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WORKING WITH CLIENTS IN INPATIENT SERVICES

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Summary

Section A

Section A presents a systematic, narrative literature review of eleven papers relating to nursing experiences of working with people who have been given a diagnosis of personality disorder. Findings relating to nursing perspectives of people with this diagnosis and their experiences of building therapeutic relationships with them are discussed. Clinical implications include ensuring optimal support for nurses working with people who have complex needs in order to facilitate positive working relationships and client recovery. Additional research could investigate the factors that nurses find supportive.

Section B

Section B presents a grounded theory of how nurses develop professional boundaries in inpatient forensic settings. The theory is a phased, circular model that describes how nurses initially acclimatise to the setting, assess and address multiple boundary issues and then develop their learning via reflecting on practice, social learning, using supervision and gaining vocational experience. This learning contributes to personal and professional adjustments, which affect future management of boundary issues. These additional issues and experiences then provide further experiences for learning and further adjustments. The model is linked to learning theory and clinical and research implications are discussed.

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Section A: Nursing experiences of working with people who have a diagnosis
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Abstract

Personality disorder diagnoses have had a long and complex history marked by ambiguity, change and stigma. Nurses in particular may find it challenging to work with individuals diagnosed with personality disorder, especially in inpatient settings. Previous reviews have focused on specific subtypes, however the current review systematically searched PsycInfo, Medline, Wiley, Elsevier and British Nursing Index databases for studies relating to nursing experiences in inpatient settings with people who had been given any personality disorder diagnosis. This was in order to recognise all experiences that may come under this category and the comorbidity of personality disorder subtypes. The search terms [*nurs* AND (inpatient OR hospital OR ward) AND personality disorder*] were searched for in the titles, abstracts and key words of the databases. Eleven papers were elicited from this search process, including one of mixed design, two using thematic analysis and eight employing a quantitative design. The review, presented narratively, suggested that inpatient nurses may hold some negative perceptions of individuals with personality disorder diagnoses and experience difficult emotions in response to their interactions with them. However, they also may show more positive views of this client group if they had volunteered to work with them. Qualitative studies added rich descriptions of the difficulties nurses face in trying to build therapeutic relationships. This review highlights the importance of supporting nurses working with this client group in order to optimise working relationships and client recovery. Further research could explore factors nurses have suggested to be helpful in working with this client group, but which we currently know little about.

Keywords: personality disorder, nursing, inpatient, experiences, perspectives

Introduction

Personality disorder (PD)¹ diagnoses have had a long and controversial history. Individuals who receive this diagnosis represent some of the most vulnerable in society and typically have complex needs requiring intensive support. Often, psychiatric nurses form a significant part of this support and intervention can be challenging for both nurse and client. Research into working with people diagnosed with PDs as a nurse is therefore needed to ensure optimal working relationships and client recovery. While previous literature reviews in this area have focused on more common PD diagnoses, the current review aims to bring together what we know about nurses' experiences of working with people who have been diagnosed with any PD. A narrative review of the available literature will be followed by relevant research and clinical implications.

How is Personality Disorder Defined?

The *Diagnostic and Statistical Manual* (DSM-V; American Psychiatric Association, 2013) defines PD as the following:

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. (p.645)

Ten separate diagnoses are grouped into three clusters (Table 1), with each cluster reflecting different presentations. Similarly, the *International Classification of Diseases, Tenth Revision*

¹ The phrase 'personality disorder' will be used throughout this report for clarity, however the author acknowledges the controversy around this term, described later.

(ICD-10) refers to PDs as persistent, characteristic and clinically significant ways of interacting with self and others (World Health Organisation; WHO, 2016).

Table 1
The clustering of personality disorders according to the DSM-V (2013)

Personality Disorder Cluster	Presentation	Diagnoses
Cluster A	Odd, bizarre, eccentric	Paranoid Personality Disorder Schizoid Personality Disorder Schizotypal Personality Disorder
Cluster B	Dramatic, erratic	Antisocial Personality Disorder Borderline Personality Disorder (Emotionally Unstable Personality Disorder ^a) Histrionic Personality Disorder Narcissistic Personality Disorder
Cluster C	Anxious, fearful	Avoidant Personality Disorder Dependent Personality Disorder Obsessive-Compulsive Personality Disorder

^aAlthough not currently recognised by the DSM-V (2013), emotionally unstable personality disorder (EUPD) is an alternative term to borderline personality disorder that is considered by some to be a more sensitive and accurate description of an individual's experience. For this reason, EUPD will be the term used in this review.

Classification Controversy

Although PD diagnoses are widely used in the UK, their classification in diagnostic manuals has been controversial. The DSM-III (APA, 1980) was the first to categorise specific personality disorders under their own axis and the first to refer to borderline personality disorder (BPD). Although this version was considered an improvement on its predecessors (Widiger, Frances, Spitzer & Williams, 1988), the PD categories were widely criticised for overlapping and being diagnostically unreliable (Pfohl, Coryell & Zimmerman, 1986). The separate axis model continued across the DSM-IV (APA, 1994) and Bernstein et al. (2007) found that 80% of professionals surveyed were unhappy with the DSM-IV classification of PD due to the lack of structural and discriminant validity. Additionally, the separate classification of PDs in the DSM was thought to suggest that they are fundamentally different

to other mental health diagnoses and that individuals diagnosed with PD are perhaps more accountable for their actions and less deserving of support (Widiger & Shea, 1991). The association with ‘personality’ inferred that people diagnosed with PD have something inherently wrong with them that will persist, despite evidence suggesting that more than 50% of individuals will no longer meet diagnostic criteria after five years (Zanarini, Frankenburg, Hennen & Silk, 2003).

In response to criticisms the DSM-V (APA, 2013) eliminated the multi-axial system and the ICD-10 (WHO, 2016) began to consider PD category labels, changing BPD to Emotionally Unstable PD (EUPD). The ICD-11 proposed a dimensional construct of PD, with diagnoses reflecting the severity of difficulties rather than the type of problem (Tyrer, Reed & Crawford, 2015). This too has received disapproval from both service users and professionals who remained concerned about the term ‘personality’ and suggested that a dimensional construct will insensitively group together disorders linked to trauma and those related to perpetrators of such trauma (Watts, 2017). The debate continues currently, however despite controversial terminology, the distress experienced by people with these diagnoses is real and therefore research with this client group remains an important area of study.

What Do We Know About the Personality Disorder Diagnosis?

Prevalence.

Research suggests that individuals who receive a diagnosis of PD may comprise a noteworthy proportion of the population. The World Health Organisation (WHO) reported an international prevalence estimate of approximately 6% (Huang et al., 2009), while a UK study found a higher prevalence rate of around 10% (Coid, Yang, Tyrer, Roberts & Ullrich, 2006). Obsessive-compulsive PD has been reported to be the most common PD diagnosis in

the UK generally (Coid et al., 2006), whereas the National Institute for Clinical Health and Excellence (NICE) states that EUPD is the most prevalent subtype in non-forensic mental health settings (NICE, 2009b). High rates of EUPD and antisocial PD (ASPD) have been reported in inpatient settings particularly, with an estimated 19% of psychiatric inpatients meeting the criteria for EUPD alone (Piersma, 1987). Table 2 provides further description of these subtypes.

Table 2

The presentation of emotionally unstable personality disorder and antisocial personality disorder according to the DSM-V (2013)

Personality Disorder	Presentation
Emotionally unstable personality disorder	<p>A. Poorly developed or unstable self-image; instability in goals or values; compromised ability to empathise with others; intense and conflicted relationships.</p> <p>B. Emotional lability; separation insecurity; impulsivity and risk taking; antagonism</p>
Antisocial personality disorder	<p>A. Egocentrism; goal setting based personal gratification; lack of concern for others and remorse for harmful actions; exploitative relationships with others.</p> <p>B. Manipulative behaviour; deceitfulness; callousness; hostility; irresponsibility; impulsivity and risk taking.</p>

Cause.

A clear aetiology of PD has not yet been explained, however research indicates that genetics, early experiences and life stressors all play a role (Sampson, McCubbin & Tyrer, 2006). The literature has particularly focused on links to early trauma (Berenz et al., 2013),

alongside proposals that understanding these distressing experiences may be more meaningful than focusing on symptoms, for example the Power Threat Meaning Framework (Johnstone & Boyle, 2018).

Implications of being diagnosed with personality disorder.

Having a diagnosis of PD has been linked to frequent contact with health services and experiencing stigma. Bender et al. (2001) found that individuals diagnosed with PD had more extensive histories of inpatient and community care compared to people with major depressive disorder. Multiple studies have shown high comorbidity rates among PD subtypes and with other mental health diagnoses (Zanarini et al., 1998). People diagnosed with PD may also have concurrent physical health difficulties (Quirk et al., 2016; Gerlach, Loeber & Herpertz, 2016) and they show a substantially lower life expectancy than those without a PD diagnosis (Fok et al., 2012).

Research has suggested that people who have been diagnosed with PD attract stigma, possibly because difficulties often manifest during social interactions (Oltmanns, Friedman, Fiedler & Turkheimer, 2004; Aviram, Brodsky & Stanley, 2006). Individuals diagnosed with PD may experience pejorative, judgemental and rejecting attitudes from mental health professionals (Shedler & Weston, 2004; Lewis & Appleby, 1988) and experience a lack of empathy and understanding with regards to self-harm behaviour (Commons Treloar, 2008). Encountering discrimination from healthcare professionals has been linked to negative self-image and self-harm behaviour (Veysey, 2014), early termination of treatment and poorer clinical outcomes (Tull & Gratz, 2012).

Relevant Policy Guidance.

Considering the range of difficulties faced by people who have been diagnosed with PD, multiple guidance documents are available. In 2003, the National Institute for Mental Health for England (NIMHE; 2003) published *Personality Disorder: No Longer a Diagnosis of Exclusion*, which aimed to challenge beliefs that PD is not an NHS problem. The document set out a rationale for improving PD services in the UK and encouraged the development of specialist services. NICE guidelines (2009a; 2009b) emphasised the importance of accessible, consistent and positive interventions for people diagnosed with PD.

In addition, the British Psychological Society (BPS; 2006) discredited some of the myths around PD diagnoses and provided an alternative definition of PD as “variations or exaggerations of normal personality attributes” (p.4). Further guidance (BPS, 2015; 2017) considered potential limitations of diagnostic categorisations and suggested alternative terms to ‘personality disorder’ including ‘complex trauma reaction’ and ‘relationship or attachment difficulties’. While acknowledging the usefulness of such terms, the term ‘personality disorder’ (PD) will be used in this review for clarity, as this remains the main term used in published studies.

Working With People Diagnosed With Personality Disorder - the Theory.

Despite the above guidance, working with individuals diagnosed with PD has often been seen as challenging, emotionally demanding and threatening to health workers’ professional identities. Theories around why this might be are often described using a psychodynamic perspective, acknowledging the role of early attachments.

Attachment and emotion regulation.

Having a responsive, reliable and containing caregiver in childhood is thought to lead to a secure and coherent sense of self (Fonagy, 1999; Bion, 1962), however an insecure or unresolved attachment may form if a child's needs are not consistently fulfilled (Levy, Johnson, Clouthier, Scala & Temes, 2015). Bowlby (1973) suggested that early attachment styles help individuals to form internal working models of themselves and others, which help guide later, adult interactions. People with a diagnosis of PD may be more likely to have had neglectful or abusive early experiences that have led to insecure attachment styles, maladaptive internal working models of themselves and others and emotion dysregulation (Bowlby, 1973; Levy et al., 2015; Scott, Stepp & Pilkonis, 2014).

Hinshelwood (1999) suggests that people diagnosed with PD therefore interact within a context of extreme emotional distress, possibly as a result of not having experienced emotional containment in childhood. These emotional interactions, perhaps a subconscious attempt to defend against underlying anxiety (Bowins, 2010), can seem intolerable and intrusive to staff around them. Professionals may feel overwhelmed at the strength of both the client distress and their own emotional responses, for example fear, guilt or anger. Perhaps equally disconcerting is the frequency and speed at which emotions may change in individuals diagnosed with PD (Bland, Tudor & Whitehouse, 2007), causing staff members to have to contend with unpredictable responses that may also be perceived by staff as abusive towards them and their professional care (Hinshelwood, 1999).

A threat to professional identity.

Staff may experience the intense, emotional interactions of a person diagnosed with PD as a devaluation of their professional role and feel helpless, angry and exhausted. These

emotions push healthcare staff to defend themselves, by rejecting individuals or becoming hostile towards them (Hinshelwood, 1999). Placed in an 'abuser' role, in direct contrast to their professional identity as a 'caregiver', it may be harder to perceive their client as people in need of support. However, these responses potentially confirm the life experiences of people with PD, many of whom have had rejecting or hostile caregivers. Cremin, Lemmer and Davison (1995) viewed these interpersonal processes as projective identification, which refers to the unconscious projection of unwanted parts of an individual into those around them (Klein, 1946). In these situations, the client may distrust caring actions and project feelings of vulnerability and insecurity onto the professional. This may lead the professional to defend themselves from the intensity of these feelings, in a way that may feel similar to previous rejection or hostility experienced by the client in early attachment relationships. These re-enactments are thought to cause staff members to feel destabilised from their professional footing and both parties to feel violated (Hinshelwood, 1999).

The psychiatric inpatient setting and nursing.

Working with people diagnosed with PD might be particularly difficult in inpatient settings, where clients are typically experiencing significant difficulties. This might mean that emotional dysregulation experienced by clients may be especially intense and responses such as high distress or self-harm may be evident. In addition, the secure nature of an inpatient setting, where clients are often staying against their will, might exacerbate a client's interpretation of help as threatening or disempowering.

Nurses in inpatient services are traditionally responsible for providing a significant proportion of direct patient care and they have a diverse range of duties (Department of Health, 2002). The theory described above may therefore be particularly relevant to these

professionals, particularly as intense interactions make the establishment of trusting relationships challenging (Hinshelwood, 1999) and nursing staff rely on effective therapeutic relationships as the principal component of nursing care (Peplau, 1991). Melia, Moran and Mason (1999) considered that the switch from traditional ward nursing to primary nursing, whereby one nurse is assigned particular responsibility for named clients, has isolated individual nurse-client dyads and amplified the intensity of relationships. Consistency in the nursing team may be helpful, however this is also problematic due to splitting, where a person who has difficulties with emotion dysregulation may project good and bad aspects of themselves onto members of the nursing team (Neilson, 1991). This results in idealising some staff members and denigrating others. Individual nurse-client relationships are then seen by the wider team in terms of being either sentimental and possessive, or hostile and avoidant, leading to conflict.

Previous reviews of nursing in inpatient settings.

Previous reviews of nurses' experiences of working with people diagnosed with PD focused on EUPD only, due to the frequency of this diagnosis in inpatient settings. Westwood and Baker (2010) reviewed nurses' attitudes towards clients with a diagnosis of EUPD in acute inpatient settings. They found that nurses in this context appeared to distance themselves more from clients diagnosed with EUPD compared to other mental health diagnoses and, in some cases, displayed rejecting behaviours. Behaviours nurses associated with EUPD, such as aggression and manipulation, adversely influenced their attitudes, which appeared to negatively affect the care they offered. The review also found that having negative experiences with clients was linked to having less optimism for recovery and suggested a need for increased training and supervision.

Summary and Literature Review Rationale

Stigma and the difficulties faced by people diagnosed with PD have contributed to a view that these clients are potentially more difficult to work with, which may have in turn led to negative outcomes for these clients. Inpatient nurses often have more intimate and varied relationships with clients compared to other disciplines and therefore may face more challenges when working with this client group. As the number of inpatients with PD diagnoses continues to be significant (Bender et al., 2001), it would be useful to further examine inpatient nursing experiences of working with this client group. Although there have been previous reviews in similar areas (Eastwick & Grant, 2005; Filer, 2005; Bland et al., 2007; Westwood & Baker, 2010), these have focused exclusively on EUPD, despite the overlap and comorbidity amongst PD subtypes. The current review will systematically review nursing experiences in adult inpatient settings with any PD diagnosis in order to recognise all experiences that may come under this category. The following questions will be addressed:

- A. What are nursing attitudes and perceptions of adult clients diagnosed with PD in inpatient mental health settings?
- B. What do we know about the inpatient nurse-client working relationship where the adult client has been given a diagnosis of PD?

Method

PsycInfo, Medline, Wiley, Elsevier and British Nursing Index databases were searched in June and July 2017 alongside Google Scholar and the reference lists of relevant journal articles. A second search in December 2017 confirmed that results were still current

and alerts set up with the above databases found no additional, appropriate studies. The search terms [*nurs* AND (inpatient OR hospital OR ward) AND personality disorder*] were exploded to capture all narrower headings and were searched for in the titles, abstracts and key words of the above databases. The PRISMA flow diagram in Figure 1 (adapted from Moher, Liberati, Tetzlaff, Altman, The Prisma Group, 2009) displays the elimination process that led to the final eleven papers.

Inclusion Criteria

Studies were included if they had been published in peer reviewed journals from 2003 onwards. This date limit was chosen due to the publication of *Personality Disorder: No longer a diagnosis of exclusion* (NIMHE, 2003), which may have changed the culture and provision of inpatient services. Previous literature reviews on nursing experiences of clients diagnosed with EUPD exclusively were not included, as most were not transparent about their methodology and all included studies from before 2003.

Any study that specifically investigated the experience of nurses working in inpatient services with any type of PD was considered, in order to maintain a broad focus in a small area of literature. Studies referencing nurses working in therapeutic communities were included as these residential settings were considered comparable to inpatient units. Studies concerning other professionals, patients or non-residential settings were included only if the experiences of nurses working in inpatient settings with people diagnosed with PD could be explicitly distinguished from other professional groups or settings. One study recruited two participants who formerly worked in inpatients settings, however this was considered acceptable due to the emphasis placed by researchers on this prior experience during the study.

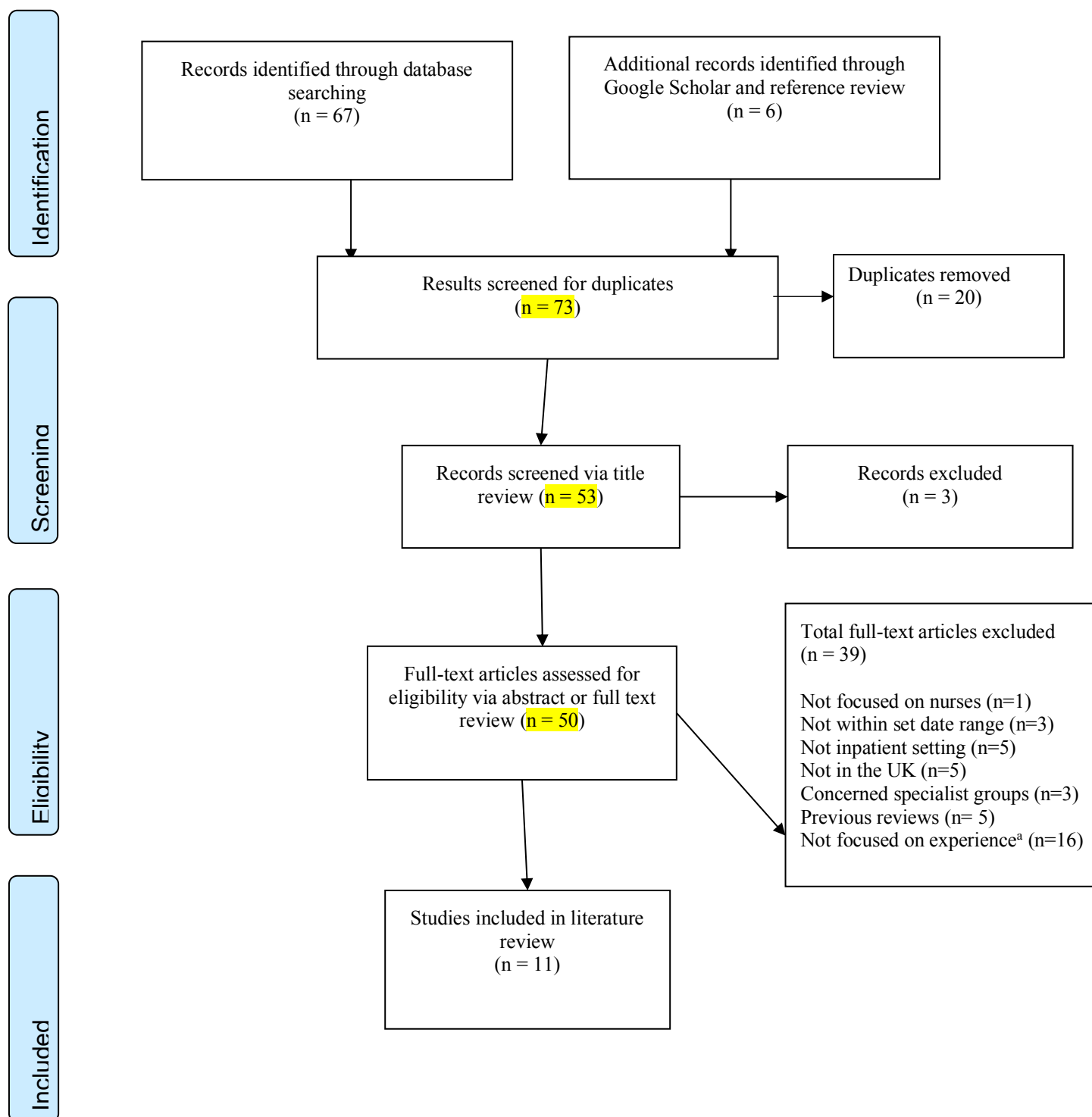


Figure 1: A PRISMA diagram depicting the screening process. ^aIn practice this mostly referred to studies appraising specific nursing interventions, treatments or approaches

Exclusion Criteria

As this review focused on the experience of NHS nurses, studies from countries outside of the UK were excluded, as were papers that were only indirectly or peripherally related to nursing experiences. Studies that focused exclusively on specialist client groups, such as young people or individuals with intellectual disabilities, were also excluded as these were considered to reflect potentially different nursing experiences.

Review Structure

The main findings of the review are presented narratively according to overarching themes across the literature that describe how nurses may perceive people with a diagnosis of PD and their experiences of building therapeutic relationships with this client group. This is followed by a brief explanation of methodological issues that multiple studies had in common. The review ends with a discussion around how the research findings fit with the wider literature and consideration of clinical and research implications.

Literature Review

Eleven papers were included in the final review. One of these studies used a mixed design with a Delphi study and thematic analysis (Aiyegbusi & Kelly, 2015), two studies used thematic analysis (Woollaston & Hixenbaugh, 2008; Jones & Wright, 2015) and the remaining eight studies employed a quantitative design. Table 3 presents a summary of each study and Table 4 presents the main methodological critiques of each study.

NURSING CLIENTS WITH PERSONALITY DISORDER

Table 3

Information on the aims, participants, methodology and key findings of each study

Study	Aim	Design and Methodology	Participants	Key Findings
Aiyegbusi and Kelly (2015)	To explore the lived experience of the nurse-patient relationship in specialist forensic and therapeutic community settings for people diagnosed with PD and the nursing staff who work with them.	Delphi Study with expert nurses informed topic guides for qualitative methods. Thematic analysis (with a psychoanalytic lens) of interviews with nurses and focus groups of patients with PD.	Delphi: n = 12 Interviews: n = 13 Focus group: n = 12	Main theme of pain reflecting the basic emotional brutality of experience in the nurse-patient relationship Nurses described being battered by an onslaught of emotional abuse and pain, experiencing verbal abuse which encouraged feelings of humiliation and anger, experiencing lasting effects of verbal abuse, receiving complaints or accusations, feeling worthless and useless in the face of self-harm and witnessing violence towards others.
Bowers and Allan (2006)	To explore the components of attitudes to PD as assessed by an attitude to PD scale. To ascertain test-retest reliability of this scale.	Principal components analysis Test-retest reliability coefficients Confirmatory factor analysis	PCA: n = 652 2:1 ratio of men to women Reliability: n = 23 CFA: n = 196	The scale was found to show five factors that allow the underlying structure of attitude to personality disorder to be seen: Enjoyment vs loathing, security vs vulnerability, acceptance vs rejection, purpose vs futility, exhaustion vs enthusiasm. There was good to excellent test-retest reliability for the APDQ as a whole and for each of the five factors. A hospital setting was associated with more positive scores on each on the five factors. Female gender was associated with more positive scores for enjoyment and a purposeful outlook. Higher nursing grade was associated with more positive enjoyment and acceptance scores.

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Carr-Walker, Bowers, Callaghan, Nijman and Paton (2004)	To investigate the effect of profession on attitudes towards people diagnosed with PD.	Between-groups self-report questionnaire Between-groups comparison of SAPDI: Qualitative components were analysed thematically and then quantified using chi-squared analyses of codes.	Nurses: n = 651 2:1 ratio of men to women Prison officers: n = 54 4:1 ratio of men to women	Prison officers, compared to nurses, indicated they felt more of a liking for and interest in people with PD. They felt less fear, hopelessness, anger, frustration and were more optimistic about treatment. However, these differences disappeared when voluntary/non-voluntary recruitment was controlled for. Nurses expressed more concern in the SAPDI about caring for and managing people with PD and felt more vulnerable and less accepting towards them.
Daffern, Duggan, Huband, and Thomas (2010)	To investigate the relationship between severity of PD and the interpersonal styles of nurses and patients as rated by each other.	Within (severity of PD) and between (rater) groups Self-report questionnaire	Nurses: unknown Patients: n = 50	There were no differences between nurses' ratings of patients with a severe PD and patients with a milder PD on any of the interpersonal domains. Patients with a more severe PD rated nurses more variably in dominance and submissive domains of interpersonal style, compared to patients with a milder PD. This trend was replicated using a second method of grouping participants into milder/severe groups.
<u>Forsyth (2007)</u>	To investigate the effects of diagnosis and reasons for patient non-compliance on nurses' anger reactions, empathy and helping behaviours.	Within-participants crossover design Self-report questionnaire	26 participants	Nurses were angrier when causes were perceived to be due to controllable factors. They were more helpful with those who had MDD and less helpful when the causes were perceived to be due to stable factors. Nurses were less helpful towards those with EUPD compared do those with MDD.

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<u>Jones and Wright (2015)</u>	To compare the perceptions of nursing students with experience in secure services to those who had not, with regards to their perceptions of building therapeutic relationships with patients with ASPD.	Thematic analysis Two focus groups One group of students who had experience in secure forensic settings One group of students who had not.	Experience group: 4 women Non-experience group: 6 women, 1 man	Main themes of diagnosis, safety, engagement and environmental influences. Both groups stated importance of seeing the person behind the diagnosis and the influence of other staff in their placements on their perceptions of people with ASPD Experience group talked about professional boundaries more, but did not appear to entirely understand what this meant.
<u>Markham (2003)</u>	To investigate the effects of the label EUPD on staff attitudes and perceptions	Within (diagnosis) and between (professional role) groups factorial design Self-report questionnaire	Nurses: n = 50 32 women, 13 men, 5 NDC HCAs: n = 21 15 women, 5 men, 1 NDC	Nurses expressed more social rejection towards patients with EUPD compared to depression or schizophrenia. Nurses rated people with EUPD as more dangerous than other diagnoses. Nurses were less optimistic about working with people with EUPD and rated their experiences of working with this client group as more negative compared to other diagnoses.
<u>Markham and Trower (2003)</u>	To investigate whether a label of EUPD affected nursing staff's perceptions of behaviour and the causes of negative behaviour.	Within-participants crossover design Self-report questionnaire	33 women, 12 men, 3 NDC	Nurses offered more negative responses to patients with EUPD than patients with schizophrenia or depression. They rated patients with EUPD as more in control of their behaviour and rated the causes of their negative behaviour as being more stable. Nursing staff reported less sympathy and optimism towards patients with EUPD compared to those with schizophrenia or depression. They rated their personal experiences of working with people with EUPD as more negative than their experiences with other patients.

