient's perception of the staff member's ability to contain the situation (Duperouzel, 2008; Jacob, 2011).

Forensic staff developed skills for aggression management over the course of their career (Jacob, 2011), but often felt under skilled (Tema, 2011). Hinsby (2004) reported that violence management strategies were undeveloped, with the exception of resorting to restraint, and although staff were aware of limit setting processes, they had not heard of the actual term. When staff felt ill equipped to deal with aggression they resorted to more restrictive practices,

such as; medication use (Kindy, 2005), authoritarian limit setting which “had negative connotations of control” restraint and seclusion, and higher levels of surveillance (Maguire, 2014).

Relating in the Forensic System

Acknowledging the importance of relationships:

Relating to patients. The importance of patient and staff relationships were mentioned in seven of the studies (Allen, 2010; Duperouzel, 2008; Hinsby, 2004; Jacob, 2011; Kurtz, 2011; Trenoweth, 2003; Wright, 2014). Allen (2010) found some nurses referred to the term ‘alliance’, others referred to “positive regard, trust, honesty, safety, stability which provided a therapeutic alliance”. A good relationship protected against assault, reduced the risk of aggression and increased staff confidence in managing aggression (Allen, 2010; Trenoweth, 2003). The staff-patient relationship was considered ‘pivotal’ (Jacob, 2011) to patient care and the “development of rapport with patients aided communication” (Duperouzel, 2008) and compliance (Allen, 2010). Wright, (2014) found a good relationship was dependent on staff approaches that were “demonstrating fairness, respect and consistency”. Staff exerted much effort in ensuring the relationship was authentic, reciprocal and based on ‘trust’ (Jacob, 2011). The “right attitude” (Wright, 2014), “trust, honesty and stability” and “staff confidence” were considered important for the therapeutic relationship, which in turn enhanced the patients compliance with treatment (Allen, 2010). Trust took time to develop, and involved working in partnership and empowerment (Duperouzel, 2008). However, the requirement for safety was sometimes prioritized over relationships with patients (Hinsby, 2004). Only Allen (2010), in their study in a women’s forensic service, mentioned tripartite security and relational security, which acted to protect staff.

Functioning as a team. Team working was mentioned in six of the articles. A successful team approach involved availability, cohesiveness, experience and knowledge, and required a mixed gender staffing (Kindy, 2005; Tema, 2011; Trenoweth, 2003). Relationships with direct colleagues and multidisciplinary colleagues were viewed both positively and negatively (see inter-professional ruptures). The staff team used their colleagues for support (Allen, 2010; Jacob, 2011; Trenoweth, 2003), including “in everything from direct work with patients, through talking through complicated clinical issues, to dealing with external agencies” (Jacob & Holmes, 2011). Feeling supported by colleagues aided confidence in working with aggressive patients. Staff members felt ‘responsible; for their colleague’s safety and wellbeing, and supported staff who blamed themselves for not preventing aggression (Duperouzel, 2008).

Acknowledging relational obstacles.

Obstacles in the staff patient relationship. Relationship challenges were mentioned in six of the articles. The challenges were found to relate to ‘othering’ processes (Jacob, 2011), breached trust as a consequence of hostility and bullying by patients (Jacob, 2011; Kurtz, 2011; Tema, 2011), and authoritarian nursing styles which patients found disrespectful (Maguire, 2014). Staff stereotyping patients could hinder the therapeutic relationship (Jacob, 2011). Furthermore, Jacob (2011) and Hinsby, (2004) reported nurses incorporated a paternalistic model of care, where patients were positioned at the bottom of the hierarchy of knowledge. Duperouzel (2008) reported that staff felt that although patient aggression “let them down....this did not ultimately lead to a loss of trust”. In contrast to this Jacob (2011), Tema, (2011) and Kindy, (2005) reported that patient aggression led to a mistrust and suspicion of patient motives by staff. Staff were hopeful for patients (Tema, 2011), but sometimes questioned patients motives for engagement, expressing suspicions of their seemingly

disingenuous interactions (Allen, 2010). Despite encountering ruptures, Jacob (2011) and Kurtz (2011), reported staff felt proud when they had overcome relational obstacles.

Inter-professional ruptures. Inter professional ruptures were mentioned in four of the articles. Sometimes ruptures appeared in staff relationships resulting in the exclusion of staff (Jacob, 2011), and staff feeling blamed, held accountable and ‘punished’ by colleagues, and splits were recognised in the team (Kindy, 2005). Staff often reported feeling undermined by their colleagues (Kurtz, 2011). Tema (2011) described staff experiences of feeling ‘marginalised’ and ‘ignored’ by management in their pleas for support with aggressive patients. Kurtz (2011) reported staff felt that management were focused on outcomes rather than having a “human focus”. Differences in staff opinion related to “unwarranted decreases in medicines, not following the treatment plan, (un)cooperation with staff splitting, slow responses to emergency situations, professional elitism, limited availability, and disrespect for ethnic, racial, and gender issues” (Kindy, 2005).

Forensic service having a culture of its own. The forensic service culture was mentioned in five of the articles. Staff held mixed opinions about wider organisational relationships but in the main the forensic institution was denoted by negativity (Hinsby, 2004; Jacob, 2011; Tema, 2011; Wright, 2013). Staff described a sense of isolation and feeling ostracised from community services (Wright, 2014). Forensic services were considered as having “its own culture of violence” in comparison to other healthcare settings, where aggression is tolerated as part of the forensic staff role (Hinsby, 2004; Tema, 2011). Staff felt unsupported by the forensic establishment, disempowered and dictated to (Hinsby, 2004). The forensic environment was described as “closed and deeply absorbing” (Kurtz, 2011). Despite this, the predictability of the establishment created a “sense of ‘order’ and routine” (Wright, 2014).

Reacting To Aggression

Fear and the psychological and emotional burden. Reference was made to staff experiences of fear and the psychological and emotional toil of working with inpatient aggression in seven of the articles. Tema (2014) reported staff were afraid of patients, and the emotional aftermath of aggression (Jacob, 2011; Kindy, 2005). Some staff considered the longer-term professional and financial repercussions of being injured (Kindy, 2005). Jacob (2011) revealed how nurses experienced fear in relation to potential aggression. Where aggression impacted on self-worth, beliefs about self-competency and job satisfaction, staff members felt demoralised, angry, traumatised and confused following aggressive incidents. In contrast to this, Kurtz (2011) found staff minimised violence. Instead fear was experienced in relation to the staff member's colleagues' failure to provide 'emotional safety'.

Tema (2011) reported details of the emotional repercussions of working with aggression, where verbal abuse affected "the personal worth and dignity" of staff and their quality of life and relationships inside and outside of work. Some articles reported staff describing post-traumatic like symptomology including emotional exhaustion, nightmares, insomnia, flashbacks (Tema, 2011) and hypervigilance, emotional 'shut down' and withdrawing from patient contact (Kindy, 2005). Kindy (2005) reports staff struggled with returning to work following the incident and having to face the assaultive patients, this resulted in staff searching for new jobs. Furthermore, staff reported feelings of guilt and self-blame for not protecting colleagues (Allen, 2010).

Coping strategies. Three articles described staff avoiding burnout and stress caused by working with aggression by 'suppressed emotions' and withdrawing from patient contact (Jacob, 2011; Kindy, 2005; Tema, 2011). Staff psychologically prepared themselves for work, and were 'different' people in their professional and personal lives. They used their colleagues

for emotional support as formal spaces were unavailable (Tema, 2011). Post aggressive incident support was unavailable and staff were often afraid to return back to the ward where the violence occurred (Kindy, 2005). Nurses rationalised aggression as caused by illness and in doing so failed to deal with their frustrations. They also used maladaptive coping strategies such as self-defence, smoking and alcohol to cope with the stress of working with forensic patients (Jacob, 2011).

Juggling Professional Roles and Ethical Tensions

Accountability and intuition. Four of the articles reflected staff perspectives on accountability and using professional intuition. Kindy (2005) felt staff were often unable to rely on the procedures in place to manage aggression and instead reverted to nursing intuition, a ‘gut feeling’ and person centred skills. Nurses were able to quickly and intuitively personalise their intervention based on their knowledge of the patient, whilst also considering situational factors (Trenoweth, 2003). However, drawing on professional experience, flexing the rules and using nursing intuition was discouraged, and staff members felt great anxiety regarding their accountability when managing aggression and autonomous decisions which “carried greater potential risk of blame” (Hinsby, 2004). To minimise the risk of blame staff utilised the most restrictive practice, which in turn risked ruptures in the therapeutic relationship (Tema, 2011).

Caring and controlling. The nursing role was referred to in seven of the articles. This was complicated by the requirements of offering therapeutic person centred care whilst maintaining safety, where the responsibility to maintain safety was paramount (Jacob, 2011; Kindy, 2005; Kurtz, 2011). Some staff experienced tensions related to their professional identity, responsibilities and limits on their approach to care, because of having to maintain their own safety (Kindy, 2005). Hinsby (2004) found nurses were highly reliant on policy and

procedure, and more senior nursing staff were dissatisfied with their lack of client contact (Kurtz, 2011). The focus on offending within forensic services meant “being security minded is a central element of psychiatric nursing” and nursing was done from “a safe distance” (Jacob, 2011). Nursing practice was thought at risk of becoming purely functional and institutionalised, and if safety wasn’t achieved then care was compromised. Allen (2010) felt “coercive strategies were often used by nursing key workers to engage patients who lacked motivation”. In contrast to this, Kurtz (2011) found staff felt patient centred care was their primary focus, where the reduction of risk held less precedence.

Hinsby (2004) suggest both patients and staff use strategies to exert their control over one another. This was complicated by nurses struggling to empathise with patients and sometimes adopting a punitive approach (Jacob, 2011). Staff felt being in control of ward safety took precedence over the caring aspect of their job (Hinsby, 2004; Jacob, 2011). However, there is some inconsistency in opinion as Maguire (2014) found that staff struggled to be imposing and controlling which was associated with limit setting rather than reinforcing positive behaviours.

Summary

The synthesis resulted in the model ‘Safety First: A Culture of Its Own’. The model encapsulates how safety is often maintained as a priority in forensic services, at times over the therapeutic relationship. Four dominant themes and sub themes with multiple interacting processes were identified.

This metasynthesis of qualitative literature on staff understanding of inpatient aggression, was mainly conducted in male services with the exception of one article exploring female aggression. The articles encapsulate how frontline staff are required to judge risk, and manage forensic inpatient aggression, whilst also battling with ethical tensions relating to their professional role, including caring whilst maintaining security. A number of articles referred to

staff wellbeing, including how staff often work in fear of aggression, feel unsupported by management and feel alienated within the forensic institution. Many of the articles referred to staff prioritising ward safety which sometimes jeopardised relationships with patients. Furthermore, feeling unsafe meant staff maintained a 'safe distance' from patients, both in a physical and relational context. This is concerning if the relationship is a predictor of therapeutic outcome and used as a tool to manage aggression. It was felt that without ward safety the relationships between patients and staff would be compromised. Interestingly staff used their relationships with patients to manage aggression, which was seen as a protective factor preventing aggression.

Only one article (Allen, 2010) explored women's secure service staff perspectives on judgements of violence risk. Although relationships were not the primary focus of this study, in women's services they were seen to protect against violence. Although a majority of the articles mentioned relationships with patients it is unclear how staff personally perceive aggression, and how the experience of aggression impacts on the therapeutic relationship. There is a scarcity of qualitative literature exploring female inpatient aggression in women forensic inpatient services, particularly medium secure services, and in the context of relationships. I propose that this area requires further study.

Justification for present study. The literature highlights the importance of forensic staff fostering strong therapeutic relationships with women in secure services. However, challenges to, and ruptures within the therapeutic relationship have been associated with aggression in service user settings (Allen & Beech, 2012; Beauford, McNiel & Binder, 1997, Jacob & Holmes, 2011; Kurtz & Jeffcote, 2011; Tema, Poggenpoel & Myburgh, 2011). This is of concern considering the therapeutic alliance is reported as the most important contributing factor to therapeutic outcome, and the relational aspect of care is greatly emphasised in

women's secure services. Martin and Daffern (2006) state research into inpatient aggression has changed direction, focusing more on interpersonal and systemic factors, rather than features internal to the patient. This shift in focus has motivated the current research's exploration of aggression and the therapeutic relationship.

Ross et al. (2008) proposed a revised model of the therapeutic alliance in offender populations. However, one might argue that the therapeutic relationship between female service users and frontline-staff has different parameters than that of male service users. The theory is lacking in relation to how frontline staff perceive the therapeutic relationship and negative interactions such as involvement in women's forensic inpatient aggression. Considering this, there is an evident need for a coherent theory that considers aggression and the complexities of relationships, and the interpersonal dynamics between women forensic inpatients and staff. Such a theory could be used to inform forensic practice. This study examines frontline staff perceptions of inpatient aggression and the therapeutic relationship in women's medium secure services.

The Main Research Aims and Questions:

The Research Aims:

1. To gain a deeper understanding of how forensic frontline staff perceive aggressive incidents occurring in women's medium secure services.
2. To gain a deeper understanding of how forensic frontline staff perceive therapeutic relationships with service users following an aggressive interaction.

The Research Questions:

1. How is the therapeutic relationship perceived by forensic frontline staff supporting women in secure services?

2. How do forensic frontline staff perceive female service user aggression?
3. How do staff perceive the therapeutic relationship following an aggressive interaction?

Chapter Two: Philosophical and Methodological Framework

Overview of Chapter

This chapter presents an overview of the philosophical and epistemological considerations which steered the methodological framework of the study. I will refer to myself in the first person throughout the final chapters (Webb, 1992). This chapter is split into four parts:

Part 1: An overview of the epistemological and ontological positioning of the research, including methodological decision making

Part 2: Describes the method, including: Information on the study procedure, participant sampling, recruitment, data gathering, and the data analysis process.

Part 3: Describes issues relating to data confidentiality, ethical considerations and quality assurance procedures regarding trustworthiness, rigour and integrity.

Part 4: A statement of reflexivity explains my personal and clinical experience in relation to the research topic.

Part 1: Methodology

Considering Philosophical Assumptions

Before embarking on the research process one must consider the philosophical assumptions relating to how knowledge is discovered and understood. In order to evaluate research it is important to consider both the ontological and epistemological assumptions which frame the research. I therefore provide the reader an account of the guiding philosophical assumptions which underpin my methodological choices. To describe the philosophical assumptions I refer to that which Grix (2010) labels the ‘building blocks of research’ (See Appendix H for Grix’s five stages). This is not a definitive guide of the philosophical underpinnings of a research study, but the guide I have selected.

Defining what is real, and what is out there to know? The Ontology is the “starting point for all research” (Grix, 2002, p.3). According to Creswell (2013) the ontological assumption considers “the nature of reality and its characteristics” (p.20). This differs depending on the researcher’s ontological positioning which lies on a continuum (Potter, 1996). On the one end lies naïve realism. A naïve realist stance is deterministic and endeavors to discover one truth by experimentally testing causality. In opposition to this lies relativism. A relativist stance rejects the possibility of discovering one definitive reality and proposes multiple realities instead.

In the current study I adopt a relativist position, and I believe that multiple realities exist. Therefore, I feel no one individual construction takes precedence, or is conceived closer to the truth than another.

Defining what we know? What and how can we know about it? Epistemology is concerned with the creation of, and what constitutes, knowledge (Guba & Lincoln, 1994). The

epistemological stance is determined by the researcher's ontological approach, and governs the theoretical perspective and the research methodology selected.

Epistemological stances also lie on a continuum ranging from objectivism to subjectivism (Madill, Jordon & Shirley, 2000). The objectivist stance provides the theoretical foundations for experimental quantitative research (Gall, Borg & Gall, 1996). It is anchored in the realist ontology, and proposes predictable linear relationships between objects (Snape & Spencer, 2003). On the other end of the continuum lies the subjectivist stance which is grounded in the relativist ontology. The notion of one reality is rejected and replaced by the notion that reality varies depending on one's interpretation of it, and what we come to 'know' is contextually and socially bound. In this study I align with a subjectivist epistemology. I believe that, in women's medium secure services, 'knowledge' is created by individuals, both staff and service users, immersed within it.

Stating the theoretical positioning of the research. Stating my theoretical positioning enables the reader to better evaluate the chosen methodology. Broom & Willis (2007) propose "a researcher's paradigmatic position relates to their understanding of the nature of knowledge (epistemology) and of reality (ontology)" (p.17). The paradigmatic or theoretical position determines the research design. Charmaz (2014) recommends viewing theoretical positions on a 'continuum', ranging from a positivist stance to a postmodernist stance, as this enables the researcher to clarify their position when proposing a theory.

Appraisal of Positivist and Interpretivist positions

The positivist paradigm adopts a realist ontological and an objective epistemological stance, and utilises experimental methods and statistical techniques to make inferences about truths. Quantitative research is deductive and systematic, and aims to uncover causal

relationships through statistical analysis and the manipulation of variables. One of the strengths of the quantitative approach is that large studies can be conducted and the findings generalised. The research findings are objective and thought to be uninfluenced by the researcher, where confounding factors are controlled. However, Pope, Mays & Popay (2007) suggest the quantitative approach is limited, in that it fails to gain a deep understanding of the phenomena of interest. Positivism overlooks the minutia of more complex social phenomena and individual experience which are the focus of this study.

Interpretivism stems from social constructionism (Charmaz, 2006) and aligns with a relativist ontological position, and an epistemological subjectivist stance. Interpretivism views what is real as 'individually constructed' with multiple interpretations based on the individual experience (Scotland, 2012). Interpretivism rejects the view that reality can be understood through causal links, instead proposing that knowledge is gained through understanding the meanings and interpretations of social phenomena which are contextually bound.

Interpretivism and the qualitative approach. The Interpretivist paradigm, among others guides qualitative research. Qualitative research attempts to address the complexities of individual experience and how people come to make sense of their experiences (Cresswell, 2013). Some have critiqued qualitative research, disputing its 'scientific value' and generalisability (Charmaz, 2006). However, qualitative researchers argue generalisability is not the aim of qualitative research. The subjective/interpretivist aspect of qualitative research has been proposed as unscientific as the research findings are coloured by the researcher's perspective and personal presuppositions. However, to account for this the researcher adopts a reflexive approach, explicitly acknowledging and incorporating their own position and viewpoint throughout the research process.

Weighing it up. Evidence based practice is increasingly used to measure effectiveness of clinical interventions and to guide clinical decision making and healthcare policy. Quantitative research is scientifically rigorous and highly influential in informing healthcare practice. However, it is unrealistic to assume that the researcher does not bring subjectivity to the findings. When exploring the social complexities of human experience qualitative research may be more suitable, but lacks in generalisation. In summary, quantitative and qualitative methods have strengths and weaknesses, both have their own interpretation of ‘truth’ seeking, and when used independently or in unison can enhance or provide robust findings dependent on researcher aims.

I position myself with Interpretivism which lies on the continuum between positivism and postmodernism, and is the position adopted in this study. I believe that front line staff are the experts of their experience, where their constructions of the world are unique. Therefore a qualitative methodology was considered appropriate to explore the perceptions and unique experiences of forensic staff.

Constructing meaning. Constructivism proposes that humans have the capacity to idiosyncratically interpret the world and construct ‘meaning making of the individual mind’ (Crotty, 1998 p.58). Interpretivist researchers consider their interactions with the research participants as ‘constructivist’, and attempt to interpret ‘meanings and actions’ through the interaction (Charmaz, 2006). In adopting a constructivist approach I was able to incorporate my own perceptions and interpretations with those of the research participants, otherwise known as the ‘co-construction of meaning’ (Henwood & Pidgeon, 2012). Furthermore, Gardner, Fedoruk & McCutcheon (2012) propose that a constructivist approach fits with contemporary mental health nursing research, particularly when exploring the therapeutic relationship. They propose both the researcher and the mental health worker are ‘...interested

in forming a connection. They understand that their relationships have an element of ‘mutuality and reciprocity’ (p.72), as did I during the interview process. Furthermore, the meta-synthesis (Chapter 1) highlighted a dearth of qualitative research exploring staff perceptions of aggression in women’s secure services. This supports an inductive approach.

How can we go about Acquiring Knowledge?

Grix’s (2010) third ‘building block’ determines the methodology and ‘how we go about acquiring knowledge?’ I will now provide a brief overview of grounded theory methodology and justify why CGT fits with my philosophical position.

Introducing Grounded Theory Methods

Grounded Theory was conceived by Glaser and Strass (1967) to explore social processes ‘grounded’ in the data. Glaser and Strauss positioned themselves within a realist ontology and objectivist epistemology. They believed the researcher should enter the research process with an ‘open mind’ and hold no assumptions about the research phenomena. The researcher does not begin with theory, and instead distances themselves from a ‘theory-driven’ deductive approach to research (Flick, 2009) and focuses on “the discovery of theory from data” (Corbin & Strauss, 2008, p.1). Grounded theorists believe concepts are latent in the data waiting to be “discovered”, and from this a theory is generated which is ‘grounded’ in the data. The analysis becomes more deductive as it progresses. Therefore, traditional grounded theorists do not support that data is co-created by the researcher and the participants. Charmaz (2003) continued to develop grounded theory and her Constructivist approach is positioned between positivism and postmodernism.

Constructivist Grounded Theory. Like interpretivism, constructivism rejects the notion of an objective reality, asserting instead that individual's perceptions of what is real are part of dynamic social interactional or/and psychological processes. Charmaz and Bryant (2011) add "...constructivist grounded theory accepts the notion of multiple realities, emphasizes reflexivity, and rejects assumptions that researchers should set aside their prior knowledge to develop new theories" (p.293). Furthermore, Charmaz (2000) questions the idea that categories and theory in the data are 'latent' and awaiting discovery. Instead she states "...concepts and theoretical level of an analysis emerge from the researcher's interactions within the field and questions about the data" (p.522).

Why the constructivist grounded theory method fits. The CGT approach is attractive to me as it fits with my ontological and epistemological stance, and is therefore appropriate to meet the aims of this study. I am interested in the diversity of human experiences, I feel there is no objective truth 'out there' waiting for me to uncover it. Instead, I believed what I would come to know would be an interpretation through mutual meaning making. Where both I, and frontline staff working with female inpatients would 'co-construct' meaning through our interactions. In support of this Safran and Muran (2000) suggest a relativist ontological stance incorporating a constructivist paradigm is more appropriate to explore the subjective experience of the therapeutic alliance, than an objectivist positivist ontology and realist paradigm. Furthermore, Gardner, McCutcheon & Fedoruk (2012) report that CGT fits with the ethical principles of contemporary mental health nursing.

Grounded theory techniques. Despite the epistemological and ontological differences in grounded theory methods, a number of key research processes and analysis stages are consistent.

Why not a different methodology? I will explain why CGT was preferred over Interpretive Phenomenological Analysis (IPA) (Smith, Jarman & Osborne, 1999) and Thematic Analysis (TA) (Braun & Clarke, 2006).

Constructivist Grounded theory is appropriate when exploring contextually bound social processes where there is little previous research. Theoretical sampling is used to develop the emerging categories. This means that a heterogeneous sample of participants can be selected, depending on the direction of the research enquiry and their relevance to either support or negate the developing theory. Within the current study I explore frontline staff perceptions of aggression and the therapeutic alliance within women's secure services.

Within the IPA methodology the aim is to recruit a homogenous sample in order to gain an understanding of the 'lived experience' of the participants. IPA tends not to consider the social context and processes, and therefore would not fit with my aims for the current study. TA is considered a method rather than a methodology, the upside to this is that the researcher can fit TA with their philosophical orientation. Furthermore, grounded theory is as a form of thematic analysis. However, TA recruits a homogenous sample and draws descriptive patterns of meaning from across the sample, rather than focusing on socially and contextually bound individual meaning making. I felt that forensic frontline staff role is different to that of other inpatient staff as their role involves maintaining both care, and safety and security of offenders, which is specific to the forensic social context. I felt that it was important to provide an opportunity for forensic staff to voice their experiences. This fits with the CGT approach.

I hoped to produce a tentative theory from the generated data which neither TA nor IPA would have enabled. My stance embraces the possibility of multiple realities, where the subjective social experiences of both the researcher and the research participants inform theory. I felt that it was important to not be constrained by the interview schedule or sample and be

able to pursue different topics and leads presented by the participant during the interview. Within the CGT approach this was possible.

Part 2: Method

Design

This study adopted a naturalistic, qualitative design. The CGT methodology guided data gathering and analysis.

Participant selection.

Inclusion and exclusion criteria. With the research aims and questions in mind, inclusion and exclusion criteria were incorporated into the recruitment procedure to enhance the trustworthiness of the findings (Bellamy & Rubin, 2012), and to protect the wellbeing of the participants. The criteria were applied to the recruitment of the initial purposive sample. The subsequent sampling was ‘loosely’ theoretically driven and incorporated a range of frontline staff.

Initial inclusion criteria. Participants were registered mental health nurses, over 18 years old, who had worked in the medium secure unit for longer than three months. This was thought long enough to develop a therapeutic relationship. Participants must have experienced (victim or witness) at least one aggressive incident with a female service user. Participants required a good comprehension and expression of the English language to be able to engage in the interview and not require a translator.

Initial exclusion criteria: Participants were excluded if their participation may have been detrimental to their emotional and psychological wellbeing. This included staff on sickness leave because of their personal experience of workplace aggression.

Sample characteristics

In total 13 frontline staff were recruited from the women's secure service. All staff had worked on the ward for at least three months. Two support workers, and one healthcare assistant were employed in the capacity of bank worker, all three had worked on the women's ward for longer than six months. Full demographic information about the participants is not provided. I felt this may jeopardise the anonymity and may identify the participant to the reader. Throughout the analysis participants will be referred to with pseudonyms. (See Table 3 for participant characteristics).

Two registered mental health nurses withdrew prior to their interviews due to 'difficult personal circumstances' (n=1), and a 'lack of time' (n=1). There were a number of staff members who did not offer to participate in the study. At the time of recruitment there were 25 members of staff working on the women's ward.

Table 3: A Table Detailing Participant Characteristics.

