City Research Online

City, University of London Institutional Repository

Citation: Akinsulire, O. (2020). Exploring the experience of emotional stress and burnout in nursing health care professionals working in personality disorder forensic settings. (Unpublished Doctoral thesis, City, University of London)

This is the accepted version of the paper.

This version of the publication may differ from the final published version.

Permanent repository link: https://openaccess.city.ac.uk/id/eprint/26162/

Link to published version:

Copyright: City Research Online aims to make research outputs of City, University of London available to a wider audience. Copyright and Moral Rights remain with the author(s) and/or copyright holders. URLs from City Research Online may be freely distributed and linked to.

Reuse: Copies of full items can be used for personal research or study, educational, or not-for-profit purposes without prior permission or charge. Provided that the authors, title and full bibliographic details are credited, a hyperlink and/or URL is given for the original metadata page and the content is not changed in any way.

City Research Online: http://openaccess.city.ac.uk/ publications@city.ac.uk

Exploring the experience of emotional stress and burnout in Nursing Health Care Professionals working in Personality Disorder forensic settings

Oluwakayode Akinsulire

City, University of London

Department of Psychology

Schools of Arts and Social Sciences

December 2020

Portfolio submitted in fulfilment of the

Professional Doctorate in Counselling Psychology

Dedication

For Idowu Awojobi.

Table of Contents

City, University of London
Northampton Square
London
EC1V 0HB
United Kingdom

T +44 (0)20 7040 5060

THE FOLLOWING PARTS OF THIS THESIS HAS BEEN REDACTED FOR COPYRIGHT AND DATA PROTECTION REASONS:

List of tables and figures

Part A: Research

List of Tables and Figures

Declaration of powers of discretion

I grant powers of discretion to the City, University of London Librarian to allow this thesis to be copied in whole or in part without further reference to me. This permission covers only single copies made for study purposes, subject to normal conditions of acknowledgement.

Acknowledgements

First and foremost, I would like to thank God. In the process of completing this doctoral training I realised what a gift I have been given. You have given me the power to believe in my passion and pursue my dreams.

I would like to express my sincere appreciations to City, University of London for letting me fulfil my dream of becoming a counselling psychologist. I would also like to extend my thanks to the social science department and all my lecturers for giving me an opportunity to complete this portfolio.

A special thanks goes to my ever supportive and humble supervisor, Dr. Jacqui Farrants for her voluminous and invaluable contributions and instructions throughout my studies. Your amiable presence and support have made this journey seamless and at times even enjoyable.

I could not have completed the thesis without the contribution of my participants. It was humbling to share this experience with these inspiring individuals as I realise the essential work they carry out. I would like to use this venue to thank the participants for their time, effort and trust in the process.

On a personal note, I would like to thank my parents whose support have been invaluable. Your wise counsel and sympathetic ear have been the most important push through the difficult moments. I hope that I can be as good a parent as you both are and always have been to me. I love you both.

To my ever so present brother, I would like to thank him for persevering and tolerating me through all the difficult moment of this journey. You have been a real

anchor and source support to lean on. A special thank you goes to my little sister Temi, your help has been unwavering and unrestrained, you have been such a blessing, thank you so much.

I would also like to thank all my friends that have been with through this journey and have supported me as a student. Thank you for all the encouragements, flexibility and the free dinners.

Lastly, I would like to appreciate my lovely partner who has been there with me through it all. I admire you and appreciate it all. You are the real definition of selflessness in how you have supported me even when you had so much going for yourself, thank you.

Glossary of terms and abbreviations

NHCP: The term Nursing Health Care Professionals, adopted in this thesis, refers to those roles where workers are required to spend a significant amount of time with patients on a daily basis. Another term often used is frontline workers who bear the same meaning as NHCP. NHCP comprises the two roles of Mental Health Nurses and Health Care Assistants within the personality disorder forensic units.

FMHP: The term Forensic Mental health professional refers to health, social and human services provider or care practitioner who offer services for the purpose of improving an individual's mental health or to treat mental disorders within a forensic setting. The most common roles associate to this term, although not limited to these, are psychologists, therapists, mental health nurses, psychiatrist, social workers and health care assistants.

OPD: The term Offender Personality Disorder is a term used to describe those establishments that cater explicitly for patients with forensic history who have a diagnosis of personality disorder. This national initiative was launched in 2012 consultation, led by the Department of Health and the Ministry of Justice, which resulted in the re-investment of resources following the re-configuration of the Dangerous and Severe Personality Disorder programme. The different reinvestment affected prison systems where Psychologically Informed Planned Environments (PIPE), and Offender Personality Disorder (OPD) Community Specification Service within hospitals and the community, were implemented.

Secondary Trauma Stress: Secondary trauma stress involves the transfer and acquisition of negative affective and dysfunctional cognitive states due to prolonged and extended contact with others, such as family members, who have been

traumatised (Cohen & Collens, 2013). Although the term is now used universally, it was initially devised to capture a condition that was observed in service providers whereby they exhibited symptoms similar to Post-traumatic Stress Disorder (PTSD) (Pearlman & Saakvitne, 1995). The significant difference between secondary trauma and PTSD is that in the former service providers have not been exposed to direct trauma themselves.

Vicarious Trauma: Vicarious trauma is described as the transformation in the self of a trauma worker or helper that results from empathic engagement with traumatised clients and their reports of traumatic experiences. Pearlman and Saakvitne (1995) suggest that the transformation involves a profound shift within a person perception of the world. Vicarious trauma is regarded as a form of countertransference incited by exposure to traumatic material. Pearlman and Saakvitne (1995) believed that traumatic material can impose a new set of fundamental damaging beliefs about the world. Vicarious trauma and Secondary trauma are often used interchangeably due to their similarities in aetiology, both vicarious trauma and Secondary stress are products of indirect trauma.

Stress: It is the psychological and physical state that results when the resources of the individual are not enough to adapt to the pressures of the situation (Taylor & Barling, 2004). Thus, stress is more likely in some cases than others and in some individuals than others. Stress can undermine the achievement of goals, both for individuals and organisations. Although burnout is applicable in other scenarios than work, the use of the term stress will be focus solely for job-related scenarios.

Burnout: This is referred to as a prolonged state of physical, emotional and mental stress that eventually leads to exhaustion due to the different demands exerted on

the body and mind (Nathan et al., 2007). According to Maslach et al. (1996) burnout occurs in the place of work as a result of interpersonal conflict with colleagues, workload and other job-related stress. Although burnout is applicable in other ambits, the use will be focus solely for job-related stress.

PG: Tedeschi and Calhoun initially coined the term Post-traumatic Growth (1995). This term is often associated with the term resilience, and although it bears similarities, it has significant differences. PG refers to a personal growth that is achieved through a considerable struggle, traumatic events or sustained difficulty (Ben-Porat, 2015). According to Tedeschi and Calhoun (1995), this process can take an extended period, and there are five areas in which they can be observed: Appreciation of life, new possibilities in life, personal strength, spiritual change, and a better relationship with others.

Microsystem: A component of the ecological systems theory developed by Bronfenbrenner. The term microsystem describes the individuals, groups, and institutions that directly influence a child's development (1992). As suggested, this term is usually employed in relations to a child's development and its surrounding. However, the word is borrowed in this study to signify the elements that are in the participants' immediate surroundings and connections. Family, friends, peers, work, religious groups, and neighbourhoods are all part of the microsystem.

Personality Disorder: A personality disorder involves one or more pathological personality traits that create significant impairment in a person's life (Crocq, 2013)**.** A personality disorder is a way of thinking, feeling and behaving that deviates from the expectations of the culture, causes distress or problems functioning, and lasts over time (Craissati, Joseph & Skett, 2015). One of the major aspects of the disorder

which the current research focuses on, is the part that relates to the difficulty of forming and maintaining healthy relationships with others.

PTSD: Post-traumatic Stress Disorder also known as complex trauma is mental health condition caused by traumatic events, such as natural disasters, war and chilhood abuse. The symptoms associated with the conditions are anxiety, nightmares, flashbacks, depression and insomnia.

Overview of portfolio

This preface provides an overview for the three parts of the portfolio. The portfolio contains an original piece of qualitative research, a publishable paper for a peer-reviewed academic journal and a clinical case study. These three pieces showcase how I have developed during the professional doctoral programme in counselling psychology. This portfolio represents examples of my clinical practice and research skills developed in the years of training. The three elements of the portfolio are linked through the theme of Post-traumatic Growth: the ability to achieve growth through adversity.

Preface

Part A: Research

Part A contains a qualitative research that explores the experience of stress and burnout in frontline staff (NHCP), that work within a medium forensic hospital for patients with personality disorder. The main quest of the research was to explore how the challenges of the job would inform the lives of the staff exposed to the challenges of constant mental stressors. As a trainee counselling psychologist, interested in the impact of work and mental well-being of trauma workers, I was keen to research this topic and carry out an original piece of research to expand the knowledge in the field. I was further motivated to carry out this research as I had first-hand experience of working in this field and I could notice the dearth of research and support offered to the frontline staff working in this challenging field. The available research on stress and burnout in the workplace focused on the use of scales to homogenise the experience of workers from all kinds of fields. The study

employs a qualitative approach instead, to give a voice to frontline workers that are engaged in challenging environments, such as the one been explored. I employed Interpretative Phenomenological Analysis (IPA), not only for its propriety in exploring the inter-subjectivity of the participants in relation to stress and burnout, but also its potency in accounting for relationship with the material by maintaining phenomenological and hermeneutic foundations (Smith et al., 2009).

The research used semi-structured interviews to explore the experiences of Nursing Health Care Professionals (mental health nurses and support workers), to understand how stress and burnout from the work environment informs their lives. The objective of the study was to answer two main questions:

- How do NHCP make meaning of their experience of stress and burnout in a forensic personality disorder unit?
- How do NHCP working in a forensic personality disorder unit experience the stress and burnout from work in their personal lives?

The IPA analysis generated three interconnected themes. The first theme evidenced how unique the elements of stress and burnout can be in a specialised unit such as the one being researched. The theme evidenced that NHCP experience of stress and burnout is experienced at an emotional and mental level notwithstanding the risk element of violence and aggression. The second theme evidenced how NHCP experience the stress and burnout in their lives and how this had profound change beyond work. Participants expressed that through the constant pressure and challenges of the job, they had noticed significant positive and negative changes in their microsystem. Nevertheless, the descriptions of participants bore significant similarities to Post-traumatic Growth. The third theme highlighted how participants viewed themselves within their work and how they had not previously reflected on

the impact of the job on their lives. The implications of these subjective experiences for the well-being of NHCP were discussed, particularly in order to answer to the counselling psychology mandate to empower individuals (Larsson, Brooks, & Loewenthal, 2012).

Part B: Journal Article

Part B is a publishable paper prepared for submission to the *Journal of Occupational Health Psychology*, which focuses on one of the three themes which emerged from the research conducted in Part A., entitled “Post-traumatic Growth”. This largely accentuates how the mental and physical health of NHCP is impacted by the job they do. The theme shows two sides of a coin. One, where participants feel the impact of the work negatively and, the other, where they experience growth. Participants shared the experience that the work has somewhat increased a sense of isolation and inability to compartmentalise the struggles from work. Furthermore, participants highlighted how they now have a heightened sense of paranoia and feel more increasingly that the world is not safe. One of the most striking aspects of the theme was how participants described their loved ones reacting to their experiences of working as NHCP. Such descriptions showed striking similarities to those of secondary trauma. On the other hand, it appeared that through the different difficult experiences that the participants have, they had begun to notice some positive change within themselves that affects their circles and work. The most noticeable changes were that they become assertive, confident, self-aware and tolerant.

It is hoped that these initial findings can be disseminated across the field of psychology and beyond, in order to encourage further research and provide

information to support frontline staff to make informed choices with regard to potential and current risks and rewards they may experience from such roles as this.

Part C: Case Study

Part C is a case study based on a clinical piece of work I carried out during the final year of my counselling psychology training. [redacted] The main host was Person Centred Approach (PCA) which was integrated at different points with Narrative therapy and Gestalt therapy. The integrated approach borrowed by Boy and Pine (1999) is showcased in the case study where it shows a clear rationale for the choice taken to diminishing incongruence and increasing Post-traumatic Growth with trauma clients (Joseph, 2015). [redacted] He began to believe that his traumatic experience as a child was not in vain, rather, a chance to grow as a person (Post-traumatic growth).

Personal reflections

Upon enrolling in this doctoral course, I have since seen a personal transformation occur in different aspects of my life. I recognise that I as well have experienced post-traumatic growth in the larger sense of the term. Through the multitude of challenges posed by the training, I, and people close to me, have recognised significant growth in thinking, behaviour, clinical practice, and ability as a researcher. Just like my experience of the doctoral training, the findings of the research surprised and humbled me significantly. As a researcher, I had my preconceived expectation through personal experience that participants would express and paint their experiences negatively. However, I was humbled to see how challenges and hardship have also brought about positive changes and a sense of pride and resilience in participants.

The Post-traumatic Growth link emphasises such a beautiful aspect of the human experience, whereby a person can grow in the midst of trauma and hardship, and given the right tools, they can even make sense of horrible situations. I believe that different elements of the portfolio have shown me personally as a clinician that trauma is not the end, rather, it can be the beginning of a significant transformation. Perhaps, just like the participants in my research, I am able to look back at my experiences, and see the different huddles as a journey towards growth, that provides me with a special outlook as a clinician, to better support anyone that would be in my care.

The completion of the portfolio is a testament to my growth, especially with regards to the case study that highlights my long-term work and my development through the training programme. I have developed as a clinician in multiple approaches, and I

have made it my quest to align myself with the counselling psychology ethos to give a voice to marginalised groups and individuals. Just like in my study, I felt that the frontline staff are often overlooked and that their well-being was not prioritised. I believe that as a trainee counselling psychologist and a social justice advocate, I needed to act upon this issue and I hope to continue to carry on the work, even beyond the end of my training as I am a firm believer that by prioritising, empowering and catering for the well-being of carers, this can eventually benefit the people they care for and thrive whilst doing it. As a trainee counselling psychologists, I believe it is our compassionate wish, and ethical duty, to ‘care for the carers’ and protect them (ourselves) from the professional and personal costs associated with stress and burnout. This could form a part of the process of expanding and developing our professional best practice in the field of counselling psychology. Though this study is not void of limitations, it is hoped that it would provide a canvass which future research can build on and provide more understanding in the current field.

Part A: Research

Exploring the experience of emotional stress and burnout in Nursing Health Care Professionals working in Personality Disorder forensic settings

Word Count: 40011

Abstract

In the last two decades, the mental health system and the Ministry of Justice have shown a marked shift on how forensic patients with personality disorders are viewed and treated. This had signified an evolution directed towards creating more therapy-based pathways for Offenders with Personality Disorder (OPD). However, little to no research has been dedicated to understanding the impact of this change on the staff who work with OPD. More importantly, there is a dearth of research with regard to how stress and burnout are expressed in the lives of Nursing Health Care Professionals (NHCP) who work in this environment. This study employs interpretative phenomenological analysis to explore the experiences of seven NHCP working in a medium forensic unit specialising in treating patients with a diagnosis of personality disorder. The research answers two main questions: 1) How do NHCP make meaning of their experience of stress and burnout in a forensic personality disorder unit? And 2) How do NHCP working in a forensic personality disorder unit experience the stress and burnout from work in their personal lives?

This paper focuses on how participants expressed the different challenges of their work and how such challenges fostered a Post-traumatic growth (PG) in their personal lives. The analysis generated three interlinked main themes: 1) Operational trauma 2) Post-traumatic Growth and 3) Reflection.