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Mason, Caulfield, Hall and Melling (2010)	To investigate whether differences in the perception of PD could be found between and within two groups of professionals: nurses and non-nurses	Within (diagnosis) and between (profession) groups Self-report questionnaire	Nurses: n = 416 287 men, 129 women Non-nurses: n = 129 48 men, 81 women	Both professions perceived people with diagnoses of PD as more of a management issue than a clinical issue. Both professions perceived people with a diagnosis of MI as more of a clinical issue than a management issues. Nurses rated PD as significantly more of a management issue and less of a clinical issue than non-nurses.
Mason, Hall, Caulfield and Melling (2010)	To investigate the effect of diagnosis and work setting (high vs medium vs low secure) on the extent to which nurses view a patient as more of a management or clinical concern.	Within (diagnosis) and between (work setting) groups factorial design Self-report questionnaire	287 men, 129 women	Nurses in high secure settings mainly see patients with PD as requiring behavioural management rather than clinical care and treatment. This difference in management vs clinical was less marked in medium secure settings and even less marked in low secure settings (although still statistically significant). Patients with MI were predominantly seen as a clinical concern rather than a management issue.
<u>Woollaston and Hixenbaugh (2008)</u>	To explore inpatient nurses' perceptions of patients diagnosed with EUPD.	Thematic analysis Semi-structured interviews	2 women; 4 men	A core theme of 'destructive whirlwind': Perception of patients with EUPD as powerful, dangerous, unrelenting force that leaves a trail of destruction. Other major themes of care giving, idealising and demonising, patients with EUPD as manipulative and patients with EUPD as threatening.

Key: EUPD = emotionally unstable personality disorder; ASPD = antisocial personality disorder; NDC = non-disclosed by participants; HCA = Health Care Assistant; MDD = major depressive disorder; PD = personality disorder; PCA = principal components analysis; CFA = confirmatory factor analysis; APDQ = Attitudes to Personality Disorder Questionnaire; SAPDI = Staff Attitude to Personality Disorder Interview; **bold** = studies in forensic settings; underlined = studies investigating one type of PD.

The qualitative studies in this review were assessed using the Critical Appraisal Skills Programme Qualitative Checklist (CASP; 2018; Appendix A) and the quantitative studies were assessed using the checklist available in Kmet, Lee and Cook (2004; Appendix B). The mixed methods study was appraised using the CASP Qualitative Checklist as the qualitative component was the main element presented. Although critique is considered throughout, some common methodological issues across the studies are described in a separate section.

Attitudes and Perceptions

All of the papers except one (Daffern, Duggan, Huband & Thomas, 2010) considered attitudes nurses may have towards people who have been given a diagnosis of PD.

How do inpatient nurses perceive people with a diagnosis of PD?

Eight studies explored how nurses may perceive people diagnosed with PD (Bowers & Allen, 2006; Markham, 2003; Markham & Trower, 2003; Woollaston & Hixenbaugh, 2008; Jones & Wright, 2015; Forsyth, 2007; Carr-Walker, Bowers, Callaghan, Nijman & Paton, 2004).

The Attitude to Personality Disorder Questionnaire (APDQ; Bowers & Allan, 2006) was constructed due to the lack of a global measure of attitudes towards people diagnosed with PD. Bowers and Allan (2006) presented the results of a principal components analysis of this measure that suggested nursing attitudes towards people diagnosed with PD demonstrated an underlying structure of five factors. ‘Enjoyment vs loathing’ was thought to represent the extent to which nurses feel warmth for and interest in clients diagnosed with PD; ‘security vs vulnerability’ indicated fear, anxiety and helplessness; ‘acceptance vs

rejection' represented feelings of anger; 'purpose vs futility' focused on pessimism and the final factor was 'exhaustion vs enthusiasm'. This structure was confirmed by a factor analysis using a different sample and evidence was provided for good to excellent test-retest reliabilities for each factor.

The study also suggested that the environment nurses were working in and some demographic variables influenced attitudes measured by the APDQ. A forensic hospital setting, for example, was associated with more positive scores across all factors. Being on a specific, forensic unit for people with PD and being female were both associated with more positive scores on the enjoyment and purpose domains. A higher nursing grade was associated with more enjoyment and acceptance, while being young was associated with more enthusiasm.

Despite the above factors describing continuums with both a positive and negative aspect, other papers in this review tended to find more negative perceptions of people with a PD diagnosis than positive ones. Woollaston and Hixenbaugh (2008) used thematic analysis to explore six inpatient nurses' perceptions of people diagnosed with EUPD. Participants described these clients as being akin to a 'whirlwind' that is powerful, dangerous and unrelenting. They described experiencing people with EUPD as manipulative and dishonest and considered them to have an agenda behind their interactions with staff. They felt that people diagnosed with EUPD were threatening towards staff, other residents and themselves when their demands were not met. This emphasis on threat and risk echoed previous findings that nurses perceived people diagnosed with EUPD as more dangerous than clients with other psychiatric diagnoses (Markham, 2003).

Four nursing students in a study by Jones and Wright (2015) discussed similar perceptions they had heard about people diagnosed with ASPD while on placement in secure wards. These perceptions included viewing people with ASPD as ‘difficult’ or ‘manipulative’ and not wanting to work with them. The students felt that staff members’ negative preconceptions about ASPD were a key cultural influence on their own attitudes and were thoughtful about the impact of this on their relationships with clients. However, the voluntary nature of the sampling in this study may have meant that the sample was not reflective of the nursing student population as a whole. Non-participants, for example, may have been less interested in this client group and perhaps less thoughtful about staff perceptions and their impact. Additionally, all participants were female and it is therefore questionable how far these views extend to male nurses given that Bowers and Allan (2004) found female gender was associated with more positive attitudes. This group of students were reportedly positive and enthusiastic about forming working relationships with clients diagnosed with ASPD.

Other studies in this review suggested that inpatient nurses perceive people with PD more negatively compared to individuals with other mental health diagnoses. Markham and Trower (2003) and Forsyth (2007) both used vignettes concerning clients with EUPD to explore nursing attitudes experimentally. Markham and Trower’s (2003) vignettes described clients with a diagnosis of either EUPD, depression or schizophrenia displaying challenging behaviours, while in Forsyth (2007) the vignettes concerned individuals with an EUPD or depression diagnosis who had failed to complete a therapy task. Both studies found that nurses had more negative attitudes towards EUPD compared to the other diagnoses. Nurses rated individuals diagnosed with EUPD to be more in control of challenging behaviours (Markham & Trower, 2003) and rated themselves as angrier when causes of not completing the task were perceived to be controllable (Forsyth, 2007).

Nursing participants in Markham and Trower (2003) reported less sympathy and optimism towards people with EUPD compared to the other diagnoses and rated their experience of working with them as being more negative, replicating results from Markham (2003). However, the vignettes in this study described female clients and the sample was 69% female, therefore there are limitations on how far these results can be generalised outside of a female nurse-female client dyad.

Forsyth (2007) additionally found that nurses reported significantly fewer intended helping behaviours towards people diagnosed with EUPD compared to those with depression. As helping behaviours were found to be related to stability (i.e. whether the cause of the behaviour happened often or was a one-off), nurses were perhaps less likely to be helpful when challenging behaviours were perceived to be happening repeatedly. The vignettes in this study concerned clients of an unknown gender and so were perhaps less influenced by participant gender biases, however the study did not describe the gender demographics of the participants themselves. This could be important given that Bowers and Allan (2006) found that being a female nurse was associated with having more warmth towards and being more interested in people with PD.

Nursing views have also been compared with those of other professional groups. Carr-Walker et al. (2004) initially found that nurses were more fearful, angry and frustrated and less optimistic towards people diagnosed with PD compared to prison officers. However, when the factor of working voluntarily or not with people diagnosed with PD was investigated, all significant differences between professional groups disappeared. This indicated that volunteering for a role with people diagnosed with PD may be more influential

to more positive staff attitudes than professional role. Bowers and Allan (2006) supported the importance of voluntary recruitment with anecdotal statements that the most positive attitudes in their study came from settings which recruited voluntarily. In contrast to Bowers and Allan (2006), no significant gender differences in attitudes within or between the professional groups were found in Carr-Walker et al. (2004).

Results from the Staff Attitude to Personality Disorder Interview (SAPDI) in Carr-Walker et al. (2004) suggested that nurses were more likely than prison officers to see individuals diagnosed with PD as cognitively competent and able to control their actions. They also tended to place more emphasis than prison officers on rules and rigidity, staff consistency and the importance of listening to clients. Prison officers were more likely than nurses to feel confident in their ability and were less likely to feel vulnerable. However, the results of the SAPDI were not investigated according to whether or not staff members volunteered to work in services and therefore they may also be due to a difference between volunteers and non-volunteers. Additionally, the SAPDI appeared to be designed for this study and data on reliability and validity were unavailable.

What emotions are raised by nurses when working with people who have a diagnosis of personality disorder?

Two studies in this review (Woollaston & Hixenbaugh, 2008; Aiyegbusi & Kelly, 2015) provided an insight into the feelings and emotions that nurses might experience when working in inpatient settings with people diagnosed with PD. Nurses in Woollaston and Hixenbaugh (2008), for example, described feeling drained by individuals with a diagnosis of EUPD as they spent vast amounts of time and energy with some of these patients. They

described feeling helpless, disheartened and frustrated by the perceived slow pace of progress, as well as incapable and inadequate when people did not appear to be getting better. Conversely, participants felt pleased when individuals showed signs of progress and some felt motivated by the challenge of working with complex clients.

Participants in Woollaston and Hixenbaugh (2008) described feeling uncomfortable when individuals with a diagnosis of EUPD were perceived to be idealising them and feeling distressed when they felt demonised. Nurses felt used and devalued when they thought they were being manipulated by clients and were frightened by threatening behaviour. This behaviour was perceived to be controllable and participants resented feeling responsible for individuals' self-harm and suicide attempts, although they were also hugely distressed by them. Similarly, thirteen nurses in therapeutic communities, specialist PD inpatient services and women's secure services described feeling emotionally battered by frequent incidences of violence, self-harm and verbal abuse (Aiyegbusi & Kelly, 2015). These incidents reportedly left nurses feeling disturbed, overwhelmed, belittled, vulnerable and worthless.

Management vs clinical care.

Two studies with large sample sizes (Mason, Hall et al., 2010; Mason, Caulfield et al., 2010) used self-report questionnaires to investigate whether nurses working in inpatient settings perceived individuals with a PD diagnosis as more of a management issue (i.e. were viewed primarily as requiring behavioural management) or a clinical issue (i.e. requiring therapeutic treatment for ill-health). Mason, Hall, et al. (2010) found that in high secure settings, nurses perceived people diagnosed with PD as primarily a management issue rather than a clinical concern. This difference was less pronounced in medium secure settings and even less marked in low secure settings, although still statistically significant. Conversely,

people with other psychiatric diagnoses were perceived by nurses in low secure settings as being much more of a clinical concern than a management issue, although this difference was less pronounced in medium secure settings and not statistically significant in high secure settings. However, given that the sample contained a high frequency of more experienced nurses in high secure settings and a high frequency of less experienced nurses in low secure settings, it is possible that the results of this study reflect differences in nursing experience rather than setting. The suggestion that nurses across all security levels perceive individuals diagnosed with PD as more of a management issue would still stand in this case, however hypotheses about potential influences on these perceptions would differ.

Mason, Caulfield et al. (2010) used the same group of nurses to compare the findings above to a group of non-nurses. Both professional groups perceived people diagnosed with PD as more of a management than clinical issue and people with other mental health diagnoses to be more of a clinical than a management issue. However, nurses rated PD as significantly more of a management concern and less of a clinical issue than non-nurses. As some of the professions in the non-nursing group were overrepresented compared to others, the results of this study would be potentially more meaningful if potential similarities and differences within this group were studied.

In support of the above research, Carr-Walker et al. (2004) found that nurses were more likely than prison officers to emphasise aspects relating to management issues of people with a diagnosis of PD. In non-forensic inpatient settings, participants in Woollaston and Hixenbaugh (2008) described the management of devastation caused by people diagnosed with EUPD and referred to 'dealing with' these clients. However, a major theme of this study was about care-giving and all the participants reportedly perceived people diagnosed with

EUPD as having mental health difficulties. Additionally, Aiyegbusi and Kelly (2015) described how nurses working in either therapeutic communities or medium secure services extensively used psychodynamic-based interventions to try and work with the psychological distress of people with a PD diagnosis, suggesting that work setting cannot be the only factor influencing whether or not people diagnosed with PD are seen as predominantly requiring clinical care. The study highlights the roles of training and work culture, as all participants had received training in psychodynamic nursing practice and described working in settings where this was integral to the model of care.

The Therapeutic Relationship

In addition to considering nursing perceptions of people who have been diagnosed with PD, the studies in this review also suggested how nurses try to engage this client group and develop therapeutic relationships with them. Five studies contributed to this (Woollaston & Hixenbaugh, 2008; Jones & Wright, 2015; Aiyegbusi & Kelly, 2015; Markham, 2003; Daffern et al., 2010).

Engagement.

Two groups of student nurses in Jones and Wright (2015), with and without experience in inpatient forensic services, felt that it was difficult and would take time to engage people with an ASPD diagnosis and identified trust as an important factor. Both groups remained positive and enthusiastic about engagement and discussed the importance of approach, with the group with experience in forensic inpatient settings mentioning being wary of talking to clients in this group. They also spoke more about the importance of professional boundaries (although did not appear to know what this meant), in contrast to the group without experience who highlighted shared activity. Both groups talked about people

diagnosed with ASPD avoiding staff and mentioned themselves avoiding clients who they found difficult to engage.

Developing therapeutic relationships.

Studies in this review acknowledged the importance of developing a working alliance after initial engagement. Participants in Woollaston and Hixenbaugh (2008) described some of the processes in their interpersonal relationships with individuals with EUPD, including idealisation, demonization, team splitting and nursing attempts to protect themselves from being manipulated. Nurses referred to being idealised by clients with a diagnosis of EUPD, and then demonised when they did not live up to the client's expectations. They referred to clients causing splits in the staff team by the process of idealising some staff and demonising others, which led to two camps being formed of those who liked the client and those who disliked them. Nurses in the first camp would be perceived by the other as being over-involved, whereas the second camp would be branded as harsh and uncaring. This suggested a polarised, either/or view of both nurse-patient and nurse-nurse relationships, which was somewhat supported by Daffern et al. (2010).

This study found that people with a supposed 'severe' PD rated nurses' interpersonal styles more variably than people with 'milder' PD on dominant and submissive domains. This may reflect ideas that people with a PD diagnosis use extremes in their judgements of others, for example idealisation or demonization. However, unexpectedly, the study found no differences in how variably the nursing group rated people diagnosed with severe or mild PD, suggesting that nurses did not respond to clients' extreme judgements in an equally polarised way. The study therefore contrasted with the idea of team splitting, where nurses' ratings of clients would presumably be more varied, with some liking certain clients and disliking

others. However, the study used nurse and patient ratings of each other just two weeks after they first met, and it is feasible that it might take longer than this for differences in nursing perceptions of people to appear.

Participants in some of the studies suggested that they sometimes avoided or distanced themselves from clients diagnosed with PD in response to difficult interpersonal processes or threatening behaviours (Woollaston & Hixenbaugh, 2008; Jones & Wright). Nurses in Aiyegbusi and Kelly (2015) suggested that avoiding this client group was perhaps easier than trying to understand and work with intense interactions. These qualitative studies provided ecologically valid support for the suggestion that nurses may be more socially rejecting towards people with EUPD compared to other diagnoses (Markham, 2003) and gave an insight into why nurses may use rejecting responses instead of those which may be more emotionally demanding.

Nurses in Woollaston and Hixenbaugh (2008) also described difficulties in trying to build relationships when they felt clients were being dishonest or manipulative. They highlighted the importance of self-awareness and described a culture of documenting interactions with people diagnosed with EUPD in case something was used against them. Nurses emphasised the importance of personal boundaries in these circumstances and maintaining those boundaries when interacting with clients. Some of the nurses in Aiyegbusi and Kelly (2015) also referred to the importance of self-awareness and personal boundaries as they tried to manage interpersonal relationships. They described trying to understand client projections of pain and contain their distress, although they acknowledged that this was difficult.

Nurses in Aiyegbusi and Kelly (2015) considered the emotional “onslaught” (p.284) they received from patients diagnosed with PD as central to the nurse-patient relationship and considered the attachment functions of such interpersonal processes. They understood that clients’ responses were shaped by their early experiences with caregivers and therefore clients could view nurses as not wanting to provide care or being unable to do so, if that is how early caregivers had also been perceived. They understood client actions as complex attempts to elicit care and considered the unhelpful impact of re-enacting traumatic attachment experiences, offending experiences or both. Again, nurses cited self-awareness and the importance of maintaining personal boundaries as being key. They felt they needed significant support, training, resilience, supervision and a reflective space in order to form secure, therapeutic relationships that did not cause them to lose professional footing and adopt anti-therapeutic positions.

Quality Appraisal

When evaluating the findings of the literature review, it is important to consider critique of the studies included alongside the findings above and in Table 4, as well as some common methodological issues across the studies described below. All the studies were considered to have used appropriate designs to explore clearly stated aims. Conclusions largely followed from results and were mindful of study limitations.

NURSING CLIENTS WITH PERSONALITY DISORDER

Table 4

The main methodological critiques of each study

Study	Sample	Design/Methods	Data collection	Results	Transparency
Aiyegbusi and Kelly (2015)	Good sample size achieved. No participant demographics were recorded. Unclear how many participants came from each setting.	Appropriate mixed design, however neither methods nor data from the Delphi study were offered. Lack of credibility checks.	Sampling guided by theoretical saturation. Themes enriched via the use of interviews with staff and focus groups with patients.	Only one main theme was presented. Plenty of quotes from a range of participants helped to show how themes were elicited from the raw data.	Researcher owned their psychoanalytic approach to analysis. Very brief explanation of data analysis processes.
Bowers and Allan (2006)	Large sample sizes, particularly for PCA. Younger staff underrepresented in PCA sample.	Compared demographics of participants to invitees in order to control for potentially confounding variables.	Anonymised return of questionnaires via mail reduced social desirability bias in PCA.	Comprehensive descriptions of data analysis processes. Full details of regression equations, reliability coefficients and factor analysis were available, including factor item loadings and APDQ normative values.	Authors acknowledged the context of the study and the influence that might have had on results, e.g. the hospital with the most negative staff had recently undergone a public enquiry into care.
Carr-Walker, Bowers, Callaghan, Nijman and Paton (2004)	Much smaller prison officer sample compared to nurses, however this was similar in terms of demographics. Female staff were underrepresented in both samples.	Reasons provided for prison officer non-participation. Recruitment procedure as a potentially confounding variable was controlled for in the analyses.	APDQ has good, established psychometric properties. SAPDI appeared to be designed for the study and reliability/validity data was not available.	The effects of gender were investigated statistically and presented. Clear, thorough results section.	A brief description of the qualitative aspect of the SAPDI analysis was presented. The interview questions were not included in the paper.

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Daffern, Duggan, Huband, and Thomas (2010)	No demographic variables presented for the nursing sample. Small sample of patients indicates small scale of study. No power calculations given non-significant results reported.	Nurses acted as their own controls in a within-participants design.	Two methods for classifying severity of PD increased validity of results. Data from completed questionnaires was compared to data from incomplete questionnaires.	Poor results section with inadequately labelled tables and contrasting results in text and tables. Used an alpha value of $p < 0.10$, increasing the likelihood of type I error.	Unclear how many different nurses participated. Authors did not state which statistical tests were used and did not include self-report measures. Failed to comment on some significant findings in discussion section.
Forsyth (2007)	Sample size did not meet power calculation requirements, which may mean significant findings are conservative. Neglected to report gender of participants.	Questionnaire items and vignettes were randomised, however there was little information on how. Participants were able to do the survey vignettes in their own time and may have compared ratings, potentially biasing the sample.	Power was increased by using 5 scales for each measure of anger, empathy and helping. However, the empathy scale was modified, therefore validity is potentially reduced. Social desirability bias may have limited the number of significant findings.	Graphs may have emphasised trends suggested by the researcher rather than clarified the statistically significant findings.	Pilot study results apparently showed the added scales have validity but evidence for this was excluded from the study.
Jones and Wright (2015)	Small size of focus groups, although all second-year students were invited. Clearly reported strategy. Sample situated with some demographic details.	Appropriate qualitative design. Lack of credibility checks.	Lack of theoretical sampling or saturation. Lack of explicit reasoning for use of focus groups over individual interviews. Interview schedule pilot tested and available.	Multiple quotes by a range of participants from both focus groups. Sometimes quotes did not appear to connect with the reported themes.	Researcher reported keeping a reflexivity log and meeting regularly with supervisors to review their response to the work.
Markham (2003)	Smaller sample size. Recruitment strategy unclear. No details about non-participants.	Counterbalanced design controlled for order effects. Data was collected on potentially confounding demographic variables.	The social distance scale showed good reliability, however referred to social situations and was therefore not so ecologically valid. Self-report scales were vulnerable to social desirability bias.	Clear results section. Graphs clarifies main findings. Results may be conservative given desirable answers would be high across all diagnoses.	Clear, detailed report of self-report measures, data analysis process and statistical tests used. Inclusion of social distance scale only.

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Markham and Trower (2003)	Fairly small sample size. Only brief description of demographic variables.	Counterbalanced design controlled for order effects. All of the vignettes concerned female patients to control for gender confounding variable.	Used an attribution measure recommended in a study of attribution methodology validity. Anonymised return of questionnaires via mail reduced social desirability bias.	Results may be conservative given desirable answers would be higher across all diagnoses. Lack of power calculations given some non-significant results.	Inclusion of self-report scales would enhance transparency. However, there was a full and clear description of analysis procedure and results.
Mason, Caulfield, Hall and Melling (2010)	Fairly large nursing sample size, although non-nursing group was a lot smaller. Contrasting ratios of men and women between the two groups.	No explanation of counterbalancing of questionnaire items to improve control of confounding variables. The variable of nursing gender was not controlled for.	Self-report measures used with no psychometric properties available for reliability or validity.	Good range of other professions (n= 129) represented but as these are grouped together in the results, potential differences in subgroups are unable to be examined.	Questionnaire validity and reliability calculations were not reported and the scale itself was not included.
Mason, Hall, Caulfield and Melling (2010)	Large sample size. Detailed description of demographic variables. Overrepresentation of more experienced nurses in high secure settings and less experienced nurses in low secure settings.	Lack of counterbalancing of scales to improve control of confounding variables.	Self-report measures used with no psychometric properties available for reliability or validity.	Could the results be showing the differences between nursing experience rather than setting?	Questionnaire validity and reliability calculations were not reported and the scale itself was not included.
Woollaston and Hixenbaugh (2008)	Small sample size. Recruitment strategy not reported. Sample situated with demographic details.	Appropriate qualitative design. Lack of any credibility checks.	Lack of theoretical sampling or saturation. Fairly detailed description of interview schedule and transcript analysis.	Detailed write up of themes using multiple quotes. No labelling of quotes by participant.	No consideration of how data collection and analysis may be impacted by participants being known to the researcher.

NURSING CLIENTS WITH PERSONALITY DISORDER

Key: PCA = principal components analysis; PD = personality disorder. Studies in **bold** were analysed using the CASP (2018) Qualitative Checklist while the remaining studies were analysed using the Quantitative Checklist provided by Kmet, Lee and Cook (2004)

Participants and Recruitment

All of the studies reported recruitment procedures with the exception of Woollaston and Hixenbaugh (2008). It is unknown how many participants were originally invited, whether any declined and for what reasons, therefore no details were available about sub-groups of inpatient nurses who may not have contributed to the study's findings. Only one study in the review (Carr-Walker et al. 2004) gave reasons for invitee non-participation. Bowers and Allan (2006) was the sole study to compare the demographics of their participants to invitees who did not take part, thereby reducing the likelihood that the sample underrepresented an important demographic characteristic of the population. Some papers neglected to give full demographic descriptions of their participants, such as Forsyth (2007), who neglected to provide information on gender and Daffern et al. (2010) and Aiyegbusi and Kelly (2015), who did not provide any demographic details for their nursing participants.

Sample sizes were fairly small in two of the quantitative studies (Markham & Trower, 2003; Daffern et al., 2010), which meant conclusions were limited in terms of their validity and reliability. Both Daffern et al. (2010) and Forsyth (2007) expected to find differences that were not in fact statistically significant and it could be that additional participants might have increased the power of the study and added to results. Forsyth (2007) had a sample size that was less than half of the required target set by power calculations.

Only one qualitative study (Aiyegbusi & Kelly, 2015) reported theoretical saturation. While there is a debate about whether theoretical saturation should be routinely applied to *all* qualitative studies (O'Reilly & Parker, 2012), it would have been particularly useful to increase confidence in the richness of Woollaston and Hixenbaugh's (2008) themes, given the small sample size in this study. Similarly, it would also have been useful to enrich

understanding of the key themes in Jones and Wright (2015), as themes in this study did not appear very full or, in parts, very cohesive. Guidance around both the frequency of focus groups and the number of participants in each is scarce (Carlsen & Glenton, 2011), however as both can impact on the quantity and depth of information obtained (Sandelowski, 1995), the findings from this study may have been enhanced by the process of theoretical saturation.

Data Collection and Analysis

As the included studies took place in variety of settings it is probable that the clients participants were working with represented a wide variety of individuals with assorted diagnoses made using different classification systems. Any conclusions from this review therefore reflect both the variety and ambiguity of PD diagnoses and cannot be specific about particular groups. One study that had clients diagnosed with PD participating alongside nurses (Daffern et al., 2010) used criteria from the DSM-III (APA, 1980) and DSM-IV (APA, 1994) to confirm diagnoses and provided information on subtypes and comorbidities in the sample.

Many of the studies in the review used self-report measures, which rely on respondents' honesty, openness and self-awareness. Using these measures exposed the studies to social desirability bias, however considering that in most cases the desired response is likely to be a positive score, findings of negative attitudes self-reported by inpatient nurses may be underestimated in this review. Inclusion of questionnaires would have increased research transparency in a number of the papers, particularly where researchers modified established measures or designed their own (e.g. Forsyth, 2007; Carr-Walker et al., 2004; Mason, Hall et al., 2010).

Some studies did not provide adequate details of data analysis methods, while others neglected to provide evidence of a rigorous analysis process. Daffern et al. (2010) neglected to state which statistical tests were used and presented conflicting information across tables and paragraphs. This study used a value of $p < 0.10$ when determining significance, whereas values of $p < 0.05$ are more stringent and conventionally used (Marco & Larkin, 2000). The qualitative studies in the review showed few attempts to enhance confidence in their findings by using methods such as triangulation or member checking. Some of the quantitative studies did not examine the impact of gender, despite others (Bowers & Allen, 2006) suggesting gender differences in perceptions.

Researcher Reflexivity

The researchers in the qualitative studies did not pay as much attention as they could have to the impacts of researcher influence during recruitment, data collection and data analysis, especially as the researcher in Woollaston and Hixenbaugh (2008) had previously worked with participants in the study. The authors considered that this pre-existing relationship may have influenced participants' ability to speak candidly, yet they did not consider the potential influence these shared experiences of working with people with EUPD might have had on the way the researcher understood the participants and analysed their comments. The lack of clear and critical examination of the researchers' roles, prejudices and drives limited the ability to conclude that the findings from the qualitative studies in this review fully reflected the perspectives of the participants.

