The Needs of Staff Who Care for Offenders with a Diagnosis of Personality Disorder: An Organisational Case Study

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CONTENTS

Note: For reasons of confidentiality, transcripts of staff interviews and the group discussion with Unit Z patients were bound separately in an Addendum and are kept safely by the principle researcher. They can be viewed on request.

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Thank you to Nikki Jeffcote for a long-standing exchange of experiences and ideas which form a background to the current study. Thank you also to Keith Turner and Heather Wood for thoughtful and thorough supervision, to Conor Duggan, Alison Tweed and Lucy McCarthy for useful discussions and practical help, and to Marilyn Lawrence for transcribing intimidating amounts of interview data.

I would like to pay tribute to the generosity and interest of the staff of Unit Z for facilitating this study. I have always seen their willingness to engage in a potentially threatening - but hopefully rewarding - piece of research as a sign of strength and creativity. Thanks are also due to the four Unit Z patients who took part in a group to discuss the research with great enthusiasm.

My family has borne the brunt of my absorption in this study and my husband, Nick Everett, has provided practical, intellectual and emotional support. I would like to dedicate this to him and our children: Eben, Michael and Kezia.

ABSTRACT

Individuals with a diagnosis of personality disorder who are considered a risk to others are a current concern for healthcare providers, the government and society. Service provision for this group has recently increased, making it especially important to learn about the needs of staff who care for these demanding and complex individuals. Little research has been done in this area to date. The theoretical and empirical literature relevant to a consideration of the topic is reviewed. An in-depth interview study with staff working in a unit for offenders with a diagnosis of personality disorder (Unit Z) is presented. Its purpose was to develop understanding of the needs of staff who work with individuals with a diagnosis of personality disorder who are judged to be a risk to others. An eventual aim was to inform an intervention with staff, which could then be evaluated.

Twelve in-depth interviews were carried out with multi-disciplinary staff from Unit Z. These were analysed according to the grounded theory method (Strauss & Corbin, 1998; Charmaz, 2003). An interview with a community practitioner from a different service was carried out to enhance thinking about the effects of setting. Four Unit Z patients were randomly selected to participate in a group discussion to test initial findings and integrate their perspectives into the study. Main categories were generated from analysis of the data, and a core category was identified entitled 'Risk of Isolation'. Further categories were divided into 'Areas of Concern' and 'Key Contextual Factors' and a model was developed. This is discussed in relation to the existing literature.

Implications for an understanding of the needs of staff who care for this patient group are outlined. Recommendations include: the provision of individual and group supervision to help staff reflect on the personal impact of the work, and the way in which staff relationships are affected by contact with the patient group; a focus by service heads on recruiting staff who are able to offer stability and understanding to patients and on retaining experienced workers; and the development of links with agencies for onward referral. Suggestions are made for future research and practice, with particular reference to the profession of clinical psychology. The importance of investigating the influence of changes in practice on long-term therapeutic outcome is emphasized.

STATEMENT REGARDING OWNERSHIP OF DATA

This study formed part of a larger research project, conducted in collaboration with psychologists Nikki Jeffcote, Consultant Clinical Psychologist at Three Bridges Regional Secure Unit in West London, and Lucy McCarthy, Research Psychologist at Arnold Lodge Regional Secure Unit in Leicester. The larger study consisted of 27 interviews with staff from three contrasting forensic mental health services: a medium secure unit, a secure unit for individuals with a diagnosis of personality disorder and a community service. This researcher, referred to throughout the thesis as 'the principal researcher', chose to do a focussed piece of work on the 12 interviews with staff working in the unit for offenders with a diagnosis of personality disorder. Nikki Jeffcote looked at the interviews with staff working in the medium secure unit and is referred to in the thesis as a 'research associate'. It is intended to bring the two parts of the larger study together to build a picture of the experiences of staff working with different patient groups in a variety of forensic mental health settings.

The semi-structured interview schedule was designed in collaboration with Nikki Jeffcote, who conducted pilot interviews with colleagues in the summer of 2002 when Arabella Kurtz was on maternity leave. Arabella Kurtz developed the interview during the course of the study, adding questions designed to elicit clinical material and making the format less structured. Of the 12 Unit Z interviews, eight were conducted by Arabella Kurtz and four by Nikki Jeffcote. Lucy McCarthy listened to the tapes of Nikki Jeffcote's four interviews and checked the transcripts. For the purposes of the current study all 12 Unit Z interviews were analysed by Arabella Kurtz alone. One of the two interviews with community forensic practitioners was carried out by Arabella Kurtz and both were analysed by her alone. The group discussion with Unit Z patients was facilitated by Arabella Kurtz and analysed by her alone.

NOTE REGARDING STRUCTURE OF THE THESIS

The researcher started to write this thesis when changes to existing guidelines for the thesis were being discussed, including a recommendation that the literature review be written as if for publication in a specified journal. These regulations come into effect in 2005. In anticipation of them, but in conformity with current guidelines, Part One consists of a literature review written as if for publication in The Journal of Forensic Psychology and Psychiatry. Part Two is an introduction to the current study, which summarises the literature review and shows how the research questions for this study arise from it. The structure of the rest of the thesis follows the usual conventions.

REVIEW ARTICLE

The needs of staff who care for people with a diagnosis of personality disorder who are considered a risk to others

Arabella Kurtz

1.1 Abstract

In recent years much attention has been given to the question of how to manage individuals with a diagnosis of personality disorder who are judged to be a risk to others. This review is part of a corresponding attempt to understand the needs of those who work in healthcare settings with such a challenging group.

Current political and service developments are described and the potential effects of these on staff are discussed. The patient group is briefly defined to inform accounts of the impact on staff of the work situation at both individual and organisational levels. There is a consideration of the needs of staff in dealing therapeutically with the patient group, drawing on ideas from psychoanalytic, organisational and attachment theories. Staff needs are discussed in the light of findings of research into the evaluation of interventions with offenders and individuals with a diagnosis of personality disorder. Studies of ward atmosphere and team functioning are reviewed in order to enhance understanding of the environmental needs of staff. Research on the associations between job satisfaction, occupational stress and burnout is considered.

There is a discussion summarising the implications of the review for developing understanding of the needs of staff. A table is presented describing these. The main areas identified are: the importance of receiving regular clinical supervision which incorporates the opportunity to reflect on the personal impact of therapeutic work; the value of group supervision aimed at building awareness of the way in which patients affect staff's relationships with each other; the need for help from managers and senior clinicians in developing an integrated sense of a complex and potentially contradictory task; and the usefulness of training staff with regard to research into the effectiveness of different interventions to address the issue of therapeutic pessimism and to encourage evidence-based practice.

Keywords: staff needs, personality disorder, forensic mental health, risk

1.2 Social and Service Context

The question of how to manage individuals with a diagnosis of personality disorder who present a risk to others is a concern at the moment for society, government, mental health services and the criminal justice system. The closure of the large psychiatric hospitals in the 1980s and 1990s, the lack of resources available for new and expanded community services, as well as sensationalist media reporting of violent incidents involving psychiatric patients, have all contributed to a cultural preoccupation with 'dangerousness' and mental disorder (Laurance, 2002; Blumenthal & Lavender, 2002). Recently there has been a focus on a number of high profile cases of homicide by people who were not suffering from a psychotic illness but had serious and long-term psychological and social problems. These individuals often had contact with mental health services and the criminal justice system, but were not engaged in any form of intervention at the time of the offence. Although professionals may have been concerned about the risk they presented to other people (and themselves), they could not be detained in hospital within the terms of current mental health legislation because they were, rightly or wrongly, not considered treatable.

The government has responded by proposing substantial changes to the 1983 Mental Health Act, now in the form of a Draft Bill. The second part of the Draft Bill is exclusively concerned with legislation concerning people with a diagnosis of personality disorder who are judged to be a significant risk to others. It suggests the removal of the 'treatability' criterion for compulsory detention, replacing it with the less stringent condition that behaviour can be managed in the treatment setting. In

addition it recommends detaining people on the basis of an assessment of risk, rather than actual conviction by the courts. If these changes become a reality the need for services for this group is likely to increase greatly, and the government has directed funding towards the creation of four pilot units (two in the Special Hospitals and two in prisons), as well as research into the best ways of helping these patients.

The proposed changes have provoked criticism from both mental health practitioners and those concerned with civil rights. Unease has been expressed at the increased emphasis on the custodial role of psychiatric services. Research has also been cited which suggests that by far the majority of people detained on the basis of a risk assessment under the new proposals would not actually go on to do anything dangerous (Taylor, 2002; Cooke *et al*, 2001; Critical Psychiatry Network, 1999).

On the positive side, many have welcomed the plan to increase clinical and academic resources for this patient group. Current services for those with a personality disorder diagnosis were characterised by a recent report of the Personality Disorder Network as extremely limited, as well as uneven in type, quality and distribution (National Institute for Mental Health in England, 2003). There is widespread acknowledgement that more research is needed on the effectiveness of psychosocial interventions for people with a diagnosis of personality disorder who present a risk to others, and on what education and support should be given to the staff who care for them (Grubin & Duggan, 1998).

1.3 Implications for Staff Needs

In a recent article, Lavender characterised society's attitude towards people with a diagnosis of personality disorder who are considered a risk to others as conflicted, unsure of whether it wants to treat, to punish or simply to lock away (Lavender, 2002). Lack of certainty about the task of services in dealing with these individuals is demonstrated by the range of terms used to describe them: they are referred to by turns as patients, offenders or offender-patients, and the derogatory term 'dangerous and severely personality disordered' or 'DSPD' remains in currency despite the controversy surrounding it (Blackburn, 2000b; Castillo, 2003a).

Ambivalence on the part of government and wider society is likely to intensify any confusion of attitude or feeling in staff working with this group. Lavender argued that the contradictory demands that society makes of services for individuals with a diagnosis of personality disorder who are considered a risk to others, mean that managers have an especially difficult and important task in defining a coherent sense of purpose for their staff. If practitioners in this area do not receive thoughtful and consistent guidance from managers, they will be vulnerable to the contradictory demands of the external environment. This will then make it hard for them to provide care and stability for patients.

An argument has been put forward for a more integrated view of the custodial and therapeutic needs of offender-patients (Tumin, 1996). Watson and colleagues' model of the needs of women in secure mental health settings presents therapeutic

risk-taking as dependent on the right degree of safety and basic containment (Watson *et al*, 2004). Containment and change appear at either end of a balance beam, along which each patient's needs are plotted at different stages of their care. Within this formulation, the task of the multidisciplinary team is understood to be the maximisation of therapeutic opportunities in a context of proper and continuous attention to the security of patients. It can seem extremely hard for staff to combine the therapeutic task with the duty to protect and keep safe. Although intended to help inform the needs of secure hospital patients, a model of this sort also addresses staff's need for integration of a complex and potentially contradictory task.

1.4 Who Are the Patient Group?

Personality disorder is a diagnostic term. It is defined in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) (THE U.S.A.n Psychiatric Association, 1994) as

> an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.

The ICD-10 Classification of Mental and Behavioural Disorders (World Health Organization, 1992) makes the additional observation that personality disorders are "frequently, but not always" associated with personal and social problems. DSM-IV divides personality disorder into three groups: Cluster A consists of Paranoid, Schizoid and Schizotypal Personality Disorders; Cluster B includes Antisocial, Borderline and Narcissistic Personality Disorders; and Cluster C consists of Avoidant, Dependent and Obsessive-Compulsive Personality Disorders. Most

people with a diagnosis of personality disorder who are judged to be a risk to others fall into the second grouping, in particular the diagnostic categories of antisocial and borderline personality disorders (Widiger & Trull, 1994).

There are well-argued problems with the concept of personality disorder, which are relevant to a consideration of the needs of staff. Research suggests that the problematic behaviours that characterise the disorder are best understood as extremes on certain key dimensions of personality that are common to everybody (Blackburn, 2000a; Eysenk, 1998). But the widely used terms 'personality disorder' and 'PD' communicate a categorical theory of personality, in which disorder exists as a discrete and stable entity within an individual and normal and abnormal personality are seen as separate. This is likely to influence the way in which staff view patients, contributing to widespread pessimism about the possibility of therapeutic change, and increasing the difficulty of establishing points of connection and developing empathic relationships with patients. The objection has been made that such terms medicalise what is really a social problem between people, thus obscuring the nature of difficulties and the best ways of addressing problems (Kendell, 2002; Koerner, 1996).

Individuals who are thought to be a risk to others and have a diagnosis of personality disorder have been referred to as 'psychopaths' and 'personality disordered offenders'; or in the case of assessment of severe personality disorder, as 'dangerous and severely personality disordered'. The usefulness and validity of such terms has been questioned extensively, particularly with regard to their derogatory nature (Blackburn, 2000b). The regular use of labels of this sort runs the

risk of creating distance between staff and patients. For this reason it would be important to provide training sessions for staff in which the concept of personality disorder and attitudes towards it were subject to critical discussion. It would also be useful to directly address the issue of the impact of psychiatric diagnosis and labelling on patients and public attitudes in an effort to prevent the unthinking use of powerful and value-laden terms (Angermeyer, 2004; Angermeyer, 2003; Hayne, 2003).

Individuals with a diagnosis of personality disorder who are considered a risk to others are a heterogeneous group in terms of both clinical presentations and the problematic behaviours that may have led to an offence. There are high levels of co-morbidity in this population: many are likely to meet criteria for an Axis 1 diagnosis, such as anxiety or depression, and for more than one diagnosis of personality disorder (Coid, 1992). Forensic services generally accept referrals of those with mental health problems on the basis of a general assessment of risk to others. This means that those who have committed, or are thought to be at risk of committing, sexual offences or acts of arson may well be on a ward alongside those with problems in controlling their aggression.

In addition, the aetiology of the difficulties of individuals with a diagnosis of personality disorder who are considered a risk to others are varied and complex. The literature on the pathways leading to antisocial behaviour suggests that its causes are multiple and that it is useful to distinguish between direct and indirect influences. For example, an antisocial peer group or the abuse of certain drugs can have a direct negative impact, making it more likely that a young person will commit an offence

in the here-and-now; whereas the effects of hyperactivity or impulsivity in childhood - risk factors that are strongly mediated by later experiences - are indirect (Rutter *et al*, 1998). Quality of parenting emerges as both a direct and an indirect influence, and the aspects that appear to be of most relevance are a hostile family environment and a neglectful style of parenting (Kurtz, 2002a). It also seems likely that constitutional factors, or 'temperament', have a significant influence on the development of offending behaviour, but this is mediated by aspects of the environment. The literature on the aetiology of personality disorder is similarly complex, suggesting that temperament plays a part in the formation of antisocial personality problems, but that environmental factors such as early maltreatment, are also significant (Castillo, 2003b; Salekin, 2002). Castillo describes psychodynamic theories of personality development and bemoans the reluctance of clinicians working with those with a diagnosis of personality disorder to incorporate such knowledge into their practice.

It is likely that problems develop in different individuals for different reasons, and that individuals vary in terms of whether their problems are more environmentally determined, more weighted towards constitutional factors, or a combination of both (Salekin, 2002). The suggestion is that the treatment of patients needs to be informed by a close understanding of the complexity of each individual's particular problems, and that a more general approach is unlikely to succeed. Staff will need time to assess patients fully before embarking on an intervention. The resources required to offer effective treatments for the patient group are considerable. But it should be remembered that they are likely to vastly outweigh the personal and financial costs that could result from the lack of a successful intervention.

Greenwood and colleagues did an interesting study with young offenders in California, in which they demonstrated that an intensive counselling and supervision programme was less expensive than existing responses by the youth justice system (Greenwood *et al*, 1996).

The different personalities and problems of individual patients influence each other in unpredictable ways. Staff not only manage individual difficulty and distress, but have to deal with the sometimes intense impact of the relationships between two or more patients. In a recent chapter on forensic mental health nursing for women entitled 'Thinking under Fire', Aiyegbusi describes the way in which women on a locked ward take up the roles of victim and/or perpetrator, resulting in bullying and exploitation (Aiyegbusi, 2004). In such situations, staff need proper opportunities to work towards understanding individual patients and the relationships between them. The best place for this would be a group supervision slot because staff working with individual patients can then coordinate their approaches.

1.5 Impact on Individual Staff

1.5.1 Psychoanalytic theory Psychoanalytic accounts of the dynamics of the therapeutic relationship are relevant to a consideration of the needs of staff who work with people with a diagnosis of personality disorder who are considered a risk to others. Winnicott saw the emotional burden of caring for 'antisocials' (sic) as a result of the extreme inadequacy of care in their early environments (Winnicott, 1949). His argument was that the needs of these patients are so basic, so great and so immediate as to put staff in an intensely demanding position, similar in many

ways to that of a parent with a newborn baby. This group of patients is characterised, not only by neediness and vulnerability, but by hostility – particularly towards custodians and carers, who are likely to trigger associations with formative figures from childhood. The combination is likely to produce hate and fear, among other feelings, in staff who are in close contact with them.

There is agreement that these emotions must be consciously acknowledged and understood in order to stop them from having a destructive effect on therapeutic work (Aiyegbusi, 2004; Temple, 1996). Practitioners working closely with individuals with a diagnosis of personality disorder who are considered a risk to others need to be self-aware in order to think properly about the meaning of feelings and experiences within the therapeutic relationship (Winnicott, 1949). It is important to be able to distinguish between a patient's feelings of rejection and resentment, for example, and the therapist's anxiety about their potential aggression.

In Casement's chapter 'Forms of interactive communication', he introduced the idea of 'communication by impact' (Casement, 1991). He gave examples of ways in which a patient will communicate unacknowledged and painful feelings unconsciously to a therapist. One form is projective identification or 'making others suffer', of which an example is when a patient causes the therapist to experience something painful, such as rage or abandonment, on their behalf, in an unconscious quest for understanding (Aiyegbusi, 2004). Another form is 'actualization', when a patient unknowingly brings about a re-enactment of a damaging or abusive aspect of a formative relationship (Casement, 1991; Davies, 1996). It is important to work to understand the complex unconscious communications of patients and the way in

which they interact with the personalities and experiences of staff if a 'toxic environment', characterised by conflict and the repetition by staff and patients of traumatic past relationships, is to be avoided (Aiyegbusi, 2004). Regular, ongoing supervision is regarded as indispensable in helping practitioners acknowledge the personal impact of contact with these highly distressed and sometimes threatening people, aiding the exploration of dynamics that develop in the context of the therapeutic relationship (Cox, 1996). This sort of supervision aims to promote a reflective approach to practice, and should be distinguished from a more managerial type of supervision, in which tasks are monitored and evaluated.

1.5.2 Attachment theory & research In recent years ideas from attachment theory have been used to develop understanding of the aetiology of violence, as well as vicissitudes in the therapeutic relationship (Adshead, 2002; Fonagy *et al*, 1997; Bowlby, 1988). Individuals with a diagnosis of personality disorder who are also considered a risk to others have usually experienced inconsistent, neglectful or abusive behaviour from primary attachment figures. According to the attachment model, these experiences are internalised as a 'working model' of important relationships for the individual. They are likely to rely on models of frustrating, unavailable or abusive carers, identifying themselves to a greater or lesser extent with the adult position as they grow up. Research has suggested that children who bully or take up the role of victim in their play with others tend also to be avoidant in their style of relating, defensively minimising the significance of their relationships and finding it hard to ask directly for the love and attention they need (De Zulueta, 1996). In considering the possible lack of a moral sense in some offenders, Fonagy and colleagues postulated that the absence of a responsive and

consistent relationship in early childhood thwarts the development of the capacity to think reflexively about oneself and other people (Fonagy *et al*, 1997).

Mental health practitioners, especially those who work in in-patient settings, will often trigger associations with primary attachment figures or become emotionally significant to patients in their own right (Adshead, 1998). In forensic services this is enhanced by the power and control vested in staff, evoking memories of authoritarian and depriving relationships in childhood. Adshead has argued that the ubiquity of threat and fear in forensic institutions make it important for them to function as a 'secure base' for both staff and patients (Adshead, 2002). Factors which contribute to this sense of emotional safety include: the creation and maintenance of boundaries between staff and patients to protect therapeutic space, particularly for nursing staff who are on the wards for hours at a time; the careful management of separation, loss, and the avoidance of abrupt endings; and the monitoring, naming and regulating of affect in staff and patients to promote the capacity of patients to think about and understand themselves in relation to other people.

1.6 Impact on the Staff Group

Since the second world war, organisational theory in the U.K. and the U.S.A. has grown in its engagement with the behaviour of groups in a variety of settings. The model of the social defence system is useful in thinking about work with individuals with a diagnosis of personality disorder who are considered a risk to others. It describes the way in which organisational structure and practice function to limit or

avoid painful affect amongst its members (Jacques, 1955; Jacques, 1953; Menzies Lyth, 1960). The difficulty arises when these social defences undermine the main task of the organisation. In an earlier paper, the author gave a relevant example of this when she suggested that a moralistic attitude towards those with a diagnosis of personality disorder can act as a way of distancing staff from patients (Kurtz, 2002b). This attitude prevents the patient group from getting the hospital care they need and deserve: it stops many of them from gaining access to such care in the first place, and once they are admitted to hospital it can place a custodial, rather than therapeutic, emphasis on their management.

Another relevant model of defensive practice amongst groups is Bion's description of basic assumption groups. This is when groups react to a perceived threat by losing touch with the real demands of the external environment. A common example is a group that becomes focussed on the needs of its members at the expense of its engagement with the working task, over-investing its leader with power and responsibility in a somewhat dependent and regressive fashion (Stokes, 1994). Bion described such a group at Northfield Hospital during the second world war (Bridger, 1946). Staff and patients colluded in an avoidance of the painful and traumatic experiences of combat and, as a consequence, failed in their rehabilitative task.

Consultancy to the staff group by someone external to the organisation is thought to be a useful way of addressing defensive processes that operate at the social level. Individual supervision on its own would not address the dynamics within the staff group, and supervisors from within a service are inevitably constrained in their

ability to make observations regarding the organisation of which they are a part. It is also difficult for them to comment on the practice of their colleagues, and particularly on those more senior than them.

Provision of external consultancy to staff who care for individuals with a diagnosis of personality disorder who are also considered a risk to others is unlikely to be straightforward. It is both intellectually and emotionally demanding to get in touch with anxieties, often primitive, within an organisation, to begin to make links between the experiences of patients and staff, and to attempt to understand defensive processes at the individual and the group level. A number of authors have described the way in which help can be rejected in complex settings as a result of the defensive processes the consultant is trying to address (Lloyd-Owen, 1997; Moylan & Jureidini, 1994; Hinshelwood, 1993). Hinshelwood described the dismissal of psychological thinking as 'soft' when he worked in the 'hard' culture of a prison (Hinshelwood, 1993). Moylan and Jureidini wrote about their feelings of demoralisation in response to being characterised as unhelpful and disagreeable during their consultative work to two separate bone marrow transplantation units, in which the dilemma of whether to undergo palliative care or unpleasant but potentially curative treatment was a daily reality for patients and staff (Moylan & Jureidini, 1994). It is clear that much work needs to go into preparing a contract for consultative work, and in helping services to understand the role of the consultant. The work requires endurance on the part of the consultant, who, in turn, will need their own support and supervision (Lloyd-Owen, 1997).

1.7 Staff Needs and the 'What Works?' Literature

It is widely believed that it is difficult, if not impossible, to achieve real and lasting change with those who have a diagnosis of personality disorder and present a risk to other people. However, although studies of therapeutic outcome with this group are scarce, firm evidence is available to suggest that a range of interventions can produce significant benefits, both in terms of reduced rates of re-offending and improvements to psychosocial functioning (Blackburn, 2000b; McGuire & Priestley, 1995; Reid & Gacono, 2000; Salekin, 2002; Sanislow & McGlashan, 1998). It would be useful to train staff with regard to the findings of the relevant outcome literature with two aims in mind. Firstly, in recognition of the fact that this is a new and difficult clinical area, it would be important to inform staff about the current state of knowledge. Secondly, it would be valuable to correct pessimistic views about the possibility of achieving change with this group of patients. Negative staff attitudes towards the effectiveness of treatments for these individuals has been identified as a problem affecting both the recruitment of staff and the willingness of services to accept patients with a diagnosis of personality disorder into healthcare services (Bowers, 2002; Bowers *et al*, 2000; National Institute for Mental Health in England, 2003).

Relevant research into therapeutic outcome comes from three areas. These are: studies of interventions with those with a diagnosis of personality disorder (usually from Cluster B of DSM-IV, which includes the diagnoses most commonly associated with violence and aggression); studies which focus specifically on therapy for those with a diagnosis of antisocial personality disorder or a label of

'psychopathy' (sic); and research on reducing recidivism in the prison population, a significant proportion of whom meet criteria for diagnosis of personality disorder (Moran, 1999). Possibly as a response to the multi-faceted nature of the difficulties faced by these groups, interventions are usually eclectic or integrative, combining elements from psychodynamic, cognitive-behavioural and systemic therapy. Prominent examples are cognitive-analytic therapy or CAT (Ryle, 2004) and dialectical behavioural therapy or DBT for those with a diagnosis of personality disorder (Berzins & Trestman, 2004; Evershed *et al*, 2004), and multi-systemic therapy or MST for young offenders (Borduin *et al*, 1995).

The need for staff to be educated with regard to the relevant outcome literature and research into the aetiology of these patients' problems, is confirmed by findings that complex and intensive interventions, which are rooted in a sound and explicit knowledge of the multiple causes of difficulties, are comparatively successful (Bateman & Fonagy, 2000; Salekin, 2002). Reviews of treatments for personality disorder conclude that effective interventions tend to have an explicit focus, are well-structured and are integrated with other services (Roy & Tyrer, 2001; Perry *et al*, 1999). Reviews of research into the reduction of re-offending show support for interventions based on a multiple model of cause and an acknowledgement of the complicated developmental pathways of this group (Kurtz, 2002; McGuire & Priestley, 1995). For example, in the U.S.A. Multisystemic Therapy (MST) has emerged as a promising response to the problem of youth offending (Henggeler *et al*, 1996). MST is based on individualised assessment and incorporates approaches from both cognitive-behavioural and family therapy to intervene at the level of the family, the school, and the community.

There is general agreement in the outcome literature that successful interventions are long-term (at least six months or more), intensive, and characterised by extensive one-to-one contact with mental health professionals (Copas *et al*, 1984; Salekin, 2002). For example, programmes are more effective if group therapy is combined with frequent individual therapy, and interventions in which patients do not have much contact with staff – but mainly interact with each other, such as in the traditional therapeutic community – are less successful (Salekin, 2002). Therapy is also more likely to be effective if concentrated, such as in a residential or day-hospital setting.

The therapeutic relationship emerges as a possible key factor in determining success. A recent review concluded that effective interventions for personality disorder are based on a rationale that is clearly understood by both patient and therapist, and underpinned by a powerful therapeutic relationship, which is actively explored during treatment (Bateman & Fonagy, 2000). Breaches in the therapeutic relationship or treatment contract also appear to be particularly significant with this patient group (Jones, 1997). A review of the effectiveness of therapeutic communities for offenders with a diagnosis of personality disorder suggests that those who leave prematurely are likely to fare particularly badly, and recommends that future research investigate ways in which to reduce drop-out rates (Lees *et al*, 1999).

This evidence is in support of the theoretical literature, which argues for the importance of understanding the dynamics within therapeutic relationships with

these individuals in order to prevent destructive re-enactments from occurring (Cox, 1996). The outcome literature suggests a need for staff to receive support in facing up to the difficulty of face-on therapeutic work. This is because there is evidence that programmes lacking such contact, are comparatively less successful. There is also the possibility that staff might avoid close therapeutic work with individuals with a diagnosis of personality disorder who are considered a risk to others if proper support and supervision for it are not provided.

Staff ought to be educated with regard to important gaps in existing knowledge about interventions for the patient group if they are to use available research findings to inform their practice properly. There is a dearth of literature on the relationship between personality disorder and offending, but limited evidence exists to suggest that the two are not necessarily causally related. A recent meta-analytic review of alternative education programmes for young offenders found substantial improvements in psychosocial functioning without related effects on offending behaviour (Cox *et al*, 1995). McMurran and colleagues reported positive results for their problem-solving approach to impulsivity in an in-patient sample of male offenders with a diagnosis of personality disorder. It would be interesting to know whether this had an impact on rates of re-offending after discharge (McMurran *et al*, 2001). It seems useful to distinguish between underlying personality function or 'disorder' and specific behavioural or emotional difficulties, since most intervention studies address the latter although they may describe themselves as evaluations of therapy for personality disorder (Salekin, 2002). Such an approach would complement discussion about the function and context of any service for individuals with a diagnosis of personality disorder who are considered a risk to

others. For example, if the aim of the service is primarily criminological, it would be important to look at research into the reduction of re-offending rates, rather than mistakenly applying more general research into healthcare interventions with the patient group.

1.8 Studies of Ward and Team Environments

Consideration of the environmental needs of staff is informed by studies of violence and ward atmosphere in a range of in-patient psychiatric settings and growing research into the general functioning of healthcare teams. Studies have shown a significant association between the increase of violence on psychiatric wards and a lack of stability and experience amongst nursing staff. James found that violent incidents on a high-dependency psychiatric ward increased when experienced staff were absent and there were relatively large numbers of agency nurses of duty (James, 1990). This was confirmed by Davis, who demonstrated an association between raised frequency of violence and the inexperience of workers (Davis, 1991). With regard to staff attitudes, the comparative tolerance of violence by managers and what is described as a 'coercive' approach to communication with patients have both been linked with increased rates of violence in in-patient settings (Davis, 1991; Morrison, 1995).