These themes highlighted how the challenges of work have informed the lives of NHCP at work and beyond. Results showed that participants experienced features resembling operational trauma that appear to link with the concept of PG. The two themes also highlighted experiences of secondary trauma, vicarious trauma, domestic violence and difficulty to compartmentalise work and home. The theme

Reflection explored participants' novelty with regard to their experience in generating a meta-analysis of their experiences. The limitations and findings of the study suggests further exploration into "intersectionalities" (such as race) and longitudinal studies to explore further implications. The study showed significant relevance to the field of counselling psychology and occupational health psychology.

1. Chapter 1: Introduction

Current literature highlights the high stress rate experienced by Health Professionals working in the mental health sector (Azam et al., 2017; Dickinson & Wright, 2008; Edwards et al., 2000; Eliacin et al., 2018). Moreover, it has been identified that the average mental health professional (MHP) who works in the mental health sector experiences high levels of emotional exhaustion, linked to stress and burnout (O'Connor et al., 2018). Literature has shown that the impact of stress and burnout contributes to a myriad of difficulties for MHPs such as distressing emotions, physical ailments and low job satisfaction (Fink, 2016). Clark and Gioro (1998) captured the phenomenon and suggested that it can contribute to the development of vicarious trauma which can lead to work fatigue, low productivity and behavioural changes that include cynicism and increased irritability (Fink, 2016). Studies in the field have mainly focused on causation, prevention and the immediate impacts of stress and burnout, and fewer resources have been allocated to explore the phenomenon beyond. Nevertheless, the available literature emphasises the need to examine the complexities and intricacies that the impact of stress and trauma may have on workers beyond what is currently known (Clark & Gioro, 1998; Eliacin et al., 2018).

The majority of the available research on emotional stress and burnout focuses on quantifying, defining and etymologising. Even so, available evidence indicates that existing findings are still unreliable and inconsistent due to design and methodological issues (Sabin-Farrell & Turpin, 2003). As a result, very little research has been directed towards the qualitative analysis of the impact of stress and burnout on health care professionals' personal lives. There are even fewer resources available to determine how these stressors may differ depending on the nature of the mental health sector a person may work in (Taylor & Barling, 2004). For example,

the stressors encountered in a psychosis ward may not be the same as the stressors faced in a personality disordered ward. As such, the impacts may be different. The current research explores the effects of stress and burnout on workers within a Forensic Unit for Patients with Personality Disorder (FUPPD). I chose to research this sector as I have first-hand experience of this environment. I also believe there is a need for a further exploration of stress and burnout because the current study highlights a dearth of research and information on the subject. It is thus believed that the outcome of this and other future studies in the area will support different institutions to develop more tailored support for individuals.

This chapter will shed some light on the available literature and the key points relevant to the study. Firstly, I will be looking at the relevance of the study with regard to counselling psychology and how counselling psychology positions itself within the topic. Furthermore, the chapter will explore the concept of stress and burnout by presenting a conceptual overview. This will be followed by a discussion of the scope and rationale for the study. The review will centre on forensic units and, more specifically, those designed for patients with a personality disorder. I will also explore why I mainly focus on Nursing Health Care Professionals working in a medium secure hospital rather than the broader population of health care professionals. Finally, the reflexivity section will cover my initial reflections and how such reflections have motivated this study.

1.1 Literature Search

An extensive literature research was conducted from 1995 to June 2020 with a focus on specific phrases and search words. These included forensic units, stress, burnout, medium secure units, personality disorder, Offender Personality Disorder (OPD), staff well-being, nursing and health care professionals. In order to complete the literature search, many databases and journals were utilised. These included Journal of Mental Health, UK, American Psychological Association (APA), PsychInfo, Google Scholar, Counselling Psychology Quarterly, City Search, Journal of Advanced Nursing, etc. I chose to begin the search from the year 1995 because it provides ample data on the concept of stress and burnout. Although the OPD pathways were formed in 2012, there were prior similar institutions that are related to this study.

1.2 Relevance to Counselling Psychology

Given that counselling psychology is a relatively young discipline within the broader field of psychology, it is essential to define the ethos with which counselling psychology operates and how this contextually relates to the current study. In 1982, counselling psychology was granted the status of a speciality within the British Psychological Society (BPS) and from there a steady growth began (Jones Nielsen & Nicholas, 2016). Counselling psychology was recognised as a distinct profession with a full division status in 1994 by the BPS. Since then, there has been a battle to maintain an identity based on the philosophical stance that deviates from a purely pathological one (Corrie & Callahan, 2000). Turpin (2009) challenges the status quo of counselling psychology and poses the idea that clinical psychology and

counselling psychology will, in the course of time, share the same values. The belief expressed by Turpin (2009) is that counselling psychology will start to resemble clinical psychology to the point where counselling psychology loses its identity. As such, counselling psychologists have over time searched and explored how counselling psychology can move into the future with a distinct identity and ethos. Cooper (2009) suggests that the essence of counselling psychology is located within humanistic values described by Levina's (1969) concept of "welcoming the other". This concept highlights five important elements that are in line with the counselling psychology ethos and are found within the objectives of the thesis (Levina, 1969):

- Developing our capacity to see beyond diagnoses
- Enhancing our responsiveness
- Focusing more fully on our client's intelligibility
- Taking a lead in giving psychology away
- Developing our evidence base

These elements are at the heart of the current study as it promotes the humanistic narrative where the other is regarded as un-classifiable and unique.

The distinct philosophical perspective of counselling psychology lies within the belief placed on the strengths and resources people have and how these can be accessed through collaboration to improve psychological functioning (Steffen et al., 2015). The hope through this stance is to depart from pathologising and bring about meaningful change through a therapeutic relationship. As summarised by Jones Nielsen and Nicholas (2016, p. 6): "The aim of counselling psychology is to reduce psychological distress and to promote the well-being of individuals by focusing on their subjective

experience as it unfolds in their interaction with the physical, social, cultural and spiritual dimensions in living."

Furthermore, there is an acknowledgement from counselling psychology that there are multiple ways to knowledge and understanding. As a result, different epistemological stances have influenced the field of counselling psychology over the years. As described by Strawbridge and Woolfe (2010), counselling psychology has positioned itself within humanistic models, the scientist-practitioner model, the reflective-practitioner model, as well as systemic models. However, counselling psychology has positioned itself mainly within the humanistic frame, as a quest to understand the uniqueness of individuals and their actualising selves. This position contrasts with the medical model of psychology and the use of manuals such as the American Psychiatric Association's (APA) *Diagnostic and statistical manual of mental disorders* (APA, 2013). Nevertheless, in recent years, counselling psychology has begun to veer to an integrated position in order to maintain the humanistic ethos as well as the scientific and empirical base (Hage, 2003). Although it can be argued that the move towards aetiology and pathology has already begun, the main focus of counselling psychology is still to empower rather than to control (Hage, 2003). In order to achieve empowerment, there is a need to dedicate more resources to the qualitative understanding of experiences rather than retaining a homogenous approach to all (Larsson et al., 2012).

As mentioned above, counselling psychologists' main concern revolves around the emotional and mental well-being of individuals, whether that be patients, clients or even mental health workers (Koocher & Keith-Spiegel, 2008). An in-depth study and understanding of the way NHCP experience and communicate through the challenges of working in inpatient forensic settings can offer great insight into

adaptations made and the quality of life outside of work. It is the duty of counselling psychologists to identify the subjective experience so that we can inform our practice to build a broader and deeper awareness as well as enrich existing knowledge (McLeod, 2011). The health of mental health workers is often overlooked by policymakers and by systems that are put in place to cater for the health care of workers (Gould, 2006). Even more so, during the Coronavirus pandemic, it appears relevant to find better ways to identify how to support frontline staff as they continuously put their lives on the line.

It is crucial to acknowledge that an individual will often present to therapy as they struggle to cope with the world they live in. It is essential to understand the lived experiences of burnout and emotional stress involved when working with people who seek therapy. An empirical review of the literature suggested that burnout can manifest in a myriad of psychological (e.g., anxiety, irritability and depression), physical (e.g., somatic symptoms), and behavioural (e.g., alcohol and drug misuse) ways (Duquette et al., 1995). Over extended periods of time, people are more vulnerable to developing physical and mental health problems (Maslach et al., 1996). The field of psychology has the skills and tools to understand individuals' needs and to address them appropriately through the process of therapy. More specifically, counselling psychologists can offer clients an opportunity to better understand and equip themselves with the skills required to overcome or even lessen the impact that might be present in working in highly stressful jobs (Wong, 2012). The uniqueness of the role (NHCP in forensic settings) is such that it might provide a novel understanding of how lives can be shaped differently even within the mental health sector.

1.3 Stress and Burnout

In the current study, the term “stress” is closely linked to the term “burnout”, and as such, the two terms overlap and are often used interchangeably. Nevertheless, it is worth defining both terms and providing a context of how both are used in the study. The term “stress” in the mental health field is often used interchangeably with the word "occupational stress", and in this study, they are used to refer to the same thing. Stress in the workplace refers to the mental and physical responses to demands that work situations can present (Taylor & Barling, 2004). More specifically, stress is a phenomenon that occurs when the strategies available are not sufficient to cope with particular demands or strains. If these are not carefully managed, they may lead to psychological and physical difficulties (Marcia & Gioro, 1998). Similarly, burnout is the experience of stress for an extended period which cannot be alleviated or managed (Dickinson & Wright, 2008). The significant difference between stress and burnout for this study is the acknowledgement that in the case of burnout, there is a prolonged sense of stress which the individual cannot manage with their available resources, thus leading to profound negative implications (Cohen & Collens, 2013).

Burnouts often affect employees and organisations in different ways and can lead to illness, turnover, absenteeism, low morale and reduced efficiency and performance (Eliacin et al., 2018). Research has identified that stress is often prevalent in working environments where many employees have been negatively affected by a range of factors, among them intense workload, low job satisfaction and negative relationships with the team (Meier & Cho, 2018). Specifically, between 2017 and 2018, it was recorded that 595,000 people were affected by work-related stress and other mental health issues in the UK (Health and Safety Executive, 2017). To give an

economic value to this problematic phenomenon, a recent systematic review carried out by Hassard et al. (2018) estimates that work-related stress and burnout accounts for more than £4 billion a year in the UK. This estimation was arrived at solely by examining the loss of productivity through work-related stress and burnout. The figures did not consider other hidden costs such as possible mental and physical issues that affect households, the National Health Services (NHS) and the economy as a whole (Hassard et al., 2018). These numbers become even more concerning when looking into the National Health Service (NHS).

Professional occupations, which include nursing and different NHS occupational groups, have statistically one of the highest rates of stress, anxiety and depression of all occupational groups (Health and Safety Executive, 2017). According to a recent study, work-related stress and burnouts within the NHS have maintained a flat trend since 2001, indicating that not much has changed in tackling stress and burnout in almost two decades (Health and Safety Executive, 2017). In addition, in 2018 Public Health England reported an estimated cost of £2.4 billion per year to deal with the poor mental health of NHS workers (Kline & Lewis, 2019). These figures indicate that there is still much room for improvement in the implementation of strategies to reduce and understand the phenomenon of stress and burnout (Kline & Lewis, 2019). Nevertheless, the purpose of this study is not to dispute the costs and resources available to tackle this phenomenon within the NHS. Instead, it is to underline that a multitude of studies have quantified stress and shown that it constitutes a significant health, societal and economic problem (Sprang et al., 2007).

Similarly, qualitative studies of stress and burnout do not show encouraging findings. Most qualitative studies emphasise the negative impact of stress and burnout and how common both phenomena are. It is noteworthy that most findings in this field

often appear to use homogenous designs for different population groups. Although this is a positive aspect from an empirical standpoint, it does negate the understanding of stress and burnout in a more subjective manner (O'Connor et al., 2018). For example, it is widely accepted that burnout is measured by the Maslach Burnout Inventory (MBI), where the three indicators are depersonalisation, emotional exhaustion and reduced personal accomplishments (Maslach et al., 1996). This sort of measure, although very important, can, at times, hinder a more in-depth exploration of the effects of stress and burnout, as findings from one NHS occupational group are assumed to fit with those of other NHS occupational groups. Furthermore, a systematic review carried out recently indicates that the Maslach Burnout Inventory is the basis of most enquiries involving stress and burnout (O'Connor et al., 2018). Part of the aim of this study is to attempt to go beyond these fundamental, yet basic, indicators that might suggest how stress and burnouts are experienced. This study attempts to highlight and explore an in-depth experiential account of occupational groups that are often overlooked. By taking this approach, it is hoped that more could be discovered about this field, and consequently, that such knowledge will help in advancing the current supports available.

1.3.1 Stress and Burnout in Mental Health Settings

Research conducted across different health care systems repeatedly highlights the emotional strain attached to working within them, especially when the focus is shifted particularly towards mental health care (Dickinson & Wright, 2008). Past studies have emphasised the prevalence of staff burnout in mental health settings, and how the experience of stress can be a significant contributor to this phenomenon (Edwards et al., 2000; Eliacin et al., 2018). Dickson and Wright (2008) reported the

strain that mental health workers undergo throughout their working life in the UK mental health sector. Maslach and colleagues, the authors of the 'Structural Model of Burnout', paved the way by highlighting the predictive factors of burnout, which were strategically divided into three main elements: Emotional Exhaustion, Depersonalisation, and Reduced Personal Accomplishment (Maslach et al., 1996). Their work suggests that a depletion in affective components such as experiences of anxiety, increased fatigue, insomnia and a reduced sense of patient-care fulfilment led to 'Emotional Exhaustion'. They went further and explained how depersonalisation acts as an inhibitor with the intention of compressing the mental toughness that is required to work with those in high need of support, thus compelling one to adopt a withdrawn approach to client-nurse care as well as towards work in general. Equally important, research has demonstrated how increasing levels of stress and burnout in mental health workers can hinder their natural ability to form professional empathic relationships with those in their care (Coffey, 1999). Given that empathic understanding is seen as critical in developing and maintaining therapeutic relationships, exposure to emotional strain has often been linked to burnouts.

A recent study carried out by O'Connor et al. (2018) estimates that the average MHP will experience emotional stress and up to a third will experience burnout. It has been recorded that emotional stress and burnout often lead to a high rate of sick leave, physical exhaustion, and psychosomatic illness alongside a wide range of mental health issues (Grossi et al., 2015). Factors particular to the mental health field which make workers in this sector more vulnerable to burnout have been identified. These include the stigma of the profession regarding working with clients with complex forensic histories, threats of violence from patients, patient suicide/self-

harm, and demanding therapeutic relationships (Rossler, 2012). When it comes to Psychology, it is imperative to understand the different ramifications of this phenomenon to support mental health care professionals more adequately. This is to ensure that MHPs are fit enough to support patients adequately and effectively, and their mental health is also looked after appropriately. Failure to safeguard the mental health of MHPs can lead to potentially severe consequences where MHPs might not be able to adequately perform their duties, thus putting the care of patients at risk. Furthermore, it is important to corroborate earlier averments that the health of MHPs is important and should therefore be safeguarded with adequate resources put in place for that purpose.

1.3.2 Secondary Trauma Stress, Vicarious Trauma and Post-traumatic Stress Disorder

In order to better understand the implications of working in a forensic hospital for personality disordered patients, it is essential to understand the emotional stress involved in working with trauma patients. This is a necessary step as patients in forensic hospitals would typically have an extensive traumatic history alongside a criminal one, and MHP would be expected to work therapeutically alongside NHCP on the ward (Sadock et al., 2000). Research has shown that trauma workers often experience high degrees of Secondary Trauma Stress (STS) alongside Vicarious Trauma (VT) (Cohen & Collens, 2013). These two concepts are also significant contributors to MHPs experiencing stress and burnouts (Sadock et al., 2000). STS refers to the trauma that health care professionals experience from hearing patients' or clients' traumatic experiences. It is a phenomenon often experienced by workers

when witnessing traumatic narratives and being exposed to patients' or clients' suffering (Beck, 2011). STS is seen to compromise the professional functioning and the general health of the sufferer (Cohen & Collens, 2013).