Sample Characteristics		Number
Gender	Male	n=4
	Female	n=9
Professional Role	Registered mental health nurses (RN)	n=4
	Support workers, healthcare assistants and activity coordinators.	n=9
Ward Experience	Women's Medium secure	n=13
	Women's Medium and Low secure	n=3
	Women's and Male wards	n=6
Length of service	7mth – 7years	
Age Range	21-58 years ($M=37.7$)	

Sampling and Saturation.

Charmaz (2014) recommends an initial purposive sampling method, followed by a theoretical sampling method to recruit participants. A purposive sample is selected strategically as a micro-representative subgroup. The purposive method “provides a point of departure” (Charmaz, p. 197) in the recruitment process, whereas theoretical sampling provides direction. Through purposive sampling “you establish sampling criteria for people, cases, situations, and/or settings before you enter the field” (Charmaz, p.197). I was selecting a very particular kind of purposive sample (nursing staff), with a particular experience (aggression, training and role), to begin the data gathering phase in order to explore the research questions. The participants were self-selecting, possibly because of their interest in the study. I assumed, although was not certain, nurses would have some knowledge of the therapeutic alliance through their training.

How many participants are acceptable for a research project? Patton (2002) proposes “there are no rules for sample size in qualitative enquiry” (p.244), and the amount of participants required often depends on the quality of the information generated. Within CGT and theoretical sampling the sample size is undetermined and decided upon iteratively as data gathering advances, and the emerging categories become more refined. Sampling ceases when theoretical saturation is thought to have been reached (Charmaz, 2014).

Procedure

Identification of service. In the first instance I contacted a Consultant Clinical Psychologist working within a Secure and Forensic Service in my local region. A subsequent meeting was arranged to present the study to both the Consultant Clinical Psychologist and the Women’s Secure Service Manager. Approval for the study was sought from the Secure and Forensic Service Managers Board meeting by the Consultant Clinical Psychologist.

Ethical approval. The study was conducted in accordance with the Health & Care Professional Council (2008) and the British Psychological Society’s (2006) codes of ethics. Following the forensic service board meeting approval (20th March 2013) (See Appendix I), an application for ethical approval was submitted to the University of Essex Faculty Ethics Committee (FEC). Approval was granted (2nd December, 2013, see: Appendix K) for the proposed recruitment method and procedure. Following this a further application was submitted to the participating local National Health Service (NHS) trusts Research and Development Committee. Approval was granted on 31st January 2014 (see appendix J).

Ethics amendment. In July 2014 an amendment (see Appendix L) was submitted to the local trusts NHS Research Ethics Committee and the Research and Development Committee.

Two amendments were requested:

- 1) To broaden recruitment to all frontline staff (rather than just nurses), in line with theoretical sampling.
- 2) To interview participants in their own homes (to aid the recruitment process).

Approval for the amendment was received on (13th August 2014, See Appendix M) and a further application was submitted to the University of Essex FEC who also approved the amendments (25th September 2014, see Appendix N).

Interviews.

Charmaz (2014) recommends ‘intensive interviewing’ for interpretive inquiry. This approach supports the researcher to “understand the research participants language, meanings and actions; and emotions and body language” (p. 58). The development of a good rapport is considered crucial to gather rich data. Therefore, the opening questions were loosely related to the research question and were intended to facilitate building a rapport. I used prompts throughout the interview, so as to avoid leading the participant in their accounts.

Semi-structured interviews. Semi-structured interviews provide richer information otherwise not attainable through quantitative methodologies (Patton, 2002). I decided to conduct individual interviews rather than a focus group. It could be argued that focus groups enable participants to share their experiences more readily. However, in line with Charmaz (2014) I felt the individual interview better enabled observation of non-verbal communication and provided a forum where staff would not fear judgement from their colleagues. I was

therefore able to gain a deeper understanding of individual experiences more so than would have been possible in a focus group.

Development of semi-structured interview (SSI). The interview schedule was developed following: a brief review of literature related to the therapeutic alliance and aggression in healthcare settings; a discussion with my research and placement supervisors; and a pilot interview. The interview questions were 'provisional' and open ended (Charmaz, 2014). I adopted a dynamic and flexible approach to questioning whilst using the interview schedule (Appendix R) as a loose guide. Later interviews became more focussed and were influenced by the emerging categories and theory.

Conducting the interview. During the interviews participants were invited to vocalise their experiences of relationships with aggressive service users. A digital voice recorder was used to record the interview. All participants were offered the opportunity to ask questions prior to and during the interview. I met with most participants in the workplace ($n=11$) whereas others preferred to meet in their homes ($n=2$). The interviews lasted between 46 - 82 (mean = 72) minutes.

At the start of the interview participants were asked to re-read the information sheet and sign the consent form. All possible future participation options were explained such as; involvement in reviewing the analysis and generated theory (Miller, Birch, Mauthner & Jessop, 2009). Participants were paid £13 as a gesture of good will on completion of the interview. Following each interview I recorded my reflections and observations in a memo journal.

Recruitment

Dissemination of research information. Following service and ethical approval I contacted, and met with, the women's medium and low secure ward managers individually on site. The research study was discussed and arrangements made to disseminate the research information to the nursing team. The study incorporated two phases to recruitment:

Phase 1: Review of interview schedule and pilot study. Prior to the data gathering phase the ward manager provided the staff team with an outline of the study. A registered mental health nurse and a support worker from the medium secure ward volunteered to review the interview schedule. A meeting was arranged which occurred in a private meeting room off the ward. The staff members were informed of the provisional nature of the pilot interview schedule. Both staff members considered the schedule clear and appropriate. No amendments were made at this time.

The pilot interview was completed with a registered mental health nurse. The data generated from this interview corresponded with the research questions and was incorporated into the formal analysis. Frankland and Bloor (1999) suggest that piloting a study helps the researcher yield a "clear definition of the focus of the study" (p.154), supporting the researcher to focus on the phenomena of interest.

Phase 2: The process of recruitment. The ward manager sent an email detailing the study to all qualified nurses, attached to this was the letter of invitation (see Appendix O), and information sheet (see Appendix P) detailing the study procedure, and participant involvement. The research poster (see Appendix Q) was displayed on the staff room notice boards, communication book and staff pigeon holes. Through distribution I hoped to capture all nurses, including night-shift and bank nurses.

I attended the qualified nurses' meeting which occurred once per month and staff hand-overs. I completed three interviews with nurses. During these interviews participants mentioned differences in approaches to working with, and relationships with patients, depending on professional roles. In CGT the iterative analysis and emerging theory guide the following selection of participants and questions asked. Theoretical sampling commenced after the third interview and cases were sought based on the emerging concepts and constructs. At this point I felt that it was important to increase the diversity of the sample to enrich the data. An ethical amendment was submitted requesting to recruit from all frontline staff working within the female secure service.

The information sharing was slower than I anticipated, due to high level of absence and sickness within the staff team during the recruitment phase. The ward was regularly staffed by bank workers with no or minimal experience of working on the ward. Furthermore, the wards were often unsettled, and because of the high frequency of incidents interviews were often postponed or cancelled.

Due to slow recruitment the Consultant Clinical Psychologist helped to disseminate the information to the women's medium secure staff. Spending more time on the ward seemed to aid recruitment and I could discuss the research to staff who expressed an interest. This time in the ward office also enabled me to observe staff/patient interactions and enhanced my understanding of ward milieu. Mills, Bonner and Frances (2006) suggest spending time within the research context of the research can facilitate a better understanding of the phenomena being explored, which fits with the premise of co-constructing knowledge.

Managing Data

Transcribing data. There are many different styles of transcription. Mishler (1986) states "the analysis of speech is central to the use of interviews as research data...an accurate

record is needed of the questions that interviewers ask and the responses that interviewees give” (p.36). Taking this into account, I completed a verbatim transcription of the interview straight after the interviews. This ensured I could note any non-verbal communication. I listened to each audio three times to correct errors and ensure the transcripts were anonymised. This also helped familiarise myself and get ‘closer to the data’, whilst reflecting back to earlier interviews.

Data Analysis

The interview data is gathered and analysed concurrently using a CGT approach. This process is used to inform the direction of, and interview format for following interviews. Within the CGT approach a constant comparison method and memo writing are used in the on-going analysis to reduce the extrapolated data to form categories and codes (Mills, Bonner & Francis, 2006). The data gathering and analysis was completed concurrently the ‘core categories’ were deemed sufficiently full (Glaser, 1998). Dey (1999) proposes ‘theoretical sufficiency’ is more suited to grounded theory studies, where categories are suggested rather than saturated. Because of the time constraints of the study and difficulties recruiting, I feel I achieved ‘theoretical sufficiency’ rather than saturation.

All of the interviews were initially descriptively, and openly coded line-by-line (Charmaz, 2014) (see Appendix S). The analysis then moved to more focused coding including the added identification of action codes. The first six interviews were completed and analysed/line-by-line coded concurrently using the software programme MAXQDA. The validity of emerging categories was reviewed by the researcher, and primary and secondary researcher supervisors. Following the analysis of the first six interviews a meeting was held with my research supervisors. I explained I was struggling to ‘stay close’ to the data because of my inexperience with the computer programme and felt my coding had become more

descriptive and thematically orientated. I decided at this point I would analyse the remaining interviews manually. I then returned to the first six interviews on MAXQDA and completed the remainder of the line-by-line and focused coding manually, and later with comments on a word document. The codes were recorded in the margins alongside the interview transcription, at this stage some of the codes were very close to the interviewees own words, and some were more conceptual and interpretive. This process helped reconnect me with each individual participant's experience and move to the focused coding stage. In the final stages of the analysis once I had completed the constant comparisons and my categories were tentatively formed I returned to MAXQDA to organise the data and extract quotes from the interview transcripts for ease of management. I will now describe the stages of the CGT analysis process in more detail.

Constructivist Grounded Theory Methods of Analysis.

All coding was completed with the three main research questions in mind. Charmaz (2006) describes coding as a three stage process including initial, focused and theoretical coding.

Initial line-by-line open coding. Line by line coding is the first stage of the analysis. Charmaz (2014) states "coding full interview transcriptions gives you [the researcher] ideas and understandings that you otherwise miss" (p.136). For each case, key parts of the interviews, which focused on aggression and the therapeutic alliance were reviewed using line-by-line coding. I worked through each transcription shortly after completing the interview, I remained close to the data, attempting to "analytically and critically" (Charmaz, 2006, p.51) line by line code each individual participants account that was grounded in the data. I began to look for the "actions and meanings" within the transcripts, I was also looking for data that related to the research questions but also data that was inconsistent within the participant account. Each

interview produced hundreds of line by line codes, some similar some distinctly different. I found it difficult to focus on the data related to the research questions and put the contextual information to one side whilst holding it in mind. This was a skill I refined over the course of the data collection and analysis process. The process of line by line coding created category leads to be explored in the following interviews, I also kept note of interesting metaphors and in-vivo codes (verbatim quotes), which were “symbolic markers of participants speech and meanings” (Charmaz, p.55).

Focused coding. Focused coding is the second stage of the analysis. These combined codes are more interpretive and begin to identify constructs and concepts (Charmaz, 2006). In this phase, the most significant and/or frequent earlier codes were used. Some focused codes were topical in nature, and others were conceptual, such as the identification of potential processes or tensions emerging relating to the therapeutic relationship and aggression. The coding became more focused on active concepts, and gerunds were used to encapsulate the processes described by the individual participants. This process was emergent and my ideas relating to categories began to form (see Appendix T, W).

Theoretical coding. Theoretical coding was the final stage of the analysis. Theoretical codes begin to draw links “between the categories formed during the stage of focused coding” (Charmaz 2006, p.63). This helps to refine the categories and for the developing theory to stay grounded in the data. As the coding progresses it becomes more interpretive and analytical, I constantly referred back to the research questions and asked myself what *the individual meaning making was for the participants in this (women’s medium secure) context in which they are embedded*, this helped subsume the codes and form categories.

Constant comparison. Part of the process of coding is the constant comparison of data within and between the interviews. The constant comparative method continues throughout the data collection and analysis, until a theory grounded in the data emerges. Boeije (2002) states “the cycle of comparison and reflection on ‘old and ‘new’ material can be repeated several times” (p. 393). This process is completed until the categories appear saturated. Boeije describes a five stage process for constant comparison, two of the stages were completed in this study. These were 1) ‘comparison within a single interview’; 2) ‘comparison between interviews within the same group’.

The ‘within’ comparison aims to develop codes within the participant accounts related to “difficulties, highlights and inconsistencies” (p.395). Important questions included what are the similarities of data assigned with the same code and how do they differ, what is the general message or sense of meaning making provided by the participants; and finally is any of the account inconsistent? (Boeije, 2002). A within interview comparison was completed on all 13 interviews.

In the between interview comparisons (see Appendix V) I was looking for whether similar focused codes by different participants were referring to the same subject matter. I looked for inconsistencies and similarities whilst interpreting the codes (Boeije, 2002). The between comparison for Judith (nurse) and Jay (support worker) was selected as both participants were tearful during the interview and yet at other times during the interviews both expressed they were unaffected by aggression and ‘brushed off’ and “let go” any aggressive incidents. Yet Judith was planning on leaving due to ‘burnout’. This constant comparison revealed possible differences in stress levels and burnout between a nurse in charge and a support worker. The nurse held the added responsibility of managing the safety of both staff and service users. Despite this, both participants found aggression towards colleagues more distressing than personally experienced aggression. During this stage of analysis I completed

multiple between interview, and concept comparisons which were driven by the forming categories and emerging theory.

Theoretical sampling. Theoretical sampling is a data gathering technique whereby the iterative analysis and emerging theory leads the direction of the subsequent sampling (Pidgeon & Henwood, 1996). To guide the theoretical sample a tentative category must already be identified for the researcher to pursue and further refine (Charmaz, 2014). It is a unique feature of grounded theory, which restricts the researcher from planning in advance decisions relating to; sample size, or direction of recruitment (Cresswell, 2013). Unlike most other forms of sampling this method is not driven by the literature search and preconceived theory (Glaser & Stauss, 1967); is not about ensuring the most homogenous population of participants, or ensuring the findings are transferable to other populations (Charmaz, p.198).

As I progressed through the data gathering process my questions became more focussed on the emerging categories to clarify any ideas possibly relating to an emerging theme. However, due to the time constraints of the research study I was unable to analyse and recruit concurrently for the last four interviews. Therefore, theoretical sampling in its pure sense was not completed. The final four interviews were conducted with the content of the previous interviews and tentative emerging categories in mind.

Memo-writing. Memos were written during both the data gathering and data analysis stages. Onsite memos were written following interviews to summarize key ideas and potential questions for follow-up, as well as emerging issues that required further exploration. Charmaz (2014) suggests memoing is a two stage process involving both “early and advanced” memos (pp.169-170) for concept and construct generation. Charmaz suggests this is a “crucial method in grounded theory because it prompts you (the researcher) to analyse your data and codes early

in the research process” (p.162). Memos were created through each stage of the analysis, and were used to link the categories together and record constant comparisons within and between interviews. Early memos included reflective notes, construct ideas and questions and later memos included theoretical reflections and others visual representations linking categories together. An example of a memo completed following the interview and during the constant comparison process are included in Appendix U and V.

Theory generation. The coding process, constant comparisons, memos and entries to my reflective journal all contributed to the final emerging grounded theory. Grounded Theory has been widely adopted in psychology and nursing research (Mills, Bonner & Frances, 2006) and research specifically exploring staff experiences of inpatient aggression (see literature review). It is important to state the theory I have generated from my constructivist position is just one representation or construction of the participant’s accounts which may be used to contribute to and further develop a theory (Charmaz, 2006).

Part 3: Considering Ethics

Confidentiality

Limits to confidentiality were explicitly stated, and participants were informed of the protocol on ‘whistle blowing’ (British Psychological Society, 2009). Participants were advised of my obligation as researcher to breach confidentiality should concerns have been raised about professional malpractice, or risk to self or others.

Identifying patient information should be removed to protect their anonymity. However, omitting information risked participants’ stories being unheard (Parker, 2005). At the start of the interview I informed the participants I would not use any identifying information in the final write-up of the results. During the process of transcription and analysis it became

apparent that some of the participants referred to one another in a way which would have identified them to the service or colleagues. Even though the transcripts were anonymised, there was still a risk of identification therefore this data was omitted. Some interesting data could not be included in the final results.

Data gathering and storage. In light of the sensitivity of the experiences being discussed it was important to consider the appropriate means of storing data which ensured the confidentiality of participants and security of data. The interviews were digitally recorded, anonymity was assured and digital files were double password protected. Interviews were transcribed immediately following the meeting and all names and places were replaced with pseudonyms (Miller, Birch, Mauthner & Jessop, 2009). Anonymised transcripts and digital recordings were stored on my computer in accordance with Medical Research Council good practice guidance. Participants were advised of the dissemination process of the findings regarding the use of the data.

Informed Consent

Prior to and just before the interview the participants reviewed the information sheet. All participants were informed of the risks and benefits of taking part, and were reminded they could withdraw from the study at any time without any consequences. Participants provided their written informed consent after asking questions regarding their participation (see Appendix Y).

Potential beneficence and risks. It was important to consider the potential risks to the participant before recruitment commenced. I recognised that discussing the aggressive incident could be stressful in itself and could result in the participants re-experiencing the traumatic

event. I raised this at the start of the interview and advised participants that talking about stressful incidents occurring in the workplace could unsettle them. I reiterated that participants were able to withdraw from the study at any time. In two of the interviews the participants became tearful, both participants wished to continue with the interview. These participants were advised they could self-refer to occupational health. I gave these participants a Personal Wellbeing Workbook, provided by the secure service consultant psychologist. This had a phone number for the staff counselling service which was private and confidential.

Potential harm to researcher. I was aware that being exposed to participant's emotional accounts of their experiences of aggression could be unsettling and was aware of the risks of vicarious traumatisation. I used supervision and peer discussion to reflect on the personal impact of the research.

Avoiding coercion. All participants were offered a token financial gesture (£13) (see Appendix Z) whether participating in or outside of their working hours. The British Psychological Society (2009) offers guidance on financial incentives, this sum is thought to be appropriate to ensure participants do not feel coerced to participate. I made very clear that participation was entirely voluntary and participation had no implications for their future employment.

Quality Assurance

It was important to consider the study quality and my rigour as a researcher. In this section I will provide evidence of the processes I undertook to ensure the study was of high quality.

Trustworthiness. Establishing the trustworthiness of a qualitative research project is an important methodological consideration, in quantitative research this is achieved through evaluating reliability and validity. A variety of strategies can be used to improve the trustworthiness of a study, thus helping the reader to examine the utility, and limitations of the findings. I considered Lincoln and Guba's (1985) quality criteria to ensure the research was trustworthy these were: credibility, transferability, dependability and confirmability (Creswell 2013). I will now discuss the measures that were undertaken to meet these criteria, including providing a reflexive statement.

Credibility. I provide a reflexive statement to help the reader understand the generated theoretical model but also my motives to study this area. I have attended advanced research methods teaching throughout my DClinPsy training which has advanced my ability to critique research and therefore enhanced my knowledge of research credibility. I attended training in 'the art of qualitative interviewing' at the University of Essex (2013), Grounded Theory training at Cambridge University (2013), and metasynthesis training at the University of Essex (2014).

I met regularly with my research supervisors and participated in peer supervision throughout the study. This helped to gain insight into any 'blind spots' (Flick, 2009) in the research process and to stay closely grounded in each of the participants' experience.

I have closely followed grounded theory techniques in the analysis and completed systematic constant comparisons between the categories, and between and within the interviews. Through this I further explored negative cases. The categories are supplemented by participant's quotes to show their 'fit' to the participant's perceptions. The categories tentatively represent social processes occurring in this service, despite participants having different approaches to their relationships with the women. I would question whether

theoretical saturation was reached, but believe the findings are valid in their proposition of an emerging descriptive theoretical model. Although I asked participants for feedback on the findings only one participant responded. However, this participant felt the findings were “good and accurate” and resonated with her experiences of supporting women who can be aggressive in this service.

Transferability. This is a small constructivist grounded theory study which offers a tentative descriptive theoretical model of participant’s perceptions of aggression and the therapeutic alliance in this particular medium secure service. Although the study is small the participants provided very rich interviews, which enabled the emergence of five rich categories. At this stage in the research it would be premature to transfer the findings to other settings.

I provide a detailed account of the research procedure and the participant recruitment process should another researcher wish to replicate the study. However, the findings are context specific and co-created by the participants and myself. It might be that another researcher interprets the findings differently. Despite this, the experiences described by the participants in this study were similar to those which I witnessed as an AP working in a different women’s service. It is therefore plausible to consider, with further replication of this study that these findings may be transferable to similar settings.

Dependability. Dependability relates to whether the research has followed the correct process of the chosen methodology. I provide a detailed account of my philosophical beliefs a thorough account of the methodology and study implementation. I have explained the coding process and provided examples in the appendix. I provide a clear description of the analysis and an audit trail. The originality of the study is evidenced during the metasynthesis.

Some of the findings of the current study support the metasynthesis, whilst other findings are novel and related to women's services which is a poorly researched area. I attempted to generate a tentative theoretical model which offers new insights into forensic staff perceptions of aggression and the therapeutic relationship in this women's service.

Classic grounded theorists propose that completing a literature review prior to the analysis can contaminate the research process therefore impacting on whether the emerging theory is 'allowed to emerge' and the 'groundedness' of the analysis. In Constructivist Grounded Theory the researcher's presence and previous knowledge is acknowledged through a reflexive statement. I have included a reflexive statement later in this chapter to guide the reader to a more informed understanding of my personal influences and experiences. Ramalho, Adams, Huggard and Hoare (2015) propose "it is not a "researcher's free" quality that ensures the groundedness of a theory, but rather the researcher's active, ongoing, and deliberate commitment to prioritize the data over any other input". Furthermore, Charmaz, (2006) recommends that the researcher allow this previous knowledge to "lie fallow" (p.166), until the latter phases of the research project to facilitate the development of a 'grounded' theory. Despite having knowledge of previous literature, I attempted to not let this influence my analysis, this was done through frequent support from my supervisors and ensuring I reminded myself to stay grounded and immersed in the participant data.

I did not complete an ethnographic observation of the participants in the women's medium secure service. Neither did I research the women's perspectives on aggression and the therapeutic relationship. This would have enhanced the dependability of the study. Despite this I believe the theory could be used in this service to enable frontline staff to better understand their experiences and responses to aggression, which could potentially enable relational repair. In the discussion I offer a reflective appraisal of the research process and project.

Confirmability. Confirmability relates to whether the findings can be corroborated. To ensure I have portrayed an accurate picture of the participant accounts I support my interpretations of the participants meaning making with quotes extracted directly from the interviews (Lincoln & Guba 1985). I attempted to stay close to the data throughout the analysis and feel the findings are thoroughly grounded in the experience of the participants. The categories are full and representative of the idiographic experience and meaning making of the participants in this study. I ensured confirmability by documenting the research process and leaving an audit trail. To further enhance credibility the developing theoretical model and analysis were checked by my research supervisors and during peer supervision sessions (Kitto, Chesters & Grbich, 2008). During the four month analysis stage of the research, I engaged in fortnightly face to face supervision with my primary supervisor. He supported the thorough analysis and helped me to remain grounded in the data, ensuring I remained focused on the research questions.

Part 4: My Reflexive Position.

Reflexivity refers to the practice of the researcher making explicit their personal influence on the research study. Reflexivity is “described as a key element in ensuring the groundedness of a theory in constructivist grounded theory methodology” (Ramalho, Adams, Huggard, Hoare, 2015). In qualitative research it is important to offer a reflexive statement, as the presentation and choice of study will be guided by the researcher’s “cultural, social, gender, class and personal politics” (Creswell 2013, p. 215). Stiles (1993) asserts “good practice requires investigators to disclose their expectations and preconceptions. But these are meant as orientation for the reader and as an initial anchor point, not as hypotheses to be tested” (p. 600). Assuming this, a reflexive position has enabled me to consider how I have influenced the

different stages of the research process, and how this influence as a research may have supplemented or undermined the research.

I am a 37 year old white British female. I am second youngest of six siblings from a working class family. I started University at 26 and Clinical Psychology Training at 35 years old. I have worked in the National Health Service for almost ten years. My experience lies mainly in adult mental health services. Prior to commencing training I worked for over two years as an Assistant Psychologist (AP) in women's medium secure and community forensic services. I am oriented to an integrative approach, although lean towards psychodynamic and systemic models. The impetus for this study originates from my time working in a women's medium secure service as an AP where I witnessed, and was aware of, boundary transgressions by both staff and female inpatients. Although this research specifically explores patient perpetrators of aggression, I do not wish to vilify patients and am aware of the complexity of interactional factors which occur in secure care.

Reflections on the research process: I will now discuss my experiences of the research process as interpretive research requires a reflexive approach Charmaz (2006).

Qualitative research design has always appealed to me. I am interested in the complexity of human experiences, the context of people's stories, and the meaning they make from relational interactions. I believe it is important to capture individual meaning making in research. This interest influenced the study design and methodological decisions. I feel it would be difficult to capture individual experience and the complex social interactive processes relating to aggression and relationships through quantitative means. I believe every person brings their own unique story, understanding and personal experiences to their professional relationships. The nature of staying grounded in each of the individual participant's accounts appealed to me and I hoped to capture this in my findings.

Managing relationships. The recruitment of participants was slower than I anticipated. The ward was often understaffed, and incidents involving the women meant the interviews were often cancelled. I was aware of my role as researcher, but also as a Trainee Clinical Psychologist, and how this difference in profession could have reflected a power imbalance. During the recruitment process, I disclosed my previous work experience to potential participants and found that such transparency aided recruitment rates. The participants appeared to appreciate the opportunity to talk, and think about their experiences. Kvale (1994) proposes that participation in a research interview can be rewarding for participants who have not had prior opportunity to speak about their experiences. I believe participating in the interviews created questions and new insights for the participants which they would have taken back to their work. I believed this helped the participants to “describe and reflect upon his or her experiences in ways that seldom occur in everyday life” (Charmaz, 2006, p. 25).