It seems useful to distinguish between the need for a structured and containing ward environment, which directs and enables the activities of both staff and patients, and a regime that is experienced as oppressive and over-controlling. For example, Kirby and Pollock showed that in a secure facility, where staff felt in control and regarded

the environment as therapeutic, the expression of anger and aggression by patients was viewed as part of the therapeutic process and tolerated with little need for restriction or control (Kirby & Pollock, 1995). Caplan published an interesting study of a functional and benign ward environment, in which control may nevertheless have acted to prohibit therapeutic discovery (Caplan, 1993). Staff and patients on a ward in a maximum security hospital rated the atmosphere using the Ward Atmosphere Scale (Moos, 1974). The environment was regarded as therapeutic by patients and staff, who saw themselves as receiving a large amount of concern and help from each other. The patient group perceived staff as controlling, although staff thought they exerted only minimal control. In addition, patients and staff agreed that tolerance on the ward for the open and spontaneous expression of feeling, particularly regarding conflict of any sort, was low. The study also confirmed Moos' earlier finding that a low level of disturbed behaviour on a ward was associated with patients' view of a controlling group of staff (ibid).

There is also likely to be an associated need for balance with regard to structure and organisation in the ward environment. Barnard and colleagues carried out a study of factors associated with an increase of violence in a maximum security treatment facility in the U.S.A. (Barnard *et al*, 1984). They found that aggressive acts were most likely to occur when staff were available and trying to structure patients' activities for the day. But organising interventions of staff can be beneficial if delivered in a way that is co-ordinated and well planned. Katz and Kirkland did a detailed piece of observational research into the relationship between violence and the social structure of five general psychiatric wards (Katz & Kirkland, 1990). They described the wards as either 'peaceful', 'moderately violent' or 'violence-prone'.

The peaceful wards were characterised by structured and predictable routines and contact between patients and staff, comprehensive therapeutic activities, a reasonably organised staff group, and committed and involved leadership by the team psychiatrist (Katz & Kirkland, 1990).

Recently there has been a growing interest in the functioning of teams, and West and colleagues have laid particular emphasis on the study of the relationship between innovation and effectiveness in healthcare teams in general psychiatry (West, unpublished document). At this point there is a somewhat circular feel to this research because it is largely based on team image, rather than those aspects of team functioning that are associated with positive outcomes for patients. West and colleagues gathered data from 32 secondary healthcare teams and found that ratings of effectiveness were linked with clarity in relation to leadership, and that innovation and effectiveness were more present in teams who regard themselves as able to communicate well and think together about their work. Of particular relevance to the care of a demanding group of patients such as individuals with a diagnosis of personality disorder who are considered a risk to others, was the finding that an organised, well-led and innovative team environment, in which members meet often and engage in thoughtful discussion, was associated with lower levels of stress amongst staff (Borrill *et al*, 2000).

West and colleagues' study of primary healthcare teams found that their work was hampered by the difficulty in establishing a shared sense of purpose across different professional groups (West, unpublished document; West *et al*, 1997). They suggested that this was partly because the different professions were managed

separately. This may be relevant to mental health staff working in hospital settings with people with a diagnosis of personality disorder who are considered a risk to others. Practitioners are usually divided into a ward-based, nursing team and a multi-disciplinary team. In the latter, practitioners are often allied to separate professional departments.

1.9 Job Satisfaction, Occupational Stress and Burnout

Large-scale questionnaire studies from within general mental health settings have indicated that job satisfaction exists alongside burnout and high levels of reported stress in the workplace. Researchers based at Claybury Hospital in the early 1990s collected data from 250 community psychiatric nurses and 323 ward-based psychiatric nurses (Carson *et al*, 1995; Fagin *et al*, 1995). They concluded that stress and burnout were significant problems for nurses: nearly half of both samples scored in the high burnout category of the Maslach Burnout Inventory (Maslach *et al*, 1997), and 41% of the community sample and 28% of the ward-based sample were rated as 'high scorers' on the General Health Questionnaire (Goldberg & Hillier, 1979). However, the community nurses, who were the group reporting more stress in general terms, were considerably less detached in their feelings towards patients; and on a scale of personal accomplishment, they registered high levels of fulfilment from their clinical work. These results were confirmed by Onyett and colleagues, who looked at job satisfaction, burnout and occupational stress as part of a survey of structure and process in 57 community mental health teams across the UK (Onyett *et al*, 1997). They also found that nearly half their sample of nurses fell into the 'high emotional exhaustion' category of the Maslach Burnout Inventory,

but staff across professional disciplines reported high levels of job satisfaction as well.

One explanation for the unexpected combination of stress and satisfaction in adult mental health nurses is that they tend to be committed and motivated practitioners, who are intrinsically likely to experience stress and satisfaction at work. This may be of particular relevance to staff working with individuals with a diagnosis of personality disorder who are considered a risk to others. This patient group is widely regarded as a therapeutic challenge and is therefore likely to draw workers who want to be stretched. However, it is not clear from existing research whether stress and satisfaction in mental health nurses are inter-related or simply co-exist. Further investigation of this relationship is required to enable service developers to focus on reducing those stresses associated with real dissatisfaction in staff.

Initial findings suggested that working conditions and resources, rather than direct clinical work, are the top stressors for staff and have the biggest influence on job satisfaction. In the Claybury study two issues that emerged as particular irritants for community nurses were lack of availability of facilities for onward referral and long waiting lists for such services (Carson *et al*, 1995; Fagin *et al*, 1995). This suggests that there is a need for staff and managers to define their task in the context of discussions with stakeholders and related agencies, so that their work is supported by the external environment in practical ways. If such conversations remain internal, there is the possibility that workers' notions of what they are doing will not be coordinated with the demands and resources of the outside world, leading to staff feeling unsupported and isolated.

The recent concept of 'vicarious traumatisation' is likely to be applicable to staff who care for individuals with a diagnosis of personality disorder who are considered a risk to others. It developed out of work with survivors of sexual abuse and refers to the negative impact on clinicians of exposure to traumatic material in patients (Sexton, 1999; Steed & Downing, 1998). This is often similar to the effects of direct trauma on survivors, although less acute. Writers about vicarious traumatisation suggest that a therapist's ways of thinking about the world, as well as themselves and other people, may be profoundly affected by their work with survivors of trauma. Individuals with a diagnosis of personality disorder who are judged a risk to others have almost always suffered extreme forms of abuse or neglect in childhood, and therapy with them often involves listening to these traumatic experiences in some depth (National Institute for Mental Health in England, 2003). There is a strong possibility that forensic mental health staff are affected by their work in a similar way to those who work with survivors of sexual abuse. This remains to be investigated.

1.10 Summary and Discussion

What do staff need in order to care for individuals with a diagnosis of personality disorder who are considered a risk to others? Any answer to this question ought to consider findings of research into therapeutic outcome with this group, ensuring a focus is kept on what staff need in order to achieve positive changes for patients. Available studies on interventions with offenders and individuals with a diagnosis of personality disorder suggest that more successful programmes are integrated with

other services, well-structured, operate at multiple levels, and are based on a coherent rationale from the point of view of both patient and clinician (Bateman & Fonagy, 2000; Blackburn, 2000b; McGuire & Priestley, 1995). They also tend to be long-term, intensive and involve regular individual contact between patients and mental health staff. Staff should receive training so they are informed about recent findings regarding effective interventions for the patient group and can develop their practice with reference to current knowledge.

Teaching about what treatments work for these individuals is also likely to be a valuable corrective to prevailing therapeutic pessimism about the possibility of intervening effectively with those with a diagnosis of personality disorder (Bowers *et al*, 2000). With regard to staff attitudes, training should be provided on debates surrounding the concepts of personality disorder and psychopathy and the impact of labelling (Blackburn, 2000b). In the author's opinion, staff should also be informed about the complexity of causal models for personality problems and offending behaviour. Learning about the significance of the influences of social disadvantage and constitutional factors is likely to increase positive feelings towards the patient group. The aetiological literature should guide thinking about the development of particular patients' difficulties, rather than being applied in a general way. Interventions should be guided by formulation of the causes of each individual patient's difficulties, and staff will need substantial resources to enable them to undertake such detailed and thorough assessments.

It is widely acknowledged that individuals with a diagnosis of personality disorder who are considered a risk to others are particularly difficult to work with, often

Table 1. 10: Summary of Needs of Staff

Staff Need	Source & Key References	Practical Implications
Integration of a complex & potentially contradictory task	Systemic theory (Lavender, 2002; Watson *et al*, 2004)	Help from managers and senior clinicians in defining coherent service aims balancing needs of staff & patients for containment and therapeutic opportunity
Match between service aims & expectations & resources in external environment	Large-scale studies of stress & burnout (Carson *et* al, 1995; Onyett *et al*1997)	Discussion of service aims with stakeholders & linked external agencies focussing on expectations & resources
Education about debates regarding the concept of personality disorder & negative influence of labelling	Literatures on concept of personality disorder & labelling (Angermeyer, 2003; Blackburn, 2000a; Castillo, 2003)	Staff training
Education about relevant outcome literature to address therapeutic pessimism & encourage evidence-based practice	Aetiological literature (Blackburn, 2000b; Salekin, 2002)	Staff training
Interventions informed by thorough individualised assessment	Aetiological literature (Salekin, 2002; Rutter *et al*, 1998)	Resources to support this
Ability to reflect critically on responses to patients	Forensic psychotherapy literature (Cox, 1996; Davies, 1996; Winnicott, 1949)	Assessment of reflexive capacity at recruitment stage & regular individual supervision aimed at encouraging reflective practice
Avoidance of abrupt & unplanned separations & losses	Attachment theory & research (Adshead, 2002)	Principle of practice
Awareness of possibility of defensive practice at group & organisational levels	Organisational literature (Hinshelwood, 1993; Lloyd-Owen, 1997)	Group supervision facilitated by an external consultant & including service heads
Stability & experience within the staff group	Attachment theory & ward studies of violence (Adshead, 2002; James, 1990)	Focus by service heads on retention of staff
Organised & predictable routines regarding patient care & staff communication	Ward studies of violence (Katz & Kirkland, 1990)	Regular staff discussions regarding organisation of ward regime
Clarity regarding leadership	Studies of ward environment & team functioning (Katz & Kirkland, 1990; West *et al*, 1997)	Priority for service heads at setting-up stage

finding it extremely difficult to make constructive use of help, and that these patients can arouse intense negative feelings in staff (Hinshelwood, 2002). Supervision for individual staff caring for these patients ought to promote a reflective approach to practice, encouraging practitioners to think about the way in which they can be affected at both conscious and unconscious levels by patients; and how, if unexamined, problems can be played out in the therapeutic relationship so that damaging past experiences are re-enacted (Casement, 1991; Cox, 1996; Davies, 1996). It is the author's view that if supervision is to enhance thinking of this sort, it will need to be explorative in nature, to incorporate an acknowledgement of unconscious functioning in relationships, and to be perceived by staff as supportive and non-critical.

The potentially contradictory roles of carer and custodian and society's ambivalent approach to the patient group mean that an additional task of supervisors and service heads is to help staff to define a coherent sense of purpose (Kurtz, 2002b; Lavender, 2002). It would be important to discuss service aims with staff at all levels of the organisation and to include external stakeholders, such as those running facilities for onward referral. This is because of evidence that the lack of external support for staff is a significant stress, and the suggestions that complex public attitudes towards individuals with a diagnosis of personality disorder who are considered a risk might undermine practitioners' understanding of their task (Carson *et al*, 1995; Lavender, 2002).

Discussions regarding service aims could best take place in the context of regular group supervision facilitated by an experienced and well-supported external consultant (Lloyd-Owen, 1997). Systemic and organisational theories indicate that in the absence of such an intervention, unhelpful group defences are highly likely to develop. For example, according to the model of the social defence system, organisational defences in the work setting develop with the, largely unconscious, purpose of protecting staff from the impact of meaningful contact with distressed individuals (Kurtz, 2002b; Hinshelwood, 1993; Menzies Lyth, 1960). Such defences are particularly likely to develop in services for individuals with a diagnosis of personality disorder who are considered a risk to others because therapeutic work involves contact with intense psychological distress, as well as the real possibility of aggression and violence.

A conclusion is that, in addition to individual supervision, group supervision should be provided by an external consultant who is not involved in the dynamics of the organisation and can take an impartial view. One can imagine a model in which staff receive their own weekly or fortnightly supervision, but also attend monthly consultations together with service heads. More senior staff, who are unlikely to be involved in much direct work with patients, should be included. This is because of evidence that workers at all levels of the organisation can unwittingly become involved in counter-therapeutic practice and the importance of developing service aims and objectives in line with the expectations of key stakeholders (Fallon, 1999; Lavender, 2002).

Ward studies suggest the importance of creating and maintaining an experienced and stable group of hands-on staff, which means that service heads need to look at ways of increasing the use of permanent ward staff and retaining them (James, 1990; Davis, 1991). Research into the therapeutic environment and team functioning indicates the value of a certain degree of structure to ward life. Studies have demonstrated an association between, on the one hand, a comparatively peaceful atmosphere and staff well-being and, on the other, clarity with regard to staff leadership and organised and predictable routines regarding communication with patients (Katz & Kirkland, 1990; West *et al*, 1997). These findings are reinforced by contributions from attachment theory. The suggestion is that the regulation of affect in patients and staff, including adherence to rules limiting staff involvement with patients, are important in ensuring that the workplace operates as a 'secure base' for staff and patients alike (Adshead, 2002). An additional point is that abrupt separations and losses, such as the sudden discharge of a patient or the unannounced departure of a staff member, should be avoided as strenuously as possible.

Ward studies have generally looked at associations between characteristics of the therapeutic environment and levels of violence and aggression in patients. But it is worth questioning whether the absence of aggressive incidents is necessarily indicative of therapeutic success, and distinguishing between a peaceful, well-run ward and a staff group in which a counter-therapeutic fear of addressing and working with issues of aggression and violence has taken hold. This is particularly the case with people with a diagnosis of personality disorder who are considered a risk to others, for whom it is not possible to manage risk through a primarily

medical approach to treatment. Instead it is important for staff to develop an understanding of the patient's interpersonal problems as a context for their antisocial behaviour. This may well involve direct work with staff and other patients, in which difficult feelings and interactions are explored as a way of illuminating difficulties that have led to an act of violence (Morris, 2002). It might be useful to develop criteria for productive and unproductive incidents of aggression for the purposes of clinical audit and research. A hostile communication towards a staff member, which is spoken about afterwards and resolved, can form part of a genuinely therapeutic episode. Alternatively it can have a destructive effect on therapy.

Large-scale research with mental health nurses suggests that it is not contact with patients that staff see as producing most stress in their jobs, but working conditions and organisational factors (Carson *et* al,1995; Fagin *et al*, 1995; Onyett *et al*, 1997). This may represent a displacement, whereby difficulties in the relationship with patients are so hard to think about that feelings of anxiety and frustration are transferred onto external, concrete issues. At any rate, the finding should not be taken to mean that work with people with complex mental health problems is not demanding. Indeed, this research shows that nurses experience large amounts of both stress and satisfaction in their jobs. This could be explained as the consequence of high levels of commitment in staff. It might be that workers are highly motivated in relation to the clinical aspects of their job, which are regarded as meaningful, interesting and valuable. Organisational difficulties, such as a lack of resources for onward referral, are then perceived as significant obstructions, interfering with the core therapeutic task.

There is an obvious need for greatly increased and integrated service provision for this patient group, which is currently being addressed. Specialist services for people with a diagnosis of personality disorder are scarce, and the healthcare resources for those who are considered a risk to others are even less. It is particularly difficult to find services for these patients in medium security, in standard locked wards and in the community. In-patient services for individuals with a diagnosis of personality disorder who are considered a risk to others are growing. But if community resources are not also increased, the rehabilitative task of such units will be threatened.

INTRODUCTION TO THE CURRENT STUDY

2.1 Overview

Here the literature reviewed in the previous section is briefly summarised in order to provide a rationale for the study and show the context for the development of the research questions. These are shown in Table 2.6 at the end.

2.2 Depth Versus Breadth: the Qualitative Approach

Little has been published in terms of empirical research or theory regarding the experiences and needs of staff in the forensic mental health field. This area of work is regarded as particularly challenging because of a complex and demanding patient group and perceived tension in combining therapeutic and custodial responsibilities. Government inquiries into malpractice at Broadmoor and Ashworth have highlighted systemic difficulties within these organisations, suggesting that serious mistakes can result from the general impact of the work and working environment on forensic mental health staff, rather than the failures of particular individuals (Blom-Cooper, 1999; Fallon, 1999).

The empirical literature relevant to the needs of staff who care for serious offenders with a diagnosis of personality disorder consists of broad-brush questionnaire studies measuring stress and burnout in staff in adult mental health services, and research into violence, ward atmosphere and team functioning across a range of

psychiatric and healthcare settings (Carson *et al*, 1995; James, 1990; Katz & Kirkland, 1990; Kirby & Pollock, 1995; Onyett *et al*, 1997; West, unpublished). Key terms such as stress, burnout and job satisfaction, and violence, coerciveness and peacefulness in relation to the ward environment, are loosely defined; and their relationship to clinical outcomes remain unexplored (Caplan, 1993; James, 1990; Katz & Kirkland, 1990). Although findings suggest interesting and possibly unexpected relationships between, firstly, stress and job satisfaction and secondly, therapeutic atmosphere and control (Onyett *et al*, 1997; Kirby & Pollock, 1995), there is a need for in-depth exploration of these associations and the mechanisms underlying them.

Offenders with a diagnosis of personality disorder have often been the victims, as well as the perpetrators, of physical and sexual abuse (Department of Health, 2002a; Department of Health, 2002b). The theoretical literature addresses the issue of how work with such patients might impact on staff at both the level of the individual and the organisation (Lavender, 2002; Menzies Lyth, 1960; Winnicott, 1949). But there is a dearth of theory pertaining to the forensic mental health field in particular, leading to curiosity in this researcher about how the dual responsibility to provide therapy to patients and protect the public influences staff-patient relationships and organisational processes. There are a couple of rich accounts of consultative work with forensic and prison staff which describe the challenges of bringing a reflective depth-psychological approach to these settings (Lloyd-Owen, 1997; Hinshelwood, 1993).

Future research would do well to look in detail at the needs of staff in this area, with a focus on the meaning of concepts such as stress, burnout, safety and control, in

terms of both their relationship with the day-to-day well-being of staff and clinical care of patients. It would be important to give particular attention to the context within which forensic mental health services operate as so little work has been done in the area. For the present study it was decided to interview a selection of staff using a semi-structured schedule to explore areas highlighted by the literature and provide openings to issues which were less familiar to the researchers. Transcripts of the interviews were analysed in depth using techniques from the qualitative research tradition. More detail as to the choice of qualitative methodology will be provided in the Method section.

2.3 Service Context

The systemic organisational literature holds that clarity in relation to task has a positive effect on the effectiveness of a working group, but is difficult to achieve in the 'human services' where concepts of positive change or output are complex and potentially controversial (Miller & Rice, 1990; Menzies Lyth, 1979). Clarity about the working task is likely to be even rarer in forensic mental health services because these services relate to both the healthcare and criminal justice systems, which each have their own powerful, distinct, and sometimes competing agendas (Kurtz, 2002b). The unit that formed the basis for this study was situated in a medium secure hospital. Its patients were all in the process of serving long prison sentences. They were transferred to the unit from prison and usually returned to prison after their stay in hospital, a good outcome being referral to a less secure prison or a therapeutic community within a prison. All the new units for individuals with a diagnosis of personality disorder who are considered a serious risk to others, answer

to both therapeutic and public protection agendas (although an actual conviction will not be necessary for admission to them, they have largely been designed with the aim of preventing future offending). It would therefore be useful in the present study to explore whether there is a measure of confusion amongst staff as to the nature of their task. It would also be valuable to see how understanding about the function of the service relates to patient care on a day-to-day level.

The attitude of society to individuals with a diagnosis of personality disorder who are considered a serious risk to others has been characterised as ambivalent, alternating between a rehabilitative emphasis and the desire to punish or simply to lock away (Lavender, 2002). A previous theoretical paper by the researcher proposed that society's anxiety about the risk presented by these patients results in unrealistic demands being placed on forensic services (Kurtz, 2002b). Such pressures may serve to exacerbate practitioners' confusion in relation to the working task, leading to staff taking on a public protection role without having the necessary resources or authority. Future research in this area could usefully maintain a focus on how staff understand their relationship with the external environment and how this impacts upon their working lives.

2.4 Therapeutic Environment

The literature deriving from general psychiatric settings suggests that instability in the staff group and the increased use of agency nurses are associated with a greater frequency of violent incidents (James, 1990; Barnard *et al*, 1984). A structured and organised ward environment is associated with a more peaceful atmosphere, and

clarity with regard to leadership is linked with increased satisfaction amongst staff with regard to teamwork (Katz & Kirkland, 1990; West, unpublished document). There is no published research with forensic staff who care for individuals with a diagnosis of personality disorder, where violence and aggression are often the specified problems which workers attempt to address. In considering such findings, it is worth asking the question as to whether it is necessarily therapeutic to aim to minimise displays of the behaviour that has caused difficulties in the past. Safety is obviously important for both staff and patients, but it is possible that an over-controlled ward environment might function to prevent real therapeutic work from occurring. Relevant studies of ward culture present contradictory findings: an association has been shown between therapeutic atmosphere and patients' perceptions of a controlling, somewhat conflict-avoidant staff group (Caplan, 1993). But another study found a link between therapeutic atmosphere and staff's tolerant and comparatively relaxed attitude towards the expression of aggression by patients (Kirby & Pollock, 1995). In the context of the present study, it would be useful to find out about how controlling staff and patients perceive the unit to be, and how the question of control relates to issues of safety and the capacity to carry out meaningful therapeutic work.

2.5 Impact of Work on Staff

The psychoanalytic literature relating to individual practitioners and working groups asserts that staff who care for those with severe and long-term psychological and social problems will be profoundly influenced by it, often unconsciously (Winnicott, 1949; Casement, 1991). There is also the proposition that if feelings

aroused by such work are not acknowledged and understood within supervision, staff will develop defensive attitudes and practices which will obstruct real therapeutic work (Menzies Lyth, 1960). Such defences can operate within individual staff-patient relationships or manifest themselves in the structure of the organisation (Menzies Lyth, 1960; Jacques, 1955). These accounts do not specifically concern those who might be considered dangerous (Winnicott's paper focuses on the intensity of the psychological demands of 'antisocials' (sic) rather than the threat they might present), giving additional weight to the need to embark on empirical investigation of the impact of intimate contact with those with a diagnosis of personality disorder who are regarded as a serious risk to others (Winnicott, 1949).

Two large-scale studies have indicated that mental health staff are capable of simultaneously reporting high levels of stress and job satisfaction (Carson *et al*, 1995; Onyett *et al*, 1997). Stress was viewed primarily as the result of organisational difficulties - such as the lack of availability of services for onward referral - rather than direct contact with patients. It is hoped that an open and explorative approach will shed light on the complicated question of practitioners' attraction to this area of work and the relationship between the difficulty of the task and job satisfaction.

2.6 An Initial Reflection on the Stance of the Researcher

In qualitative research it is considered important to make the biases and assumptions of the researcher explicit and, as far as possible, to address them during the research

process (Charmaz, 2003; Strauss & Corbin, 1998). This researcher has always been interested in psychoanalytic approaches, although she has used cognitive-behavioural and systemic approaches extensively in clinical practice in both general adult and forensic mental health services. Her experience as a clinical psychologist working for four years in a medium secure unit and a community forensic service led to an interest in the dynamics of such organisations and, in particular, the way in which services sometimes develop so that it can be hard to keep the therapeutic needs of forensic patients in mind. These experiences were written about in a theoretical paper, which is included as Appendix 1 (Kurtz, 2002b). This article invoked Menzies Lyth's model of the social defence system in an attempt to understand the need to develop ways of working which could be seen as obstructions to meaningful clinical work (Menzies Lyth, 1960). The present study aims to test these ideas, asking whether there is: a) evidence in the interviews for the negative psychological impact of clinical work on staff who care for individuals with a diagnosis of personality disorder and are considered a risk to others; and b) how the influences of the task and setting on staff can best be understood in terms of the relationship with patient care. Specific research questions appear on the next page in Table 2.6.

Table 2.6: Research Questions

Description of study: A qualitative study based on in-depth interview data with staff in a secure unit for offenders with a diagnosis of personality disorder.
Main question: **Does clinical work with offenders with a diagnosis of personality disorder have a negative psychological impact on staff?**
In relation to the service context: **Is there confusion in relation to a complex task?** **What are the characteristics of staff's relationship with the external environment?**
In relation to the therapeutic environment: **How do staff and patients experience control on the Unit?** *Is there a distinction between aspects which enhance or impede therapeutic work?*
In relation to the impact of work on staff: **What is the relationship between stress and job satisfaction in staff?** *Are some stresses associated with dissatisfaction at work while others are not?* *What is the nature of the impact of work on staff?*

METHOD

3.1 Overview: Basic Research Design and Ethical Approval

The current study was based upon a Grounded Theory analysis of interviews with staff working in a Unit for offenders with a diagnosis of personality disorder, which will be referred to as Unit Z. In addition, a group discussion with patients from the Unit and an interview with a community practitioner from a separate service were carried out to test the validity of emerging findings and incorporate a variety of perspectives into the analysis.

In this section the rationale for choosing Grounded Theory as a method is explained. Unit Z and the sample of staff participants are then described. An account of the development of the interview is provided. The analysis of the interview data is then given, moving from line-coding of eight of the interview transcripts, to more focussed summary coding, to the development of categories and the construction of a model to enhance the understanding of the needs of staff working in the Unit. There is a description of ways in which the rigour of the analysis was enhanced, using the comparative analysis of a research colleague, feedback from presentation of the research to two different groups of forensic staff, and incorporation of a discussion group with patients from Unit Z.

Approval from the relevant NHS Trust Local Research Ethics Committee for the main interview study was obtained in May 2002 (see Appendix 2). Approval from

the same committee for a group discussion with patients was gained in February 2004 (see Appendix 3).

3.2 Choice of Grounded Theory as a Qualitative Method

To explore experiences of staff in a relatively uncharted area, the principal researcher needed a rigorous and in-depth procedure for the examination of interview material. Grounded Theory is a well-regarded method for the analysis of textual data, which is designed to generate rich and complex category descriptions; these are then used to inform the development of a model or theory of the phenomena under study (Charmaz, 2003). Main principles of the method are the close and systematic attention to detail in the data, the aim of checking the assumptions and biases of the researcher, and the importance of moving beyond summary description to make a contribution to theory regarding the topic under study (Strauss & Corbin, 1998; Pidgeon, 1996; Pidgeon & Henwood, 1996). The goal of theory-building is to conceptualise the work in such a way that it is made available to others, by making it possible to apply it to other settings and to use it to generate further questions for research. The extent to which Grounded Theory researchers develop proper theory has been questioned, with the suggestion that immersion in textual data produces a tendency towards description rather than analysis (Charmaz, 2003).

The principal researcher was aware of a personal tendency towards theorisation, influenced perhaps by a long-standing interest in depth-psychological approaches to clinical situations. In a previous paper the counter-therapeutic characteristics of two

forensic services in which she had worked were described (a medium secure Unit and community forensic team), and she attempted an explanation for these based on concepts from the psychoanalytic and systemic organisational literature (Kurtz, 2002b). It was important to put these abstract ideas to the test, and a method aimed at the rigorous analysis of complex data was appealing.

The study was intended to inform an intervention with staff on Unit Z and at the time of writing there is a plan to spend three half-days discussing the analysis with them. Psychosocial interventions should always be based on a proper formulation, which attempts a description of influences upon a problem and an explanation of the nature of causal relationships, with the goal of informing any plan to achieve positive change (Eells, 1997). Theory-generation is integral to the Grounded Theory method, which lends it to research aimed at the practical application of findings.

The current study aimed to investigate the experiences of staff at both the level of the individual and the organisation. In other words, the principal researcher was interested in the working environment and how this affected practitioners, as well as in the work experiences of individual staff. Grounded Theory, which allows for the division of texts into Units of meaning that are coded and can then be compared across transcripts, seemed more suitable for this task than, for example, Interpretative Phenomenological Analysis, where the emphasis is on generating themes in the context of individual experience (Smith & Osborn, 2003; Strauss & Corbin, 1998).

The principal researcher was aware of a potential tension between the Grounded Theory method and an interest in the possibility of the influence of unconscious

processes in the working environment, as outlined in the relevant theoretical literature (Hinshelwood, 1993; Menzies Lyth, 1960; Lloyd-Owen, 1997). At the coding stage the Grounded Theory procedure is concerned with an emphasis on what participants actually say, rather than with inferences about what is said. Such a focus on respect for detail in the data is laudable; however, it is worth questioning the assumption that interviewees are always experts with regard to the subject under study. Grounded Theory aims to correct the traditional and patronising view of the researcher as objective 'expert', with the equally questionable idea that the participant is always an 'expert' (Hollway & Jefferson, 2000). Hollway and Jefferson have given consideration to this problem in a recent book which describes their research participants as 'defended subjects': as people capable of valuable insights, often in possession of important knowledge, but - like the researchers themselves - vulnerable to blind-spots and self-deception, particular when it comes to the need to protect aspects of themselves and their sense of identity (Hollway & Jefferson, 2000). They propose a holistic approach to textual analysis, in which contradictions, omissions and inconsistencies that emerge as coding proceeds can be held in mind, commented upon and eventually incorporated into the analysis.