Similarly, VT is acquired by the continuous exposure to distressing materials presented by clients. The distressing material ranges from the clients' traumatic histories to their current challenging presentations. VT is a more holistic life transformation, potentially leading to long-term changes of how the trauma worker views others, themselves, and the world (Collins & Long, 2003). Although these changes are often negative, Collins and Long (2003) highlight how MHPs have acquired post-traumatic growth through VT and STS. Similarity, Post-traumatic Stress Disorder (PTSD) is another concept often associated with nursing (Jacobowitz, 2013; Olszewski & Varrasse, 2005). Mealer and Jones (2013) report that nurses often describe suffering from traits common to those of clients suffering from PTSD, which include intrusions, avoidance and hyperarousal, with the effect that they consequentially have world view changes, sleep disruption and retention issues.

It is expected that the participants will be exposed to a degree of traumatic material from the forensic patients. This is because most patients in a forensic unit have extensive traumatic histories and often present current traumatic and challenging behaviours (Penny & Exworthy, 2015). Studies have suggested that the phenomena of STS and VT are not exclusive to therapists and can be experienced by people working in different professions (Levin & Greinsberg, 2003). As such, part of the aim of the study is to understand how the traumatic material impacts participants' experience of stress and burnout. Thus far, there are different accounts that link trauma work with PTSD, VT and STS (Collins & Long, 2003; Jacobowitz, 2013;

Olszewski & Varrasse, 2005). Nevertheless, there are also contrasting views which suggest that the sources of stress and burnout are solely located in work-related stressors and question the very existence of the phenomena of VT and STS (Devilly et al., 2009). VT and STS are relatively new concepts that are still developing within the field of psychology. As such, the current literature on VT and STS is still a work in progress (Cohen & Collens, 2013).

1.4 History of Offender Personality Disorder (OPD) Pathways

This section provides a brief history of how forensic personality disorder units were created. It also outlines how new this field is and gives a further rationale for the current study.

Personality disorder has been a topic of interest since the late nineties, especially regarding treatments and assessments (Horgan et al., 2019). This interest was ignited from the recognition by the Department of Health that there was a significant lack of services available for individuals with a personality disorder (Feeney, 2003). As a result, a mandate was put forward by the Department of Health to all health trusts in England to incorporate inclusive services for personality disorder patients within the general and forensic mental health settings (Home Office and Department of Health, 1999). Initially, this raised some concerns among policymakers as they felt that there were offenders with a personality disorder who posed too high a risk of recidivism and "untreatability" (Joseph & Benefield, 2012). Nevertheless, according to the Mental Health Act, treatability is deemed a legal right for all patients with a mental illness (Mental Health Act Section 37(2)(a)(i), 1983) (Department of Health, 2006). This legal concern generated so much momentum that by the end of the

nineties, the UK government established pilot services within prisons and health care systems to cater for patients categorised as having 'Dangerous and Severe Personality Disorder' (DSPD) (Feeney, 2003). These facilities offered treatments and assessments to patients whose risks and offences appeared to be directly linked to their personality disorder (Joseph & Benefield, 2012).

The pilot service continued to evolve over the following years. After over a decade, the Department of Health, in conjunction with the National Offender Management Service, restructured these services (Horgan et al., 2019). The restructure was mandated in 2012 when high secure DSPD hospitals were closed, and new programmes were approved in prisons and integrated into medium secure hospitals and the community service (Trebilcock et al., 2019). Interestingly, even the name of the new mandate changed from 'Dangerous and Severe Personality Disorder' to 'Offender Personality Disorder' (OPD) (Horga et al., 2019). The OPD pathway which is still in operation in the UK has the core aims of including high-quality formulations, treatment plans, and therapeutic programmes in a safe environment to reduce the risk of serious reoffending and when legally possible, allow reintegration into the community for some (Minoudis et al., 2012). This change in investment affected prison systems where Psychologically Informed Planned Environments (PIPE) were implemented and Offender Personality Disorder (OPD) Community Specification Service within hospitals and the community were created. Other services established under the OPD pathway include the Mentalisation Based Treatment (MBT) Service, Intensive Intervention and Risk Management Service (IIRMS) and M-TREM Treatment Service (Trebilcock et al., 2019).

As suggested above, the development of the specialised units is relatively recent and has undergone a recognisable restructuring in the last decade (Horgan et al.,

2019). There are not many stand-alone services of this nature available as the specialised high secure units for DSPD were shut down. The new formats for OPDs can be mainly seen in prison settings and inpatient medium secured units (Joseph & Benefield, 2012). The aforementioned form part of the rationale for the current study because there are no studies that have looked at the experiences of people who work within this field. Although it has been acknowledged that stress and burnout have been explored in mental health sectors, not much research has been dedicated to specialised medium secure units with workers who are not necessarily specialised in personality disorders or in working with patients transitioning from prison. Part of the research question aim is to explore the experience of stress and burnout for workers in this field. The hope is that by taking a more qualitative and targeted approach, real change and support can be developed for specific work groups.

1.4.1 Current Forensic Hospitals

This segment explores how forensic hospitals are currently run in the UK and the implications of such to the current study. As mentioned earlier, forensic units were built to reduce the risk of reoffending and improve the mental health of patients with different mental health diagnoses. Forensic units began to gain notoriety in the 1980s when regional secure units started to transition into general psychiatric hospitals (Feeney, 2003). In some ways, the physical shift of the forensic units into general psychiatric hospitals also indicated a change in ethos (Seppäne et al., 2018). The new ethos places an emphasis on rehabilitation and treatment in the least restrictive setting possible whilst trying to maintain a secured environment. Moreover, this is seen and translated in the design of these units as they are built on

the principles of mitigating harm to self and others whilst recreating less institutionalised prison structures (Seppänen et al., 2018). These structural changes are also reflected in the ideological shifts in how offenders with mental illnesses are viewed (Penny & Exworthy, 2015) in that they are no longer perceived only as violent offenders but also as patients with mental health ailments and needs. The offender with mental illness has a dual position: As a person constrained within the criminal justice system and as a vulnerable member of society in need of treatment. This duality has often created cognitive dissonance within health care professionals caring for patients with violent histories (Jacob, 2012). It creates difficulties for people working with patients with offending behaviour as they often have to balance the caring nature of their role with their moral beliefs (Penny & Exworthy, 2015). The struggle to maintain the balance between the moral beliefs of right and wrong, evil and good, and more holistic views can sometimes account for the compassion fatigue experienced by health care professionals in mental health settings (Kim et al., 2014).

Nevertheless, risk issues lie at the very core of the forensic psychiatric practice, as the environment must be safe and stable before any real treatment progress can take place. The settings have to be secure enough to protect the patients (self-harm, violence to others and, absconding), the workers and the community. As such, three substantial security branches were identified by Reed's report to tackle the risks in forensic units (Reed, 2011):

- Physical security: this includes structural and physical measures put in place to minimise risks, such as alarm systems, locked doors and high walls.

- Procedural security: this includes regulations and protocols to safeguard appropriate carrying out of procedures on the ward, such as monitoring of restricted items and search protocols.
- Relational security: this has to do with a more dynamic element and centres mainly on how the relationship between patient and carer can mitigate risk. This includes understanding of the forensic population, professional relationship and patients' clinical and forensic history.

Although all aspects of security are essential, it has been highlighted that relational security is at the heart of maintaining a therapeutically safe environment (Kennedy, 2014). To a degree, this links to the complicated nature of forensic units and especially the forensic personality disorder units, as significant parts of the treatments rely on patients-carer dynamics and the relational security aspect, which is where we often see stress and burnouts (Burgess et al., 2010). For example, most forensic inpatient wards attempt to foster a therapeutic environment where patients are met with compassion, positive regard and boundaries. These elements can often prove triggering to patients who have spent most of their childhood and adult life in abusive patterns. As a result, the work environment is characterised by frequent emotionally charged interactions, which increases the risk of staff burnout (Nathan et al., 2007).

Additionally, Mason (2002) emphasised that MHPs working in forensic units would inevitably be subject to a greater risk of violence and aggression, stress and burnout, compared to those working in any other field within mental health services. This argument highlights the importance of making the distinction between the quality of stressors experienced in forensic hospitals and different mental health settings. This will then accentuate the type of psychological support which can be offered to protect

the workers' mental well-being, in addition to ensuring that they can provide adequate support for the patients they are working with.

Following on from earlier sections of the chapter, the theory that one size fits all may be at the root of why the concept of stress and burnout still represents a significant issue for the mental health sector (Health and Safety Executive, 2017). Many studies fail to recruit homogenous samples, often including nurses, trainees, psychotherapists, psychiatrists, social workers, interpreters and psychologists in the same sample (e.g., Iliceto et al., 2017; Lipke, 1995; Ogińska-Bulik, 2006). These limitations in the design highlight the dearth of research relevant to counselling psychology's central ethos where support is individualised and empowering (Palmqvist, 2016). Furthermore, a large proportion of the available research employs quantitative methods, including the use of self-assessment scale designs. These can often limit the exploration and discovery of new and richer data. Additionally, it has been highlighted by Sabin-Farrell and Turpin (2003) that the findings from quantitative measures in regard to stress, burnout and trauma are inconsistent at best. In contrast, the available qualitative studies show a consistently negative impact of stress, burnout and trauma (Sabin-Farrell & Turpin, 2003).

As such, the current study goes beyond understanding solely the toll a forensic unit may have on an individual; it further tries to add to existing research and knowledge on burnout and health care workers by focusing in particular on specialised forensic units for patients with personality disorder.

1.4.2 Personality Disorder and Forensic Units

This section briefly outlines the role of personality disorder in the study and why this is an important aspect of the study with regard to forensic units and NHCP.

Phillippe Pinel was one of the pioneers of the medicalisation and categorisation of personality disorder (Kavka, 1949). Pinel's initial description of personality disorder was that of "mania without delusion" (Crocq, 2013). His intuition appears to be very relevant today, as it considers that personality disorder is a disorder ("mania") without apparent psychosis ("delusions") (Crocq, 2013). Interestingly, this narrative is part of what links the negative attitudes and stigma on personality disorder (Beryl & Völlm, 2018). A personality disorder is defined as a disturbance in the perception of self and others. For it to be considered a disorder, the disturbance must be persistent and create a significant level of destabilisation and disruption in occupational, social and interpersonal relationships (APA, 2013). The primary emphasis is placed on the core self-impairments and interpersonal impairments. The self-impairments include the severing of the self-concept, identity integration and self-directedness. On the other hand, the interpersonal impairments involve the severing of mental representation of others, intimacy and cooperativeness.

The covert nature of personality disorder can elude the untrained eye, which, in return, informs how people react to challenging behavioural expressions, especially given the central role of interpersonal dysfunction associated with personality disorders (Wilson et al., 2017).

Knowledge in this area has evolved since it first emerged, and the theory associated with it continues to evolve significantly. Both the *Diagnostic and statistical manual of mental disorders* (DSM-MD) and the *International classification of diseases* (ICD)

have made significant steps with regard to the topic, and these were reflected in the most recent updated manuals. The DSM-MD revised its classification of personality disorder from ten categories to a proposed five, and the ICD shifted to the use of a scale of severity rather than placing emphasis on categorisation (Bach & First, 2018; Skodol et al., 2011). These shifts show a continual evolution in the field.

As described above, personality disorder is often one that does not always have explicit traits, and the detection and understanding of it can be elusive at times (Cooke, 2018). Nevertheless, part of the necessary knowledge in these specialised forensic units is that patients have had encounters with the law, demonstrating an incapability to follow societal rules. As such, most patients in these units would have strong Anti-Social Personality Disorder (ASPD) traits aside from other possible personality disorder diagnoses due to their past crimes, anti-social behaviours and traumatic pasts. Moreover, there are substantial overlaps in the assessment measures for ASPD and psychopathy (e.g., lack of remorse, lying to others frequently, lack of empathy and impulsivity) (Archibald et al., 2014).

1.5 Nursing Health Care Professionals (NHCP) in Medium Secured Forensic Settings for Personality Disorder Patients

As mentioned above, the narrative on personality disorder is usually negative, and the diagnosis is considered to be associated with a degree of stigma. For example, a study conducted in the UK by Beryl and Völlm (2018) highlighted a significant level of negative attitudes associated with personality disorder in forensic settings. The study reported that staff holding clinical roles held negative views that were positively

mediated by either having staff training relating to personality disorder or being from a non-nursing professional background. This is an important finding regarding the current research as it highlights the perceptions and stance of nursing roles concerning personality disorder within the forensic community. Beryl and Völlm (2018) have also suggested that perhaps improving access to training would mitigate these views and perhaps the attendant attitudes. The current study, however, intends to go one step on from Beryl and Völlm's (2018) findings and investigate the idea that perhaps the nature of the nursing role and what it entails may impact their experience. A meta-analysis carried out by Wilson et al. (2017) suggested that personality disorders are essentially disorders of relating with others. It was worth noting that perhaps the experiences of nursing roles may be different, as these interpersonal issues may manifest more readily; the relationship with nurses is the main interpersonal one that patients have, since patients have a limited access to their family members and friends due to their detention status.

Looking closer, Forensic Mental Health Professionals (FMHP) experience elevated levels of occupational stress and psychological distress. Equally important, significant levels of burnout were shown in terms of emotional exhaustion, depersonalisation, and reduced personal accomplishment (Elliott & Daley, 2013). The findings confirmed that FMHP utilised a range of palliative coping strategies (e.g., excessive smoking and drinking). Very little research has been dedicated to probing the effect of burnouts and emotional stress on the personal lives of FMHP working in forensic settings. 'Senior' staff in inpatient wards (psychologists, ward doctors, ward managers and social workers) report fewer cases of burnout. This is closely linked to the belief that such workers have less direct contact with patients in addition to being offered more targeted and intense training (Greenberg & Shuman,

1997). There is a need to be able to capture what burnout means for NHCP who work alongside forensic patients, given the magnitude of the work they do. This is why an inpatient medium secure hospital informed the proposed research, as such a setting demands that NHCP consistently work long stretches with patients who have distressing histories as well as challenging presentations on the ward (Jacob & Holmes, 2011). These distressing histories often include extensive childhood trauma, neglect and a considerable offending background (Jacob & Holmes, 2011).

The term NHCP (which encompasses health care workers and mental health nurses) was devised in order to capture the lived experiences of frontline staff. There is a clear distinction in this study between the FMHP and NHCP, as some literature suggests that the impact of the forensic environment is different. As mentioned earlier, there is a notion that training perhaps plays a significant role in the experience of the individual. However, the high rate of stress and burnout may be experienced more by nursing roles due to their primary function of being caregivers (Beck, 2011). Moreover, nursing roles require a significant amount of patient contact in comparison to other roles. The patient contact would signify that often nurses will be at the forefront of incidents on wards and would experience the challenging behaviours associated with personality disorder and forensic units.