Because of my professional role as a trainee clinical psychologist I often felt drawn to, but resisted a counselling role. Brinkman & Kvale (2007) propose “A research interviewer's ability to listen attentively may also in some cases lead to quasi-therapeutic relationships” (p. 267). I felt it was important to remain in my role as researcher and not be drawn into a therapeutic role, but also show compassion and understanding. The participants described feeling as though the women’s aggression may be specific to their service, and I wondered how this would exacerbate a sense of isolation, helplessness and inadequacy in the forensic service. I wondered how increased unity and communication between forensic and other community services could alleviate this.

Reflections on the analysis: In line with constructivism, my prior knowledge, interests and experiences are incorporated throughout the stages of research, thus influencing the final analysis. I felt it important to address my reflexive position and describe how my professional

and personal experiences influenced my decision to explore staff experiences of aggression and the therapeutic relationship in women's secure services. As a trainee clinical psychologist with previous experience of working in women's medium secure services, it was difficult not to be influenced by my previous observations of the medium secure environment and not to allow these observations to colour my interpretation of the participant's accounts in this study. Inevitably, to some extent this will have influenced the research during the data generation phase, such as what questions were asked during the interview, but also my interpretations during the analysis phase. I wondered whether the disparate accounts offered by the participants were representative of the fragmentation of the staff approach because of the high levels of trauma the staff experience vicariously and literally. I wondered whether this reflected a lack of coherence relating to the primary task and service philosophy, which was later evident in the participant accounts. During this phase I reflected on personal biases, remaining sensitive to the participant's experiences, yet also cautious not to allow my personal opinion to leak into the interviews. To account for this I incorporated methods of analyst triangulation where the aim is not to seek consensus, but to explore multiple viewpoints in participant's accounts. I also included triangulation of sources such as comparing people with different viewpoints and using both supervisors and peers to illuminate blind spots in my analysis. I further incorporated triangulation of existing literature by comparing the research findings with current research and literature. These methods of triangulation helped to enhance and validate the study findings (Dallos & Vetere, 2005). I tried to maintain my impartial position as researcher, and I kept an audit trail, memos and a reflexive journal throughout the research process. When I found my thoughts wandering to past experiences, theory or research literature (such as that included in the literature review and metasynthesis). I reminded myself to stay grounded in the participant's experiences. During the constant comparative process I actively prioritised the data over the literature, and memo writing throughout the research

process helped me to keep track of any decisions made throughout the study. It was also important to consider my interactions with the interviewees and how this may have influenced their approach to answering questions, this was a learning process for which I sought advice from my research supervisors.

It is important to note that the writing up of the research project was influenced to some extent by the Division of Clinical Psychology and the training curriculum at the University of Essex. In Classic Grounded Theory studies it is recommended a literature review is completed after the analysis to prevent idea contamination during the analysis process (Glaser & Strauss, 1967, Glaser, 1978). In Constructivist Grounded Theory it is recognised that most researchers come to the research process with at least some prior understanding of the topic of interest (Charmaz, 2014; Romalho, Adams, Huggard & Hoare, 2015). In fact I had presented the research idea at my interview for clinical training so had already begun searching the literature to explore the research project viability. However, at the outset of this study I had originally proposed IPA as a methodology as I was unfamiliar with Grounded Theory. It was through discussions with the academic team, that my understanding of grounded theory developed and I began to feel confident in using this new approach. Furthermore, as part of the University of Essex training curriculum trainees complete a literature review on their chosen research topic in the first year of training, this is submitted prior to the thesis research proposal and application for ethical approval. The application for ethical approval also required a literature review pertaining to research in the field, but also consideration of the relevance and the impact of the study. Because of this process I was already acquainted with literature in this field prior to the analysis phase. However, at this point I had not completed the metasynthesis of qualitative articles. This was completed with some overlap of the data generation phase and analysis of the participant's interviews. It was important to consider with my supervisor how completing these two phases of the research process concurrently influenced the final categories. I cannot be

certain that if I had been able to complete the literature review post analysis I would have extracted different codes and categories.

During the analysis phase I became overwhelmed by the volume of data from 13 long interviews, I struggled to conceptualise categories and a theoretical model which reflected the different yet shared experience of all the participants, yet also remained grounded in the participant accounts. My supervisors reviewed my initial codes and categories, and often advised me to return to the data and reconsider my ideas which would sometimes be linked to psychological theory, they noted when I had strayed from the data and helped me ground the analysis back into the participants' own language.

To some extent what was included in the final analysis was also influenced by the reader and participants. I was aware that some of the participants may be easily identifiable by their accounts, but also by their demographic information. I was aware that the medium secure service were interested in the findings being presented at a management meeting, and that managers may be able to identify certain staff members by their experiences of aggressive interactions through incident recording. Because of this some interesting information was left out of the final analysis, this is not unusual for research such as this but none the less influences data which reaches the public domain and that which does not.

Personal reflection. This was my first attempt at a major piece of qualitative research. I have found the entire process incredibly challenging, there have been many periods of writers block and despair, and other more enjoyable and gratifying moments such as pulling together the results. It has been hard juggling personal relationships, clinical work and the thesis. I am inspired by these participants and the work that they do. I hope this research highlights the impact of working with very damaged, marginalised and disadvantaged women. I believe this particularly vulnerable group of workers in the NHS, and independent sector need recognition

for their hard work. I believe it is important for their voices to be heard, so that change is possible. The entire research process has facilitated much learning professionally and personally. I have developed research skills, often through experiential learning rather than through the teaching and lectures I attended. This thesis has by no means been an easy feat, it has consumed a huge amount of emotional and cognitive energy. Despite this I believe the skills I have acquired throughout this process will help me contribute to research throughout my career as a Clinical Psychologist.

Chapter Three: Findings

Chapter Overview

The present study aimed to generate a theoretical model grounded in forensic frontline staff perceptions of the therapeutic alliance and aggression in women's services. This chapter provides an overview of the emerging theory, including a diagrammatic representation (See Figure 3). The results, including the core categories and sub categories, are supported by quotes extracted from the participant interviews. The contextual information was more descriptively coded, whereas the emerging theoretical model was conceptualised through the interpretive process of abstraction.

The results are presented in three parts:

Part 1: Outlines the emerging theoretical model.

Part 2: Outlines contextual information.

Part 3: Presents the main theoretical model. This can be understood in light of the contextual information.

Navigating the reader

- All of the participant quotes are verbatim and in italics.
- Any comments which I made during the interviews are in bold text.
- All participants are given pseudonyms to ensure confidentiality.
- Pause in speech ...
- Unfinished sentence ...
- Text that I added for clarification is in closed brackets []

The order in which the interviews were completed, including details on professional status, is provided in Table 4. The professional roles are simplified into registered nurse or support worker to aid confidentiality.

Table 4. Order of Interviews and Professional Role.

Interview Ord	Pseudonym	Professional Role
1	Pauline	RN
2	Carly	RN
3	Judith	RN
4	Sita	SW
5	Amanda	SW
6	Ryan	SW
7	Simon	SW
8	Jay	SW
9	Chris	SW
10	Anita	SW
11	Jenna	SW
12	Lori	RN
13	Tanya	SW

RN= Registered Nurse, SW = Support worker, Healthcare assistant etc.

Part 1: The Emerging Theoretical Model.

The emerging theoretical model (see: Figure 3) is grounded in the 13 participant's constructions of the therapeutic relationship and female forensic inpatient aggression. The preliminary model presents how the context in which the participants are imbedded, influences their perceptions of the therapeutic relationship and aggression. It is important to note that the emerging theoretical model is a descriptive model of process grounded in the participants' constructions of aggression and the therapeutic alliance in this workplace. The model requires further research and replication to determine whether it can be further applied to forensic staff practice.

The core category "**Relating Following Aggression**" encapsulates the social process of how frontline staff experience a number of changes in their therapeutic relationship and

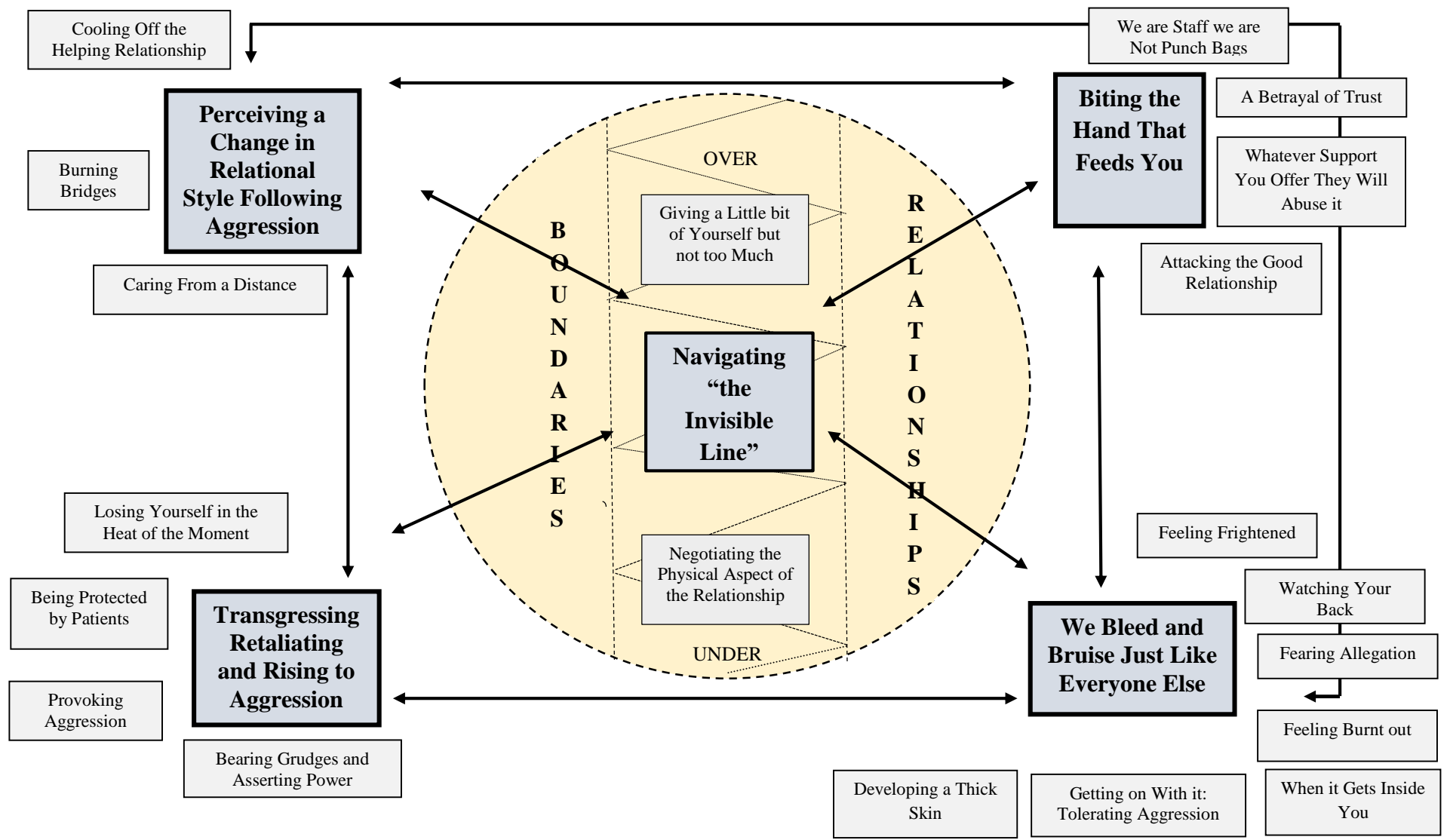
relational boundaries with women who are aggressive towards them in medium secure services. Participants referred to their emotional, physical and professional vulnerability when working in an environment where aggression is present. A sense of staff feeling objectified and unappreciated by the women was presented within the model. The participants perceived that the therapeutic relationship was challenged when patients became aggressive, the descriptive model conceptualises how aggression was experienced as a breach of the trusting relationship. In aggressive encounters the participants described their, or their colleagues', faltering professionalism as 'human reactions' to aggression, where aggression often resulted in a withdrawal from the therapeutic 'helping' relationship.

Five core categories were constructed from the frontline staff perceptions of the therapeutic relationship and the experience of aggression. The categories include: 'Navigating the invisible line', 'Perceiving a change in relational style following aggression', 'Transgressing, retaliating and rising to aggression', 'Biting the hand that feeds you' and 'Bleeding and bruising like everyone else'. Each category contains a number of associated sub-categories. The categories describe the perceived changes in relational interactions, including crossing professional boundaries, relating to colleagues, relating to the women, and the personal implications of boundary crossing relating to aggressive interactions. The proposed theoretical categories and subcategories are dynamic and unidirectional, and were not experienced by all of the participants. The model depicts the individual meaning making of the participants in the shared social context of the women's medium secure ward. The clinical implications of the theory will be discussed in the discussion.

Figure 3.

RELATING FOLLOWING AGGRESSION

CONTEXTUAL FACTORS



Part 2: Context

I begin by providing an overview of the context in which the research took place. The women's medium secure ward is housed within a larger secure hospital which also includes medium and low secure male wards, and a low secure and rehabilitation ward for women.

The women's medium secure unit is a 12 bedded ward offering treatment and intervention for women aged 18-65 with severe and enduring mental health problems. In the main women are detained under the criminal justice system for their offending behaviour, of which includes aggression perpetrated towards others. The service also provides treatment for women on civil sections who are deemed to be a high risk to themselves. Commissioners require there to be 'forensic risk' present within all patients, even if the presenting problems relate primarily to self-harm. Both populations of women can exhibit very high levels of self-harming behaviour. The women on the ward have a complexity of needs, have many different diagnoses, including personality disorders, psychotic illnesses, autistic spectrum disorders, mild/borderline learning difficulties, comorbid with Axis 1 disorders, and dual diagnosis. Many of the women have experienced multiple stressors throughout their lives, including childhood and adult trauma, sexual abuse and neglect. Some have children living with their families or in care.

Women can be transferred to the medium secure service from prison for psychological assessment or from alternative psychiatric inpatient settings including community, low secure and high secure services. Some may be placed outside of their home region. For some women their referral to the medium secure service might be their first admission to hospital, for others it might follow a succession of previous admissions. This means that admissions to the medium secure service can vary in duration from being a few weeks, to a number of years. Also, because the women may have previously been in the service, they may have already established positive or negative relationships with the staff team.

The Multi-Disciplinary team is comprised of 27.53 equivalent team of frontline staff. The ward has one Responsible Clinician (Consultant Psychiatrist), typically at least one Junior Doctor (a mixture of core and specialist psychiatric trainees), one Occupational Therapist, one Social Worker, and one Clinical Psychologist. The staff work shift patterns; one shift is up to 12 hours long, although some work double shifts and work extra bank hours. Each shift runs on two qualified (nurse) and four unqualified (support work staff) on all shifts. Unqualified staff are increased in line with required observation levels, this has reached 12 staff when the ward has been unsettled. All staff wear a uniform. The ward is often reliant on bank staff because of the high level of staff sickness (5.5%) caused by environmental stress and sometimes aggression. There have been two successful prosecutions for inpatient aggression in the women's service since the service opened in 2009. There is currently a 10.4% vacancy rate. The staff are mixed gender.

All staff working on the ward must participate in mandatory training held by the forensic service. The forensic service induction includes various forms of mandatory training, with frontline staff, specifically, completing PMVA training (5 day training course in Preventing and Managing Violence and Aggression; includes restraint but also de-escalation). More recently the psychology department offered basic training in working with personality disorder across the unit; training appropriate staff in structured professional judgement approaches to risk assessment (i.e. the HCR-20) and theoretical aspects of the needs of female inpatients with a personality disorder (e.g. in Attachment Theory).

Contextual Information Taken from the Participant's Accounts

Constructing mental illness and personality disorder. The participants held a number of perceptions about the women's mental health. These perceptions influenced participant's views on the support the women required, and their perceptions of aggression. The majority of

the participants felt that the women with a diagnosis of personality disorder, and women with a psychotic illness had very different treatment needs. This made it very difficult for the staff team to manage the ward: *“Erm and obviously you can’t treat them the same so obviously what will work for one definitely will not work for the other it would have the complete opposite effect erm” (Pauline).*

Almost all of the participants described finding the work *“hard”* or *“challenging”*, and the women *‘demanding’*, *‘attention seeking’*, and *‘manipulative’*. This was mainly associated with women with a diagnosis of personality disorder, who many staff felt *“choose”* to be in hospital. Women with a diagnosis of personality disorder were considered by some participants as in control of their aggressive actions and as not having a *‘mental illness’*.

“Some people...crave attention and would harm themselves or others to get that attention from peers or staff. Then there's... psychotic people, who...who where we.... help with their day-to-day needs, but they wouldn't necessarily have any incidents and they just need help like just maybe just prompting to go to the shower or to eat” (Jay).

Judith explained how aggression from women with personality disorders was intolerable, as their aggression felt *‘intentional’*. However, she was able to *“accept it a lot more with the ones who are unwell...”(Judith).*

“....The way I see it you've got the two types of violence, you have the ones that know what they are doing and do it on purpose, and then you have the ill ones that really don't know what they are doing and are remorseful afterwards” (Judith).

Amanda described struggling to understand why women with a diagnosis of a personality disorder were unable to manage their emotions, when patients with other mental illnesses could. Again aggression from women with a diagnosis of personality disorder was deemed intentional

“Like the borderlines they are intense, they’re kind of like, they have got this ambition to fuck you off and they are gonna do it and it, whereas the ones that have got a diagnosis and that, they might be demanding in some ways but they’re kinda more like chilled out and more like manageable and you can understand them better, and it kind of makes you, kind of get really annoyed with the other with the girls that have got mostly, I think most have got borderline personality diagnosis. But it gets you annoyed with them because you think well they are containing their feelings why can’t you?”(Amanda).

Sita described how easy it was to forget how the women with a diagnosis of personality disorder were unwell. She challenged her colleagues’ opinions that the women choose to be aggressive.

“...sometimes they don’t act like they are unwell, and it’s easy to forget that they are not well and sometimes...I think people think that it is not their illness making them do that. That it’s just behavioural and they are choosing to do it” (Sita).

Construction of the forensic service. Several participants shared their own perceptions of the forensic service, and how they believed those external to the service perceive it. The women’s ward was described as a “cocoon” (Tanya), and a “*just a crazy, crazy place to be (laughs) for them and for us*” (Amanda) by the participants.

“...it’s a bubble...enclosed a lot. Like you feel, you feel as a member of staff you feel quite trapped because you have a lot of locked doors to get through to get out so that can be a lot of pressure or sometimes I think oh I just want to go” (Simon).

Pauline described how the work pressures affected the ward milieu: “*and that creates a negative atmosphere*”. Judith described how the ward environment “*stressed*” her out. Carly, amongst other participants, described how some new staff do not expect the level of violence to

be so high on the women's ward, suggesting a public misconception that male services are more violent.

"People do leave some people find it very stressful very challenging, some people come into this environment not really knowing what it is going to be like and don't really have any idea of the level of violence. I think the general public tend to think 'oh working with the men they must be really more violent' but in our experience female services has far more incidents than on the male side, so people do leave" (Carly).

Changing referrals. Some of the participants described how the referrals to the service had changed 'over the past year', with more 'violent and younger' (Carly) women being referred. Jay commented that the women's aggression had "gone from being destructive to being...aggressive....to taking it out on other people". Carly added that this change in presentation had required the service to reevaluate their staff training:

"We have had especially on the medium secure side a significant number of young women with really extreme violence towards others which is not something that we have necessarily dealt with before which has made us really have to keep evaluating our service and thinking about what we do and how we do it and what do we need and training and that sort of thing" (Carly).

"I remember spending most of my day four years ago restraining because of self-harm because somebody was really, really, really badly wants to crack their head open. Whereas now, most of our restraining is done because of violence. It just seems like there has actually been a massive shift from self-harm into violence. I don't know if that is a reflection on society, or, or the local environment, or what, I don't know. . . But violence is a massive thing that we have to deal with and the staff is, usually are at the end of it" (Lori).

Accessing support. In the main, participants sought support from their colleagues following an aggressive incident. This often happened in informal spaces, such as in the ‘office’ or the ‘corridor’.

“Staff members have supervisions where you can go and talk to your supervisor about the things that have happened. But if there has been an incident, we don't actually get to go anywhere where we can talk about it as a team. Because we do not have the staff for that. We were saying it would be good if now and again we could perhaps talk about the incident itself, why it happened, erm if we could have handled it differently, and things like that about how you are feeling - but you don't no it's unfortunate. We can talk about it in the nurse's office afterwards, but it only briefly while we are in there I don't know writing something down. It is not an actual sit down” (Anita).

Participants described the formal spaces for support as harder to access. This is where nursing and support worker opinions differed. Support workers often struggled to use the formal spaces such as reflective group or supervision, and found little benefit from attending.

“Everyone avoids it [reflective practice]. If someone comes on and says we are doing reflective practice no one ever wants to do it because I, I and I think that we all feel really the same. It's that, it's not really gonna change anything...Unless our psychologist was gonna er...get rid of a patient then that problem isn't gonna go away, and you are still going to have to deal with that problem whatever it is you have to deal with all the time” (Sita).

Lori thought the reflective group was poorly attended by “*mainly the support workers to be honest. And quite a lot of the nurses*”. She went on to explain why:

“I think it’s quite intimidating for them [support workers] because they walk into a room where you have got this psychotherapist who says nothing...other than sort of like observes...umm...and then you've got like the consultants, to the doctors an' it tends to be like the senior people from her team even though everyone's invited, umm... and I think those people are much more confident to talk in that kind of forum so the support workers tend to sit back um...” (Lori).

Amanda felt support was important to “*keep the morale going*” (Amanda). Sita, Chris, Ryan and Simon described feeling very supported by the team following aggressive incidents.

“We have had incidents on my ward the support that we had was brilliant. I couldn't fault that because everyone was ringing me and texting me all the people that I worked with, people that I had never even heard of that had heard about it were getting in touch with me and saying ‘are you alright blah blah blah’” (Simon).

Part 3: Main Theoretical Model

1: Navigating “The Invisible Line”

Navigating “The Invisible Line” encompasses the perceived ambiguity in boundaries and relationships. The participant/patient relationship and boundaries were so intrinsically linked to the therapeutic relationship they were incorporated into the same category. A continuum of opinions was expressed by the participants in relation to the importance, unimportance, and flexibility of relational and professional boundaries in women’s medium forensic services. An inconsistent approach caused friction in participant/patient relationships. The relationship was described as having two levels; Level 1: A complex interpersonal relationship; Level 2: A complex interpersonal relationship complicated by aggression. Participants alluded to boundary crossings by themselves and colleagues.

1.1. Giving a “little bit of yourself” but not too much. Trust was facilitated through sharing just the right amount of personal information, through consistency of approach and maintaining boundaries. The participants knew trust was established when participants “*Come to seek you out to talk to you*” (Amanda). But the women were inconsistent in their relationships with participants where “*one day you can come in [to work] and they all love you and the next day they can hate your guts*” (Chris). There appeared to be a disparity in the participant’s approach to sharing personal information. Some participants shared more than others and found it difficult to establish boundaries, others got it “*horrendously wrong*” (Carly) and shared too little which could offend and anger the women. It was important to share some personal information as the women are expected “*to give us [staff] lots of personal information*” (Judith).

“*...you have to give a little bit of yourself for them a little understanding say maybe your taste in music or maybe your favourite food or you know just general stuff that is not too personal cos otherwise you are never going to develop that relationship with them*” (Carly).

Sharing personal information was a personal decision, but also governed by policy relating to professional boundaries. In the following account Carly conceptualises the ambiguity of the relational boundary line. Boundaries were ‘*permeable*’ (Lori) and learned experientially over time, making new staff more vulnerable to boundary violations.

“*it’s about finding that, that invisible line really of being able to, to, to give something of yourself but not too much, to build up a relationship with, with the women but also maintaining your professionalism as well it’s something I think that erm you can’t really teach*” (Carly).

Judith explained the importance of mutual sharing in the developing therapeutic relationship, but equally recognised the need to limit the amount of personal information shared:

“Erm I think it’s difficult in this environment because you can’t really give out too much personal information. So sort of like trying to build up that trusting relationship is difficult when you are not divulging information to them but you want them [to] ...” (Judith).

Simon added how being over boundaried could get in the way of the relationship for both participants and patients, *“Sometimes people with boundaries they build up that much of a wall with boundaries that no one can ever get past it. And the patients can build up a wall that they can’t even let anyone try help them” (Simon).*

The participants were cautious of disclosing personal information to colleagues whilst at work. This was because personal information could be overheard by the women and used against the participants. This could breach the trust in the relationship, which could be further jeopardised after aggression (See: *Biting the Hand That Feeds You*):

“...and you have to be careful, how you when you’re out there if you are talking about your life as well because they have ears like radars and they will you know pick it up and use that against you” (Anita).

The relationship took time to develop. In her account Carly shares how one of the patients became overly attached and Carly was required to adjust her boundaries to a more ‘*healthy boundary*’. This type of over-familiar attachment was experienced by a number of female participants, but not the males, although the male participants picked up on the inappropriateness of this potential boundary crossing:

“Sometimes it does. You will get people that erm interrupt. You know...(who?) and mummy, sort of mummy patients. I don’t know all of the staff members on this ward, erm but you get some of the female staff members that are like mothers and tend to mother the girls a bit you know. So you know which is a bit...It is not good. You have got to be professional about your job” (Simon).

1.2. Negotiating the physical aspect of the relationship. All of the participants raised opinions on negotiating physical contact with the patients, and patients and colleagues ‘*pushing boundaries*’ in relation to this. There was a range of perceptions within the participant’s accounts; some felt physical touch was inevitable, whilst others felt strongly that it was unprofessional or took a middle ground. Participants were torn between being able to physically comfort patients, whilst also maintaining their own safety and professionalism. Some participants described wanting to offer the comfort and care they would expect for their families. Both Sita and Anita felt the women missed out on physical comfort in childhood which they now ‘*craved*’ from staff.

Although several participants felt some patients may have benefited from physical comfort, others felt it presented a risk to the staff team. Some members held a ‘one rule’ fits all approach to touching the women, whilst others varied their approach to different patients, causing difficulties when aggressive patients requested comfort.

Interviewer: “Who breaks the boundaries?”