3.3 Recording the Research Process: The 'Paper Trail'

Reflexivity on the part of the researcher is considered important in qualitative research. This is so the perspective brought to the topic under investigation can be made explicit to readers of published research and, if appropriate, questioned during the course of the study (Elliott, 1999). It is also so the influence of the relationship between the researcher and participants on the production and interpretation of data

can be considered (Elliott, 1999; Hall, 2001). To aid the reflexive process, the principal researcher kept a Research Log, which consisted of notes on developing thoughts with regard to the study over a two-year period. She also wrote down her impressions immediately after doing each interview. During the analysis of interview transcripts, the principal researcher kept a box-file with cards, which listed line-codes under headings for developing categories, and a Record of Category Development, which charted the relationship between the analysis of individual transcripts and changing category descriptions. An extract from the Research Log appears below, showing how it was used to reflect upon the research process and develop ideas. An extract from the Interview Notes is included in the section on the Design and Administration of the Interview. An extract from the Record of Category Development appears in the section on the Transcription and Analysis of Interview Data.

3.4 Description of Unit Z

Unit Z was a medium secure 12-bedded ward for male offenders with a diagnosis of personality disorder, situated in a Regional Secure Hospital in a rural setting. It had opened a few years previously and had received a prize early on in recognition of high quality of work in an innovative area. The Unit had a full multi-disciplinary team (consisting of two Consultant Psychiatrists, a Specialist Registrar, an occupational therapist, a psychologist, and input from a social worker, a probation officer and a teacher) and three to four nurses on duty around the clock. A prison sentence of two years or more was a usual criterion for admission, corresponding to

Box 3.2: Extract from the Research Log

17/10/03
First day doing line-by-line coding. More or less completed 13 pages. It is such a discipline really attending to the text and staying close to it. Similar to the skill of a good therapist...

27/10/03
Feeling somewhat overwhelmed by the amount of interview data ahead of me at this early stage of the analysis, which makes me want to rush the coding, which would be a mistake, so am consciously trying to slow myself down and do things methodically...

27/11/03
I have a strong feeling at this point – having line-coded seven interviews – that I need to take stock rather than just plough on through the data...Want to do this with a view to thinking carefully about theoretical sampling. Have three ideas about this:

1) Need to address fact that at the moment all the interviews are with staff from a single Unit and therefore may say more about particular character of the organisation than work with the patient group. Could incorporate interviews from two other different services into the analysis...
2) Conversation with X [senior clinician at The Portman Clinic] drawing on his extensive experience of consultancy to discuss the analysis and strengthen the emergent theory...
3) Group with patients on the Unit to learn about their thoughts about the needs of staff and to look at how/ whether these needs are met or not impacts on them.

the Unit's two-year programme, although men were sometimes admitted for a shorter period nearer the end of their sentence.

Men were assessed for suitability for the Unit in prison and admitted on a criminal section under the terms of the 1983 Mental Health Act. Assessments laid an emphasis on their level of motivation to change and the appropriateness of conditions of medium security for them. Once admitted, patients were more thoroughly assessed during the first three to four months of their stay, going on to take part in a full and structured group programme on the ward. A social problem-solving approach underpinned much of the group work, and a more open meeting at the start of each day provided the opportunity for patients and staff to check in with

each other and deal with general issues as they came up. In addition, patients received individual therapy and input from a teacher, a social worker and a probation officer.

3.5 Description of Sample of Unit Z Participants

The staff on Unit Z consisted of a ward-based nursing team and a multidisciplinary team, with psychiatrists, an occupational therapist, a clinical psychologist and social worker, as well as a liaison teacher and probation officer. A stratified nursing sample was selected for participation, consisting of four nurses who were chosen randomly from within bands graded in terms of seniority. A senior nurse who had recently left the Unit was also interviewed on the recommendation of staff. At least one member of staff was interviewed from each additional professional discipline providing input to Unit Z. In most cases there was no need for selection of interview participants because there was only one member of staff from each profession working on the Unit. It was decided to interview the more senior Consultant of the two in post because he had been recruited to set up the service and worked there since its inception, while the other Consultant had been recruited more recently. There were two social workers providing a service to men on Unit Z, so the one whose input to the Unit was greater was chosen.

Selected staff were telephoned by the principal researcher. They were told about the study and issues such as confidentiality were discussed. Staff were then asked by the principal researcher whether they were willing to participate in the study. All

Table 3. 5: Background Information on Sample of Unit Z Participants

Code	Interviewer	Gender	Age band	Ethnicity	Profession	Years in profession	Years in current post
Z1	AK	M	31-40	White UK	Nursing (A/B Grades)	3	3
Z2	AK	M	41-50	White UK	Probation Officer	14	5mths
Z3	AK	F	41-50	White UK	Nursing G	27	4
Z4	AK	M	51-60	White UK	Medicine Consultant	20	4.5
Z5	NJ	F	31-40	White UK	Medicine SpR	14	6 mths
Z6	NJ	F	26-30	White UK	Psychology (A Grade)	6	2 mths
Z7	AK	F	31-40	White UK	OT	13.5	2
Z8	NJ	F	51-60	White UK	Social Work	25	5
Z9	NJ	F	41-50	White UK	Teacher	20	4
Z10	AK	F	20-25	White UK	Nursing	2	2
Z11	AK	M	31-40	White UK	Nursing	17	4
Z12	AK	M	26-30	White UK	Nursing	8	4

staff approached agreed to take part. Appointments were organised and staff were sent an Information Sheet and a Consent Form (see Appendices 4a and 4b).

Twelve staff from Unit Z were interviewed. The principal researcher conducted eight interviews and a research associate carried out four (see Statement Regarding Ownership of Data, page 8). Two of the latter's interviews were with staff who were known to the principal researcher in other contexts, which might have inhibited discussion during the interview.

3.6 The Question of Confidentiality

Identifying details regarding Unit Z participants were removed when the interviews were transcribed. Concern remained about the scarcity of units of this type leading to the possibility of locating staff through knowledge of the Unit, and staff being able to identify each other with relative ease. The name of the ethics committee, which granted approval to the current study, was removed, and efforts were made to disguise the Unit's identity in ways that did not interfere with presentation of the research. Unless it was relevant to the analysis, the gender and profession of individual participants was not given in the write-up. Interview transcripts were not kept in the University library, but in a locked cabinet by the principal researcher. Requests to view the transcripts should be directed to the principal researcher.

3.7 Design and Administration of the Interview

3.7.1 Semi-Structured Interview The interview was designed to explore participants' experience of their work according to the areas outlined in the Review Article and Introduction. A semi-structured interview schedule was used, consisting of carefully worded questions with follow-up questions where needed (see Appendix 6). Efforts were made to stick fairly closely to the schedule in order to enable comparisons to be made between individual participants and groups of participants.

The questions were worded to balance the need to make explicit the intended area of exploration with the aim of biasing the participant's reply as little as possible. For example, the first 'warm-up' question asked what 'brought' the participant into 'this kind of work'. It was worded so as to avoid defining the specific area of work and suggesting active selection, so it was possible to find out about how work was defined for individual participants and whether it had been selected or more passively 'fallen into'. Similarly the researchers asked what participants thought 'people outside' the Unit thought about their job, without specifying whether this meant their family or more distant colleagues or society in general, in order to find out about which relationships were important to staff in this regard. Initially there was a plan to ask about times when participants had felt 'upset' at work. But after discussion of the possibility that this would limit what could be learnt about different sorts of manifestations of loss of equilibrium amongst workers, particularly male ones, the decision was made to ask about incidents of getting 'either worked up or upset'.

Qualitative researchers tend to favour asking open questions in research interviews (Burman, 1994; Pidgeon, 1996). But there has also been discussion of the need to ask for concrete detail to avoid getting material that is overly abstract and unfocussed (Hollway & Jefferson, 2000). The principal researcher was familiar with the Adult Attachment Interview, which yields categories of representations of an individual's most significant relationships through assessment of the coherence of the interview data (Main *et al*, 1985). One of the principal ways in which coherence is assessed is through the consistency or otherwise of the relationship between general descriptions and specific examples. For this reason, throughout the interview there was an attempt to learn about how abstract description fitted with the concrete reality of lived experience. Pilot interviews were carried out with colleagues working in a medium secure hospital. These suggested that the interview schedule was capable of eliciting interesting and relevant material.

Ten interviews were conducted using the above approach. Background information regarding all participants was collected regarding gender, ethnic background, professional discipline, years since qualification and years in the current post. This is shown in Table 3.5, together with information about who conducted which interview. After each interview, notes were made about anything that struck the interviewer about the encounter and an extract is shown in Box 3.7 below. It was interesting to note how the emotional 'feel' of conversations was sometimes lost from the verbal recordings, presumably because of the absence of non-verbal communication. It was useful to be able to look back at notes made on the day and to remember the way in which a particular encounter made the principal researcher feel and how this was, or was not, borne out by analysis of the transcript.

3.7.2 Towards a Less Structured Interview Format

When discussing one of the Unit Z interview transcripts a colleague commented, with some disappointment, that it read as if the participant were working in a school or any other organisation, rather than caring for such a complex and demanding patient group. This led the

Box 3.7: Extract from Interview Notes

Z4 Interview Impressions:

I found this interview increasingly compelling and very moving...I had the impulse after the interview to send [the participant] an interesting book that had recently been published. He made me feel concerned for him – I wonder whether he inspires such feelings in his staff.

At first I felt the respondent was reluctant to think about his own part in selecting his area of work and tended to lecture me on the history and philosophy of the Unit instead. I tried to get him to talk in a more personal way during the course of the interview and he seemed to become increasingly thoughtful and flatter in affect. The theme which emerges later in the interview – of taking on a great sense of responsibility for the continuing life of the Unit and of the personal costs for doing this – is a striking one...

principal researcher to wonder whether the interview questions had laid undue emphasis on organisational and service issues, or whether a tendency to minimise the impact of the clinical experience was indeed characteristic of some staff in Unit Z. The principal researcher was also concerned that the relative formality involved in using a semi-structured schedule was not helping participants to talk openly. This had not been a problem in the pilot interviews, possibly because they were conducted with colleagues with whom the research associate was already familiar.

To address these concerns, three questions were added at the start of the remaining interviews (see Appendix 7). These focussed attention at the beginning of the interview on looking in-depth at clinical experiences. In addition, the principal

researcher adopted a more conversational and fluid style, aimed at helping participants express their way of looking at work experiences and follow their particular interests and concerns. It was possible to cover most of the desired topics using this approach, and the principal researcher only had to ask the odd pre-prepared question later in the interview. A couple of questions that had not yielded particularly interesting data were taken out of the schedule. The principal researcher also split interviews across two meetings to learn about any thoughts the first conversation had provoked in the participant and achieve a slower, more reflective pace. Two interviews with staff on Unit Z and the interview with a community practitioner were conducted using the less structured interview format.

3.8 Transcription and Analysis of Interview Data

Interviews were audio-taped and transcribed by a secretary using a combination of the guidelines recommended by Burman and those used for the Adult Attachment Interview (Burman, 1994; George *et* al, 1985) (see Appendix 9). The principal researcher listened to the tapes and went through transcripts of the interviews, filling in unclear words or phrases where possible and tidying up the transcripts. Identifying details were removed and, if necessary, noted in a key, which was kept in a separate location from the interview transcripts. The tapes were wiped.

3.8.1 Line-Coding and Focussed Coding

Interviews were line-coded according to principles outlined in the Grounded Theory approach to the analysis of textual data (Charmaz, 2003; Strauss & Corbin, 1998). Units of meaning were kept small because of the aim of attending to the experiences of staff in-depth. The

principal researcher went through the text once dividing it into 'meaning Units'. The aim was to code once per line, although the principal researcher coded more often if the text was particularly compact or less often if suggested by punctuation. When coding, the principal researcher sought to stay as close as possible to the transparent meaning of what was being said and to avoid using abstract or jargonistic terms. The codes were written down on post-it notes and stuck in the left-hand margins of the text so they could be revised if necessary.

The principal researcher went back through the transcript after line-coding a few pages and selected Focussed Codes. These are chosen from the first, detailed set of codes and represent an initial summarising of the data (Charmaz, 2003). Some Grounded Theory researchers start conceptual work more actively at this stage of the analysis and attempt to generate low-level categories. The principal researcher's preference was for the selection of codes that remained closer to the transparent meaning of the text because of the aim of attending carefully to the detail of the actual data for as long as possible. Developing summarising Focussed Codes also provided the chance to check the accuracy of the line-codes.

Towards the middle of the analysis, the principal researcher developed a combined method, using selected line-codes wherever possible and more abstract codes when this was more useful in summarising a group of codes, an obvious example being a list. Box 3.6.1 below shows examples of line-coding and focussed coding for the same excerpt of text.

Box 3.8.1: Illustration of Line-Coding and Focussed Coding

Line coding		Focussed coding
254 contradictory impressions 255 what you see/knowledge of offence 256 what you see	/everything contradicts and it's hard sometimes everything contradicts in your mind / the behaviours you see in him / knowing what they've actually done, how violent their offending can be / and how they're actually presenting to you. /And I	249-256 contradictor impressions of patient
257 talked to colleagues 258 disbelieving of feelings of vulnerability 260 informal supervision 261 contradicted by colleague 262 agreed with colleague 263 difficult to accept vulnerability	actually erm went in the office saying I think you know it'll be this particular patient / he's he he'd complained that he felt vulnerable and erm I was I was quite cynical really and I was saying I he was vulnerable because he you know he couldn't watch the telly last night / and you know sort of office supervision / *(laughing)* and erm one of my colleagues I get on really well with erm said to me 'I'm sure he does feel vulnerable' / I thought 'Yeah you're you're dead right you know I'm sure he does as well really'. / But it for a while it was hard for me to actually try and acknowledge that he probably does feel vulnerable / because I was suppose I was so irritated by the fact that he'd done this offence, / he's a really	257-265 difficult to accept patient's feelings of vulnerabilit & anger about offence
265 angry about offence 266 patient violent/sense of unreality 267 not being able to make sense of him	violent man yeah, / but it was almost playing games / nothing seems real on the ward / you know he he didn't weight up I suppose in my mind /	266-269 not being able to make sense

3.8.2 Pathway Through the Data The principal researcher anticipated that the order in which the interviews were coded would be important in that the analysis of the first interviews would build a frame through which the others would be approached. It was decided to start with interview Z10 - one of the nurses with whom the principal researcher had carried out the more fluid, clinically-focussed interview over two sessions. This nurse had struck the principal researcher as particularly open with regard to the areas under discussion, talking at some length about the personal impact of therapeutic contact with patients, so this interview

seemed like a good starting point. The principal researcher then decided to analyse Z7, which was a memorable interview with the senior Consultant on Unit Z. It provided a contrast to interview Z10 because it addressed issues arising from the lack of meaningful contact with patients. The principal researcher then went to Z4, an interview with the Occupational Therapist, which was characterised in her mind by a preoccupation with relationships in the staff group and did not treat clinical issues in the same depth as the first two interviews. Next Z11 was analysed, which was the other less structured interview carried out on the Unit. This was an interesting interview with an experienced nurse who was firmly grounded in clinical experience and particularly coherent in his thinking. The principal researcher thought this would be a good interview through which to develop and solidify developing categories in the analysis.

At this juncture, the principal researcher checked her preference for analysis of interviews she had carried out. After consultation with her associate, the principal investigator coded Z5 and Z9, interviews which the associate had done with the Specialist Registrar and Teacher. These had left an impression on the associate for different reasons: the encounter with the Specialist Registrar had felt somewhat awkward and inhibited in a way that seemed to characterise some of the Unit Z interviews; by contrast, the Teacher seemed more relaxed and expansive. The principal researcher then coded Z3, which was important to include as it was with the ward manager. Z10(A) and Z10(B) yielded a total of 19 categories summarising line codes and Z4, the second interview that was analysed, produced an additional 6 categories. The yield was far less by the time she analysed the seventh and eighth interviews. No new categories were added at this point in the analysis, although the name of a category was altered. It felt as if 'saturation point' had been reached

(Strauss & Corbin, 1967). This is the point at which textual data stops producing significant new material for analysis. Box 3.8.2 below shows an extract from the principal investigator's Record of Category Development. It illustrates the way in which each interview yielded progressively fewer categories of meaning, leading to a point at which line-coding comes to a natural end.

Box 3.8.2: Extract from 'Record of Category Development' Showing 'Saturation Point'

1st Transcript Analysed Z10(A) & Z10(B): 19 Categories Generated
Balance of power in the relationship with patients
Desirability of open communication
Difficult nature of the work
Difficulty in speaking out
Experience leads to increased competence
Feeling of vulnerability
Inadequacy of understanding
Lack of fit between desired professional identity and daily activities
Mixed feelings with regard to the patients
Mixed feelings with regard to the job
Need for support
Need to address patients' behavioural problems
Personal significance of the work
Positive and negative impact of relationships with colleagues
Self-knowledge as a primary aim of treatment
Sense of the Unit's difference
Sense of instability amongst staff
Sense of satisfaction in one's working life
Value of the supervisory relationship

2nd Transcript Analysed Z4: 6 Categories Generated
Attraction to the challenging nature of the work
Significance of depth of contact with patients
Tension in the relationship with outside
Obstructions to patients' progress
Departure from traditional medical hierarchy
Impossibility of certainty

6th Transcript Analysed Z9: No Categories Generated
No new categories.

7th Transcipt Analysed Z3: Name of 1 Category Changed
'Lack of understanding of personality disorder' becomes 'Lack of understanding from outside'.

The remaining five transcripts were coded using larger meaning units of half a page. Because transcripts were not yielding new category descriptions by this stage, these interviews were coded in terms of whether they confirmed or disconfirmed the main categories that formed part of the emerging model.

3.9 Theory-Building

3.9.1 Category Development The principal researcher started to develop categories after three interviews had been coded. Focussed Codes were used to recall the overall detail of the textual data and categories were generated which summarised sets of these codes. The principal researcher filled in box-file cards for each category with lists of the relevant Focussed Codes. She realised that categories were going to shape and re-shape themselves as the analysis progressed and that the reason why they formed in the way that they did would be forgotten. A Record of Category Development was useful in reminding the principal researcher of the current titles of categories so that data could be found in the box file, since when names of categories changed it was possible to lose track of sections of the data.

The process of categorisation involved comparing transcripts prospectively as well as retrospectively: knowledge of themes that were not yet systematically coded influenced the development of a category in the same way as a previously coded transcript. This process, whereby the researcher comes up with a category description, checks whether it fits the data, alters it in the light of subsequent data, and then goes back to coded data again to see whether it still fits, is referred to in the literature as the method of 'constant comparison' (Pidgeon, 1996). A core

category was developed, which, in keeping with the principles of the Grounded Theory method, was intended as a summary of the analysis (Strauss & Corbin, 1998).

3.9.2 Memo-Writing Building theory from textual data is meant to be a gradual process, which starts during memo-writing. This is when the researcher begins to define categories of particular interest, to notice relationships between categories, to infer processes which might explain such relationships, and to identify gaps in the research, some of which it may be possible to address through 'theoretical sampling'. This is the selection of further participants on the basis of the emerging analysis (Charmaz, 2003). Theory-construction involves moving beyond summary and description towards a more abstract mode of understanding, which compensates for loss of concrete detail by increasing explanatory power and the potential for generalisability. The principal researcher found it difficult to move beyond the stage of coding and categorising the data, having sought to remain close to it for some months. Initially it was hard to decide which categories to select in order to build a theory.

Bearing in mind the eventual aim of designing a staff intervention, it was decided to focus on categories that were a source of concern to staff and those that could be regarded as contextual. This method of theory-building was influenced by the principal researcher's clinical background. It is similar to the process of formulation in therapeutic work, in which one starts with a definition of a problem and attempts an understanding of a causal pathway upon which to base an intervention. Memos were then drafted to describe these categories, using the card index to make close reference to the interview data and noting relationships between categories and

material which did not fit the emerging accounts of the main categories of the model.

A model of the needs of Unit Z staff was developed and is presented in Part Four by means of a diagram and written accounts of the main categories that emerged from the analysis.

3.10 Enhancing Rigour

Rigorous qualitative research ought to incorporate relevant and multiple 'credibility checks', in order to establish whether the developing analysis resonates with people who have knowledge of the topic under study, but who may have perspectives which vary in significant ways from the researcher (Elliott *et al*, 1999). In order to check the reliability of the analysis, a clinical psychology colleague who was unfamiliar with the research but had substantial experience of Grounded Theory, read a transcript. She wrote down the main themes and line-coded a page. The principal researcher compared the colleague's analysis with her own. The line-coding was similar to the principal researcher's and satisfied her that she was not imposing an overly personal perspective on the material. The themes noted by the colleague were already included in the main categories being developed by the principal researcher. However, two of the colleague's observations were influential. They were: descriptions of other staff as the greatest source of stress rather than patients, and the mixed message involved in expecting openness from patients while finding it difficult to be honest with the organisation oneself. These observations

emboldened the principal researcher in the development of two categories: 'Feeling Physically Safe but Emotionally Vulnerable' and 'Emphasis on Staff Relationships'.

It is common for Grounded Theory research to seek validation of the analysis from participants themselves. A date was arranged to meet with Unit Z staff to describe the analysis and receive feedback, but was rearranged by the Unit at short notice. Therefore it was not been possible to incorporate the responses of staff participants into the analysis at this stage, although this will be done later. However, the research was presented at two meetings of forums of professionals with considerable and varying forensic expertise: the research group of The Portman Clinic in North London, which offers a specialist service in forensic psychotherapy, and the Forensic Section within the School of Psychology at the University of Leicester.

To check the validity of the analysis, a brief questionnaire was given to those who attended presentations of the research at both The Portman Clinic and the University of Leicester. The questionnaire asked about general responses to the presentation and whether the analysis confirmed or contradicted any relevant experiences (see Appendix 10). Ten questionnaires were returned out of a possible twelve, comprising five from each group. Eight respondents said that the analysis accorded with their experiences. (Of the remaining two, one did not fill in the relevant section and the other answered so as to suggest that the analysis neither confirmed nor contradicted their experiences.) The category 'Tension with the Outside' was mentioned as having particular resonance in relation to experiences of work with the police force and sex offender treatment programmes. Other points of recognition were: the fact that Unit Z staff talked of finding relationships with each other more

stressful than relationships with patients, and reports of their lack of a sense of physical danger. Discussion of the principal researcher's explanation of the category 'Feeling Physically Safe but Emotionally Vulnerable', as described in Part Five, led her to widen her viewpoint and consider Maslow's model of a 'hierarchy of needs' as an alternative (Maslow, 1962).

3.11 'Theoretical Sampling': Discussion Group with Patients and Community Interview

'Theoretical sampling' is a cornerstone of the Grounded Theory method, and refers to the continued collection of data based upon the analysis and the development of emerging theory (Barbour & Barbour, 2003). Since the current study was based on interviews with staff from a single unit, it was felt to be important to address the question of generalisability; that is, which aspects of the analysis should be considered to result from work with the patient group and could therefore be applied to other clinical settings, and which were likely to result from the particular service context. For this reason, an interview was conducted with a forensic mental health nurse working in a different part of the country from Unit Z, who had a split post involving both ward and community work. Background information regarding this participant is given below. The Revised Interview Schedule was used, but questions were also asked about variations in the experience of work in different settings (see Appendix 7).

It was felt to be important to include the perspective of patients because of the need to include mental health service users in the development and planning of services

in general, as well as the dearth of available research in this area looking at the relationship between the well-being of staff and therapeutic outcome (Department

Table 3.11: Background Information regarding Community Practitioner

Code	Interviewer	Gender	Age band	Ethnicity	Profession	Years in profession	Years in current post
C2	AK	M	41-50	White British	Nursing	33	5

of Health, 1999). Initially the researcher planned to seek the views of a group of users separate to the particular unit under study, as the result of anxiety about upsetting staff by receiving comments that might be considered too 'close to the bone'. Marcia Gelson, who counsels the National Institute of Clinical Excellence on involving users in research, was consulted. Her view was that if users are to be treated as real sources of authority, individuals should be involved who have as much knowledge as possible about the actual issues in question. This is consistent with recent discussion of the need to involve users as active collaborators in research (Trivedi, 2002).

A group with a small number of patients from Unit Z was planned with two aims in mind: to enhance validity by testing out aspects of the developing model, and to learn about their views on what the staff who care for them need in order to do their job properly. The principal researcher sounded out the idea with staff, who were supportive and curious to learn about patients' views. It was decided to exclude

individuals who had been admitted to the Unit within the last month or were too unsettled to take part in a research group. A ward round discussion concluded that no one should be excluded from selection on these grounds. A list of the initials of all patients currently on Unit Z, dividing them into the three who had been admitted within the past three months and the eight who had been on the ward for between three months and just over two years, was provided. One participant was randomly selected from the group of more recent admissions and three were randomly selected from the group who had been on Unit Z for longer. Nursing staff asked the selected men if they were willing to talk to me about participation in the group. All agreed.

It was not thought necessary to get information regarding individual patients who took part because they participated as representatives of the patient group in general. At the time of submission, the ages of men on Unit Z ranged between 20 and 33. In terms of ethnic background, they were all white British. They were sentenced prisoners, had one or more diagnoses of personality disorder and had been assessed by members of the Unit Z multidisciplinary team as motivated to change.

The principal researcher's pre-group discussions with individual patients were interesting. One patient participant said that those who had not been selected were keen to contribute and suggested getting them to write something down for him to bring the following week (although this did not happen). Another expressed the view that staff need to actively seek out similar experiences to those of patients to do their job well. This unexpected approach to the question of staff needs suggested how refreshing the group discussion would be. The principal researcher was asked

to bring copies of journals to the group to show the men what form the research would take when published.

The Schedule for the Patient Discussion Group was designed to explore thoughts the men might have about the needs of staff working in Unit Z (see Appendix 8). The clinical psychology colleague who had coded part of an interview transcript also made suggestions about the schedule to avoid wording questions so as to produce a bias towards confirmation of the developing model. For example, the principal researcher proposed asking whether patients ever noticed staff appearing unduly 'concerned'. However, the wording was changed to ask about observable changes in staff, whether positive or negative.

The discussion with patients lasted for an hour and a quarter and was taped using a mixer to reduce interference on the recording. The transcripts of the patients' group and the community interview were coded using larger meaning Units of half a page because of time constraints. The principal researcher was involved in theory-building at the point at which these were analysed. It was therefore most useful to code these transcripts with a view to whether they confirmed or disconfirmed the main categories or altered the emerging model significantly.

ANALYSIS

4.1 Overview

The analysis of transcripts of interviews with Unit Z staff, a community practitioner and a group discussion with patients, focussed attention on those areas of concern for staff that could usefully be addressed in a future intervention. A model, entitled 'Areas of Concern for Unit Z Staff' is presented here. It is shown in diagrammatic form and a core category is described, which summarises the analysis. This is followed by descriptions of the higher order categories that make up the model. These were divided into 'Areas of Concern' and 'Key Contextual Factors'.

Category descriptions are structured into sections. First there is a brief summary, defining the category in general terms and describing how material relating to the category is distributed across interview transcripts. The latter shows, for example, whether the category was developed from significant passages in a selection of interviews or whether relevant material is spread more evenly across transcripts. Middle sections present the material relevant to the category description with supportive quotations. Section titles usually correspond to lower order categories to show how these were brought together during the analysis to create larger units of meaning. Lastly, negative cases are described. These are instances that do not fit with the category descriptions and are provided to help readers judge the degree of congruence between category descriptions and the data set.

A definition of the needs of staff who care for offenders with a diagnosis of personality disorder, as suggested by both the literature review and the current study, is presented in the Discussion. The implications of these for the development of services are also considered in this section.