Discussion

This review aimed to explore inpatient nurses' experiences with individuals who have been diagnosed with PD. The current literature suggests that inpatient nurses may hold negative perceptions of this client group, although they may also show more positive views if they had volunteered to work with them. Mixed results were found for the impact of gender with some studies suggesting that being female was related to more positive views and other studies finding no gender differences. Research also suggested that nurses experience difficult emotions in response to their interactions with this group and are perhaps more likely to perceive people diagnosed with PD as more of a management than clinical concern. Little evidence was found for the idea that nurses rated people with PD diagnoses more negatively than other professional groups. Qualitative perspectives provided some experiences of forming working relationships with clients and how nurses tried to manage relationship difficulties.

What Does This Review Offer?

All the studies in this review were considered to be of adequate quality to be included and for their findings to be synthesised with each other. As described in the critical appraisal, there were opportunities for some of the studies to have been even more stringent in their methodology and transparent in their reporting, however generally researchers were thoughtful about how to improve the trustworthiness of results. Studies showed the use of appropriate quality assurance methods, such as the consideration of confounding variables in quantitative designs and good use of quotes in qualitative designs, to enhance confidence in the validity and reliability of the above findings. However, the frequent use of self-report

measures may mean some of the results underestimate attitudes and perceptions of clients with diagnoses of PD.

The review covered a range of PD diagnosis types and both forensic and non-forensic inpatient settings. Five of the eleven studies (mostly in non-forensic settings) explicitly focused on one type of PD from cluster B, with four of these concentrating on EUPD (Forsyth, 2007; Markham, 2003; Markham & Trower, 2003; Woollaston & Hixenbaugh, 2008) and one on ASPD (Jones & Wright, 2015). The remaining six studies (mostly in forensic settings) either did not focus on any specific type of PD (Aiyegbusi & Kelly, 2015; Bowers & Allen, 2006; Carr-Walker et al., 2004; Mason, Caulfield et al., 2010; Mason, Hall et al., 2010) or covered multiple types (Daffern et al., 2010). The latter study covered a range of PD subtypes from all three clusters, however cluster B diagnoses represented over 60% of the total PD diagnoses given to the participating clients. Due to these study differences, it is important to take care before generalising findings inappropriately amongst specific PD subtypes or to PD diagnoses more widely.

Taking this into account, the review found some support for negative attitudes towards clients with both specific, cluster B diagnoses and a general PD label. There was also some evidence that clients with EUPD diagnoses were rated more negatively by nurses than clients with MDD diagnoses and that clients with non-specific PD labels were rated more negatively by staff who did not volunteer to work with them, compared to staff who volunteered to work in PD services. Nurses described similar emotional responses and relationship-building difficulties when working with people who had specific cluster B diagnoses and a more general PD label. There was evidence that nurses perceived people with general PD diagnoses as more of a management issue than a clinical concern, particularly in high security settings.

A strength of this review was that it provided rich and ecologically valid examples from qualitative studies of how nurses work with people diagnosed with PD. The review described the ways in which nurses' perhaps distance themselves from individuals via avoidance or rejection in difficult situations, however also detailed how nurses attempt to contain the intense emotions of clients and recognise their attachment functions (Aiyegbusi & Kelly, 2015). The benefits of psychodynamic training and approaches, reflective spaces and professional boundaries were described, lending support to theory around working with complex clients described below. The current review also suggested that negative perceptions could contribute to a stigmatising culture on wards that might affect the views of nursing students (Jones & Wright, 2015).

Who Is Considered in This Review?

Broad similarities were found across forensic services, specialist PD services, therapeutic communities and acute inpatient services in this review. Studies that focused on any PD or one specific sub-type were also often comparable. It is therefore unclear from this review whether inpatient nurses experience all clients with PD in a similar way or whether there are differences between subtypes that may have been disguised by larger samples of people with EUPD or ASPD in study samples, or by the particular stigma of these subgroups that might mean they dominate nurses' thoughts. Further research focusing on non-cluster B subtypes may shed more light on how similarly, or not, staff experience different presentations of PD. Additionally, ethnicity of participants was largely ignored across studies in the review, which is surprising given that constructs of personality and how people relate to one another are highly influenced by cultural and societal norms (Ascoli et al., 2011).

Relationship to Previous Research

The current review shows some similarities to previous research. The review found that inpatient nurses may perceive people with a PD diagnosis as predominantly requiring behavioural management and having more control over challenging behaviour than other clients. These findings support previous research indicating that people diagnosed with PD are viewed as fundamentally different to people with other mental health diagnoses and are seen as more accountable for their actions (Widiger & Shea, 1991). Additionally, the review found that nurses may use similar distancing behaviours in the face of aggression and manipulation as described by Westwood and Baker (2010). Both reviews suggested a positive impact of training and supervision.

Relationship to Theory

Qualitative studies in the current review reflected theory around projective identification (Cremin et al., 1995), splitting (Neilson, 1991), emotional dysregulation (Levy et al., 2015) and nurses feeling that their professional role was being threatened (Hinshelwood, 1999). Nurses from Aiyegbusi and Kelly (2015) described feeling helpless, angry and exhausted in the face of client projections of emotional pain and discussed examples of clients being unable to contain and regulate their emotional responses. This sometimes prompted rejection and hostility that caused nurses to feel devalued in their role. Participants from Woollaston and Hixenbaugh (2008) discussed experiences of when nurse-client relationships were perceived as either over-involved or hostile by colleagues which appeared to reflect splitting within the team (Nielson, 1991). However, results from Daffern et al. (2010) suggested that although people diagnosed with PD may have polarised views of nurses in some domains, the nursing team did not perhaps respond with equally polarised views of clients that could potentially split teams.

Clinical Implications

The current review suggests that inpatient nurses may have some negative perceptions about people with a diagnosis of PD. It would therefore be useful for individual clinicians to acknowledge and question perceptions and the impact they could have on client care. Policy guidelines around working with people who have a diagnosis of PD (NICE 2009a; NICE 2009b; BPS, 2006; NIHME, 2003) recognise the importance of training and supervision, however it might be that this support is not enough given the intensity of the role, or is being overlooked in overstretched services. Prioritising appropriate training, regular supervision and reflective spaces might be effective in helping nurses to discuss the difficult interactions and emotions raised. It is unclear whether particular approaches might be more effective for different contexts or individuals, however the benefits of psychodynamic training have been suggested. Clinical psychologists could be particularly suited to providing forums that normalise and reflect on inherent difficulties in working with complex clients in a secure environment. They could also facilitate sessions where nurses could consider the impact of clients' early experiences and attachment styles on their current interpersonal difficulties.

A systemic awareness of the difficulties related to working with this client group could consider the potential impact of pejorative statements on both the culture of a team and student nurses coming into the profession. Services might consider placing nurses who would volunteer to work with people diagnosed with PD in positions where contact with this client group would be most likely or intensive, although this may also reinforce distancing behaviour in others. Opportunities for nurses to have positive experiences with people diagnosed with PD that may challenge existing assumptions and help prevent burnout could therefore be explored.

Research Implications

A benefit of this review was increased inclusion of qualitative studies, which strengthened and enriched quantitative findings. Further qualitative work could therefore increase our understanding of what it is like to work with this client group and build therapeutic relationships, particularly if the trustworthiness of these studies is heightened via the use of measures such as triangulation to improve credibility. Longitudinal studies of nursing experiences would increase our understanding of how attitudes grow, change and develop over time or across contexts.

Research with a solution-focused approach may help reduce the stigma of this client group on the academic stage, particularly research which adds to the evidence for helpful processes. Training, supervision, reflective spaces, self-awareness and professional boundaries have all been tentatively suggested to be helpful by this review, however further research could provide more evidence towards the exact mechanisms in these processes that are useful. Professional boundaries, for example, have been suggested in this review both as helpful and not well understood by nursing students. Research investigating nurses' understanding and development of professional boundaries may therefore be enlightening. Given the current lack of NHS resources, it would appear important to investigate the most effective support for nurses working with people who are diagnosed with PD, taking into account increased pressure on inpatient services.

Conclusion: an opportunity for change?

The findings of this review and their similarities with the wider literature suggest that despite efforts to address the stigma of PD and the care individuals with this diagnosis receive from the NHS, nurses who work with this population still find it difficult to build therapeutic working relationships with this client group and perhaps hold negative perceptions about them. It is also worth noting that a focus on the difficulties and negative aspects of working with this client group in the literature may in itself contribute to the stigma surrounding people diagnosed with PD, although the desire to understand these difficulties is both reasonable and useful. However, the current review also provided evidence for more positive attitudes, staff enthusiasm and processes that help nurses with the difficult elements of working with this client group. Future clinical and research aims might find it useful to increase our academic and vocational understanding of what can help nurses to enjoy positive, therapeutic work with this vulnerable population.

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Section B: “We deal here with grey”: A grounded theory of professional
boundary development in forensic services

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Abstract

The question of how to maintain appropriate professional boundaries with clients can be complex and further difficulties can arise for forensic inpatient nursing and healthcare workers. The literature in this area focuses mainly on boundary violations and there is little research on how staff members develop and maintain boundaries on forensic wards, despite this being beneficial for staff experience and client recovery. Interviews with eleven psychiatric nurses and healthcare workers were analysed using a grounded theory methodology, which led to the formation of a cyclical model of boundary development. Staff initially acclimatize to the forensic environment using their existing experiences and personal values and then enter a phase of calibration, where they constantly assess and address professional boundary issues in the course of their daily responsibilities. Staff members use this experience alongside reflection, social learning and supervision to undergo individual learning that parallels team development. In a fourth phase, staff members use this learning to recalibrate their views on boundaries, themselves and how they work with clients. This recalibration impacts on staff members' further management of daily boundaries, which provides more material for learning, which leads to further recalibration. This study emphasises the consideration staff have for boundaries and echoes previous literature suggesting the importance of supervision and reflective spaces. The model is comparable to existing learning theory and highlights the importance of social and experiential learning. There are implications for training, team building, supervision and reflective spaces. Further research could explore cultural aspects of boundary development.

Keywords: nurse, healthcare worker, professional boundaries, development, forensic, inpatient

Introduction

Professional boundaries involve the “edge of appropriate professional behaviour” (Aravind, Krishnaram & Thasneem, 2012, p.21), where violation of these boundaries indicates a breach of trust. Although they represent a core component of working relationships, professional boundaries are often vaguely defined (Peternelj-Taylor, 2002) and require a large degree of subjectivity to manage, taking into account profession, service context and client group (Beauchamp, 1999). Safe boundaries can facilitate a secure space that protects both parties and the therapeutic alliance, while boundary violations can cause harm to either party, their relationship and the service. The distinction between safe and unsafe, however, is subjective and insidious boundary crossings confuse the matter further (Peternelj-Taylor, 1998; Gutheil & Gabbard, 1993). These brief, minor transgressions from classic therapeutic processes can support a client’s needs, yet can easily slip into violations if there is no return to the established relationship.

Different professionals experience different perspectives and challenges in professional boundaries. Psychiatrists, for example, may view and manage boundaries differently in the context of a more parental model of healthcare (Veatch, 1972) compared to psychotherapists, whose approaches are often shaped by the orientation of their training (Bridges, 1999). Psychiatric nurses and healthcare workers traditionally have the most varied and intimate roles in healthcare (Remshardt, 2012) that may encompass physical interventions, psychosocial education, role modelling and advocacy (Bernal, 1992). They therefore often encounter situations where boundaries are tested, by both the requirements of their role and the behaviours of their clients (Peternelj-Taylor, 2002).

Nurses and healthcare workers additionally tend to spend much more time with clients than other professionals and the concentrated nature of this working relationship may cause both clients and professionals to experience confusion about where the relationship begins and ends (Peternelj-Taylor, 2002; Peternelj-Taylor & Yonge, 2003). Nurses may experience a “seductive pull” towards helping a client (Peternelj-Taylor & Yonge, 2003; p55) or experience problematic emotional responses to powerful client emotions. The staff member’s own vulnerabilities may therefore also contribute to violations if they are not acknowledged and understood (Valente, 2017), for example a personal characteristic or previous experience may lead to over- or under-involvement in an individual’s care.

The maintenance of safe boundaries may be particularly challenging in forensic services due to the nature of the work, the client group and the secure environment. Forensic mental health services in the UK include high, medium and low security hospitals, alongside some prison or community-based services. Forensic hospitals commonly provide treatment for people with mental health diagnoses who pose a level of threat to the community. Clients will often have had contact with the criminal justice system and may have a history of offences such as violence, sexual assault and fire-setting. Often, clients will have been involuntarily admitted to these services under certain sections of the Mental Health Act (2007) due to the necessity for treatment in a secure location. This restricted space, in addition to being the nurse’s working environment, is also the client’s home for the time they are there (Kelly & Wadey, 2012). Nursing and healthcare workers in forensic services therefore face additional challenges as they manage the threat of risk, their own emotional reactions to client index offences and the lack of opportunities for contained, allotted time with clients (Kelly & Wadey, 2012).

The majority of forensic clients will have already shown their potential to misunderstand or ignore societal and legal boundaries via their offending behaviour. Many will have had difficult early experiences that limited their exposure to and understanding of appropriate relationships (Coid, 1992). This could include experiencing abuse or neglect by their primary caregivers, leading to problematic attachment styles and defences that may influence later relationships with staff (Adshead, 2012). Clients with neglectful or hostile early experiences may have disrupted attachment styles that lead them to use psychic defences against further threat or rejection. These could include manipulation, aggression, projecting intolerable emotions onto others and idealising or demonising staff resulting in team splitting (Aiyegbusi, 2009). Nursing and healthcare workers are required to manage the distress of these coping strategies, alongside enforcing security procedures and contributing to clients' risk assessments, which may affect a client's discharge (Kelly & Wadey, 2012; Peternelj-Taylor, 2003). These responsibilities can heavily impact on the power differential between the client and the nurse, confusing boundary management further. Additionally, as the length of stay in forensic hospitals tends to be long-term (NHS Confederation, 2012), therapeutic relationships can evolve and present new challenges, although the benefits of good working alliances for client recovery have been well documented (Hewitt & Coffrey, 2005).

Research has also suggested that forensic nursing staff may be particularly vulnerable to burnout (Dickenson & Wright, 2008), in part due to the constant, draining experience of battling with client emotions and behaviours. Burnout is thought to include the loss of concern and empathy for clients (Pines & Maslach, 1978) and may lead to under-involvement in the therapeutic relationship. This may be a particular concern when working with clients diagnosed with personality disorder as research has suggested that nursing staff may show

less sympathy and optimism towards this client group (Markham & Trower, 2003) and be less likely to help them compared to other clients (Forsyth, 2007). This is important as up to 70% of forensic clients may have a personality disorder diagnosis (Adshead, 2012).

Qualitative studies have reported nurses feeling exhausted, incapable, devalued and overwhelmed while caring for this client group (Aiyegbusi & Kelly, 2015; Woollaston & Hixenbaugh, 2008), which is also likely to have an impact on boundary management.

Johnson, Worthington, Gredecki & Wilks-Riley (2016) found that a higher frequency of boundary violations by nurses was associated with increased depersonalisation of clients.

Although the above literature suggests why maintaining professional boundaries may be more difficult for nurses in forensic services, knowledge around *how* nurses develop boundaries in these settings is scarce. Currently, information on this subject comes indirectly from qualitative research in related areas. Jones and Wright (2015) found that nursing students were aware of professional boundaries when trying to engage clients in a forensic setting, yet they did not appear to have a clear understanding of the concept. Evans, Murray, Jellicoe-Jones and Smith (2012) found that forensic healthcare workers' perspectives on boundaries tended to differ across staff members, with some finding it difficult to maintain appropriate boundaries while fostering a positive, recovery-focused alliance. Other studies have suggested the importance of self-awareness and professional boundaries when trying to manage interpersonal relationships with complex clients (Aiyegbusi & Kelly, 2015; Woollaston & Hixenbaugh, 2008). Nurses emphasised boundaries as being key in attempting to contain clients' intense behaviours and responses, which they understood as projections of psychological pain. They highlighted the need for significant support, training and reflective spaces in order to maintain a professional, therapeutic footing (Aiyegbusi & Kelly, 2015).

While boundaries are mentioned in professional guidance, the nature of this guidance often reflects the subjective nature of boundary decision making. The Nursing and Midwifery Council (2008) Code of Conduct states that nurses must “maintain professional boundaries” (p. 4) and provides advice on common issues, such as gift-giving. Unqualified healthcare workers, who encounter similarly varied and intimate roles to nurses, do not have a professional body to receive guidance from. However, the Department of Health (Allen, 2015) produced *See, Think, Act*, which included more in-depth information on relational security, boundary management issues and practical advice. It is unknown whether, or how, this is used clinically.

In summary, the literature base around nursing boundary management in inpatient forensic services is small and focuses mainly on violations. While the need to share and document difficulties is understandable, it might be helpful to explore how inpatient nurses develop their understanding and practice around boundary management, given the inherent challenges. The opportunity to elucidate what happens in this complex process could help clinicians and services to understand how safe, therapeutic relationships could be facilitated and supported. It could also affect service operation, training, staff experience and client recovery. The current study aims to address this gap in the literature by providing a theory around how nurses and healthcare workers develop boundary management in secure, forensic services.

Methodology

Design

This study used a grounded theory design (Glaser, 1978), which was considered useful due to the limited research in this area. Streubert-Speziale and Carpenter (2003)

suggested that this approach can provide staff with a way of generating theory about human interactions so that theory is grounded in the actuality of everyday clinical practice (as cited in Elliot and Lazenblatt, 2004). Using this rigorous, systematic approach therefore allows for a rich understanding of an area that is currently not well understood (Urqhart, 2013).

Recruitment

Participants were opportunistically recruited due to the difficulties in recruiting staff from busy NHS services that require certain numbers of staff on shift for security purposes. Nurses and healthcare workers working in three medium security forensic inpatient wards in the South East of the UK at the time of the study were eligible to participate. Medium security wards typically provide assessment, treatment and rehabilitation for adults with complex mental health needs who pose a moderate risk to others. Most clients will have had contact with the criminal justice system and will stay on the unit for an average of 18-24 months (NHS Confederation, 2012). One ward (A) was an acute unit where mental health symptoms were more severe and florid. Staff from the low security or rehabilitation wards were excluded, however it was noted that staff sometimes work across different units and may have been drawing on these experiences during interviews.

Procedure

An email advert (Appendix C) and participant information sheet (Appendix E) were forwarded to all relevant staff and the researcher visited each ward to discuss the study. Staff were invited to register their interest by providing their work contact details or by contacting the researcher via email. A staff contact on the site raised awareness of the study and was available to discuss it with staff where desired. Interested staff members were then contacted

by the researcher to arrange an interview time. Before the interview, staff members were encouraged to ask further questions and asked to sign the consent form (Appendix F) if they remained happy to participate. Participants were also asked to provide demographic information they felt comfortable sharing (Appendix G) before the audio-recorded interview could begin (Appendix H contains the interview schedule). The interviews lasted an average of 40 minutes each.

The above procedure was repeated for further participants and after eleven people were interviewed, the researcher considered that theoretical sufficiency (Dey, 1999) had been reached, meaning that the data collected were thought to be enough for well-developed categories. Data analysis began after the first interview had been transcribed and continued concurrently with data collection.

Participants

The eleven participants comprised a range of ages and levels of experience and included healthcare workers and nurses of both genders. The average age of the sample was 38 years. Attempts were made to recruit participants who did not identify as White British (see Appendix D), as it was thought that different ethnicities might produce richer categories, however this was unsuccessful. Table 1 shows the demographic information of all eleven participants.

Table 1
Demographic Information of the study participants

<u>Participant</u> <u>(ward)</u>	<u>Age</u>	<u>Gender</u>	<u>Ethnicity</u>	<u>Profession^a</u>	<u>Time at current</u> <u>site^b</u>	<u>Time in</u> <u>forensic mental</u> <u>health^b</u>
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A (b)	26	M	British	HCW	0-4 years	0-4 years
B (b)	68	F	Not given	HCW	15-19 years	15-19 years
C (c)	51	F	British	nurse	5-9 years	5-9 years
D (c)	32	M	White British	nurse	10-14 years	10-14 years
E (b)	19	F	White British	HCW	0-4 years	0-4 years
F (b)	33	F	British	nurse	5-9 years	5-9 years
G (c)	42	F	British	nurse	20+ years	20+ years
H (a)	48	F	British	nurse	20+ years	20+ years
I (b)	20	F	British	HCW	0-4 years	0-4 years
J (a)	48	F	White English	nurse	0-4 years	0-4 years
K (a)	34	M	White British	nurse	0-4 years	5-9 years

Key: HCW = healthcare worker. ^aFour staff members indicated they had senior roles and more than one ward manager took part, however these leadership positions have not been specified to protect anonymity. ^bThese figures have been presented as year groups in order to maintain participant confidentiality.

Ethical Considerations

This study received Canterbury Christ Church University ethical approval in January 2017 and Health Research Approval in March 2017 (Appendix I). Participants were given at least 24 hours to consider the information sheets and were encouraged to ask questions about the study in order to provide informed consent. Participants were advised via the information sheets that data would be handled confidentially and that they could withdraw from the study at any time.

A pre-interview briefing reminded participants to consider the confidentiality of themselves, their colleagues and clients. Participants were advised that interview transcripts may be seen by the researcher's supervisor who was known to some of the participants and they were asked to only share information they felt comfortable providing. Participants were reminded of the researcher's duty to break confidentiality in the event of boundary violation or risk disclosures, however this did not occur.

Data Analysis

Interviews were transcribed by the researcher and then analysed using a Glaserian grounded theory approach (Glaser, 1978) of open, selective and theoretical coding (Urquhart, 2013; Charmaz, 2014). The analysis was undertaken within a constructivist paradigm that acknowledged the researcher role in analysis (Charmaz, 2014). The coding process is described below.

Open coding.

Open coding consisted of going through each transcript line-by-line and attributing descriptive or analytic labels that captured the essence of participant comments (Urquhart, 2013). Examples can be found within extracts of a coded transcript in Appendix K.

Selective coding.

Codes from each transcript were grouped together into tentative categories related to the research question. Codes and categories from later transcripts were added and compared to those of previous transcripts so that possible re-groupings could occur.

Theoretical coding.

Theoretical coding suggested how the emerging categories could be related to each other (Glaser, 1978). Theoretical codes and memos (Glaser, 1978) noted ideas about possible relationships between categories or subcategories and these relationships were consolidated in later stages of analysis using evidence from the transcripts. This constant comparison between memos, categories and transcripts enabled a theory to be drawn directly from the raw data, rather than shaped using coding paradigms. Integrative maps (Strauss, 1987;

Appendix L) kept track of how categories were thought to relate to each other throughout analysis.

Finalising the theory.

Once the last transcript was coded and incorporated with the rest of the data set, the categories, subcategories and theoretical codes were further explored and refined. This involved using theoretical memos and the raw data in an iterative process until the cyclical model described in the results section was finalised.

Quality Assurance

In order to acknowledge researcher preconceptions and influence, the researcher maintained a reflective diary throughout (Appendix O) and participated in a bracketing interview prior to data analysis (Drew, 2004; Creswell & Miller, 2000; Appendix J). A positioning statement can be found in Appendix J. A section of one transcript was co-coded and discussed with the researcher's supervisors, which was vital for drawing the researcher's attention to potential bias and considering how to stay true to the data. Memos, maps and documentations of the coding process helped to provide an open account of category development (Appendices L, M and P). The finalised model was shared with participants for respondent validation (see Appendix N for details). The CASP checklist for qualitative research was used to assess quality assurance, alongside Elliott, Fischer and Rennie's (1999) guidelines for producing good quality grounded theory studies.

Results: A cyclical process

This study aimed to explore how nurses and healthcare workers develop professional boundaries in forensic inpatient services. Data analysis using grounded theory resulted in a cyclical model of professional boundary development consisting of four main categories and 21 subcategories (see Figure 1 for a visual depiction of the model). The model suggests that staff move through four main phases of boundary development during their time in forensic services, starting with ‘acclimatisation’ to the setting using their previous experiences and personal values. In phase two, ‘calibration’, staff constantly assess and address difficulties related to boundaries in the course of their daily duties. Staff undergo individual and team ‘learning’ in phase three, which they use in phase four to ‘recalibrate’ their views on boundaries, themselves and how they work with clients. This recalibration is suggested to impact on future management of boundary difficulties, which in turn affects learning and further recalibration, so that staff move in a continual development cycle through phases two to four. These phases are perhaps not as distinct as they are portrayed in Figure 1 and may overlap. This model will be discussed in more detail below.

Phase 1: Acclimatisation

This phase describes participants’ experiences of acclimatising to forensic inpatient services. They appeared to draw on both the experiences they had had before starting in the service and their own personal values while adjusting to the ward environment.

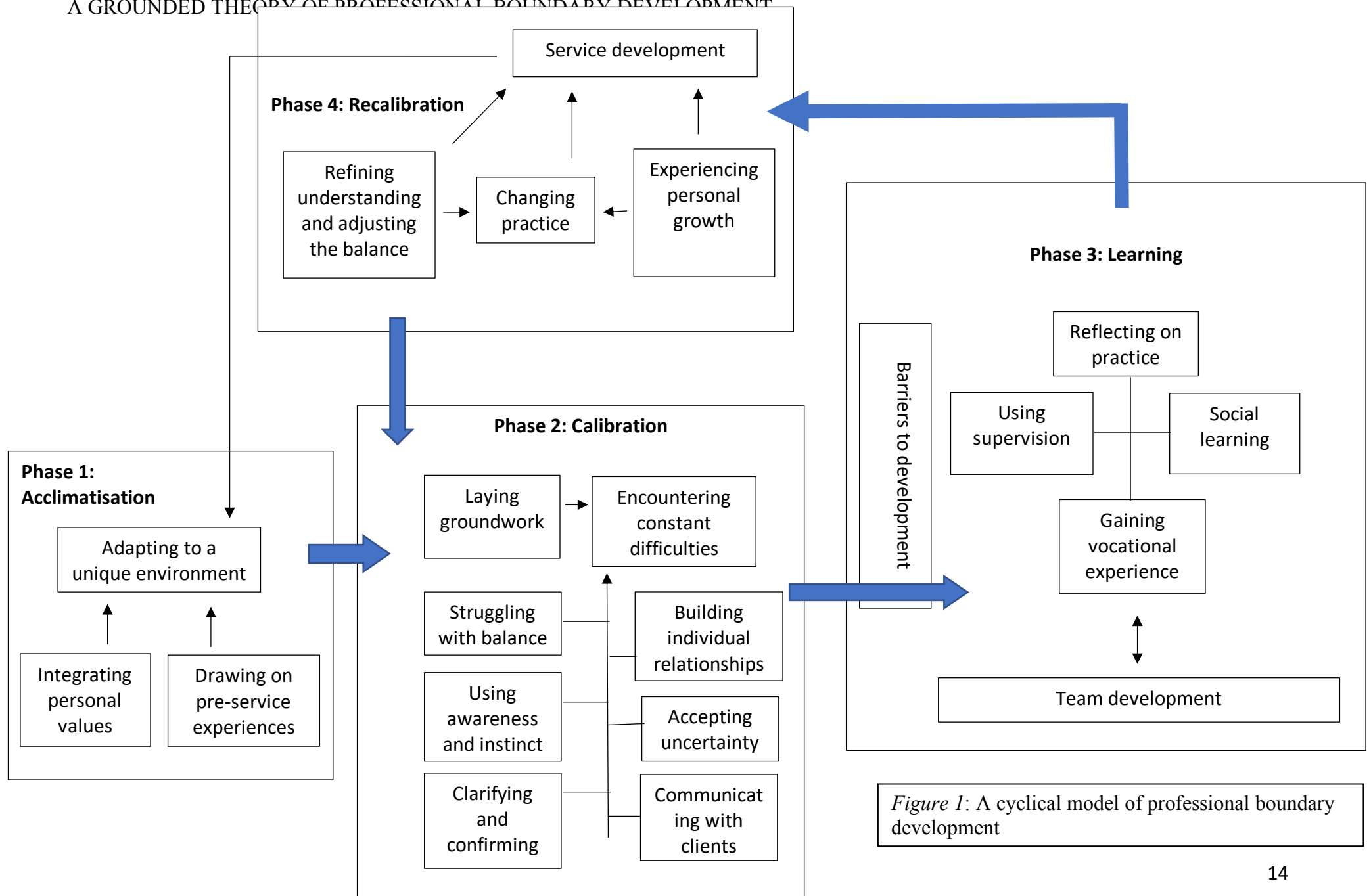


Figure 1: A cyclical model of professional boundary development

Adapting to a unique environment.