Pauline: “...I know for the physical contact one...umm I think at the moment it's a fifty-fifty thing, it's both patients and staff. Because I think obviously ummm from the staff point of view I think they are seeing it as they're trying to offer comfort, but it's not necessarily in the right way” (Pauline).

Some participants were absolute in their opinion that physical touch and hugging patients should not be allowed, and was against hospital policy applying a “*one rule for everyone*” approach:

“You shouldn't be doing that. You shouldn't be doing it. You just basically you shouldn't be doing that. Because you know it sets a bad precedent for all the other staff like, "Oh she does that, but you don't. "It is not good and you should not be doing it. It's against hospital policy to be doing that probably, if we were to look in the policy. You should not be stroking a patient's hair or doing stuff like that to them. You shouldn't really be hugging them” (Chris).

Other participants occupied a middle ground, feeling compelled to offer physical comfort, but resisting for professional reasons.

“It is hard, because I think when someone is sitting crying, there in front of you crying your natural instinct is to comfort them isn't it? and I'm quite a touchy person and I love cuddles and hugs and stuff so I it's really hard to just sit next to someone and just talk to them, and they will actually say, they will actually say to you 'I just want a hug' and you just have to stand there and say 'I can't!'” (Sita).

Amanda was the only participant who ‘*cuddled*’ or ‘*hugged*’ the patients obligingly, although others might “*place a hand on a shoulder*”. Amanda did not feel this was against policy, having never seen one, and felt this was meeting the emotional needs of the patients. This caused tensions in the team, but also made it harder for Amanda to assert her physical boundary when patients with a record of aggression also requested hugs.

“I would never go up to a patient and hug them or anything but if they come to me and they hug me I let them, because I just feel they need that closeness. But then it's like erm...Some staff say it's a no touch service and this and that. I don't think I have ever

seen a policy that says it's no touching and I think if my daughter was in a place like that I would want to know if she needed a hug somebody was gonna give her a hug. So I just let them, if they want to, if, but some of them do and some of them don't, well some of them are all over me and I can't get them off, and some of them just aren't bothered but like... I let them kind of...I don't know, I have a relationship with them where I don't tell them my personal life or be friends with them. But I let them know that like they are no different from me or any other person on the planet" (Amanda).

However, for Amanda, and other participants, hugging came with the added risk of assault and the difficulty of knowing how to break the physical contact if necessary. In one instance Amanda's colleagues thought she was being 'groomed' by the patient so she ended the physical contact, leaving the patient questioning why:

"...and she will be like (cross) 'why are you being like this to me' and I will say 'that's enough now no more hugging that's enough' and I will be more like probably quicker than I would have been before because I don't want all the staff talking about me so (laughs). So and she's like 'why are you being like this? And I'm like 'I'm not being like anything" (Amanda).

2. Biting the Hand That Feeds You

This theme encapsulates how aggression is experienced by the participants, as a betrayal of trust by the women, which is central to the therapeutic relationship. The participants described feeling unappreciated, and their offerings of help depreciated through the women's aggressive and dismissive responses towards them. A number of participants referred to having closer relationships to some women than others. Some participants described being drawn into special relationships with the women only to find themselves later pushed away. The participants were left feeling rejected by the aggressive interactions and unable to do the job they set out to do; to care for the women. This theme is related to contextual factors, which

influenced participant's opinions of the patient population and their understanding of aggression.

2.1. "Whatever support you offer they will abuse it". The impact of aggression was complex, and complicated by feelings of resentment towards the women. Resentment occurred following conflict, where some participants felt the patients were ungrateful with their attempts to care for them which were met with 'abuse', where "*the nice things here get turned into being horrible things*" (Simon). Amanda and Ryan exemplify this in their accounts:

"...it's really hard to say, because whatever support you offer they will abuse it, and they will push it to its limits they will push it to it's (inhale)" (Amanda).

"...I think that's why if there's any incident I'm like... I was nice to you all day but now that's crossed the line. We're here to provide a service not to be punched, we're here to take care of you and this is [the] thank you for bringing you the breakfast, for helping to change, thank you for everything..." (Ryan).

Lori described a patient distancing herself in her relationships with staff who made an effort with her, "*I don't believe there is anybody that is exempt and it tends to be that she assaults people who particularly make an effort with her. It is like she is trying to push them away*" (Lori).

Anita was helping escort a patient out on leave when the patient absconded. When the patient was returned by the police she verbally attacked Anita, who was left questioning why:

"And erm they [police] put her back upstairs and the abuse that came out of her mouth to me was horrible. I was, I never, I didn't think anybody could come out with such horrible things. Especially since I thought I hadn't actually done anything. 'I was taking you out

for your area leave. You know you was going out and erm you were going out to the shops, having a coffee, and things like that, and then you decided to run'. So I couldn't understand why she was erm attacking me verbally like that so" (Anita).

2.2. "We are staff we are not punch bags". Over half of the participants described feeling objectified by the women, as if they were null of emotion and feelings, and relationships felt functional. The participants described how their individualism felt ignored and irrelevant to the women. For some participants their relationships with the women felt one sided and lacking in gratitude in return for their support.

"I think we are all, we are there doing the same thing really... for them [patients] (coughs) excuse me. Erm, yeah you, you are just someone on the ward that can give them the attention that they want. So it don't matter who you are!" (Sita).

"She only really wants to speak to you when she's wants medication or drugs" (Ryan).

Tanya felt the women were disingenuous in their claims to value staff, evidenced by their aggressive interactions.

Interviewer: Do you think they [women] value the relationship with staff at all?

Tanya: "No, not at all, not. We're just there. They don't give a damn about any of us. They say they do but they don't, because if they did they wouldn't behave the way they do. No, they don't. We're just there, we're just here to look after them aren't we, we are nothing" (Tanya).

Judith felt the women were disrespectful to staff. She compared her experience to working in the male service where *"the males have got the respect whereas the females haven't...yeah they don't care"*(Judith).

2.3. Attacking the “good relationship”. This sub-category encapsulates how six of the participants described ‘good relationships’ with patients, up until the point of assault. Prior to the assault the relationship was used, with good effect, to settle patients. Some participants described feeling that this relationship was more therapeutic to those the patient held with colleagues, resulting in a false sense of security, and following aggression, a rupture within the ‘good relationship’. For some, the assaultive incident was unexpected and caught them off guard:

“I suppose I was a bit silly and this is where you keeping yourself in check because you can slip into kind of...yeah ‘I know this person attacks other people but they have always been ok with me’ that kind of false sense of security. And that was where I think I was at that time because I had known her about a year and always had quite a good relationship with her and thought yes she has attacked other people but I don’t think she was gonna attack me and that was a shock” (Carly).

“When I first started I was told I, that there was a particular patient that would just randomly hit staff, and I seemed to get on quite well with her. Erm, and erm, one morning I went in and was just talking to her like normal, like the same way I do every day, and then she just hit me in the face and...it was a shock talking to her like normal, like the same way I do every day, and then she just hit me in the face and...it was a shock” (Sita).

Amanda chose not to heed her colleague’s advice regarding a patient’s risk of assault.

However, her feelings of sympathy towards the patient dissipated following an assault:

“Everyone was like “right stay away from her” and I hadn’t been hit at this point and I was just like ‘oh but, she is, I do feel a bit sorry for her’ and I used to do her hair for her and brush her hair and I used to say ‘oh I do feel really sorry for her’... and then when I got hit I realised what everyone else was talking about. And I was like ‘bitch’ (laughs) sorry! And I think, I also had this thing where I felt I had a relationship with her that she wouldn’t hit, but that turned out, that wasn’t true that wasn’t true at all. That’s not true with any of them [patients] either” (Amanda).

2.4. A betrayal of trust. The participants felt that the building of trust had to be a mutual endeavour. For some, aggression was experienced as a betrayal of trust; they felt unappreciated and a sense of rejection of the care and support provided for the women. This subcategory is linked to the category ‘Perceiving a Change in Relational Style Following Aggression’. Anita described a betrayal of trust following the verbal assault:

“I said "I can't actually take you out for a while so it will be a while before I would trust you going out again, because it wasn't the fact that you ran away from me you now, it was what I had to put up with when you came back. I said you know "I just don't think that was fair what you did” (Anita).

Tanya and Jay, amongst other participants (particularly the male staff), felt strongly that the patients were fully aware of the implications of making allegations and were purposefully manipulating situations to get staff into trouble. These participants felt the women were insincere and untrustworthy. This negatively affected their relationships with the women, *“I think she knows how to get that because she has done it [allegation] before against male staff. I'm thinking, "You know what you're doing," and she knows the effects it has” (Jay).*

“She [the patient] went "No", "I like to complain about people and I like to get them [staff] in trouble," but she sits there and all sweetness and light. And that's what I think... How awful is that? She wants to get the staff into trouble. So that is why she complains so that's not very nice. And this is what they are like with the "He said, she said," all the time and gossip. They listen to everything you say and they will twist it” (Tanya).

3. Perceiving a Change in Relational Style Following Aggression

This category encapsulates a change in the relational style experienced by eleven of the participants following aggression. Some of the participants and their colleagues changed their proximity to the patient following aggression and cared ‘*from a distance*’. Some also experienced a change in their willingness to support the patient, ‘*cooling off*’ the helping relationship. Creating a distance is related to the subcategory ‘Getting on with it: Tolerating

Aggression'. When the women were repeatedly aggressive and unsettled the participants felt unable to support them, sometimes resulting in the loss of the therapeutic relationship. The duration of this loss varied from one day to never fully returning to the relationship as it was prior to the assault.

3.1. Caring from a distance. More than half of the participants reported becoming more self-aware, and more spatially aware, of the women, and caring from a distance, following an assault. This was often related to a breach of the trusting relationship.

"...because to be honest personally I'm still going to be helpful if they need my help or anything. It just I'm going to keep distance, I'm going to be more careful of course I'm careful, if I get the all clear and then she does it again I really don't want to go through all this again. Of course I'm going to keep distant if I'm going to talk to her, not at arm's length I'm going to be further away so I can protect myself" (Ryan).

Jay described finding it hard to be in close proximity to the patient after a serious allegation was made against him, *"I just couldn't bare the thought of being next to her and was thinking that some time" (Jay).*

In some cases the patient questioned the participant as to why the change in proximity had occurred. Tanya was very honest with the patient.

"In the past I was sitting and chatting with a patient and she came towards me and she smacked me straight in the face (shocked expression). Now when they come to me I stand up. She said, "Why do you do that?" and I go, "Because you're going to hit me," and she says, "No I'm not, no I'm not," and I say, "Well you've done it in the past and it makes" and I say "you make my nerves bad", you know so that's a shame" (Tanya).

In comparison to the other participants Pauline presented a different perspective, she described becoming more risk aware and how changing her proximity to patients following an assault was a positive outcome.

Interviewer: *“And what was the impact on you?”*

Pauline: “Erm I am very aware of [aggression], I don’t like to be near anyone. Erm...so I suppose in that, but I don’t necessarily see that as a negative effect, really I suppose it’s quite positive” (Pauline).

3.2. ‘Cooling off’ the helping relationship. A personally experienced incident of aggression could be traumatising for the participants and sometimes resulted in diminished willingness to support the patients. Participants described not wanting to communicate with the patient as they had done prior to the incident, although they continued to maintain a ‘*professional relationship*’. Amanda felt the women “*pick up on*” the changes in relationships. Both Lori and Judith reported a loss of the therapeutic relationship, or “*rapport*” (Lori), after an assaultive incident, “*I have told them [management] how I feel about this patient and that I have not got a therapeutic relationship with this patient anymore because of how I am feeling*” (Judith).

For some participants maintaining a professional stance following an assault was difficult. Amanda described feeling ‘*angry*’ with the patient after getting kicked, and how the relationship rupture was not resolved immediately following the incident.

“I got kicked in the leg by Laura, she kicked me right in the leg, and I remember I didn’t I wouldn’t like, I wasn’t the same with her for a couple of weeks after. I just couldn’t bring myself, I was just angry with her and I just, and even though I know I shouldn’t be and I know I need...It’s just not the same it’s not, I can’t be as...I just think well why should I be

sitting here joking with you now when you have just been a cow for like the last month, and you get angry so it is difficult to be the same” (Amanda).

Some participants described a loss of empathy, and a changing willingness to support the women once they had witnessed a colleague get assaulted, *“I think...well if she hits like one nurse...like...When (colleague) got hit, a support worker, I felt no remorse, like she was getting restrained I was like I couldn't care” (Jay).*

Sita, having previously gone out of her way for a patient, described how this changed after witnessing a racial attack on a colleague.

“What she has asked me to do her favours like buy her, pick her up some stuff. Because obviously she can't go to the shops and things and I don't won't want to do it. Whereas I probably would have before these things had happened, but now I don't” (Sita).

Lori, Judith and Carly all described how difficult it was watching a colleague get assaulted. As nurses they were in charge of the shift and felt the added responsibility of managing ward safety:

“I am human at the end of the day, and if they hurt a member of staff that I am meant to be protecting so you know you still try and be professional with that patient. But it does take a while to get over I think...well it does me!” (Judith).

Lori described losing compassion, and an unwillingness to help:

“I think you, what you do lose is, you start to lose compassion for the individual who has been violent, which is sad. Again, it affects your approach and the way you treat that person. But I don't think you feel, I don't personally don't... I think it is tough every time I see it, erm but I think you start to lose compassion for the individual and your willingness to step forward is affected to kind of help them if you like” (Lori).

In some instances participants noticed their colleague's relational style changed with the women following aggression, where staff were more 'wary' but still maintained a caring approach.

"Possibly because again maybe they have been attacked by a patient where they would be more wary of striking up too much conversation I don't know but yeah...still caring....that would be their approach and that is them as a person, not as a mental health care worker yeah" (Jenna).

Lori describes how being targeted was inevitable, but some staff changed their interaction with both the patient and their colleagues following an assault.

"...you know it's clear to see that we work in an environment where you are going to get targeted at some point, but when people are targeted on a regular basis, it is hard not to take it personally. And then I think that when that is the case their interaction changes, not only with the patient but also with the staff" (Lori).

3.3. Burning bridges. A number of participants described how they, and the staff team, had lost 'hope'. They felt the women had 'burned [their] bridges' in the current service, had 'exhausted all other services', and were 'stuck in a cycle' of aggression. In some instances, because of their aggression, the women were considered unmanageable. Jay and Judith described how they had pushed the staff to their limits and were being transferred out of the service:

"She was just draining every member of staff. We could not cope with it anymore it was just too much and, as I say, we had her for, I think it was about two years and we were not getting nowhere with her and she was just attacking everybody and anybody" (Judith).

"...she has burned all of her bridges that she has assaulted every member of staff on this floor," (Jay).

Jay explained how he thought an aggressive patient's therapeutic relationship was 'lost' within the multi-disciplinary team. However, he felt the patient should have a 'fresh start' elsewhere, suggesting some element of hope remained for the patient. Lori described how one patient appeared to have deteriorated since her admission, and how her perception of this patient changed over time:

"She has assaulted absolutely everyone, every single patient, and every single member of staff....It has gotten to the point now where people [staff] don't want to sit with her and people...Which is really sad because actually when she came to us, despite being violent at times, she had a lot of endearing parts to her character" (Lori).

Amanda described how the team felt at a loss with some patients, and struggled to know how to support their needs. When everything was stripped away this came down to the bare basics of still caring, "...because they have pushed it to the end they have pushed it to the limits there is nothing you can do for them that's really except be nice to them I suppose" (Amanda).

4. Transgressions, Retaliating, and Rising to Aggression

Some participants felt very strong negative feeling towards the women during or following aggressive acts. Professional transgressions were common, although a colleague's transgression was more frequently described than transgressions by the participant themselves. Some participants described reacting verbally, or acting unprofessionally, in the 'heat of the moment'; justified as 'being a normal human reaction'. Some participants witnessed colleagues misusing their position of power to teach the women a lesson, even literally fighting back.

4.1. “Losing yourself in the heat of the moment”. All of the participants described instances where either they, or a colleague, had struggled to maintain a professional stance during an aggressive incident. Pauline described how ‘*in the heat of the moment*’ staff can unintentionally rise to the incident, becoming aggressive and retaliatory, “*You know, it’s difficult sometimes obviously in the heat of the moment obviously people [staff] can do and say things and do things that they don’t necessarily mean to*” (Pauline).

Amanda’s account reflects how she acted in ‘*self-defence*’ when a patient had pretended to hit her. This account describes how, because of the risk of assault, some participants experience a hyper vigilant state (see category):

“I’m on edge and I’m talking to her from this distance and another patient has seen the interaction and sees that I’m on edge, So for a laugh she came up and went like that (pretend punch) to pretend to punch me just for a laugh, and I erm I just turned around and I pinned her up against, the telephone. Because I didn’t know it wasn’t a real punch coming in and I pinned her up against the telephone booth wall and then I felt really bad and then I went ‘what the fuck did you do that for?’ Because I was so angry, and she said “oh I was just joking” and I said ‘you know that’s not funny’ and erm it just puts you on that. And then I felt really bad because I thought there was no need to pushed her as hard as I did. But it was self-defence it was in any normal situation, anyone would have reacted, anyone would have reacted in some way, to protect themselves and so she kind of swung her arm as if she was like swiped it by my face” (Amanda).

Instances of expressing anger and frustration following episodes of aggression were described by over half of the participants. Anger was experienced in response to personally experienced aggression, and aggression directed towards, and experienced by, colleagues. Judith and Amanda describe instances where they lost their tempers when a patient attacked a colleague,

“I will kind of say to the patients ‘don’t fucking hit staff, do not hit staff’ and then they look at me, ‘well what you gonna do about it?’ (laughs)” (Amanda).

“I get very angry over that. Erm we have a member of staff who she is lovely, absolutely lovely and does not have a bad bone in her body. And we had a patient that attacked her quite badly and I did lose the plot by shouting at this patient by saying ‘you do not attack sort of like staff, there was no need for it” (Judith).

Participants tended to reflect on witnessing their colleagues retaliate to patients, rather than talking about their personal experiences of retaliating. These incidents were managed by colleagues, the individual or could result in the staff member *“no longer working here” (Amanda), “I have seen where staff members had to be like sent like in the office to calm down because they’ve been swearing at people, or clients because they have lost their temper” (Ryan).*

“But this one day they were really stressed out they had come into work really stressed. They didn’t want to be there that day and they took it out on a patient and it was it, it wasn’t something that they had ever done before and I just think that they lost themselves in a moment” (Sita).

4.2. Provoking aggression. In their accounts, some participants described witnessing aggression provoked or *“aggravated” (Pauline)* by their colleagues. This was caused by *“being punitive” (Carly)*, the *“way that staff spoke to patients”* which would *“antagonize”* them and *“wind them up” (Tanya)*. Ryan described agency staff with no experience of the ward treating the women *“like animals”*. In these circumstances the incidents could have been prevented and deescalated if the staff member had removed themselves from the situation or acted appropriately:

“I don't condone any violence, but sometimes you can see the reason behind it. But still I don't condone violence! If it was me, if I was pissed off I would swear and take myself away from it. But...there is...some times where you, sometimes thinking I could see that coming up...you...like...Once I saw a staff member shouting and did swear at a patient and then the patient pulled their hair - but you done! ... you escalated that patient and you know that is going to come from them!” (Jay).

There was the added moral predicament of witnessing a colleague perpetuate an aggressive incident but feeling unable to intervene because the colleague was more senior:

“Erm and it was quite it was awkward for me because the member of staff was my senior so I didn't want to say anything to that person at the time in front of the patient because I didn't want them to think I was talking down to them in front of the patient as well erm...But then afterwards then I sort of thought you know I probably could have stopped something if I had said to that person you know 'do you want to just come away and I will deal with it'. But I don't know how that person would have reacted... ” (Sita).

4.3. Being protected by patients. This category represents how over half of the participants described patients defending them from other aggressive patients, where they might “warn” (Anita) staff of an attack. The protector could also be the perpetrator a different time. Sometimes patient intervention was more successful than staff intervention:

“When staff is constantly being targeted by maybe one of the service users, the other service users will erm stick up for the staff if you want...you know and verbally they will say, "Pack it in. That's enough. Stop attacking the staff," or sometimes they will take it into their own hands to move patients away from the staff” (Chris).

“Erm some of the other girls have kind of decided that they are going to be staffs 'back up' and they have decided right if she hits any staff I'm going to hit her so they are kind of every time she goes and hits someone, one of the patients will go and hit her” (Amanda).

Participants suggested that the aggressor was often disliked by the other patients. This could result in further incidents which they would be required to manage. Tanya described how she liked it when the patients defended her after she returned to work with a black eye following assault by one of the women, *“The patients are going, “oh you are well out of order hitting Tanya you are?” and all that, so they were giving a little bit of a dig which was lovely”* (Tanya).

4.4. “Bearing grudges” and “asserting power”. This category relates to the common experience of participants bearing “grudges” after an incident of aggression. The experience of bearing a grudge, or witnessing a colleague bear a grudge, was highlighted in the accounts of seven participants. Rather than creating distance in the helping relationship, they took advantage of their position of power to discipline the women, for example withholding items from the women, *“I think sometimes, and I hate to say it, but when they [staff] want one up on the patient sometimes like when the patient has been rude to them and they are like “no you can’t have that now”* (Jay).

Jay further described how his approaches to supporting a patient changed after he witnessed a colleague get assaulted:

“What she wanted she lost something like a bit of paperwork just like that, and I was like I’m not dealing with that at the moment, you, I would have dealt with that if you manage, manage yourself accordingly instead of attacking staff” (Jay).

Ryan: “I have seen people hold grudges or, “I won’t do this for them. No. You go do that because I’m not talking to that person” (Ryan).

A misuse of power was present in some interactions witnessed between colleagues and patients. This was often in response to staff feeling frustrated when the women were continuously unsettled and an attempt to assert some control over them:

“Erm I think it almost comes down to power and like...I think the frustration of obviously you tell someone they can't do something and they go and do it. It's very frustrating, whereas obviously we are fully aware of the reasons why the person can't do whatever it is. Erm but then, so I think some people try and reinforce that, they can get a bit up themselves in how they are with the patients if that makes sense which obviously, well it definitely has a negative effect on the patients, incidents have been caused by it” (Pauline).

Simon described a colleague's misconduct; he felt his colleague's actions were unprofessional but identified with their frustrations with the women:

“I think if someone, if one person in particular has been restrained all day and they have not stopped...sort of...kicking off I suppose and they have constantly been needing to be restrained and I think near the end some people will quite enjoy that restraint. Cos they will be like “well they are getting on my nerves now” and I mean I can't necessarily blame someone for thinking that cos I have thought that. I've thought 'just stop, please just stop, stop I have had enough'. I guess some people...take it sometimes a little too far when they are sort of on their last legs but they will be like 'no I'm gonna hold you down for five minutes longer now cos you have got on my nerves all day” (Simon).

However, not all participants felt that bearing grudges against patients was acceptable or inevitable. Carly for example, felt a certain type of personality was required to cope with the work and avoid grudges. Jenna also felt it takes a certain kind of individual to ‘do the job’; one that doesn't take assaults ‘personally’:

“Oh yeah but I'm generally a person in life that I don't hold grudges anyway and I think sometimes staff we are only human and I think they do find it difficult to forgive people on

a human level they will continue to work with people, I'm the reverse I'm a bit in life anyway I'm a bit of a pushover so (laughs)" (Carly).

5. "We Bleed and Bruise Just Like Everyone Else"

All of the participants referred to their sense of vulnerability and the emotional impact of working in a service where aggression was encountered on a regular basis. Judith explained that staff were assaulted on "*probably two out of three, maybe three out of five*" shifts per week. Some participants were tearful during the interview, but described having to present as 'coping' for their colleagues, and also disguise their fear to the women.

Some participants conveyed their vulnerability, and in certain circumstances felt obliged to tell the patients how they unsettled staff. Some participants described feeling 'burnt out' by the women's aggressive acts and relentless demands, wanting to leave the service themselves, others spoke of their colleagues leaving or going on sick leave. Some participants referred to their 'human' side, as if this was unrecognised or acknowledged. This is linked to the category 'Biting the Hand That Feeds You'

5.1. When 'it' get's "inside you". Some of the participants described how one serious experience of aggression affected them more than previous incidents, suggesting that aggression affects staff on different levels depending on its nature and severity. These incidents could be verbal and physical, and "*hurt something inside*" (Ryan). These incidents had significant, long lasting, ramifications that impacted the participant's private lives, professionalism, psychological and emotional wellbeing, levels of stress, and sense of safety in the workplace. Ryan described his distress caused by the possibility of having contracted an infectious disease following one of the women spitting at him. This placed significant pressure on his personal life and emotional wellbeing, affecting him in the longer term:

“I have been hit by a patient before something like punched or something like that, it never really bothered me. But one of the patients spat into my eye. And the patient is [infectious disease] positive...I haven't been injured... for those three years and this is the first time and it's not really painful, but it's painful inside. You know what I mean? It's this level of stress (sighs)...I felt like, I felt serious like really down and the whole thing I never felt really upset about something so much...Like to be honest...if someone's going to punch you in the eye you're going to have a black eye for 2-3 weeks and then it's gone but if someone's going to constantly be calling you with names and trying to attack you with weapon then I think it's a much more big issue than just punching” (Ryan).

When one of the women Judith key-worked threatened to ‘kill’ her, Judith was tearful for the first time in her career. She described feeling targeted, singled out and treated differently from the team:

“She was threatening to kill me, she, she was horrid, absolutely horrid. And you know I have had lots of abuse thrown at me, it's part of the job but this particular, it was on a night shift. This particular night she was really just aiming at me and nobody else, everyone else was lovely. It was just me but that was because I was a key worker and I've told her that this is what's happening and she did not like it and that really got to me and, it did actually really get to me and I ended up going into, because she went for me as well, and I actually went into the office and cried and that's the first time in my whole career that a patient has made me cry (laughs)” (Judith).

Whilst Jay described having a rape allegation made by one of the women, he became tearful stating how much stress this had caused him. He described how he feared the worst and, despite being cleared, this went on his record:

“Yes, and it goes on my record...I was thinking I was going to some kind of special prison or wouldn't be able to work in nursing again - or anywhere for that matter” (Jay).