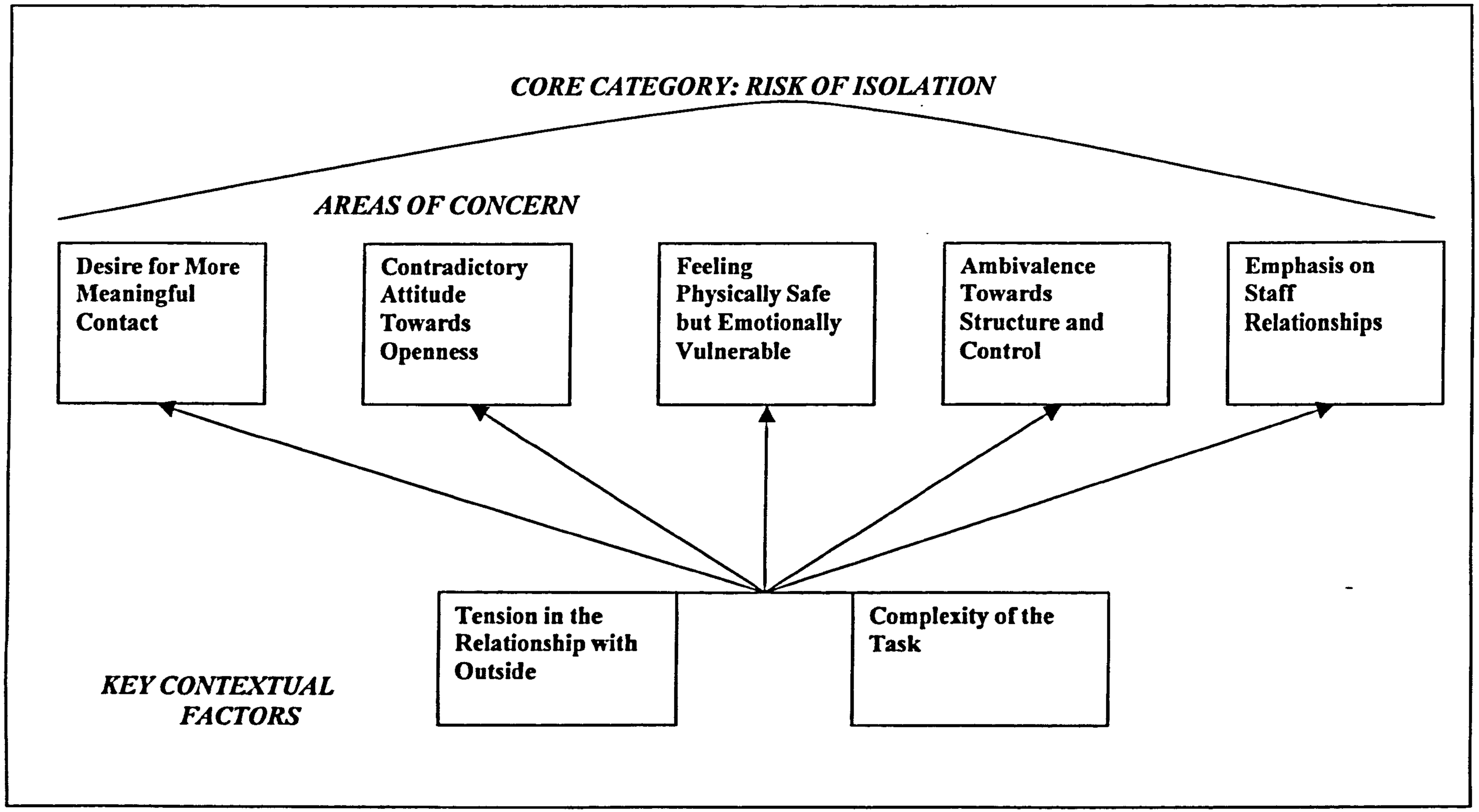
4.2 Model of Areas of Concern for Unit Z Staff

The main model produced by the analysis is presented in Figure 4.2 below, showing areas of concern for staff on Unit Z and key aspects of the context of their practice, which were suggested by the analysis to be a significant influence on difficulties. Consideration of relationships between areas of concern for staff and contextual factors appear in the Discussion.

4.3 Core Category: Risk of Isolation

Isolation came up in different ways throughout the interviews and was a theme running through most of the categories generated by the analysis. The vulnerability and potential isolation, both mental and physical, of the patients on Unit Z was evident from dramatic descriptions of uncaring responses to self-harm in prison: *"if you're not swinging from the windows, from the bars, they ain't bothered...(Participant 2, Patient Discussion Group, ll.843-844)"*. The environment of Unit Z was regarded by patients as considerably more caring than prison. But there was still a firm acknowledgement by staff that their life

Figure 4.2: Areas of Concern for Unit Z Staff



experiences were very different from those of the men on Unit Z, and that it could be a struggle for them to achieve a real understanding of patients and their problems.

> *"if you haven't had that experience it's very difficult to actually really, really sort of truly catch on to where they're coming from, I think we all say "Oh yes it must be awful for you" but I think a lot of the time we actually pay lip service and we don't really know how awful it is (Z11, ll.193-197)".*

Patients distinguished between those staff who could and those who could not convey a sense of understanding that is genuine and not *"talking from text book (Participant 3, Patient Discussion Group, ll.318)"*, and expressed appreciation of moments of real connection with staff. However, both groups saw themselves as communicating across a considerable divide. A staff participant described how a feeling of betrayal by another staff member led to the realisation that she had not previously understood what patients were saying about difficulties relating to trust:

"it sounds naïve but I don't think I ever realised...the whole situation from my perspective shocks me 'cos I thought for the first time I can actually relate [to] where they're coming from...(Z10(B), ll.80-85)". Only one male staff participant spoke of a sense of unforced identification with patients, commenting on how easy it would have been for problems to escalate during adolescence without the support of family and friends. In contrast, a female practitioner partly defined her attraction to the work by describing an interest in the otherness of male offender-patients:

"they're a more damaged group of patients...I suppose they're less like me, you know, you don't have the sort of er neurotic and depressed patients...(Z5, ll.340-343)".

Unit Z staff described themselves as both geographically and mentally cut-off from the world outside. The Unit was physically difficult to find. But this was not

regarded as an explanation for the lack of interchange with hospital colleagues because a previous therapeutic community for individuals with a diagnosis of personality disorder in the same hospital was also regarded as separate although it was next to the other wards. There was a widespread view that both mental health colleagues and people external to the hospital system did not understand the nature of the difficulties of patients with a diagnosis of personality disorder or the work carried out by Unit Z staff. Society and the media were described as having a highly unsympathetic attitude towards secure hospital patients, and it was suggested that the approach of most hospital colleagues suited patients with a diagnosis of mental illness but did not enable understanding of those with a diagnosis of personality disorder.

In this context, clinical work with individuals with offenders with a diagnosis of personality disorder was described as difficult and different. It was also seen as exciting and cutting-edge, and the lack of knowledge and understanding regarding it were part of its mystique for staff. An image of splendid isolation was used by the Consultant Psychiatrist when speaking of his attraction to work with people with a diagnosis of personality disorder. He described a colonial advance into uncharted territory:

> *"[Name of psychiatrist] said...that the reason he studied affective disorders was that all the clever people were (indistinct word) schizophrenia...when he had colonised affective disorder, I felt that there was another area of personality disorders, but that's...being rather flippant (Z4, ll.137-141)".*

The interviews suggested that there is an ambivalent attitude on the part of staff towards their separateness: it could make staff feel isolated and attacked, but also lent a feeling of exclusivity to the Unit.

Experiences of closeness and isolation within the staff group appeared to be inter-related. The dominant view of the team was of a particularly cohesive group, who communicated honestly and openly with each other and allowed a range of voices to be heard. However, one staff participant described feelings of isolation because of not being part of the close-knit group of staff, and another talked of not being welcomed when the job started: *"no one had spoken to [me] all day and it was just absolutely bizarre um and that...affected me as well 'cos I was so soon in, I was thinking "Well am I you know are they marginalizing me? (Z2, ll.755-758)"*.

Interviews suggested that Unit Z staff had reacted to a feeling of attack from 'outside' by retreating into a close and protective staff group and investing in a positive team image. Comments indicated that this, in turn, had had an impact on the way outsiders perceived Unit Z staff. The issue of envy of the resources and developments in practice on Unit Z came up in several places. The probation officer, who had been seconded to the Unit to build up links with public protection agencies, reckoned that he was regarded as a *"jammy git (Z2, l.208)"* by probation colleagues weighed down by casework; another practitioner talked of hospital colleagues' envy of the recognition received by the Unit; and covetous feelings towards Unit Z's academic and staffing resources were mentioned at several points. The following quotation suggested the possibility of a reciprocal process, whereby external hostility and an internal attitude of superiority may have acted to reinforce each other:

> *" people may see them as a clique, you know, not...wanting to get involved with the rest of the hospital, maybe a team that thinks they are a bit special...they feel they're quite elitist, don't fit in...but what other people think of them, they think they are anyway (laughing) (Z6, ll.95-101)"*.

Although communication with healthcare colleagues outside the Unit was not good, it was clear that academic researchers were welcome and visitors attended open days, which took place as a result of the Unit's special status. It was suggested that the special attention of such visitors may have served to strengthen the idea of the Unit as elitist.

The sense of the importance of feeling connected with other people in the work environment and the devastating impact of isolation within the staff group, were repeatedly expressed in the interviews. Staff were highly emotional when they spoke about the significance of feelings of welcome and belonging in the team, and the impact of receiving positive comment from colleagues: *"everybody was so pleased to have me up here...I think that that's something that I'll always remember...(Z7, ll.95-96)"*. On the other hand, when things went wrong amongst staff, resulting emotions of instability, vulnerability and isolation were described, and staff departures occurred. The loss of well-being that resulted from isolation within the staff group was pronounced, leading to the threat of break-down or madness. To illustrate this, here is a practitioner talking of the danger of professional isolation and the need for a colleague: *"I was very very keen to get somebody else, er here with me in order to probably prevent me going mad, if I did go mad at least somebody would be here to spot it...(Z4, ll.697-699)"*.

4.4 Area of Concern: Desire for More Meaningful Contact

4.4.1 Definition of the category and distribution of the material

This category refers to the wish, expressed by both staff and patients, either for more or

deeper contact in staff-patient relationships. In six of the staff interviews this was articulated either in terms of a desire to increase direct contact with patients, or a sense of struggle in bringing together an understanding of the different aspects of patients' experience and presentation, or the desire to move to a more personality-oriented psychology on the Unit. From patients' point of view, staff did not spend as much time interacting with patients on the ward as they had previously, and there was variation in different practitioners' ability to develop an in-depth understanding of individual patients.

4.4.2 Reaching towards a 'resonance with the person' There was a desire, expressed by medical and senior nursing staff, to *"look beyond behaviours (Z11, l.426)"* and pay more attention to underlying issues of personality and whole-person functioning. This wish incorporated the need to work with an understanding of the causes of behavioural difficulties rather than focussing too narrowly on the behaviour itself. A leaning towards more holistic contact with patients was given concrete expression in a recent development on Unit Z, in which the core beliefs of individual patients were assessed and linked with problematic behaviours. The aim was to make it easier to predict the risk of individual patients, and the process felt meaningful to both patients and staff. It represented a departure from the programme set up when the Unit opened, which consisted largely of groups designed to address the specific behavioural difficulties of the patient group.

Development of an understanding of the causes of patients' problems was seen as both a professional duty and a source of considerable personal satisfaction. Change as the result of interaction within the therapeutic relationship was gratifying for

staff, and work with individuals with a diagnosis of personality disorder – in contrast to the 'mentally ill' - afforded the possibility of a fuller, more active exchange:

> *" you're dealing with a live conditioning, [sic] person...very disorganised and all over the place, but...I suppose it's a bit like having a machine and all the bits are there (pause) and you can kind of put it together, as opposed to some of the bits missing and it never really functions really quite well so I think...the kind of resonance with the person is much more lively (Z4 ll. 155-160)".*

For the Consultant Psychiatrist, dissatisfaction in the job was the direct result of a lack of close, meaningful contact with individual patients. He and the ward manager regarded one-to-one therapeutic work as incompatible with their responsibilities to all the patients: to work with some individuals and not others would be perceived as unfair. Instead the role of the Consultant was to admonish or lay down rules when he would have preferred a deeper, more intimate relationship. He would have loved to return to regular psychotherapeutic work with patients and giving up this activity was regarded as a sacrifice. The teacher spoke too about wanting to work with patients more frequently, but for her, it was staffing resources that stood in her way.

Failures of proper communication or understanding were a frustration for patients and staff alike. Staff were categorised by patients largely in terms of their ability to show an in-depth understanding of patients' experiences. Their view was that such understanding results from giving time to patients and being able to relate one's own life experience to theirs. It was difficult to accept advice or guidance from staff who were not able to communicate with patients out of a sense of common experience: *"I know personally that makes me mad, and...I can't accept... somebody telling me how my life is when they have no clue, other than what they've read out of a text book (Participant 3, Patient Discussion Group, ll.241-243)".*

The patient who had been on the Unit the longest recalled that two years' previously staff were more patient-centred in their approach and spent time on the ward talking to the men and getting to know them. There was a perceived change in the priorities of nursing staff, many of whom spent much of the day in the office filling in forms and entering data onto the computer. There was also recognition that some staff might be actively avoiding contact with patients: *"for some it's frustrating, for others it's easier...they don't have to put up with the verbal abuse that they might get if they're out on the ward...it's a quieter life for them sitting in the office (Participant 4, Patient Discussion Group, ll.483-486)"*.

4.4.3 Split view of patients In the more exploratory interviews with nurses there was talk of the struggle to connect simultaneously with both the victimised and victimising aspects of patients. It was hard to link a familiar person, who inspired feelings of fondness and protection, with the violent offence they had committed; or alternatively, to integrate a patient's aggression with their evident sense of vulnerability and persecution. This provided a parallel with the lack of coherence with regard to the task of the service: in particular, the tension between the duty to care for patients and the obligation to protect society. There was talk of the need for balance in clinical approach. A less experienced worker wrestled with the difficulty of accepting a patient's more vulnerable side. A more experienced worker described the importance of keeping the offence in mind: there was a need to *"keep in mind why he's here and what he should be doing and not let his boyish charm...get in the way of er giving him boundaries...(Z11, ll.242-244)"*.

It seemed to be more difficult to bring together different aspects of individuals and the work experience in a secure Unit than in a community setting. The safety inherent in the physical environment of the Unit made it possible not to think all the time about the risk presented by individuals. The community practitioner, who had worked in both community and secure settings, described this difference: " *before, maybe it's lax of me, but before I didn't need to do that, I knew it would be safe right [speaking of a ward setting]? Now in the community you ask yourself those questions all the time, you don't not ask them, right? (C1, ll.873-876)*".

The difficulty in remaining in touch with the vulnerability of patients was discussed at some length in an interview with a nurse. This split and the accompanying emotions of guilt, unreality and frustration, are well expressed here:

> *"Sometimes I think I should be less assertive with him because you know he...comes across as somebody who's very vulnerable and erm very weak and "Yes you know you know" (said in a quiet voice) like "Please" and "Thank you" and all the time you think "Well you're telling me you're not an angry person you're passively sitting here yet you've [description of the offence]" and you know everything contradicts in your mind the behaviours you see in him, knowing what they've actually done, how violent their offending can be and how they're actually presenting to you...it was almost like playing games nothing seems real on the ward you know he didn't weigh up I suppose in my mind and I was getting frustrated...(Z10(A) ll. 248-268)".*

A lack of balance accompanied talk of staff's reactions to patients' potential to victimise or to suffer victimisation. A practitioner took sides on a patient's behalf, expressing anger towards a system that kept a talented young man locked up, possibly indefinitely, because of the high profile of his case and continuing uncertainty about his risk to others. The view taken on such issues depended on whether one worked inside the Unit or not. The insider view was that patients *"probably have a worse time than their, a lot of the victims [of] their crimes (Z5,*

ll.367-368)" and deserved to be given a second chance; the outsider perspective, as perceived by staff, was that patients are inhuman, and even monstrous.

4.4.4 Growth of cynicism over time The view was that staff could grow hardened and cynical. Interestingly, negative feelings towards patients tended not to be a direct response to their offences. Instead frustration resulted from patients' reluctance to engage in therapeutic work and show remorse about what they had done. Cynicism could be a defensive reaction to feelings of disappointment because of perceived therapeutic failure, presumably leading to a reduced ability to build relationships with patients: *"I think they feel upset I think they would be feeling let down they feel emotional I think part of that emotional toughening up is to stop you making perhaps becoming as attached...(Z11, ll.384-387)"*.

4.4.5 Negative cases The teacher compared the ratio of staff to patients with prison and commented on the amount of contact compared to the neglect of inmates. A patient talked about how close he felt to some members of staff, describing the bond as something that went beyond a limited professional relationship: *"I do feel attached to some staff here...I don't believe in that therapeutic relationship (Participant 1, Patient Discussion Group, ll.183-185)"*. It was suggested by patients that the significance of relationships with staff may be limited, as real understanding often only comes from other patients because they have shared many similar experiences. The role of staff was partly to facilitate learning between patients rather than carry out therapeutic work themselves.

One staff member regarded the development of a cynical attitude as, at least in part, a healthy, reality-oriented response to the deceptive way managers and patients behave in the work environment. It was seen as a sign of experience: *"people um stop being a floppy bunny nurse and [start being]...a forensic nurse (C1, l.499-500)"*.

4.5 Area of Concern: Contradictory Attitude Towards Openness

4.5.1 Definition of the category and distribution of the material This category refers to the desirability and acknowledged difficulty in achieving genuinely open communication regarding problems. Such honesty was a therapeutic aim with patients and was regarded as a characteristic of the staff group, while also being described as an area of difficulty. Discussion of the value of patients' honesty about current problems and past actions occurred in five interviews. Consideration of the importance of staff being able to discuss things fully and non-defensively with each other was brought up in seven interviews; problems in relation to staff communication within Unit Z were mentioned in five interviews, and difficulties with communication with staff outside the Unit were discussed in two.

4.5.2 Self-knowledge as a therapeutic aim The importance of openness and honesty in enhancing the therapeutic process was a recurring theme. Staff encouraged patients to be honest about what they had done and to be open to exploring difficult feelings towards staff or other patients on the Unit. Openness about problematic feelings and experiences was regarded as necessary in order to develop an understanding of the real nature of an individual's difficulties, which

was an important step towards being able to embark on meaningful therapeutic work: *"there was an acknowledgement on his part that... "I've to admit to...what I've done if I'm gonna ever progress (Z11, ll.271-273)"*.

Openness in relation to difficulty was seen as something that required time and the development of trust. It was generally not part of the prison culture, out of which patients had come, and so staff needed to work to build relationships with patients that were based on understanding and not criticism: *"that's part of the reason why they don't maybe open up and talk as much as they should for fear of being judged they've been judged most of their lives anyway...(Z11, ll.265-267)"*. Open talking was often regarded as a marker of significant and hard-won progress and several staff spoke of the satisfaction that resulted from patients becoming able to talk about painful, and sometimes disturbing, material. A practitioner was impressed when a patient was able to say how angry he was with her about a particular episode on the ward, and to reflect on his contribution to the situation. This resulted in a real change in their relationship: *"it would be very problematic for me working with him, but it hasn't been like that 'cos it felt like he's actually worked through something properly...So that was, yeah, something that was very rewarding (Z7, ll.462-465)"*.

4.5.3 Mixed view of the team environment Open communication was described as important for staff as well as patients. It was cathartic and helped staff feel less isolated in the face of clinical dilemmas, as well as enabling them to draw on the ideas of colleagues. The multidisciplinary team on the Unit was regularly described as particularly open and democratic. All staff were seen to have a voice in team meetings, irrespective of professional background or seniority. Although the

exchange of views could make the decision-making process confused and laborious, the openness of the team environment was thought to be a definite strength of the Unit.

There were qualifications to this image of the staff team, however. There was an expectation on Unit Z that staff would think about struggles they were having in their work with patients and try to resolve them. Some staff thought team discussions were open enough to talk about such feelings and allow for the expression of different ideas within the team. Others said that it was difficult to talk directly within the staff group about problems that sometimes developed in relationships with patients. Avoidance of conflict may have been linked to the team's sense of itself as *"a good nice team (Z7, l.314)"*, in which there was an investment in people getting on well together. There was a fear that picking a colleague up on their approach to a particular patient would be regarded as attacking:

> *"we never ever became a completely open team...there 's of lots of fantasies about you should be able to challenge your colleagues erm about any, anything at any time, anywhere really, erm. I don't think we ever got to that point...so whilst we did challenge each other...it probably was only when it felt safe rather than necessarily when it was needed, erm (pause). But I think that got better with time (Z12, ll.65-67)".*

Lack of openness amongst staff was seen as partly responsible for the past development of an unprofessional staff-patient relationship. This was regarded as destructive and resulted in the resignations of staff. There was the view that it might be valuable to have group supervision to create a safer space for such reflection as a staff group.

4.5.4 Difficulties in communication with managers

Where relationships with managers both inside and outside Unit Z were described, they were characterised by a difficulty in achieving open communication. This was in contrast to descriptions of relationships with other senior figures, who were generally seen to enhance practitioners' confidence and sense of professional identity. This was illustrated by an interview with one worker, who began to talk about discontent with regard to working conditions when the tape was turned off, although there was agreement for it to be switched on again for discussion of these issues to be recorded. Forums existed to which clinical problems could be taken, but there was nowhere to take staff issues. It could be seen as pointless to air problems because of the likelihood of being labelled a trouble-maker; or open talking about difficulty could be strongly desired on the part of staff, but managers seemed to avoid opportunities for such communication.

4.5.5 Negative cases

In contrast to the general view that open talking was a good thing, no matter how much of a struggle it could be to achieve, one staff participant preferred to remain quiet about the inadequacy of secretarial support because of her trainee status.

4.6 Area of Concern: Feeling Physically Safe but Emotionally Vulnerable

4.6.1 Definition of the category and distribution of the material

This category refers to the finding that, in general terms, staff felt physically safe on the Unit but expressed feelings of extreme vulnerability and isolation, more often in the context of relationships with colleagues than patients. Assertions of physical safety

took place in at least six interviews, and there was a tendency for participants to answer the question about feeling physically or emotionally unsafe by focussing on the latter. Extended accounts of vulnerability in relationships with colleagues, either inside or outside the Unit, featured in four interviews, and the subject was mentioned in a further three.

4.6.2 General sense of security Staff generally felt physically safe on the Unit, which was distinguished by the infrequency of incidents involving violence or aggression. Contrary to expectation, forensic wards were described as particularly safe places: *"the safest place on earth (C1, l.848)"; "particularly in the secure hospitals you actually go "oh we're safer than any open psychiatric ward because we sort of"- people are just more aware...(Z5 ll. 377-379)"*. There was a view that staff could become somewhat blasé about working with angry people. One participant, who felt generally safe on the Unit, argued for the importance of remaining fresh in one's response to aggression from patients: *"if there is a patient who's effing and blinding and blowing their top, I st- st- I get butterflies and and I feel nervous and God what could happen here? (Z4, ll. 699-701)"*.

The interviews with doctors contained quite surprising assertions of the lack of stress and worry about risk in the job: *"It's been very easy to manage erm, it hasn't been stressful in that sense (Z4, ll.207-208)"*. This participant went on to present very contradictory feelings of precariousness regarding professional survival and uncertainty about the possibility of predicting risk in the patient group. His medical colleague explained her fairly relaxed attitude by saying that a less experienced practitioner would be more likely to feel unsafe on the Unit, and that nurses were

more vulnerable than doctors because of their responsibility for the enforcement of discipline.

4.6.3 Sense of instability amongst staff A worker described feeling isolated in the clinical context as the result of recent changes in the staff team and the loss of familiar and trusted colleagues:

> *" you come on shift and you feel like you're constantly challenging people and you feel like you're very much doing that on your own and I... think I said last week there are a lot of my colleagues have said that as well to me (Z10(B), ll.103-106)".*

At another point in the interview, a specific night shift was mentioned, when staffing levels were low and the participant was the only qualified member of staff on duty. Feelings of vulnerability and anxiety were mixed with anger at being put in an unsafe position and being forced to ask an unqualified nurse to carry an alarm in an attempt to ensure the safety of the ward:

> *"I probably feel very much on my own that he wouldn't even carry the response and then annoyed at the fact that I'd had to ask him to do that and admit that he was he was right in a way I think to refuse to do that... and then I suppose just...vulnerable because you know if I'm... in charge I shouldn't leave the ward erm the response goes off I take the meds keys with me what if something goes off up here? (Z10(B), ll. 507-519)".*

Vulnerability in relation to the patient group was mediated by the level of support in the staff team. It was exacerbated when staffing levels were low, or trusted and experienced practitioners were not on duty.

4.6.4 Vulnerability in the face of external threat Staff expressed a sense of vulnerability in response to what was perceived to be hostile or critical behaviour on the part of colleagues, mainly outside the Unit. The type of actual or anticipated attack varied in terms of whether it came from professionals within the hospital,

from a national inquiry in the case of homicide or, in one case, from trusted colleagues on Unit Z. All accounts were characterised by admissions of emotions of intense vulnerability and hurt, to the point where professional survival was in question:

> *"I think had we had, maybe if we still had, a major inquiry, i.e. if someone committed homicide under my care and we went through every single thing we'd written or hadn't written for the last, er, um, three or four years or whatever it was, er, I I think that's an absolutely devastating experience. I'm not sure that I could survive that...(Z4, ll.179-183)".*

One staff participant spoke about the importance of not giving in to such feelings and continuing to work as normal; another questioned their robustness, and the strength of the service, in the face of rigours of the inquiry process. Difficulties with staff were harder to deal with than problems with patients because there were no forums for discussion of the former. Also staff issues could be too sensitive to talk about in the workplace, and might result in the withdrawal of established lines of support if problems involved important colleagues:

> *"the issues I I do get with patients I feel there's the right systems in place for me to take those issues to, erm, the conflict I have there, erm, is is more difficult to deal with. That that's the hardest thing (Z7 ll.483-486)."*

4.6.5 Negative case Experiences of physical vulnerability in the ward situation occurred in two nursing interviews. The dominant theme of one of these was the need for support from nursing colleagues rather than an actual incident involving a patient. In one interview there was a dramatic description of a frightening incident involving direct contact with a patient. The patient had a life-threatening and highly contagious illness and had deliberately infected someone previously. He threatened to do the same to the nurse when challenged about breaking a minor rule on the Unit. The nurse was in charge of the shift and had to

shield junior staff from the patient's threats. The patient was placated to avoid a dangerous confrontation and sent back to prison.

4.7 Area of Concern: Ambivalence Towards Structure and Control

4.7.1 Definition of the category and distribution of the material This category refers to an ambivalent attitude towards structure and control on Unit Z. The Unit was favourably compared with other, more chaotic environments in three interviews, and seven of the participants spoke positively about the clarity and structure of the group programme and the motivation of the patients. Encouraging patients to take responsibility for their actions was described as central to the ethos of Unit Z. But unease was expressed in two interviews regarding an infantilising attitude to patients. Inconsistency in the application of rules on Unit Z was a principle theme of the group discussion with patients.

4.7.2 Sense of the Unit's difference The organised nature of the environment was regarded as a benefit for both patients and staff. The latter commented particularly on the satisfaction of feeling that they were working actively with patients to bring about change and on being able to measure progress through the regular use of assessments of the outcome of the various groups that make up the programme: *"we do the psychometric scores prior to every CPA [meeting to monitor the Care Programme Approach] so you can actually see if there's improvements or deteriorations with the patients...(Z3, ll.44-45)"*. The group programme was generally regarded as very helpful by both staff and patients,

and the Unit was positively contrasted by staff in the levels of activity and motivation expected of patients:

> *"I think the difference is they're making a choice to be here erm (pause) and that I suppose the structure because it's so structured there's very clear boundaries erm (pause) there's an expectation that people attend groups, there's an expectation people are here on time...(Z10(A), ll. 78-81)".*

An inconsistency emerged in relation to the question of therapeutic motivation. On the one hand, patients were only admitted to the ward if they were judged to be highly motivated to take part in the programme, in contrast to elsewhere in the hospital where patients were often detained against their will. On the other hand, it was clear that a level of control existed because of firm expectations regarding participation in the programme and the threat of return to prison if patients became violent or were not willing to work towards positive change. The possibility of a mixed message to patients was touched upon by the teacher, who stressed throughout the interview the importance of people wanting to learn for themselves and said that she did not teach anyone against their will:

> *'you do still get like the negative "Oh I don't want to be there on that...bloody day"...and the staff around are more sort of like "Well that's where you're going to be"...whereas the rest of the unit as a whole if somebody really doesn't want to attend it would be far easier for them not to...(Z6, ll. 349-354)".*

4.7.3 Balance of power in the relationship between staff and patients

Inconsistency in the application of rules governing life on Unit Z was a concern for patients. They considered that there were an overwhelming number of rules, and many of these were regarded as petty. Patients described struggling to accept the regime when a rule was applied one day but not the next, and an episode was recalled when a member of staff encouraged a patient to hide another patient's property and then told on him to other staff: *"that's consistency gone mad there, but er you know it's hard to explain (Participant 4, Patient Discussion Group, ll. 582-*

583)". They talked also of their experience of the moods of certain staff members, and said that this made it seem unfair when patients were criticised for taking their feelings out on other people.

In staff interviews a sense of unease was articulated with regard to the lack of balance of power in the relationship with patients. The control vested in staff was seen to obstruct the development of honest, open communication, and to sit awkwardly with the image of a caring professional. A member of staff expressed discomfort, partly though nervous laughter, with the way in which the threat of a return to prison was used to control the behaviour of patients.

> *"I suppose really as much as I hate to say it there is a control element to it...any other ward if they don't comply they can stay in bed all day...the control thing is people have to otherwise you know they lose their place which sounds awful but you know that's how it works really (laughing). You see that sounds awful (laughing) (Z10(A) ll. 81-90)".*

There was discussion of the infantilising way in which staff could find themselves relating to patients. This was related to a sense of duty to challenge patients when their behaviour was judged to be troublesome and to a feeling of professional failure if patients were allowed to get away with things. A senior practitioner talked of the importance of understanding the staff's need for order and control because of the damaging experience of the chaos of the previous therapeutic community:

> *"the kind of power nexus is too far tilted towards the staff in my view for comfort. I would like something a bit, not equal, but it's very difficult to get a real sense I think of what our residents really think of us...part of the reason was anxiety...the residue of the previous therapeutic community which...left staff in a very very fragile state...I think people felt that if we kind of give on X, then we have to give on Y and Z and everything else...I've found some of that decision making was very very petty indeed...it would have been nice to have been a bit more sort of, as though you...were managing teenagers rather than toddlers...(Z4, ll. 661-674)".*

4.7.4 Complexity of the task A senior nurse and the community practitioner's accounts of the forensic mental health task placed therapeutic work firmly, if uneasily, within the context of the need for social regulation and control (see the description of the Key Contextual Factor: Complexity of the Task, for more on this). Again, it is worth noting the discomfort expressed by this participant's laughter: *"WHAT DO YOU THINK ITS [referring to the community forensic service] FUNCTION IS IN TOTAL? (Laughing) Social control (C2, ll.157-158)".* This was in contrast with other interviews with Unit Z staff, where there was talk of the need to balance or combine separate duties involving therapeutic work and public protection.