The delivery of therapy, whether psychosocial or pharmacological, relies to no small degree on the relationships between the patients and the clinical staff in their immediate surroundings (Johansson & Eklund, 2004). Johansson and Eklund (2004) emphasise that NHCP are always offering therapy with every interaction that they have with patients, and as these roles are confined and ward based, they are often more intense. This is different for other professional groups as they benefit from having more insulation due to the imposed time and space boundaries. For example,

most staff working outside of the NHCP bracket (such as psychologist, psychiatrist and social worker) would spend most of their working hours in the office away from the wards and would have a more official and pre-planned meeting with patients. This, in a way, can serve as a protective factor for these senior roles. This then raises the important question of the cost on NHCP well-being, of how the intense and demanding role of NHCP impacts their lives in and outside of work. Though studies suggest that external support can often be a protective factor for frontline staff, not many studies have been dedicated to the understanding of the lived experiences and the changes made by NHCP to their environment as a consequence of their demanding role (Sprang et al., 2007). It is important to understand the impact this might have on the well-being of NHCP beyond the work environment and how services could cater for the possible needs the job may present (Sprang et al., 2007).

The current study is interested in exploring other ways in which stress and burnouts are manifested, significantly beyond the work environment. As such, the study seems to be of some relevance to the understanding of the experiences of NHCP with regard to stress and burnout, and how this impacts them in their personal lives.

1.6 Research Question

This study attempts to investigate two main questions. The first is to ascertain the experience of NHCP within the forensic personality disorder unit as a way to explore whether there are any new subjective data discoverable. The second is to determine how NHSPs are affected outside of the work environment and how they experience

the world in response to stress and burnout from work. Therefore, the two research questions for this study are:

- How do NHCP make meaning of their experience of stress and burnout in a forensic personality disorder unit?
- How do NHCP working in a forensic personality disorder unit experience the stress and burnout from work in their personal lives?

1.7 Reflexivity

Personally, I have a significant connection to the topic of this project as I am currently working in a medium secure inpatient ward at a forensic hospital with patients having a diagnosis of Personality Disorder, with violent and aggressive criminal histories. As this is a relatively new service and the demands for such services are increasing, it appeared important to look into how this may affect care providers, especially NHCP. During my experience in this field, I have often observed how services and patients have been prioritised over workers and how the workers' health is disregarded. As an aspiring counselling psychologist, I was drawn to this study as I identified this population as an atypical marginalised one. As described earlier, NHCP fall under the general bracket of nursing and a significant aspect of experiences of stress and burnout may be similar. Nevertheless, I believe that bracketing all experiences as one is an over-simplification, and this may be one of the reasons for the poor progress identified in the field of stress and burnout. I believed that by giving NHCP a voice, this could establish a foundation to build on concerning NHCP mental health and self-care, which would in return inform the field of psychology.

On a different note, it was vital for me as a researcher to be reflective at all points of the research in order to not unconsciously skew the analysis of the data with my own experiences and perspectives, and so ensure objectivity, transparency and lucidity of the study. This adds to the understanding of the role that the researcher can play by keeping a reflective eye on possible reactions to the material uncovered (Berge, 2015). For example, as I currently work with patients with extensive forensic histories, I have developed my personal and palliative coping strategies in dealing with the challenges of the job I am exposed to (e.g. physical violence, sexual offences and so on), which themselves can hinder objectivity if not appropriately managed. As the research progressed, I revisited my reflexivity across each stage and highlighted any possible influences that my personal experiences might have on the data and vice-versa.

1.8 Summary

Stress is described as a phenomenon that can arise as a consequence of feeling run down, overwhelmed and distressed, which can lead to physiological and emotional changes (Baum, 1990). Work-related stress has translated into an economic burden of approximately £4 billion in the UK (Hassard et al., 2018). Persistent stress in a work environment can contribute to burnout, which is defined as a long-term response to persistent stressors in a work environment (Baum, 1990). This is recognised by high work fatigue, low productivity and behavioural changes such as cynicism and increased irritability (Fink, 2016).

It was found that many people would associate burnout and stressors with complaints of psychosomatic illnesses, physical exhaustion, a wide range of mental

health difficulties and sick leave (Grossi et al., 2015). The available literature has highlighted significant gaps on the impact this has on the personal lives of individuals outside of their work environment, how they think they are viewed and how they view themselves (Sprang et al., 2007). Although it is essential to know about the direct implications of stress and burnout on physical and mental well-being, it is just as important to understand how an individual's relationships and relations in social contexts are also affected and how this in turn might influence their well-being (Taylor & Barling, 2004).

This research aims to explore the lived experiences of nurses and health care assistants who work in a medium secure forensic ward for patients who have received a clinical diagnosis of personality disorder. The term Nursing Health Care Professionals (NHCP), which is adopted throughout this thesis, refers to roles where workers are required to spend a significant amount of time with patients on a daily basis (frontline workers). The research aims to understand more about how these individuals experience stress and burnout both individually and collectively, specifically regarding the impact on their personal lives outside the work environment. I believe it is important to give a voice to NHCP working in this complex and demanding environment by exploring their lived experiences (Collins & Long, 2003). Moreover, in the present case, the research will specifically look at NHCP working closely with clients that have been clinically diagnosed with a personality disorder with forensic histories, which in itself has its difficulties (Dickson & Wright, 2008).

This research aims to inform organisational structures and the field of counselling psychology regarding the lived experiences of NHCP working in a forensic personality disorder unit. The potential knowledge gained could inform organisational

structures to reform their policies to be better tailored to support and promote the well-being of employees within this field. Also, this research could inform counselling psychologists on how to help frontline workers in a forensic setting, particularly given the stigma and difficulty linked to the area of personality disorder (Goffman, 2009). The current study firstly explores the impact of stress and burnout as a way to keep the relevant literature on workplace stress and burnout up to date. However, the study moves beyond the scope of apprising and investigates the impact beyond work. As such, two research questions were devised:

- How do NHCP make meaning of their experience of stress and burnout in a forensic personality disorder unit?
- How do NHCP working in a forensic personality disorder unit experience the stress and burnout from work in their personal lives?

Chapter 2: Methodology

The aim of this chapter is to address a number of methodological principles. I will start by introducing the research paradigm, including the underpinning epistemological stance and ontological position. I will then introduce the chosen methodology with a number of discussions regarding the theoretical underpinnings, the rationale for selecting this approach, and the consideration of other approaches. The exact procedures that were followed will then be outlined and discussed in relation to ethical considerations. A section is also dedicated to my reflexive stance with regard to the methodology. Finally, I will explore how the validity and quality of this study were maintained.

2.1 The Research Paradigm: Philosophical Underpinnings

In order to maintain a sound methodology, it is important to define the ontological and epistemological stances as they inform the research outlook and outcomes significantly (Gregor, 2006). As highlighted by Wahyuni (2012), a research paradigm gives insight into the guiding perception of the researcher, via the understanding of the fundamental beliefs and assumptions about the world that is adopted. A quantitative approach was deemed redundant for this study as the majority of existing studies in the field have focused on quantifying, defining and etymologising stress and burnout in health care systems (Collins & Long, 2003; Sprang et al., 2007). Laverty (2003) submits that a positivist research stance should not be adopted if a researcher intends to explore the subjective experience of individuals. Hence, my research study will gather qualitative data to capture the rich nuances of a person's experiences. Moreover, a qualitative approach adheres more closely to the values of counselling psychology as it aims to explore and capture subjective

experiences that can be interpreted for the advancement of knowledge (Fletcher, 2017).

2.1.2 Philosophical Underpinnings

Philosophical underpinnings are at the base of any research quest as they provide a shape and form to the enquiry and exploration of the phenomenon in question (Sprang et al., 2007), and provide both a lens and a language to observe and divulge realities. In the case of the current study the quest is of a social scientific nature. This is different from a pure scientific knowledge which attempts to examine only that reality that has been previously created as knowable and defined as its object (Fletcher, 2017). The social aspect of psychology introduces a different layer to the observable reality and presupposes that knowledge can be malleable and dependant on other factors (Laverty, 2003). Amongst many, these factors include culture, language, personal experiences, and so on (Wahyuni, 2012). These factors often represent the elements that sway social sciences away from the more “objective” view associated with pure scientific knowledge (Laverty, 2003). However, in a world where organisms communicate and live together, epistemology and ontology create a base language where realities can meet. Considering that most of the questions posed by social sciences have different responses depending on which model is assumed, I presume that the knowledge acquired through this present study complements the understanding of a chosen perspective.

Thus, ontology attempts to answer the questions: what is the nature and form of reality? What can be understood about this reality? The questions can be refined depending on the quest and enquiry (Guba & Lincoln, 1994). In this case, the

research intends to shed light on the phenomena relating to stress and burnout. These are phenomena that are informed by language, culture and scientific underpinnings. Nevertheless, ontology assumes that these realities are based on well-argued beliefs that serve to observe the world (Speer, 2000). These well-argued beliefs are known in the field of psychology as theories and concepts. The introduction chapter has served to determine and explore the available theories, concepts and realities. These will serve as a foundation from which to explore the aims of the research but also give an understanding to the reader of what is being explored.

Similarly, epistemology aids in the discovery of knowledge although it is limited by the ontological frame being used, as the understanding of a reality is based on the entity it is given (Guba & Lincoln, 1994). Thus, epistemology attempts to understand the nature of knowledge by tapping into the relationship between the nature of knowledge and the ways of knowing. This provides a philosophical grounding for deciding what kinds of knowledge are possible and how we can ensure that they are both adequate and legitimate (Mingers et al., 2013).

In summary, Guba, and Lincoln (1994) define ontology as a search for the form and nature of reality, in terms of what can be discovered about the world through it, whilst epistemology is the study of the nature of knowledge and how it is carried out. The current study adopts a critical realist paradigm. This is characterised by an ontological critical realist stance and an epistemological relativist stance. It is important to have a base of reference that highlights the mode with which knowledge is retrieved and gained. A strong foundation to the aetiology of the knowledge gained can provide context to findings and become a point of reference for future studies in this field.

2.1.3 Critical Realist Ontology

The systems of beliefs set by ontology range from realism to relativism. Relativism perpetuates the varying apprehendable realities that are influenced by varying social constructs (Speer, 2000). By contrast, realism perpetuates the naive reality where an apprehendable truth is sought beyond language; this paradigm stance is argued to be deterministic and reductionist in nature (Fletcher, 2017).

Bhaskar (2013) presupposes that the depth of a critical realist ontology is by nature stratified and interrelated. This allows for different realities of a concept, idea or structure to coexist. This meta-theory assumes that many of the stratified domains of reality exist beyond our awareness, and they cannot always be quantified and examined hermeneutically. The value of critical realism is captured in the exploration of scientific, social phenomena such as processes, ideology, structures, beliefs and causes. This is often why empirical studies may not fully capture certain realities and concepts. However, critical realism also encapsulates a need that goes beyond this, as it assumes that important features of the world can escape existing theories and models if these are not done through sensitive conceptual resources and by keeping in touch with the nature of things in the social world. As such, critical realist theory suggests that an exploration can be done through abductive and retroductive inferences that are based on theories that are case sensitive to the phenomenon being explored (Mingers et al., 2013).

It is still paramount that the exploration of a phenomenon is grounded in empirical evidence, as long as it remains "ontologically reflexive". In the case of the current study, one of the sub-questions answerable through this current ontological frame is the understanding and exploration of whether there are consistent traits to stress and

burnout in PD forensic units. Critical realist ontology appraises the use and need of statistical and interpretative models provided that the aim of an enquiry is not merely based on causation but takes account of the investigator's presuppositions, human actions and reactions, social structure, culture and individuals' views. A critical realist ontology accepts varying implicit and explicit ontologies that provide a better understanding of social structures, agency and relations.

2.1.4 Epistemic Relativism

Epistemic relativism views the enquiry of knowledge as a concept that is context and activity dependent (Holland, 2013). This stance emphasises the importance of historical knowledge to inform the present knowledge. Epistemic relativism does not assume to have the key to all truth but instead accepts that all acquired knowledge is fallible and has its limitations (Pritchard, 2010). These fallibilities are mediated by understanding and acknowledging that the enquiry of truth is achieved through a chosen conceptual framework. The conceptual frameworks in return are not infallible either. Instead, they recognise that the differing perspectives mediate the search for the truth through historical contexts (Bhaskar, 2013). The critical realist paradigm, therefore, acknowledges the differing realities (ontology) and acknowledges that different lenses can be adopted to search for a truth about a phenomenon (epistemic relativism) (Yucel, 2018). This does not mean that knowledge cannot be achieved but that acquired knowledge is fallible and requires methodological pluralism.

2.1.5 Context of Research

As described in the earlier chapter, the concepts of stress and burnout are phenomena that have been constructed and regarded as measurable realities (Baum, 1990). This aligns with the critical realist stance that the social structures in the world can be understood through subjective interpretations, such as the experiences of NHCP regarding stress and burnout (Onweugbuzie, 2002). The research being reported here adopts a relativist epistemology, as I understand that the participants and I have a role in the meaning-making of the study through our knowledge which is context and historically dependent (Fletcher, 2017). This philosophical stance incorporated by Bhaskar adopts a non-reductive account of a given phenomenon to emphasise the need to appraise social constructs from a more subjective view (Bhaskar, 2013). Critical realism treats the ideas and meanings held by individuals – their concepts, beliefs, feelings and intentions – as equally real as physical objects and processes (Maxwell, 2012).

The study was epistemologically grounded in a critical relativist construct. This critical realist stance perpetuates the values of the investigator as linked to those of the investigated. Findings are, therefore, value mediated (Guba & Lincoln, 1994; Weaver & Olsen, 2006). I am aware as the researcher that my experiences and knowledge in the field will inform the interpretation of the material gathered. This has been considered and addressed in the ethical considerations and reflexivity sections. For example, as I currently work in a forensic personality disorder unit, I did not recruit participants from my place of work but from a different trust where I would have had no previous relationships.

2.2 Methodological Consideration

As differentiated by Polkinghorne (2005), methodology and method serve different purposes in the research field. Methodology refers to the theoretically informed framework, whereas method relates to the specific procedure and modes in which data is collected and analysed (Seebohm, 2007). The methodological approach for this study is phenomenological; a term that describes those studies interested in exploring the human experience with regard to a specific phenomenon (Smith & Osborn, 2007). These experiences are recognised to involve emotion, imagination, memory, thoughts and perception as the individual focuses on a particular "object" or event (Husserl, 1954). Edmund Husserl, who established the phenomenological approach, describes phenomenology as the ability to enter the living world of participants without any presupposition and by "bracketing" the investigator's perception. This version of phenomenology is what is now known as descriptive phenomenology (Husserl, 1954; Moran & Husserl, 2005). Husserl's concept of phenomenological reduction seeks to suspend the judgement of the investigator in order to focus on the understanding of the world indiscriminately (Creswell, 2017). This concept, although of value, receives criticism as it assumes that researchers can estrange themselves from the data gathering and interpretation process of research (Grondin, 1997).

On the other hand, Martin Heidegger emphasised the importance of interpretation as a critical factor in understanding (Heidegger, 1999). The standpoint of hermeneutic phenomenology is that nothing can be encountered without reference to a person's historical knowledge, claiming that to be human is to interpret through an individual's historical value, in this present case through my understanding and experiences (Grondin, 1997). Heidegger's philosophical standpoint expanded on Husserl's theory;

Heidegger believed that "bracketing" is impracticable as one cannot interpret a phenomenon in the life world without some form of pre-understanding of one's experience (Ho et al., 2017). Hermeneutical phenomenology, according to Alase (2017, p. 2) "is the 'lived experiences' of research participants (phenomenology) and the interpretation (text) of the life they have lived and experienced (hermeneutics)". Hermeneutic phenomenology, thus, does not believe the investigated can exist without the investigator as they are responsible for each other's existence through mutual understanding. Notably, personal biases can still be kept in check and highlighted by maintaining a reflexive stance through a reflexive diary, individual therapy sessions and supervision (Walsh, 2003). As Guba and Lincoln (1994, p. 113) encapsulate: "the aim of inquiry is an explanation, ultimately enabling the prediction and control of phenomena, whether physical or human".