5.2. Feeling “burnt out”. The participants described being challenged by the aggressive incidents encountered in the women’s service, and how over time, this impacted on their emotional and physical wellbeing, an altered caring behaviour, and sometimes a loss of ‘hope’ (Lori). A sense of burn-out was perpetuated by unsupported pleas for support, and resulted in absenteeism, a loss of the therapeutic relationship and changes in temperament towards the women:

“Yeah I think the staff, I think it’s just very...it kind of wears you down I suppose you kind of there is only so much of it you can kind of deal with. So I think yeah it does have a negative effect on the staff as well” (Pauline).

“...I think especially the past few months we've had a really difficult period on the ward and I think on the whole some of the staff feel burnt out and I think that they don't, quite a lot of what we do in here goes unnoticed and we get criticised a lot by, just by the whole unit...”(Lori).

Judith described how she initially enjoyed working in the women’s service after moving over from the male service. However, over time she feels burnt-out and despairing; she has physical health problems possibly caused by the stress:

Judith: “You know unfortunately the girls do burn you out and (sigh) you know I am getting to the point where I am burnt out and I need to change so I have actually asked to move but they [management] won’t move me...”(Judith).

Interviewer: “So then there is a sense of what is this, what is the feeling of being burnt out?”

Judith: “You don’t want to come in (whispers under breath). You know that it’s gonna just be the same things, the girls are just so demanding, and ARGH I need a break! Basically that’s how I feel and I don’t want to be here now, I really don’t want to be here...And I think sort of like you know it makes your patience less, you tend to have less patience.

Well I've noticed I've got less patience for the girls than what I did have...because I don't want to be here now I need a break from here" (Judith).

Amongst other participants, Amanda described three separate occasions of colleagues leaving the service because they were unable to cope with the aggressive incidents and stressors of working with the women. These colleagues requested to move to a different ward, and if this was unsupported, they left altogether:

"Because like I know for a fact that Jemma [staff] has gone because of what happened she got attacked by Claire [patient] quite badly erm and she is refusing to come back onto [the ward] and they're...She is asking to move to another ward and they are saying they cannot facilitate that...She just wasn't motivated she didn't seem to care, she didn't. She wouldn't never be nasty or horrible to a patient, but her attitude was just like, this place, 'I'm fucked with this place I can't deal with it anymore'. And that was her whole attitude, and I think if she wasn't that worn out and that burnt out from being in women's services then erm"
(Amanda).

Both Amanda and Chris referred to how working extra bank shifts increased risk of burnout; it was *"emotionally and physically draining"* (Amanda) and resulted in a short fuse.

"You shouldn't be doing loads and loads of shifts in this environment cos this is what makes you...You can lose concentration and you might lose a plot with a patient as well. So it has, It has it can have a domino effect" (Chris).

5.3. Feeling frightened. Most of the participants reflected on encountering fear when working with aggressive women. This was experienced on different levels depending on their experiences, and severity of aggression. Anita verbalised the fearful anticipation of being unable to predict how settled the shift would be. *"Really heavy furniture"* could be used as a weapon, and there was the added risk of attack whilst managing unsettled patients in seclusion.

For some, fear left them questioning whether to go into work, or worrying what risks the women might present with. Chris felt that “*having enough members of staff*” around enhanced safety.

“I have had them start pacing. Then all of a sudden, they'll turn and they run for somebody - me or whoever. That is frightening because they are there on you. And like you know before you know it, they can either knock you to the floor or something like that, but that is the kind of thing I get frightened by” (Anita).

“She does that to be frightening and her behaviours are very intimidating. I actually watch staff around her sometimes and I admire their strength around her. Because I don't know if that is because it has been the only situation I have ever been in in that way, but she does frighten me “(Lori).

Some of the accounts described the ward reputation, on one occasion even likening it to a war-torn city, and how this impacted on bank staff's willingness to cover shifts:

“I mean one girl was rota'd to work here oh...three months before Christmas I think and she went off sick. She is not back yet simply because she had to come and work here. So it was the stress and things like that, that made her... but she didn't come over here once (laughs). So it can be quite...quite daunting and frightening...” (Anita).

Two participants were not afraid of being assaulted by the women. Jay explained that he expected aggression and was therefore not afraid; this was in contrast to his fear of allegations, which he experienced as personal attacks.

“No, I'm not scared of them. No, I'm not scared of getting wacked or anything like that...just. No I'm not scared because you expect it, you know” (Jay).

Some participants described how staff withdraw to the office and “*some people are scared to come out of the office*” (Lori), and spend less time with the women when there is tension on a shift, or when they are feeling ‘unsafe’:

“It could be that they don’t want to be on the floor, they want to be in the office where it is safe, you know. I get that but you are here to work so get out on the floor!” (Judith).

However, it is clear that participants were not always hiding in the office due to fear. Amanda, for example, said she moved to the office to manage angry feeling towards the women:

“Like with Laura [patient] I just get so angry and I have to go into the office and I have to remind myself what a terrible life she has had and how hard she has had it and the kind of life she has been brought up with. And remind myself that’s why she is such a bitch, and then I have to go back out and start again. Cos I just get to the end of my tether and I think I can’t believe you are doing this I can’t believe you are being like this!” (Amanda).

5.4. ‘Watching your back’. Around half of the participants described a sense of hypervigilance and having to “*watch your back*” (Tanya), arising from the risk of unprovoked assault but also of the potential for allegation. Ryan described how he was more alert to risk since being assaulted, “*I mean you can’t be in a safe place all the time, I mean you can’t feel safe, you need to be always on the edge*” (Ryan).

Several participants described how some assaults were unprovoked and therefore impossible to prepare for. This can be seen in the following two accounts:

“The last incident we had here, erm the member of staff walked into the lounge and said to the patient ‘are you going to come in and have some dinner’ and she just grabbed her

hair pulled her head down and kneed her in the face and I was the witness to that and I, you just couldn't quite believe that it was happening cos you, what instigated? What was the trigger there you know? And you just never know to this day what that trigger was" (Carly).

"I got (laughs) punched in the face for no reason really it was completely unprovoked attack. I just stood there talking to a patient and then she just hit me so" (Pauline).

5.5. Fearing allegations. Eight of the participants including all of the male participants described their concerns about the risk of allegations and a resulting mistrust of patients. The risk of sexual assault allegations preoccupied both male and female participants. In cases where allegations had been made, it was not only the allegation which was distressing for the participant, but also the repercussions. In most cases staff were suspended until cleared and some never returned to work, not necessarily because they were found guilty of the allegation, but because the experience of having an allegation made against them was so distressing. Tanya felt staff should be treated as *"innocent until proven guilty"*. Anita and Chris depict the implications of allegations on their colleagues as *"mud sticks"* (Chris):

"...only he pushed her away. She said that he had groped her and pushed her to the floor and things like that. It was allegations that were made that were not true, but he had actually physically touched her...But he, he found it was too much for him and he couldn't take it so he ended up leaving" (Anita).

"He has had to go home to his wife and tell her he has been accused of rape stuff like that yeah. That is not nice for him" (Chris).

For Chris, allegations could be made out of simple physical gestures, and maintaining boundaries protected staff from allegations:

“There has got to be boundaries because these people, they can make allegations at any time. You know you have only got to shake their hand and they could say something. You have to be very, very careful when you work on the female ward about touching or saying inappropriate things” (Chris).

“Just, obviously fair enough that [NHS trust] take investigations really seriously and they have to do what they have to do, but if it’s a false allegation that could really, it could put something on your record that shouldn’t have been there in the first place really” (Simon).

Some of the participants described how the women made false allegations because they wanted a staff member moved, *“...So she knows they [procedures] have to be followed and knows she can get whoever she doesn't like off the ward. If they're male, she can make a sexual allegation and they have to be moved” (Jay).*

Sita, however, felt allegations were directed at male staff because of the angry feelings the women held towards the abusive men in their life prior to being detained:

“I think when we have a male staff they seem to get more of the aggression. I think a lot of the women are angry at men in general and when we have got males on our ward. I think that a lot of their anger is aimed at them and erm and allegations of rape and things will come up when there is men, or exposing themselves and nothing ever like that happens with the women with all female staff” (Sita).

Jenna mentioned the sense of injustice in the women being believed over her colleagues, particularly as staff were of sound mental health:

“And then she and I just think it is so unfair that these girls have got mental illness, that are under section for mental health act, but you or I that have got no mental illness and

so not under section - they believe them over the staff which I find very frustrating” (Jenna).

5.6. “Getting on with it”: tolerating aggression. Most of the participants described their response to aggression. It appeared the participants felt “*the trust (NHS)*” (Tanya) expected them to tolerate aggression and to “*get on with it*” (Anita). Ineffective coping mechanisms such as “*you just have to brush it, you just have to let it go over your head*” (Chris) were used following an aggressive encounter. Judith described how, despite being very upset following an assault, the following day she had to return to work and carry on as normal. Participants mentioned that the emotional aftermath of aggression was often overlooked:

Interviewer: “How do you cope with that, you cry and then what?”

Judith: “Go home, come back the next day (laughs). It's...you know, it's part of the job unfortunately. Erm...you just accept it and move on don't you?” (Judith).

Similarly, Carly described a sense of helplessness, and feeling ‘*violated*’ yet having to carry on working despite being seriously assaulted:

“I lost a bit of hair that night that was particularly nasty because I felt that I hadn't even really had a conversation I just said 'ooh yeah I'll get her' and it felt very unprovoked and quite a shock, quite shocking as well and then you are in charge of the shift you have to carry on (laughs) dust yourself down and you know yet you feel you have been sort of violated in some way you know” (Carly).

Staff shortages meant staff needed to return back to work as soon as possible which put participants in charge of rota management in a moral predicament:

“...You know I think there’s a fine line sometimes between showing them that I’m supporting them because they’ve been injured but at the same time almost encouraging them to come back as soon as possible because we can’t cover the team” (Lori).

Some participants believed aggression management strategies were failing, and expressed a sense of hopelessness, powerlessness and suppression:

“If a woman...particularly as she does this sort of thing a lot I think it’s almost, sometimes it gets brushed under the carpet, cos we know literally there is nothing else we can do. We can’t erm stop her from doing cos she is going to do something to someone at some point...it’s almost as if you just have to try, not forget it happened but move on I suppose” (Simon).

“I think the staff is so used to it now, that they do. They just get on with it and go onto the next sort of thing” (Anita).

In contrast to this hopelessness, Carly described an assault which she reported to the police, after which the patient appeared to reflect on her aggression and alter her behaviour. Carly also describes how the longer term relationship with the patient enabled reparation:

“I did actually erm funnily enough I didn’t report to the police the hair pulling but I did report the punch and funnily enough that was the last time that that individual patient ever hit anybody and the last time she ever had an incident and we had quite a good relationship because, because I had been here on of the longest she had known me on of the longest and erm I think that she was quite shocked that she, she had done that as well and we sort of talked about it afterwards as well(...)I’m not saying it was an epiphany but it I think it made her think about, because I was I’m like the old part of the furniture, I’m always here and have been for years and I think she felt ‘oh no, what have I done’ you know so erm she really engaged after that” (Carly).

5.7. Developing a “thick skin”. In order to cope with the aggression, stress and emotional toil faced at work, eleven of the participants described developing coping mechanisms such as a ‘thick skin’ (Simon). The participants described finding the women’s acts of violence very shocking when they first started the job, but how over a period of “6 months” (Pauline) of working in the service they had become desensitised. Jay commented on how he had “bad dreams” when he first started, but now feels “it’s only a slap at the end of the day. I’m not really severely hurt. It might be slightly uncomfortable” (Jay). However, the thick skin wasn’t fallible and not everyone became desensitised; for some the work was too stressful and there appeared to be a self-filtering process in operation, with a steady stream of people leaving the service. The participants talked about shutting off their emotions, to prevent them from going “nuts” (Tanya) but also to cope whilst in work and managing restraints: “I don’t, to be honest I don’t feel anything I just do it” (Sita).

“When I walk through the doors I’m a different person, when I walk through those doors I’m at work and like I don’t think about my home life, and when I walk out of those doors I’m at home and I don’t think about work. Obviously sometimes at night if something’s is going on it goes through your head or whatever but I just think I’m gonna put it in two separate compartments” (Amanda).

New staff were particularly vulnerable to the stresses of the environment and it was up to the nurses or more senior staff to support them. However, sometimes, as Carly describes, it was easy to forget how traumatic the work is once you have become desensitised:

“I have been here a long time now you sometimes forget how these things can affect new staff and you sometimes have to check on them to make sure they are ok and that you know cos it can be traumatic for people to see some of these things for the first time” (Carly).

Despite recognising that the work was stressful, Judith felt that expressing the emotional impact of the work was not something nurses participated in.

“I think it’s the nature of the job nurses do tend to just get on with it don’t they? They don’t really sort of like say right this is how I am feeling you know but we are not very good at it (laughs)” (Judith).

It is important to note that the amount of data generated from the 13 interviews was very large, therefore the emerging theoretical model presented here does not capture the breadth of all that the participants brought to the interviews. Furthermore, this emerging descriptive theoretical model of the participants meaning making, in this medium secure setting is co-constructed between myself and the participants. Another researcher may have conceptualised the data differently. In the next chapter the findings will be considered in light of previous literature and theory.

Chapter 4: Discussion

Chapter Overview

This chapter provides an overview of the entire study and discusses the findings. The chapter is split into two parts:

Part 1: Provides an overview of the emerging theoretical model. I relate this to previous literature, and psychological theory.

Part 2: I evaluate the research in terms of its methodological strengths and limitations. I present the implications of the current study's findings with regards to future research and clinical practice.

Part 1: Overview of the Theoretical Model

The study had two research aims and three research questions. The primary aims were to gain a deeper understanding of forensic frontline staff perceptions of aggression, and the therapeutic relationship. The three research questions aimed to explore how:

1. The therapeutic relationship is perceived by forensic frontline staff supporting women in secure services?
2. Forensic frontline staff perceive female inpatient aggression?
3. Frontline staff perceive the therapeutic relationship following an aggressive interaction?

This constructivist grounded theory study is novel in that it explores frontline staff perceptions of aggression and the therapeutic relationship in women's forensic services. The findings and emerging theoretical model highlight how frontline staff-patient relating changes following an incident of aggression, this can lead to, or result from, relational ruptures, boundary crossings and violations, by both the participants and the women. Furthermore, the participant's experiences of aggression had a number of personal and professional implications, and participants dealt with these, and coped to varying degrees. This study explored the individual experience of 13 frontline staff working in a women's medium secure unit. The results present the perceptions of the participants which are contextually bound and therefore specific to the service in which the research was undertaken. Through the analysis five interrelated co-constructed core categories, each containing a number of sub categories, emerged; 'Navigating the Invisible Line', 'Biting the Hand That Feeds You', 'Perceiving a Change in Relational Style Following Aggression', 'Transgressing, Retaliating and Rising to Aggression', and 'We Bleed and Bruise Just like Everyone Else'.

The theoretical model presents a continuum of approaches to boundaries and relationships, and highlights how participant experiences were varied in relation to their perceptions and responses to the therapeutic relationship and aggression. However, the categories also revealed some shared elements of contextually bound social processes for these participants. This study highlights the complexity of processes occurring between these participants and the women they support who are aggressive. The accounts reveal how aggression may destabilise the therapeutic relationship, and in some cases the relationship is deemed irreparable.

In the following section I present some of the key findings which I feel have the greatest clinical significance. Findings from each of the categories and subcategories will be considered in relation to the existing literature on the therapeutic relationship and aggression. Although the findings are specific to frontline staff process in this medium secure context, considering them in light of past research enables consideration of a wider contextual interpretation. I will not refer to how the results answered each individual research question. Instead this will be incorporated into the overview.

The Theoretical Model and Existing Literature

The emerging theoretical model is presented in chapter three, interestingly a number of similarities were evident in the accounts of the participants in this study and the synthesised existing literature. These are presented below.

Literature on aggression in forensic services. The analysis of the participant's accounts revealed a very rich depiction of how aggression is perceived at the coalface of women's forensic care. The participants reported increasing admissions for women perpetrating aggression towards others. This presented a challenge to the participants and the

service as a whole. Although this finding is unsupported by quantitative data, it is supported by previous literature (Loper, 2000; Kindy et al., 2005; Long, 2012).

The theoretical model highlighted contextual factors revealing differences in participant's perceptions regarding the treatment needs of, and aggressive interactions with women with a diagnosis of personality disorder and those with a diagnosis of psychosis, supporting previous research (Allen & Beech, 2010; Hinsby & Baker, 2004; Jacob & Holmes, 2011; Trenoweth, 2003). Allen & Beech reported how nursing staff in women's services believed aggression perpetrated by patients with a diagnosis of personality disorder was intentional, this is supported in the current study. In relation to the research questions, beliefs about the intentionality of aggression, influenced the participant opinions of, and relationships with the women.

Hinsby & Baker (2004) reported how forensic staff and patients were caught in a power struggle, where nursing could become punitive in an attempt to maintain ward safety and gain 'control' over patients. The findings from the current study theorised that some frontline staff misused their position of authority and professional 'power' to manage aggression, and following aggression. Under the category 'Transgressing, Retaliating and Rising to Aggression' participants disclosed boundary crossings and violations in the frontline staff-patient relationship, such as how they, or their colleagues had retaliated to, held grudges against, or provoked the women's aggression. In certain circumstances, this was in self-defence. Previous research by Jacob & Holmes (2011) reported how staff acted in self-defence when afraid or under stress. Adshead (2012) suggests power disparities can be played out between both staff and patients, which can lead to relational ruptures. It could be that patient aggression is an opportunity for patients to challenge injustices and experience self-empowerment (Shepard & Lavender, 1999). As such aggression could be a reaction to staff

attempts to gain control, but also because of patients perceived deprivation of liberty due to entering the forensic service (Carr & Havers, 2012).

An important aspect of the theoretical model suggests that aggression can threaten frontline staff capacity for objectivity, particularly when perceived as a personal attack. In the category ‘We Bleed and Bruise Just like Everyone Else’ participants described the psychological and emotional manifestations of aggression. Similar accounts have been provided in previous literature (Kindy et al. 2005; Maguire et al., 2011). Participants often operated on high levels of anxiety, fear and hypervigilance when working with women who are aggressive, this was also reported by Jacob & Holmes (2011). The literature supports the current findings, in that aggression impacted on the participant’s job satisfaction, and led to some participants dreading their work, and poor staff retention (Kindy et al. 2005).

Furthermore, the fear of allegations and the longer term repercussions of allegations, resulted in both male and female staff feeling angry towards the women, potentially rupturing the therapeutic relationship. Both the previous literature in women’s services, and current study reported how frontline staff could blame themselves for not having prevented aggressive interactions with the women, and experienced guilt in relation to not having ensured their colleagues safety (Allen & Beech, 2010). The current study made theoretical links between staff-patient relational ruptures and anger at colleagues being injured by women inpatients.

The participants in this study described having to tolerate aggression as part of the job, and having to continue working with the women following assault despite feeling ‘violated’. The participants tried not to think about the aggressive incident and one participant commented “*it’s the nature of the job, nurses do tend to just get on with it don’t they*”. Feeling burnt out was a key active description of some of the participants. Although not explicitly mentioned in the literature, previous research did allude to staff experiencing emotional exhaustion, and trauma symptomology (Kindy et al. 2005; Tema et al. 2011). In this study the findings

suggested that burnout effected the standard of care provided by forensic staff, and their relationships with the women who are aggressive. Nathan, Brown, Redhead, Holt & Hill (2007) compared levels of burnout in forensic staff working in male and female wards. They found significantly higher levels of burnout in staff working in women's wards.

In the current study new staff were considered particularly vulnerable to aggression and boundary violations, and more senior staff, because of the process of desensitisation, could forget how frightening and shocking working with aggression and self-harm could be. If participants are desensitised to aggression, aggression may become ingrained in the ward culture. Wright et al. (2014) reported staff perceived the forensic service as having "its own culture of violence". The participants in this study felt there was a public misconception regarding the severity of women's aggression. The forensic service was conceptualised as in isolation to other services, which reflects previous research (Kurtz & Jeffcote, 2011). If staff become tolerant of aggression then a potential underreport is possible (Aberhalden et al. 2007). Furthermore, participants believed aggression was tolerated by the forensic organisation, which could be suggestive of 'organisational collusion' as reported by Aiygebusi (2011).

Maguire et al. (2011) reported nurses used defences such as suppression and rationalisation to cope with their emotional reactions to aggressive male patients. High anxiety, fear, and negative feeling towards the women resulted in some staff actively avoiding engaging with patients and withdrawing to the office. These findings are similar to those reported by Kindy et al. (2005). The participants in this study felt the strategies used to manage women who were aggressive were ineffective. Being poorly equipped to manage the shift may lead to feelings of helplessness and high anxiety, which may increase the risk of hostile interactions (Bowers, 2009; McGuinness, 2011).

Literature on the therapeutic relationship. The participants in this study described the unpredictable nature of their multifunctional relationships with the women. In relation to the research questions, participants in this study, and research conducted by Allen and Beech (2010), perceived trust, safety and mutuality to form the foundations of the therapeutic alliance. The participants described valuing their work with the women, and wanting to care, but at times feeling rejected, unappreciated and objectified by the women. Furthermore, 'good' therapeutic relationships were damaged by aggression, which destabilised the relational foundations.

In relation to the first research question, the therapeutic relationship was considered a mutual trusting endeavour between participants and the women. The most important relational feature was collaboration through mutual trust. Trust, and therefore the relationship took time to develop, and required the participants sharing personal information. Participants felt the therapeutic relationship was established when the women sought them out for help. This represented the acquisition of trust. However, the participants described ways in which the relational trust was breached; these included when participants made allegations about participants and their colleagues, used personal information against participants, and following aggressive interactions. A betrayal of trust following aggression has been reported by staff in other studies (Jacob & Holmes, 2011; Kurtz & Jeffcote, 2011; Maguire et al. 2011). As reported by Kindy et al. (2005), and Jacob and Homes, aggression and a breach of trust resulted in participants maintaining a hyper-vigilant stance, where fear and anxiety adversely guided relational style.

When considering participants' experiences of fear it is important to consider Peplau's (1952) theory of interpersonal relations in nursing. The theory suggests that staff are required to provide the basic requirements of safety (Maslow, 1943) before the patient and staff member can progress through the stages of the therapeutic relationship. This requires the staff member

becoming attuned to the patient's distress and traumatic past. If this process doesn't occur then the relationship becomes purely 'custodial' (Callaway, 2002). Although Peplau's theory relates specifically to nursing practice, it appears to have similarities to the broader practice of frontline staff. The theoretical model highlights how participants pulled away from the relationships with the women following aggression, but continued to maintain a 'professional' stance. Some participants described their colleagues provoking, or retaliating against aggression. This is important to consider as relational security should be facilitated in women's services rather than an emphasis on physical and procedural security which would represent a 'custodial' approach. Aggression occurring in the accounts of participants may suggest that safety is compromised, which may inhibit the development of the frontline staff relationship with the women who are aggressive, but also perhaps with other patients whose sense of safety may be compromised through witnessing aggression.

The relationships following aggression were perceived as complex and fraught with tensions. In relation to the third research question, participants described changes in their therapeutic relationships to the women following an aggressive interaction such as; experiencing resentment and animosity towards the women, a loss of compassion, a change in their willingness to support the women, and changing their proximity to the women. This is supported by Jacob & Holmes (2011), who found nurses distanced themselves from patients who they were afraid of. Aggressive interactions were considered by some participants as having a negative impact on relationships, the ward atmosphere and staff morale. This is concerning as previous research in women's services touched on the importance of the therapeutic relationship as a protective factor against aggression in women's services (Allen & Beech, 2011).

The theoretical model portrays how the participant's relationships and boundaries with the women are intrinsically linked. Previous literature suggests therapeutic relationships require

the maintenance of predictable and consistent boundaries (Dziopa & Ahern, 2008; Wright et al., 2014). In this study participants described conceptualising the boundary 'line' as 'invisible' and 'permeable', with an ambiguous middle ground. Boundary ambiguity placed frontline staff at risk of boundary crossings and violations. The pushing of boundaries was bi-directional in this study, and could damage the therapeutic relationship. Multiple approaches to boundaries created 'splits' and disagreements in the team. These findings are important as forensic staff are expected to model boundaries and safe and trusting relationships to the women (Aiyegbusi & Kelly, 2012).

Some participants found it hard to relate to women personality disorder, describing the women as 'the diagnosis' rather than 'having' a diagnosis. Jacob & Holmes (2011) reported 'othering' processes, where stereotyping patients could create impasses in the therapeutic alliance. The participants described feeling objectified by the women who they described as ungrateful for the participants' support. Because of the women's aggressive behaviour, some participants found it hard to empathise with the women, and conceptualise the women's vulnerability manifested through their traumatic pasts. Kurtz & Jeffcote (2011) reported similar findings in male secure services.

Novel Findings

The current study offered further insights into frontline staff perceptions of aggression and the therapeutic relationship. I will now go on to reflect on two novel findings which emerged from the interviews.

Negotiating the physical aspect of the relationship. Participants held varied perceptions on the use of physical touch. Some participants found the physical aspect of the relationship was paramount to supporting the women and the developing therapeutic

relationship, others felt the use of physical touch was highly unprofessional. I am not aware of any research exploring staff perceptions of the use of therapeutic touch in women's forensic services. However, research into therapeutic touch has been conducted in non-secure psychiatric inpatient units. Gleeson and Higgins (2009) explored mental health nurses' perceptions of therapeutic touch. This study reported that nurses felt touch was an essential component of the care for patients, but staff required careful clinical judgement for when a physical intervention was appropriate. Furthermore, male and female staff felt unsure about using touch with opposite gender patients as this increased the risk of allegation. Carlsson, Dahlberg & Drew (2000) reported how the tacit use of therapeutic touch in nursing aggressive patients can result in 'positive resolution' of relational tensions, which enables clarity on boundaries through reflection, whilst reducing the 'them and us' dynamic between staff and patient, and 'containing' the patient in the moment.