The community practitioner described himself as working within a legislative context, such as the laws concerning child protection, which determined aspects of his practice whether he liked it or not. The practitioner on Unit Z saw therapeutic work as inextricably linked with issues regarding public protection: patients were, hopefully, discharged to a less secure prison or a therapeutic community within a prison, so that the care of patients was judged in terms of its impact on their perceived level of dangerousness. In addition, the ability to exert a reasonable amount of control over destructive behaviour was regarded as a prerequisite for therapeutic work on underlying psychological issues.

4.8 Emphasis on Staff Relationships

4.8.1 Definition of the category and distribution of the material This category refers to the immense importance for staff of their relationships with each

other. This was an area of concern because of suggestions of an idealised team image, which may have partly represented a refuge from a difficult relationship to external agencies, rather than the basis for a genuinely reflective approach to practice. Staff understandably needed each other for practical and emotional support, but there was some evidence that the degree of their dependence was unhelpful. A high level of appreciation of the team environment was voiced in all but one of the interviews. Problems about speaking openly in the team about areas of difficulty were voiced in four interviews and enacted in another, when certain topics were addressed when the tape recorder was turned off (although permission was given for it to be turned on again).

4.8.2 Positive view of team environment All staff defined themselves as belonging primarily to the 'Unit team', apart from two staff who provided input to all wards within the hospital and identified themselves with professional departments as well, and another practitioner who had recently joined. There was widespread agreement that the team environment was particularly good: *"I mean it was a pretty good team, I thought, of all the teams I've worked with...(Z5 ll. 52-53)"*. The team was characterised across interviews as an open, *"honest forum (Z3 l.349)"*, democratic in the way decisions were made, and promoting of high levels of collaboration between professional disciplines. The more senior Consultant's belief in empowering front-line workers, and in particular nursing staff, was greatly appreciated. The team environment was a draw for staff. It was one of the reasons they came to work on Unit Z and was identified as a factor keeping them in their jobs. A number of emotional statements were made about the positive impact of the team on individual staff members. It produced a sense of welcome, of belonging, of *"being wanted (Z10(A) l. 572)"*, which was tremendously important:

> *"the most...overwhelming thing which...really helped everybody was so pleased to have me up here, erm, and I think that that's something that I'll always remember and... it was (pause) I suppose it's like "Yes we wanted you to come up on the ward X, we're really keen to work with you and work alongside you"...(Z7, ll. 94 –107)".*

There were contradictions within the data that suggested that there might be some measure of idealisation of the staff group on Unit Z. One staff member gave a very positive description of the openness of team discussions and the shared nature of decision-making and close working between professions in delivering the programme: *"getting disciplines to work together instead of in isolation...everybody's opinion is listened to within our forums...any patient that comes into the ward it's a shared decision...(Z3, ll.286-296)".* She later defined her most difficult working experience as a time when she was criticised by trusted colleagues. This led to the unhealthy development of sub-groups within the staff team and the participant struggled with feelings of paranoia and isolation. In another interview, a practitioner described senior staff's unwillingness to listen to colleagues' difficulties with a particular patient. There was not a sense of a shared process of decision-making in this instance; instead staff felt they had simply been overruled by their seniors: *"we was told you know well this is the kind of person we've got to learn to deal with and erm you're all wrong basically...(Z10(B), ll.51-53)".*

There were differences in the way the staff saw themselves as a group and patients' experiences of them. The staff view was that Unit Z had an unusually patient-centred culture, with practitioners spending time on the ward working with patients rather than sitting in the office. But the patient view was different: they thought that staff spent increasing amounts of time in the office and were often unavailable. Staff characterised the team as highly collaborative and, as an example, described how

the Occupational Therapist worked with nursing staff in delivering the group programme. However, in the discussion with patients, a marked distinction was made between the nurses and other staff: nurses and nursing assistants were the focus of conversation about relationships with staff and were seen as considerably more involved with the patient group:

> *"the nursing staff on the ward deal with us far more than doctors and psychologists...I don't have much time for them [non-nursing staff] to be quite honest...I've got Doctor 1 as my RMO, I've been here for over two years and I can still count on two hands the amount of time I've seen him in that time (Participant 4, Patient Discussion Group, ll.59-60 & 346-348)".*

4.8.3 Impact of senior colleagues The positive or negative influence of experienced members of staff was a key theme in some of the interviews. Several staff talked of the important role of a mentor in giving them confidence about their work. A supervisor who had recently left the Unit was greatly missed, but had a lasting effect on this nurse's sense of competence: *"the feedback that I've had in supervision still gets me through a lot of days now...that kind of advice and support and positive feedback you know him telling me "Yes you're doing well, you did really good this week (.) has helped me to feel competent... (Z10(B) ll.197-201)".* There was reference to the role of one of the Consultants in setting the tone for the democratic and supportive nature of the team environment, and the balance of skills and new approach brought by a second Consultant. The Consultants were seen as responsible for creating the identity of Unit Z: *"obviously I mean I think your sort of, your Consultant tends to set the scene for for your team, erm, I suppose 'cos they are sort of the top of the pecking order if you like...(Z7 ll.266-268)".* Participants talked of the personal and professional significance of receiving recognition and praise from the more senior Consultant: *"it's kinda like you know sort of Doctor 1's*

like suddenly this very significant you know you know sort of person...(Z2, ll.789-790)".

However, the more senior Consultant struck the primary researcher as drained and over-burdened by his work. He greatly missed research and clinical work, and did not enjoy the administrative work and fund-raising that dominated the job. After the first interview, the researcher made a note of how sorry she felt for him (see page 60 of the Method); and in a follow-up meeting there was discussion of his sometimes overwhelming physical sense of identification with the continued survival of Unit Z. Here is a quotation from his interview, in which he is talking about his current lack of spontaneity and interest:

> *'I'm wound up and set off in a particular direction I think and just keep sort of travelling and I I you know I I can't say that that I find this is my outlet and it's really particularly fulfilling I don't have anything like that at the moment. I mean I used to do stuff but it's become progressively less. It's sad really (laughing). I'm a sad person (Z4, ll. 721-725)".*

4.8.4 Need for support The need for close support from colleagues was a theme, comprising both practical assistance and help with thinking things through. From the nursing perspective, support with day-to-day contact with demanding patients was seen as crucial. A nurse spoke of the importance of whom she worked with each day in determining how supported she felt in her communications with patients. A supportive colleague would not be afraid to back her up, making her feel that she was working in a team instead of on her own. The Occupational Therapist spoke of the value of being able to talk openly to colleagues about difficulties with patients. The view was that colleagues have often had similar experiences and could give advice; their support also militated against the tendency to blame oneself whenever things go wrong. For senior staff, the support that mattered was less direct

but just as crucial. It was important to have someone with whom to discuss decisions and developments, particularly in the context of a tense and occasionally hostile relationship with people outside the Unit. In this regard, the Consultant spoke of the need to have a medical colleague in order to lessen his isolation and prevent him from going mad: *"I was very very keen to get somebody else, or here with me in order to probably prevent me going mad...(Z4, ll.697-698)".*

4.9 Key Contextual Factor: Complexity of the Task

4.9.1 Definition of the category and distribution of the material . This category describes the multi-dimensional nature of the work, its difficulty, staff's positive and negative experiences of this difficulty, and often unacknowledged tensions in combining the duty to care for patients and protect the public. It draws from all the interviews: seven participants talked of their attraction to the challenges of their jobs and seven commented on the satisfactions to be gained from direct work with patients on areas of difficulty. Across interviews the task was either defined in a way in which healthcare and public protection duties were kept separate, or they were seen as integrated. Eight participants gave responses which presented these two core tasks as distinct and three described them as interlinked.

4.9.2 Attraction to the challenging nature of the work Work on Unit Z was a source of satisfaction, stimulation and frustration. Two patients described the mixture of feelings they imagined producing in staff:

> *"Participant 1:...you've got to have a lot of patience to work on somewhere like this, I think anyway, with all the hassles and backchat from us lot...*

Participant 2:...I've been here six months now and I feel I've changed anyway and I've been also fed back from the staff that I've changed a bit. They must, they must sort of feel some satisfaction...(Patient Discussion Group, ll.29-36)".

Nursing staff were in almost continual contact with people with severe and long-term psychological and social problems and their job, as they understood it, was to combine a caring, sympathetic approach with the need to address patients' antisocial behaviour. This is a nurse communicating, partly through the excitement of her manner, something of the exhaustion and the buzz of this emotionally intense and sometimes confrontational work:

Just sometimes it's pretty unbelievable you know the kind of (laughing) things that you're challenging throughout the day...it can seem pretty constant I suppose. You can feel like you've if I go home now and gave someone a complete description of my day it would be I got here, I've had a handover, I've done negotiations, somebody approached me I said "No not now not until after negotiations" and then they go down to breakfast somebody does something with a knife you know you have to do an incident form and then you're challenging that all morning that issue and may- you know the patients and erm just it can be constant all day, you can feel like you're constantly challenging some days and you know and you have to be (Z10(A), ll. 474-487)".

In this extract, the word 'challenge' stood for the need to address problematic behaviour directly with patients. It was also suggestive of the sense of what might be required by staff to meet demands which could be intimidating in their magnitude and complexity.

Many participants spoke about their attraction to challenge. Work with people with a diagnosis of personality disorder who are considered a risk to others was seen as a new and exciting area. The view was that a job elsewhere would be boring by comparison. In this connection, staff talked of the appeal of the work's complexity and saw themselves as being drawn towards stimulation and difficulty:

> *"I like to have challenges (laughing) constantly, I like to be doing something that I'm gonna really be able to get my teeth into and see a result at the end of it (Z3, ll.79-81)".*

One of the patients picked up on this view of Unit Z as professionally glamorous.

Participant 4 was asked about the purpose of the work there and he replied: *"Experience for quite a lot of them, so to aid them moving on to a better job...(Patient Discussion Group, l.430)".*

4.9.3 Satisfaction develops out of difficulty Satisfaction was seen throughout the interviews as something that derived from hands-on work with patients, and the Consultant Psychiatrist largely attributed his dissatisfaction in the job to the fact that he did not do any face-on therapeutic work. In both one-to-one and group sessions, staff helped patients face up to interpersonal difficulties which often arose in the context of problematic relationships on the Unit. It was exciting for staff to participate in such episodes of transformation, and gave them a sense of value and purpose in their work.

Therapeutic activity was sometimes stressful and uncomfortable, but could result in real changes in the way patients interacted:

> *"that doesn't necessarily have to be in a very nice safe group where everybody talks lots and lots and it all feels great...the best group can [be] when you come out and you feel "Oh my God, you know, that was Phew!" but you know you've actually really picked up on some important issues...(Z7, ll.407-411)".*

Patients had often spent years in prison where they had not been encouraged to explore or understand their difficulties. They often started to do this for the first time with Unit Z staff. Difficulty and progress with the therapeutic task were linked in the minds of the patients as well as the staff:

> *"Participant 3: Prison's much easier...*
> *Participant 2: I've learnt more in these six months of being here, I've changed more that I have in the 15 years I've spent in prison (pause) (GD, ll. 709-723)".*

The work sometimes involved staff in facing up to personal difficulties because of the need to examine their responses to individual patients in order to separate out a patient's problems from their own. This could have a positive impact on the member of staff, as when one practitioner described a re-examination of the relationship with a son as the result of reflections on reactions to a patient. It could also lead to feelings of closeness with patients, of reciprocal fondness and appreciation:

> *"to get into that stage I thought was really good because I couldn't stand them when he came in, we hated the sight of each other (laughing)...And that's part of the thing I suppose about supervision you have to sort of look at...what is it that he brings out in me that...just frustrated me and drove me mad? So we kinda worked through that, we had a really good sort of therapeutic relationship right the way through. He still phones every so often still ...(Z11, ll.531-537)".*

4.9.4 Complexity of task The work on Unit Z had a dual focus: it was a healthcare service and addressed patients' general therapeutic needs, but had a responsibility for ensuring the safety of patients and staff and aimed to reduce the risk of patients re-offending in the future.

Descriptions varied in whether they presented the healthcare and public protection tasks of the Unit as integrated or not. A minority of staff regarded them as interlinked, either in terms of the way work was organised or from the perspective of patients: *"most people actually do want to be better people...and don't actually want to do the kind of things...they've done (Z2, ll.696-698)"*. In another comparatively integrated account there was a description of the Unit's relationship

with the prison system, defining its aim as discharge to a less secure prison or a therapeutic community within a prison. Behavioural control, and particularly impulse-control, was seen as a pre-requisite for therapeutic work on underlying issues. Accounts of the task from practitioners with strong links to agencies outside Unit Z (the social worker and the probation officer, for example), as well as the interview with the community practitioner, presented therapeutic and public protection duties as inter-related. All of the more integrated task definitions occurred in interviews in which there was minimal material coded under the category heading 'Tension in the Relationship with 'Outside''.

In terms of patients' experience, the Unit's relationship with the prison system was an uneasy one. One staff participant wondered about whether patients are receiving mixed messages because of the extremity of the difference between hospital and prison culture. Most of the men were discharged to prison. On Unit Z they had been encouraged to open up, to think and talk about themselves and their problems. They would need to bottle things up again in prison *"In order to survive (Z5, l.292)"*.

The therapeutic and criminological tasks of Unit Z were generally seen as separate and an ambivalent attitude was expressed towards public protection issues. Staff often started by defining aims in healthcare terms, using the rhetoric of personal advantage, choice and fulfilment. They then tended to refer to the need to reduce the risk of re-offending as an add-on: *"it's to help...the badly damaged...group of people with personality difficulties hopefully have a better future, and also I suppose which is their offending...(Z5, ll.328-330)"*. Alternatively, a sense of connection between the two tasks was expressed; but it was vague, and therapeutic

work was given explicit priority over concern about possible re-offending: *"It's not to reduce re-offending...This is about helping people address the problems that they...have in life and maybe one of the results will be that they don't re-offend...(Z6, ll.392-396)"*.

In one interview, an abstract definition of the task contradicted detailed discussion of a patient as it developed. The overall goal of the work was defined as self-awareness, and there was a sense of uncertainty about whether this would have a positive effect on antisocial behaviour: *"if at the end of the day they...re-offend...Hopefully at least people are more aware of the choices they've made you know if that's all they come out of here with...Z10(A) ll. 149-152"*. Later a particular patient was considered at some length, and the staff participant articulated a growing sense that talking and sympathy were insufficient to produce all-important behavioural changes. The response was frustration. This, together with the participant's discomfort with a perceived need to relinquish her identity as the sympathetic carer or *"floppy bunny nurse (C1, l.499)"*, illustrated how hard it could be for staff to bring together therapeutic and public protection roles in their work:

> *"this is a guy who in a few weeks may be going back to prison if he doesn't do something and all he's done is talk and you know it's not going to move him forward..."that's not gonna help you look forward and... think about the future you want and think about if you're going to re-offend again. You need to do something concrete rather than sit here for two years"... Sometimes I feel quite harsh to say "Go away, think about it, do something, I won't talk any more about this", 'cos it's you know it's not the reason you go into nursing to push people away and tell them not to talk to you (Z10(A), ll.198-211)"*.

Lack of clarity about the purpose of the Unit was also illustrated by a variation of terms used to describe the men that live there: usually they were 'patients', but they

were also 'residents', a word more in keeping with the prison system, and 'clients', a term that refers to voluntary use of health and social services.

4.9.5 Negative case In contrast with staff, the patients showed a relatively clear understanding of the task of Unit Z in contrast with the function of the prison system. The primary focus of prisons was seen as public protection; the Unit was concerned with public safety, but also with helping the men to make positive changes in their own lives.

4.10 Key Contextual Factor: Tension in the Relationship with 'Outside'

4.10.1 Definition of the category and distribution of the material This category refers to the sense of distance between Unit Z and its 'outside', which could mean society (in particular the government and the media), the wider hospital environment or the domestic world of family and friends. It was difficult for staff to communicate with people outside about the nature of the patient group and the work that goes on in the Unit. This was seen as the result of a widespread lack of knowledge about, and hostility towards, people with a diagnosis of personality disorder who are considered a risk to others. It was also regarded as a consequence of hospital colleagues' feelings of envy towards Unit Z, which was perceived by staff there as different and, in some ways, special.

The media and society's ignorance and/or hostility with regard to the patient group was referred to in all but one of the interviews. Descriptions of envious attacks by colleagues were a prominent theme of two interviews. Accounts of the Unit's

distinctiveness, as well as a strong perception of it as different, featured in the interviews of eight participants.

4.10.2 Distance and difficulty in the relationship with 'outside' Unit Z was set apart, both physically and psychologically. The secure hospital environment was cut off from society anyway because *"forensic patients are the patients that the world would like to forget exist (Z5, l.363)"*. In addition, staff felt distant from the hospital within which they were situated. This was put down to a lack of support and interest for Unit Z, motivated, at least in part, by envy. An encounter was described with some nurses who had worked in the hospital for a year but had not set foot inside the Unit, even though they were supposed to be able to provide cover to any of the four hospital wards.

The media was regarded as ignorant and hostile towards the patient group, portraying them as *"Hannibal Lecter-type (Z3, l.253)"* individuals and failing to appreciate that offenders have usually themselves been victims of terribly abusive experiences. The influence of the media was seen as unhelpful, even destructive: *"I absolutely hate the media...extraordinarily destructive. I won't have anything to do with them (Z4, ll. 240-241)"*. Attitudes towards the government were more ambivalent: on the one hand, it could be hard to distinguish its approach from the media because *"they are so media-driven (Z4 l.242-243)"*. On the other, appreciation was expressed for the Department of Health's generosity to Unit Z.

Hospital colleagues were seen as hostile to the Unit and resentful of its success. Staff questioned whether or not they had become paranoid about the situation, but

held to the view that Unit Z staff were attacked in hospital-wide meetings and that colleagues would be pleased if the Unit failed. The language of conflict was used to describe these relationships: preparing for a meeting involved anticipation of a *"situation where I'm going to be attacked (Z3 l.446)"*, and staff were described as *"casualties of our own success (Z3 l.449)"* in an attempt to explain the negative attitude of hospital colleagues. Talking about a relationship with an envious colleague outside Unit Z, a practitioner spoke of needing *"to get my army around me (Z7 l.208)"*. The external NHS environment was perceived to take from the Unit, leaving it resentful and depleted. Nurses were keen to come and work on Unit Z and this was *"dangled as a carrot (Z3, l.266)"* to prospective nursing staff, who were then used to staff other wards in the hospital. Staff who did come to work on the Unit and received specialist training moved on to better their careers at an alarming rate. An in-house model of training was favoured because of a view that when staff received input from outside they could become precious and were less likely to share what they had learned.

4.10.3 Lack of knowledge and understanding of personality disorder Lack of knowledge, and an absence of motivation to learn, about therapeutic work with individuals with a diagnosis of personality disorder, was a general theme in the interviews. A staff participant spoke about a desire to share her developing expertise with professional colleagues and her distress at rejections of offers to present her work. She talked about a need for recognition of what she had achieved from colleagues outside the Unit, and feelings of isolation and exclusion that came from not being able to share her knowledge and skills: *"I am actually made to feel very separate...(Z7, l.140)"*. Basic differences of philosophy were also invoked as a way

of explaining the lack of connection with the wider hospital environment. The belief that people with a diagnosis of personality disorder are not 'treatable' and are therefore unsuitable for hospital care was contrasted with the view that work with these patients can produce significant positive change, although unlikely to result in a complete cure. A patient put it like this: *"this ward's not about being cured it's...about learning to cope and developing (Participant 4, Patient Discussion Group, l.698)"*.

External ignorance about 'personality disorder' provided the context for a definite sense of excitement about working on the cutting-edge and moving into unknown professional territory: *"when he had colonised affective disorder, I felt that there was another area of personality disorders (Z4, ll.140-141)"*. For some, their family's lack of knowledge about their work helped them to cope, forcing them to separate mentally from Unit Z and to focus on the world outside:

> *"to do something like...with my daughter, something very normal, like...I don't know, whatever...she wants to do and... my husband he doesn't he's nothing to do with the Health Service so I mean if something really stressful's happened then I do talk to him, but in a sense he brings me back...they ground me again (Z7 ll.766-770)"*.

4.10.4 Sense of the Unit's difference The distinctiveness of Unit Z was a central theme of the interviews. It was positively compared with other psychiatric settings in its structure and clarity of purpose, and the group programme was seen as particularly successful in this regard. It was contrasted favourably with a ward in which the nurses sat in the nursing station and spent relatively little time working actively with patients. It was also seen as different in emphasising close, collaborative teamwork and favouring a democratic method of decision-making in ward rounds.

The Unit was compared repeatedly with a therapeutic community that existed previously within the hospital for those with a diagnosis of personality disorder who were considered a risk to others. It was important when setting up Unit Z to avoid any hint of a repetition of the experience of the therapeutic community, which became out-of-control and was closed down. The episode was described as traumatic and damaging for staff, some of whom were recruited to work on Unit Z and needed to be convinced that it would operate in a different way. Unit Z was also contrasted with another chaotic ward in the hospital where the ward manager had worked before. This was described using metaphors of war and destruction: *"they talk about sort of Beirut it was you know there was lots of staff injuries, the place had been the environment had been stripped of its of everything you know, it was an awful place to work in...(Z3, ll.89-91)"*.

The interviews were permeated with a sense of contrast between what it was like to be either inside or outside Unit Z. The ward manager expressed curiosity about how differently she functioned in and out of work: *"I'm a different person you know 'cos*

he asks me to sort of leave a letter for the milkman...I'll forget and yet here I've got so many aspects of my job and...I'll do it it's really quite strange. I often think about that (Z3, ll.684-687)."

The views of insiders and outsiders were construed as radically different. People outside thought the job was scary and dangerous. But staff experienced Unit Z as relatively safe, certainly from a physical point of view. Unease about the risky nature of the work and staff's motivations for doing it was located in people outside the Unit. One staff participant spoke of people outside judging her to be an irresponsible mother for putting herself in danger, although she did not consider herself to be at risk. A nurse reflected on how different her perspective of a situation concerning a patient would be if she did not work on the Unit. The patient concerned had hurt animals in the past and was now embarking on some voluntary work involving contact with animals. The nurse was supportive of the plan. It offered a real opportunity for reparation and she commented on the importance of giving people a second chance.

> *"from an outside perspective I think I would have thought "This is a guy who's...hurt animals... you can't let him be in a position where he can do that again. But working with him and seeing the progress he's made and realising that he needs a chance really and that's what we're here to provide, what more can he do what more can we do? And...it's surprised me that I've handled that so well really (Z10(A), ll.396-398)".*

Just as experiences differed hugely depending on whether one worked in Unit Z or not, there was change over time as one became more of an 'insider'. A worker described feeling anxious when she started the job and was getting used to a hospital rather than a prison culture. When she first visited the Unit and queued at the shop, she felt uneasy because she was not sure which of the men were patients

and which were staff, unlike in a prison setting where different uniforms clearly demarcate inmates and officers.

4.10.5 Negative cases In keeping with Unit Z's commitment to trying out and testing new approaches, a probation officer had recently been seconded with the brief to develop links with external public protection agencies. The Unit was regarded as research-friendly and senior staff were both welcoming and helpful to the principal researcher during the course of this project.

DISCUSSION

5.1 Overview

In this section the analysis is considered in terms of the general strengths and weaknesses of the study, whether the findings confirm or cast doubt upon the initial assumptions of the researcher, their relationship to the existing theoretical and empirical literature, and implications for clinical practice and future research. The Discussion is structured according to the research questions set out in Table 2.6 in the Introduction. These are repeated as headings for each section and the relevant findings are discussed underneath. A section on the patients' perspective appears at the end because this fitted best outside of the framework of the original research questions.

5.2 Main Question: Is there Evidence of a Negative Psychological Impact on Staff?

5.2.1 Positive impact of work but negative experience of staff relationships

Staff interviews indicated that many staff enjoyed their work, gaining high levels of reward and satisfaction from it. Key influences on practitioners' positive experience of work were pride in being involved in a successful new venture and a close and supportive team environment, which differed from the traditional medical hierarchy in giving importance to the views of ground-level practitioners.

Large-scale questionnaire studies of stress among mental health nurses have found that general difficulties with external conditions, such as the lack of availability of services for onward referral and waiting lists for these resources, were rated as more stressful

than direct work with patients (Carson *et al*, 1995; Fagin *et al*, 1995; Onyett *et al*, 1997). The current study suggests that communication with external colleagues and agencies was a problem for Unit Z staff too, but emphasizes the emotional rather than practical aspects of this relationship. Although mention was made by staff of the fact that there are problems with finding community placements for patients after discharge, a general lack of interest and support for the work of the Unit was a deeper and more widespread concern, leading to feelings of persecution and isolation in staff.

Difficulties in communication with colleagues - whether internal or external to the unit - were found to have a pronounced negative impact on staff. They produced thoughts of resignation and professional failure, and were judged to influence patient care directly because it could feel too threatening to openly address the counter-therapeutic dynamics that sometimes develop between staff and patients.

5.2.2 Physically safe but emotionally vulnerable: Is there a connection?

Participants' dismissal of concern about safety described in the category 'Feeling Physically Safe but Emotionally Vulnerable', was striking. The fact that emotional threat, particularly in the context of relationships with colleagues, was such a ubiquitous and dramatic feature of the interviews, suggests the possibility of a connection. It is important to note that a relationship between these two themes in the analysis was not explicitly mentioned in any of the interviews; the argument for it is based upon the inference of Maslow's notion of a 'hierarchy of needs and concepts from psychoanalytic theory (Maslow, 1962). These are used because they explain a possible association between a surprising lack of anxiety relating to physical safety, and the

presence of unease with regard to relationships with colleagues, an area in which stress might be expected to be comparatively less.

Anxieties about patients and the nature of the task are likely in this line of work, however safe the physical environment is in reality. These might include: fear of contamination from contact with perverse and sadistic states of mind, fear of one's own power to hurt or heal in an environment in which staff have so much power and patients have so little, and fear of vengeful attack by patients, including those who have left prison and hospital services and are at liberty (Kurtz, 2002b). If such feelings did not exist on Unit Z, it is interesting to ask why this was the case.

One explanation is that the setting was appropriately safe and structured, and relationships with colleagues were genuinely more difficult and upsetting than those with patients. Another way of understanding the phenomenom is to invoke Maslow's concept of a 'hierarchy of needs'; according to this model, it could be argued that staff focussed on difficulties in relationships with colleagues because the more basic question of physical safety was simply not a concern (Maslow, 1962). However, given the nature of the patient group and the complex responsibilities of staff, this does not seem entirely convincing. An alternative explanation uses the analytic concepts of 'displacement' and 'projection', in which unwanted feelings are located elsewhere and are not consciously experienced as part of the self (Bateman, 1996). Fears regarding patients and the nature of the task existed, but were disowned and attributed to outsiders because they were felt to be overwhelming. This would mean that external colleagues were experienced as particularly threatening because they carried the burden of practitioners' unwanted feelings towards patients, in addition to their own real curiosity

and suspicion towards Unit Z. This does not mean that Unit Z staff did not genuinely feel physically safe at work; however, a high degree of security in the Unit could be argued to be, at least in part, an avoidance of anxieties about potential risk that are best addressed if real rehabilitative work is to take place. This idea is explored further in section 5.5. Further research would be necessary to see whether this finding is repeated in different services for people with a diagnosis of personality disorder who are considered a risk to others, and to test the validity of the various explanatory hypotheses.