Participants described finding it very hard to manage boundaries when coming into the role, due to a naivety about boundary understanding and lack of knowledge.

When I first came into mental health, I didn't really know a great deal in all honesty about boundaries... you don't fully understand it. (Participant K, Ward A)

Participants talked about having a reliance on rules and using them where possible, although they later realised the limitations of these guidelines.

I think when I started working here and doing mental health training and stuff you sort of get this idea that these are the rules, this is now you are and how you work with people. You don't do this and you don't do that. But actually, it's not that simple (Participant A, Ward B)

Participants described coming into the service at either end of a boundary continuum, with most acknowledging being initially too firm in their approach to boundaries. Participants acknowledged support from more experienced staff members, who kept an eye on new staff members. Participants also felt they were being noted as new staff by clients. In turn, new starters looked to their superiors for guidance and practice examples.

You shadow people and you sort of see how they do it. (Participant E, Ward B)

Being young when starting out was noted to be particularly difficult and this was connected to being less experienced in both mental health and general life and to receiving more attention from clients.

When you're young as well you're quite impressionable some patients can be quite manipulative and I think when you're young and inexperienced it's quite easy to fall into the trap of being pulled in by somebody (Participant H, Ward A)

Integrating personal values.

Participants described how their personalities, preferences and personal styles of working influenced their boundary management, particularly in the beginning. They talked about the personal nature of boundaries and how this interacted with the professional setting, for example using their own expectations of social interactions to assess the appropriateness of client comments.

Like if someone's said it to you on the street.... well I wouldn't take it if someone said the things they say to me on the street (Participant I, Ward B)

Participants described acting in ways that were in line with their own characters, adapting some of these personal ways of interacting to the ward environment and using their own values as part of their initial way of working with clients.

*I'm a person at the end of the day and you're a person....my values, morals, principles, that's my basis, that's my grounding point for how I move on.
(Participant K, Ward A)*

Drawing on pre-service experiences.

Participants acknowledged the impact of previous personal and professional experiences on their boundary management when they first arrived.

I have six children of my own - not that I'm equating children to patients at all, don't get me wrong – but I will tend to set those boundaries so that people don't overstep the mark. (Participant J, Ward A)

Participants felt that it was particularly beneficial to have had some prior experience in mental health settings, as these had offered training or vocational experiences that had raised awareness of boundary issues and risk. Participants also said that it was better to come onto the ward as qualified staff members with some placement experience.

There are some people that will come in and be very boundaried, you will find that they generally have mental health experience ... and there'll be people that have come in straight from university if they're a nurse or straight from school and they, they like mental health because they've got someone in their family that suffers with something or their friend suffers with something or they might even suffer with bits and pieces themselves, but they don't understand the boundaries. (Participant K, Ward A)

Phase 2: Calibration

After their early experiences, participants described beginning to ‘lay the groundwork’ for future boundary management and ‘encountering constant boundary issues’ on the ward.

Laying the groundwork.

Participants described attempts to prepare for boundary issues where possible, for example by protecting their personal lives and family.

All my family know where I work Now, they all know that when they see nan.... and I've got someone with me they don't know, they will politely say 'hello' and they will go on by. They don't run to grab me, they don't do anything. (Participant B, Ward B)

There was also an emphasis on making the most of information available about clients in order to get to know them. Knowledge of clients was highlighted as being key to understanding how to manage individual boundaries.

The really important bit about knowing the patient is 'ok, that's what I need to set up with that patient because they are going to potentially try and push a little bit more than somebody else (Participant F, Ward B)

Participants described attempts to understand clients’ presentations, including being aware of how attachment issues and early experiences may affect their relationships with staff.

This guy, like he would get, you know, aggressive and push people away

Because that's what he kind of knew probably, being abandoned and being left by people by not playing into that and kind of continuing to kind of, you know just maintain the relationship and not be like 'oh well, you were horrible to me, I won't talk to you' or whatever, that would just perpetuate what is going on for him.

(Participant A, Ward B)

Encountering constant difficulties.

Participants talked frequently about facing constant boundary issues and dilemmas.

It's kind of something that keeps coming up. (Participant A, Ward B)

The task of managing boundaries appeared central to their professional role and this included both enforcing rules and managing interpersonal relationships with clients.

Although participants spoke about just managing difficulties as they arose, many things fed into this process in a given situation and these are detailed below.

Accepting uncertainty.

Participants spoke about having to accept uncertainty and ambiguity in boundary management, which felt uncomfortable for both staff and clients. There was a distinction made between fixed boundaries that included concrete, absolute rules and flexible boundaries, where staff were required to use their own judgement, such as what personal information to disclose to someone.

We deal here with grey...As I said there are certain black and white boundaries in terms of no, you can't have a relationship with a patient, no you can't be giving them money or bits and pieces like that, but the majority of our boundaries and rules are all grey areas which is open to interpretation, which is horrible. Patients don't like that, staff certainly don't like that, but what can we do about that?
(Participant K, Ward A)

Participants felt it was difficult when there was no definitive answer to boundary dilemmas, although acknowledged a need to be flexible. In contrast, some participants used absolute language that conveyed a sense there was a “perfect” or “best” way of doing things.

Struggling with balance.

Participants discussed trying to work towards a fine balance within working relationships that was neither too strict with clients nor too lax.

The one end of the scale is you could be like that and have no boundaries or you could be at the bottom of the, of that ladder and be too boundaried and not give anything of yourself away and be very strict...the skill is getting the right balance of both (Participant D, Ward C)

They described risks of being too firm with boundaries, including a negative impact on the therapeutic relationship. Participants attempted to weigh up potentially competing demands, for example balancing empathy for a client's situation with their role as a nurse.

You just don't want them to take offence ... obviously they've been sort of rejected all their life and they've had a really bad upbringing and some of them don't have a family and it's sort of us they rely on to feel wanted and, so, when you're sort of rejecting them in a way you just feel really harsh, like really, really nasty...but it's your job (Participant E, Ward B)

Participants acknowledged difficulties in balancing risk with the client's recovery and reintegration into society, with participant K noting an apparent trade-off between staff safety and client learning.

It would be very easy for me at these points to say 'oh let's just give in because I won't get death threats'.... What does that achieve? How are you helping that patient at that point in time? When they go out to society you can't just go around the streets just doing what you want, there are rules. (Participant K, Ward A)

Participants often linked more lax boundaries with increased risk, however they also noted that being strict could also put staff at risk and giving some personal information could enhance trust in relationships, which was thought to reduce risk incidents. Some participants also acknowledged an internal conflict around managing rules and boundaries that they didn't personally like or agree with and having to balance professional responsibility with personal principles.

Forging individual relationships.

Participants often described a need for individualized care, which included using different boundaries with individual clients.

It will change depending on the client, it will definitely change depending on the situation you are in. (Participant B, Ward B)

Participants also suggested using consistent boundaries within each individual relationship. Personal characteristics, such as age and gender, of both staff member and client could influence their working relationship and the boundary management within that relationship.

I get the youngsters coming to me as a mother figure and sort of saying, you know, 'look I'm having trouble and I'm really bad and I don't know what to do'. They're looking for a bit of reassurance and comfort.... I wouldn't use that with everybody (Participant C, Ward C)

Using awareness and instinct.

Participants described using instinct to help manage day to day situations.

Your gut instinct goes a long, long, long way in terms of mental health... you just know there's something in your gut feeling, that sixth sense that tells you something don't feel right, and you should go with that, 'cos pretty much the majority of the time that's correct. (Participant K, Ward A)

However, they also described being mindful, self-aware and thinking about what to do for the best, when they had time to do this.

You can see yourself sometimes maybe heading towards going over a boundary and thinking, you know, ‘oh God yeah’ and remembering where you are and what you’re doing. (Participant H, Ward A)

Participants were aware of people distancing themselves from difficult boundary situations, whether consciously or unconsciously. Participant J noticed staff particularly avoiding clients who had a diagnosis of personality disorder.

I feel that one of the most difficult things with PD is that staff tend to go and hide.... Because it’s demanding work” (Participant J, Ward A)

Clarifying and confirming.

Participants described using the team hierarchy to manage difficult boundary situations by seeking confirmation of their actions and backing from superiors, or taking boundary concerns to superiors to be passed up the chain of command.

Nine times out of ten I believe I’ve made the right decision because I’m experienced and confident but it, it’s just getting the manager or someone higher saying ‘yeah, I agree’ (Participant C, Ward C)

Participants acknowledged the benefits of support from others, who could offer to step in where needed and share decision-making.

It's nice when you've got someone else as well ... if you're constantly having to do it [handle inappropriate comments], someone else can be like 'right that's enough now' (Participant I, Ward B)

Communicating with clients.

Participants discussed addressing boundary issues explicitly and verbally with clients and emphasised the importance of explaining boundary management decisions.

I think if you can give someone a reasonable explanation as to why... you know, people see that you're human. (Participant H, Ward A)

Other participants talked about being open, respectful and clear with clients, whether advising them about boundaries, verbally reinforcing the roles of clients and staff or, in some cases, expressing empathy about rules staff are expected to enforce.

You have to find that balance between saying 'this is the rules, however I do understand...it must be really hard for you' (Participant J, Ward A)

Phase 3: Learning

During this phase, participants spoke about developing their boundary management practice individually by 'using supervision', 'social learning', 'gaining vocational experience' and 'reflecting on practice'. These processes all appeared to interact with each other and individual learning interfaced with 'team development' amongst nurses. Participants also identified barriers to development, which impeded learning.

Gaining vocational experience.

Experience on the ward was identified by participants to be central to boundary development.

A lot of it is so individual and personal... it's not really something you can necessarily get from books or writing. (Participant A, Ward B)

Participants described how spending more time on the ward, working with different clients or staff members and being exposed to boundary issues provided reality checks and heightened awareness of risk issues.

My charge nurse kept saying to me 'there's something going on with this girl' and I was like 'no, no it's all in your head, don't be silly', couldn't see the wood for the trees... it was the shock really ...it was right there under my nose and I didn't see that someone was like really going over the boundaries... actually what people do doesn't surprise me sometimes now." (Participant H, Ward A)

A need to have this practical and vocational experience was emphasized as having an impact on practice and judgement, as described in **Phase 4**.

Reflecting on practice.

Participants emphasised a constant need for reflecting on and assessing their own practice. This could include thinking about and learning from their own management and mistakes.

I think I sort of came away from it and thought ‘did I, did I handle that well? Is there any other way I could have handled that?’ (Participant E, Ward B)

Participants noted that training prompted reflection. They discussed being open to learning and willing to develop their self-awareness and professional knowledge.

I think it’s important to keep your own, erm, your own practice the most recent, keep up to date with what’s going on, be willing to learn (Participant D, Ward C)

Using supervision.

Individual and group supervision was seen as extremely important to boundary development and was viewed by participants as an opportunity to gain feedback and to have open, neutral discussions about personal experiences on the ward.

I think it’s more healthy to bring up things rather than bury them and hope they go away, so like, ‘oh actually, let’s talk about this - I did this the other day, what do you think about that?’ (Participant D, Ward C)

Participants also mentioned having supervision from psychologists to help consider patient presentations and formulate their interactions.

The psychologist talking to them really helps [staff] to kind of understand what the patient might be like and what’s the best way to work with them and understand their formulations (Participant F, Ward B)

Senior staff explained how they used supervision to try to encourage supervisees to reflect on their practice and decision-making.

You try to explain that even though it might be something they see as genuinely helping the patient out but actually it's causing conflict within the team. You try and make them understand that, you try and make them see it from others' perspective. (Participant G, Ward C)

Social learning.

The impact of being part of a team was discussed by many participants as being helpful to development. Nurses described the importance of learning from each other, exchanging different perspectives and advice and supporting each other.

Just from working with good nurses and bad nurses you pick up the proper way to do things and when you see things that you're not too sure of you think 'what would you do in that situation?' and erm, whenever I have to make a decision I can always relate it to something I've seen in the past or a good nurse that I've worked with and I've thought 'that was dealt with brilliantly' (Participant D, Ward C)

Barriers to development.

Some participants identified what appeared to be barriers to development, meaning that staff members get stuck in the learning phase. These included hiding mistakes, being defensive about actions, lacking self-awareness and being complacent.

The worst thing you can do is to try and cover it up if you've made a mistake or get defensive (Participant D, Ward C)

Complacency – they always say the big C - complacency is one of our biggest issues (Participant K, Ward A)

Team development.

The process of team development appeared to interact with individual learning. All participants described difference and disagreement amongst nurses' boundary management, which could cause friction, inconsistency and splitting in the team.

A newer member of staff has questioned some of the older members' of staff relationships with patients, they thought they were a bit too tactile if it is to become common place and everyone's giving everyone hugs then why is she, why is the newer member of staff not hugging people, it sets her apart from everyone, it splits the team. (Participant D, Ward C)

They noted attempts to find team balances and compromises using communication or by trying to empathise with other staff members' situations.

It's again finding that balance and getting the team talking to each other...we'll have that discussion and we'll meet in the middle (Participant C, Ward C)

Some participants suggested cohesion in the team by explaining the unique position and boundaries of the nursing profession and spoke about justifying this to other disciplines.

Our staff are out there with them 24/7, like they see them in their beds sleeping, they see them in the toilet, they're supporting them at every stage of the day, they're playing pool with them at night, ... it's so much harder being in that sort of role because you're not in that obvious professional situation all the time (Participant F, Ward B)

Phase 4: Recalibration

In this phase participants described using what they had learned to adjust their understanding of boundaries, themselves and how they work with clients. These adjustments affected their management of future daily boundary issues and therefore began a cycle of continual development over time with repeated learning, adjustment, practice and re-learning. More experienced participants spoke about influencing 'service development', which in turn affected the experience of new starters.

Refining boundary understanding and adjusting the scale.

Participants said that their understanding of boundaries changed substantially over time, including a deeper understanding of the role of boundaries and why they are used in forensic inpatient services.

Over time you start to realise the more information you give about yourself will be – can be used against you, so you do start to kind of go, actually I need to not be giving all this information out ...considering the type of clients [that] we have here and some of their index offences. (Participant K, Ward A)

Participants referred to making bi-directional adjustments to their boundary management, becoming firmer in some areas and less firm in others.

There are things that I've thought 'oh yeah actually, I can see that you can work this way, you don't have to be as strict about that'. There's other times where I go 'yeah this is not the way to work, I definitely think that in this sort of situation you do need more rigid boundaries' (Participant A, Ward B)

Personal growth.

Participants described going through personal changes over time, including becoming more confident and relaxed, having increased resilience and having more finely tuned instincts.

When you start to relax a bit and you get into the job a bit more, you sort of do your own thing.... I think you become a bit more confident (Participant E, Ward A)

I'm a lot sturdier in myself, I've worked in mental health, the experience is a key factor. You, you have your inner strength, you just know in yourself what you can take and what you can't take. (Participant K, Ward A)

Participants spoke frequently about the potential for ever-increasing development, with only one participant considering that the potential for growth was limited.

Changing practice.

Participants talked about doing things differently in their practice as a result of learning, often taking into account personal growth and refined boundary understanding. This included changes in how they managed boundaries and how they continued learning about them, for example becoming more active in supervision.

If [staff] are guided and if they're prompted you do notice changes ... then they might get a bit more confident with patients to be able to say not 'I'm not going to talk about that' because sometimes that can upset the patients (Participant F, Ward B)

Service development.

Participants often referred to service context and the focus on boundaries that was necessary due to the demands of the forensic setting. More experienced participants noted how this emphasis had increased since they first started working in the service.

In my opinion there's certainly been a change in ethos around training staff around boundaries.... So it's definitely improved (Participant G, Ward C)

Participants in leadership positions spoke about trying to influence the service further by creating open cultures, attempting to empower their colleagues, sharing practice advice and suggesting service improvements.

I've made that clear to my manager that's what I want and we are, I think, hoping to get more of a whole day set up for new starters where we do get into, sort of, self-awareness and we do introduction to teams and we do more specific boundary awareness (Participant F, Ward B)

A report detailing the study findings was shared with participants and the ethical panel and NHS research departments who approved the study (see appendices).

Discussion

The cyclical model outlined above suggests that nurses and healthcare workers begin to develop boundaries in forensic inpatient services by acclimatising to this environment. They then appear to move through a cyclical process of calibrating their boundaries according to everyday situations, learning from these experiences, readjusting themselves and their practice and then calibrating further. Participants initially felt naive and ignorant with regards to boundaries, although having some experience in mental health services was considered better than none. This supports findings from Jones and Wright (2015), where student nurses spoke about the importance of professional boundaries, however did not appear to understand boundaries clearly. These results indicate that although there may be a more superficial knowledge of boundaries earlier on, a deeper and more refined understanding perhaps is not gained until later in someone's clinical experience.

Participants acknowledged boundaries that were both concrete and subjective, which echoes the idea of non-negotiable and flexible boundaries described in *See, Think, Act* (Allen, 2015). The difficulty of balancing security and risk with the power differential in

relationships was also noted, similarly to Peternelj-Taylor (2003). Participants acknowledged that empathy was a factor in gauging professional boundaries and discussed wanting to facilitate things for clients, indicating care and compassion. This may contrast with previous suggestions that nurses have negative perceptions of clients with complex presentations such as personality disorders (Markham & Trower, 2003) and be less likely to help them (Forsyth, 2007). Participants did suggest that it may be harder to maintain professional boundaries with this client group, however the infrequency with which this diagnosis was mentioned could indicate that these difficulties are not as noteworthy as could be expected. It might be that personality disorder diagnoses are either not common on the wards included in this study, or perhaps so common that they do not need to be explicitly mentioned. Either way, the nurses and healthcare workers in this study did not appear to focus discriminatorily on this client group.

Theoretical papers in the literature have suggested that a forensic client's early childhood experiences with their caregivers may affect their understanding of appropriate relationships and their ability to maintain safe boundaries between themselves and clinicians (Adshead, 2012). This was reflected in the current study where participants described using information about a client's history to inform working relationships. Participants discussed using client formulations to try to understand their patterns of relating to others and what boundaries might be required in order to maintain the working relationship and benefit client recovery. These descriptions were similar to those in Aiyegbusi and Kelly (2015), where nurses discussed using boundaries carefully with clients to avoid re-enactments of harmful relationship patterns. These findings further emphasise how appropriate, therapeutic staff-client relationships can be crucial for client rehabilitation and recovery, perhaps in other inpatient settings as well as speciality forensic services.

The model from this study reflects existing learning theory and is particularly similar to Kolb's (1984) experiential learning cycle. Both theories emphasise the value of reflecting on vocational experience in order to form strategies or adjustments that can help in the future. In both models, individuals then apply what they have learned to future situations, so that practice and experimentation can provide more experiences to learn from. Similarly, the way that participants described supervision sounded comparable to scaffolding (Wood, Bruner & Ross, 1976), as supervisors provided active, focused support for boundary learning.

Previous research has emphasised the need for support, reflective spaces and training in order to maintain professional relationships and it was clear from the current study that reflecting on practice and having support from colleagues were key to learning. Participants did not emphasise training as much as the nurses in Aiyegbusi and Kelly (2015) and this may be due to differences in the type and depth of training experienced.

Participants in the current study discussed both procedural and relational boundary dilemmas, indicating that they found it difficult to manage ward rules and routines, as well as interpersonal boundaries within their relationship with clients. Their examples suggest that staff were mindful of distancing themselves from clients by being overly restrictive, as well as becoming too involved. This is encouraging given that clients in forensic services may otherwise encounter stigma and discrimination due to their diagnoses or offences (Adshead, 2012). Participants did not appear to acknowledge many relational boundary issues other than disclosure and reasons for this could include participants not being as aware of other components of relational boundaries, or a human preference towards things that are more structured and predictable. The presence of rules and policies, even if there are difficulties

associated with enforcing these, may offer comparatively more containment in boundary decision-making than the infinite choices and responses available in relationship building.

Being part of a nursing team appeared to be an essential component of learning, in terms of providing supervision, learning from others and exchanging support. People in leadership positions appeared to try and foster an open, encouraging atmosphere and there was a sense that mistakes were understood sensitively and as a part of the learning process. However, nurses and healthcare workers were expected to report boundary concerns, which might create an internal conflict in individuals who must weigh up professional responsibility with the risk of creating friction amongst colleagues they rely on. Previous research has found that people working with individuals who could pose risks to staff tend to prioritise relationships with colleagues over reporting responsibilities as they depend on the wider team for their safety (Fisher, 1995). This further supports the benefits of an open, forgiving culture where staff can feel safe to discuss both mistakes and good practice.

Clinical Implications

As the first study to examine the process of professional boundary development in forensic services, the resulting theory provides new information on the processes that are important for learning, which have evident clinical implications. Individual clinicians, for example, might consider increasing their own sense of reflexivity, openness and self-awareness during supervision, or even personal therapy. Service managers might consider assessing potential candidates on these characteristics during recruitment, increasing vocational learning opportunities available for nursing students and maximising reflective spaces.

Training sessions could facilitate consideration of relational components other than personal disclosure and normalise feelings of uncertainty inherent in ethical decision-making. Discussion groups in collaboration with clients could be particularly significant for the client experience, given that previous research has suggested that clients in forensic services also feel most uncomfortable about relational aspects of boundaries (Schafer & Peternelj-Taylor, 2003). Similarly, forums in collaboration with other professionals may help to share the unique challenges ward-based staff face, so that the multidisciplinary team are more aware of different boundary perspectives. Plenty of opportunities for team building and peer supervision might help to enhance trust amongst team members and build open cultures, where different levels of understanding are viewed sensitively and supportively. However, it is noted that this could be challenging in the current climate of austerity in the NHS, which can mean staff shortages and high turnover.

Clinical psychologists (CPs) might be particularly well placed to increase opportunities for nurses and healthcare workers to work on shared formulations of client relationship difficulties, as well as sharing their own understanding of clients' responses and behaviours. Team formulations in inpatient settings have been suggested by both this study and other research to increase staff understanding of clients and to improve the staff-client relationship (Summers, 2006). Written recording of such formulations may contribute to information available to staff about individual clients and promote a culture of psychological thinking in relation to professional boundary issues.

CPs could also offer individual or group supervision around professional boundaries to new staff members, or those who are finding boundary management difficult with particular patients. They may also be involved in preparing, improving and evaluating

boundary training for staff, given their professional training in reflective practice, therapeutic relationships and use of an available literature base to enhance clinical outcomes. It might be particularly useful to consider the potential benefits of mentoring schemes and the type and timing of training for new starters and students. On a wider level, CPs could take a leadership role in evaluating clinical and staff wellbeing outcomes of the above practice changes and adding to the currently limited literature base around professional boundary development.

Limitations and Research Implications

While this study provides a richer understanding of the processes involved in developing professional boundaries plenty of questions still remain. The model highlights reflection and supervision as important processes in managing boundaries, however further research could clarify whether particular supervision models or reflective approaches are more useful than others.

The participant sample in this research was not ethnically diverse despite nurses and healthcare workers in forensic services comprising a range of cultural backgrounds. Further qualitative research with a more diverse participant sample could explore similarities and differences between people from different backgrounds in how they develop boundary management practice. Additionally, the site where this research was undertaken had a particularly current focus on professional boundaries due to recent incidents. While this might have helped staff to consider boundaries during interviews, it might also have limited what staff felt comfortable to share. Further research could therefore help to see whether similar learning processes are described by participants whose service has not had such a specific focus on this area. Finally, while it is recognised that the ultimate responsibility of

maintaining appropriate boundaries rests with the professional, relational boundaries in particular rely on both staff and clients. Further research that includes both staff and clients might provide further information about the development of boundaries in individual relationships.

Conclusion

This study is the first to explore how nurses and healthcare workers in inpatient forensic services develop their understanding and management of professional boundaries over time. The findings provide a theoretical model that suggests nurses go through a cyclical process of professional boundary development, where supervision, reflecting on practice, social learning and vocational experience are all key to learning. The model emphasises the care and attention that nursing and support staff dedicate to boundary issues and highlights the team process in working through difference to achieve understanding and compromise. The importance of social learning is highlighted, as well as membership of a supportive team that views minor mistakes as opportunities for development. The findings also indicate that inpatient nurses and healthcare workers do not appear to focus discriminatorily on clients with diagnoses of personality disorder, in contrast to literature suggesting this client group are perhaps viewed as difficult. In fact, staff members showed empathy, described willingness to help and appeared to be considerate of client needs when working with boundaries. The model of development is comparable to existing theories of learning and this has important implications for training, experiential learning, peer supervision and enhanced opportunities for reflective spaces. Further research could explore cultural aspects of personal boundary management and investigate the specific mechanisms

within different supervision and reflective practice approaches that may be most helpful for staff.

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Appendices

Appendix A: Qualitative Checklist Scoring (CASP, 2018) for Section A

Qualitative Checklist	Woollaston and Hixenbaugh (2008)	Jones and Wright (2015)	Aiyegbusi and Kelly (2015)
Clear statement of aims?	Yes	Yes	Yes
Qualitative methodology appropriate?	Yes	Yes	Yes
Appropriate research design?	Yes	Yes	Yes
Appropriate recruitment strategy?	Can't tell	Yes	Yes
Appropriate data collection?	Mostly	Mostly	Yes
Adequate consideration of researcher-research relationship?	No	No	No
Consideration of ethical issues?	Mostly	Yes	Somewhat
Sufficiently rigorous data analysis?	Mostly	Somewhat	Somewhat
Clear statement of findings?	Mostly	Mostly	Mostly
Valuable research?	Yes	Less valuable	Yes

A GROUNDED THEORY OF PROFESSIONAL BOUNDARY DEVELOPMENT

Appendix B: Quantitative Checklist Scoring (Kmet, Lee & Cook, 2004) for Section A

Quantitative Checklist	Markham (2003)	Markham and Trower (2003)	Forsyth (2007)	Bowers and Allan (2006)	Carr-Walker et al. (2004)	Mason, Hall, Caulfield and Melling (2010)	Mason, Caulfield, Hall and Melling (2010)	Daffern et al. (2010)
Question/objective sufficiently described?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Study design evident and appropriate?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Method of subject/comparison group selection described and appropriate?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Subject (and comparison group) characteristics sufficiently described?	Yes	Partly	Partly	Partly	Yes	Yes	Yes	Partly
Random allocation described?	N/A	Partly	Partly	N/A	N/A	N/A	N/A	N/A
Blinding of investigators reported?	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Blinding of participants reported?	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Outcome measures well described and robust to bias?	Partly	Partly	Partly	N/A	Partly	Partly	Partly	Partly
Sample size appropriate?	Partly	Partly	No	Yes	Yes	Yes	Yes	Partly
Analytic methods described/justified and appropriate?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Partly
Some estimate of variance reported for the main results?	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Controlled for confounding?	Partly	Partly	Partly	Partly	Partly	Partly	Partly	Partly
Results reported in sufficient detail?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Conclusions supported by the results?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Appendix C: Recruitment email

Hi [Ward Manager],

Thank you for speaking with me yesterday. As promised here is an email to send around to your colleagues about the study. Thank you very much for your support!