A phenomenological approach offers a way to understand the range of factors that can affect NHCP. This study therefore adopts a hermeneutical phenomenology as devised by Heidegger (1999), which fits in more appropriately with the ontology and epistemology of the current study (Laverty, 2003).

2.2.1 Rationale for IPA

The study is conceptualised within an interpretative phenomenological analysis framework. Notwithstanding the method and methodology, it was essential to remain faithful to the investigator's epistemological and ontological stance as this would ensure that the aim of the research was kept in focus (Wahyuni, 2012). The study adopts an interpretative phenomenological analysis with a hermeneutic phenomenology framework as being the most appropriate in addressing the

research questions and providing a meticulous and reliable approach to the research analysis, as this approach emphasises the role and experience of the investigator with the data. The study is further intended to explore how participants experience stress and burnout in a manner that allows individuals to express their experiences individually (idiographically) but also as a part of a larger group. This fits well with the study at hand as this methodology allows the discovery of new idea, concepts and experiences that may have not been captured by previous studies.

2.2.2 Interpretive Phenomenological Analysis (IPA)

IPA is an approach that was first developed by the health psychologist Jonathan Smith (1996) to undertake experiential research in psychology. Since the development of the methodology, IPA has been adopted more often in the field of psychology, especially in the UK (Biggerstaff & Thompson, 2008). IPA aims to discover what an experience means for a person through a process of in-depth enquiry (Peat et al., 2019). Moreover, as IPA uses a standard framework, its philosophical and phenomenological stance fits well with the epistemological, ontological and phenomenological framework of the study as described in the earlier sections. IPA was regarded to be suitable for the study at hand as the aim is to explore the subjective experiences and perspectives of NHCP concerning stress and burnout (Smith, 2012). Furthermore, as explained by Tuffor (2017), IPA is significantly influenced by hermeneutic phenomenology, which is philosophically aligned with an in-depth exploration to understand, interpret, and inform the meaning of experience. With IPA, the engagement of the researcher with the data is referred

to as a circular or double hermeneutic, where the researcher seeks to make sense of the participants making sense of their world (Peat et al., 2019).

Consequently, IPA considers my experience of working in a forensic unit which is similar to the one being researched, as this will inform the interpretation of the information gathered from participants. IPA was favoured above other approaches for its dual focus on idiographic exploration (singular) and on the patterning of meaning across participants (collective) (Smith, 2012). This allows the researcher to explore the subjective experiences of NHCP in depth as well as highlight and bring to the surface common meanings across participants. As mentioned by Smith, IPA has a theoretical commitment to a person's cognitive and affective domains, linking people's thinking with their emotions and words (2012). As informed by the research question, the objective is to explore how NHCP experience stress and burnout, which tallies well with IPA's prerogative of exploring the subjective experiences of a phenomenon. IPA offers a reliable, tested and standardised framework that enables me to stay close to the data (hermeneutic phenomenology) in a manner such that I can explore the research question in greater depth than would be the case with most other methodologies (Willig & Billin, 2012).

2.2.3 Limitations of Interpretive Phenomenological Analysis

As suggested in the section on philosophical underpinnings, there are multiple epistemological roots for qualitative approaches. However, they all converge in the context of how meaning-making takes place. As such, IPA, similarly to other qualitative approaches, seeks to understand the internal perspectives of the

participants from the participants themselves. Nevertheless, IPA has some limitations in attempting to capture the experiences of individuals.

Firstly, the very essence of IPA, which is based on idiographic understanding, conflicts with the scientific quest to standardise findings (Tuffor, 2017). Although the ethos of counselling psychology tallies with IPA's idiographic paradigm, this has often found itself at odds with other scientific approaches as it places restraints on categorising and standardising findings (Vicary et al., 2016). Another limiting aspect of IPA is within the scope of exploration, where perception and experience are given prevalence over causation (Tuffor, 2017). Similarly to other phenomenological approaches, IPA is concerned with the perception of the individual, which can be limiting in the understanding of a phenomenon as it does not focus on individual histories, past triggers and social cultural domains which can provide significant information relating to any inquiry (Tuffor, 2017). Nevertheless, Smith et al. (2009) argue that the lacunas relating to the social and cultural context of the individuals' experiences are mediated by IPA's use of hermeneutics, idiographic and contextual analysis.

Lastly, it has been debated whether IPA is truly capable of capturing individuals' experiences rather than opinions (Vicary et al., 2016). A major part of IPA relies on the experience of the researcher and the accounts of the participants. In a scenario where language does not serve the participants and the researcher to convey the nuances of an experience, significant aspects of the enquiry can be lost along the way. As such, the evidence would appear to support the argument that IPA is an approach that serves only those eloquent speakers who are skilled in communicating their experiences. This limitation can appear elitist and exclusive but in fact serves

as a note to researchers to be aware of the important role of language within IPA and the need to gather rich, in-depth and exhaustive data from participants.

Notwithstanding the limitations of IPA, the benefits of the approach supersede and outweigh the limitations. Moreover, these limitations can be resolved by keeping a keen eye on procedural aspects of the approach and by holding a reflexive stance with regard to the interaction between researcher and participant (Smith et al., 2009). Lastly, the notion that IPA does not provide standardisation of experiences tallies well with the research aim to understand the personal experiences of participants in order to enrich the current available literature.

2.2.4 Consideration of other Methodologies

2.2.4.1 Thematic Analysis (TA)

As described by Braun and Clarke (2012), TA is a method for offering insight into meaning through the systematic identification and organisation of the information gathered. This process allows the finding of meanings and experiences across the data set as a whole. IPA and TA often share some similarities that stem from the philosophical underpinnings (critical realism) to some of the analytical procedures (themes and codes) (Larkin et al., 2006). However, what made IPA more relevant to this study is that it encapsulates the objectives of TA and goes beyond, especially when the principal aim of IPA is that of understanding the subjective experiences, which is not always the case with TA. Often, thematic analysis explores meaning by finding commonalities and differences with the research group. As highlighted by Solovieva (2015), however, commonalities and differences are not always necessarily meaningful or important, more so as some previous studies have

adopted methods to highlight commonalities and differences in the current topic it is important to veer towards a different option in order to explore what it might have to offer (Azam et al., 2017). IPA's analytical procedure is such that it allows me to stay closer to the data, as it focuses on the analysis of the data item by concentrating on the unique characteristics of the individual participant.

In contrast, TA aids the researcher in identifying patterns across the entire data set (Maguire & Delahunt, 2017). Although it is valuable to highlight patterns, IPA offers a good insight into the unique experiences of participants and searches for meaning with a depth that TA could not provide (Alase, 2017). The following research is concerned with expanding the range of study beyond coding and the search for commonalities and differences. Moreover, IPA has its roots in the field of experiential psychology in the ambit of mental health, which makes it uniquely relevant to the subject of investigation as it provides an already tested framework suitable for doctoral-level project (Tuffor, 2017).

2.2.4.2 Grounded Theory

Glaser and Strauss (1967) proposed a grounded theory to develop new theories through qualitative data gathering, as opposed to data collection to illustrate how the theory informs an existing phenomenon (Birks & Mills, 2015). Although there are different types of grounded theories, the commitment to developing a theory remains the same (Charmaz, 2000). IPA's framework makes it such that the analysis of the data can inform already existing knowledge (Guba & Lincoln, 1994), whereas grounded theory analysis often circumvents active engagement with current theories (Glaser & Strauss, 1967). This approach could have been of relevance to the study if

there were no past studies that had researched the effect of emotional stress, stigma and burnouts on mental health workers. As such, the current research does not aim to generate a new theory as past studies have been dedicated to this area.

2.2.4.3 Discourse Analysis

Discourse analysis explores the running conversation involving a speaker and listener and how meaning is constructed through language by considering the social and cultural context (Alvesson & Karreman, 2000). Discourse analysis's primary purpose is to understand the meaning, motives, opinions, and purposes within a context (Sgier, 2012; Vaismoradi et al., 2013). In contrast, IPA is concerned with idiographic exploration, that is, how the individual makes meaning of their experiences (Braun et al., 2016). The main objection to using discourse analysis in relation to the current study is that the researcher can give priority to a participant's particular discourse in order to find meaning, whereas with IPA meaning is found during data gathering and exploration. The study with NHCP is not solely about understanding their context within society but goes further, to understand how NHCP make meaning of their experiences concerning the stressors and their environment, and how this has affected their lives with family, friends, community, and self.

2.3 Summary

The following study is interested in exploring the quality of life of NHCP outside of their stress-prone environment (medium secure unit for personality disorder). As highlighted in the previous paragraphs, the research is conducted through an interpretative phenomenological approach. The ontological and epistemological

stance is derived from a critical realist standpoint (Archer et al., 2013). This was seen as best fitted to a hermeneutic phenomenological methodology as the epistemological stance of the study is relativist, and the ontological stance is critical realist, where both stances acknowledge the role of the investigator in the process of data gathering and analysis.

2.4 Procedural Aspects

The following section outlines the research design, conceptualisation, ethical considerations, reflexivity, validity and quality of the research.

2.4.1 Design

The research design section addresses some of the procedural aspects of the study. This section presents the setting of the research, research sample and interview schedule. This is followed by an outlining of the recruitment and data collection, the transcription and the analytical strategy employed. Finally, the section outlines how the study will be disseminated.

2.4.2 Setting

The seven participants who were recruited for the following study were nurses and care support workers in a male medium secure unit for forensic patients with a diagnosis of personality disorder. Although the ward was similar to the setting I work in, the interviews were carried out with participants from a different trust, which

meant that I had no previous encounters with the participants. The research topic was reviewed and approved by the Health Research Authority in January 2019 and by NOCLOR in February 2019. In return for participation, participants were offered a £10 Amazon voucher as compensation for their time. Participants were invited to attend the interview on a voluntary basis.

2.4.3 Research Sample

2.4.3.1 Recruiting Participants

In accordance with the available literature in regard to IPA, seven participants were recruited and interviewed for the research (Smith et al., 2009). The calculation of the number of participants is context dependent and part of a subjective process (Schulz & Grimes, 2005). Research suggests a small and homogenous sample of typically fewer than 12 participants (Alase, 2017). The main objective of IPA is to explore the subjective experience. As such, the sample does not need to be large as the aim is not generalisability (Smith, 2012). In terms of feasibility and to uphold the standard for a doctoral-level project, six participants is the number suggested to attain minimum data saturation with IPA. However, it has been argued that this number can be up to eight participants (Turpin et al., 1997). Due to the high turnover of staff in the ward, the pool of participants was limited. This highlights the data from previous literature, showing that forensic units have an intense rate of frontline worker turnover (Paris & Hodge, 2010). The interview pool was composed of five males and two female participants with the age ranging from 24 to 59 years.

2.4.3.2 Participant Inclusion and Exclusion Criteria

The participants included in the study were mental health nurses, care support workers, and other health care professionals who spent the majority of their working hours alongside patients on the ward. Participants were currently working on the ward and had been doing so for a minimum of one year. As suggested by Halfer and Graf (2006), mental health care workers start to experience significant levels of stress six to twelve months after hire. The inclusion criteria took this factor into account, as it would also have provided a period for the potential participants to have settled down in their role.

To partake in the study, participants were required to meet the following criteria:

- Must self-report to have experienced either burnout or emotional stressors whilst in their current role.
- Must be able to express themselves in the English language.
- Must have worked in a Forensic Medium secure Hospital (Ward) for at least a year.
- Must have other work experiences in mental health other than the present one to allow them to draw on different experiences of work-related stress and burnouts.

The exclusion criteria were:

- Nurses and care support workers who had not accrued a year of working in a medium secure forensic unit for personality disorder.

- Roles in the medium secure setting that did not require a significant amount of patient contact time in relation to the participant's working hours.

The exclusion of particular roles (such as consultants and psychologists) was adopted since the research was set out to investigate the experiences of those roles subject to a high degree of daily stressors due to the high degree of patient contact (more than 80% of working hours). There were no gender specifications, and in terms of age, all participants were of the legal working age for a medium secure forensic unit (18 and above).

2.4.4 Semi-Structured Interviews

A semi-structured interview was adopted in order to produce in-depth qualitative data (Ryan et al., 2009). The questions were informed by past studies on stress and burnout. However, the questions were left open-ended in order for the participants to have room to reflect on their in-depth experiences and to limit my possible biases (Fugard & Potts, 2015).

2.4.4.1 Interview Schedule

The interview schedule (Appendix A) was devised after a rigorous search of the literature available on stress, burnout, coping strategies, and the possible impact of stress and burnout on personal lives (Godoy-Izquierdo et al., 2011; McVicar, 2003). The search enabled me to create a draft of the initial questions, which were refined after the pilot study to improve the relevance and sensitivity of the questions (Appendix A). For example, a set of questions was: Is the emotional stress and

burnout in the forensic unit different from what you have experienced outside of work? If yes do you have an idea why? What changes have you noticed outside of work? How do you feel about these changes?

2.4.5 Recruitment and Data Collection

The internal collaborator (the ward consultant) served solely to introduce me to the staff on the ward where I was able to introduce the study and distribute the flyers (Appendix B). During the introduction, I informed the participants from the ward that participation was voluntary. Since I recruited staff from a secure unit, it was necessary to have an internal link that could aid me with the appropriate permissions to carry out the research in the unit. Nonetheless, ethical considerations were taken into account. The internal collaborator was not made aware of participating members or staff members who did not show interest so that no one felt obliged to participate in the study. An information sheet (Appendix C) was handed over to those who made their interest known either by email or in person. The information sheet provided the participants with more information and time to decide whether they were interested in participating in the study. Participants were able to take the information sheet away, and if interested in the study, they confirmed this at a later date by email (my email address was provided on the information sheet). Participants were made aware through the information sheet and consent form (see Appendix D) that participation was voluntary. Once participants made their interest known, an interview was organised and held within a week. Participants were interviewed at their place of work away from the ward, in an office where they had privacy and were not seen or heard by their colleagues. Before the interview commenced, participants were able

to ask any other clarifying questions about the study. Participants were asked to sign the consent form at the start of the interview once they made the decision to participate. Participants were interviewed individually for 60-90 minutes. The seven interviews carried out were semi-structured and audio-recorded. At the end of the interview, participants were debriefed (Appendix E), after which they were not required for any further engagement.

2.4.6 Transcription

The seven audio-recorded interviews were instantly transferred to my encrypted drive and shortly after were transcribed. In order to maintain and reflect the participants' expressions and communications, I transcribed the audio-recording myself. I was able to render and convey the participants' verbal and non-verbal communications more authentically as I annotated, and I ensured that I carried out the transcription as soon as I could in order to ensure that contextual meanings were highlighted. I identified other non-verbal communications such as nail-biting, pauses, and laughs. I also had a notepad where I noted my personal reflections and how I felt during the interview.

2.4.7 Analytical Strategy - Interpretative Phenomenological Analysis (IPA)

This segment of the analysis showcases the analytical process that was adopted throughout all transcripts. The six steps highlighted by Smith et al. (2009) were adopted for the collected data in this study: familiarising oneself with the text and initial noting (Steps 1 & 2), developing emergent themes and generating subordinate

themes (Steps 3 & 4), and creating initial sub-themes and superordinate themes by moving to the next cases and looking for a pattern across cases (Steps 5 &6).

2.4.7.1 Familiarising with the Text and Initial Noting (Steps 1 and 2)

This initial stage was completed by immersion in the raw data by re-listening and re-reading the transcript and making initial notes. The second part consisted of coding line by line and by systematically commenting on the data (Appendix F). The data was commented on by using the four different coding strategies: descriptive, linguistic, conceptual, and de-contextualisation. A page of the transcript has been attached to the appendix section to demonstrate the systematic approach utilised (Appendix F).