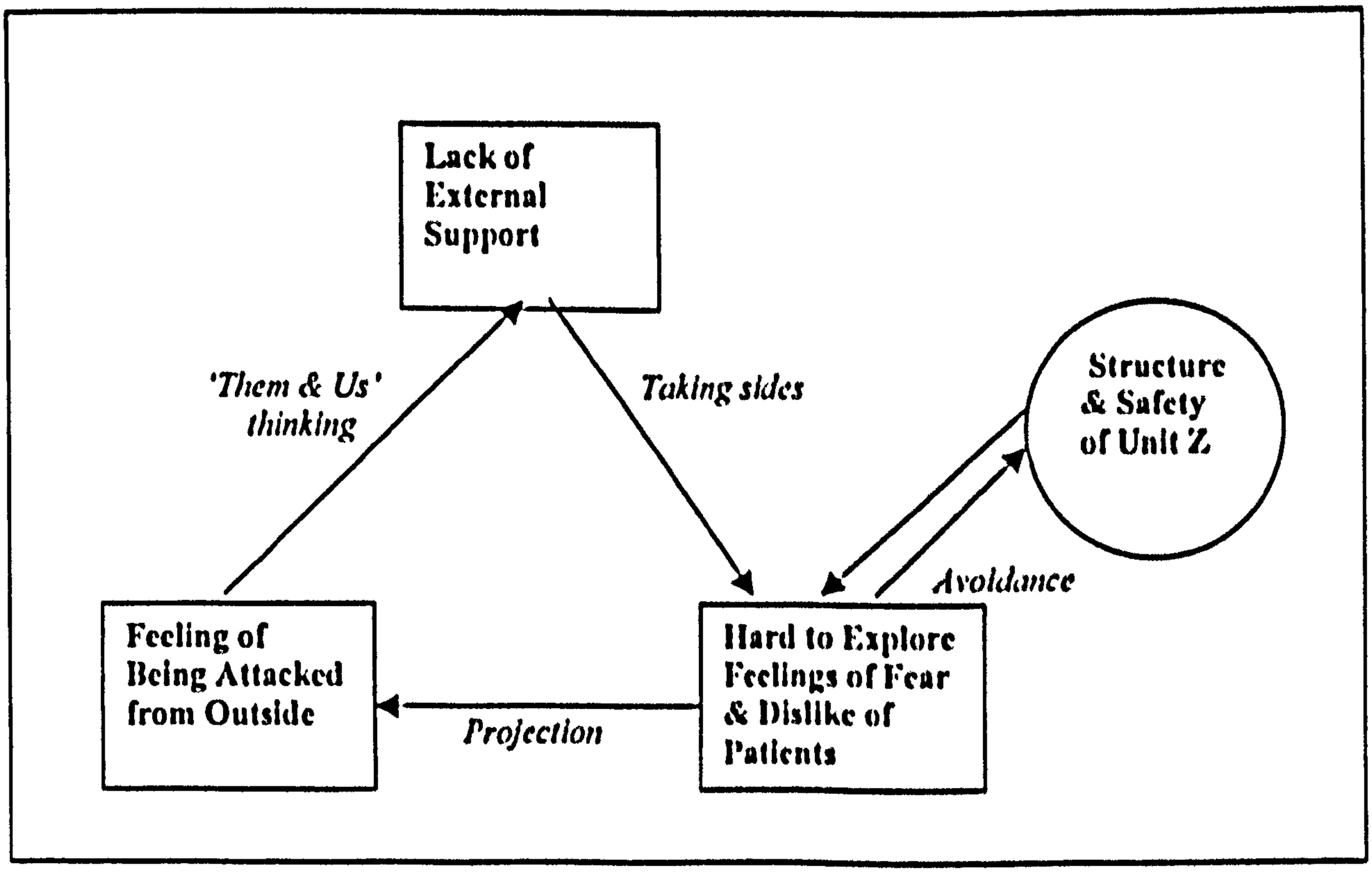
In connection with the idea that anxieties regarding the patient group are displaced onto relationships with external colleagues, it is interesting to note that the community practitioner who was interviewed spoke of a greater daily awareness of risk than Unit Z staff, and did not report any real difficulties with colleagues either in or out of the service. This illustrates the way in which the institutional setting creates strong feelings of confidence and safety for both staff and patients, but can also contribute to an avoidance of issues regarding potential risk. This is problematic because it is important for staff to be able to endure a certain level of anxiety regarding possible risk for meaningful therapeutic work with offenders to take place (although this should, of course, be distinguished from putting them in situations that are genuinely dangerous).

5.2.3 Implications for staff intervention & research The current study confirms that there should be proper opportunities to acknowledge and address difficulties in relationships with colleagues inside and outside the Unit, in recognition of the impact of these patients on relationships between staff (Davies, 1996). The best place for this would be in a regular group supervision slot, facilitated by someone

external to the organisation, who is not caught up in internal dynamics and can attempt to take an impartial and unbiased view.

In keeping with the psychotherapy literature, a cornerstone of any future intervention with Unit Z staff would be the provision of regular individual supervision for all staff, in which anxieties about direct work with patients could be explored (Cox, 1996; Davies, 1996; Winnicott, 1949). It would be interesting to see whether the opportunity to discuss ambivalent feelings towards patients results in a reduced need to project feelings of threat and danger onto the external environment, and a feeling of improvement in relation to the outside world. The hypothesized relationship presented in Figure 5.2 could also be tested by observing whether measures to improve the relationship between Unit Z and the external environment (described in Section 5.4) result in an increased capacity for staff reflection with regard to feelings of anxiety and ambivalence towards both patients and the task.

Figure 5.2: Feeling Physically Safe but Emotionally Vulnerable and the Relationship with the External Environment: a Hypothesized Relationship



5.3 Service Context: Is there Confusion in Relation to a Complex Task?

5.3.1 Lack of integration of healthcare & public protection duties may be more significant than task complexity

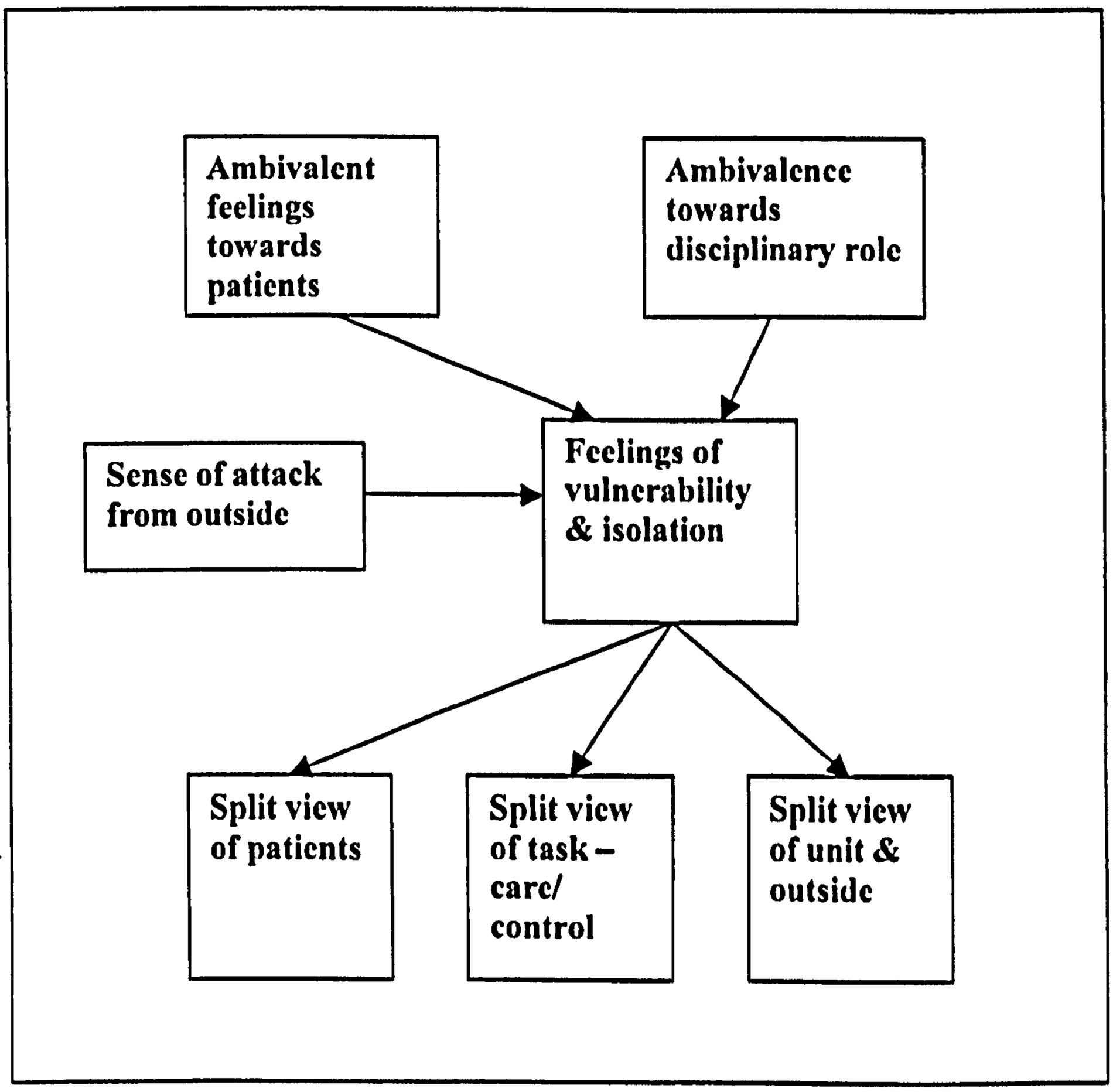
Accounts of the task in interviews with Unit Z staff varied in whether they presented the dual responsibilities of therapy and reduction of risk as separate or inter-linked. The majority of participants described the two concerns as distinct, either explicitly prioritising healthcare needs over criminological work, or expressing an ambivalent attitude towards the latter.

Confusion with regard to the definition of the task in staff interviews took a different form from the one anticipated by the researcher. There was an expectation that task confusion would arise as a direct consequence of the combination of therapeutic and custodial duties that were intrinsic to work in forensic mental health services. The concepts of 'primary task' and 'anti-task' from the psychoanalytic theory of organisations were influential in this regard. Menzies Lyth's essay on a service for troubled adolescents, in which she wrote about the difficulty for 'human services' in defining a clear, central function, strengthened the idea that it is likely to be intrinsically problematic for a service to operate to two powerful and potentially contradictory agendas (Menzies Lyth, 1979). After the second world war, the early work of The Tavistock Institute of Human Relations, which informed systemic and psychoanalytic thinking in the U.K. and U.S.A. about groups and organisations, was largely based on studies of business and industry (Hinshelwood & Chiesa, 2002). The simplicity of services for which the main aim is financial profit, in contrast to the multiple, more nebulous functions of 'human services', may have contributed to this view of task complexity as essentially problematic.

However, interviews with Unit Z staff suggest that more difficulties are likely to arise from the separation of healthcare and public protection concerns than from bringing them together. This is because 'integrated accounts' occurred in interviews in which both the service context and the question of long-term outcome for patients are comparatively explicit. These also featured less problematic descriptions of contact with external agencies, including reference to activities that involve more interaction with community networks. The 'integrated accounts' communicated a hard-won acknowledgement that forensic mental health staff operate within a larger legal and criminological context: Unit Z, which admitted men from prison and usually returned them there, measured success in real terms through discharge to conditions of lower security, which is absolutely dependent on a perceived reduction of the risk of re-offending. Therapeutic work was something to strive for wherever possible within the constraints of fixed legislative requirements relating to safety and control. In addition, focussed work on antisocial behaviour, whether this related to impulse control or aggression, often had to take place before it was possible to explore underlying issues.

5.3.2 Lack of task integration & staff-patient relationships There was likely to be a relationship between practitioners' difficulty in making coherent sense of combined therapeutic and custodial tasks, their struggle to form an integrated sense of individual patients, and frustrations regarding patients' lack of open communication. A description of this relationship is shown in visual form in Figure 5.3 below. Presumably, if staff regarded their work as unrelated to concerns regarding public protection, or focussed on risk-reduction at the expense of an understanding of patients' suffering, it made it harder to develop full and meaningful therapeutic relationships. In the psychoanalytic literature, the separation of 'good' and 'bad' aspects of patients or

Figure 5.3: Difficulty in Achieving an Integrated Understanding of the Task in Context



the therapeutic and public protection duties of the Unit, is referred to as 'splitting' (Bateman, 1996; Klein,1946). Splitting is a defence mechanism which acts to protect against the discomfort and sense of conflict associated with ambivalent feelings. Conflicted feelings towards patients lead to difficulties in bringing together an understanding of their vulnerable and threatening aspects; ambivalence in relation to professional duties involving both discipline and care is likely to result in a lack of integration of therapeutic and custodial tasks.

The analysis suggests that staff found it easier to think of themselves as carers who provide help and sympathy to deserving people in distress, and more difficult to accept a disciplinary role. Davies writes about how staff working with offenders can become punitive or unthinking in their responses, inadvertently blaming them for uncomfortable and unexplored feelings of ambivalence of their own (Davies, 1996). It could be that there was a link between ambivalent attitudes towards the custodial task and a cynical and/or over-controlling approach on Unit Z, whereby unacknowledged feelings regarding patients' antisocial behaviour assert themselves more strongly than if staff were aware of them.

5.3.3 Implications for staff intervention & research It was not feasible to collect outcome data within the confines of the current study. But it would be interesting to assess the progress of Unit Z patients after discharge, both in relation to whether they continue to offend and their general psychological and social functioning. A meta-analysis of different types of alternative education programmes for young offenders found that improvements in well-being and relationships were not associated with reductions in offending (Cox *et al*, 1995). If improvements across different

domains of outcome in Unit Z were also inconsistent in this way, it would be possible to hypothesise a connection with a lack of integration in staff's definition of the task.

The analysis confirmed the argument in recent theoretical articles for the value of incorporating a thorough discussion of both the nature and context of a complex task into any intervention with staff caring for individuals with a diagnosis of personality disorder who are considered a risk to others (Lavender, 2002; Watson *et al*, 2004). In attachment research, an association has been found between incoherence in accounts of formative relationships (for example, the lack of fit between abstract and specific levels of description) and lack of availability and consistency as a caregiver (Fonagy *et al*, 1993; Fonagy *et al*, 1991). Therefore, it could be that the absence of an integrated sense of the duality of the task in caring for offenders with a diagnosis of personality disorder has a negative impact on staff's ability to interact with patients in a therapeutic fashion.

Feelings of ambivalence towards both patients and the task of the Unit could be explored in individual and group supervision. But the latter would be a more appropriate place to connect ground-level experiences with service aims and objectives. Group supervision would need to be facilitated by someone external to the organisation to prevent service agendas from inhibiting the expression of feelings of concern or conflict. If it became easier to acknowledge and examine complex feelings regarding individual patients and the task of the Unit, it is likely that they would become more integrated and consistent. This is likely to have a very positive impact on direct work with patients. It would also be useful to enable staff to develop a coherent and integrated sense of the task by working through details of specific cases and dilemmas that have arisen in practice, as an alternative to producing the usual abstract 'mission

statement'. It would be important for any statement of aims to fit with actual clinical experience, so that it could, in turn, inform hands-on work.

5.4 Service Context: What are the Characteristics of Staff's Relationship with the External Environment?

5.4.1 Non-reciprocal relationship with the external environment Widespread dissatisfaction was expressed in interviews with the Unit's relationship with the external environment. Lavender has suggested that society has a conflicted attitude towards offender-patients with a diagnosis of personality disorder, unsure of whether to offer punishment or care (Lavender, 2002). However, the experience of Unit Z staff was of a largely negative, rather than ambivalent, attitude. Society and the media were described as generally hostile and ignorant in their approach to the patient group; hospital colleagues were viewed as envious of staff working in an innovative and different area. Unit Z's isolation is in keeping with the characteristics of closed institutions as described in the literature on institutionalisation (Goffman, 1967). But there are additional aspects to the Unit's relationship with the outside world, which are interesting in their own right.

Systems Theory provides the notion of the permeable boundary in a work organisation (Miller & Rice, 1990). Such a boundary allows for a full and proper exchange of workflow into and out of the organisation, but also gives workers a sense of identity and containment in relation to their task. The boundaries around Unit Z were described as permeable, but staff's view was that they only allowed for a flow out of the organisation. The Unit was seen to give away good things to the outside world, but not

to receive them in return. Staff who wanted to work for the Unit were recruited from other wards in the hospital, and practitioners who did come to work there received substantial training and often then left for a better job. It was likely that staff in Unit Z reacted to a sense of hostility from outside by seeking comfort in their relationships with each other and a positive sense of the Unit's identity. This probably exacerbated feelings of hostility and envy from colleagues outside.

The emphasis on staff relationships on Unit Z was reminiscent of some aspects of Bion's notion of the Alpha group (Stokes, 1994). This is a working group that has become diverted from its task as it relates to the external environment. Instead it is preoccupied by the needs of its members, who have regressed and become unhelpfully dependent on a leader. There is a need for some caution in applying Bion's description to Unit Z, which is a high-functioning unit staffed by extremely capable practitioners. However, in interviews the staff group did come across as possibly unhelpfully focussed on their relationships with each other. Material in support of this observation is included in one of the main categories generated by the current study, entitled 'Emphasis on Staff Relationships'. There were also suggestions that an inward focus had a negative effect on relationships with outside colleagues, and possibly resulted in a withdrawal from contact with patients and difficulty in reflecting on the development of unhelpful staff-patient dynamics. In addition, a group leader spoke of feeling drained and burdened by responsibility, and there were several mentions of the extreme importance of this figure to the well-being of others.

A proviso should be included regarding the mention of a lack of in-depth engagement with patients. The desire for more meaningful contact is expressed by both staff and patients. But the questions and standard format of initial interviews may have produced

an emphasis on organisational issues in the data. The more fluid and patient-focussed interviews conducted later elicited richer and more detailed material regarding contact with patients. This was probably partly a result of professional background: the more patient-focussed interviews were with nurses, who spend far more time with patients than anyone else. But it is likely to reflect an aspect of Unit Z's staff's approach to clinical work as well because in interviews with multidisciplinary team members, unsuccessful attempts were made to encourage participants to talk more deeply about their clinical work.

5.4.2 Task definition & the relationship with 'outside' The more integrated definitions of the task occurred in three interviews in which there was comparatively little material categorised under the heading 'Tension in the Relationship with 'Outside''. It is likely that feeling unsupported by external colleagues and agencies had a negative impact on staff's ability to make contextual sense of their task. Perceptions of the hostility of colleagues, society and the media towards the patient group may have made it more difficult for Unit Z staff to acknowledge their own understandable feelings of fear and dislike towards patients' offending behaviour. There may have been a temptation to take sides with patients against the outside world, increasing the potential for the development of disillusionment and cynicism when antisocial behaviour manifests itself.

There was also the likelihood that a dichotomous view of the Unit as positive and the external environment as negative, acted to undermine the rehabilitative task of the service. Concern was expressed about how men fare in prison after being encouraged to open up on Unit Z, raising the question as to how well the service prepares patients for the reality of their lives after discharge. In the discussion with patients, the Unit was

contrasted with prison culture, which was seen as uncaring and concerned only with public protection. On the face of it, it was flattering for the Unit to be compared so positively with prison. But too polarised a view could be unhelpful if it makes it more difficult to adapt to prison after discharge. Such a situation would be reminiscent of the situation described by Harold Bridger in his description of the therapeutic community at Northfield during the Second World War. He observed staff colluding with patients' reluctance to talk about the horrors of war, such that the primary function of the Unit - which was to help soldiers return to active duty - was obscured (Bridger, 1946).

5.4.3 Implications for staff intervention & research In the absence of longitudinal data, it was not possible to comment conclusively on patients' adaptation to the prison environment after discharge. Future discussion with staff about the function of the Unit ought to encourage a decision about the point at which to admit men during their prison sentence. If men are to return to prison for long periods, it would be worth thinking about how to build up links with receiving institutions to make the experience of re-entry into the prison system easier. The creation of a liaison post for a probation officer was obviously intended to bridge the gap between the hospital and prison systems. However, the probation officer spoke in his interview about liaison with community probation services (such as Public Protection Panels), which would not be of immediate benefit to patients who return to prison for significant periods of time.

Negative aspects in the relationship with external colleagues suggested that a key aim of an intervention with Unit Z staff would be to increase constructive dialogue with those outside the Unit. This could partly be achieved through the development of outreach services, and there is currently a plan for such an expansion. It would also be important to include hospital managers at some stage in regular, facilitated group

discussions with staff about their task. The point of this would be to encourage more widespread ownership of Unit Z, to break down barriers between 'insiders' and 'outsiders', and to gain support for any changes in direction taken by the service. It will be important for such a dialogue to emphasise points of similarity in the activities of Unit Z and outside agencies rather than difference, because of suggestions that the special status of the Unit has hindered cooperative working in the past. From a research point of view, it would be interesting to assess whether the development of outreach services has an impact on the Unit's relationship with external colleagues and the successful rehabilitation of Unit Z patients. The development could be described in detail and outcome data from before and after the expansion could be compared, including, for example, information about difficulty in finding community placements.

5.5 Therapeutic Environment: How do Staff and Patients Experience Control on the Unit?

5.5.1 Structure & control: getting the balance right The structure of the programme on Unit Z was generally viewed positively by staff, giving them a sense of purpose and organisation in their work which contrasted with previous chaotic experiences. The Unit was seen as very safe from a physical point of view and incidents of violence and aggression were extremely rare. It was not clear at what point benign control, in the form of order and structured therapeutic activities, may or may not have tipped into a restrictive influence on the work of Unit Z. A minority of staff expressed ambivalence towards the level of control of patients. There was concern about their infantilization and unease about the use of the threat of return to prison if a patient was violent or uncooperative. There was the possibility that patients were receiving a mixed message in that they were expected to be highly motivated but did not, in effect, have a

choice about whether they attended the programme. The question was raised about how possible it was to develop genuine and open relationships with patients under such conditions. An ambivalent attitude towards regulatory control was also suggested by patients' experience of inconsistency with regard to rules on Unit Z.

A lack of clarity about the task of the Unit in relation to the service context was likely to influence mixed feelings about open communication and the issue of control. If the aim for most patients was return to a less secure prison for a considerable length of time, a high level of control on the Unit might have been useful in providing consistency with the prison environment and expectations regarding honesty and openness from patients were possibly unrealistic. If, as interview data suggest, the aim of the Unit was more ambitiously therapeutic, it might be advisable to take prisoners nearer their release date and provide more focus on community rehabilitation. If fostering open communication, personal responsibility and the growth of independence are aims that relate to the pathways actually taken by patients, a high level of control might serve to undermine the work of the Unit. Such considerations fit with Lavender's theoretical paper on the importance of careful clarification of the role of services for this patient group in relation to the complex demands of the external environment (Lavender, 2002).

5.5.2 The concepts of the corrective script & the social defence system

Structure and control were prized by Unit Z staff because of an acknowledged need for distance from previous experiences of chaos. Loss of control by staff is a theme of national inquiries into the mismanagement of forensic services (Fallon, 1999; Blom-Cooper, 1999). There is the possibility that a 'corrective script' had developed in Unit

Z, in which a highly structured environment was seen by staff as the only alternative to chaos. The concept of the 'corrective script' is from narrative theory, which postulates that individuals and groups can become stuck within fixed scripts or ways of making narrative sense of a situation, and that it can be helpful to consider different modes of discourse (Papadopoulos & Byng-Hall, 1997).

Drawing on the model of the social defence system, it is also possible that there was a partly defensive function to control on Unit Z (Jacques, 1955; Menzies Lyth, 1959). Presumably a busy, structured group programme greatly limits opportunities for spontaneous and unregulated contact with patients, thereby restricting the potential for the communication of threat and anxiety. An alternative view would be that the orderliness of the Unit was necessary to ensure the basic safety of staff and patients and enabled staff to carry out therapeutic work with a challenging and demanding group.

5.5.3 Implications for staff intervention & research The incorporation of information collected using a variety of sources and methods is a hallmark of good research, particularly within the case study method (Bromley, 1986). Within the confines of the current study, it was not possible to carry out a structured observation of daily activities on the Unit over a working week, which would have complemented the analysis of staff interviews. It would have been particularly useful to gain more information about the level and function of structure and control on Unit Z. An analysis of antecedents and consequences of rule-enforcement would have suggested the extent to which control acts to enhance therapeutic progress (for example, teaching patients to regulate their emotions and cope with being part of a group), or to avoid anxiety-provoking but potentially useful communications with patients.

In future work with Unit Z staff it would be useful to look at staff's negative experiences of a previous therapeutic community. The aim would be to think about possible connections between this and the approach to structure and control on Unit Z.

5.6 Impact of Work: What is the Relationship between Stress and Job Satisfaction in Staff?

5.6.1 Confirmation of previous findings Unit Z staff talked about their work in extremes: it was seen as, by turns, challenging, rewarding and frustrating. This experience of both satisfaction and difficulty confirms the results of previous studies, although the intensity of the highs and lows spoken about by Unit Z staff were not found in the questionnaire data collected from practitioners in general adult and community services (Carson *et al*, 1995; Onyett *et al*, 1997). A recent large-scale national survey of NHS staff reported findings that were consistent with this picture of a highly motivated and satisfied workforce, who also experienced considerable difficulty in their working environments (Commission for Health Improvement, 2004). Of the 203,911 staff surveyed from 572 different NHS organisations, three quarters said they were generally satisfied with their jobs; but 15% had experienced physical violence at work in the past year, half had endured illness or injury as a result of difficulties in the workplace in the past year and 39% reported suffering from work-related stress.

In the theoretical and empirical literature, stress is construed as a negative affective reaction to difficulty, which is mediated by the belief that one does not have the internal or external resources to cope (Lazarus, 1999; Lazarus, 1995). In the literature on occupational stress it is generally assumed that stress is undesirable and acts to reduce

satisfaction and well-being (Howard & Hegarty, 2003; Prosser *et al*, 2002). However, the current study suggests that in work with this patient group, satisfaction in the job and sense of difficulty are strongly linked.

A sense of value and professional identity was often based on hands-on therapeutic work, and dissatisfaction emanated from a lack of clinical contact. The interviews with staff on Unit Z indicated that problems they experienced at work were often intrinsically connected with their professional sense of value and purpose, and that these could usefully be distinguished from problems that were seen to obstruct clinical work. It could be very hard to help a patient talk about traumatic past experiences, which may include details of the cruelty involved in a serious offence. But this was felt to be an achievement. There were also numerous descriptions in interviews of satisfaction gained from working through interpersonal problems with patients, which sometimes involved emotional confrontations in staff-patient relationships and the need to pay close attention to one's own actions and reactions. Such work could be absorbing and difficult to put to one side, but this was seen to result from a sense of the importance of the task.

The experience of caring for offenders with a diagnosis of personality disorder was contrasted with other areas of mental health work, which were considered dull by comparison. Unit Z staff tended to define themselves as people who like challenge, making it hard to tell whether the 'buzz' of the working environment was produced by the patients and the nature of the work or whether the staff contributed to it in some way. The potential impact of the individual characteristics and behaviour of practitioners was suggested by the emphasis placed in the patients' discussion on

moodiness in staff. Their view was that certain workers were sometimes moody at work, and that this resulted from experiences in their lives outside the Unit.

An interpretation of the concern with external working conditions and resources found in the large-scale studies of stress and burnout among mental health nurses, was that such factors prevent clinicians from getting on with what they see as their core task, whereas difficulties in face-on work with patients is seen as integral to it (Carson *et al*, 1995; Onyett *et al*, 1997). Interviews with Unit Z staff presented a slightly different picture. As mentioned above, some difficulties were associated with reward and satisfaction and others were not. In addition, relationships with colleagues and the external environment were regarded as more stressful than direct clinical work. However, negative difficulty was consistently associated with lack of opportunity to address and resolve issues, whether this was in relation to patients or colleagues, both inside and outside the Unit. This was for a variety of reasons: in problems communicating with close colleagues it was because of the absence of a safe forum within which concerns about staff-patient dynamics or the organisation of work and working conditions could be addressed; in tensions with colleagues outside Unit Z, but also occasionally within the Unit, it was also related to a perceived unwillingness to listen; in relationships with patients, it was linked to patients' reluctance to admit to what they had done or the need for help.

The literature on occupational stress in the helping professions indicates that perceived locus of control and self-efficacy are related, and have a positive relationship to job satisfaction and comparatively low levels of reported stress (Kircaldy, B. & Shepard, R.J., 2002; Mirabella, R.L, 2001). In interviews with Unit Z staff, the lack of

opportunity to safely discuss problems with colleagues and patients' reluctance to talk openly about their difficulties, were both associated with feelings of frustration and impotence. The analysis suggested that aspects of the task and the working environment over which practitioners had no control or influence produced most stress and dissatisfaction, and that this was independent of whether individuals perceive themselves to have an internal or external locus of control.

5.6.3 Implications for staff intervention & research Limited research has been done into the characteristics of mental health staff and their possible influence on the clinical care of patients (Prins, 2002; Schuengel & Van Ijzendoorn, 2001). A study by Dozier and Tyrell used the Adult Attachment Interview to rate the relationship styles of case managers in an out-patient general mental health setting (Dozier & Tyrell, 1997). Those who were classified as 'secure' were regarded as more able to deal with the 'neediness' of clients, whereas 'insecure' workers behaved in ways that matched the expectations of 'preoccupied' insecure clients more closely. Data from the current study on staff's attraction to challenge and the focus on staff relationships, suggest that it would be valuable to do further research looking at styles of attachment in staff who choose to care for this group of patients. It would be interesting to see if these staff are characterised by a particular relational style and to bear this in mind in developing the selection and training of staff.

In terms of practical implications, it seems important to understand the need for a safe environment for staff in which potentially difficult issues in their relationships with each other can be addressed without fear of attack. This would probably be useful in a number of work settings, but there will be a particular need for it in services for patients

who have a large impact on staff at both an individual and a group level (Davies, 1996; Norton, 1996). This need could be addressed in the previously mentioned group meetings, facilitated by someone external to the organisation. In the light of findings of the current study relating to staff stress, the occasional attendance of managers as well as ground-level staff would be crucial for two reasons. The first is the possibility that organisational difficulties might develop at all levels, including management, as a recent inquiry report noted the collusion of managers and Mental Health Commissioners in the over-liberal regime in the Personality Disorder Unit at Ashworth Hospital (Fallon, 1999). The second is the suggestion that staff dissatisfaction results from the frustration of not being able to address a difficulty and take the necessary action, which could be worsened by airing difficulties without having people present with the authority to make changes or take ideas to the relevant decision-making bodies.

5.7 The Patients' Perspective and the Influence of Staff on Patients

5.7.1 The role of life experience The discussion group with patients suggested that from patients' point of view, the aspects of the Unit which had most impact on patient care were not associated with immediate characteristics of the task and work setting; instead they were the internal attributes of particular staff members. This perspective differed from that of the researcher, who, in defining questions for the study, laid an emphasis on the influence on staff of patients, task and setting, rather than the other way round. It is also a neglected topic in the literature, with only a small handful of studies on the type of people that enter this area of work (Dozier & Tyrell, 1997; Prins, 2002; Schuengel & Van Ijzendoorn, 2001).

Patients spoke about the impact of the 'moodiness' of individual staff, but saw this as the result of events going on in their lives outside work. The patient discussion group also indicated the importance of experience as a factor influencing staff's ability to form helping relationships. Patients talked of the enormous value of experience in developing the ability to understand patients' perspective and the helpfulness of such understanding. Such experience was of two types: relevant life experience, which the younger and more privileged staff were less likely to have; and ground-level experience of clinical work with patients, which was not the same as qualifications and professional seniority. The patients' perspective was that more senior staff, such as doctors and psychologists, spent less actual time with them than nursing staff, and knew them less well. The value of the contributions of nursing assistants was repeatedly mentioned. These are often mature people who have a great deal of clinical and life experience.