A Grounded Theory study exploring how nurse and support staff views of professional boundaries are developed in forensic secure inpatient services.

My name is [trainee name] and I am a trainee clinical psychologist at Canterbury Christ Church University. I am currently leading a research study exploring staff views on professional boundaries in secure forensic settings and how these perspectives develop.

This study is interested in your thoughts about staff-client relationships in forensic mental health services, how your experiences have shaped your views and how your views change over time and between clinical contexts. These perspectives and experiences can hopefully ground theory around the management of professional boundaries in forensic inpatient services and influence policy and training in this area.

Given that nursing and support staff embrace a range of roles which may make managing professional boundaries more difficult, this study is looking for nursing and support staff who would be interested in taking part in an interview about their views and experiences in managing boundaries.

If you are a nurse, support worker or healthcare assistant currently working on [Ward Name] and you are interested in taking part in this research, please email me back for a more detailed information sheet.

With best wishes,

[trainee name]
Trainee Clinical Psychologist

Appendix D: Adapted recruitment email

This was sent after the eighth interview with a participant who identified as 'white British'. Participants were talking about bringing their own personal values into boundary work when starting out and I felt that this could be strongly related to someone's cultural background. I wanted to thicken this subcategory if possible by exploring people's views who identified as a different ethnicity.

Hi [Ward Manager],

Many thanks for your support in this Professional Boundaries study. I am now at the point where I have done lots of interviews with members of staff from a similar cultural background. I am therefore now looking specifically for participants who do not identify as 'white British'.

Would you mind asking around on the ward to ask if anybody who identifies as a different ethnicity/nationality would like to participate?

Either let me know their names (with their consent), or do feel free to pass my contact details on.

With best wishes,

[trainee name]
Trainee Clinical Psychologist

Appendix E: Participant Information Sheet

Information about the research

A grounded theory study exploring how nurse and support staff views of professional boundaries are developed in forensic secure inpatient services.

Hello. My name is [trainee name] and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide whether or not you would like to take part, it is important that you understand why the research is being done and what it would involve for you.

Talk to others about the study if you wish.

(Part 1 tells you the purpose of this study and what will happen to you if you take part.

Part 2 gives you more detailed information about the conduct of the study).

Part 1

What is the purpose of the study?

The term 'professional boundaries' refers to keeping relationships between staff and clients appropriate and safe. This is a complex issue, however there is little guidance around managing boundaries and therefore navigating optimum boundaries appears to be a rather subjective experience. Theories in the literature suggest that the difficulty in managing boundaries may be even more pronounced in forensic services, however there is little research in this area and mostly this focuses on the number and types of violation by staff members. The study is interested in your thoughts about professional relationships in forensic mental health services and how your views have developed. These qualitative perspectives and experiences can hopefully ground theory around the management of professional boundaries in forensic inpatient services and influence policy and training in this area.

Why have I been invited?

The study is open to nursing (qualified and unqualified) and support staff (healthcare assistants, support workers) working at the [Name] Unit. The study has been advertised across this service and this information sheet distributed to those who have enquired further.

Do I have to take part?

The study is entirely voluntary and it is completely your decision whether you would like to be involved. You might like to take some more time after finding out about the study to make your decision. You can change your mind about participating at any point without having to give a reason.

What will happen to me if I take part?

If you would like to take part in the study you would be asked to participate in an interview with the researcher where you will be asked about your views on professional boundaries and how these views have developed. The researcher will also ask you for some demographic information. The interview will last no longer

than one hour and breaks can be taken as needed. The interviews will be audio-recorded.

What are the possible disadvantages and risks of taking part

We do not anticipate that there are any risks to taking part, however you may find some of the questions a bit personal and you can choose not to answer them. You will not be asked to provide any information you do not want to share, including demographic information.

What are the possible benefits of taking part?

There are no direct benefits to you taking part in this study, however the responses you give will help to ground theory around how staff perceptions of professional boundaries are developed in forensic services. The resulting theory could influence policy and training in this complex area.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

This completes part 1.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Information Sheet: Part 2

What will happen if I don't want to carry on with the study?

You can change your mind about participating in the study at any point without having to give a reason. If you withdraw from the study, any data we have collected from you up until this point will be destroyed.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to me or use my contact details below and I will do my best to answer your questions.

[Contact details]

If you remain unhappy and wish to complain formally, you can contact Professor Paul Camic using the contact details below:

Professor Paul Camic, Research Director, Salomons Centre for Applied Psychology
Telephone number: 03330117114

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential. All information or notes from the study will be anonymised and stored securely on encrypted memory sticks. Only the researcher and two supervisors involved in the project will have access to your information. Information from the study will be stored securely at the Salomon's Centre for Applied Psychology for five years after the project is complete and will then be destroyed. If you choose to stop participating in the study at any point, we would still like to retain the information given up until the point of withdrawal. The interview recording will also be kept confidential (and stored on encrypted memory sticks), however we may have to break confidentiality in rare circumstances where there are concerns about risk to you or another person. Participants have the right to check the accuracy of data held about them and correct any errors.

What will happen to the results of the research study?

Data from all the participants will be analysed and the results written up in the form of a Major Research Project, as this research forms part of clinical psychology training. It is also possible that the research will be published in a peer reviewed academic journal, however no identifying information will be used in the Major Research Project or journal publication. It is possible that a quote from the interview will be used in the project write-up and journal publication, however we will ensure that you cannot be identified from this.

Who is organising and funding the research?

Canterbury Christ Church University is funding and organising this study.

Who has reviewed the study?

This study has been reviewed and given favourable opinion by the Salomons Centre Research Ethics Committee at Canterbury Christ Church University.

Further information and contact details

Please ask me using the contact details above should you require any further information.

Appendix F: Participant Consent Form

Participant Identification Number for this study:

CONSENT FORM

Title of Project: A Grounded Theory study exploring how nurse and support staff views of professional boundaries are developed in forensic secure inpatient services.

Name of Researcher: [Name]

Please initial box

1. I confirm that I have read and understand the information sheet dated..... (version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

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

3. I understand that data collected during the study may be looked at by the lead supervisors [Names]. I give permission for these individuals to have access to my data.

4. I agree that anonymous quotes from my interview may be used in published reports of the study findings.

5. I agree to take part in the above study.

Name of Participant _____ Date _____

Signature _____

Name of Person taking consent _____ Date _____

Signature _____

Appendix G: Demographic Information Sheet

Participant Demographic Information

Participant ID:

Age:

Gender:

Ethnicity:

Job title:

Length of time at [unit] (years, months):

Length of time working in forensic mental health setting (years, months):

Appendix H: Initial Interview Schedule

NB: Further reflections on the interview process and questions can be found in the reflective diary extracts.

A grounded theory study exploring how nurse and support staff views of professional boundaries are developed in forensic secure inpatient services.

Intro: Introductions, reminder of the study and confidentiality information. Invitation of questions and concerns before the interview starts.

Collection of Demographic Information: *Using a guidance form, ask the participant for relevant demographic information, including age, gender, ethnicity, occupation, length of time in the service and current/previous unit experience. Check whether previous experience is inpatient or community.*

Interview: This will be guided by the following questions, but as per grounded theory, follow up questions can be guided flexibly around the participant responses.

1. Can you tell me a bit about how you understand and manage professional boundaries?

Prompts: What does the term professional boundaries mean to you? When did you first start to think about professional boundaries? What is your experience of professional boundaries on the ward? What do you think about when managing boundaries? Can you give me an example?

2. What do you find helpful in managing boundaries with clients?

Prompts: In what ways is this helpful? Has this always been the case? Why do you think this is helpful? What has led you to see it as helpful? Can you give me an example?

3. What are the challenges of managing boundaries for you?

Prompts: Can you give me an example of a previous difficulty? What did you think of this experience? How did you feel? How did it impact your later experiences? Did you learn anything from this? What other challenges have you faced? How do you think these have shaped your views of professional boundaries?

4. Do you think your understanding of boundaries has changed during the time you have been working in forensic inpatient services?

Prompts: If so, in what ways has it changed? What do you think has influenced these changes? What are the differences? How did you think about professional boundaries before, as compared to now? What have you learned? How has this impacted on your clinical work?

5. Do you always manage boundaries in the same way?

Prompts: Are the same things important in every situation? In what situations do you think about boundaries in a different way? In what situations do you manage boundaries in a different way? Do you think about/manage boundaries in the same way with every client? Or when working with different staff members? Have you always done this? What has changed? How did these changes come about?

6. Are there any experiences or factors that have been really important for you in terms of developing your understanding of professional boundaries and how best to manage them?

Prompts: What are these experiences/factors? When/how did you notice these? Why do you think they were important for you? How have they helped you? Has anything changed in your clinical work as a result of this?

7. How confident do you feel in managing professional boundaries effectively?

Prompts: Has this always been the case? What has changed? How has this changed over your time in forensic inpatient services? What is likely to affect your level of confidence in navigating boundaries? How have you noticed this? How has this impacted in your clinical work? Do you think your colleagues feel the same way?

8. Do you have any further thoughts about professional boundaries that you think it would be helpful for me to know?

Appendix I: Ethical Approval Documents

This text has been removed from the electronic copy.

Appendix J: Positioning Statement and bracketing interview mind-map

Positioning statement

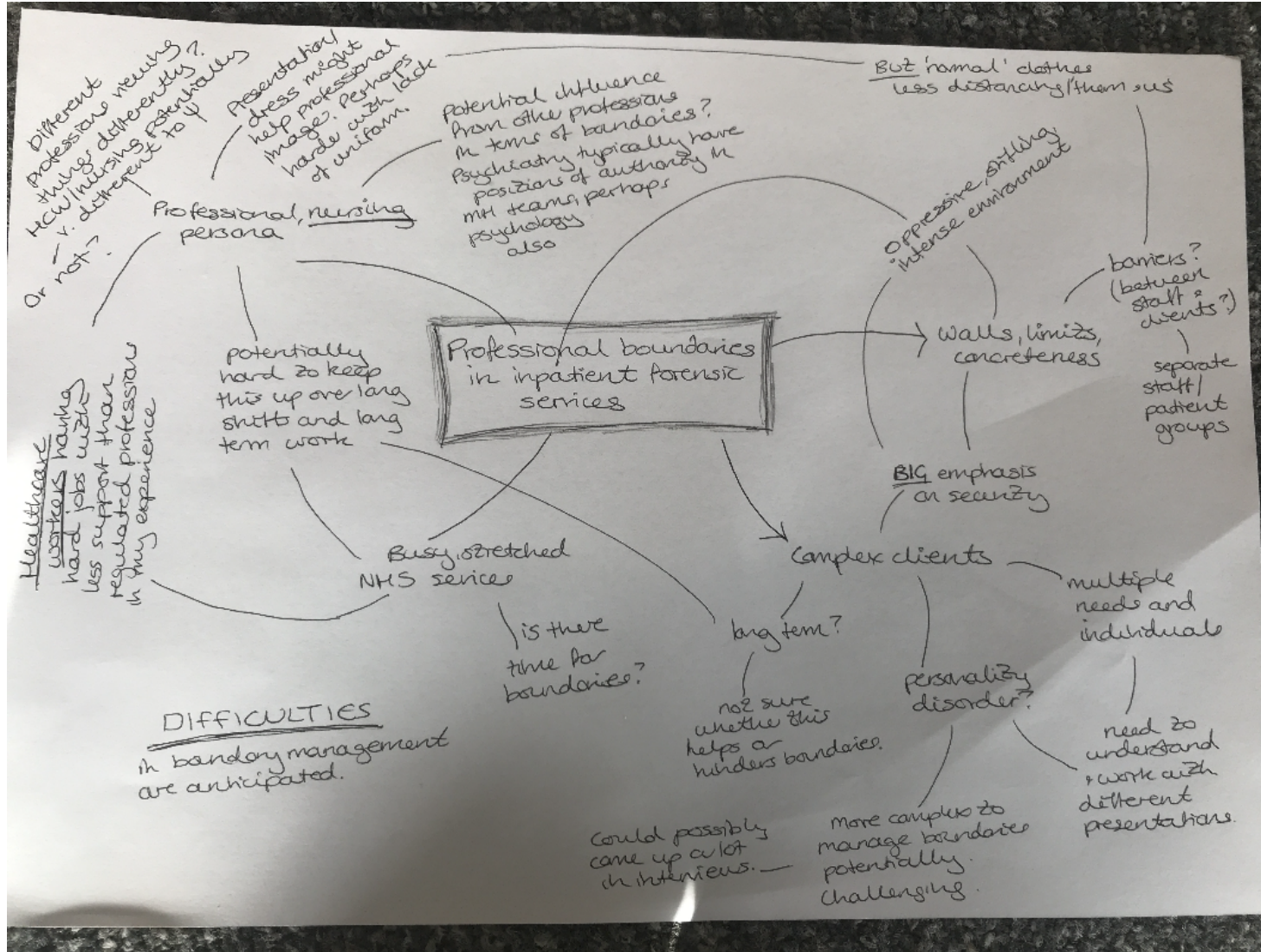
I am a twenty-seven-year-old, female second year trainee at the time of starting this research. I have no previous experience in forensic settings and only have limited experiences of working with people in an inpatient setting. I was fortunate enough to grow up in a stable, middle class family, have a good education and lots of opportunities in life. I am interested in working with people whose complex presentations may prompt stigmatising or judgemental reactions from the public and I think this is why I chose to complete research in a forensic setting. I find the idea of personal and professional boundaries intriguing and have considered this a lot in various placement experiences. I find that professional boundary issues come up a lot for me and perhaps I am particularly sensitive to difficulties around these, as my placements have often been close to home and therefore my personal and professional lives have had a tendency to overlap more than I would like.

Bracketing interview mind-map

The following mind-map, inspired by Tattersall, Watts and Vernon (2007) was developed during the bracketing interview to highlight some of my key thoughts and perceptions about personal boundaries in forensic services.

Tattersall, C., Watts, A. & Vernon, S. (2007). Mind mapping as a tool in qualitative research. *Nursing Times*, 103(26), 32-33. <https://www.nursingtimes.net/mind-mapping-as-a-tool-in-qualitative-research/199503.article>

A GROUNDED THEORY OF PROFESSIONAL BOUNDARY DEVELOPMENT



Appendix K: Sections of a coded transcript

I: So just to start them, erm, thinking about how you understand boundaries now and through your time here, do you think your understanding of boundaries has changed, or the way that you think about them changed?

D: Mm, constantly changing. Erm, even quite recently I've had to, sort of, assess my own understanding of boundaries in relation to the therapeutic relationship with patients. It's quite hard when you spend a lot of time with people like you do on, erm, inpatient wards, erm, to build a relationship with someone for the good of the working relationships, when actually you'll find patients you have a bit more in common with on a personal level. So umm, an example I can give recently is, we had a patient on our wards who had the same sort of music taste as me, so we get into 'oh what bands do you like, have you heard their latest CD?' – 'oh yeah, I've got that I can, I can lend that to you'. Which, on the, on the surface seems erm innocuous enough, but then on other wards you've had problems with people seeing that as favoring patients over other ones so there was a big email put around, not about the situation I found myself in with that but just a general reminder to erm, erm, not favor patients above others by bringing things in for lending to them directly. If you want to do something like that you can donate it to the ward and they can pick it up and listen to it and put it back and someone else can come and er have a listen to that. Ahh, I've got to go already –

I: That's fine! I'll stop it.

- Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Understanding of boundaries constantly changing.
- Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Assessment of personal boundaries in relation to therapeutic relationships with patients
- Pettman, Hannah (h.pettman194@canterbury.ac.uk)
How much time you spend with people influences how hard working relationships are
- Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Interaction between time and how much in common you have with clients
- Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Example of having something in common
Example of personal disclosure
- Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Idea of different levels of harmlessness
- Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Relationships with patients being assessed by others
- Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Others judging your actions
Others noticing what you do
Visibility
- Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Top down reminders of rules/guidelines
KMPT/unit react to ward events
- Pettman, Hannah (h.pettman19... November 30, 2017
Favouring the ward rather than one patient
- Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Top down suggestions of good practice

A GROUNDED THEORY OF PROFESSIONAL BOUNDARY DEVELOPMENT I

[break while participant speaks to other staff member]

I: Erm, so you were talking about, was that a situation where you might have wanted to lend one of your CDs to a client –

D: Yeah it was just, it was just a sort of responding to your question which has your understanding of boundaries changed and I think it was to illustrate that after having been here for so many years, erm. I think it's important not to think that you know it all and you can constantly think about your own practice in relation to boundaries and if you're identifying where you're, where you're falling short then that's ok, I think the most, the worst thing you can do is to try and cover it up if you've made a mistake. Or get defensive, we've had a few people like that that have been questioned on their conduct relating to boundaries and they've got very defensive, tried to put the blame on other people and I think it's a lot more healthy to think 'oh ok, maybe, maybe that wasn't the best thing to do, I'll take that forward and improve my practice'.

I: Mmm, so there's something there about sharing and being open with other people and having some thought for yourself about what you're doing and why I guess.

[break while participant speaks to other staff member]

I: Erm, so you were talking about, was that a situation where you might have wanted to lend one of your CDs to a client –

D: Yeah it was just, it was just a sort of responding to your question which has your understanding of boundaries changed and I think it was to illustrate that after having been here for so many years, erm. I think it's important not to think that you know it all and you can constantly think about your own practice in relation to boundaries and if you're identifying where you're, where you're falling short then that's ok, I think the most, the worst thing you can do is to try and cover it up if you've made a mistake. Or get defensive, we've had a few people like that that have been questioned on their conduct relating to boundaries and they've got very defensive, tried to put the blame on other people and I think it's a lot more healthy to think 'oh ok, maybe, maybe that wasn't the best thing to do, I'll take that forward and improve my practice'.

I: Mmm, so there's something there about sharing and being open with other people and having some thought for yourself about what you're doing and why I guess.

Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Importance of experience not leading to complacency

Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Constant need for reflection

Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Self-awareness
Identification of own inadequacies

Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Covering up mistakes is the worst thing
Implication of a continuum of responses to mistakes
Implication of choice in responding to mistakes
Importance of openness (M: with self? With team?)

Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Defensiveness is bad

Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Visibility
Formal questioning of behavior
Others noticing what you do
Others making judgements on what you do

Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Example of defensiveness?

Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Reflection and identification of mistakes better than defensiveness.
Suggestion that there are better/worse things you can do after mistakes

Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Importance of experience not leading to complacency

Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Constant need for reflection

Pettman, Hannah (h.pettman194@canterbury.ac.uk)
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Identification of own inadequacies

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Formal questioning of behavior
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Example of defensiveness?

Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Reflection and identification of mistakes better than defensiveness.
Suggestion that there are better/worse things you can do after mistakes

A GROUNDED THEORY OF PROFESSIONAL BOUNDARY DEVELOPMENT

D: Yeah, if we use that example, if you were to just go and fix the telly and you were in there

5, 10, 15 minutes and someone notices you're gone, you cause mass hysteria – 'where are

they, have they been taken hostage, they haven't let anyone know where they're going

I: mmhmm

D: So then the consequences fall on you for not telling the nurse in charge where you were,

but then if you just say – if you, if the patient asked you and you just say tell them that I'm

going, the consequences could be that you are harming the relationship with the patient

'trust me, I thought we got on

I: Right, mm.

D: but, working in a place like this, it is about keeping everyone safe and I think the perfect

thing to do would be to say to the patient 'I'm just going to tell them where I'm going so

they don't worry about where I am and think I've gone off the ward in case they need me.

Pettman, Hannah (h.pettman194@canterbury.ac.nz)
(Potential) big impact of rule breaking

Pettman, Hannah (h.pettman194@canterbury.ac.nz)
Concern for peoples safety
Visibility
People noticing when a rule hasn't been followed

Pettman, Hannah (h.pettman194@canterbury.ac.nz)
Personal responsibility for consequences of actions

Pettman, Hannah (h.pettman194@canterbury.ac.nz)
Weighing up of consequences for you and the relationship
Both actions carry risk/negative outcome

Pettman, Hannah (h.pettman194@canterbury.ac.nz)
Safety as a priority for all

Pettman, Hannah (h.pettman194@canterbury.ac.nz)
Suggestion there is a 'perfect', right thing to do

Pettman, Hannah (h.pettman194@canterbury.ac.nz)
Good to be open with patients and explain actions

D: No I think I would have just gone and fixed the telly

I: Would you

D: If I had no real concerns about the patient, yeah I would've gone 'it'll only take a couple

of minutes

I: Yeah. So what's, what's instigated that change in, in what you would have done, in using

that as a specific example?

D: Erm, I think my own development and just realizing that the dangers and why, why you

get told these things when you get on to the ward and not to be so flippant about them,

age, experience, seeing – seeing things where people have been asked to come into a room

to look at a photo and been attacked by a patient

Pettman, Hannah (h.pettman194@canterbury.ac.nz)
Example of change from earlier in career
Doing things differently later in career

Pettman, Hannah (h.pettman194@canterbury.ac.nz)
Rationalisation from early in career

Pettman, Hannah (h.pettman194@canterbury.ac.nz)
Personal sense of development

Pettman, Hannah (h.pettman194@canterbury.ac.nz)
Difference between knowing rules and understanding why they are in place
Understanding came later

Pettman, Hannah (h.pettman194@canterbury.ac.nz)
Earlier flippancy about rules
Suggestion of different levels of depth in rule understanding






Pettman, Hannah (h.pettman194@canterbury.ac.nz)
Higher age, more experience and seeing negative consequences all impact development of understanding of rule

Pettman, Hannah (h.pettman194@canterbury.ac.nz)
Example of negative consequence








A GROUNDED THEORY OF PROFESSIONAL BOUNDARY DEVELOPMENT

I: So that's been quite a factor for you then, erm, in thinking about how you respond to boundary situations on the ward and that -

D: And just from working with good nurses and bad nurses you pick up the proper way to do things and when you see things that you're not too sure of you think 'what would you do in that situation?' and erm, whenever I have to make a decision I can always relate it to something I've seen in the past or a good nurse that I've worked with and I've thought 'that was dealt with brilliantly'.

-  **Pettman, Hannah** (h.pettman194@canterbury.ac.uk)
Judgements of other staff
Good and bad nurses
-  **Pettman, Hannah** (h.pettman194@canterbury.ac.uk)
Suggestion of a 'proper' way to do things
-  **Pettman, Hannah** (h.pettman194@canterbury.ac.uk)
Learning from other staff members
-  **Pettman, Hannah** (h.pettman194@canterbury.ac.uk)
Witnessing others encourages reflection
-  **Pettman, Hannah** (h.pettman194@canterbury.ac.uk)
Good examples are noted, remembered
Relating own experiences to other peoples
M: Good examples are imitated?

D: I'll try and think of an example, I'm sure I can. [pause]. We've had erm, there has been something on the ward recently where a newer member of staff has questioned some of the older members of staff's relationships with patients, they thought they were a bit too tactile with them, not in like an overly concerning way but where the older members of staff have worked on this ward for a long time, it would be quite – not common practice – but if there was a patient they've worked with for a long time coming onto the ward they'd be like 'oh', they'd give them a quick hug and say 'hello, how are you'. The newer member of staff, erm, questioned that so I think the older member of staff – there was a bit of friction between the two members of staff that I'm talking about and erm, the older member of staff's argument was that her own nursing – what's the word – her own nursing practice is a bit more maternal, a bit more caring, the motherly sort of role, whereas the other, the newer member of staff was very therapeutic relationship but very boundaried and strict and the argument was we've got to show a human side to these people who are going through a particularly tough time, I mean their life, how can you say that a rub on the arm or a quick hug to show that I care is inappropriate and what are you trying to make me out to be? And the newer member of staff was trying to explain to her the risk that she's putting herself in and the other members of staff – if patients are seeing her favor that one over them, then if it is to become common place and everyone's giving everyone hugs then why is she, why is the newer member of staff not hugging people, it sets her apart from everyone, it splits the team. So I think that there is erm like an example of the difference in boundaries between what some people find appropriate and some don't find appropriate.






-  **Pettman, Hannah** (h.pettman194@canterbury.ac.uk)
Recent example of new vs experienced staff difference in boundaried practice
-  **Pettman, Hannah** (h.pettman194@canterbury.ac.uk)
Sometimes experience on a ward can lead to more tactile relationships with patients
-  **Pettman, Hannah** (h.pettman194@canterbury.ac.uk)
Friction amongst staff at times of disagreement
-  **Pettman, Hannah** (h.pettman194@canterbury.ac.uk)
Suggestion of a personal sense of own practice guides boundary understanding
-  **Pettman, Hannah** (h.pettman194@canterbury.ac.uk)
Consideration of role in nurse-patient relationships
-  **Pettman, Hannah** (h.pettman194@canterbury.ac.uk)
Conflict in boundary discussions
-  **Pettman, Hannah** (h.pettman194@canterbury.ac.uk)
Human-ness in working relationships
Experienced staff suggesting that caring reactions are not inappropriate
-  **Pettman, Hannah** (h.pettman194@canterbury.ac.uk)
Nurses taking disagreement with their actions personally
Disagreement with my actions = disagreement with me?
-  **Pettman, Hannah** (h.pettman194@canterbury.ac.uk)
Newer staff members highlighting risk
-  **Pettman, Hannah** (h.pettm November 30, 2017 
Actions create expectations that others will act in the same way
If people don't act in the same way towards patients it splits the team
-  **Pettman, Hannah** (h.pettman194@canterbury.ac.uk)
Appropriateness of boundaries
-  **Pettman, Hannah** (h.pettman194@canterbury.ac.uk)
Awareness of individual difference in opinion about boundaries

A GROUNDED THEORY OF PROFESSIONAL BOUNDARY DEVELOPMENT I

I: No it's a good one though, I see what you mean. Do you think that's a pattern generally that the more experienced you get the more flexible you become with boundaries, or do you think that was just one example?

D: Oh I think so for a number of reasons, the pressure that people work on in a largely thankless job make people jaded quite quickly and they think, 'to hell with it, it doesn't matter if I let this little thing slide'. Whereas, this might be quite cynical of me to say but quite newly qualified people are quite enthusiastic and want to save the world and want to do everything by the book, erm, I think that comes into it as well.