“An embodied moment is characterized by pliability, the professional's ability to be at the same time close as well as distant, active as well as passive, willing to wait as well as to take action....The caregivers acknowledge their own fears and instinctively choose the right manner of touch. Recognizing the shared mutuality, the human bond between themselves and their clients, they draw on their own capacity for steadfastness in answer to the exigency of the moment. In this moment the caregivers decide how to set the boundaries of the situation and how to convey their understanding of the situation to the clients” (Carlsson, Dahlberg & Drew (2000) p.542)

However, research findings relating to staff perspectives on therapeutic touch do not always mirror patients perspectives. Salzmann-Erikson and Eriksson (2005) interviewed psychiatric patients on their experiences of physical touch by mental health care staff. This

research highlighted how patients perceived some positive aspects to touch, but also recalled feeling “violated and oppressed” if touched by a member of staff whom they had not established a therapeutic relationship. Interestingly the participants described their need for touching increased when their mental health was suffering. Shattell, Starr, & Thomas (2007) reported patients how the use of touch including ‘a hold of the hand’ made them feel the staff member ‘related’ to them. In contrast to this Mulaik et al., (1991) reported how some patients felt staff use of touch to be controlling. Moyle’s (2014) study investigating psychiatric patient’s experiences of the nurse-patient therapeutic relationship found a dichotomy between the closeness in relationships expected by patients and distancing behaviour exhibited by nurses. Patients with a diagnosis of severe depression felt comforted when they were physically embraced by staff, but staff were resistant to physical closeness for fear of becoming ‘over involved’ and the patient becoming ‘overly dependent’. This conflicting expectation results in confusion for both staff and patients and potential relational impasses. The participants in the current study considered the increased risk of allegation in using physical touch interventions with the women. But also felt torn, recognising the women had no other means to get their physical needs met. Differences in approach to physical touch led to conflict between the women and participants and their colleagues, which adversely impacted on the therapeutic relationship. In their literature review Dziopa and Ahern (2008) found the use of touch was used to connect to and comfort patients and was used or not at the individual nurse’s discretion. These findings are demonstrated in the current study.

Whilst taking into account the research mentioned above it is important to highlight the risks of therapeutic touch re-traumatising women who have experienced past physical and sexual abuse, who may feel shamed and repulsed by touch, and yet feel starved of touch (Johnson, 2006). The use of therapeutic touch may not be beneficial for all clients and should be decided on an individual basis. However this ambiguity, and lack of clarity around which

patients are touched by staff, and which patients are not, and why, can be confusing for the patients and staff group. This can lead to tensions between staff members and the tensions in the therapeutic relationship. The benefits and tensions surrounding the use of therapeutic touch in mental health nursing are not easily defined, and ambiguity in staff and patient opinions is evidenced in the research. As such research on the use of therapeutic touch and its influence on the therapeutic relationship in psychiatric nursing particularly in women's secure services is required.

Being protected by patients. Boundary violations can occur when the staff member's needs are being met over the patients' needs, thus violating the trusting foundation of the therapeutic staff-patient relationship. Furthermore, in their quantitative study Johnson, Worthington, Gredecki, & Wilks-Riley (2016) found that boundary violations by staff in forensic services were related to 'higher emotional exhaustion and depersonalisation'.

In this study participants described role reversals where the patients switched from perpetrator of aggression, to protecting the participants and their colleagues from other aggressive patients. This role reversal includes staff being cared for rather than performing a caring role. This may result in relational ambivalence, and a lack of clarity thus blurring the relational boundary. To my knowledge this was the first qualitative study in women's services to report this phenomena.

Women inpatients may have experienced role reversals and poorly defined boundaries in their family systems. Disorganised attachment has been linked to a lack of "maternal psychosocial problems" (Meloy, 2003, p. 513), where role reversals may have been commonplace in the family system, such as the care giver also being the abuser, but also the child having to be a carer. This offers one explanation as to how women who may have experienced role reversals in childhood, can easily adopt role reversals in their later relational

interactions. As such role reversals could be used to understand women's aggression in relation to their past experiences. Drawing on transference and countertransference that occurs in therapeutic relationships with carers can enable a better understanding for the staff member.

The findings in this study could also be considered in relation to Karpman's (1968) Drama Triangle. This theory describes three connected roles, involving control and responsibility, that individuals can find themselves in in family dysfunctions, these include; 'persecutor, rescuer and victim'. Individuals involved in a conflict can shift between the different roles, such as described in the theoretical model. In this model the reversal of role between victim and rescuer ensures that both parties (staff and patients) meet their needs to be looked after. For instance, under threat frontline staff are protected, and women experience a sense of control through becoming the rescuer.

Boundary violations such as role reversals can occur when staff are overly involved with patients (Nursing and Midwifery Board of Australia, 2010). This may be when the staff member confuses their personal needs with the needs of the person under their care (Jones, Fitzpatrick & Rogers, 2012). Chadda and Slonin (1998) outline how severely traumatised patients can consistently test the relational boundary, and this can lead to staff feeling exploited and like a victim themselves. Pternelj-Taylor (2003) describes forensic services as "hotbeds" for boundary violations because of the isolation of forensic services along with the intensity of the therapeutic encounter. For relational violations to be resolved a third person may be required to reflect on what is occurring in the staff patient relationship. Furthermore staff should engage in regular supervision to develop a sense of self awareness, and to better understand and monitor transference and counter-transference in their interactions with patients (Pternelj-Taylor and Yonge, 2003). Jones, Fitzpatrick & Rogers suggest staff need to frequently ask themselves "whose needs are being met by this action, the nurses' or the patients?" (p.62). Although there is much reference to role reversals in nursing literature, there appears to be very

little research in the field, and no specific research relating to women's secure services. I would therefore suggest further attention is required to explore this interesting phenomena.

The Emerging Theoretical Model in Relation to Theories of Aggression

I now go on to consider the emerging theoretical model in relation to existing psychological theories. I have opted to relate the model to Attachment Theory, Psychodynamic and Psychoanalytic theory and Social Defence's Theory specifically as I feel they are most relevant to the findings. This is a tentative attempt to use the theoretical models to understand processes relating to how aggression effects therapeutic relationships in this women's medium secure service.

Attachment theory. Attachment theory can be considered in relation to the entire theoretical model, and enables a better understanding of the processes these participants encountered in their work with the women who are aggressive. The findings may be compared to the work of by Sarkar and Di Lustro (2011) who proposed women's aggression is regularly directed towards 'attachment figures'. Some participants described believing they had good therapeutic relationships with the women, and were shocked when the women unexpectedly became aggressive towards them, experiencing a sense of rejection.

Holmes (2001) suggests that both frontline staff, and the forensic service can represent the 'secure base' for mentally distressed women who perceive themselves under threat, such as when they are admitted to medium secure services, but also because the ward can be frightening when unsettled. Women in secure care have often experienced 'cycles of abuse', and their primary caregivers may have failed to protect them in basic fundamental ways (Bowlby, 1988). The participants in this study referred to the women 'burning bridges' and like Bowlby (1973) being stuck in 'cycles of abuse'. Women with insecure, particularly

disorganised attachment behaviours can externalise their distress (Motz, 2008), becoming hostile and aggressive when their attachment systems are activated. Moreover, adults with disorganised attachment styles may have developed rigid self-independence, are inflexible and likely to need compulsive control over their life circumstances (Lyons-Ruth and Jacobvitz, 1999). Aggression occurring in the women's services, either perpetrated by the women or witnessed by the women, may re-awaken women's previous experiences of aggression, which they may re-enact in their violent interactions with staff. Fonagy and Target (1999) propose disturbed attachments can lead to poor self-reflective and mentalizing capacity. This might help to explain why the participants in this study felt the women were unaware of the emotional and physical impact of aggression, but also why the participants felt objectified by the women.

As a result of the women's aggression some participants distanced themselves from the relationships with the women, and experienced a change in their willingness to support the women. The women may have experienced this as a threat to the attachment relationship or even abandonment. It is possible this may have aroused defensive anger and aggressiveness towards the participants (Bowlby, 1973; Adshead, 1988). It could be that the women's aggressive acts may have unconsciously sought to increase closeness, but instead lead to therapeutic ruptures (Bowlby). Attachment theory suggests that when women with secure attachments feel 'rejected' they can either reject staff, or may experience an intense need for 'proximity and care'. The participants described how the women were desperately seeking attention and physical contact and yet simultaneously rejecting and aggressive. This type of behaviour is characteristic of emotionally unstable personality disorder (Adshead & Aigebusi, 2014).

Psychodynamic/psychoanalytic theory. Freud (1914) described aggression arising from instincts and drives, and patients compulsively repeating and re-enacting trauma or

aggression through 'repetition compulsion'. This would involve women unconsciously re-enacting their experiences of aggression and disempowerment onto staff to rid themselves of fear, and in doing so the staff member experiences their sense of vulnerability, powerlessness and humiliation (Aigebusi & Tuck, 2008; Taylor, 2012). In this theoretical model the participants described feeling violated, burnt out, afraid, powerless and at times helpless in the face of the women's aggression. Psychodynamic theory might propose that staff are identifying with the women's victim experiences, through countertransference and projective identification (Klein, 1946).

In this study the category 'Biting the hand that Feeds You' offers insight into the participant's experiences of feeling their attempts at caregiving are initially accepted, and close relationships formed, only to be rejected by the women further down the line. The rejection of care is symbolised through the aggressive interaction. Women in secure service may want to build relationships with staff, but feel afraid they will be rejected or hurt, and so reject the relationship first (Bowlby, 1969; Clarke-Moore & Barber, 2009). Furthermore, Motz (2012) argues that women in secure care have often experienced neglectful, abusive and abandoning maternal figures who may have failed to protect them from abuse (intentionally or unintentionally) during their childhoods. These female patients can feel overwhelmed by the presence of so many women (staff and patients) on the ward. Motz suggests this needs to be held in mind when caring for women with a complexity of needs, such as those in medium secure services.

Defences. Klein's (1946) concept of the 'paranoid-schizoid position' describes how women's intolerable feelings (e.g. badness, anger, rage, powerlessness) are split off, defended against and unconsciously projected onto others, in secure services this will often be staff members, who may identify with these projections. The woman transfers her powerlessness

onto staff and gains a sense of 'control'. To some extent this may explain why "allegations of cruelty, neglect and sexual abuse on the part of nursing staff are routine in the life of such services" (Aiygebusi & Tuck, p.11). Furthermore, the women may have been in residential care for periods in their childhood and may experience transferences that are linked to their earlier residential institutional experiences, good or bad as distinct from their earlier family based neglect or abuse, or protective factors. A number of 'splits' were evident in the participant's accounts, Judith described feeling singled out from the team "*This particular night she was really just aiming at me and nobody else, everyone else was lovely*". Klein's (1936) theory of part-objects and the paranoid schizoid position could help understand these processes, where the bad parts of the women are split off and projected onto frontline staff. Projective identification acts as a defence, if the women project their hostile thoughts and feelings onto the staff team, the staff may begin to identify with this and become persecutory in their interactions, as seen in the participants accounts (Hinshelwood, 2002). If staff are able to identify these projections they can be used to facilitate psychological change, if not they may create impasses within the therapeutic relationship.

Lowdell & Adshead (2008) describe a defence where staff see patients as "all good or all bad" (p.60). They describe this split as "a manic defence against the reality of what the patients have done, and a cruel identification with the hopelessness of their position" (p.60). Hinshelwood and Skogstad (2000) propose that the unconscious processes that frontline staff face can undermine their perceptions of competency and undermine the therapeutic relationship. Women's externalised internal distress (Motz, 2008), can leave those in direct care for them 'feeling helpless, manipulated and attacked' (McMillon & Aiyegbusi, 2009, p. 172). Healthcare professionals require an element of perceived attainment to competently support patients to recover (Main, 1957). Hinshelwood and Skogstad further state when staff begin to feel helpless they can project this onto patients, which leads to resentment towards the patient

for not improving. Unless worked through this two and fro of projections can result in relational ruptures. In the current study participants felt helpless to manage aggression, and despite their best attempts to care for the women, some women continued to be aggressive. In these instances staff felt resentful, the relationships was sometimes considered irreparable, and these patients were often moved on to new services because they were not improving.

Motz (2010) proposes aggression as a means of communication, proposing that female violence is a “defence against underlying psychological distress” (p.5). Furthermore, when supporting women who are emotionally disconnected and ‘out of touch’ with their life experiences “the workers awareness of his or her feelings is the main vehicle for understanding the patients emotional states, psychopathology and offending behaviour” (Gordon & Kirtchuk, 2008 p.2). Participants in the current study described, emotional suppression and ‘brushing’ angry reactions ‘under the carpet’, and are therefore missing opportunities to understand the women through these reactions. It could be that the participants are having to rely on defences such as ‘suppression’ to manage their emotional reaction to carry on with the shift. Similar responses were reported by staff in the study completed by Maguire et al. (2011).

Social Defences theory. Social Defences Theory can aid understanding of the theoretical model. In the current study participants described feeling anxious, hyper vigilant, resentful and fearful of the women following aggression. In response to an aggressive incident participants created a distance between themselves and the perpetrator of aggression, although continuing to maintain a ‘professional’ stance. Furthermore, the participant’s rejected attempts to support the women aroused feelings of frustration and anger. Menzies Lyth (1960) describes how nurses develop unconscious social defences to cope with the ‘intolerable feelings’ experienced when working in highly stressful situations with very distressed patients (Lowdell & Adshead, 2008). Menzies Lyth described how one defence was to limit the amount of time

spent with patients. Frontline staff working in forensic services rarely move wards. In the current study attempts to create distance from the women may have included sickness absence, wanting to move wards, hiding in the office and changing proximity to women. The current theoretical model described how women who are aggressive are considered unmanageable and 'burn bridges'. When this occurs these women are discharged and admitted to other services. This could be seen as a defence against the anxiety relating to the women not improving and as such the women are moved on from the service. This defence may be just as effective as the staff moving wards.

Summary

The therapeutic relationship between staff and patients is considered central to patient recovery. The finer details of the therapeutic relationship, including therapeutic ruptures are difficult to capture through experimental research. As the research and theory suggests women develop a sense of self-worth through their connections with others, and aggression is thought to have a strong relational component for women. The women's and the participants sense of safety and connection through their relationships, and therefore relational security, may begin to erode following the aggressive interaction. The therapeutic relationship is therefore jeopardised following aggression. Birch (2012) proposes "Until they [women] have developed a dependency on the service and the people in them, which is restorative, they will not be able to relinquish this dependence in order to find greater independence". In the current study the restorative relationship is compromised. The participants described multiple approaches to their approaches to boundaries with the women, which could lead to conflict and impasses in the therapeutic relationship. It is unclear whether these impasses are worked through as the participants described struggling to utilise their reflective practice.

Part 2: Review and Clinical Implications

Strengths and Limitations of the Current Research

Theoretical model. When considering the strengths and limitations of the theoretical model it is important to note that these findings reflect frontline staff social processes relating to interactions and relationships with women forensic inpatients who are aggressive in this service. All of the participants in this study personally experienced aggression perpetrated by women inpatients at differing levels of severity. This study did not identify whether the perpetrators of aggression were a small subsample of women. It may be that changes in the therapeutic relationship following aggression relate specifically to only a small proportion of patients. Cutcliffe (2005) states the ‘credibility’ of many grounded theory studies is questionable as rather than an emerging conceptualisation, many researchers ‘force’ a theory from the data. The process of ‘forcing’ results in the failure to conceptualise the “basic psycho-social process” (p. 421). It was likely that I achieved theoretical sufficiency rather than saturation, and this study offers an emerging descriptive model of “psycho-social’ process grounded in the participants’ responses. It would be premature to state this is a ‘grounded theory’ of frontline staff practice in relation to aggression and the therapeutic relationship, as this would require extension and replication of the research in other women’s medium secure wards. I am satisfied with the emerging model and feel that pushing the analysis further would have risked ‘forcing’ a theory. As such this study offers opportunities for further research.

Participant validation. Cutcliffe (2005) highlights literature advocating the importance of researchers returning to the study participants to establish whether the findings fit with their perceptions and experiences. Cutcliffe goes on to propose that in nursing research returning to nursing participants, helps identify whether the theory has “fit and grab” (p. 425) and can help conceptualise the psycho-social processes. To enhance the credibility of the study I would

have liked to have presented the results to all the research participants. Despite emailing the participants, I received feedback from only one participant who commented “all looks good and accurate to me” (Amanda, personal communication, 22nd July 2015). Although, participant feedback was limited, I feel I completed a rigorous data analysis and remained grounded in the participant experiences, this enabled theory generation in an area where little previous research has been conducted.

Metasynthesis. The process of searching the literature and writing the metasynthesis started prior to the constructivist grounded theory analysis. This could have influenced the analysis of the participant data. I have attempted to maintain theoretical sensitivity and to ‘stay open’ to the data. Heath, (2006) states it is important to “challenge emergent theory and locate the emergent theory within the current body of knowledge” (p.527). I provided a detailed explanation of the strategies I utilised to ensure I remained grounded in the participants accounts during this process (See quality appraisal section in methodology). The meta-ethnography included qualitative research with varied epistemologies and methodologies. The research and data was derived from different forensic contexts; including different levels of security, male and female services, and different staff groups. Furthermore, articles referred to different types of aggression, included the management of aggression, and only one article provided a definition of aggression. Furthermore, qualitative data is thought to be context specific and non-transferable. I made the decision to include these varied contexts due to the limited amount of research in the field. The aim of the synthesis was not to disentangle these multiple perspectives, instead it was to gain new insights into forensic frontline staff perceptions of aggression. Moreover, my interpretation of the second order constructs is only one interpretation, a different researcher may have construed different themes. Despite this I feel the synthesis of data offered important insights into aggression within forensic services.

Implications of the Current Research

Research Implications

The results of the current study add to this field of forensic research, the literature review in chapter one revealed very little qualitative research on staff perceptions of aggression in forensic services, and a paucity specific to women's services. A greater understanding of aggression occurring in women's forensic services is essential considering the impact on patient and staff wellbeing, the therapeutic relationship, and the considerable financial cost of women's medium secure care.

Replication. This Constructivist Grounded Theory (CGT) of frontline staff perceptions of women's forensic inpatient aggression and therapeutic relationships is in its infancy and requires further research. I felt I was only part way to constructing the complex processes involved in the frontline staff/ women's relationship following aggression. For instance, interviewing staff who no longer work in the women's service due to their experiences of aggression could have been pursued through theoretical sampling. Furthermore, interviewing staff who had not experienced aggression about their relational experiences with the women could have offered interesting opportunities for comparison.

Observation. I used semi structured interviews for data collection. Future research should consider replicating the study on a larger scale and combining both interview and ethnographic observation. This could support, extend or refute the theoretical model. I feel an ethnographic element to the study to explore systemic factors would have enriched the findings and provided more insights into the interactions between staff and the women, otherwise not attainable through interview.

Use of therapeutic touch. The study revealed the participants approach to physical contact varied. There was lack of clarity on policy relating to physical touch used by staff to comfort women. This begs the question, how do women forensic inpatients meet their physical needs, if indeed they wish to? Particularly as women can remain in secure units for up to five years. This research highlighted the risk of allegation, and harm participants faced working in this service, which some participants considered was increased by physically comforting the women. Future research could explore how both frontline staff and patients perceive physical comfort as an intervention in women's medium secure services. There has been research into 'touch' in psychiatric nursing but none in women's secure services as far as I am aware.

Role reversal. This study revealed common boundary transgressions between participants and women in this medium secure service. One of the more interesting and novel finding of the study was staff experiences of being protected by patients. Interestingly, the patient 'protectors' could also be the perpetrators of aggression. Furthermore, the patient intervention was described as an effective de-escalation device. As far as I am aware there is no previous research exploring staff or patient experiences of role reversals such as this in forensic services. A grounded theory study to could be conducted to explore this further.

Obtaining the women's perspective. Prior to starting the project I was interested in how both staff and service users come to understand aggression and therapeutic relationships on women's secure wards. Further research exploring the women's experiences of aggression and the therapeutic alliance in this service would complement this research. This project is being conducted concurrently in the same service by another trainee and will be submitted in 2016.

Clinical Implications

I will now consider the findings in relation to the implications for frontline staff, women forensic inpatients, and the forensic service as a whole. In addition to this I offer my thoughts on the importance of Clinical Psychology in applying this research to clinical practice. These findings have social significance in that these staff are working with a particularly marginalised and traumatised group of women. The relational component of care is crucial in women's services and for women's recovery.

Coming together. Rice (1963) proposed a coherent understanding of the 'primary task', individually and collectively is required by the entire team/organisation "if it is to survive" (p. 17). Hirschhorn (1993) suggested anxiety is at the core of relational break down in the workplace and can seriously jeopardise completion of the 'primary task'. The study found participants held many different approaches to working with the women, and there was lack of clarity in relation to boundaries and service policy. A shared understanding, and consistent approach could create a holding environment for both the women and the staff team. In the longer term this could enable the staff to better manage their anxieties, discuss boundary crossings openly, thus enhancing the safety and 'containing' function of the ward (Norton, 2012). However, the management and organisation must also be involved in modelling boundaries and nurture the staff team, offering a 'secure base' for the staff, enables facilitate a 'secure base' for the women. This will require the appropriate support systems being put in place; this could include timely supervision, mediation and debrief following the experience of aggression.

Clinical Psychologists often fulfil a leadership and consultancy role and as such are able to have some influence in and outside of the forensic system in relation to policy and service procedure. It may be important for the service to review policies on physical touch on the

women's ward. I believe that the DoH are currently reviewing the See, Think, Act document to reflect a more psychological approach to thinking about the importance of the therapeutic relationship in forensic care. Clinical Psychology can support integration of the new policy into working practice.

Staff support systems. This research suggests that frontline staff are required to manage aggression at work, whilst also providing care for patients who are aggressive towards them. It is important to facilitate a space where communication of the negative feelings arising in working with women can be shared and responded to sensitively with understanding. In order to understand these experiences and manage the feelings aroused by their work forensic staff should participate in regular supervision and reflective practice (Norton, 2012). Supervision was incorporated into nursing practice following the publication of 'A Vision for the future' (DoH, 1993), since then policy developments have ensured clinical supervision is mandatory for all staff, particularly staff working in forensic settings (Quality Network for Forensic Mental Health Services, 2011). It was recognised that supervision and reflective practice could protect against staff burnout, particularly when working with women (Kurtz, 2005), in medium secure services with a diagnoses of personality disorder (Long, Fulton & Hollin, 2008). The participants in this study referred to staff reflective practice as a formal intimidating space. Long, Harding Payne & Collins (2013) found that health care assistants in women's forensic services engaged less in supervisory practice, placing them at greater risk of workplace stress. The participants suggested some of the team found struggled in utilising this space to explore their work with women, thus impeding reflection on the difficulties encountered in their work and dividing the team. Team cohesion is linked to team performance and functioning, this has been described as "an individual's sense of belonging to a particular group and his or her feelings of morale associated with membership in groups" (Bollen & Hoyle, 1990, p. 482). In

secure services Clinical Psychologists as ‘reflective practitioners’ with experience of group dynamics and facilitation and psychological theory often facilitate reflective spaces for staff and patients, and help teams understand why difficulties in teams occur. The term reflective practitioner was initially introduced by Schon (1983) who proposed a reflexive stance could be used to learn from previous experiences, in order to recognise and consider complex professional issues. Given the findings in this study it may be important for the service and Clinical Psychologists to review the reflective practice process in women’s secure wards, this should be considered through collaboration with staff and inpatients with the aim that attendance increases. Working through issues occurring in their work with women may aid staff retention.

Implications for training. Stokes (1994) puts forward that differences in approach to working with regards to “values, priorities and preoccupations” (p.24) can occur in multidisciplinary teams. This is because staff vary in their training backgrounds and knowledge. The service already offers a brief training on attachment theory which has been set up more recently in response to the high level of incidents in the service. It will be important to incorporate thinking about both boundaries, trauma, psychodynamic and psychoanalytic concepts, and attachment theory into the everyday practice of staff on the women’s ward, but also bank staff, including staff transferred from the men’s service who are used to working within the ‘masculine’ model of care. All staff should be provided training on gender specific interventions and approaches, with a particular emphasis on relational security, and women’s relational experiences. The establishment of a boundaried, caring and trusting relationship should enable the women to develop their own internalised carer, and modelling of boundaries transcends to future relationships. It is also imperative that the staff are provided space to consider their emotional reactions to working with this very difficult client group. This might involve case discussion as a joint venture rather than taking a merely didactic approach.

Clinical psychologists have a number of transferable skills, these include assessment, formulation, intervention and evaluation. These skills can be applied through direct and indirect client working as well as working with teams, service development and research. Furthermore, Clinical Psychologists have a “commitment to reducing psychological distress and enhancing and promoting psychological well-being through the systematic application of knowledge derived from psychological theory and evidence” BPS (2006). As such in forensic services the Clinical Psychologists experience and psychological knowledge can support the system (team, management, governing board and community services) to work holistically around the forensic inpatient, supporting both inpatient and frontline staff wellbeing. Clinical psychologists working in women’s secure wards could incorporate formulation teaching sessions, psychological supervision (alongside management supervision) or consultation drop in training slots for staff. This could include sessions on the functions of dangerous behaviour (to self and others), psychological models, and appropriate interventions. Team formulation of the women’s experience may support the staff team to objectify the women’s aggressive interactions. Furthermore, this would support staff to fulfil their learning needs, and contribute to personal and professional development requirements and would also create an environment where psychological thinking and continuous learning is encouraged, perhaps increasing staff morale (Goleman Boyatzis & McKee, 2002). This is particularly important because of the limited mental health experience many of the support staff had prior to entering the service.

Patient support systems. It will be important to encourage the staff team to think with the women about why they are aggressive, this could be through a process of mediation, or through a support group incorporating mentalization theory (Bateman & Fonagy, 2004) Bowlby (1973) proposes that relational ruptures are important to establish a secure base, it is possible that if worked through, the aggressive act could lead to relational repair. Exploring the

aggressive incident with the women could enable a better understanding of what is being communicated in the aggressive interaction. Jones (1997) introduced the concept of ‘offence paralleling behaviour’. He suggests that aggression occurring in healthcare is part of an ‘offence chain’ which can resemble the patient’s index offence. This mirrors onto theory proposed by Freud (1914) and Bowlby (1969) which suggest early life experiences of aggression can be played out in later life. Both frontline staff and patients can work together and use the aggressive act as a therapeutic tool to better understand the women, but also to enable the women a better understanding of themselves. Jones proposes the cycle of aggression can be broken or changed where “the links between thoughts, feelings, and behaviours in the offence chain could be adapted in a pro-social way” (McDougall, Pearson, Bowles & Cornick, 2010). Clinical psychologists can be incorporated into this work by facilitating reflective spaces for the women alongside the staff team, this parallel learning and development could work towards engendering holistic change throughout the system.