2.4.7.2 Emergent Themes and Generating Subordinate Themes (Steps 3 and 4)

Appendix G and Appendix H show the emerging themes, subordinate themes, the line referencing from the transcript, and the explanatory notes retrieved from the transcript. An example of how the emerging themes were gathered is shown in Table 1.

Table 1. Examples of explanatory comments for emergent themes.

Emergent themes	**Transcripts line**	**Explanatory comments of the emergent themes**
"winter jacket" (protection)	Line 413-415, 425, 426-428, 432, 433, 501, 556, 570, 627, A52, A56, A68, A87, B7, B126, B136, B138, B156, B158, E150, E401, E459, E470, E528, F108, F339	*The use of the imaginary winter jacket dripping water is a metaphor used by one of the interviewees to indicate that there is a need to use a winter jacket in a PD forensic unit as a form of protection from the stressful nature of the environment and work. This is an element sustained with other participants who describe the difficult nature of compartmentalising work. For example, in line 414 there is an indication that the stress can often be so pervasive as to cause the winter jacket to "be dripping of water".* *Later on the interviewee refers back to the winter jacket and emphasises the importance of leaving this jacket somewhere away from his family as this could impact his microsystem negatively. As he describes in line 416, the winter jacket belongs to the unit he works in, it is not his possession. In line 413, bringing the "dripping winter jacket" to the doorstep of his house appears to be an attempt to describe the pervasive element of the job, however, in line 416 the interviewee changes the narrative where he states that he leaves the jacket at work. This might indicate the struggle encountered in succeeding with separating his work from his family.* *The repetition and mannerism of how the words "you don't take it" (referring to the difficulties from work) would suggest that there is an internal struggle, perhaps a difficulty in succeeding at the task of compartmentalising that has been experienced by the participants. He uses the word equip in line 501, 556 and 627 to suggest that there is something to protect the self and others from. Also used as a metaphor of armouring oneself against a war.*

Transferable behaviour/ Developing skills	334, 340, 346, 354, 361-365, 388, A65-66, B101, B177, B300, B305, B350, E163, E296, 485, 508, 510-513, 518, B177, B295, B300, B306, C28, E198, E201, E216, E231, E296, E378, F193, F218, F229, F238, F251, F254, F256, F258, F310	*This concerns noticeable behaviours developed whilst in the unit. This appears to be acquired behaviour used in their personal lives outside of work. For example, one of the interviewees has experienced being more tolerant and accommodating of others outside of work as there is an emphasis on the chance that people in his personal life might not be "psychologically very normal" (361). Another interviewee stated "I think it changed me profoundly, I am naturally introvert, natural introvert, socially anxious" (A65).* *"you are better at picking up signals which normally you wouldn't picked up, yeah that's in different level , the tension maybe, the body language yeah I think there is something to it" (B177).* *The participants tell of acquired positive changes that they have associated with working in the environment. There is an acknowledgement that they experience a higher general sense of confidence, conflict resolution skills and assertiveness in their personal lives.*

In line with the framework devised by Smith et al. (2009), the initial notes and coding from the transcript were refined and selected by focusing on the research question. The coded data were synthesised into emerging themes using polarisation, sub-sumption, abstraction, contextualisation, and understanding the function and frequency of the themes (Smith et al., 2009).

Table 2: Synthesising modes (adapted from Smith et al., 2009).

Sub-sumption	A theme which becomes superordinate and encompasses other emergent themes.
Abstraction	Themes which can be grouped by likeness under a superordinate theme.
Contextualisation	Local influences on the data, such as culture, narrative, and temporal events.
Polarisation	Related themes which can be compared by differentials in the responses.
Function	Themes which emerge as a result of the 'self'.
Numeration	The frequency of the theme within the responses.

The explanatory notes show a summary of the initial interpretations of the coding and how these were grouped initially. As shown in Table 1, the emergent themes were listed, and part of the analysis consisted of making links and clustering the themes into subordinate themes.

2.4.7.3 Moving to the Next Cases and Looking for a Pattern across Cases (Steps 5 and 6)

At this stage, Steps 1 to 4 were repeated with the six remaining transcripts, and more emerging themes and subordinate themes surfaced. At this point, subordinate themes began to merge together to form initial superordinate themes. These superordinate themes were consolidated once the emerging themes and subordinate themes were clustered by highlighting the themes that were shared across the transcript. In the case of this study, the transcripts generated three superordinate themes (Appendix I).

In keeping with the ethos of the critical realist epistemology, the interpretation of the data was grounded on the credence that it underpins the development of a theoretical frame, which in this instance is that of stress and burnout (Clegg, 2016). As such, looking back at the data generated, both empathic and suspicious interpretations created valuable themes (Willig, 2017). The more suspicious approach allowed an interpretation that was based on pre-existing knowledge on the subject. However, when a more empathic approach was adopted, it generated and enabled the discovery of novel concepts (Willig, 2017).

2.5 Dissemination

The findings of the research will be disseminated as part of the requirements for a doctoral programme, which will be available to the public on the City, University of London database. The study will also be expected to be published/presented in the wider fields. Furthermore, summaries of the findings and outcomes will be sent to participants if they opted for this on the consent form.

2.6 Ethics

2.6.1 Ethical Approval

An approval from the Health Research Authority was granted on the 15th of January 2019 (Appendix J) and NOCLOR on the 11th of February 2019.

2.6.2 Ethical Consideration

This research has been devised to work within the ethical framework set out by City, University of London, the British Psychological Society code of ethics (BPS, 2018), HCPC guidelines (2016) and NHS guidelines (National Health Service, 2016). The participants recruited were adults employed in the ward in question, which is a different trust from where I work. The research did not necessitate exposure to any risks greater than those experienced in typical everyday life. An information sheet and a written consent form were handed individually to the participants, and they were given ample time to decide whether or not to participate. Participation was wholly voluntary, and the partakers were briefed about the nature of the study and their right to withdraw if they wished to. I informed the participants that they were able to stop the interview at any time without feeling obliged to provide a reason. Furthermore, a few steps were taken to mitigate any possible risks to participants and provide them with adequate support if any issue arose. Participants were debriefed after the interview, and they were handed details about psychological support they could seek if the need were to arise (Appendix E). In order to keep confidentiality and a level of privacy, the interviews were offered away from the wards, so patients and other staff were not present. During the interview, participants were offered breaks and some refreshments (water and snacks).

All information gathered on participants was used with their consent. All data were anonymised in line with ethical standards. If there were any identifiers in the recordings, these were removed from the transcripts. The transcripts and recordings were only available to me and kept securely in an encrypted computer drive in accordance with the General Data Protection Regulation. Upon request, the

transcript was shared solely with my supervisor, albeit without any personal identifying elements.

It was worth noting that participants were made aware of refraining from using their names or any identifying data of patients, as this would constitute a breach of patient confidentiality and privacy. Participants were aware of their obligation to keep patients' and others' privacy and confidentiality as they would have been accustomed to the NHS's policies with regard to privacy and confidentiality (NHS, 2016).

Finally, some consideration was taken regarding my role and how to mitigate any potential risks. I made provisions to constantly check in with my supervisor and explore in therapy my research topic and the possible effects it might have on me as I work in a similar setting. Furthermore, consideration was given to my safety as I interviewed staff in a medium secure unit. I made arrangements to call the unit before visiting to enquire that the work environment was settled, and most importantly, as mentioned, I carried out the interviews away from the wards, so I would not have any patient contact, and the anonymity of participants remained protected.

2.6.3 Data Confidentiality

In order to aid transcription, a digital audio recorder was used. All data was immediately transferred to my computer’s drive, which is password protected, and it was kept in an encrypted password-protected file. Although direct quotations from respondents are utilised in the analysis chapter, once the audio-recorded interviews were transcribed, any identifying information was pseudonymised, and only the

researcher would be able to identify the participant. The study followed the privacy and confidentiality policy guidelines set by City, University of London, and the East London NHS Foundation Trust. Consent forms and other sensitive data were kept in a locked filing cabinet at my home address. All the data generated from the study will be kept for ten years in accordance with the university's guidelines for published work.

2.7 Reflexivity

I acknowledge my connection to the topic of this project as I am presently employed in a medium secure inpatient ward at a forensic hospital with patients with a diagnosis of personality disorder, who also have violent and aggressive criminal histories. This field has indeed shaped my understanding of personality disorder and has made me more sensitive to the client group as well as to others outside of work. I realised that my sensitivity towards others was not the only change in me; there was also a shift in the way I see the world around me and with regard to my resilience in the face of difficult events. Consequently, this sparked my curiosity to understand how working in such a complex and demanding environment might influence others who work in similar contexts.

Most qualitative methods recognise the power of the investigator's impact on the research. Consequently, reflexivity is a prerequisite in all qualitative research (Willig, 2013). As such, it is important to be aware of how I can be influenced by the material (Berger, 2015). As I currently work with clients with extensive forensic histories, I have developed my own coping strategies in dealing with the diverse types of crimes they have committed and anti-social behaviours (e.g., sexual offences, physical

violence, and so on) that I am exposed to in such environments. I recognise that I might identify with some of the participants I interviewed. As mentioned by Finlay (2011), it is paramount not to be too self-absorbed with one's own emotions as a researcher, and this can be done by something as simple as acknowledging what biases or beliefs I bring into the study. In this way, throughout the duration of the study, I reflected on my role as an investigator and how to remain aware of my own influence and subjective views with regard to the data and the analysis aspect. This was done through self-reflection and by exploring my thoughts about the subject area during my personal therapy sessions. I made use of my supervision as well as a reflexive journal to keep account of my work and how it interacted with the project at hand. I also decided to carry out the research not just in a different unit but in a different trust from where I work. This would minimise over-identifying my personal experiences with those of the participants.

As the research developed, I revisited the reflexivity chapter at each stage by highlighting any possible influence I might have on it and how this was dealt with to keep the research as objective as possible.

2.8 Validity

To conduct reliable and accurate research, it is important to define the validity of the analytical process to reflect the multiple ways of establishing truth (Golafshani, 2003). Yardley (2008) outlines the importance of validity in research as the ability to employ the findings from one research to other similar contexts and practices. The most salient guidelines of validity outlined by Yardley that have been adopted by this study are: sensitivity to context; coherence and transparency; rigour; and impact and

importance. Sensitivity to context was achieved by familiarising myself and keeping up to date with the literature on the topic. Moreover, one of the research questions (How do NHCP make meaning of their experience of stress and burnout in a forensic personality disorder unit?) ensures that findings from the past literature are in line with the current experiences of stress and burnout. Coherence and transparency were achieved by providing extracts of my reflections from my personal diary and showing extracts of the transcripts in my analysis chapter. This ensured that I was aware of my biases and how these might have informed the research (Willig, 2013). The rigour of the research was achieved by delineating the analytical strategy, which in this case was interpretative phenomenological analysis through the step-by-step framework devised by Smith et al. (2009). This ensured that the data collection, analysis, and interpretation were carried out according to a tested and approved framework. Finally, the impact and importance of the study were stated earlier in the chapter as well as throughout the research by highlighting the potential implications of the findings for the field of counselling psychology and mental health for individuals, collectives and structures.

Nevertheless, in the literature relating to the validity, other frameworks are identified. For example, Smith suggests that validity is mediated by personal judgment (Smith, 2011). However, Vicary and colleagues believe that validity in IPA is best achieved through reflexivity, journaling, and reflection (Vicary et al., 2016). The new elements found in these new frameworks have been incorporated into the current research. For example, the journal that I have been using as part of the process came into being as part of my developing understanding of the importance of reflexivity.

2.9 Quality

For the current research to meet the standards of a qualitative doctoral-level project, I referred to the guidelines devised by Elliot et al. (1999) and Yardley (2008). They highlighted the importance of quality checking through coherence, the impact of the study, providing credibility checks, holding a clear perspective, and providing clarity throughout the methodological process. For example, the research went through a rigorous process of ensuring high engagement with the literature to provide a study that could potentially impact the lives of NHCP.

Given the varied forms of qualitative studies, however, there are numerous suggestions on how to evaluate and assess the quality of qualitative research study. One of the leading voices in this connection are Dixon-Woods and colleagues who place great importance on the methodology of the study (Dixon-Woods et al., 2004). In order to meet this requirement, Treloar and colleagues devised the ten questions (Table 3) for the critical appraisal of qualitative research (Treloar et al., 2000).

Table 3. The Ten Key Issues in Critical Appraisal of Qualitative Research (Treloar et al., 2000).

1. Is the purpose of the study clearly stated?
2. Is an appropriate rationale provided for using a qualitative approach?
3. Do the researchers clearly outline the conceptual framework (if any) within which they are working?
4. Do the researchers demonstrate an understanding of the ethical implications of their study?
5. Is the sampling strategy appropriate and will the sample represent the target group?
6. Does the research provide information about data collection procedures and how they were derived?
7. Do the researchers describe the procedures for keeping data organised and retrievable?
8. What methods of data analysis are used and are they appropriate to address the study purpose?
9. Does the researcher address the threats to reliability and validity in data collection, analysis and interpretation?
10. Is there a clear progression from research question to conclusions drawn from data?

Of equal note is the emphasis posed by Lincoln et al. (2011) on the rigour of interpretation of result, which is attained by transparency and systematicity. These are aspects of the research that I have been able to maintain through supervision and by keeping a good level of clarity in my decisions and procedures throughout the

research development. The next chapter shows how the procedures described in this current chapter were adopted to analyse the data gathered.

3. Chapter 3: Analysis

3.1 Overview

This chapter covers the systematic process described in the previous chapter and showcases how the superordinate themes were derived, refined and clustered. The 46 emergent themes (Appendix G) will be illustrated through quotes which will amplify, inform and expatiate the understanding of the subordinate and superordinate themes. Three main/superordinate themes were identified, which are aligned with the research questions (Table 4): **operational trauma**, **post-traumatic growth** and **reflection**.

Table 4. Superordinate themes

Main/Superordinate Themes	Subordinate Themes
Operational trauma	• Mental warfare • The affected mechanical body • Imposed passivity
Post-traumatic Growth	• Microsystem • Growth
Reflection	• Experience of work • Meta-reflection

The natural progression of the analysis highlighted an overall progression and evolution of NHCP experiences. At first glance, the three main themes would appear to highlight an experience that occurs in stages, beginning with operational trauma, followed by post-traumatic growth and culminating with the theme of reflection. The three main themes appear to be experienced by the seven participants in one way or the other although when looked into closely, it can be seen that this is experienced in

different ways. For example, under the superordinate theme operational trauma, some participants experienced the concept of imposed passivity due to the intense level of manipulation experienced when working with forensic clients, whilst others experienced it due to the helplessness they have experienced with regard to being verbally attacked by patients and not feeling able to assert themselves. This chapter therefore highlights and captures the idiographic as well as collective experiences of the participants by looking closely into the subordinate themes and making references to the emerging themes (Appendix I) that were generated from the transcript. This chapter will also touch on the researcher's stance in analysing the data and other possible ethical considerations that might have been derived from this.

The analysis segment aims to respond to the following questions, and consequently, these questions were adopted to inform the analytical process:

- How do NHCP make meaning of their experience of stress and burnout in a forensic personality disorder unit?
- How do NHCP working in a forensic personality disorder unit experience the stress and burnout from work in their personal lives?

As described in the methodology, the first question serves two purposes. Firstly, to strengthen the validity of the research with regard to existing literature on stress and burnout in the mental health sectors. Secondly, it would serve to determine further if there are advancements in the literature. The second question is the main focus of the study, where the themes will explore the experiences of the participants regarding stress and burnout in their personal lives.