I: Mmhhh, yeah. Wow, ok. Erm, so you've got, yeah, there are lots of things going on there, lots of discussions about that and about different peoples' views of boundaries and – are









-  **Pettman, Hannah (h.pettman194@canterbury.ac.u**
Experience increases personal sense of flexibility with boundaries
-  **Pettman, Hannah (h.pettman194@canterbury.ac.u**
Rebelliousness
Impulsivity
-  **Pettman, Hannah (h.pettman194@canterbury.ac.u**
People become more flexible over time due to boredom/tiredness.
-  **Pettman, Hannah (h.pettman194@canterbury.ac.u**
Newly qualified staff as enthusiastic, motivated and 'by the book'
Newly qualified staff as stricter with boundaries
-  **Pettman, Hannah (h.pettman194@canterbury.ac.u**
M: Contrasts with this participants earlier suggestion that their boundaries became firmer over time (tending/going to patients rooms examples)

I: Ok

D: Erm and again I find that helpful for myself to get a lot of peoples' opinions on different subjects and think why – just because I might do something one way it doesn't mean the way someone else is doing it is wrong. Seeing the reasons why they chosen to do it that way and we can talk about the reasons if that's been particularly helpful view or not, what they would do differently in the future. I try and make – if I have to have a particularly difficult conversation with someone – try and make it not like I'm telling them off but trying to make them see the reasons why this discussion needs to take place and its not to say you've been bad, you've done something wrong -









I: Yeah

D: - but I try and help them with their own practice. Staff meetings when there's a lot of people turns into a bit of a war zone, because as soon as someone says something that

-  **Pettman, Hannah (h.pettman194@canterbury.ac.u**
Supervision helpful to hear different opinions
-  **Pettman, Hannah (h.pettman194@canterbury.ac.u**
Helpful to be curious about the reasons for people's actions
Reflection
-  **Pettman, Hannah (h.pettman194@canterbury.ac.u**
Acknowledgement of more than one right way of doing things
Comparison of your actions with other peoples
-  **Pettman, Hannah (h.pettman194@canterbury.ac.u**
Supervisor facilitating reflection of practice
-  **Pettman, Hannah (h.pettman194@canterbury.ac.u**
Discussion of boundaries can be hard as a supervisor
Uncomfortable to point out/judge someone's actions
-  **Pettman, Hannah (h.pettman194@canterbury.ac.u**
Importance of discussion without reprimand
-  **Pettman, Hannah (h.pettman194@canterbury.ac.u**
Aim to help rather than reprimand
-  **Pettman, Hannah (h.pettman194@canterbury.ac.u**
Staff meetings as a place of conflict

A GROUNDED THEORY OF PROFESSIONAL BOUNDARY DEVELOPMENT

D: Yeah. Yeah, we have erm, excuse me, a weekly community meeting for the patients and these things again will always come up and we'll say 'guys, I know' (again, the smoke break), 'guys I know the times been getting closer to 20 past instead of half past so we've really got to reign it in and these are the reasons why, hope you understand. We also have a lot of other things to do than to do the smoke breaks as well, hope you understand. And they'll say 'yes yes ok, can we get away from this meeting now' and then it, it'll last a day and it won't change and it is like a constant battle. But I, erm, when you've got a ward full of 12 guys here that don't have a lot more to look forward too than a smoke break every two hours, you can understand why they're, why they're impatient, why they put so much emphasis on this ten minutes and some staff don't see that. But if they were at home they wouldn't need to ask someone to open the door for them or to get their cigarette for them. Again, that's something that the people with less firm boundaries are probably thinking – it's a bit of empathy and 'oh well, I probably wouldn't need to ask someone, I wanna make their life as easy as possible, that if they were at home it must be frustrating for patient to say 'oh can I have my drink out the fridge' and someone to say 'oh in a minute, I'm just writing this thing that's not of any benefit to you and you've just got to stand here and watch me to do that'. So some people want to do, you know, to facilitate as much as they can for patients.

-  **Pettman, Hannah (hpettman194@canterbury.ac.uk)**
Weekly community meetings as a boundary forum
-  **Pettman, Hannah (hpettman194@canterbury.ac.uk)**
Clear, open communication to patients
-  **Pettman, Hannah (hpettman194@canterbury.ac.uk)**
Rule consistency is a constant battle
-  **Pettman, Hannah (hpettman194@canterbury.ac.uk)**
Patients requests to challenge rules can be seen as understandable
-  **Pettman, Hannah (hpettman194@canterbury.ac.uk)**
Less firm boundaries might be connected to empathy and wanting to provide a normal experience
-  **Pettman, Hannah (hpettman194@canterbury.ac.uk)**
M: Consideration of reality can be linked both to more and less firm boundaries
-  **Pettman, Hannah (hpettman194@canterbury.ac.uk)**
Consideration of patients' views
-  **Pettman, Hannah (hpettman194@canterbury.ac.uk)**
Nurses facilitating patients

I: Yeah, ok. And would you – is that something you've always done? Is there, have you not always found those kinds of things quite unhelpful?

D: I wouldn't even say unhelpful, just not very, not very relevant to the way I work.














I: Right ok

D: I like to think that if you, if you approach this with common sense and you treat these people like people then you don't need to bring it back to some legislation and if you are unsure about something then there are plenty more experienced people around for you to speak to that can help you.

I: Ok. Yeah.

D: Probably not the best way to work but its worked so far!


I: Well it sounds like it's helpful because you've described talking to people and interaction and other peoples' good examples

-  **Pettman, Hannah (hpettman194@canterbury.ac.uk)**
Policies irrelevant to personal style
-  **Pettman, Hannah (hpettman194@canterbury.ac.uk)**
Policies not unhelpful
-  **Pettman, Hannah (hpettman194@canterbury.ac.uk)**
'these people' as different group
-  **Pettman, Hannah (hpettman194@canterbury.ac.uk)**
Common sense and human-ness negate the need for legislation
-  **Pettman, Hannah (hpettman194@canterbury.ac.uk)**
Importance of general human characteristics
-  **Pettman, Hannah (hpettman194@canterbury.ac.uk)**
Uncertainty
-  **Pettman, Hannah (hpettman194@canterbury.ac.uk)**
More experienced people can help (even if you're experienced?)
-  **Pettman, Hannah (hpettman194@canterbury.ac.uk)**
Advise seeking
-  **Pettman, Hannah (hpettman194@canterbury.ac.uk)**
Questioning practice, uncertainty, no right answer/no one way
-  **Pettman, Hannah (hpettman194@canterbury.ac.uk)**
The way that works isn't necessarily the 'best'
-  **Pettman, Hannah (hpettm November 17, 2017)**
Building experience
-  **Pettman, Hannah (hpettman194@canterbury.ac.uk)**
Importance of staff communication
-  **Pettman, Hannah (hpettman194@canterbury.ac.uk)**
Learning through good examples

A GROUNDED THEORY OF PROFESSIONAL BOUNDARY DEVELOPMENT


I: And do those types of things, I think you've said you've yet to go on the new one, that's coming up for you right? Have some of the other ones, the elearning, the confidentiality ones, changed the way that you work clinically or is it more about being aware or?


D: They're just nice reminders of things -


 **Pettman, Hannah** (h.pettman194@canterbury.ac.nz)
Training as a 'nice reminder'

I: Oh ok

D: - throughout the time, because you do so much when you start with the trust of - you're sort of overwhelmed with all these training courses and inductions and erm, they're just a nice reminder when you do these of how you should be working, erm.....


 **Pettman, Hannah** (h.pettman194@canterbury.ac.nz)
Induction and training overwhelming at the start of employment


 **Pettman, Hannah** (h.pettman194@canterbury.ac.nz)
Training as a reminder of work requirements


 **Pettman, Hannah** (h.pettman194@canterbury.ac.nz)
Timing of training is important


I: Makes sense


D: And then, again it'll make you reflect on your own work 'oh I can relate that to this incident that happened or this conversation I had with someone, now I know this for next time.

 **Pettman, Hannah** (h.pettman194@canterbury.ac.nz)
Training encourages this staff member to reflect on their own experiences

 **Pettman, Hannah** (h.pettman194@canterbury.ac.nz)
Applying training to practice


 **Pettman, Hannah** (h.pettman194@canterbury.ac.nz)
Relating training to own experience

 **Pettman, Hannah** (h.pettman194@canterbury.ac.nz)
Changing practice as a result of training

 **Pettman, Hannah** (h.pettman194@canterbury.ac.nz)
November 17, 2017
Learning from training
Confidence

I: Ok, so it helps you think about things and -

D: Yeah, be reflective of your own practice definitely.

 **Pettman, Hannah** (h.pettman194@canterbury.ac.nz)
Training helpful to reflective practice

I: Ok and you mentioned there like help you learn for next time, erm I guess that kind of makes me think of a bit of a trial and error situation sometimes as you learn?

D: Yeah yeah

A GROUNDED THEORY OF PROFESSIONAL BOUNDARY DEVELOPMENT















D: Yep

I: Yeah

D: Definitely, again that's things to go over in supervision, my own supervision, I think it's more healthy to bring up things rather than bury them and hope they go away, so like, 'oh actually, let's talk about this I did this the other day, what do you think about that?'





I: Mmhmm

D: Err and have that conversation, like I say, like I said at the beginning erm, I find it much more helpful and healthy to talk about the things that you're not sure of rather than just pretend they didn't happen or try to get defensive and justify yourself where if someone's questioning the way you work 'oh that's interesting that you think that, let's have that conversation'.

-  **Pettman, Hannah (h.pettm** November 17, 2017 
Supervision helps (trial and error learning – my words)
-  **Pettman, Hannah (h.pettman194@canterbury.ac.u**
Healthier to raise issues in supervision
-  **Pettman, Hannah (h.pettman194@canterbury.ac.u**
Checking things out in supervision
-  **Pettman, Hannah (h.pettman194@canterbury.ac.u**
Different options for managing boundaries
-  **Pettman, Hannah (h.pettman194@canterbury.ac.u**
Proactive requests for discussion around practice
-  **Pettman, Hannah (h.pettman194@canterbury.ac.u**
Supervision as a conversation
-  **Pettman, Hannah (h.pettman194@canterbury.ac.u**
Uncertainty, lack of clarity
-  **Pettman, Hannah (h.pettman194@canterbury.ac.u**
More helpful/healthy to discuss ambiguous situations
-  **Pettman, Hannah (h.pettman194@canterbury.ac.u**
Dilemma, choice of options
-  **Pettman, Hannah (h.pettman194@canterbury.ac.u**
Unhelpful to not acknowledge something
-  **Pettman, Hannah (h.pettman194@canterbury.ac.u**
Unhelpful to be defensive about practice
-  **Pettman, Hannah (h.pettman194@canterbury.ac.u**
Openness to conversations about disagreements in practice
-  **Pettman, Hannah (h.pettman194@canterbury.ac.u**
Reflecting/thinking

I: Mmm


D: And so it would be easy for me to say 'why are you speaking to patients like that, you know you're not supposed to speak to patients like that', but I said 'oh someone mentioned this, what hap- do you want to tell me what happened?'. For all I know, they could have been calling after them, the ward was short staffed, they called at them from far away because they didn't want to leave the ward unattended – 'oh ok, just thought I'd check on that, thank you for explaining it that's fine', rather than attacking the patient and risking your relationship with a member of staff.


-  **Pettman, Hannah (h.pettman194@canterbury.ac.u**
Easy to question but would rather understand
-  **Pettman, Hannah (h.pettman194@canterbury.ac.u**
Withholding judgement
-  **Pettman, Hannah (h.pettman194@canterbury.ac.u**
Multiple factors to consider in PB decisions
-  **Pettman, Hannah (h.pettman194@canterbury.ac.u**
Consideration of staff/supervisory relationship


A GROUNDED THEORY OF PROFESSIONAL BOUNDARY DEVELOPMENT


I: mmhmm


D: with her hand on the back on his arm. The patient, erm other member of staff came to me and said that was blurring erm professional boundary, so erm, it would have been easy for me to come in and say 'someone's been talking about you and said that you've had an inappropriate relationship because you've been touching their arm, stop touching their arm'. As I say, instead I waited for the supervision and said 'how have things been going with you, oh what about so and so, hows things going with them?' and they've brought it up and said 'oh yeah, poor soul, he looked distressed the other day, you could tell he was going through a tough time, you know, I took him to the medication room and give him PRN' and that's when I said 'yeah someone said that you put your arm round the back of them, back of the, back of their arm, can you see that that might not have looked great to other people, especially with what we've had going on here, there've been inappropriate relationships. To not do that is just an easy thing you can do to help keep yourself safe from from accusations and erm from feeling, from other patients feeling that you're giving other patient preferential treatment by having a better relationship with them'. So in, you let them bring it up rather than say 'right, everyone's been talking about you and saying you're doing this'. Does that make sense?


 Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Example of boundary issue


 Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Staff reporting boundary crossings to team leaders


 Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Easy to confront, accuse and instruct


 Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Empathy linked to tactile responses

 Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Leaders encouraging staff to see things from others eyes


 Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Leaders reminding staff of previous incidences


 Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Leaders encouraging staff to keep selves safe from accusations


 Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Ask and advise gently


 Pettman, Hannah (h.pettman194@canterbury.ac.uk) January 04, 2018
Letting the supervisee bring up potential issues


D: Some patients come in and you think, 'oh if you weren't here, I could probably be mates with you on the outside if I met you in another walk of life'. So you do have that where you gravitate to some patients more than others, so when you do get on with them and you find common ground in the personal life, it's nice for the patients because they're, they're here for a long time and they're talking to, they're talking to you about something that isn't about their mental illness and isn't about something they are probably sick to death of hearing about from all the professionals in here. So when you lend someone a CD and then get told you shouldn't be lending that person a CD, it's a bit like, just trying to make their life a bit more normal, just trying to normalize their life here a bit, you know, giving them a bit of an escape from what they're thinking about themselves all the time. The only people that come onto the ward are there to talk to them about their mental health so yeah I do struggle with the keeping it on, er, on a professional level sometimes, but only on low level things. Even when, er, there was an email put around about the CDs I was like 'you're joking, it's a CD, they're giving it back to me again at the end of the day', but then you have to go and tell everyone, you know, I had to put a note in our communication book about 'so, er, just to remind you you shouldn't be lending CDs' and I knew everyone would be reading it thinking 'you do that all the time! Why are you telling us, you're the only one that does that'.


 Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Some patients you get on with well


 Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Getting on with clients allows for conversation about things in common that aren't mental health related

 Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Trying to normalize life on the ward for clients

 Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Wanting to help clients get away from constant mental health stuff makes it more of a struggle to keep things professional


 Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Skepticism about some, seemingly minor rules


 Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Communication book reminds staff about PB related rules


 Pettman, Hannah (h.pettman194@canterbury.ac.uk)
Awareness of own hypocrisy in rule reminders

D: Yeah, I remember first week I worked here, the nurse that was giving me the induction of the ward, we have the big blue files that have got all patients information on and information on their offending. They pointed them out to me and said 'that contains all the information you wanna know'. Some people like going through the notes of the index


32

 **Pettman, Hannah** (h.pettman194@canterbury.ac.u
Memorable occasions when given the choice to look or not

 **Pettman, Hannah** (h.pettman194@canterbury.ac.u
Info is available on patients' offence histories in induction

 **Pettman, Hannah** (h.pettman194@canterbury.ac.u
Info folders pointed out when staff members start


offence so they know who they're working with and erm any information they need to not put their foot in it, you start talking about someone's mum and it turns out a lot of their delusional beliefs were about their mum' –


 **Pettman, Hannah** (h.pettman194@canterbury.ac.u
Knowing offence history helps avoid unhelpful convos


D: Then other people like to stay away from it so they can be non-judgmental and treat everyone the same. Erm, I personally liked reading them because it gave me more information on the person and I could stay away from any of the warning signs to be aware of, but I'll always give that information to people as well – this is the pros and cons of knowing, this is the pros and cons of not knowing


I: Right

D: I think that helps some people with boundaries, but for me the offending, no I've learned to be totally down the line with that and not treat anyone any different because of the offence they've done, even though when you're outside and you read something in the paper that's similar 'oh that's terrible, how can people work with them'


 **Pettman, Hannah** (h.pettman194@canterbury.ac.u
Not knowing offence history helps to stay non-judgmental and treat everyone equally


 **Pettman, Hannah** (h.pettman194@canterbury.ac.u
Passing on the choice to know as modelled by previous colleague


 **Pettman, Hannah** (h.pettman194@canterbury.ac.u
Knowing offence history can help some people with boundaries


 **Pettman, Hannah** (h.pettman194@canterbury.ac.u
Offence history doesn't make a difference to how they treat a client


D: So I think the boundary might be a bit different there, you wanna blur the line a bit for them rather than the professional patient that understands the boundaries and will adhere to it when it's put in place. Where as someone where this is their first, their first um experience with a mental health place that doesn't understand why you're setting the boundary here, again I go back to the smoking time, they've missed the smoking time by five minutes. Someone who's consistently missing that smoking time, you can say 'you know this', but someone that would be quite ill, just come in, quite young, doesn't understand the way these things work, you'd think in your head 'ahh well if they were at home they wouldn't have to remember a time

 **Pettman, Hannah** (h.pettman194@canterbury.ac.u
Tendency to blur the boundaries with younger, inexperienced patients

 **Pettman, Hannah** (h.pettman194@canterbury.ac.u
Sense that professional patients understand and comply with boundaries

 **Pettman, Hannah** (h.pettman194@canterbury.ac.u
Younger patients don't understand the boundaries and rules

 **Pettman, Hannah** (h.pettman194@canterbury.ac.u
Professional patients are expected to know the rules

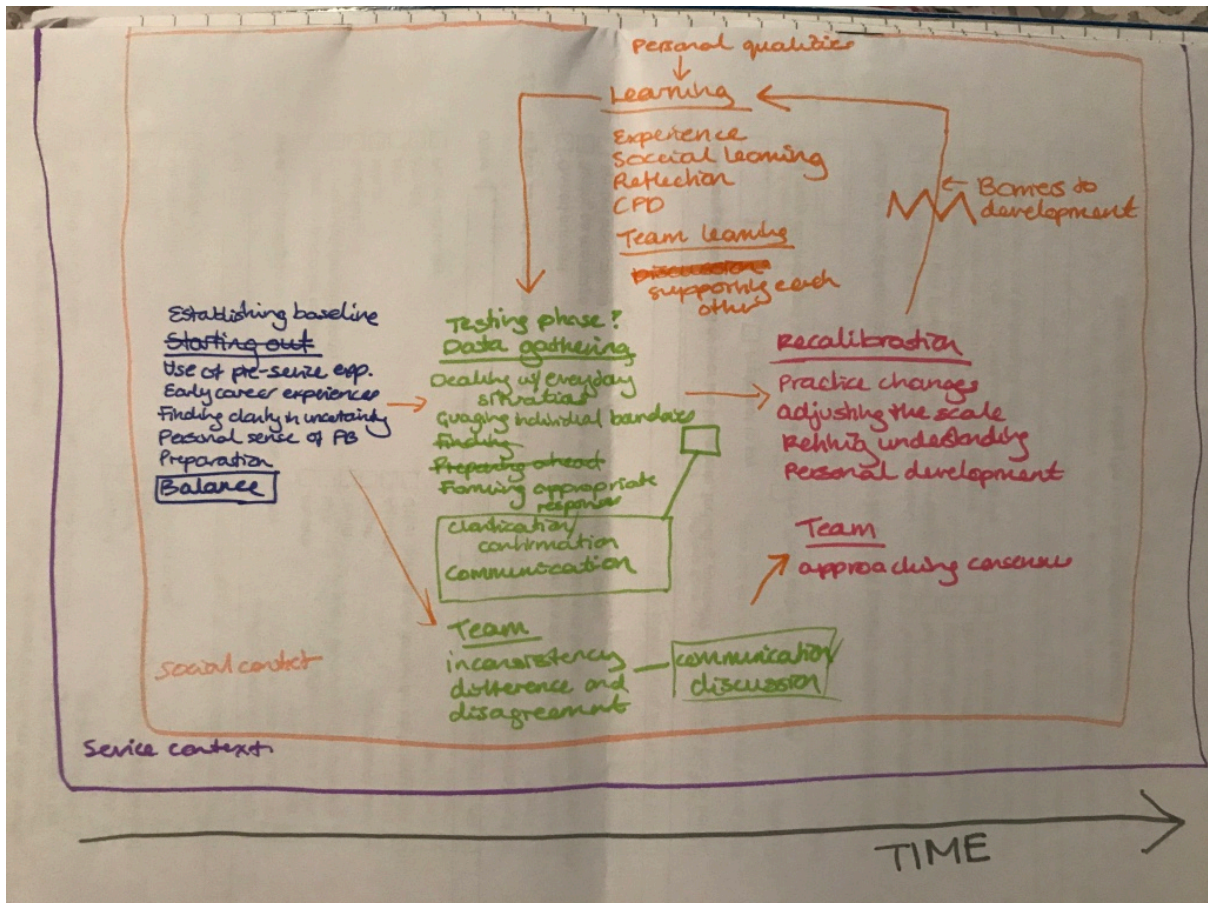
 **Pettman, Hannah** (h.pettman194@canterbury.ac.u
You can cut younger patients a bit of slack as they aren't used to ward life

Appendix L: Integrative maps

23.01.18: A map from earlier on in the analysis process. A temporal element was very clear, but I wasn't sure how some of the categories and subcategories at the top fit together. Green = category; yellow = Subcategory; pink = themes within a subcategory. There were lots of codes relating to balance that I wasn't sure what to do with yet.



31. 01.18: A later map showing progression to a more cyclical design. The different colours represent different phases, although I had got the learning and recalibration phases an odd way around. The cyclical element is depicted here within a social context and then a wider service context. This was more of a hunch at this point and changed later in analysis as some of the social subcategories were absorbed into team and social learning subcategories and a service development subcategory was formed.



Appendix M: Memo development

1. A constant change cycle

This collection of memos show the development of the cyclical aspect of the theory, alongside some of the development of the phase names.

29.11.17. There are a couple of points in the first few interviews that indicate a process of development that happens over time. For example, ***“I definitely think the vocational type learning is what has changed that for me” (Participant A)*** implies experience-based learning that leads to change, or adjustment in some way. It seems likely that the theory will include some temporal element, given that I’m exploring development and that participants appear to be talking about experience and learning – all processes that happen over time. However, it’s not currently clear how this happens or what kind of time frames are involved.

22.01.18. Some participants have now acknowledge a ‘now vs then’ comparison of when they first started vs the time of the interview. Obviously depending on the participant, various time spans have elapsed since each staff member started on the ward. These comparisons tend to be presented as distinct, separate individual states – ‘this was me when I first started here and this is me now’ or ‘this is what I did then and this is what I do now’:

“Where I first started I was, I don’t want to say just a HCW, but I was a HCW, erm, no real responsibilities with people below me so it was like ‘oh well I’m just going to do that and if I get told off I get told off. If I do that now, in the role that I’m in, erm, then other staff will see that and go ‘well he’s got a fair amount of responsibility on the ward and if he’s doing that that must be ok to do” (Participant D; Ward X)

Sometimes this idea came across as participants talked about their early actions or states in the past tense, as though the things they were acknowledging no longer applied:

“I think I struggled a little bit, particularly with unwanted attention, you know, from patients. I was quite young.” (Participant G; Ward X)

“I was 18 when I first started, I started as a HCW, hadn’t got a clue.” (Participant H; Ward X)

I think this suggests some sort of movement, from an original state A to a new, developed state B, (struggling to not struggling, for example). This movement seems more likely to be based on a gradual learning process, rather than an instant jump, given my initial thoughts of a process related to Participant A’s comment above and the idea of experiential learning that participants keep alluding to:

I: you talked about learning and I wonder how you learn, what kind of happens for that learning to take place?

C: It’s experience and you know, maturity as well... with experience you develop your own boundary knowing you know what you know. (Participant C; Ward X)

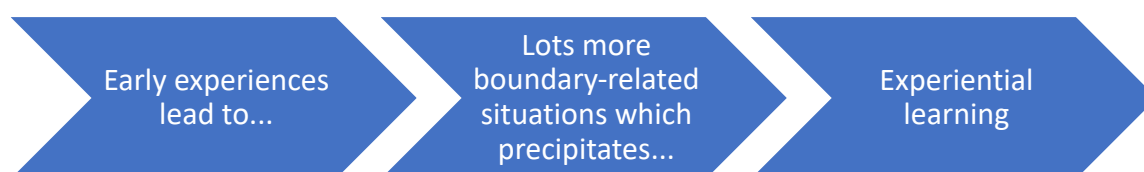
“I think because of my work experience....I’m more aware of who not to touchand who not to touch. Not that, I suppose linking it to maturity is the way I would put it because I have had a lot of working experience with people with mental health issues, so maybe maturity is not the right word, maybe it’s just life experience” (Participant J; Ward X)

Having more experience and the idea of maturing on the ward mean being a more experienced member of staff and perhaps this is the State B that people move to from State A, being a new starter. Potentially then, experience is the process through which participants move through one state to another. Inherently, experience comes from repeated exposure to the ward and participants referred to both how they managed moment to moment boundary issues that came up as part of that exposure, as well as how the impact of those experiences helped them to learn and develop, for example:

“I think I sort of came away from it and thought ‘did I, did I handle that well? Is there any other way I could have handled that?’” (Participant E; Ward X)

Both of these are potential categories and one clearly follows the other, with experiential learning a product of having to encounter situations constantly:

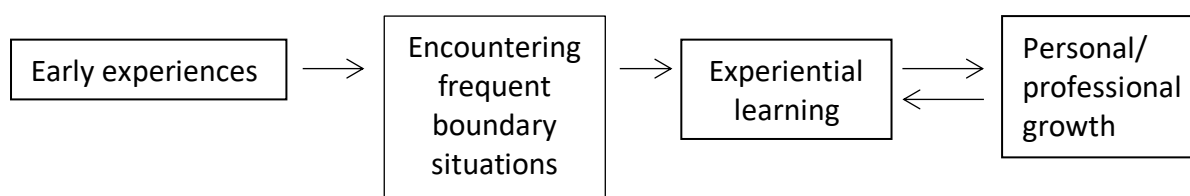
“They work on very minimal staff here so there’s a lot more one on one contact, you can’t rely on a team kind of around you, you can’t rely on someone else to kind of step in or something, so I think maybe because of that they do, they do learn it and they pick it up and they develop that themselves” (Participant F; Ward X)



31.01.18. Participants have routinely suggested that things are gained from experiential learning, though, which goes back to State B – a result of change. I am also getting the sense that these gains do not amount to a ‘finished product’ – a person does not just become an experienced member of staff and stay in that same state. People have indicated a more ongoing, fluid process of learning and change that could do on indefinitely:

“I think we can always learn, I think we can always grow and develop as people. (Participant J; Ward X)”

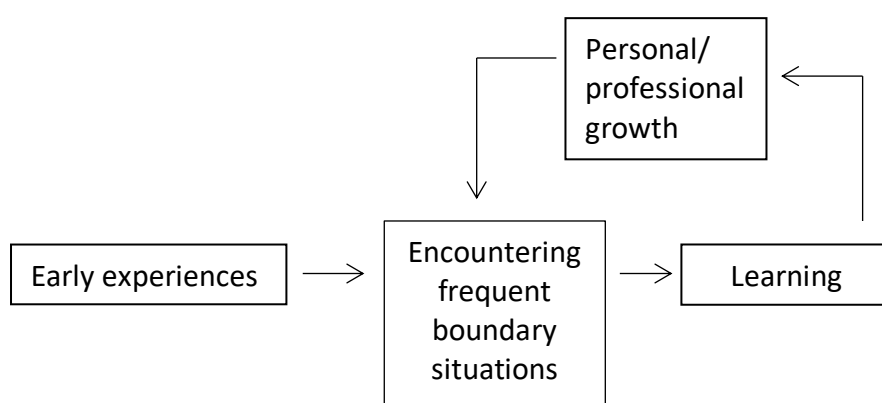
Perhaps there is an interactive process of learning and personal/professional growth that go hand in hand?



05. 02. 18. Reflecting on the above, after a reshuffle on some of the subcategories, I think there is more evidence from the data to show that learning and growth don't simply go hand in hand, it is more complex than that.