Conclusions

The purpose of the research was to explore frontline staff perceptions of aggression and the therapeutic relationship. The theoretical model describes how the process of change in staff-patient relating were frequently perceived to occur by the participants following aggression. The repercussions of a breach of trust within the relationship could be far reaching. The emerging theoretical model and categories are supported by previous literature and enhance the theoretical understanding of the participants’ contextually bound constructions of aggression and the therapeutic relationship. The study strengths and limitations are presented. These support the trustworthiness of the findings and allow the reader to judge my rigour as a researcher. These findings are important in understanding how aggression in women’s services can have a detrimental effect on the therapeutic ‘helping’ relationships with women who are

aggressive in medium secure services. I believe this tentative theoretical model ‘sparks’ ideas regarding the potential for service and policy development, and further research. With regards to future research a greater understanding of women’s inpatient aggression and the therapeutic relationship is essential considering the impact of aggression on these participants, but also to ensure the future safety and wellbeing of both frontline staff and women in forensic care.

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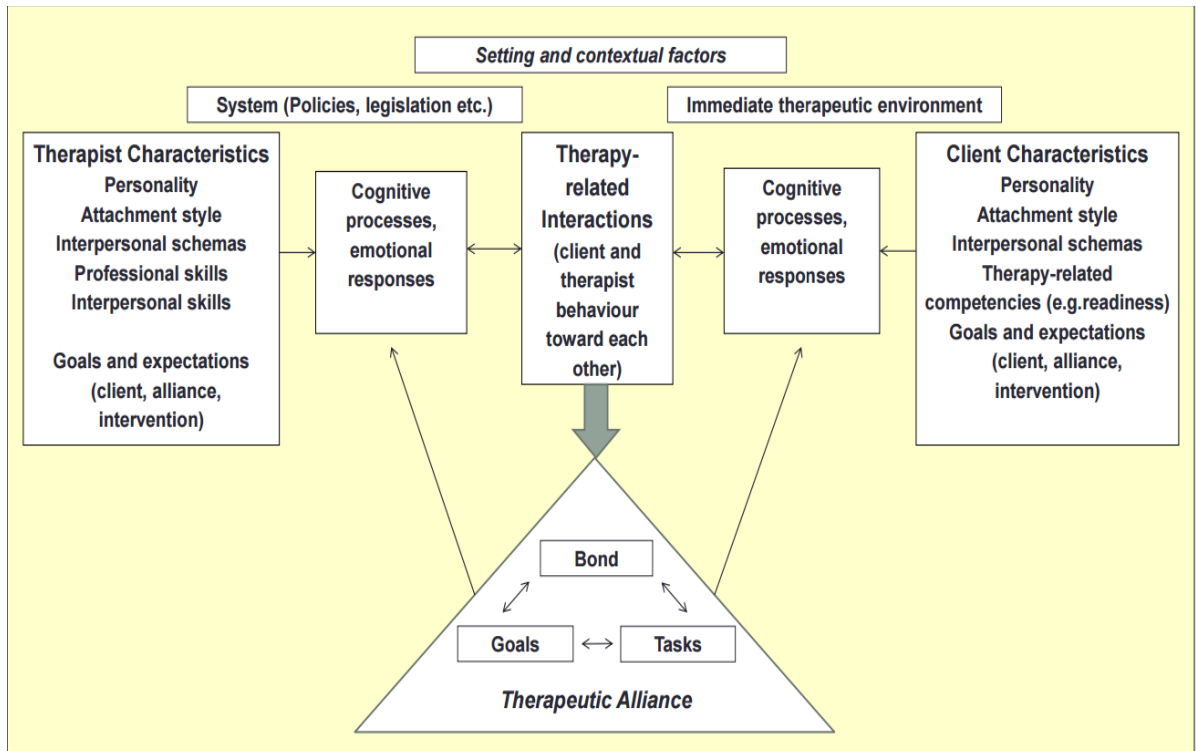
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**APPENDIX A: THE REVISED THEORY OF THE THERAPEUTIC ALLIANCE
(RTTA), (ROSS, POLASCHEK AND WARD, 2008)**



APPENDIX B: NOBLIT & HARE (1988) SEVEN PHASE APPROACH.

Noblit & Hare, (1988) propose a seven phase approach to meta-ethnography these are:
'1) Getting started and formulating the research question, 2) researching the existing literature, 3) reading studies and extracting data, 4) determining how studies are related (making a list of metaphors, common themes and concepts), 5) translating studies onto one another (second order [authors interpretation] constructs through constant comparison, identifying heterogeneity and contrasting findings), 6) synthesising translations (third order constructs: merging second order constructs) and 7) expressing the synthesis. The remainder of this chapter will be structured around the seven phases'.

APPENDIX C. INCLUSION AND EXCLUSION CRITERIA FOR METASYNTHESIS

Justification for Inclusion

Inclusion Criteria	Rationale
Peer reviewed articles	
Qualitative research published between 1980 and 2015	As qualitative research was rarely published pre 1980
Articles exploring staff experiences of physical and non-physical inpatient aggression	This was the focus of the study.
Studies recruiting frontline staff working within forensic adult (18-65) inpatient settings	Different approach to care for adult population than for adolescent and elderly or LD.


Justification for Exclusion

Exclusion Criteria	Rationale
Research in non-forensic inpatient settings (e.g. general hospital, emergency room, PICU)	The study is making an explicit attempt to explore whether staff experiences of aggression are distinct from those experienced in alternative healthcare settings
Research primarily exploring restraint And seclusion.	Different
Patient aggression related to self-harm, para-suicide or suicide.	Exploring patient aggression directed at staff rather than patient aggression directed at the self.
Horizontal workplace aggression.	The synthesis specifically explored patient to staff aggression rather than intra-professional aggression.
Aggression related to alcohol and drug use.	Aggression which has occurred secondary to alcohol and drug use was excluded as it was thought to confound the results
Articles not written in English.	It would have been too difficult to translate the articles in the time frame for study completion
Retrospective incident/patient file review.	These are likely to be biased and staff notes in files often don't detail the therapeutic aspect of staff responsibilities and perspectives.
Grey literature, literature reviews and dissertations	The meta-synthesis focused on peer reviewed studies so dissertations and the grey literature was excluded.

APPENDIX D: EMAIL FROM PROFESSOR KINDY

article request for meta-synthesis ⤴

← Reply ← Reply all → Forward ...

 Deborah Kindy <deb.kindy@sonoma.edu> Mark as unread
Sat 14/02/2015 08:45
thesis

To: ■ Barnes, Cheontell;

Hi Cheontell

Best wishes for a speedy and fulfilling dissertation experience! It's wonderful to see more and more qualitative methods used to ground, expand and inform human circumstances.

Yes, those nurses interviewed were employed at a state forensic "hospital" for those with severe and chronic mental illness. I have not continued research in this area so am not familiar with current publications however there are several journals related to the jail/prison industry in the US.

Deb

Deborah Kindy, PhD, RN
Professor
Sonoma State University

We are here to laugh at the odds and live our lives so well that Death will tremble to take us. Charles Bukowski

APPENDIX E: CASP TOOL APPRAISAL

		Trenoweth (2003)	Hinsby (2004)	Kindy (2005)	Duperozel (2008)	Allen (2010)	Jacob (2011)	Kurtz (2011)	Tema (2011)	Maguire (2014)	Wright (2014)
1	Was there a clear statement of the aims of the research?	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
2	Is a qualitative methodology appropriate	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3	Was the research design appropriate to address the aims of the research	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
4	Was the recruitment strategy appropriate to the aims of the research	Unsure	Yes, not theoretical	Yes	Grounded Theory purposive not theoretical	Yes	Yes	Yes Not theoretical	Unsure	Yes	Unsure
5	Was the data collected in a way that addressed the research issue?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Unsure
6	Has the relationship between the researcher and participants been adequately considered?	Yes	No	No	Yes previously worked with participants	No	No	No	No	No	No

APPENDIX E: CASP TOOL APPRAISAL

		Trenoweth (2003)	Hinsby (2004)	Kindy (2005)	Duperozel (2008)	Allen (2010)	Jacob (2011)	Kurtz (2011)	Tema (2011)	Maguire (2014)	Wright (2014)
7	Have ethical issues been taken into consideration?	Yes	No	No	sufficient	Yes	No	No	Yes	Yes	Yes
8	Was the data analysis sufficient and rigorous?	Yes	Sufficient	Yes	Yes	Yes	Yes	Unsure	Yes	Yes	No
9	Is there a clear statement of findings?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	yes	yes	yes
10	How valuable is the research?	Good	Good	Good	Good	Good	Good	Unsure	Good	Good	Unsure

Adapted from the Critical Appraisal Skills Programme (CASP, 2010) checklists

APPENDIX F: EXTRACTED THEMES FROM METASYNTHESIS

1: Trenoweth, (2003)	2: Hinsby (2004)	3: Kindy (2005)	4) Duperozel (2008)	5) Allen (2010)
Knowing the patient <i>-Knowing the patient's history of violent behaviour</i> <i>-Getting to know the patient's background and beliefs</i> <i>-Knowing about the impact of the mental health problem on the individual</i>	Control <i>-construction of identities</i> <i>-care and control</i> <i>-parents and children</i> <i>-following the written rule</i> <i>-segregation and the outside world</i>	Safety Fortifications <i>-Personal preparation</i> <i>-Tangible devices</i>	Safety and de-escalation Attribution and control Building and maintaining relationships Understanding and empowerment Anticipating reactions Creating a façade Communication Humour	Patient history Previous aggression <i>-Offence-related Aggression</i> <i>-Aggression while in hospital</i> Substance misuse <i>-Alcohol</i> <i>-Drugs</i>
Tuning in <i>-Observing the situation as a whole</i> <i>-Observing the patient</i> <i>Searching for causes</i>		Catalysts for Violence <i>-Facility design</i> <i>-Increased acuity and insufficient staff</i> <i>-Unpredictable and uncontrollable environment</i> <i>-Administrative and staff abandonment</i>		Symptoms of mental Paranoia illness/personality disorder <i>-Emotionally unstable</i> <i>-Impulsivity</i>
Considering the possibilities <i>-Appreciating the patient's capacity for violence</i> <i>-Appreciating the potential within the situation</i>		Perplexing Aftermath <i>-Blame and punishment</i> <i>-Fear and poor morale</i> <i>-Vigilance and distrust</i>		Patient current presentation <i>Insight</i> <i>-Mental disorder</i> <i>-Risk issues</i>
Intervening <i>-Using knowledge of the patient</i> <i>-Working in a team</i>		Pervasive invasive Sequelae <i>-Emotional burden</i> <i>-Personal life sequelae</i> <i>-Role conflict</i> <i>-Withdrawal</i>		Compliance <i>-Therapy</i> <i>-Medication</i> Motivation <i>-To change</i> <i>-To engage</i>
				Staff and patient relationship Intrinsic factors <i>-Staff self-confidence</i> <i>-Judgement of patient personality characteristics</i> <i>-Quality of therapeutic alliance</i>
				Extrinsic factors <i>-Support from staff</i> <i>Procedural security</i>

6) Kurtz. (2011)	7) Jacob (2011)	8: Tema (2011)	9: Maguire (2014)	10: Wright (2014)
Everything contracted in your mind	Context	Psychiatric nurses experienced challenges in their relationships with patients	How the participants define limit setting	Establishment
Experience of the Clinical Task	Nursing care	<i>-Ineffective communication between psychiatric nurses and patients</i>	Limit setting is important for safety	Relationships
<i>-Difficulty in Achieving Task Integration</i>	Fear	<i>-Fear related to unpredictable behaviour resulting in mistrust of the patients</i>		Gender
<i>-Motivation to Build Relationships, Work Through Difficulty Bring About Change, Minimal Sense of and Anxiety at the Centre</i>	Othering	<i>-Frustrated aspirations related to uncooperativeness from patients</i>	Engaging patients in an empathic manner is important when setting limits	Construction of difference
	Identification and Differentiation	Psychiatric nurses experiences of fear related to the of aggression from patients	An authoritative, rather than authoritarian, limit-setting style enhances positive outcomes	Medication
Experience of the Organisation		<i>- Verbal aggression from patients</i>		Identity
<i>-A Distant and Difficult Relationship with Outside</i>		<i>- Physical aggression from patients</i>		Environmental stimuli
<i>-Preoccupation with Staff Relationships</i>		Experience of disempowerment related to a lack of recognition		
<i>-Feeling Unsafe</i>		<i>- Lack of sufficient knowledge and skills</i>		
		<i>-Shortage of male nurses</i>		
		<i>- De-motivation related to lack of support</i>		
		Psychiatric nurses experience emotional and physical distress related to interactions with patients		
		<i>-Emotional distress-Physical distress</i>		
		Psychiatric nurses utilized defence mechanisms to maintain their mental health		
		<i>- Suppression by psychiatric nurse working in the forensic ward</i>		
		<i>- Rationalization by the psychiatric nurse working in the forensic ward</i>		
		<i>- Displacement by the psychiatric nurse working in the forensic ward</i>		
		<i>- Use of substances such as cigarettes, snuff and alcohol</i>		

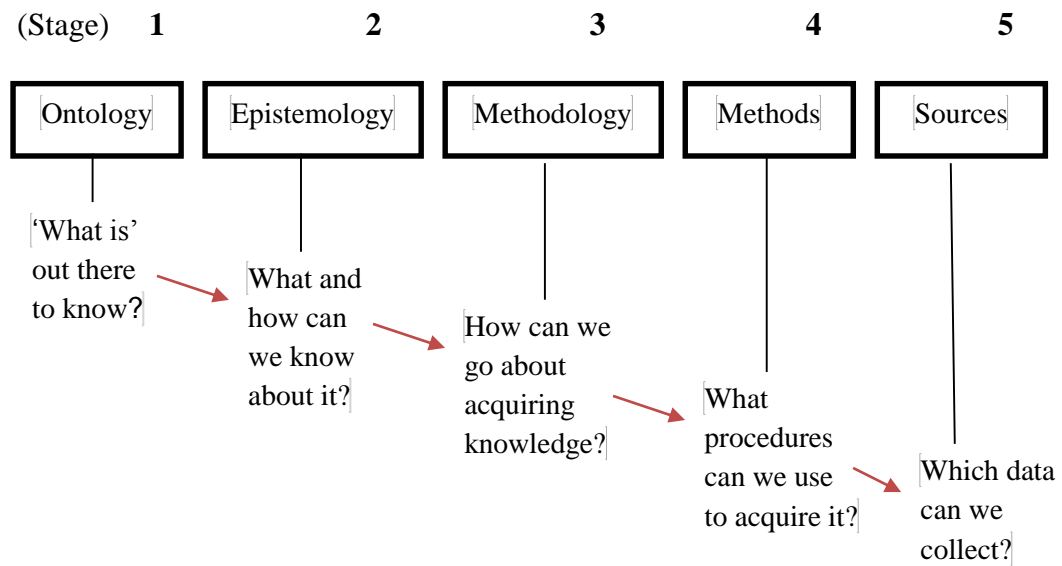
APPENDIX G: IDENTIFIED THEMES AND FREQUENCY OF OCCURRENCE

Themes	1	2	3	4	5	6	7	8	9	10	11	12	13
1 Trenoweth, (2003)	*	*	*	*	*	*	*					*	
2 Hinsby (2004)	*	*	*	*	*				*	*		*	*
3 Kindy (2005)	*	*		*		*		*		*	*	*	*
4 Duperozel (2008)	*	*	*	*	*	*	*						
5 Allen (2010)	*	*	*	*	*	*	*			*			*
6 Jacob (2011)	*		*	*	*	*	*	*	*	*	*	*	*
7 Kurtz (2011)	*				*		*	*	*	*			*
8 Tema (2011)		*	*	*		*	*	*	*	*	*		*
9 Maguire (2014)			*	*									*
10 Wright (2014)	*	*	*	*	*				*	*			

1= Guiding Risk Assessment, 2= Enabling Recognition of Catalysts, 3= Preventing and de-escalating aggression, 4= Managing aggression, 5 = Relating to patients, 6= Functioning as a team, 7= Obstacles in the Staff Patient Relationship, 8= Inter-professional ruptures, 9= Forensic Service Having a Culture of Its Own, 10= Fear and the Psychological and Emotional burden, 11= Coping strategies, 12= Accountability and Intuition, 13= Caring and Controlling

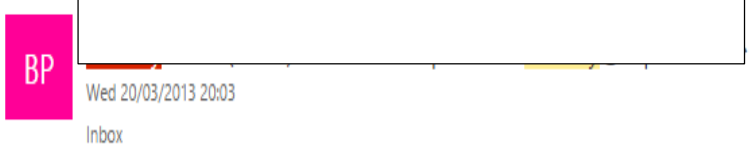
APPENDIX H: GRIX'S (2010) BUILDING BLOCKS

Figure 1.



Adapted from Grix (2010)

APPENDIX I: APPROVAL FORENSIC BOARD MEETING



To: Barnes, Cheontell;

Dear Cheontell,

Yes, it was discussed in the meeting and all were in favour of the research being carried out of course subject to ethical approval.

Best wishes

APPENDIX J: TRUST ETHICS APPROVAL

Dear Cheontell,

Research Study – Nursing perceptions of the therapeutic alliance following aggression by women secure service users

I am pleased to confirm that your research study was reviewed by the Research Governance Group (RGG) at their meeting on 31st January 2014 and your study was given final approval. You will need a letter of access to conduct your research in XXXX and I will send this under separate cover in due course. In order to issue the letter of access, I will need to see documentary evidence of your employment at XXXX Partnership University NHS Foundation Trust or a copy of a research passport issued by the University of Essex. Either is acceptable although I would think that the former will be the easiest for you.

The Trust has to meet rigorous standards set by the Department of Health for research governance so your research must be carried out subject to the following conditions:

- The research must be carried out in strict accordance with the protocol submitted and any changes to that protocol must be approved by the University of Essex and XXXX RGG before the research is undertaken or continues.
- You must report any adverse events/serious untoward incidents relating to this research to me as soon as practicable. I can be contacted by telephone on XXXX or XXXX. In my absence, incidents should be reported to Mrs XXXX, the Associate Director of Clinical Governance & Quality on XXXX or XXXX. In addition, you must complete one of the Trust's adverse incident forms and follow the requirements as set out in the Trust's adverse incident reporting policy. A copy of this form must be submitted to **me** as soon as possible. A copy of the Trust's adverse incident reporting policy can be located on the Trust's intranet or alternatively, please contact me and I will be happy to supply you with a copy.
- In cases where the research will take place over a period of more than 12 months, you are required to send to me a copy of the report on the study progress.
- Any research terminated prematurely must be notified to me immediately.
- The full final report from the study should be sent to me within 3 months of final report so that the RGG can consider it. You are also required to supply a summary or abstract of the study that would be suitable for dissemination.

- As a result of the Research Governance Framework for Health and Social Care, the Trust now has an obligation to monitor research being undertaken within the Trust.

You might be required to complete a short questionnaire although this will be no more than once a year. The questionnaire will be completed for you with as much information already known in order to reduce the amount of your time that you have to spend on this. In addition, the Trust is required to randomly select 10% of research studies to be audited. If your study is selected as part of this audit process, you will be notified to ensure your availability.

The RGG, on behalf of the Trust, will revoke or suspend its approval to any research that does not comply with these conditions or where there is any misconduct or fraud.

I would like to reassure you that these conditions are applied simply to ensure that the Trust meets its obligations under the Research Governance Framework for Health and Social Care. Please contact me if I can help with any issues that might arise for you as a result.

I wish you every success with your research and look forward to receiving a copy of the study report in due course.

Kind regards

Yours sincerely

XXXX

APPENDIX K: UNIVERSITY ETHICS APPROVAL

University of Essex

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02 December 2013

MISS C. BARNES
[REDACTED]

Dear Cheontell,

Re: Ethical Approval Application (Ref 12054)

Further to your application for ethical approval, please find enclosed a copy of your application which has now been approved by Dr Wayne Wilson on behalf of the Faculty Ethics Committee.

Yours sincerely,

Mel Wiltshire
Ethics Administrator
School of Health and Human Sciences

cc. Sarah Manning-Press, REO
[REDACTED], Supervisor

APPENDIX L: ETHICS AMENDMENT

18. 07. 14

Request for two amendments to research study recruitment process

Cheontell Barnes

Trainee Clinical Psychologist, School of Health and Human Sciences, University of Essex
Employing Trust:

Research Proposal: A Qualitative Understanding of Nursing Perceptions of the Therapeutic Alliance Following Aggression by Women Secure Service Users

Summary of Research

The management of aggressive behaviour is often a professional requirement of forensic nursing. The risk of and/or experience of aggression between staff and service users can create impasses within the therapeutic alliance impacting on therapeutic milieu and quality of service user care. Furthermore, research suggests Forensic Mental Health Nurses (FMN's) are frequently the victims of aggression by service users, which can result in psychological and emotional harm for both service users and staff, and low job satisfaction and poor staff retention in forensic services.

A containing therapeutic alliance is a central component to service user recovery and is associated with successful therapeutic outcome. This study proposes a qualitative design to explore the impact of an aggressive incident/s, on FMN's construction of the therapeutic alliance with women in secure and forensic care. Theoretical sampling will be utilised to recruit FMN's to participate in semi-structured interviews (SSI's), which will guide theory formation through Constructivist Grounded Theory analysis.

Amendment 1:

The first amendment request is to broaden the participation inclusion criteria

New title: Research Proposal: A Qualitative Understanding of Staff Perceptions of the Therapeutic Alliance Following Aggression by Women Secure Service Users

Reasons and justification for amendment:

An amendment is requested to broaden the recruitment of participants from only mental health nurses to all qualified healthcare professionals working within the women's secure and forensic wards at [secure service] where the research is to be conducted.

The first interview was conducted using a purposive sampling method. This meant that the first participant was specifically chosen from one staff group (qualified nurses). However, information from this interview suggested that other health care professionals particularly support workers were also affected by aggression occurring in women's secure and forensic services. Theoretical sampling methods suggest the chief investigator should select the next interview according to the analysis and data occurring in the previous interview. The chief investigator feels that broadening the scope of recruitment would help to gain a more comprehensive understanding of staff member's perceptions of the therapeutic alliance following the experience of aggression.

Amendment:

This study proposes a qualitative design to explore the impact of an aggressive incident/s, on clinical staff member's construction of the therapeutic alliance with women in secure and forensic care. Theoretical sampling will be utilised to recruit staff members working directly with women to participate in semi-structured interviews (SSI's). Each interview that is conducted will influence the selection of the next participant. The interview data will guide theory formation through Constructivist Grounded Theory analysis.

Inclusion criteria

- Recruitment to incorporate all healthcare professionals working within either the medium or low women's secure and forensic wards.
- Nurses must have worked in the women's service for longer than three months as this is the duration suggested as necessary to develop a therapeutic alliance (ref) particularly as the staff would be working with women who are likely to have experienced poor attachments to care givers in childhood (ref).
- As the focus of the study was aggression occurring in women's forensic services; it is necessary for these members of staff to have experienced a violent and/or aggressive incident with a service user first hand or to have witnessed a violent event involving a service user/staff in which they felt they had experienced a violent incident.

Exclusion Criteria

Two exclusion criteria were specified to protect the trustworthiness of the results and to protect the general wellbeing of the participants:

- Individuals whose first language was not English were excluded from the study as an interpreter was not available to the chief investigator. However due to the demographics of the staff team and nature of the work this did not apply to this research study recruitment process.
- In terms of ethical exclusions, if the safety of the participant was thought to be at risk as a result of the aggressive incident, and their participation in the study was thought to be at the detriment to their wellbeing and mental health participation was advised against.

Amendment 2

The second amendment requests for interviews to be conducted in a confidential space off [secure service] secure site and in participant's homes.

Reasons and justification for amendment:

The chief investigator has found that recruitment of staff during their working hours at the secure and forensic service has been difficult to arrange due to their roles and responsibilities at work. Furthermore staff members are wanting to go home after their shifts and not stay to complete their interview. It would therefore be beneficial to the research process to be able to meet with participants in a confidential meeting space off site. This is likely to be their homes. This is not thought to pose a risk to either researcher or participant as participants are members of trust staff.

If the participant becomes distressed during the interview and wishes to access further support after the interview. The chief investigator will signpost them to the support services stated in the original research proposal:

Staff can self-refer to occupational health (see flyer attached in appendix H). The chief investigator can also provide participants with a Personal Wellbeing Workbook (see appendix I). This has a phone number for the staff counselling service which is private and confidential. If the researcher is concerned about the participants wellbeing the participant will be encouraged to contact The Samaritans for confidential support. If participants expressed concerns about receiving support from seniors, they might be advised to contact UNISON.

Appendix:

APPENDIX M: TRUST APPROVAL AMENDMENT

• You replied on 13/08/2014 17:19.

Cheontell

I can confirm on behalf of [] GG that your amendment to widen inclusion criteria and interview participants in their own homes has been accepted, having heard today [] rlow.

I've been asked to ensure that meetings in people's own homes comply with the Lone Working Policy, which is attached.

With best wishes

Peter

APPENDIX N: UNIVERSITY APPROVAL AMENDMENT

25 September 2014

MISS C. BARNES



Dear Cheontell,

Re: Ethical Approval Application (Ref 12054a)

Further to your request for an amendment to your application for ethical approval, please find enclosed a copy of your signed form which has now been approved by Dr Wayne Wilson on behalf of the Faculty Ethics Committee.

Yours sincerely,

A handwritten signature in cursive script, appearing to read "L McKee".

Lisa McKee
Ethics Administrator
School of Health and Human Sciences

cc. Sarah Manning-Press, REO
Susan McPherson, Supervisor



APPENDIX O: INVITATION TO PARTICIPATE

Address

Invitation to Participate in Research Project

Hello, my name is Cheontell Barnes. I am a trainee Clinical Psychologist at the University of Essex. The following research project is part of my Doctorate in Clinical Psychology.