Operational trauma aligns with the first research question and exposes the experience of the participants in the Forensic Personality Disorder (FPD) ward. It highlights the impact of work on the participants' views and experiences, and how they are affected by this. The effect of this is then observed in the participants' lives via the **Post-traumatic growth** theme. The theme evidences how the experiences inform the participants' lives and how they re-adjust their views and behaviours accordingly. Lastly, the **Reflection** theme is one that arises from a longing that was captured organically from the participants' narratives. The **Reflection** theme evidences different experiences but mainly a novel one from the participants regarding looking inward and bringing to the surface unconscious thoughts and beliefs of self that they expressed they had not done before. The theme of reflection is one that led the participants to look back at their post-traumatic growth and the operational trauma. As such, the following chapter aims to explore the three themes in the order described above as it has a meaningful course to the experiences of the participants.

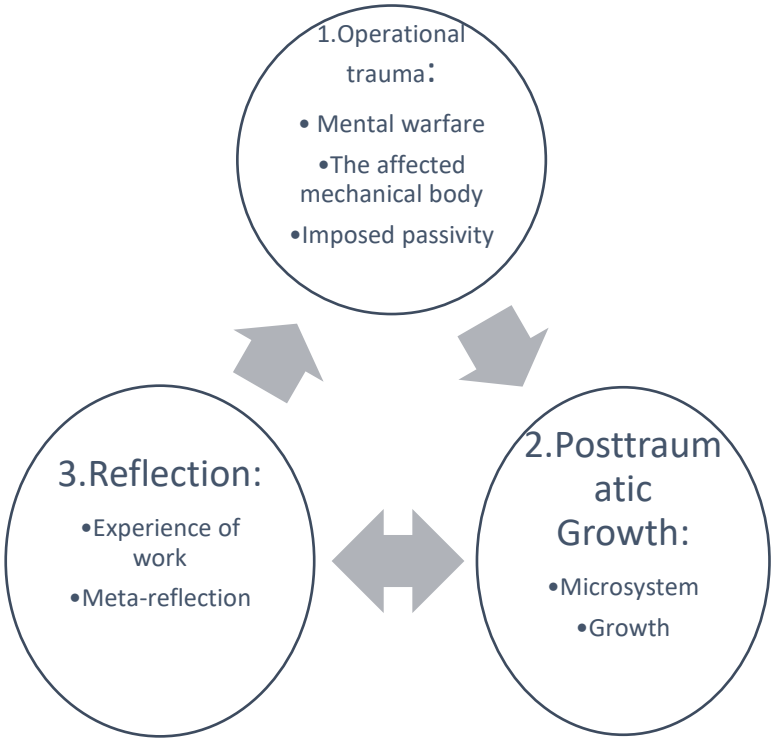


Figure 1. Themes and subthemes emerging from participants' comments.

3.2 Theme 1: Operational Trauma (OT)

The themes generated in this section highlight features of operational trauma as the language and experiences expressed by the participants in the interviews seem to bear similarities with those of combat stress (Keats, 2010). Similar to how the term is used in combat stress, the term "operational trauma" is employed to describe the manifestation of distressful events without a particular or significant physical aggressive event. This term was utilised for this theme as it was noticed that the main source of distress described and experienced by participants was derived mostly from aspects of the job that did not involve direct physical aggression. The analysis highlighted that the aetiology of the stress and burnout experienced by participants is more psychological, mental and emotional rather than physical. For

example, one of the participants narrated that before heading to work he equips himself with an armour to protect himself:

"I have gathered a lot of experience and the experience equips me in a way, they help me make sense of things you know, when I'm in a difficult situation so they have equipped me positively." (Semedo: 555-557[1])

The use of the word equip as a metaphor indicates perhaps how the work environment is perceived as a "mental warfare" and highlights a need to hold a defensive stance from the onset. In the case of Semedo, he sees his experience as a form of protection that he uses as armour, suggesting that his need to protect himself might not be of a physical nature. The most important element about this quote is not that Semedo feels the need to protect himself but instead that he acknowledges that the environment has elements that warrant protection.

To explore the OT theme, I will analyse the three subordinate themes **mental warfare**, the **affected mechanical body** and **imposed passivity**. These themes offer an exploration into the experience of participants and how they experience the FPD ward in a way that perpetuates the main theme of OT. The subordinate themes are connected by the fact that these are themes experienced in the work environment. However, whilst mental warfare and the affected mechanical body have to do with the direct and observable effect of working in the FPD, imposed passivity is an exploration of how experiences are metabolised in the FPD environment.

[1] Pseudonyms have been adopted for the seven participants in order to maintain anonymity.

3.2.1 Mental Warfare

Overall, the participants express an experience where they acknowledge that working in the personality disorder unit for offenders takes its toll on the mind and eventually on the body. The strain seems to be connected to the different demands of the unit but also to the intensity of the needs and events. This has been described by one of the participants as the "emotional pressure" (Semedo: 41). Similarly, Faye has a similar experience as she describes this element of stress as a significant discomfort:

"I think when you are kind of out of your comfort zone and you have overstretched it. Because being in a comfort zone is helpful and safe but then there is a stage where you have pushed yourself too much out of your comfort zone and then it becomes a bit stressful." (Faye: 10-11)

Faye appears to be alluding to the fact that some of the experience of stress in the work environment is due to the personal input and how much a person allows in. Nevertheless, shortly after, Faye is able to reflect on how certain traumatic experiences cannot be helped even when you do not intend to overstretch yourself. Faye in fact recounts witnessing an event that was out of her control and comfort zone:

"…that situation was quite stressful but we also had a situation also in March it was a night shift after I had to respond to an emergency whereby a patient overdose on drugs and they actually died that was quite, that was a different type of burnout like stress I guess that was definitely that was different type of stress compared to the other situation although it was stressful I was still able to kind of go into work and carry on with my shift even though it was stressful I kind of had my team but that was

something else I don't know after my shift I think it was when I was on my way home and it was like, it was like I had to take a deep breath (takes deep breath), it was a lot yeah that had more of an impact than the (Referring to earlier sentence where Faye compares this stressful event to aggression on the ward)… I guess yeah because it wasn't, I wasn't expecting to ever see that, usually you see a fight or a patient that's angry, aggressive, you know upset but then just kind of see someone on the floor cold (long pause) okay you know in the moment obviously I had to do my job, make sure you know we did all we had to do." (Faye: 47-52)

In this quote, Faye describes witnessing the death of a patient as unexpected and it could be translated also as an event out of her comfort zone, especially as I recall the long pause after she uttered the words "on the floor cold". It appeared as if briefly Faye was back in the moment when it happened and her subsequent comments in the quote appeared almost as a way to avoid re-experiencing the event and removing herself from the uncomfortable zone. Faye goes further to describe that such events impacted her way of thinking and eventually her physical health. Moreover, it appears from Faye's comment that although she felt she had the support of the team, this was an event that needed more than that. On the other hand, James describes the stress of the environment as the constant state of hypervigilance, the constant lookout for a threat or stressful event to self and others:

"Stress is those things you are actually dreading". (James: 18)

James attempts to describe his experience of stress on the FPD ward. The interpretation of this sentence suggests that some of the experiences of stress are derived from the pre-emption that an incident will eventually occur in the ward. James indeed expresses feeling a constant level of anxiety and hypervigilance when

at work. Jamal goes as far as to describe the interaction with FPD patients as a precarious one where you have to be careful about how you converse because there is often a feeling that you cannot get it right, and that might prove costly to the stability of the environment:

"…and make sure that you explore all the options at hand and pick the right one, maybe try to convince the patients that you know what you are doing and that what it is picked is the right solution for them takes some encouraging at some points, convincing". (Jamal: 295-296)

The use of the words "make sure" implies the feeling of obligation to ascertain that you do not experience a stressful outcome, suggesting that there is no room for error. Jamal tries to describe an experience where he realises that events can quickly change, and it is important to be alert:

“You need to weigh the option, if picking a mobile from your pocket and call the police in the bus uhm is it a good idea? Or is going to escalate the situation? That is a lot to think about.” (Jamal 348; 350)

The experience of stress and burnout of participants appears to be linked to different distressing emotional events that they witness and the fear of escalation. From the different quotes extrapolated in this subtheme, the intensity of the distress appears palpable, although it is not an experience of physical aggression.

3.2.2 The Affected Mechanical Body

Subsequently, the participants describe experiencing the different strains physically, shifting from the “mental warfare” to a physical one. Some participants acknowledge

that they can manage the stress by shutting down, while others experience it physiologically, like an engine that is overtasked. As such, it is observed that participants speak of their experience of managing through shutting down this "**mechanical body**". This subordinate theme showcases how the window of tolerance has been tested to its breaking point:

“But there is a time there is a limit to what the body can take. Like I told you. It has impact on the whole body you may not have enough sleep, you may not eat properly when you are really stress so there is a point the body cannot take this, it snaps (the use of a scientific term to describe stress, the concept of elasticity)*. After some time then they could be a reaction where the body would say I can take this anymore it is like shutting down.”* (Semedo: 26-29)

Semedo describes a feeling that the mental toll can bring the body to a place where it “snaps”. The imagery of the metaphor suggests how the snapping can be related to burnout as it feels as if Semedo is trying to describe a more significant damage. It would almost suggest that when he experiences lack of sleep and appetite, these might indicate that work has become stressful and perhaps the term “it snaps” relates to what Semedo indicates as the body “shutting down”. Interestingly, another participant refers to a form of shut-down. However, it appears that this participant has experienced the act of shutting down as a way of avoiding burning out and of protecting herself:

“I mean, I don’t really think I will say I step back in the sense of not coming to work, my step back will be, been at work but not, not engaging. I still come to work so I do not want to get monitored and get sickness notes. You know whatever it is I feel like I still have to come to work and just engage. I have this period of time when I was at

work I wasn't engaged but there was so much going on at work I just couldn't be asked. I was just here to be physically present but I was not in here in any shape or form. Yes I did not even want to talk with people that much or not been vocal about my perspective of things I was just disconnected. So that's my stepping back."
(Anne: 116-123)

Anne describes a feeling whereby her previous resources have not been sufficient for her, and the only way she could manage to avoid burning out was by stepping back and becoming disconnected, and to dissociate almost in a cynical manner.

It appears that Anne's level of disconnection is mental rather than physical although further description from her sees the cost of the mental strain as a physical one. This subordinate theme was titled the "**the affected mechanical body**" not only for its properties and the ability of the participants to shut down but also for the psychosomatic experiences that participants have highlighted. Throughout the transcripts, there is often a description of the body in terms of scientific concepts where there is a sense that stress and burnout would impact the organism as a whole. The frequent use of abstract concepts to make sense of the experiences may be an attempt to make the experience abstract or to disconnect and distance the self, noticed by some participants. Nevertheless, one of the participants was able to encapsulate these experiences through one of their comments, where they shared the experience of the mental toll somatised in their body:

"Actually the week, actually that I stayed home the stress took a turn on my body because I had two chest infections and that is the first ever time I had two chest infections in 6 months so I was actually ill and my grandma had to look after me."
(Faye: 337-338)

It appears that Faye is emphasising the direct link between her work and the toll on her body. In this quote, the participant was highlighting how this event was one of a kind as they had never experienced it in previous work experiences. Although the impact of these experiences is further explored in the **Post-traumatic Growth** superordinate theme, it appears to highlight and underscore the significant implications and the link that Faye made with regard to working in this environment.

3.2.3 Imposed Passivity

This subordinate theme highlights experiences described by different participants with regard to how stress and burnout are imposed on the individual in a manner that accentuates the feeling of mental warfare. Whilst the previous themes highlight the intricacies of how operational trauma is experienced, this subordinate theme looks at what other factors are encompassed by the phenomenon of operational trauma and the element of helplessness associated with it. For example, one of the most notable emerging ideas in the transcript was the emotion of anger expressed due to the volume of stress experienced. Adam describes how at times he has experienced how others become apathetic at work:

"Erm (pensive look), I can experience it coming out with people becoming snappy, irritable, rigid, almost been sadistic with patients on an emotional level." (Adam: 19)

Adam sees these feelings as a sign of burnout and describes vehemently how this is of concern. When I re-listened to the recording, I could notice that although Adam spoke in a monotone for most of the interview, this description was different as the tone changed and it appeared to be rather more passionate:

“People undermining their colleagues, been negative, putting forward pessimism with one colleague who talks about feeling disgusted by the guys we work with (Forensic patients). They are challenging guys they have done horrendous things in the past. I can acknowledge that but if you come to work with a disgust for the people who you work for, that for me was a sign of burnt out.” (Adam: 20-22)

Adam appears to associate the negative feelings as a sign of burnout. When explored further it appears that these negative feelings are generated because the NHCP cannot express, explore or react in their authentic selves. This is brought to the surface through different experiences. One such is the experience of feeling that there is a constant collusion or split within the Multidisciplinary Team (MT) (i.e. psychologist, consultant, occupational therapist, NHCP and so on), the experience of frustration and disunity with colleagues:

“*sometimes, because there is some cases where patient was telling lies about me, yes. I did not supervise a visit and a patient said ‘ooohh it is all your fault’ and I did not supervise his visit and he knew because he is such a clever liar, he knew about this, but for some reason because of other things the cravings when it comes to take medication and I stopped him and told him this is more than you supposed to get and sometimes being boundaried. So something I have done in the past makes him want to find a way to retaliate. But sometimes when it is discussed in the meeting, even though they know very well, but sometimes when it is discussed in the meeting (MT), even though they know very well, but sometimes you may not blame them even though they know very well this person is a serial liar* (referring to the PD patients) *they still listen to the rubbish they say.*” (Semedo: 301-309)

Here the participant describes vehemently how a split in the team can often bring a high level of dissatisfaction to work and invalidate their professionalism to the point of resentment towards work and the patients. The use of the words “clever liar”, “serial liar” and “rubbish” emphasises the frustration of having to succumb to aspects of the job that are not pleasant and which perpetuate a feeling of powerlessness. Moreover, the language “clever liar” and “serial liar” evidences an aspect of the environment that perpetuates a sense of constantly being manipulated.

Similarly, the feeling of imposed passivity is also experienced by participants when they feel as if they have to curb their natural responses to aggressive behaviours on the ward:

“*it is an internal battle actually a patient told me you staff are more PD than us actually I looked at it and it might be true, you actually display totally different personality to what we would be in the street* (James: 125-126) *… I don’t know, I don’t know you become I don’t know I am still learning myself maybe it’s actually a question I ask myself like that why why am I actually been able to process whatever he says you know. And I still have the same emotion, I am still the same person but they are abusing me, threatening me and I am still calm and respond in a calm and collected manner (laughter)”.* (James: 130-132)

The laughter and the content of the comment express the dissonance of the reaction from the participant. In one instant, James appears to be content with being able to maintain and manage the abuse he is subjected to, but his expression of laughter indicates otherwise. The latter response further teases out the dissonance:

“It is a question I ask myself. But if someone has tried to do that in the street, I will probably give them back." (James: 134)

This comment summarised what other participants have experienced in some way or another. James expresses how he feels the constant constraint not to react according to his true self. James highlighted feeling as if he cannot express how he feels, and this can often lead to a feeling of resentment. This experience of passivity can often contribute to a sense of helplessness that leads to surrender.