“It comes with experience as well because as soon as I met him I could tell straight away that he was somebody that I'd need to be quite boundaried with in terms of physical contact” (Participant F; Ward X)

Participant comments such as the one above indicate to me that people *do* something specific with the growth they gain from experiential learning. That growth is plugged back into the system to have a direct impact on day to day situations, for example the above nurse's experience appears to have helped her to learn how to spot people she might need to use firmer physical boundaries with. This development in her clinical judgement presumably directly affected her way of working with the particular client that she described. She adjusts her way of working according to her developed skills. Perhaps the model looks more like this:



Other participant comments support the cycle of having some experience, learning, growing, further learning, for example:

“And then when you start to relax a bit and you get into the job a bit more, you sort of do your own thing, but then you still do learn from other people, see but it definitely does change” (Participant E; Ward X)

This participant describes feeling more relaxed in the role, which I see as a form of personal growth and development. She then describes doing the job a bit more (gaining further day to day experiences), but still learning.

2. Team development

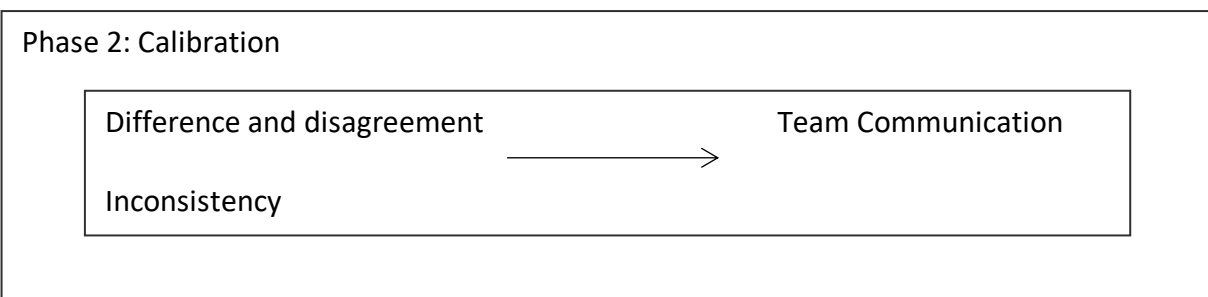
These memos detail the development of the 'team development' subcategory and how it interacts with individual learning.

23.01.18. Alongside their individual experiences, participants are talking a lot about their nursing and support staff colleagues'. Multiple codes reflecting staff differences in their approach to boundaries and the conflict this can cause in the team have led to a category of 'difference and disagreement'. A separate category reflects the difficulties that the inconsistency of the staff approach to boundaries can have. A third category relates to codes around team communication and discussions, which some

participants have suggested happen as a result of disagreement and inconsistency, for example:

“There has been something on the ward recently where a newer member of staff has questioned some of the older members of staff’s relationships with patients, they thought they were a bit too tactile with them..... the argument was we’ve got to show a human side to these people who are going through a particularly tough time..... And the newer member of staff was trying to explain to her the risk that she’s putting herself in and the other members of staff – if patients are seeing her favor that one over them, then if it is to become common place and everyone’s giving everyone hugs then why is she, why is the newer member of staff not hugging people, it sets her apart from everyone, it splits the team.”
(Participant D; Ward X)

The way that participants talked about the differences, inconsistency and communication within the nursing and support staff team makes me wonder whether this is a parallel process that happens alongside individual experiences of every day boundary management situations. The participant above, for example, spoke about a specific situation, which might suggest that the team process of managing every-day situations fits best within Phase 2:

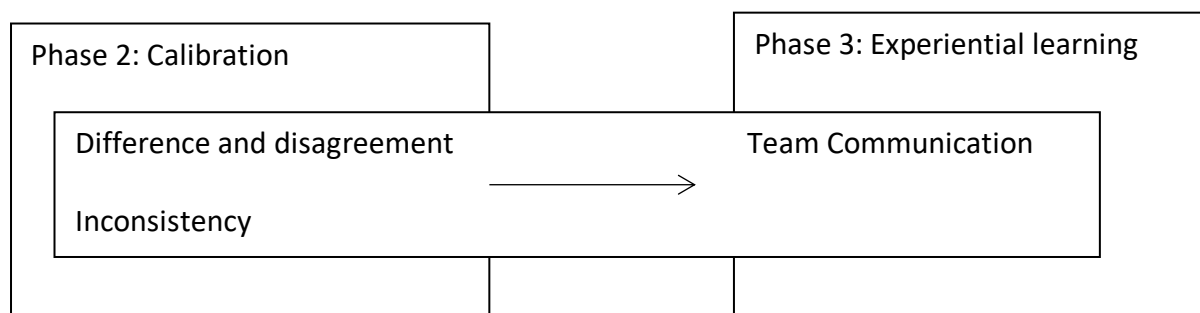


25.01.18. I’m wondering more about communication within the team and what that does – does it have an outcome or purpose that participants have mentioned. Participant C (below) indicates to me that there might be something around communication facilitating a consensus or compromise between nursing and support staff. This gives me more of a sense of team development, that something is happening between staff members in discussions that allows perspectives to be shared (and maybe understood?), disagreements to be soothed and/or finding ways of working with a boundary that are mutually suitable.

“It’s me saying, if so and so gets up and misses their smoke break for five minutes, I will allow that because it’s, we’re human and the other person says ‘well I won’t do that because they’re not learning’. Then we’ll have that discussion and we’ll meet in the middle but it is a problem” (Participant C; Ward X)

Perhaps there is also something about the day to day experiences shared by the team that leads to staff members learning from and with each other – this could be parallel to the individual experience of calibration → experiential learning that

individual team members go through. Perhaps this part of the model then looks like this:



01.02.18. I have a hunch that the above part of the model isn't quite right. I do think the team's experiences of finding ways of working together, discussing disagreements etc. are an important part of the theory, but the three subcategories above I think could be collapsed into one subcategory that reflects the team development as a whole. This could include codes such as 'team supporting individual weaknesses' and 'teamwork focus' that I think don't necessarily fit into any one of the three subcategories as they are, but would perhaps fit better in a wider subcategory that encapsulates how the team attempts to work with boundaries together. This would include having differences, working with consistency and communicating, but also how the team justifies their nursing boundaries as a profession to other professional groups, which may also indicate team cohesiveness without being about difference or within-profession consistency. For example, the participant below uses the work 'we' when talking about the difficulties of the nursing role in terms of boundaries, indicating a shared experience that might unite the team:

“Nursing I think have the hardest job because psychologists, social workers, sorry [cough], consultants, psychiatrists see patients couple of hours a week if you're lucky. We deal with them through the good, the bad and the ugly.” (Participant K; Ward X)

Perhaps the 'team development' subcategory would fit better in Phase 3?

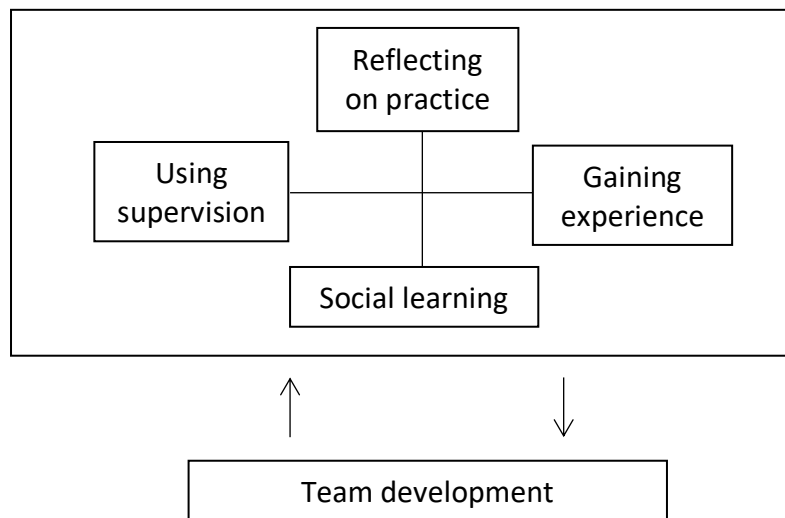
05.02.18. I think the idea of how the individual interacts with the team and vice versa has also become more evident during the analysis of later transcripts. I think that individual experiential learning has an impact on the team, for example participant G below is talking about how reflection on individual actions in supervision can aid a person's awareness of how their actions impact on other members of their team:

“So you kind of look at it and try to explain that even though it might be something they see as genuinely helping the patient out but actually it's causing conflict within the team. You try and make them understand that, you try and make them see it from others perspective” (Participant G; Ward X)

Conversely, participants have also indicated that the wider nursing team appreciation can impact on the individual participant's skills and learning too, in a reciprocal process:

“I always keep it in my mind that it’s not so much me they might want to touch, it might be a younger member of staff who won’t be able to cope with it as well, so by me setting those firm boundaries with patients that’s really important because it’s about the team, it’s not about me. It’s about the whole keeping everyone safe in this environment.” (Participant J; Ward X)

This quote gives me a sense that this person feeling like part of a team and being able to appreciate a wider team perspective has enabled her to understand how her individual actions might affect other members of staff. Again, this indicates an interactive process of individual learning and team development, where both can affect the other in Phase 3:



Appendix N: Details of member checking

Email to participants

The following email was sent to all participants individually, with a copy of Figure 1 (in the results section) and the following explanation of the model. Four participants were telephoned for their thoughts on the model, which were favourable, and two participants emailed written feedback which is displayed below.

“Dear [Participant],

You may remember participating in an interview last year about how nursing and support staff manage professional boundaries on forensic mental health wards. I have analysed the data from your interview, alongside interviews from other participants, and would like to ask your opinion of the proposed results thus far.

Specifically, I would like to ask you whether you think the attached theory reflects your comments in the interview and what you think of the theory in general.

You are welcome to email me back with anything you would like to say or ask. I also might like to speak with some participants over the phone about what they think about the theory, so **if you would not like to be contacted please do email me back to say it is not convenient for you to speak.**

Lastly, I'd like to thank you very much for your time and participation in the study, I really do appreciate it. A full report will be available when it has been finalised.

With best wishes,

[Name]

Trainee Clinical Psychologist”

Explanation of the model sent to participants

A theory of ongoing professional boundary development in forensic inpatient settings.

(NB: Please note this is not the final version of the study results. The full report will be accessible at a later date.)

The map below displays a theory about how professional boundary management is developed by nursing and support staff in inpatient forensic settings. It comes from an analysis of the data I got from my interview with you and interviews with other participants.

The theory suggests that nursing and support staff go through four main phases of professional boundary development – acclimatisation, calibration, learning and recalibration. When staff first start in the service, they **acclimatise** to the unique setting, drawing on their personal values and previous life/work experiences in order to manage boundaries in this new setting. This was generally thought to be difficult, although people with previous mental health training or experience suggested that this helped. Nursing and support staff are then required to constantly assess and address difficulties related to boundaries in the course of their day to day duties (**calibration**). To do this, they use the following processes:

- *Laying the groundwork*: preparing for potential boundary issues by gaining knowledge of their clients and formulating their presentations
- *Struggling with balance*: trying to be neither too boundaried nor too unboundaried; balance potentially competing demands (e.g. the needs of the patient, their role as a nurse, the therapeutic relationship, risk, empathy and personal values)
- *Using awareness and instinct*
- *Clarifying and confirming* boundary decisions with team leaders and colleagues
- *Building individual relationships* based on both the client and staff member age, gender, personality
- *Accepting uncertainty* and subjectivity of some boundary decisions
- *Communicating with patients*: e.g. talking to patients about the rationale for decisions

In phase three, staff members go through both individual and team **learning** (both of which influence each other). The individual learns through an interaction of *reflecting on their practice, using supervision, social learning* (e.g. imitating others) and *gaining experience*. The team uses communication and group discussion to learn how to work together more consistently and effectively on boundary issues (*team development*).

Finally, staff members **re-calibrate**, or adjust, themselves and their practice according to what they have learned. This includes *experiencing personal growth, refining their understanding of boundaries and changing their practice*. In this phase, more experienced members of staff can influence *service development* and the experience of new starters, by creating open cultures and suggesting changes to training and policy.

Individual **recalibration** impacts on staff members' future management of boundary difficulties (back to **calibration**), which further affects **learning** and additional **recalibration**, so that staff constantly moved in a cyclical fashion through phases two to four. In other words,

there is continual cycle of managing daily boundary issues, learning from them, adjusting self and practice to that learning, encountering more issues and so on.

What does this theory mean for forensic inpatient staff and services?

This theory of development could help service managers and team leaders in forensic services across the UK to understand more about how nursing and support staff develop their understanding and practice around boundaries. This understanding could then help services to facilitate boundary development in this staff group and help new nursing and support staff on forensic wards. The following, for example, might be helpful to some staff teams:

- Increasing opportunities for reflecting on practice as this was a key method of learning. Both individual and group reflection spaces were appreciated.
- Further opportunities for team building and peer supervision to increase open, trusting, cultures and normalize uncertainty around boundary decisions
- Increased opportunities for nursing and support staff to formulate client presentations alongside clinical/forensic psychologists
- Considering the type and timing of training available for new starters (particularly those who have no previous mental health training or experience)

Emailed responses from participants (included with their consent)

“I think your theory is spot on! Very good analysis” (Participant K)

“I think this looks really good and accurate to our discussions.” (Participant F)

Information from telephone conversations with participants (included with their consent)

Procedure:

Two participants chosen due to their availability were telephoned to discuss the model. Four broad questions were asked by the researcher:

- a. What are your thoughts on the model?
- b. Is there anything that particularly fits with your experiences on the ward and what you spoke about during the interviews?
- c. Was there anything that surprised you about the model? Or anything you expected it to contain that is not there?
- d. Is there anything particularly useful about the model?

Participant H (ward A):

This participation thought that the model demonstrated what they felt - that some people have to learn about boundaries and for others it comes more naturally. They felt the bit about personal experience and characteristics coming into boundary management was important. They also thought complacency was a big issue and when that's brought to attention (via incidences or someone pointing it out), that's when you need to re-look at boundaries. This participant felt it was perhaps surprising that it didn't come up more in the model, although they said it sort of linked to the calibrating/recalibrating. The participant thought the phases look at what happens in the service from their experience and that it was a good thing for staff to read and understand. The participant went on to say that the model mentioned about training too and the service has recently changed training available for new starters and is now using a boundaries questionnaire as part of interviews.

Participant F (ward B):

This participant thought the model related to what they saw in the service, particularly the four main phases. They thought the model reflected what they had seen quite a lot as new people come in to the service, spend time there and learn. They felt there was nothing particularly surprising about the model and there was nothing 'missing' that the participant would have expected. This participant thought the model would be useful to use in training as the service currently doesn't acknowledge boundary learning, development and change. They felt that by using the model, it would perhaps be good for new starters to acknowledge that things will change over time and that they don't have to get it all on their first day. They also felt it might be useful for new

starters to know from the model that perhaps learning will depend on a range of factors too.

Appendix O: Reflective diary extracts

19.5.17	<p>Meeting with my supervisor discussing options for Part A literature review. Discussion about broadening the area I am looking at to inpatient settings in general – I think it will be harder to manage boundaries in a closed environment, however this also might be quite containing.</p> <p>Also discussed different diagnoses. EUPD diagnoses traditionally link with difficult working relationships and service users with EUPD ‘known’ to push boundaries. Reflecting on a group for people with EUPD I have worked in and there were lots of examples of boundary pushing there, e.g. clients wanting to know personal info, clients wanting to connect with staff on social media, clients reporting information to staff about other group members without their consent, clients bringing friends, parents, dogs to the group. In my experience of that, consistently enforced rules helped.</p>
10.08.17	<p>Following visits to wards to talk about the study with staff during handover, I am pleasantly surprised by the interest shown by people. Staff appeared interested about studies and some seemed keen to speak more about boundaries and their issues during this meeting itself. I wonder what the context is around boundaries on the ward at this moment and whether this is contributing in some way to the interest shown. From these meetings, the issue of boundaries seems to be a hot topic.</p>
14.09.17	<p>A friend and I completed a bracketing interview this evening to try and talk about our studies and acknowledge any assumptions and preconceptions we might have. It felt quite strange at first, but also useful to talk about what I thought it might be like to work in inpatient forensic services and how this might impact on boundary management. I wondered whether the intensity of the security might feel quite stifling and whether this would come up in interviews. Thinking about my Part A literature review, I also thought that participants might talk a lot about clients with diagnoses of personality disorder and that working with this client group might be harder in terms of boundaries. I spoke about being quite aware of the differences between nursing/support work and psychology and thought that perhaps, due to differences in training, things like formulation, for example, might mean different things to participants than they would to me. However, the trainee colleague I was speaking to who had had some experience in forensic settings acknowledged the possibility that people from different professions might think more similarly about things than I would expect. She also acknowledged the possibility of individual difference and recognised that I was perhaps thinking about nursing and support staff as having a collective voice, when it may be that participants have very different ideas to each other.</p>
20.08.17	<p>Following some recent interviews, I think I’m learning a bit more about how to ask questions in interview that get to the process of boundary management. I’m also realising how to time interviews so that I get to some of those questions about boundary development, as opposed to questions about issues/challenges. It will be good to get more information on the processes around how people have come up with their views about boundaries, how these views have changed over the years or change due to different environments/people. This is more in keeping with my research aim and question.</p>
24.08.17	<p>I still feel a little bit awkward about ‘nagging’ (as it feels sometimes) people on the wards. I have received great support and enthusiasm from the ward staff that I have met, however it is taking a few reminders to get dates and times arranged with people who have said they’re interested in being</p>

	involved. Hopefully this will change over time as relationships between me and the staff teams develop.
14.09.17	I'm not sure how, but I think transcribing 'notes' such as when a telephone rings, when someone laughs/coughs etc. might be helpful so I am including them in my transcripts. Someone has asked whether I have used a specific format (which I haven't at the moment) – perhaps I need to look into this more, but the way I'm doing it seems ok at the moment.
15.09.17	Transcribing an interview with a senior member of staff, having just previously transcribed an interview with a fairly new staff member. There appears to be a slight pattern in interviews where less experienced members of staff seem more certain/concrete/confident about boundaries and more experienced members of staff are saying boundary management is still tricky and they are still learning about it. Is this to do with the complexities only becoming more evident with experience? Or perhaps what people of different seniority levels are happy to say/admit to a researcher? I am always careful to explain how important it is for people to look after themselves during interviews and only speak about things they feel comfortable with. Clearly this is necessary for ethical reasons (and to protect myself from the possibility of disclosure perhaps), however it may be limiting access to some of the participant's thoughts.
26.09.17	I met with my supervisor and a clinical psychologist at the unit today. There was a discussion around the different types of boundary incidents that have come up on the wards recently. I'm surprised at how few of these incidents have been mentioned in interviews and that when they have, it has been lower level incidences. This perhaps highlights how open, or not, participants feel they are able to be in interviews – they will be choosing their own boundaries for our conversation even as we speak about boundary management on the ward. Apparently, people are quite defensive at the moment on the wards due to the incidents – perhaps participants are thinking the interviews are a good opportunity to repair or improve the ward's reputation. Staff members are being careful to report boundary issues and safeguardings (perhaps overly so, according to the psychologist) – this indicates staff are leaning towards behaving according to how they think they should, how they think the policies advise. This might come across in interviews if people are talking about very careful to consider boundaries. Additionally, I learned that boundary training has recently changed and is being thought about at the unit at the moment. It will therefore be on people's minds and affect what they say. A lot of people have mentioned training – would they have done so last year before the training changes?
29.10.17	I'm thinking about recruitment and the pros and cons of being able to include staff from different cultures and ethnicities. It is looking unlikely that I will have an ethnically diverse group of participants and this will be a view that is therefore missing from the data. I am told that there are plenty of staff around who are not 'White British' and it is interesting that none appear to be coming forward. Is it something about boundaries that is impacting on this decision, or is it more to do with being able to speak up/be heard/have your opinions and thoughts valued?
01.11.17	I'm hoping I have almost got enough participants now – I am hearing a lot of things multiple times from interviewees. I don't feel confident in making a decision about theoretical sufficiency though, it feels like a subjective decision and I'm worried I might miss something. I'm hoping my grounded theory working group might help, or my supervisor. The books I have don't seem to be helpful and internet searching isn't throwing up the right things.

03.11.17	I'm really noticing how participants are connecting 'boundaries' to the rules of the ward. The psychologist has previously questioned whether clients requesting changes to the rules means they are challenging ward boundaries – he would not see this as a boundary issue, yet participants in my study appear to. Yet they have talked about how this connects to their working relationships with clients in that being too forceful with rules may result in therapeutic relationship being threatened. I think I expected this study to focus more on what happens when staff are too personal with clients and to focus more on that end of the continuum, but I think a large part of the study is also about what happens for staff when they may feel like they get too professional and strict with clients. This links in my mind with the PD management vs clinical issue, I feel that staff at the unit may feel that having to be stricter with rules pushes them to manage clients more than care for them, and this can emphasise their professional role, which limits opportunities for relating to clients in a more personal, human way.
16.11.17	I've started my first open coding and it feels quite alien. I am constantly wondering whether my codes are 'right' and whether or not they accurately reflect the raw data. I seem to struggle between trying to encapsulate what the data is saying in a concise way, but making sure I have enough in the code so that I'm aware of the context of it and I understand it well enough for when I'm thinking about categories. I think that's where the constant comparison between the codes, category ideas and raw data will be important. I'm also wondering about descriptive coding versus analytical coding and how interpretive to be. My Urquhart book talks about this with some examples, which is really useful. It seems to be ok to have descriptive codes and that makes me feel more relaxed about representing the raw data more accurately, rather than trying to force an analytic code that hasn't come up naturally.
17.11.17	My supervisor and I both coded a random, 3 page section of the transcript and discussed what was similar and different about our codes. I would say the majority of our codes were similar or the same, with a few differences. It was really useful to have the conversation, as it highlighted some things to think about. Some of my supervisor's codes took into account things like language used by the participant, whereas some of mine look at relationships between concepts that the participant addressed. This has opened my eyes to thinking about some of the language and how that relates to what a participant is thinking. I included more descriptive codes, which I think is still ok given Urquhart's advice.
30.11.17	I brought up how long open coding is taking me in a meeting with my supervisor today and I feel a bit more reassured. Niki suggested that coding might get quicker as I do more of it and the process becomes a bit more familiar. I also had a few questions the benefits of starting to selectively group codes after each transcript, as suggested by Urquhart. I wondered whether these initial groupings will impact on how I view the next transcripts and whether I should just focus on open coding to stay true to the raw data. However, I do realise the importance of sticking to the methodology and I recognise that doing selective and theoretical coding as I go is key to the comparative process. I'm still a bit unsure about my codes but I'm starting to accept the subjective components of the process. I think as long as I am really thoughtful about whether the coding process stays true to the participant and I stick to the GT methodology, those are the main points.
12.12.17	Lots of Part A, neglecting coding a bit.

10.01.18	I'm getting back into coding now and still struggling with it. It's hard to know what is relevant and what isn't – I think at this stage unless it's really obvious I'm tempted to keep things in and wait to see if they become any more/less relevant later. For example, I've got codes related to participants thoughts on the definition of professional boundaries, where they are used, who they apply to etc. At the moment I can't see from the data that these ideas relate to peoples' experiences of managing boundaries and the processes involved in this. I have some ideas about how they <i>could</i> be related, but these are mine and don't come from the data. I am reluctant to discard them as irrelevant yet though, in case future transcripts suggest a link.
18.01.18	My supervisor was right and I am getting faster at coding as I do more. However, the amount of codes I'm producing is really overwhelming and it's hard to think about categories. This has become the more time-consuming part of the process and can be quite frustrating when I have a potential idea about the categories and sub-categories, only for that to be over-turned when new data and codes are brought in from a new transcript. It's exciting to have ideas about groupings and how things might hang together, but it can also feel disheartening to re-jig things constantly too. I can see this is beneficial for the theory though, as I think later category maps seem to represent processes the participants are describing better than earlier versions. I have realised that I can be slightly protective of potential categories that I don't want to alter, because sometimes I think they are quite clear and assume they won't change with new data. I am making an explicit effort to be open to overhauling any categories or subcategories if this appears to fit the data better and in fact I have recently broken a couple apart and moved some of the subcategories elsewhere. I think the new categories more closely reflect the data.
05.02.18	I'm relieved to have coded every transcript and be in the process of finalising the theory. It's a little confusing to be looking back and forth at the codes, memos and raw data to think about links between categories, but it's slowly getting there. Taking breaks to get away from the data and come back to it also helps.

Appendix P: List of categories, subcategories and example codes

NB: Due to the hundreds of codes produced, the list below contains examples from each category rather than the full catalogue.