Title of Project: A Qualitative Understanding of Staff Perceptions of the Therapeutic Alliance Following Aggression by Women Secure Service Users.

Purpose of the study

The purpose of this study is to examine how secure and forensic staff perceive their relationships with women in secure care following aggressive or violent incidents. I will be conducting individual interviews with staff members in order to understand how personal experiences of aggression or violence in the workplace affect therapeutic relationships. I am really interested to hear your views, to help understand how these experiences impact on you and your relationships with the women you support.

Before you participate in the study you need to be able to answer yes to the following questions:

1. I am a member of staff (of any band) working directly with women in this service.
2. I have worked with women in the secure and forensic service for more than three months.
3. I have personally experienced at least one incident which I perceived to be violent and/or aggressive by a/the female service users I support.

Before you decide whether you would like to take part or not, it is important that you understand why the research is being completed and what it will involve. Therefore, I will be attending staff meetings and community meetings on the ward, where I will talk about the research project and provide those interested with further information. There will also be an opportunity to ask any questions about the study. I understand that not everyone will be able to attend these sessions, so I will also leave a contact number for those interested to contact me in person.

If you would like to know more about participating in research follow the link to the NHS Health Research Authority Website: <http://www.hra.nhs.uk/patients-and-the-public-2/>

I will be attending meetings on the following dates: XXXXXXXX

Thank you so much for taking the time to read this.

I look forward to meeting you.

Cheontell Barnes: email

APPENDIX P: INFORMATION SHEET

Participant Information Sheet

Title of project: A Qualitative Understanding of Staff Perceptions of the Therapeutic Alliance Following Aggression by Women Secure Service Users.

My name is Cheontell Barnes. I am a Trainee Clinical Psychologist working for North Essex Partnership University Foundation Trust. I am currently undertaking the research project as part of my Clinical Psychology Doctorate at the University of Essex.

Purpose of the study

The purpose of this study is to explore staff members understanding of the therapeutic relationship following the experience of aggression by female patients in secure and forensic care.

Before you decide to take part it is important that you fully understand what is involved and why the project has been proposed. To clarify, the project has been approved by the University of Essex research ethics committee, the Secure and Forensic Board of Governors meeting, and XXXX Trust.

Before you participate in the study you need to be able to answer yes to the following questions:

1. I am working with women secure service users.
2. I have worked in the women's secure and forensic service for more than three months.
3. I have personally experienced an incident which I perceived to be violent and/or aggressive by a/the female service users I support.

I will be attending some women's service staff meetings and community meetings at XXXX to introduce myself and the research project, and to allow a space for you to ask any questions. I will also send information to staff email addresses and put it in the communication book. If you decide to take part, you can contact me directly via email or phone on the numbers listed at the end of the information sheet. I will then contact you to arrange a convenient time to meet and complete an interview.

What will the research involve? I am seeking to recruit up to 20 staff members, from all bands, to participate in individual interviews. I will gather some brief details about you; such as age, gender, professional category, length of time working in the women's service and time since you completed your mental health nursing training. You can refrain from providing this information if you wish to.

The interview: The interviews (45-90 minutes) will be conducted in a meeting room on site, or at an alternative location if more convenient for you. I will be able to offer you £13 to thank you for your time, whether inside or outside your working hours.

During the interview I will ask about your views on the therapeutic relationships with the women you work with, and your personal experiences of violent and/or aggressive incidents involving

female service users. The interviews will be audiotaped and then analysed to identify themes in the experiences of staff members.

Once the analysis has been completed, I would like to arrange to meet with you again, at a later date. This is to ensure my interpretation of the findings is representative of your experience and beliefs. You will be notified of this in advance and I will accommodate a time that's best for you to meet again. This is not essential but can help to ensure that my understanding of your experience is correct. Unfortunately I will be unable to reimburse you for your time in the follow up session.

You do not have to decide straight away if you want to take part in the follow up session, I will provide you with my email address. Otherwise I will take your email contact, or phone contact and arrange a meeting post analysis, this could be up to one year later. This will be stored securely on a password protected database.

Participation: Your participation in this research project is entirely voluntary. If you decide to take part, you will be given this information sheet to keep and will be asked to sign a consent form to show that you understand what is involved in taking part. If you decide to participate you are still free to withdraw at any time and without offering an explanation, even if part way through the interview. Participation in the study will not affect your employment in any way.

Confidentiality and anonymity: If you decide to take part, your name and any other identifying information will remain confidential. The recorded interviews will be typed up and stored electronically. Each participant transcript will be given a unique identifying code and all names and places will be replaced with pseudonyms. All data on the computer will be anonymised and password protected. The transcript will then be used for the analysis. My academic supervisor employed by The University of Essex will be involved in supporting the initial analysis of these anonymised transcripts. The computer file of your transcript will be erased after the work has been completed.

Who else will see the findings? In the write up of the research, anonymised extracts from the interview transcripts may be included. If you like I can give you an example of what a final research thesis and any quotations might look like so you can judge for yourself. My academic supervisor Dr XXXX will have sight of extracts during the analysis but only *after* the data has been transcribed and anonymised. The transcribed interviews will not be available to your employers or management team.

Limits to confidentiality: The only circumstance when I would have to consider breaching confidentiality in the study was if there were serious concerns raised during your interview about risk to yourself or others. These concerns would be discussed with you during the interview, and arrangements made to discuss these concerns with your line managers or supervisor. Should this happen during the interview I may consult with supervisors Dr XXXX and Consultant Clinical Psychologist XXXX for advice, again this will be confidential.

Emotional impact of participation: It might be possible that talking about your personal experiences of aggression at work may be upsetting. In the event that something has affected you and that you feel that you have been caused emotional distress during the research, I can provide you with the details of where you can access the appropriate psychological support.

Should you wish to access further support following the interview I can provide you with contact details for the wellbeing service and how to access occupational health. You may also wish to contact The Samaritans.

Concerns: If you wish to raise a concern about the project, or about any aspect of the way you have been approached or treated during the course of this study, the normal NHS complaints procedures will be available to you.

If you would like to know more about participating in research follow the link to the NHS Health Research Authority Website: [xxxx](#)

Please feel free to contact me if you have any further concerns or queries.

Contact details:

Cheontell Barnes: details

Dr.....	Name	Name.....
, Academic Supervisor	Research & Development O	Secondary supervisor
The University of Essex	Email.....	Contact: email....
Contact:		

Thank you for taking the time to read this

APPENDIX Q: POSTER

Research Participants Needed

Are you

- working with women secure service users?

Have you

- Worked in the women's secure service for more than three months?

Have you

- Personally experienced an incident at work which you perceived to be violent and/or aggressive by a woman in secure care?

My name is Cheontell Barnes. I am a Trainee Clinical Psychologist at the University of Essex. I hope to interview staff members about their personal experiences of aggressive incidents occurring in their work with women in secure services. The information will be used in a research project as part of my Doctorate in Clinical Psychology.

The purpose of this study is to consider how aggression affects your relationships with female patients. I am interested to hear your personal views and experiences.

I will be attending staff meetings and community meetings on the ward, where I will talk about the project and provide further information. There will also be an opportunity to ask any questions about the study.

**I can pay you £13 as a thank you for taking part.
Your participation is entirely confidential and anonymous**

If you are interested please

Details: telephone

Details: email

APPENDIX R: SAMPLE INTERVIEW SCHEDULE

Age

Gender

Professional title

How long since professional qualification

Previous experience working in women's secure services

Length of time working in women's service

Ward: med/low secure

Background information and rapport building.

1. Can you tell me how long you have been working in the women's forensic service at [secure service]?

2. Can you tell me a bit about what kinds of services you have worked before you worked here?

Understanding of the therapeutic alliance

3. I was wondering if you could try to explain to me your understanding of a good therapeutic relationship.

Probes: Is there anything you want to add?

4. What kind of factors do you think are important in facilitating a good therapeutic relationship with women in secure services?

Experience and understanding of aggression

5. What is your understanding of why some women in secure services might be aggressive?

Probes: can you expand on that please?

6. Can you tell me about a time when you experienced violence and/or aggression from one of the women you were/are working with?

Probes: How did this experience affect you and your patient?

Impact of aggression on the therapeutic alliance

7. Did this experience impact on your ability to work with this service user?

Probes: can you expand on that please?

8. What feelings did the aggressive experience give rise to?

9. Can you tell me about your relationship with this service user following this experience?

10. Has this experience affected your relationship with other service users?

11. What was your response to this experience?

Probes: Is this kind of response common?

12. What was the service user's response to this experience?

13. Can you tell me what other factors affect your relationships with service users?

Closing questions

14. Is there anything that I have not asked you that you think is relevant?

15. Do you have any questions for me?

Bring interview to a close ensure the participant is settled.

Thank participant and pay them £13 for participating.

Collect email for participation in follow up analysis

Thank the participant for their time and offer payment for participation

APPENDIX S: LINE BY LINE CODING INTERVIEW 3

That can anything from them trying to blackmail you with personal information you have given them or you have done something that you were not meant to, so they can say do this or I will tell you have done that, which these girls would do. So yes, its cuddling as well, erm i think that's its ..sort of like you know the girls do try and push the boundaries on the cuddling side, yet again, you have to say sort of like 'enough' this is my space.

So are cuddles not allowed?

No, ...again, sort of like it can be misinterpreted sort of like if you cuddle one you have to cuddle all and some of them are not nice so you don't want to get that close to them to, so it has to be one rule for everybody so it's 'this is my space stay back'

and What is it like having one rule for everybody because it sounds like some people you would give that cuddle to but you cannot because the rules say you can't?

Yes, I feel sometimes, sort of like you know, let's say, like say when one of the girls has had some really bad news or whatever then you do feel like it but you can't because, if you do it once, you have to do it all the time but you can't no, and I think that goes right the way across the board, even on the male side you can't because just it can be misinterpreted.

Do you think everyone follows that rule?

(whispers no) (whats that?) No,(laughs) but again I think that comes down to experience erm and we have a lot of new staff here and they are manipulated. The girls do manipulate them and we have a couple of staff that have been manipulated, so it's about educating the staff and saying sort of like you know 'this needs to stop because of sort of like you know, it is going to lead on and you will find yourself in trouble'. So sort of like , I think they are finding it hard but they do get the reason why it is not allowed but I think they are finding hard to say 'no'.

Who educates the new staff when they arrive?

Erm, Obviously, us qualified's erm... and I think it should be in the induction, I think.

Is it?

I don't know, I have not had an induction for 14 years (laughs) so I would not know if it was in there but I would I imagine it is in there because I think that is one of the main things is about boundaries sort of like so. Yeah I don't know if that's in there but it should be (laughs).

Can you tell me a bit about why you think some women in this service, or in secure services in general might be aggressive or become violent?

i think that (sighs) there is two answers to that, one is obviously past history. If they have been sort of like abused or violence in their family and the other side is learnt behaviour they sort of like learn 'oh this is what we do here and so this is what I do' you know, so yeah.

Positive boundaries

getting physical needs met.

taking advantage

fear being blackmailed

wanting cuddles.

asserting the boundary verbally

one rule to fit all BUT...

Maintaining boundaries to protect staff from getting too close

- maintaining personal space!

having to resist natural want to comfort physically

holding back instinct to care - we're physical touch.

understanding boundary but will breach!

experience = boundaries learnt, learning boundaries through experience

finding it hard to say no

perceiving women as manipulative

cheques drawing attention to boundary violation

prioritizing boundaries.

experience intergenerational abuse socially learned.

socially learned past experience

intentional

women learn to be aggressive in the ward

APPENDIX T: FOCUSED CODING INTERVIEW 2

93. And that's aggression towards staff members?
94. They have done over the last few months yeah as I said they have a high population now of young women who can be quite violent erm
95. And what types of violence what kind of aggressive acts or violence is occurring?
96. everything from random sort of punching, pulling hair is quite a thing women tend to pull hair erm and then there is the more the less premeditated stuff you could be in a restraint and somebody could be kicking out or punching which may not necessarily be directed towards and individual or targeting an individual but erm it's that person kind of wanting to get themselves out of that situation and sometimes people will get injured in that respects
97. And can you tell me about a time when you have been personally involved in an incident
98. yes erm.... I was erm.... on a couple of times the first time was on a night shift and I was on observations sitting outside a patients bedroom and another patient came walking up the corridor and..she wanted some PRN medication, so I got someone, I called someone else over and said can you take over here this person wanted something, wanted some zopiclone or something and as I got up out of the chair, my keys fell out of my pocket, and the medicine keys is on quite a heavy bunch, because it's on a lanyard it kind of, sort of goes to the floor because it's quite heavy so I went down to pick my keys up and as I went to pick my keys up she grabbed my hair in two handfuls and twisted so it was kind of entwined in her fingers, and erm for all the breakaway techniques and everything that they show you there are some situations that are just really difficult to get yourself out of especially when your head is down I couldn't even pull my alarm because my hands they tell you to place your hands on top of the person's hands so that they are not scalping you basically but fortunately the person who was there pulled there alarm and it took about three people to come over and untwine her hands, I lost a bit of hair that night that was particularly nasty because I felt that I hadn't even really had a conversation I just said 'ooh yeah I'll get her' and it felt very unprovoked and quite a shock, quite shocking as well and then you are in charge of the shift you have to carry on (laughs) dust yourself down and you know yet you feel you have been sort of violated in some way you know
99. And do you think that because you are (identifier)
100. at the time I was (identifier) erm but even then if you are the only qualified on the shift of course if you are injured and your need treatment then you leave but emotionally I suppose erm that's not necessarily something you would see straight away as well but you know I mean I wasn't apart from losing a bit of hair I didn't need to go to hospital but I felt really upset and I had to carry on you know

Commented [U90]: Changing referrals

Commented [c91]: Resisting restraint

Commented [BC92]: Feeling helpless
Failing techniques to manage aggression

Commented [BC93]: Feeling shocked

Commented [BC94]: Getting on with it
Feeling violated

Commented [BC95]: Managing running the shift

Commented [BC96]: Ignoring emotional impact of aggression
The emotional effect of the assault are likely to come later, so the person carries on with work

APPENDIX U: MEMO AFTER INTERVIEW 5

I met the participant in her own home. It surprised me how little previous experience working in mental health services she had. I was very interested in her own experiences of being in secure care and wanted to pursue this more but wasn't sure if it was ethical to do so. Despite all of the difficulties this participant encountered at work she still very much enjoyed working there, she was aware of her own capacity in regards to setting limits on working hours, and described how, when she worked frequent bank shifts she felt out and exhausted by the women. This is interesting and suggests that working regular hours makes it possible to manage the work.

She talked about wanting to treat the women how she expected to be treated herself but also didn't seem to see that she was in a very different kind of service to that she experienced herself. She also mentioned providing care that she would expect for her family, I like this work ethic but wonder how easy this is to do in secure settings? I wondered what was being played out in her relationships with the women. And her need to be liked by the women, despite this meaning that she was crossing boundaries on a regular basis. She described recent discussion with her manager where the staff team thought she being 'groomed' by one of the patients and she does not seem to be able to take the advice from her team on board, or at least listens to some of the staff team. How do you manage this?? It relates to other interviews referring to special relationship!

I was also interested in the parallel process playing out between her and the management and the women, if people don't get their needs met in this service then they resort to making deals... the women use the CQC and this participant used bank shifts. The old staff are deemed to use archaic methods and the new staff come in with their own way of working and this causes splits in the team, which causes difficulties in supporting the women

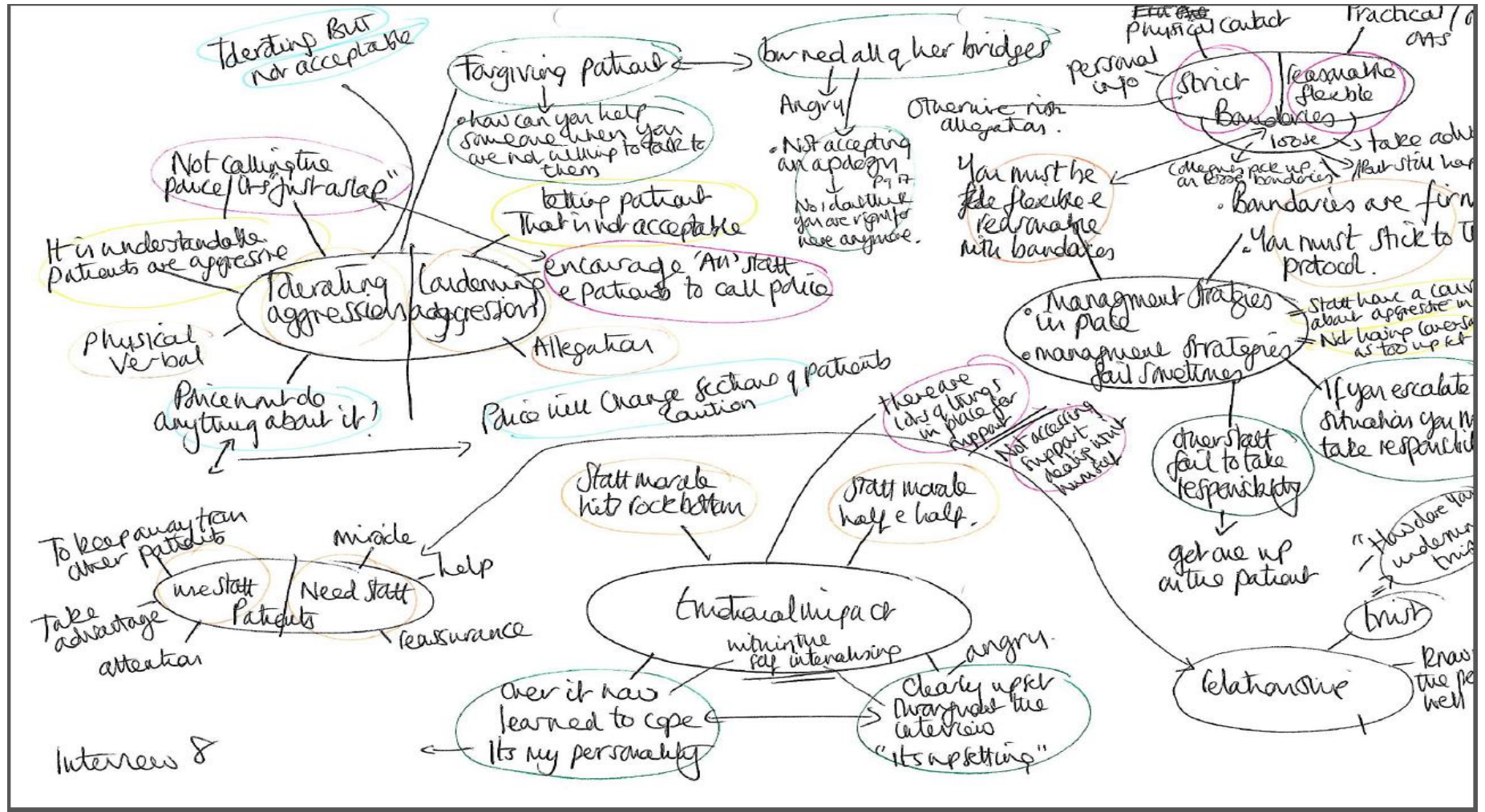
I wondered what was happening in the restraint who's excitement was she experiencing that of the patient perhaps...or was it to do with the successful procedure and management of incident?

Also I wondered how her way of communicating to the women was responded to, was she getting down to their level...what are the women used to...and how triggering this could be for some of the women...also is the work in secure services about setting examples and modelling boundaries and behaviour...yet sometimes the staff appear to step outside their professional roles to be on the 'same level'

I wondered what it would be like to work with this member of staff and thought she might be quite a challenge for the ward manager and cause her own splits in the team

This made me reflect on my own journey into working in mental health and how helpful it can be to have experience as a service user but also how this can complicate things and make it harder to remain impartial

APPENDIX V: BETWEEN COMPARISON



APPENDIX W: MAXQDA CATEGORIES

The screenshot displays the MAXQDA software interface. On the left, the 'Code System' pane shows a hierarchical tree of categories. The 'NAVIGATING THE INVISIBLE LINE' category is expanded, showing sub-categories like 'repairing the relational rupture' and 'adopting a certain approach to relating to t...'. The 'Document Browser: Judith RN' pane in the middle shows a list of segments with their corresponding line numbers and category labels. The main text area on the right shows the content of the document, with segments 42 through 51 highlighted and labeled with category names.

Segment Number	Category Label	Text Content
42	..PD MI	and that, they don't chose to be here, whereas personality disorders they do, and so and that it frustrating
43	..feeling burned out by the	42. And before that you were in elderly?
44	..feeling burned out by the	43. Laughs (yeah laughs) yeah erm that was erm again you get attacked by zimmer frames and that but it is dementia they don't know what they are doing so you its yeah (laughs)
45	..feeling burned out by the	44. And so did you chose to come over from the men's?
46	..feeling burned out by the	45. Funny enough I didn't want to come over because I had heard all about Tortoiseshell and how erm stressful and all that it is over here. But I came over and covered maternity and while I was covering the maternity I actually found I enjoyed it here and I was like hmm ok I will stay. Whereas now three years later I am thinking I would like to go back. You know unfortunately the girls do burn you out and (sigh) you know I am getting to the point where I am burnt out and I need to change so I have actually asked to move but they won't move me... so..
47	..distancing from the ..feeling burned out by the	46. So then there is a sense of what is this, what is the feeling of being burnt out?
48	..feeling burned out by the	47. (sigh) You don't want to come in (says under breath). You know that it's gonna just be the same things, the girls are just so <i>demanding</i> , and argh <i>I need a break!</i> Basically that's how I feel and I don't want to be here now, I really don't want to be here... And I think sort of like you know it makes your patience less, you tend to have less patience. Well I've noticed I've got less patience for the girls than what I did have.... because I don't want to be here now I need a break from here.
49	..feeling burned out by the	48. When do you think you noticed a change? Because you said at first you really enjoyed it, what do you think, was it over time
50	..feeling burned out by the	49. Yeah, it is over time, it wasn't a sort of like I woke up one morning and decided I don't want to be here anymore its. I, I think a lot of it is down to I've got IBS which is caused by stress so they say. I personally don't feel stressed myself whereas occy health does, my doctor does. So the only think I can put it down to is the ward environment that has made me feel stressed so sort of like <i>I need a break</i> (laughs)
51	..feeling unsupported	50. So you feel that there is another option?
	..feeling unsupported	51. Well I've asked and they won't move me so the only other option is to leave. Which I am doing I am looking for jobs elsewhere

APPENDIX X: MEMO ON EARLY CATEGORIES

1) Becoming resigned to aggression

I think this represents both feeling that nothing can be changed so participants becoming apathetic and resigned to aggression. As part of this process participants become emotionally and physically distant. Also under this is the taking it seriously and calling the police.... however the police do not always act on it and participants feel it is a waste of police time. Also within this category participants feel as though the strategies they have in place are ineffective so feel powerless to change things as aggression needs to be managed by technique rather than the relationship??

2) Retaliating (want to change the name of this as doesn't capture the whole process)

I thought participants blame the women they remove the action from the Mental illness and place the intentionality within the woman. Participants retaliate or teach the women a lesson by holding down restraints for longer etc. some literally fight back. The participants begin to create a therapeutic distance where they continue to act professionally (see boundaries) but provide only the necessities of basic functional care ...perhaps at a loss to the 'whole' relationship.

3) They bite your arm off if you sit and talk to them

This category explores the sense of the women being desperate to be close to the participants, but how the closeness comes with a risk and can be aggressive. The participants feel overwhelmed by the women's attempts to be with them and describe them as demanding challenging, wanting attention.... yet the participants appear to have no time to spend with the patients (there are more refs to this than are here). This links with physical boundary and envy and participants hiding in the office. Participants cannot cope with the demand of the relentless wanting of time and the relentless pressure of the workload

4) Biting the hand that feeds you

In the main this theme encapsulates the betrayal of trust that is not worked through by the participants and becomes personal and a rejection of the good stuff the participants are providing to the women. Participants are drawn into special relationships with the women who then sabotage these and push the participants away. The participants are left feeling rejected and unable to do the job they set out to do (hence they attack (see retaliating) this in the patient rather than work through themselves). Participants are usually able to work through attacks when they are due to resisting restraint and SH but when the attack becomes personal...gets into private life, personal attack, allegation it's much harder to understand and harder hitting. The participants feel objectified by the women and no thanks is shared for all that they provide the women...(envy?) in some cases the relationship feels lost forever as the women burn their bridges and withdraw further away from participants.

APPENDIX Y: CONSENT FORM

Address

Participant Informed Consent Form

Title of project: A Qualitative Understanding of Staff Perceptions of the Therapeutic Alliance Following Aggression by Women Secure Service Users.

If you consent please write your **initials** in the boxes

- 1: I have read and understood the information sheet providing details of the project.
9. I have had the opportunity to ask the researcher any questions I had about the research and my involvement. I understand my role in the research.
9. My decision to consent is completely voluntary, and I understand that I am free to withdraw at any time without giving a reason and without any consequences.
9. I understand that the data gathered for this project will form the basis of a Doctorate thesis, and will be used for publication and presentation.
9. I am aware that my data will be stored on a password protected computer file. This data will be stored securely until the research is completed, it will then be destroyed after 3 years.
9. I understand that my name would not be used in any report or publication, but my anonymised quotes may be included in the final report, and any identifying details will remain confidential.
7. I am aware I can request further support should I wish to further discuss the issues raised in the interview.
8. I consent to my interview being audio-recorded
9. I agree to participate in the research study

Participants signature:.....

Date:.....

.....

Name printed in capitals :.....

Researchers signature:.....

Date:.....

Name printed in capitals:.....

.

APPENDIX Z: RECEIPT OF PAYMENT

Address

Confirmation of payment for participation

Title of project: A Qualitative Understanding of Staff Perceptions of the Therapeutic Alliance Following Aggression by Women Secure Service Users.

I have received £13 from Cheontell Barnes for participation in the research study

Participants signature:.....
.....

Date:.....

Name printed in capitals :.....

Researchers
signature:.....

Date:.....

Name printed in capitals:.....
.