5.7.2 Implications for staff intervention This finding confirms the studies of ward environments, which demonstrate the importance of stability and experience in the staff group (Davis, 1991; James, 1990; Katz & Kirkland, 1990). Unit Z staff repeatedly spoke of the value of less qualified ground-level staff and this material under the main category 'Tension in the Relationship with 'Outside'' in Section 4.10.4. However, they also identified staff retention as an issue for the Unit. This should be addressed by any future intervention with staff. If interviews with staff are taking place before they leave their jobs, the data collected should be carefully reviewed; if not, exit interviews should be commenced.

In connection with patients' view of the 'moodiness' of certain individuals, it would be useful to explore ways in which staff are selected for work on the Unit. It is realistic to expect that staff will always vary in their emotional stability and the way this is expressed to patients; however, as discussed in Section 5.6.3, it could be beneficial to introduce a quick measure looking at 'relationship style', such as a modified form of the Separation Anxiety Test (Richard *et al*, 1998). This would provide relevant information on emotional availability in the context of a helping relationship, which is significant because of the emphasis placed in the group discussion on spending time with patients and demonstrating understanding of their experiences.

SUMMARY AND CONCLUSIONS

6.1 Strengths and Weaknesses of the Study

The study is an in-depth study of the experiences of a range of staff working in a medium secure unit for offenders with a diagnosis of personality disorder. It contributes to understanding of the needs of staff who care for a complicated and demanding group of patients. The validity of the findings were tested by means of an interview with a community practitioner belonging to a different service, an explorative discussion with patients on the Unit, and consultation with a variety of clinical and academic colleagues. It was unfortunate that it was not possible to incorporate the views of staff participants with regard to the analysis of interviews within the timescale of the current project.

The staff participants worked in a single Unit, which limits the generalisability of the findings, by making it difficult to distinguish between the needs of staff on Unit Z in particular and the needs of staff working with similar patient groups in other settings. In common with much qualitative research, the sample size was relatively small. This means that its findings cannot be said to be conclusive, but build upon relevant current empirical research and theory to suggest future areas of exploration.

The literature on the impact on staff and organisations of individuals with a diagnosis of personality disorders mainly draws on ideas from psychoanalytic, systemic and attachment theories. These ideas have informed the study and the way in which the

analysis is discussed. Ideally it would have been possible to draw on a greater range of perspectives in considering general issues regarding staff needs in this area of clinical work. There is relatively little relevant literature from a cognitive-behavioural perspective. However, research reviewed in Part One into the effectiveness of interventions to reduce re-offending and help those with a diagnosis of personality disorder is largely dominated by behavioural, cognitive and directive approaches.

The format and prescribed questions of the initial semi-structured interview may have produced a bias in the responses of participants towards the discussion of service issues, rather than clinical work with patients (see Appendix 6). The researcher aimed to cover too many topics that were indicated by the literature in the first format for the interview, and did not allow enough space for reflection on the part of individual staff participants. It is hoped that the data collected from the revised and more fluid interview structure served as a corrective influence.

6.2 Summary of Findings

The main findings of the current study in terms of how they contribute to existing knowledge of the needs of staff are shown in Table 6.2 below. The study confirmed the findings of previous research on stress and burnout in mental health practitioners in that aspects of the working environment were experienced as more stressful than direct clinical work. Analysis of staff interviews on Unit Z focussed attention on emotional rather than practical features of the setting, highlighting feelings of vulnerability and persecution in response to perceived hostility from external colleagues. The mechanism of 'projection' from psychoanalytic theory was inferred to indicate the possibility of the

displacement of fears regarding the patient group onto the external environment. This hypothesis could be tested by seeing if perceptions of the relationship with colleagues outside the Unit improved as a result of staff being given the opportunity to explore anxieties regarding patients in group supervision with an external facilitator. Comparison with an interview with a community practitioner indicated that structure and control on the Unit, including the institutional setting itself, allowed a partial avoidance of issues regarding risk that could be considered a necessary part of rehabilitation.

Staff were generally ambivalent about public protection duties and preferred to see themselves as carers rather than disciplinarians. A minority of accounts expressed an acknowledgement of the interrelatedness of these two tasks. Lack of integration in defining the combined therapeutic and custodial duties of the Unit was associated with a negative view of the relationship with external agencies and a reduced appreciation of the context within which service aims are defined. Discussion of the nature of the task in relation to the service context and the concrete details of clinical cases, would enhance the coherence of practitioners' understanding of their role in relation to the overall work of Unit Z.

A negative view of the relationship with the external environment was a feature of the interviews. The analysis indicated that staff have reacted to this by developing a somewhat idealised team image and becoming over-dependent on each other. An association is suggested between Unit Z's isolation from the outside world and a lack of integration in defining the task, because of the need to understand the work of the Unit in its service context. Any future intervention ought to incorporate discussion with

managers and stakeholders regarding desired therapeutic outcomes. This would include the question as to whether an increased emphasis on discharge into the community rather than prison takes place alongside the development of outreach services.

Structure and control on Unit Z were regarded as important in avoiding the potential for chaos and malpractice in services for offenders with a diagnosis of personality disorder. Unease was expressed regarding the level of control exerted over patients and its impact on staff-patient relationships. Consideration of expectations concerning patients' openness with staff and the appropriate degree of structure and control on the Unit should occur in the context of ongoing discussions about service aims. Approach to the issue of control will vary depending on whether the emphasis is on discharge to prison or the community.

Staff on Unit Z enjoyed and derived considerable satisfaction from their work, while also experiencing frustration and difficulty in their relationships with patients and colleagues. This combination of stress and job satisfaction confirms the findings of large-scale questionnaire studies of NHS staff. However in-depth interview data suggested that when staff were able to address and work through patients' considerable problems, satisfaction and difficulty are absolutely interlinked. This study indicated that it might be useful to make the distinction between positive and negative work-related stress. The latter was characterised by a lack of opportunity to address and resolve problems that arise in the workplace, whether they relate directly or indirectly to the clinical situation.

Table 6.2: Contributions from Current Study to Understanding of Staff Needs
(Repeat of table included in Part 1 with contributions from current study in italics)

Staff Need	Source & Key References	Practical Implications
Emotional stability & ability to offer understanding to patients	*Patient Discussion Group in current study*	*Assessment at recruitment stage with use of attachment measure (e.g. Richard et al, 1998)*
Integration of a complex & potentially contradictory task	Systemic theory (Lavender, 2002; Watson *et al*, 2004)	Help from managers and senior clinicians in defining coherent service aims balancing needs of staff & patients for containment and therapeutic opportunity
Match between service aims & expectations & resources in external environment	Large-scale studies of stress & burnout (Carson *et* al, 1995; Onyett *et al*1997)	Discussion of service aims with stakeholders & linked external agencies focussing on expectations & resources
Development of links with agencies for onward referral	*Staff interviews from current study*	*Part of a plan for the development of outreach services within the service*
Education about debates regarding the concept of personality disorder & negative influence of labelling	Literatures on concept of personality disorder & labelling (Angermeyer, 2003; Blackburn, 2000a; Castillo, 2003)	Staff training
Education about relevant outcome literature to address therapeutic pessimism & encourage evidence-based practice	Aetiological literature (Blackburn, 2000b; Salekin, 2002)	Staff training
Interventions informed by thorough individualised assessment	Aetiological literature (Salekin, 2002; Rutter *et al*, 1998)	Resources to support this
Ability to reflect critically on responses to patients	Forensic psychotherapy literature (Cox, 1996; Davies, 1996; Winnicott, 1949)	Assessment of reflexive capacity at recruitment stage & regular individual supervision aimed at encouraging reflective practice
Avoidance of abrupt & unplanned separations & losses	Attachment theory & research (Adshead, 2002)	Principle of practice
Awareness of possibility of defensive practice at group & organisational levels	Organisational literature (Hinshelwood, 1993; Lloyd-Owen, 1997)	Group supervision facilitated by an external consultant & including service heads
Opportunity to address tensions in relationships with colleagues	*Staff interviews in current study*	*Creation of a safe bounded space within the group supervision slot described above*
Stability & experience within the staff group	Attachment theory, ward studies of violence & *Patient Discussion Group in current study* (Adshead, 2002; James, 1990)	Focus by service heads on retention of staff
Organised & predictable routines regarding patient care & staff communication	Ward studies of violence (Katz & Kirkland, 1990)	Regular staff discussions regarding organisation of ward regime
Clarity regarding leadership	Studies of ward environment & team functioning (Katz & Kirkland, 1990; West *et al*, 1997)	Priority for service heads at setting-up stage

6.3 Implications for Clinical Psychology as a Profession

Hinshelwood wrote a paper on the difficulty of working in a prison where psychological thought was defensively dismissed as 'soft' in a culture in which a value was placed on 'hardness' (Hinshelwood, 1993). The principal researcher's experience of work as a clinical psychologist in forensic mental health services strengthened the view that forensic organisations tend to be comparatively unpsychological: a focus on legal processes and offending means that psychologists tend to be primarily regarded as assessors and agents of behavioural change, and staff groups can appear reluctant to enter into the active exploration of thought and feeling. The pivotal role of the Responsible Medical Officer has resulted in an emphasis on a medical understanding of the considerable problems that face mentally disordered offenders, although the new Mental Health Act will make it possible for clinical psychologists to take on this position.

The current unpsychological nature of forensic mental health services is perhaps one reason why this specialty is not generally popular amongst clinical psychology graduates (although it seems to fascinate a minority). Paradoxically, it also provides a strong argument for why more clinical psychologists should go into the area. This is particularly the case in forensic services for individuals with a diagnosis of personality disorder, whose problems are largely psychological but receive treatment in particularly medicalised settings. Other reasons for difficulties in recruiting are likely to be moral disapproval of and/or fear of contact with offenders, and a lack of sympathy with social mechanisms of control. The current study illustrated the way in which forensic mental health staff struggled with these feelings. Data on the relationship between direct

clinical work and practitioners' understanding of the task and the service context suggested the value of a psychological approach to thinking about factors which influence the therapeutic relationship. The discussion group with patients confirmed the value of receiving understanding and empathy to patients.

A service for individuals with a diagnosis of personality disorder has a particular need for the assessment and intervention skills of clinical psychologists. This is illustrated by the outcome literature, which indicates the value of a range of complex psychosocial interventions (Bateman & Fonagy, 2000; Henggeler *et al*, 1996; McGuire & Priestley, 1995). Material from the current study on the desire for a more person-centred approach to patients, suggested that an increased psychology presence would be welcomed by both staff and patients on Unit Z. Clinical psychologists working in this area could usefully work at three levels: in direct individual and group work with patients, in supervising other staff to deliver complex psychosocial interventions and, at an organisational level, in attempting to make the culture of these services more psychological for the benefit of both patients and staff.

The Unit under study had a liaison psychologist, but the post was not a senior one. The environment of the Unit was different from the general culture within clinical psychology; a minority of patients received psychological therapy - although patients all had long-term psychological and social difficulties - and staff did not routinely receive individual clinical supervision. The analysis of interview data made clear the importance of regular, formal supervision for staff who work with such complex and demanding patients. Material on the feelings of vulnerability in staff regarding difficulties with colleagues indicated the importance of group supervision with someone

external to the organisation. The Reflective Practice approach to supervision within clinical psychology, which emphasizes the importance of a boundaried, safe space in which therapists are able to develop self-awareness in their clinical work, would be of great value in settings of this type (Cushway & Gatherer, 2003).

The Shared Learning Agenda, which is a current movement within clinical psychology training, promotes learning alongside trainees from other healthcare professions. One of its aims is to teach trainee clinical psychologists about the work of non-psychology colleagues in order to develop their ability to work as part of multidisciplinary teams in future NHS careers. In the discussion with patients on Unit Z there was a marked comparison between the importance of ground-level staff - usually nurses and healthcare assistants - and psychiatrists and psychologists. Psychologists sometimes have a reputation for distancing themselves from multidisciplinary colleagues, preferring to work separately in their own departments. The current study indicated the value of clinical psychologists working closely with nursing colleagues to integrate with the ward team and increase their influence on patients and staff. By doing this, psychologists can influence ward culture, in addition to providing direct clinical input.

An ability to understand and work effectively within complex NHS organisations is considered a core competency for clinical psychologists in the British Psychological Society's new accreditation criteria for training courses (British Psychological Society, unpublished document). This study suggested the importance of the involvement of practitioners with such skills in the care of offenders with a diagnosis of personality disorder. The analysis indicated that there was an association between complex organisational issues regarding the unit's relationship with society, healthcare and

criminal systems and ground-level experience in terms of defining the task and clinical work with patients.

6.4 Reflections on the Research Process

The aim of the study was to test ideas about the impact of work on forensic mental health staff by using a rigorous method of investigation of in-depth staff interviews. The researcher learnt about the difficulty of identifying and challenging personal biases through the detailed analytic process. When categorizing data, it was sometimes hard to distinguish between what someone actually said and what the researcher assumed they said. The discipline required to go back to the material at each point to check details was considerable. Making comments about the views of a group of staff was a particular challenge: this involved careful phrasing to describe shared concerns so that differences of opinion were not obscured. The experience brought home how easy it is for people to misunderstand each other, even in small but potentially significant ways. It emphasised the value of close listening in therapeutic work and checking out one's understanding with clients.

It was interesting to learn about how the incorporation of a different perspective changed the entire analysis of the data, supplying unforeseen connections and contexts. This was particularly the case with the discussion with a group of patients, whose attitude towards the research was refreshing. It would be possible to feel somewhat cynical about the value of consulting a group of offenders with a diagnosis of personality disorder about the needs of staff. However, the researcher found the consultation with patients very helpful: they approached the exercise seriously and

thoughtfully, and the difference between their perspective and the frames of reference used by mental health staff forced the researcher to question aspects of the developing analysis. The researcher would always attempt to incorporate the views of users in future research.

The question of compatibility of any commentary on unintentional meaning in the analysis with the Grounded Theory method was less complicated than expected. Contradiction and inconsistency featured in fairly obvious ways in certain interviews and were coded by referring to ambivalence or contradiction in naming the category. Ascribing meaning to such inconsistencies was more difficult. There was a need to explicitly infer underlying psychological processes and to question how well they fitted with the data, so that readers could develop a view with regard to the value of the findings.

The leap from the analysis of data to building theory felt like a big one, involving the need to distance oneself from the data and make more abstract statements about the material. There is a tendency for grounded theorists to emphasise the close analysis of textual data at the expense of producing theory, posing the question of whether the method is best thought of as grounded theory or grounded description. This researcher wonders whether the striking contrast between the activities of close analysis of data and theory-building explains this. It also inspires her to use the analysis to inform an intervention with staff: it will be important to see whether it is genuinely useful in the development of an intervention and can produce practical benefits.

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A psychoanalytic view of two forensic mental health services

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ABSTRACT

The work of forensic mental health practitioners is particularly challenging because of the pervasive and long-term difficulties of mentally disordered offenders and the combined therapeutic and custodial duties of forensic services. Despite this, little has been written about the psychological impact of this type of work on staff and the organization of forensic services. The focus in this article is on two services where the author worked: a regional secure unit (RSU) and community forensic mental health service. The complexity of the task in both services is discussed. Suggestions are made about the feelings, conscious and unconscious, which the task and working environment arouse in practitioners. Observations relating to the working culture of the two services are offered, broadly understood as organizational defences against anxiety in the staff groups. Concepts from the psychoanalytic study of organizations are used to analyse these observations. There is a discussion as to how to limit the need for the development of organizational defences in forensic mental health.

Introduction

It seems obvious to say that forensic mental health staff must be deeply affected by their work. It involves contact, after all, with dangerous and mentally disturbed patients. The nature of the task is complicated because it combines therapeutic and custodial responsibilities. In addition, forensic services interact with a number of other agencies with powerful agendas of their own. These include adult psychiatry, the criminal justice system, and the prison, probation and police services. The author contends that the work has a profound conscious and unconscious impact on staff, and that this impact, if unexamined, has an adverse effect on practice. But these ideas are not generally accepted within forensic services, despite the widely publicized reports of government inquiries expressing concern about dysfunctional organizational dynamics within the Special Hospitals (Blom-Cooper, 1999; Fallon et al., 1999). Indeed little has been written in the service of a psycho-

logical understanding of the impact of work with mentally disordered offenders on staff, and the possible effects of this on clinical practice.

A number of writers have described the unconscious effects of work in prisons and hospitals from both organizational and individual perspectives (Menzies Lyth, 1959; Main, 1977; Hinshelwood, 1993). The unconscious impact of individual patients on therapists, and the unconscious dynamics that underlie destructive aspects of group functioning have also been discussed (Bion, 1961; Casement, 1991). It seems important to start to apply these profound and challenging ideas to the study of forensic mental health services. This is because these services produce difficult and complicated working environments, and the consequences of malpractice are potentially disastrous. There are also significant current developments in forensic psychiatry, such as the government's proposed units for the detention of dangerous people with severe personality disorder and the growth of community services, which would benefit from the integration of such thinking.

The aim in this article is to analyse the author's experience of the working culture of an RSU and a community forensic service. The two organizations are described and the complexity of their task outlined. There is an exploration of the anxieties, conscious and unconscious, which practitioners therein experience in their day-to-day work. Potentially counter-therapeutic characteristics of the services are described. These are understood as organizational defences against painful feelings aroused by the work. Concepts from the psychoanalytic study of organizations are used as a tool for understanding the relationship between unconscious anxiety within the staff group and defensive aspects of practice. It is proposed that forensic services need to find a way of reflecting on these feelings and their impact in order to promote high-quality care and encourage the recruitment of skilled staff.

A note on method

The author's relationship to the services described in this paper deserves mention. In both organizations she worked as a clinical psychologist, employed to conduct clinical work, supervision and research. She did not have a designated role as an observer or consultant, and the observations described here were made during the course of her daily work. She therefore makes no claim to objectivity in relation to these observations and acknowledges her involvement in some of the organizational dynamics that are the focus of this paper.

Description of services

The forensic services that are the subject of this paper were a community team and an RSU, in which the author was employed as a clinical psychologist for a total of nearly four years.

The community forensic service

The community service grew out of an RSU. All patients had a designated responsible medical officer, who was responsible for their clinical care. Initially consultant psychiatrists in the RSU shared responsibility for community cases and worked with community psychiatric nurses and RSU social workers to provide an embryonic 'outreach' service.

The belief in the community service, as it evolved, was that RSU psychiatrists and managers were reluctant to take on the care of high-risk community patients. A department of general adult psychiatry eventually took on the management of the service, which was severely understaffed, with only one consultant psychiatrist, for some months. During this time a patient under the care of the community team committed a homicide. Staffing levels grew substantially over the next couple of years, but problems in recruiting to posts in psychiatry and clinical psychology persisted.

The service was a tertiary one, receiving referrals from forensic psychiatrists in high and medium secure hospitals, from prison and general adult psychiatrists, and from probation officers. The service accepted referrals of people with serious mental health problems who were also considered a significant danger to others. There were two main patient groups: those with a psychotic illness, and those with long-term, severe psychological problems with a diagnosis of personality disorder. There was a large overlap in the clinical presentations of these groups.

The service did not have a low secure unit, although this was being built. It used beds on an open, general psychiatry ward, with designated forensic nurses. Staff were temporarily based in an old hospital building, at some distance from outpatient and inpatient facilities.

The RSU

At the time the author worked there, the RSU was a few years old and inhabited a new building at the back of a large general hospital. There was an admissions ward and two rehabilitation wards. Over two years the unit grew from three to six multidisciplinary teams, who shared responsibility for the inpatients. All patients were detained under criminal or civil sections of the 1983 Mental Health Act. The hospital had well-staffed departments in psychiatry, psychology and social work, and two joint appointments with university departments. There were difficulties in recruiting permanent nurses and occupational therapists.

The service was a tertiary one and took referrals from forensic psychiatrists, prison and general adult psychiatrists, and probation officers. The majority of patients were men suffering from a psychotic illness who had committed a violent offence. But the service admitted a small number of dangerous people with a primary diagnosis of personality disorder. There were usually two or

three women on each ward at any one time, and the need for a women-only unit was sometimes discussed. The average length of stay was about two years.

Complexity of the task in the two services

The mission statements of forensic services usually focus on the care of mentally disordered offenders, with an accompanying statement about the need to protect the safety of patients and the public. At the time of the author's involvement, the services described here had not produced mission statements. Most staff would probably have defined their main aim as the treatment of mentally disordered offenders. But in the community service, decisions about the day-to-day management of patients were often driven by the anxiety to prevent possible acts of violence or abuse, and staff increasingly complained that they were required to police patients. In the RSU, there were practitioners who felt that the emphasis in interactions with many of the patients was custodial not therapeutic. In both services, there was confusion as to the real nature of the task. Discussion of how to balance therapeutic and custodial responsibilities was scarce, as was debate about conflicts that might arise from attempts to combine these areas of responsibility.

Menzies Lyth writes about the difficulty for staff in the 'humane institutions' in defining their task realistically and clearly (Menzies Lyth, 1979). She ascribes this to tension between limited, and often inadequate, resources and the wish to carry out significant therapeutic change. Menzies Lyth also suggests that the helping professions face multiple tasks that compete for primacy, making it difficult to develop a clear sense of purpose. There is a danger of such institutions 'implicitly slipping over into anti-task' when task definition is especially difficult, or when societal pressures militate against a clear understanding of the primary task. In both services under discussion in this paper, there were occasions when there seemed to be direct conflict between concern for the therapeutic progress of patients and anxiety about preventing or reducing risk.

Community staff's anxiety about safety was largely a response to the real threat of danger from patients. But in addition to worries about physical safety, practitioners were preoccupied with professional survival in the context of what was commonly referred to as 'the inquiry culture'. Inquiries were viewed as the most significant marker of success or failure in terms of the service's relationship with the outside world. Practitioners spoke about a difficult beginning, when the service faced both internal and public inquiries into a homicide committed in the context of severe understaffing. They were pleased to have avoided a similar incident the following year and spoke of the inevitability of a patient committing a violent offence in the not-so-distant future.

Such preoccupations are mainly the result of expectations of forensic services on the part of general psychiatry, the media, society and government. There seems to be an assumption that it is the job of forensic services to

prevent acts of violence on the part of the mentally disordered, rather than to reduce their likelihood. As an example of this, a recent inquiry report talks of the responsibility of forensic practitioners to 'eliminate' risk in relation to a particular case.

This profoundly unrealistic expectation is likely to be the consequence of intense social anxiety about deviance and dangerousness, which is dealt with by investing forensic services with exaggerated powers of protection and control. Forensic mental health staff are possibly prone to collude in this fantasy of their omnipotence. This could be because of understandable, but often unacknowledged, anxiety about what it is possible to achieve in therapeutic efforts with dangerous and severely damaged people.

The difficulty in combining therapeutic and custodial responsibilities expressed itself differently in the RSU. This was largely because of the security of the setting, which presented its own obstacles to clinical work. Hospital detention reduced risk for many by removing them from situations that they found challenging. But it was then difficult to assess risk meaningfully for these people, or to prepare them properly for life outside hospital.

Other features of the hospital which presented real problems to therapeutic work with patients were close and continuous proximity to a number of other highly disturbed individuals, and the boredom and monotony of life on the wards. There were a number of occasions when the author went to see patients for therapy sessions to be met by a numbing preoccupation with the boredom and meaninglessness of two or more years of detention in hospital. This meant that material that the author regarded as grist to the therapeutic mill – personal history, relationships, and psychosocial factors relating to the offence – often felt remote and irrelevant to detained patients.

The difficulties involved in spending 24 hours a day with a group of dangerous and disturbed people was brought home to me by a talk by a patient who had previously been detained in the RSU. He spoke of his continuous fear of attack by other patients and described the atmosphere on the wards as violent and unpredictable. It would be hard enough for anyone to live in such conditions, but the environment presents particular difficulties to patients who are already prone to feelings of paranoia and vulnerability.

Feelings aroused in staff by the patients and the setting

There has been a growing recognition of the stresses that staff face in working with illness, and the maladaptive ways in which they react to defend against these anxieties (Jacques, 1955; Menzies Lyth, 1959; Hinshelwood, 1994). Menzies Lyth's seminal essay charted the profound, often unconscious anxieties aroused in nurses by their work with sick and dying patients, and the counter-therapeutic ways in which working practices developed in order for them to avoid the full impact of individual patients' distress (Menzies Lyth, 1959). A memorable example was the observation that nursing in the hospital

was organized by lists of tasks rather than individual patients. This reduced nurses' exposure to the impact of individual suffering but made the service far more impersonal than it might have been.

Menzies Lyth (1959) accounted for the unmanageable anxiety experienced by the nurses she observed by linking aspects of the nursing situation to the infant's primitive conflict between love and aggression. She described how patients' dependency arouses powerful libidinal impulses in nurses, so their experience of work was influenced by deeply rooted unconscious fantasy, in addition to the challenges of the objective situation. The combination of therapeutic and custodial tasks in forensic services will trigger conflict in practitioners between such primitive destructive impulses and the desire to protect and nurture. The opportunities for control inherent in the secure hospital system will also provoke individuals whose aggressive impulses are not contained, either through personal resources or the provision of staff support and supervision.

Forensic practitioners are also affected by detained patients' sense of powerlessness, vulnerability and isolation. These emotions are always a feature of work with those with severe and chronic mental health problems. But the harsh, bewildering reality of locked environments and the criminal justice system makes the torment and confusion of forensic patients particularly intense, and therefore more likely to be dealt with unconsciously through projection onto staff.

The community service's perceived responsibility for preventing patients from committing violent offences, without having the resources or authority to do so, only added to a sense of impotence in staff. Likewise, the claustrophobia of the RSU reinforced anxiety about marginalization in both staff and patients.

Forensic practitioners will sometimes complain about extreme negative attitudes towards those who have committed deviant acts and a tendency to identify workers with their patients. Perhaps it is more difficult for staff to talk about their own understandable but deeply unsettling anxieties about contamination through contact with serious offenders. Workers will often find it hard to acknowledge the difficult and painful feelings which emotional contact with the experiences of serious offenders arouses out of concern as to whether they will be able to cope with such feelings.

Organizational defences

A word about medical responsibility

There was a view in both services that the more uncaring and dehumanizing approaches towards patients largely came from senior medical staff. It was common for non-medical staff to complain about consultant psychiatrists' lack of contact with patients. They described a typical situation at ward rounds, in which a non-medical member of the clinical team supplied patient details to

the consultant. The non-medic would also find himself or herself advocating for the patient when the consultant took a tough line. It seemed that the high levels of responsibility involved in the role of RMO made senior medical staff especially vulnerable to the conflicts involved in combining therapeutic and custodial duties. A relative lack of interest in forming close therapeutic relationships with patients functioned as an important method of protection for them.

In both services there was an overemphasis on the role of RMO. On the other hand, relatively little attention was paid to the role of social supervisor, which is not necessarily less significant in terms of its statutory duties than that of RMO. This brings to mind Menzies Lyth's observation that 'delegation upwards' can operate to protect staff from anxieties about responsibility for the welfare of others (Menzies Lyth, 1959). Such delegation produced a sense of almost unbearable anxiety and isolation in some senior medical colleagues. This in turn led to a feeling of concern among others that should have been focused on the patient group.

Moralism and defensive use of the medical model

Most clinical trainings emphasize the importance of a non-judgemental attitude towards patients. However, it can be helpful to talk directly about an offence in order to help someone face up to what they have done. But in both the RSU and community team a certain moralistic attitude pervaded, in which particular patients were seen as 'ill' and therefore not to blame for what they had done. These patients were usually regarded as unambiguously deserving of care. Other patients were seen as intact and responsible for what they had done, and these patients were often regarded in a negative light.

Generally, an attitude of pity and concern was held towards patients with a clear, diagnosable psychotic illness. These patients were often extremely well cared for by the secure hospital and community service, partly because staff felt able to help these patients and non-ambivalent about their right to such help. A medical model of mental distress is enshrined in the 1983 Mental Health Act, which dictates that referral to a secure hospital must be on the basis of 'treatable' mental illness, psychopathic disorder or mental impairment. Medical knowledge clearly has a great deal to contribute to the care of mentally disordered offenders. But both services seemed to be invested in this model to the point of exclusion of alternative approaches to the complex and multiple problems of the patient group. For example, the caring attitude towards the patients seen as mentally 'ill' was often accompanied by a reluctance to speak in any detail about the awful things they had done. This led to a failure to take account of the links between psychotic experiences, psychosocial factors and the offence. An understanding of these connections is the basis for therapeutic work and may be the key to reducing the risk of re-offending.

In the majority of cases patients with a diagnosis of personality disorder have suffered terribly in childhood in ways for which they are not responsible. There are also high levels of comorbidity between psychotic 'illness' and long-term personality problems. Despite this, the two areas were usually regarded as separate in both services. Either patients were seen as 'not ill' and, therefore, fully responsible for their actions; or they were regarded as 'ill' and, therefore, not responsible. This dichotomous view is countered by recent research. This suggests that entrenched anti-social behaviour in those with personality problems has multiple causes, but that there is a definite genetic component to the problem, which is mediated by environmental and family factors (Rutter et al., 1998).

The approach towards patients who were not regarded as ill could be punitive. Many staff in both services demonstrated high standards of professionalism in their clinical work. But there was also a worrying degree of tolerance of staff who talked to patients in a denigrating and confrontational way, sometimes boasting about the hard line they took with difficult patients.