Category	Subcategory	Example codes
Phase 1: Acclimatisation	Drawing on pre-service experiences	Having pre-existing understanding of what you'd face helps Having pre-awareness of the unpredictability of the ward Knowledge of PBs that pre-dates service Having an understanding before arrival Prior training in mental health settings Experience in different MH settings worthwhile Placements support learning Having previous experience with boundaries Tripping up without fore-knowledge Not knowing how to respond to things you've not experienced Differences between staff coming from school and training Use of psychology degree Experience of setting boundaries in home life
	Integrating personal values	Making your own mind up about boundaries Personal nature of PB understanding boundaries Personal characteristics play a role Not pretending if that's not how you are Important to know personal boundaries Important to understand own values Having personal experience of being with vulnerable people Being brought up to be round vulnerable people Being a 'people person' Personal experience influencing career choice Remembering who you are and what you're doing People's own vulnerabilities influencing boundaries Wouldn't accept it outside the hospital Knowing how you like to be spoken to
	Adapting to a unique environment	Newer staff members highlighting risk Newly qualified staff as enthusiastic, motivated and 'by the book' Newly qualified staff as stricter with boundaries

		<p>Assumption of no consequences as a new staff member Given rules earlier in career Emphasis on getting on with patients earlier in career Earlier flippancy about rules Very difficult in the beginning of job Takes a while to realise that you shouldn't disclose Takes a while to adapt to forensic setting Needing to find other ways of building relationships Knowledge and use of policies from the start Not being aware of some things in the beginning Patients pushing boundaries with staff new to the ward Awareness of different treatment as a new starter Genuine naivety in younger staff Being really watchful with new, inexperienced staff Need people for guidance at first Watching new staff practice and demeanor</p>
<p>Phase 2: Calibration</p>	<p>Laying groundwork</p>	<p>Fruitless attempts to protect information online Family knowing where you work Limiting the patient's contact with certain staff members Preventative action Knowing what clients could find out about you Maintaining physical space Approaching with confidence and clarity about role Having a plan for patient boundaries Getting info on patients backgrounds Finding out what can help start conversation Finding out what not to say Really getting to know someone's history Getting a handover Looking at notes Quite worrying working with new clients Knowing your patients is key Thinking about offence history as a barrier to engagement Bearing in mind patient offences and relapse triggers Basing boundaries on info you have</p>

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		<p>Gaining an understanding of the client formulation Problems with boundaries can be part of a client's MH problem Awareness of attachment issues Formulation helps empathy but doesn't excuse patient behavior Longitudinal knowledge of client helps to understand their presentation Hard to formulate individual clients Potential different boundaries for patients with different diagnoses Times when you need a fixed boundary with personality disorder</p>
	<p>Encountering constant difficulties</p>	<p>Managing difficulties as they arise Dealing with things as they come Handling situations Patient pushing boundaries a lot Experiencing a lot of personal space issues Boundaries arise often Setting boundaries as part of the work Can't expect boundaries not to come up Going around in circles Repetition Expecting boundary issues Setting boundaries as difficult</p>
	<p>Struggling with balance</p>	<p>Being too authoritarian creates an 'us and them' situation Being too authoritarian is like a prison Some things can only be gained by less rigid boundaries Getting on very well with patients vs being strict, authoritarian Dropping guard enough to be friendly but not too far Balance of friendliness Disclosing enough to build a relationship Balancing being friendly but not so much that clients perceive the relationship as special Having a balance of strictness helps to gain patient respect Too nice and patients might misunderstand If you're dictatorial patients more likely to rebel Not setting boundaries makes you vulnerable Good relationships help risk Choice between your safety or helping patient Choice of personal safety vs rule consistency</p>

		<p>Balancing helpfulness with protection from manipulation Making allowances vs helping patients learn Showing you care without going over the boundary Give and take Attempting to balance relationship building with following procedure Having fair expectations Being mindful of power inequalities Obligation to set boundaries you disagree with Getting the right balance is a skill Boundaries as a fine line Balancing personal and professional personas Needing a balance</p>
	<p>Using awareness and instinct</p>	<p>Knowing yourself Importance of own feelings Intuition Alarm bell Impulsivity Use of instinct Use of gut feeling and 6th sense People feeling something is right for the situation Perception of appropriateness Rebelliousness Some lack of thinking time in the moment Thinking about how to help Exercising judgement Sleeping on a problem Not acting immediately Removing yourself from situations when you're not confident</p>
	<p>Building individual relationships</p>	<p>One boundary not suiting everyone Difficulty of boundary management depends on the situation What is acceptable depends on the patient and staff member Being aware of who you represent to patient Each situation different Management depends on patient behaviour Importance of approaching care in a person-centred way Individualised care is more effective but complex Complex to constantly change boundaries depending on patient Responsive boundaries</p>

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		<p>Right boundaries at the right time</p> <p>Repeatedly setting same boundary with client</p> <p>Consistency show professionalism</p> <p>Consistency helps patients know what to expect</p> <p>Consistency limiting confusion</p> <p>Patients respect consistency</p>
	Accepting uncertainty	<p>Suggestion of a 'proper' way to do things</p> <p>Suggestion there is a 'perfect', right thing to do</p> <p>Uncertainty</p> <p>Lack of clarity</p> <p>Ambiguous situation</p> <p>Personal decisions in blurry boundaries</p> <p>Flexible boundaries</p> <p>Difficulty when boundary lines are blurry</p> <p>Lack of concrete rules</p> <p>Concrete instructions</p> <p>Security related boundaries are more set</p> <p>Policy led boundaries are more rigid</p> <p>Needing to be flexible</p> <p>Obviously need to be flexible</p> <p>Impossible to have a rule book</p> <p>Difficult to have set rules</p> <p>Equal need to be flexible and established</p> <p>It's difficult when there's no specific answer</p> <p>No specific answer to some situations</p> <p>Having to think for yourself when there's no guidance</p> <p>Inadvertent disclosures</p> <p>No ideal solution sometimes</p> <p>Not being able to tell what's right</p> <p>Not being able to know what people are thinking</p> <p>Doing the best you can</p> <p>Sometimes can't win</p>
	Clarifying and confirming	<p>Gaining the backing of superiors</p> <p>Checking things out in supervision</p> <p>Checking out actions with manager</p> <p>Authority</p> <p>Patient more responsive to authority</p> <p>Superiors can help when patients don't want to adhere to procedures</p> <p>Beneficial to have superior back up</p> <p>Passing PB issues up the chain of authority</p> <p>Speaking to authority figure more effective</p> <p>Going to management with concerns</p>

		<p>Raising things with management You're vulnerable if no one knows about concerns Raising potential concerns Seniors protecting staff Nice to have other staff around who can reinforce your boundary setting Good to have back up from staff Good to not be on your own Making sure people are vigilant around you Mutual staff support Having staff available to cover for you Getting things sorted with help Getting advice about management Raising issues with seniors Raising concerns for personal safety Need to consider personal safety Taking over as a leader if needed Taking things up chain of command Not easy being a manager</p>
	<p>Communicating with clients</p>	<p>Giving clients clear instructions Clear, open communication to patients Explanations go further than brush offs Good to be open with patients and explain actions Communicating intentions to patient Giving staff and patients rationalization for rules is healthiest thing Explaining actions to clients Reinforcing professional role to clients Communicating with clients Sharing rationale for actions with clients Highlighting professional responsibility to client Difficult to talk to patients about rationale for procedures Being clear with patients about staff responsibility to adhere to procedures Letting patients know there can be a little flexibility Checking patients when they start to take advantage of flexibility Lots of boundary reminders to patients Reinforcing need for boundaries Discussing situation with patient Reiterating boundaries with patient Attempting to explain treatment differences Communicating how it's going to work to patient Not dismissing people Discussing things in an adult fashion</p>

		<p>Treating people like adults encourages respect</p> <p>Working with the patient and explaining why you can be flexible at that time</p>
Phase 3: Learning	Reflecting on practice	<p>Constant need for reflection</p> <p>Something that makes you assess, think</p> <p>Distance is helpful to address balance</p> <p>Questioning how to manage oversteps</p> <p>Reflecting on management</p> <p>Use of hindsight to highlight risk</p> <p>Reflection definitely links to self-awareness</p> <p>Helpful to be curious about the reasons for people's actions</p> <p>Learning from mistakes</p> <p>Using hindsight</p> <p>Using reflection</p> <p>Openness to conversations about disagreements in practice</p> <p>Questioning practice</p> <p>Self-awareness</p> <p>Training helpful to reflective practice</p> <p>Needing awareness of how your actions impact others</p> <p>Questioning ward rules and boundaries</p>
	Using supervision	<p>Supervision available as group or one to one</p> <p>Supervisor facilitating reflection of practice</p> <p>Discussion of boundaries can be hard as a supervisor</p> <p>Uncomfortable to point out/judge someone's actions</p> <p>Importance of discussion without reprimand</p> <p>Supervision as a conversation</p> <p>Discussion as an opportunity for thought and exchange of views</p> <p>Withholding judgement</p> <p>Consideration of supervisory relationship</p> <p>Supervisory discussions as interactional</p> <p>Supervision most important tool for openness</p> <p>Importance of having someone to talk to</p> <p>Supervision key to learning</p> <p>Being able to talk to someone key to learning</p> <p>Planning for future situations</p> <p>Gaining positive feedback</p> <p>Individual supervision really helpful</p> <p>Importance of talking about boundaries you disagree with</p> <p>Having issues to address with staff</p>

		<p>Helping staff to see consequences of their actions Helping staff understand consequences Helping staff see other perspectives Helping staff see health and safety perspective Exploring staff actions in risk context Ensuring discussions are following through to actions Checking staff not deferring back to issues Boundaries on the supervision agenda</p>
	<p>Social learning</p>	<p>Witnessing others encourages reflection Learning through good examples New strategy based on learning from others actions Working with others influences development of PB understanding Viewing other staff working with clients Speaking to psychologists Discussion in dyad Debating situations in peer supervision Receiving guidance Feeling able to ask for help Learning strategies to divert conversations Learning techniques to manage problems Witnessing colleagues actions Staff role modelling openness Colleagues 'bouncing off' each other Staff discussing situations Staff sharing thoughts Adapting other people's ways of managing to your own Learning from others is a big thing Staff perhaps noticing seniors dealing with things appropriately</p>
	<p>Gaining vocational experience</p>	<p>Learning new things every day Learning from situations Becoming more familiar to patients Knowing patients on your ward well Importance of experience for building own sense of PB Higher age, more experience and seeing negative consequences all impact Boundaries coming naturally after lots of time on the ward Experience means less surprises Need to have practical experience Working with different people (clients) influences development</p>

		<p>Experience helps show how your boundaries fit with others Experience of things that went well with less rigid boundaries Experience and maturity aid learning Gaining experience on the ward increases understanding of dynamics Becoming familiar with the ward dynamics facilitates understanding of why boundaries are used Experience helps confidence Being in unavoidable situations helps learning Experiencing a violation shows you it happens Learning how to deal with things Learning to not take things personally when faced with them often Learning how to talk to patients Experience as the main thing in increasing understanding of importance Seeing separation between work and home over time Reality checks helping understanding Shocking experiences hitting home</p>
	<p>Team development</p>	<p>Friction amongst staff at times of disagreement Conflict in boundary discussions Expression of difference within the staff team Battle/conflict related language Staff have different boundaries Difficult when staff members think differently Differences in how strictly staff members each manage boundaries Lack of continuity makes it difficult to manage boundaries Frustration about lax boundaries in staff team Varying styles from very firm to very lax Different boundaries leading to confusion Acknowledging individual difference in practice OK to have different styles of practice Trying to manage inconsistency for the ward and patients Consistency across the staff team guards against splitting Inconsistency blurs boundary management Managing inconsistency is about finding compromises</p>

		<p>Inter-ward discussion and agreement Finding a balance as a team Finding compromises with colleagues Thinking about other colleagues views of your actions Importance of staff communication Group supervision for situations that impact multiple staff Team supporting each other's' strengths and weaknesses Bearing in mind consequences for other staff if you allow something Communication between staff improves things Trying to have big teamwork focus Discussing pros and cons of options Creating understanding between nursing and MDT RE boundaries is hard Wanting people to understand importance of nursing boundaries Justifying nursing boundaries Nursing having it harder due to being with patients through everything Feeling a need to justify boundary rationale to other professions</p>
	<p>Barriers to development</p>	<p>Covering up mistakes is the worst thing Defensiveness is also worst Unhelpful to not acknowledge something Unhelpful to be defensive about practice Rationalising unsafe decision-making Avoidance of clients who push boundaries Some people not self aware Some people not having awareness People not seeing that they're wrong People thinking others' are wrong People repeating inappropriate behavior until it goes wrong Not being aware of the consequences Being stubborn causes problems Hiding things has consequences Not seeing the whole picture People doing things because it's easy Easier to give in than try to set firm boundaries Complacency one of biggest issues Luxury of knowing patients feeding into complacency Thinking patients known for a long time can be trusted</p>
<p>Phase 4: Recalibration</p>	<p>Refining understanding and</p>	<p>Later realization of PB complexity Big difference from the start Awareness of process</p>

	<p>adjusting the balance</p>	<p>More to boundaries than others might think Relationship building as a long-term game Nothing particularly difficult about boundaries now Bi-directional changes Sometimes becoming more firm Sometimes becoming less strict Relaxing of boundaries over time Becoming more open as relationship develops Experience increases personal sense of flexibility with boundaries Changes with firmness and flexibility are individual Seeing bi-directional change Some people might become more firm over time Not becoming more lax about boundaries Blurring of boundaries over time</p>
	<p>Experiencing personal growth</p>	<p>Personal sense of development Later sense of responsibility comes with awareness of influence and awareness of wider impact of actions on the team Learning what is appropriate for your style Learning what is appropriate for your role Learning own boundaries over time, as well as using policies Later development of your own boundaries based on own experiences and knowledge Feeling more confident after years on the ward Becoming more confident Relaxing as job progresses Intimidation lessens as confidence grows Definitely feeling more confident Feeling comfortable with job and patients over time Things becoming natural over time Developed a way of working with people that won't change Fairly confident in managing others Definitely more confident now Growing confidence Instinct is different from start Always potential to grow and develop Feeling more confident with time Possible to get more sure of self</p>

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		<p>Developing as a leader Becoming personally sturdier Increasing inner strength – resilience Knowing what you can take and can't Increasing self-awareness</p>
	Changing practice	<p>Doing things differently later in career Changing practice as a result of training Changed a lot since coming to forensics Not needing as much thinking time Altered ways of working Doing your own thing more Seeing things more now Ways of working definitely changing Definite change over time Changes in communication style Total change in use of supervision More participation in supervision later Helpful to be more active in supervision Opening up more in supervision later Becoming tactile due to work experience More experienced staff getting on with it efficiently Using supervision differently with more boundary understanding More understanding of boundaries linked to more concerns being raised 100% change in managing boundaries Literally just knowing dangerous patients</p>
	Service development	<p>Lack of debriefing, education and training formerly Good that service is discussing PB more and acting Boundaries have tightened for the better Things safer and more consistent now Starting out now is different to how it used to be Shift in boundary understanding Boundary understanding at the forefront now More discussions about PB now More talking about PB now More thinking about PB now More reinforcement of PB now Change in staff training ethos More awareness of boundaries now More staff confidence around reinforcing boundaries now Staff awareness of boundary expectations now Boundary understanding improved on unit More mandatory training now Focus on education for staff</p>

		<p>Previously more relaxed boundaries were acceptable Top down reminders of rules/guidelines Clear guidelines given from leaders Leaders encouraging staff to see things from others eyes Leaders reminding staff of previous incidences Leaders encouraging staff to keep themselves safe from accusations Leaders passing on things they learned from others Striving for open culture Trying to facilitate open sharing culture Management open door policy Leaders wanting to empower staff to be autonomous Superiors encouraging discussions of issues Promoting supportive and enabling environment for boundary discussions Being able to help if staff are open Being able to help honest people Putting in place steps to protect people after concerns Speaking up as a leader Letting management know what's needed in boundary training</p>
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Appendix Q: End of study notifications

A copy of the following cover letter was sent to the Salomons ethics panel and the relevant NHS R&D department alongside the summary in Appendix R.

Dear [Salomons ethics panel/[Trust] Research and Development Department]

RE: A Grounded Theory study exploring how nurse and support staff views of professional boundaries evolve within forensic secure inpatient services.

I am writing to notify you that the above study has been completed and a thesis has been written to be submitted for partial fulfilment of the degree of Doctor of Clinical Psychology at Canterbury Christ Church University. Please see attached a brief summary of the study. A separate report has been sent to the study participants and to the involved ward managers at the participating site.

Yours Sincerely,

Hannah Pettman
Trainee Clinical Psychologist

Salomons Centre for Applied Psychology
Canterbury Christ Church University

Appendix R: End of study summary (ethics)

A copy of the following was sent to the Salomons ethics panel and the relevant NHS R&D department alongside the covering letter in Appendix Q.

A Grounded Theory study exploring how nurse and support staff views of professional boundaries develop within forensic secure inpatient services

The question of how to maintain safe and appropriate professional boundaries with clients can be complex for staff in mental health settings due to their vague and flexible nature. Further difficulties can arise for forensic inpatient nursing and support staff due to the roles they are required to take, the tasks they are required to complete with clients, the backgrounds and presentations of the clients themselves and the restrictive nature of the inpatient setting. Previous research has focused mainly on the difficulties these professional groups face with regards to boundaries, however there is little research on *how* nursing and support staff develop and maintain their understanding of boundaries on forensic wards despite these difficulties. This is important as it could facilitate our understanding of safe, therapeutic staff-client relationships that are beneficial for both the staff experience and client recovery.

In the current study, data from interviews with eleven nurses and healthcare workers were analysed using a grounded theory methodology to produce a theoretical, cyclical model of boundary development in forensic services (see Figure 1). The model describes how staff acclimatize to their new forensic inpatient environment, bringing their existing experiences and personal values to the role. They then enter a phase of calibration, where they constantly assess and address professional boundary issues in the course of their daily responsibilities. Staff members use this experience alongside reflection, social learning and supervision to undergo individual learning, which interacts with a parallel team development process. In the fourth phase, staff members use this learning to recalibrate their views on boundaries, themselves and how they work with clients. This recalibration impacts on staff members further management of day to day boundaries, which provides more material for learning and this, in turn, leads to further recalibration.

The findings from this study emphasise the consideration that nursing and support staff have for the boundaries they use in staff-client relationships. The model relates to existing theories of experiential and guided learning and echoes previous literature suggesting the importance of supervision and reflective spaces in boundary management. This study also highlights the importance of social learning and being part of a supportive team, where more experienced staff can help scaffold educational experiences in order for development to take place. This study therefore has important implications for training, (particularly for new staff), team building, supervision and enhanced opportunities for reflective spaces. Clinical psychologists may be well

placed within teams to help structure and facilitate training and provide forums in which staff can consider client presentations and develop formulations. Further research could explore cultural aspects of personal boundary management and investigate the specific mechanisms within different supervisory and reflective practice approaches that may be most helpful for staff.

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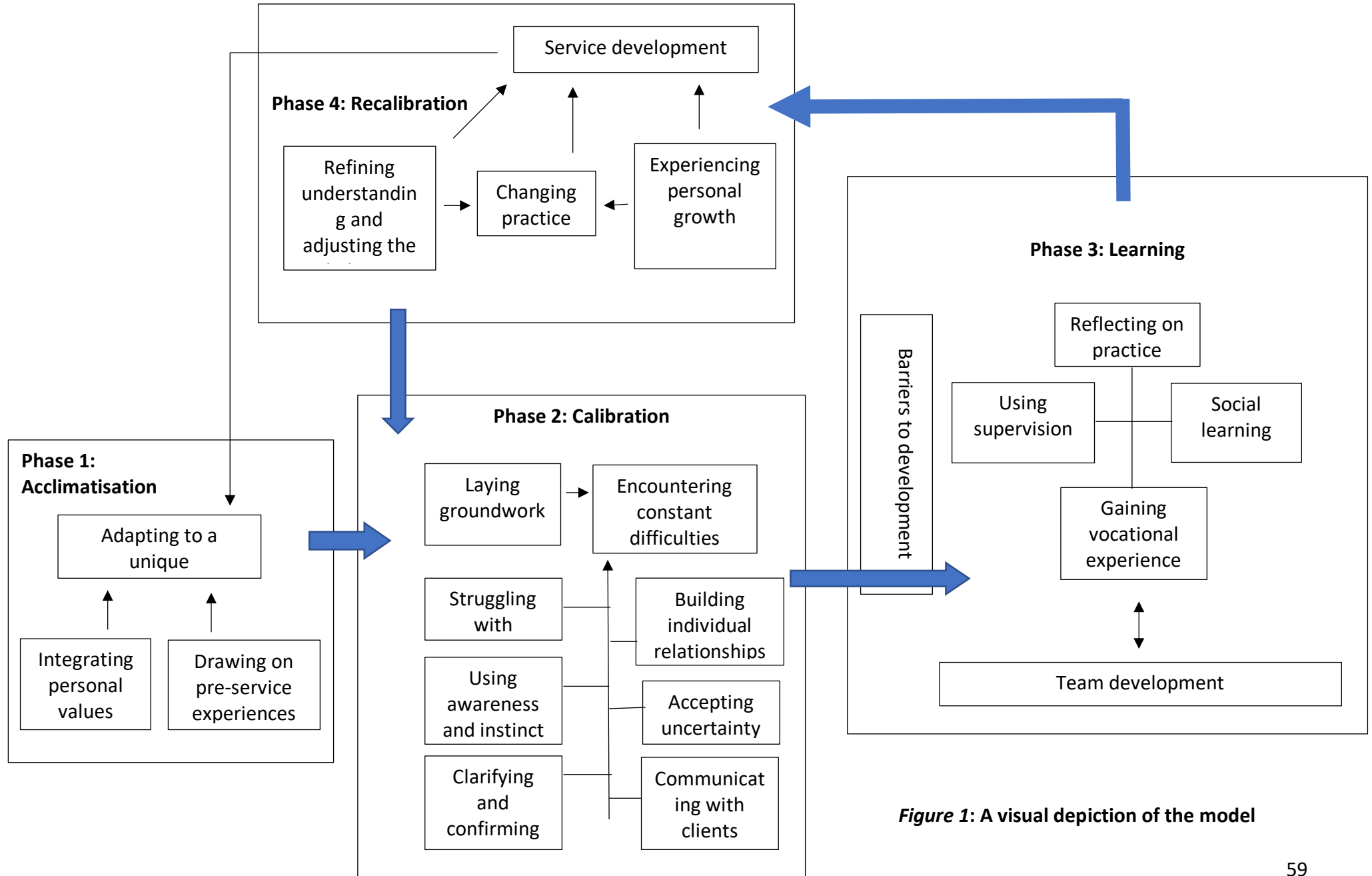


Figure 1: A visual depiction of the model

Appendix S: End of study summary (participants)

A copy of the following was sent to participants and to the participating wards' managers at the research site.

A Grounded Theory study exploring how nurse and support staff views of professional boundaries evolve within forensic secure inpatient services

The question of how to maintain safe and appropriate professional boundaries with clients can be complex for staff in mental health settings due to their vague and flexible nature. Further difficulties can arise for forensic inpatient nursing and support staff due to the roles they are required to take, the tasks they are required to complete with clients, the backgrounds and presentations of the clients themselves and the restrictive nature of the inpatient setting. Previous research has focused mainly on the difficulties these professional groups face with regards to boundaries, however there is little research on *how* nursing and support staff develop and maintain their understanding of boundaries on forensic wards despite these difficulties. This is important as it could facilitate our understanding of safe, therapeutic staff-client relationships that are beneficial for both the staff experience and client recovery.

In the current study, data from interviews with eleven nurses and healthcare workers were analysed using a grounded theory methodology to produce a theoretical, cyclical model of boundary development in forensic services (see Figure 1). The theory suggests that nursing and support staff go through four main phases of professional boundary development – **acclimatisation, calibration, learning and recalibration**. When staff first start in the service, they **acclimatize** to the unique setting, drawing on their personal values and previous life/work experiences in order to manage boundaries in this new setting. This was generally thought to be difficult, although people with previous mental health training or experience suggested that this helped. Nursing and support staff are then required to constantly assess and address difficulties related to boundaries in the course of their day to day duties (**calibration**). To do this, they use the following processes:

- *Laying the groundwork*: preparing for potential boundary issues by gaining knowledge of their clients and formulating their presentations
- *Struggling with balance*: trying to be neither too boundaried nor too unboundaried; balance potentially competing demands (e.g. the needs of the patient, their role as a nurse, the therapeutic relationship, risk, empathy and personal values)
- *Using awareness and instinct*
- *Clarifying and confirming* boundary decisions with team leaders and colleagues

- *Building individual relationships* based on both the client and staff member age, gender, personality
- *Accepting uncertainty* and subjectivity of some boundary decisions
- *Communicating with patients*: e.g. talking to patients about the rationale for decisions

In phase three, staff members go through both **individual and team learning** (both of which influence each other). The individual learns through an interaction of reflecting on their practice, using supervision, social learning (e.g. imitating others) and gaining experience. The team uses communication and group discussion to learn how to work together more consistently and effectively on boundary issues (team development).

Finally, staff members **re-calibrate**, or adjust, themselves and their practice according to what they have learned. This includes experiencing personal growth, refining their understanding of boundaries and changing their practice. In this phase, more experienced members of staff can influence service development and the experience of new starters, by creating open cultures and suggesting changes to training and policy.

Individual recalibration impacts on staff members' future management of boundary difficulties (back to calibration), which further affects learning and additional recalibration, so that staff constantly moved in a cyclical fashion through phases two to four. In other words, there is continual cycle of managing daily boundary issues, learning from them, adjusting self and practice to that learning, encountering more issues and so on.

Clinical and research implications

The findings from this study emphasise the consideration that nursing and support staff have for the boundaries they use in staff-client relationships. The model relates to existing theories of experiential learning and echoes previous literature suggesting the importance of supervision and reflective spaces in boundary management. This study also highlights the importance of social learning and being part of a supportive team, where more experienced staff can help scaffold educational experiences in order for development to take place. This study therefore has important implications for training, (particularly for new staff), team building, supervision and enhanced opportunities for reflective spaces. Clinical psychologists may be well placed within teams to help structure and facilitate training and provide forums in which staff can consider client presentations and develop formulations. Further research could explore cultural aspects of personal boundary management and investigate the specific mechanisms within different supervisory and reflective practice approaches that may be most helpful for staff.

A GROUNDED THEORY OF PROFESSIONAL BOUNDARY DEVELOPMENT

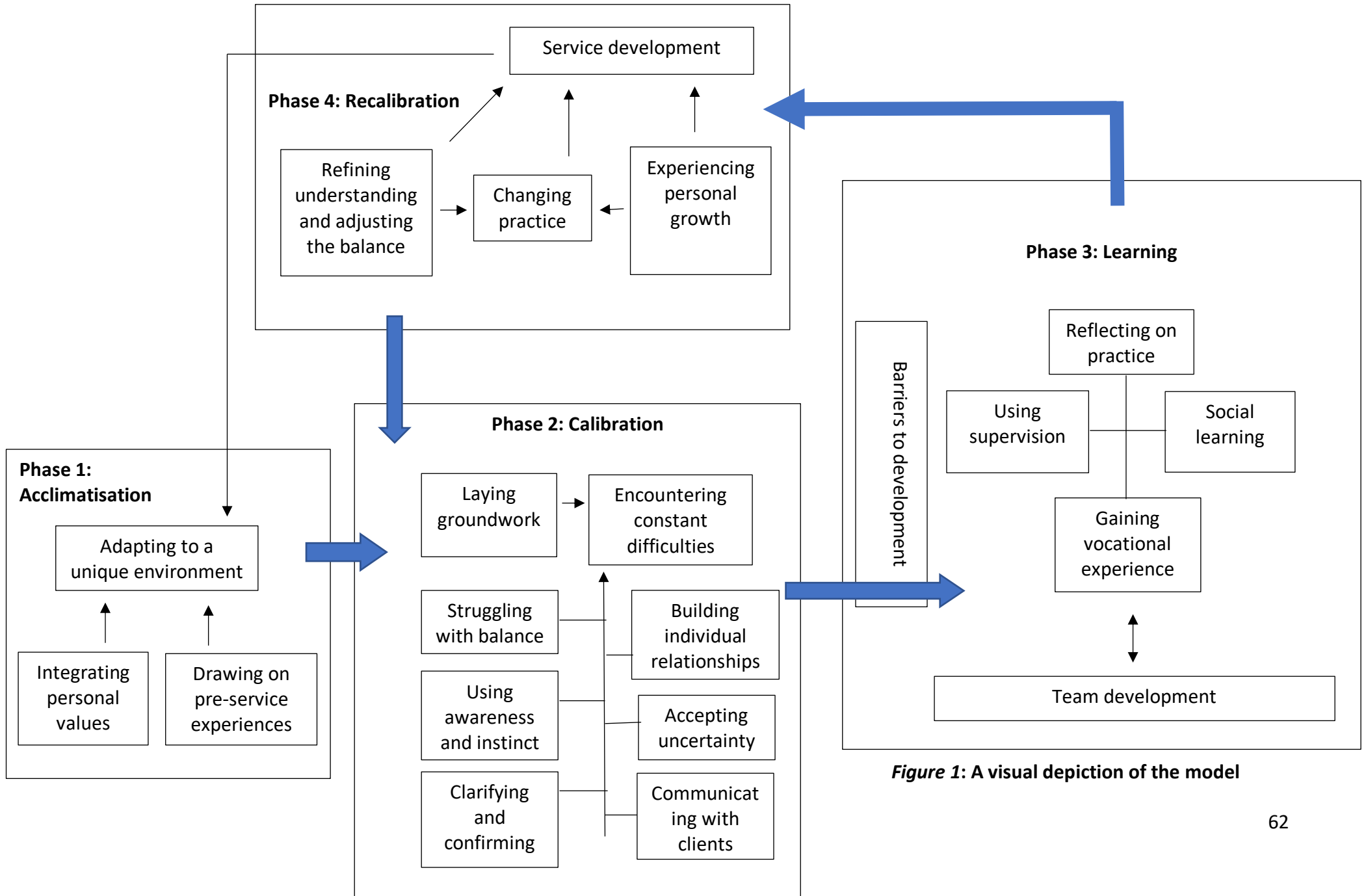


Figure 1: A visual depiction of the model

Appendix T: Author guideline notes for the International Journal of Forensic Mental Health

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- All parts of the manuscript should be typewritten (Times New Roman, 12 pt.), double spaced, with margins of at least one inch on all sides.
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Additional Considerations

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Millman, M. (1980). *Such a pretty face*. New York: W.W. Norton.

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