In the community service there was a female patient with a diagnosis of personality disorder who divided the team in strong feelings of sympathy and hostility towards her. A tribunal released the patient from a long period in hospital against the recommendations of her clinical team. A social work colleague decided that it was her duty to accompany the patient to a court hearing for a serious charge. Other workers argued that if the patient was well enough to be dealt with by the criminal justice system, she could attend court on her own. When the social worker told them afterwards of the patient's distress in the courtroom, she was dismayed by the punitive nature of colleagues' comments.

Restricted focus on the medical model in forensic psychiatry was partly explained by the fact that more is known about helping those with a clear-cut psychotic illness than those with a multitude of long-term psychological problems. But it also served a defensive function, acting to protect practitioners from emotional contact with a highly disturbed group of patients.

Over-reliance on the medical model as a way of distancing staff from patients was possibly also the result of unconscious projections by staff onto the patient group. Could it be that madness and badness – or, to a lesser degree, mental confusion and negativity – had been disowned by the staff as a group and located in the patients? The reiteration of a medical model of distress in clinical discussions in both services seemed often to serve as reassurance of the essential biological difference between staff and the patients.

The view of personality-disordered offenders as unchangeably bad put an inevitable distance between staff and patients. This attitude sometimes appeared to function to protect staff in both services from recognizing similarities, or points of connection, between patients' experiences and their own. These patients had almost always been both victims and perpetrators of abuse. Their experiences were traumatic and involved elements of deviance and

perversion, as well as vulnerability and victimization. By giving such material a largely moral frame, clinicians were protected from fears about what emotional contact with such experiences would arouse in them. In the absence of supervision aimed at an understanding of the dynamics of the therapeutic relationship, it is really no wonder that empathic work with these people felt so threatening to staff.

Protectionism and machismo

The environment in forensic psychiatry is more masculine than in other mental health settings because the majority of patients are male. But, apart from the actual gender of patients, the culture of forensic services can be both macho and controlling. Staff in both services commented on the protectionist ethos of the times, regarding this as a result of government concern with the public's perception of the policy of community care. But willingness to collude with such external pressure was also influenced by unacknowledged anxieties in staff about the achievement of therapeutic change and reduction of risk. In the two services under discussion these anxieties were rarely spoken about. The creation of a working culture that was, at least superficially, confident and potent, partly resulted from the need to compensate for an underlying sense of powerlessness.

There was concern in the community forensic service that practice was increasingly defensive and protectionist. When considering clinical issues, the phrase 'if there was an inquiry' was repeated as a team refrain, and there was also explicit acceptance of the fact that the service operated in a 'culture of inquiry'. This had some positive effects on practice, including an exceptionally high standard of record keeping and attention to details of procedure. However, practitioners complained that the service was overly concerned to reduce risk, and sometimes operated counter-therapeutically as a result.

Two patients were spoken about a great deal in this regard. They both had a diagnosis of personality disorder and found it difficult to engage in a constructive way with hospital staff. Nursing staff felt that hospital was making them worse, and their violent and self-harming behaviour was also very distressing for other patients. Despite this, both patients were detained for over a year in unsuitably claustrophobic ward environments because of a reluctance to face the risk involved in their discharge from hospital.

In the RSU there was more pressure to conform and a greater intolerance of difference among staff than in most other mental health environments. Individual workers were identified as either insiders or outsiders and there was talk of the need for newcomers to gain acceptance and 'earn their forensic spurs'. This sometimes led staff who saw themselves as outsiders to seek jobs elsewhere, reducing the mix of skills and approaches available in the unit.

The strong boundary between the RSU and the outside world, and between established and less established staff within the unit, was suggestive of a wary

and distrustful organizational culture. Unconscious communication from the patients, many of whom suffered from feelings of extreme distrust and paranoia, contributed to this. The claustrophobia and isolation of the setting also militated against a relaxed and open sense of connectedness with other people inside and outside the hospital.

Flight from thought

It was common for staff in the RSU and the community service to comment on the difficulty in stopping to think about practice. In the community team practitioners were involved in the day-to-day care of dangerous patients, whose risk was not managed by the fences and high levels of staffing in a secure hospital. The service was expanding, and there was a growth in procedures designed to monitor and manage the risk presented by individual patients. Increasingly concrete metaphors were used to describe practice. A weekly meeting was set up to talk about patients considered to be high risk. Potential dangerousness was symbolized by putting patients onto 'red' or 'amber alert', and moving them to green when concern lessened. There was also a new weekly briefing meeting. The new meetings were both referred to by the type of acronyms used in police dramas. The service seemed to be increasingly concerned with the management of risk through direct action.

Some practitioners felt that this development occurred at the expense of proper reflection about the clinical care of patients, and the role of the service. Team members were gradually less able to think together about how to develop policy and practice. Earlier on in the initial growth of the service, a monthly slot for all staff to reflect on practice had been instituted with enthusiasm. Six months on, many staff found it difficult to find time for such a slot, and felt that the presentation of cases there had turned into an additional pressure to perform in front of colleagues.

In the RSU this 'performance' or 'action culture' was connected to a sense of glamour and importance, and of being at the centre of an exciting and high-profile specialty. The Chief Executive of the Trust often visited staff in the RSU, and legal cases involving psychologists and psychiatrists who worked there received media coverage. This feeling of glamour had positive aspects, which included the attraction of new recruits to the service and high levels of energy and enthusiasm among many practitioners. But the RSU's somewhat inflated self-image also acted as a defence against anxieties about marginalization and isolation and an avoidance of contact with patients.

A large proportion of the unit's activity was for the benefit of staff with relatively high status, and not the nursing staff and patients. The wards were in a separate part of the building from the administrative and staff offices, and nurses complained that they felt cut off from colleagues, who did not visit the wards enough. At a conference the author attended, she was impressed by the unit's energetic and innovative profile. This was reinforced internally by a

thriving academic programme, and committed staff who worked long hours. This contrasted with the atmosphere on the wards, where there was often a feeling of inactivity and depression.

Conclusions

There is a perception of forensic services, and in particular the secure hospitals, as dysfunctional organizations. The many government inquiries into forensic mental health services have tended to point the finger of blame, listing incompetent staff and faulty organizational structures, and so contributing to increased anxiety among practitioners. This article has attempted to explain some of the defensive and counter-therapeutic organizational dynamics in two different forensic services, using ideas from the psychoanalytic study of organizations. An overarching aim has been to suggest that dysfunction in forensic services is, in large part, the consequence of workers' genuine efforts to deal with an extremely painful and complicated task, in the face of powerful and unrealistic projections from both health service managers and society as a whole.

It is hard to know what might act to remove some of these pressures on forensic mental health services to make the working culture somewhat looser, kinder, and more creative and integrated, for both patients and staff (while, of course, remaining safe). Bottom-up and top-down change is needed to enable staff to reflect on practice and to be self-reflexive in relation to their contact with patients. One aspect of this is the provision of regular, formal clinical supervision for individuals and staff groups to help practitioners to acknowledge the emotional impact of the work, and prevent unacknowledged feelings from getting in the way of therapeutic practice.

If staff were supported in this way they might be better able to enter into a dialogue with managers about the nature of their task, and the difficulties that can arise from unrealistic expectations. At the moment a Catch-22 situation seems to exist. Until government and managers alter their exaggerated expectations of forensic organizations, staff are unlikely to receive support to reflect on their clinical task. But without such support it is almost impossible for them to think critically about practice and make a coherent case for change. This was illustrated in the community forensic service, which unquestioningly took on responsibility for policing patients when this often ran counter to the therapeutic task, and the service did not have sufficient power or resources.

Some of the organizational dynamics described in this paper have been understood as aspects of the life of closed institutions, from which the development of community services is a welcome escape. But the overlap in the author's observations of defensive characteristics of the RSU and community service suggests that such dynamics are as much to do with the nature of the work of forensic organizations and its impact on staff, as the relative openness of bricks and mortar. The locked environment could be seen to increase the

intensity of projections between staff and patients, and between the institution and the outside world. But the similarities between the cultures of the two services indicate that increasing community provision on its own will not be enough to avoid the problems that have plagued locked institutions for mentally disordered offenders. There will need to be a fundamental psychological, not just a physical, shift towards openness in forensic mental health.

As part of this change, there is a strong need for research in this area. It would be useful to assess staff and patients across a range of forensic settings to confirm whether counter-therapeutic organizational dynamics, of the type described in this paper, are really a significant part of the experience of forensic staff and patients. The defensive aspects of forensic organizations are likely to provide particular challenges to researchers. Attempts to acknowledge the powerful emotions aroused in staff working in these services can meet with a negative response. It then becomes difficult for practitioners to tell the difference between a real, external attitude of reluctance towards an open discussion of the emotional impact of practice, and the subjective, internalized sense of intimidation which can result from working in these settings. It will be important, therefore, for researchers to be sensitive to the feelings of concern and vulnerability experienced by forensic staff, and ensure the full support and collaboration of managers before encouraging staff and patients to open up to them.

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Our ref:

Your ref:

18 June 2002

Dr Lucy McCarthy
Research Associate
Division of Forensic Mental Health
Arnold Lodge
Cordelia Close
Leicester
LE5 0LE

Ext No:

Direct Line:

Dear Dr McCarthy

An investigation into the ways in which forensic mental health staff understand the demands and experiences of their work
Reference No.

At the meeting on 10 June 2002 the Committee considered your application and could see no ethical reason why your study should not proceed. However, the Committee requested that you include a standard paragraph on the role of a Research Ethics Committee in the Patient Information Sheet. I confirm that we have since received an updated Patient Information Sheet from you, containing the information requested.

Please note that if any data is to be stored on computer, you have the personal responsibility of ensuring registration with the Data Protection Officer. In addition, please note that all data computerised or otherwise, must be securely stored for a minimum of ten years.

Please find attached a list of members of the Committee at the date of the meeting. It is not the Committee's policy to indicate which members were present when a particular protocol was reviewed, however, I can assure you that the meeting was quorate and conducted in accordance with the Constitution.

The Committee wishes you well with your project, and would welcome details of the outcome in due course.

Yours sincerely

LOCAL RESEARCH ETHICS COMMITTEE

Healthcare NHS
NHS Trust

Research & Development

E-mail:
Direct Dial:

Our ref:
Your ref:

Tel:
Fax:

3rd March 2004

Ms A Kurtz
Senior Clinical Tutor
University of Leicester
Dept of Clinical Psychology
104 Regent Road
Leicester
LE1 7LT

Dear Ms Kurtz

Re: The views of patients in a secure personality unit on the needs of staff

I am writing to confirm that this study is authorised to take place as we are now in receipt of Ethical Approval (03/02/04) and you have obtained authorisation from the relevant Clinical Director, the Medical Director and Research Programme Director.

This is a very interesting and important field of study. The Trust R&D Office follows up such work to assess its impact and influence on practice and policy. I would be grateful if you could send me a copy of the findings and recommendations if there are any when the project has completed.

All research registered with the R&D Office automatically gets included in the National Research Register (http://www.update-software.com/national/), and information on all projects is updated quarterly. If you wish to provide updates or there are any changes to the study, please let us know.

Best wishes

R&D Manager

Local Research Ethics Committee

Tel:
Fax:

3 February 2004

Ms Arabella Kurtz
University of Leicester
Dept of Clinical Psychology
104 Regent Road
Leicester
LE1 7LT

Dear Ms Kurtz

REC Ref:
The views of patients in a secure personality disorder unit on the needs of staff

The Chairman on behalf of the LREC has considered your response to the issues raised by the Committee at the first review of your application on 12 January 2004, as set out in our letter dated 30 January 2004. The documents considered were as follows:

- Cover letter
- Letter from
  .. dated 21 January 2004
- Interview Schedule
- Revised Research Protocol

The Chairman, acting under delegated authority, is satisfied that your response has fulfilled the requirements of the Committee. You are therefore given approval for your research on ethical grounds providing you comply with the conditions set out below:

Conditions of approval:

- You do not undertake this research in any NHS organisation until the relevant NHS management approval has been received.

- You do not deviate from, or make changes to, the protocol without the prior written approval of the LREC, except where this is necessary to eliminate immediate hazards to research participants or when the change involves only logistical or administrative aspects of the research. In such cases, the LREC should be informed within seven days of the implementation of the change. Likewise, you should also seek the relevant NHS management approval for the amendment, or inform the NHS organisation of any logistical or administrative changes.

- You complete and return the standard progress report form to the LREC one year from the date of this letter and thereafter on an annual basis. This

form should also be used to notify the Committee when your research is completed and should be sent to the REC within three months of completion. For a copy of the progress report please see www.corec.org.uk.

- If you decide to terminate this research prematurely, a progress report form should be sent to the LREC within 15 days, indicating the reason for the early termination. For a copy of the progress report please see www.corec.org.uk.

- You must advise the LREC of all Suspected Serious Adverse Reactions (SSARs) and all Suspected Unexpected Serious Adverse Reactions (SUSARs).

- You advise the LREC of any unusual or unexpected results that raise questions about the safety of the research.

- The project must be started within three years of the date of this letter.

'Lead' LREC – other local submissions

Where this LREC is taking the role of 'Lead' LREC, it is your responsibility to ensure that any other local researchers within the Trent Strategic Health Authority seek the approval of the relevant LREC before starting their research. To do this you should submit **one copy** of the following documents to the relevant LRECs:

- This approval letter
- Part C of the REC Application form (with pertinent local details)
- LREC-approved version of the patient information sheet and consent form, in the appropriate local format (ie on pertinent headed paper and showing pertinent local contact details)
- Principal (local) investigator's CV.

No other documents are required by the LREC to consider locality issues.

NHS LRECs are compliant with the International Conference on Harmonisation/Good Clinical Practice (ICH GCP) Guidelines for the conduct of trials involving participation of human subjects.

Your application has been given a unique reference number, please use it on all correspondence with the LREC.

Yours sincerely

PI

Chair

LOCAL RESEARCH ETHICS COMMITTEE

cc

RESEARCH STUDY INFORMATION SHEET

Title of study: An investigation into the training, support and supervision needs of forensic mental health staff

You are being invited to take part in a research study involving staff in forensic mental health services. Before you decide whether to take part it is important that you understand the purpose of the research and what it will involve. Please take time to read this information sheet and discuss it with others if you wish. Ask us if there is anything that is not clear, or if you would like more information.

What is the purpose of the study?

Work with mentally disordered offenders is both complex and challenging. There has so far been little research on the impact on staff of working in this area. The main aim of this study is to find out how staff feel about their work and about the rewards and challenges of their job. We also want to identify what kinds of formal and informal support staff find most helpful.

Why have I been chosen to take part in the study?

We want to involve staff from all the main mental health disciplines, as well as managers and a few others who have significant contact with patients. We plan to interview about 15 members of staff from each of three different forensic mental health services.

Do I have to take part?

You do not have to take part in the study if you do not want. If you decide to take part and later change your mind, you can withdraw at any stage. If you do take part, you will be asked to sign a consent form.

What will taking part in the study involve?

If you agree to take part, we will interview you for about an hour to an hour-and-a-half to obtain your views about your job, various aspects of your work, and the kind of support you find useful. The interview will be arranged at a time and place convenient to you. In the interview, you will be asked a series of open questions about your work. The interview will be audiotaped to ensure your views are recorded fully.

What about confidentiality?

The views and information you give will be entirely confidential between yourself and the researchers. During transcription of the interview, all names and other identifying

information will be removed. You will be invited to check the transcription if you wish. The information gained from the interviews will be analysed and reported in an anonymous form.

What will happen to the results of the study?

We plan to present the results to staff in the participating forensic services, as well as to write up the study for journal publication. We hope that the results will enable us to make recommendations regarding the provision of effective support for staff.

Who is organising and carrying out the study?

The study has the support of the South West London & St George's Mental Health Trust, the East Midlands Centre for Forensic Mental Health, and the Service Manager/Service Director of the two forensic services involved. The Local Research Ethics Committees have reviewed and approved this study. A local Research Ethics Committee (LREC) is a body appointed by the Health Authority. It consists of both medical and non-medical members, who review proposed research within the health district. Their role is to consider the ethical merits of any research. Research projects are not undertaken unless LREC approval has been gained.

The research will be carried out by Nikki Jeffcote, Clinical Psychologist, Arabella Kurtz, Consultant Clinical Psychologist and Dr Lucy McCarthy, Research Psychologist. They will conduct the interviews and analyse the results. All three researchers would welcome any questions or comments you have, and can be contacted as follows:

Nikki Jeffcote
Shaftesbury Clinic, 61Glenburnie Road, London SW17 7DJ
Tel: 020 8682 6019
Email: njeffcote@swlstg-tr.nhs.uk

Arabella Kurtz
University of Leicester
Ken Edwards Building
University Road
Leicester LE1 7RH
Tel: 0116 252 2462
Email: ak106@le.ac.uk

Dr Lucy McCarthy
Arnold Lodge, Cordelia Close, Leicester LE5 OLE
Tel: 0116 225 6064
Email: Lucy.McCarthy@arnoldl.cnhc-tr.trent.nhs.uk

Thank you very much for considering taking part in this study.

Centre Code:
Subject Identification Number:

CONSENT FORM

Title of study: An investigation into the training, support and supervision needs of forensic mental health staff

Names of Researchers: Arabella Kurtz, Nikki Jeffcote and Lucy McCarthy

Please tick box

1. I confirm that I have read and understand the information sheet regarding the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐

3. I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	**Date**	**Signature**

_____	_____	_____
Researcher	**Date**	**Signature**

University of Leicester
School of Psychology
Clinical Section
104 Regent Road
Leicester LE1 7LT
Tel: +44 (0)116 223 1649
Fax: +44 (0)116 223 1650

RESEARCH STUDY INFORMATION SHEET

Title of study: The views of patients in a secure personality disorder unit on the needs of staff

You are being invited to take part in a research study involving both staff and users of forensic mental health services. Before you decide whether to take part it is important that you understand the purpose of the research and what it will involve. Please take time to read this information sheet and discuss it with others if you wish. Ask us if there is anything that is not clear, or if you would like more information.

What is the purpose of the study?

There has so far been little research on the needs of staff working in forensic mental health. The aim of this study is to find out how staff feel about their work and the rewards and challenges of their job, and how this impacts upon the experience of users.

Why have I been chosen to take part in the study?

We want to consult four users from the Personality Disorder Unit. This particular unit has been chosen because staff from the unit have already been interviewed for the study. We have not included recent arrivals on the unit or those who are particularly unsettled at the present time. We have selected four users from the unit at random, and we are inviting these men to participate

Do I have to take part?

You do not have to take part in the study if you do not want. If you decide to take part and later change your mind, you can withdraw at any stage. If you do take part, you will be asked to sign a consent form. You will be given a signed copy of the consent form to keep, together with this information sheet.

What will taking part in the study involve?

If you agree to take part, we will invite you to attend a one-off group of four users in the unit in February. This will be organised at the most convenient time for the people involved, so please tell us beforehand about any important appointments you have in February. The consultation will be led by two researchers, Arabella Kurtz and Alison Tweed. We will tell you a bit more about the research, and there will an opportunity for you to ask about any concerns or queries you might have. We will then ask you for your views on the findings of the study so far, and the needs of the staff who work on the unit. The consultation will last for a maximum of an hour. It will be taped so that a transcription of the discussion can be made.

What about confidentiality?

The views and information you give will be entirely confidential between yourself and the researchers. During transcription of the interview, all names and other identifying information will be removed. You will be invited to check the transcription if you wish, and the tape will be wiped within a month after the consultation. The information gained from the interviews will be analysed and reported in an anonymous form.

What will happen to the results of the study?

We plan to present the results to staff in the three participating forensic services, as well as to the users in the Personality Disorder Unit. We will also write up the study for journal publication. We hope that the results will enable us to make recommendations to improve support for staff.

Who is organising and carrying out the study?

The study has the support of the South West London & St George's Mental Health Trust, the East Midlands Centre for Forensic Mental Health, and the Service Manager/Service Director of the two forensic services involved. The North Nottinghamshire Local Research Ethics Committee has reviewed and approved this study. A local Research Ethics Committee (LREC) is a body appointed by the Health Authority. It consists of both medical and non-medical members, who review proposed research within the health district. Their role is to consider the ethical merits of any research. Research projects are not undertaken unless LREC approval has been gained.

Arabella Kurtz, Consultant Clinical Psychologist, and Alison Tweed, Clinical Psychologist, Clinical Psychologist, will carry out the research. They will conduct the consultation and analyse the results. Both researchers would welcome any questions or comments you have, and can be contacted at the above address or by email (Arabella's address is ak106@le.ac.uk and Alison's is aet2@le.ac.uk).

Thank you very much for considering taking part in this study.

University of Leicester
School of Psychology
Clinical Section
104 Regent Road
Leicester LE1 7LT
Tel: +44 (0)116 223 1645
Fax: +44 (0)116 223 1650

Centre Code:

Subject Identification Number:

CONSENT FORM

Title of study: The views of patients in a secure personality disorder unit on the needs of staff

Names of Researchers: Arabella Kurtz
Alison Tweed

Please tick box

1. I confirm that I have read and understand the information sheet regarding the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐

3. I agree to take part in the above study. ☐

Name of Participant	**Date**	**Signature**
Researcher	**Date**	**Signature**

Introduction

- Thank you.
- Study: find out from staff their views and thoughts about working in a forensic mental health service.
- Background information.
- Then will ask you some fairly open questions for you to answer in whatever way you want.
- Will tape the interview.
- The interview is confidential.
- The interview will be transcribed and all identifying details will be taken out during the transcription.
- If you wish, you can have a copy of the transcript to check.
- Tape will be wiped.
- Consent form.

Working Interview Schedule

Orientation

I'm going to ask you about your experiences at work. I have some fairly open questions to ask you, and I'd like you to answer them in any way you want. As far as possible, I'd like you to think of this as an informal conversation and to let me know what you think and feel in any way that's comfortable for you.

Experience v. expectation

- To start, can you tell me about what brought you into this kind of work?
- How far has your experience of this work matched any expectations you had of it beforehand?
- What do you think people outside the Clinic/PDU/service think about what you do?
- Do you have any thoughts about the attitudes of the media or the government to the patients you work with?

Teams

- Do you think of yourself as a member of a team?

(If yes):

- Can you tell me a bit about how the team works?

  [What works well/ doesn't work well in the team?]

If no:

- Can you tell me about that? [How does that affect your relationship and work with your colleagues?]

- Has the way you or your team do your work or think about your work changed or developed over the past year or so?
- Can you give me an example of a change or development?

Job satisfaction

- What do you find satisfying about your work?
- Can you give me an example of a recent piece of work or interaction you found rewarding?
- What do you dislike or find difficult about your work?
- Can you give me an example of a recent piece of work you found difficult or unsatisfying?
- I'd like you to think about a patient you know well and work quite closely with. What are the challenges of working with him/her? What are the rewards of working with him/her?
- What would make you feel better about your job?
- What would help you to do the best job you can?

Primary task and conflicting tasks

- What do you see as the function of your job? [What are you here to do?]
- What do you see as the function of the Clinic/PDU/service? What is it here to do?

Impact of Work and Safety Issues

- How does your work affect your everyday life?
- Can you tell me about any times you feel worked-up or upset at work?
- Can you tell me about any times you feel unsafe at work [physically and/or emotionally]

Supervision and support

- What helps you cope with your work?
- How does that help? / Can you say a bit about how those things help?
- [And at/outside work what helps you cope?]

Working Interview Schedule: Revised 30.4.03.

Orientation

I'm going to ask you about your experiences at work. I have some fairly open questions to ask you, and I'd like you to answer them in any way you want. As far as possible, I'd like you to think of this as an informal conversation and to let me know what you think and feel in any way that's comfortable for you.

Experience v. expectation

- To start, can you tell me about what brought you into this kind of work?
- How far has your experience of this work matched any expectations you had of it beforehand?

Primary task and conflicting tasks

- What do you see as the function of your job? [What are you here to do?]
- What do you see as the function of the Clinic/PDU/service? What is it here to do?

Clinical contact

- Many patients in these settings have very troubled and sometimes tragic histories. How does this affect you? Can you give me an example?
- The patients you work with have presumably done some pretty awful things. How do you deal with this in your own mind?
- What do you think is the effect on staff of prolonged contact with these patients?

Teams

- Do you think of yourself as a member of a team?

(If yes):

- What works well in the team?
- What doesn't work well?

(If no:

- Can you tell me about that? How does that affect your relationship and work with your colleagues?)
- Has the way you or your team do your work or think about your work changed or developed over the past year or so?
- Can you give me an example of a change or development?

Job satisfaction

- What do you find satisfying about your work?
- What do you dislike or find difficult about your work?
- I'd like you to think about a patient you know well and work quite closely with. What are the challenges of working with him/her? What are the rewards of working with him/her?
- What would help you to do the best job you can?

Impact of Work and Safety Issues

- How does your work affect your everyday life?
- Can you tell me about any times you feel worked-up or upset at work?
- Can you tell me about any times you feel unsafe at work [physically and/or emotionally]

Supervision and support

- What helps you cope with your work?
- How does that help? / Can you say a bit about how those things help?
- [And at/outside work what helps you cope?]

Outside perceptions

- What do you think people outside the Clinic/PDU service think about what you do?
- Do you have any thoughts about the attitudes of the media or the government to the patients you work with?

Schedule for Patient Discussion Group

Introduction

Introduce selves, recap on purpose of research, procedures and ground rules for the group.

Questions

1. Brief check-in, starting with researchers and asking people to go around and say who they are for the recording and a couple of words about how they are.

2. What do you think it is like to work here?
   -Differentiation between different professions?
   -Answer based on experience or speculation?
   -Ask for examples of any interesting ideas.

3. Could you come up with a couple of words to tell me about how the staff and residents get on here?
   -Ask for examples to illustrate these

4. What are staff here to do?
   -Ask follow up questions to clarify answers (e.g. if the general word help is mentioned, ask 'what are they meant to be helping you to do?')

5. What are your thoughts about what staff need to do their job well?

6. Have you ever noticed staff seeming different to normal (positive or negative)?
   -If yes, what do you think this is about?
   -If no, how would you know if staff were not getting what they need to do the job?

7. Are there certain members of staff who seem to want to find out more about you than others?
   - If yes, what do you make of that?

These questions will form a general discussion which will last around 40 minutes. Arabella will then briefly follow up any areas which have not been covered.

Conclusion

Summary, thanks, debriefing, agree with participants to present results later this year.

An investigation into the training, support and supervision needs of forensic mental health staff

Transcribing guidelines

Verbatim transcription

The interview is transcribed verbatim, including indications of speaking difficulty and speaking errors on the part of both interviewer and participant. Every word spoken by both interviewer and participant must be transcribed exactly, as are stammers (*pri-, prison)*, indications of assent or dissent (*mmm-hm, prison*) and place-holders (*he came from erm, erm, prison*). Words spoken with emphasis should be underlined. The researcher will usually have to check the tape to determine whether a sound like *mmm-hm* indicated assent or dissent.

Non-speech sounds, e.g. laughing or crying, should be indicated, e.g.

> So it was a bit of a (laugh) nightmare really.

Names/identifying features

All names and places are first transcribed into the record as spoken. Following transcription of the complete interviewer, each name and place should be anonymised in the form Nurse 1, Nurse 2, Hospital 1, Hospital 2 etc. Where someone is mentioned by name and the researcher is familiar with his/her professional role, this should be put in, e.g. Ward Manager 1. At the end of the text, and on a separate page, a key should be typed, e.g.

> Nurse 1: Rosemary
> Ward 1: Turner Ward.

Distinguishing speakers

The interviewer's speech should be typed in capitals. Each major speaking turn by each speaker is assigned its own paragraph. There is no need to put 'I' for Interviewer or 'R' for respondent, as the different type distinguishes speakers.

Very brief remarks or sounds by the other speaker during a main speaking turn should be inserted in square brackets and in the appropriate lower or upper case type. E.g.

> CAN YOU TELL ME A BIT MORE ABOUT THAT?
>
> Mmm, well, it's quite hard, [MMM], I mean I know what some of these guys can be capable of. [MMM] I'm not saying I'm the best nurse that ever walked but er . having been in the coroner's court five times I think er .. I've got a bit of experience. [MMM. RIGHT]. But er

Interruptions

Where one speaker interrupts the other, this should be indicated with a forward slash for each speaker, e.g.

> SO WOULD YOU SAY THAT IT WAS/

/Yes, exactly.

Layout
Wide margins are needed on both sides (3.5cm)

Transcriber notes
Where the transcriber makes a note in the text, this should be in italics e.g. (*can't hear*).

Indistinct parts of the tape
If the transcriber cannot hear several words, the duration should be indicated, e.g. (*can't hear for 7 secs)*. If the transcriber is not sure which of two alternatives is correct, this can be indicated as follows:

I don't know if he (*would?should?*) do that.

Slips of the tongue and other speech errors and omissions
Any mis-speaking should be accurately transcribed. Dropped words should not be put in, and mis-spoken words should not be corrected.

If a speech error is particularly odd, the transcriber can step into the text with (*sic*) to indicate the words really were spoken as transcribed.

Punctuation
Commas and full stops need to reflect the actual rhythm of the speech. Sentences that do run on and on should not be 'artificially' punctuated to make them easier to read.

Pauses and interruptions
Suggested notation as follows:

(.) pause
(2) two second pause

This can be changed to (pause) in quotations to enhance readability.

Line numbering
Continuous line numbers should be inserted into the whole transcript from the beginning of the interview.