This theme of surrender is captured by the emerging thoughts and experiences, whereby participants expressed that they found it challenging to come to terms with the lack of awareness and understanding from patients with regard to the harm they constantly cause within the unit. For example, the participants highlighted the negative impact of the manipulation aspect of working with patients in FPD. This is encapsulated in James' comment:

"you always have to be that cautious of actually being, I think with PD, it's difficult as well because there is constantly people that will try to mould you, manipulate you and you always have to be aware of when you are being manipulated by all the tricks they are using". (James: 351)

This quote evidences how James feels unwillingly impacted and affected, especially with the use of the words "mould you", that feeling of being overpowered and transformed into a different self. This was a noteworthy point as it opened a myriad of explorations regarding participants feeling as if they were unwillingly subservient to the patients but also to the nature of the FPD ward. The notion was of enforced passivity to abuse because of the fear of more aggression:

"*Is it going to escalate the situation? That is a lot to think about.*" (Jamal: 350)

…and the sense that the experience of stress in this environment is always present:

"…uhm I had one situation where I think that I was kind of burn out and I think its few situations actually uhm, I guess around, it was round November last year where we had multiple patients who were taking drugs quite frequently and we had medical emergencies daily and sometimes, multiple times of the day and that was quite hectic for me to manage because it's that pressure knowing that how you respond to the patient can determine if they live or not and they do not even caring that they are taking this drug and its causing them to (pause) their oxygen level to go low. And this things and just stress you never know if a patient is going to die on your shift and everyone is safe and alive when you leave, so yeah that was quite stressful, and it was daily so throughout that whole week, I think every time I was on shift I had to deal with medical emergencies, that was quite draining." (Faye 29-35)

There is layer attached to the segment where Faye describes that there is a worry that accompanies you even beyond work and this can be retraced to feeling stressed and burnt out. This quote emphasises the imposed pressure of the work. Nevertheless, the most striking aspect of this quote in relation to the subordinate theme is seen in the last sentence of the quote; Faye's language ("I had to deal") underscores a sense of obligation and unwillingness to experience. It appears that the constant fear to keep the self and others risk free is a source of stress. The sense of obligation is strongly shared by Semedo as he describes ending a shift as significant relief:

"*I said I'll remove the jacket and hang it in the hospital and go home a free man, I don't take it, I don't take it home."* (Jamal 432-433)

Looking closely at the quote reveals a situation where part of the participant's identity or self is restricted or even imprisoned. The mere act of returning home from work

reinstates that feeling of being a “free man”. It appears that the work environment is often perceived as limiting. This almost brings a reversal in the dynamics with the patients in the FPD ward, where the restriction of liberty is placed on patients, but still, the participants are sharing a similar experience and feel constrained in some manner. From the language and tentativeness observed in the interviews, it appears as if participants were in the process of reconciling with the notion that certain actions, feelings and behaviours are reluctantly experienced and forced upon them.

Some participants offered an explanation as to why it may feel frustrating and unrewarding. One of the answers was that mental health models are shifting towards psychological interventions rather than a pharmaceutical model, which would mean that positive changes "take longer to take effect" (Semedo: 240). Adam then attributed feeling defeated and compromised to this lengthy process:

“from time to time having the uncertainty if we are doing the right thing not been completely sure it is working (referring to psychological interventions), particularly when we are seeing mirroring the other way around then it felt much more like. Are we doing the right thing? But then it is working now, and it is heading towards the right direction. I do feel that change is not measured in days it is measured over years." (Adam: 121-122).

The feeling of doubt can be felt in Adam’s remark, where he questions the essence of his job by asking “are we doing the right thing?”, referring to the lengthy process of rehabilitation in the FPD wards. There is also a sense of acceptance linked to reframing that rehabilitation and change can be observed with a different and lengthier measure. Another interesting note from the quote is the mirroring comment made by Adam which links with the earlier comment that participants may be

experiencing a reversal of experience with patients. From Adam's comment it appears that there is a concern that at times the challenging behaviour of patients is being displayed by staff. This might be a significant point as it may be a way for Adam to suggest that part of the adverse aspect of the job is that of unknowingly learning and mirroring negative behaviour from patients. If there was a chance to explore further, it would be significant to ascertain whether the role of NHCP increases the likelihood of learning antisocial behaviours and attitudes.

Similarly, the following two elements of this subordinate theme emphasise the **imposed passivity** nature of the environment. Participants expressed that the nature of the environment in which they work has an invasive and infectious aspect. Many of the participants' experiences described earlier accentuate an experience comparable to that of an environment of constant mental warfare that can bring about traumatic experiences. One of the participants encapsulates the nature of the job as all-consuming:

"it just feels everywhere you go is about the patient we have an away day, which is basically when staff are away but not away but on the ward, upstairs, talking about the patient, so it's just all consuming". (Anne: 408-410)

I could perceive a significant frustrated tone from Anne that might indicate the overwhelming experience of the job. Another participant used descriptions that accentuate the similarities and properties of a virus.[2] There is a sense that you cannot protect others and the self from being affected by distress:

[2] The interviews were carried out before Jan 2020 (predating Covid-19), therefore the language used is not connected to the current epidemic.

*“Some of them, other things could have even stressed them, stressed themselves, and then they are just kind of **transferring** that one onto you (chuckles) you know… It is better to deal with your own self, do not try to make their own worst because the more you heightened their stress level the more it **spreads**, they could kick off and start throwing things and start on you, you know. And once it goes out others are also **affected**.”* (Semedo: 98-99; 114-115)

James instead experiences this “spread” on another playing field where there is a faint suggestion that perhaps the negative attitude and behaviours can also be passed on from patients to NHCP’s family members:

“like that part I have omitted intentionally because I don’t want them to start getting worried (referring to his family), If you working with murderers you will probably going end up being mad”. (James: 323-324)

James shares the experience whereby he recognises that stress can spread very quickly to other colleagues, patients and eventually people outside of work in a vicarious manner. However, James appears to go further in his reflection by maintaining that part of the stress that leads to burnout in the job is the worry about how the job changes him. This is in fact captured by James’ tempered response:

"I think it is, it can be so, it’s been difficult to separate, it’s a fine balance, there is no guarantee that you going to go home without some element of your work." (James: 576-577)

This highlights and emphasises earlier points made by Adam and Jamal that the stress and burnout in the FPD units go beyond work and that they can **spread**, or be **transferred** to aspects of a person's personal life as they are **all-consuming**, even to the point of affecting a person’s personality.

3.2.4 Summary of Operational Trauma

Operational trauma is a term that has been used for this superordinate theme as it focuses mainly on the nature of the psychological difficulties encountered in a forensic unit for patients with a personality disorder. The analysis of the first two subordinate themes (**mental warfare** and **the affected mechanical body**) highlighted that the environment produces an enormous strain due to emotional pressure experienced in the unit. The emotional strain is often perceived as extreme. Consequently, participants have expressed that they find different ways to shut down through disconnecting from work, requesting leave, and in more severe cases, they experience somatisation of their stress. The third subordinate theme (**imposed passivity**) highlighted interesting findings. The analysis of the transcripts highlights further that participants have often had feelings of dissatisfaction and apathy towards work due to the amount of splits experienced in the team and the level of manipulation experienced from the patients. Moreover, participants expressed a concern relating to the adverse effect the job may have. There was worry captured in regard to NHCP mirroring patients' negative attitude and behaviours. The subordinate theme heading 'imposed passivity' seemed fitting as other elements of powerlessness were highlighted regarding the intensity and frequency of aggression that staff feel they are subjected to. It appears that participants find themselves operating in dynamics where they cannot be their authentic selves because of the nature and level of violence perceived. These findings are further explored in the next theme, as it highlights how the personal lives of NHCP are impacted.

3.3 Theme 2: Post-traumatic Growth (PG)

The chosen superordinate theme was particularly relevant to the following research question:

- How do NHCP working in a forensic personality disorder unit experience the stress and burnout from work in their personal lives?

Post-traumatic growth is a widely accepted psychological term initially coined by Tedeschi and Calhoun, and used to describe how enduring psychological struggles can often bring subsequent positive growth (1995). However, it is essential to acknowledge that PG can be an outcome as well as a continuous process of change. In this segment, the post-traumatic growth seemed relevant to this theme as was divided into two phases. The initial phase (**microsystem**) describes elements consonant with the psychological struggle endured from work and how this aspect has affected the participants and their close circles. The second phase looks at how participants describe growing from these struggles and observing the positive aspect of themselves.

The meaning-making of this data swayed more towards an empathic interpretation as the experience of the participants at this stage was drawn out from a naive outlook on the data. This superordinate theme evidenced how the participants explored the meaning-making through changes they noticed in their identity. It thus seemed relevant to the research question as the experiences of the participants were linked to the experience of stress and burnout. Moreover, this superordinate theme appeared particularly relevant as the changes were noticed in the personal lives of the participants. The superordinate theme **PG** explores the participants' awareness with regard to their transformation. There were marked differences within

the two subordinate themes, and as such, they were clustered into "**growth**" and the "**microsystem**". These subordinate themes indeed have different connotations with regard to the meaning-making of the participants' experiences.

3.3.1 Microsystem

The subordinate theme "**microsystem**" highlights the significant impact observed by participants regarding their own life and their close circles. In the case of the **microsystem** subordinate theme, it was noticed that there was a pattern of emerging themes where the participants emphasised how they had begun to change part of themselves as a response to the stress and burnout experienced in their microsystem. Semedo (630) indicates the need to "change your life" to work in the PD unit. The strong sense is that if you "shed off" your identity, you might avoid conflict. The NHCP sense that having an identity creates a problem and as such participants describe finding it challenging to maintain their original identity. Jamal captures this when he expresses how difficult it was to adjust to the environment:

"Massive challenge for me initially you know to find myself in this place." (Jamal: 303)

For example, one of the most significant emerging themes highlighted was "winter jacket". The participants explored how they developed ways to distance themselves from stressors either by protecting themselves with the "winter jacket" or by becoming aware of the acquired "developing skills" to manage stress. Although the term "winter jacket" was first coined by one of the participants, this concept chimed with multiple participants. The "winter jacket" emergent theme is one that describes the struggle of compartmentalisation. The participant who coined the term made

constant use of the metaphor as a way to indicate the need to learn how to compartmentalise, as he found the nature of the job so pervasive:

"you remove it and hang it, and it will be dripping water there, and you walk straight to your room you let it dry that is what I do, do, but I don't take it on, on, as soon as I'm moving out from here that imaginary jacket I hang it". (Semedo: 414-416)

Usually the use of a "winter jacket" is to keep a person dry or protect them from harsh weather. The language used, however (***"it will be dripping"***), would suggest that the nature of the experience is so overwhelming that this protective layer must come off before the participant returns to his life outside of work. Furthermore, it would suggest that the inconvenience of it (***"it will be dripping"***) would inevitably find its way to his family. This hypothesis is also evident in the subsequent lines where the participant states:

"you have to understand that your family is different from your workplace. You do not have to bring your negative emotions home. You don't have to allow them because if your children see you not being happy, it automatically affects them". (Semedo: 424-426)

This struggle is one that is shared by other participants:

"I am trying to not take my work on them if you know what I mean." (The use of the word "on" as if it is a phenomenon that has weight or pressure) (Jamal: 136)

These comments, like many others in the transcripts, would suggest the need to compartmentalise and protect family members from the emotions acquired from work. However, the participants appear to acknowledge that this is not an easy skill:

"In that kind of situation, is difficult to just leave it somewhere. To be honest it can affect you as much as you try, and you don't want to think about because if you think about it is actually major". (Semedo: 460-462)

Similarly, Adam acknowledges the difficulty of compartmentalising through his dreams:

"erm hm but more recently the only thing I get from time to time on this particular ward which I have not had on other wards, is dreams which I do not usually have dreams about patients or work. But here I have noticed it more frequently". (Adam: 68)

This is an important point as the participant in this quote compared his extensive experience on other wards (not specialised in FPD) to the present one and mentions the pervasive nature of the work which found its way into his dreams**.** More importantly, Adam had been very succinct in general during the interview process, and this point was one of only a few where he was able to reflect in depth. As I tried to investigate the meaning-making of his dream, he appeared to be reserved at first but eventually stated:

“I think there is more to think about here, working on the other wards were not as stimulating. This place is quite stimulating, in terms of, it makes me think a lot more… The boundary crossing versus the boundary violation (referring to work).” (Adam: 70; 74)

Here, Adam attempts to link the constant boundary crossing and violation experienced at work with this aspect of the work crossing over to his dreams. It appears that Adam was able to relate the impact in this environment as unique, and

as such, the experience is also unique. At the beginning of the interview, Adam mentioned that he had worked in other forensic and mental health settings:

"I have worked in many different places psychosis wards, community and forensic services." (Adam: 27)

However, in the earlier quote (Adam: 70), he recognises that he had not felt as stimulated as he has done in the FPD unit.

Furthermore, participants expressed two other themes of relevance to this subordinate theme. One was with regard to job security. The participants believed that due to the unique nature of the patients in the FPD unit, they always kept a level of apprehension in regard to their job security. Participants explained that due to the antisocial element of patients and their level of intelligence, they are often on the lookout for signs that their source of livelihood might be permanently affected. For example, the constant fear of losing your job due to a lie from a patient or facing litigation because of a complaint made by a patient:

"It feels like that is the wrong motivation, people doing things because they are concerned with been punished because they are afraid of been litigated against or complained at or having complaints thrown at them is the wrong kind of motivation." (Adam: 145-146)

Particularly NHCP who are registered with professional bodies fear that this can be a real threat to their future.

The other theme that was experienced was expressed by James who stated that the job can often create a feeling of loneliness and a desire to seek isolation:

“like going out doesn't excite me as much anymore, I think I kind of like to be alone, and just do my own thing, instead of being in a company; chill yea yea, I think that is one element where things have changed, I don't enjoy, going out in a group as much”. (James: 387-388; 398)

The participant describes how in his personal life, as a result of his experiences, he has felt a need to distance himself from others, creating an increased lack of social connection. James reflects deeper on how this change may have occurred, and similarly to Adam’s earlier quote, there is a link to feeling overstimulated even after work and still feeling as if he is at work even when with friends and family:

“So yeah, when you are in a group and you thinking this, like this and you are analysing everybody, it defeats the purpose, it's rather you just chillax and be on your own and do your own thing”. (James: 401-403).

It could be interpreted that James is in a constant state of vigilance where he is continuously assessing people around him. From the expression “It defeats the purpose, it's rather you just chillax”, it would appear that James finds it challenging to relax and not over-use his energy as he is constantly thinking and formulating people around him. It appears that this experience of vigilance informs his social life and circle in a way that appears to create distance between him and others.

So, what happens when NHCP are not able to compartmentalise these issues and pressures? The first notable answer to this question is the participants’ recounting their experience of finding the outside world as more unpredictable and dangerous, which has led to a higher level of vigilance and sense of protection of close relatives. As mentioned above, participants have noticed how they have become increasingly hypervigilant of the outside world, describing that since working in the FPD ward, the

world is perceived as unsafe. The reflection from participants underlines that this new heightened outlook can feel like paranoia. For example, James goes as far as saying:

“But where do you draw the line and what do you do define as careful? I think, it is probably sometimes I feel I think it’s just paranoia…”. (James: 362-363)

When prompted to reflect on this statement, James expresses in greater detail how the hypervigilant state is manifested:

“one thing I know is that I am more aware of my space I am more aware of my surroundings I am more aware of people who are around I can tell you from a mile that the guy is a mental ill patient, I know the behaviour , I know even when I get to a train I just look around and I know where I want to seat and you know so that will follow me, that will stay, that stays with me and actually it shapes the way I interact with people on the outside yes it does so when I see somebody from a mile, I can tell the way they are walking, from the way they look, probably the clothes”. (James: 367-373)

It appears that James is attempting to express that this paranoid state is now part of his identity. This seems to be connected to the hypervigilance at work which does seem to remain with the person beyond work. The use of the expression “that will stay, that stays with me and actually it shapes the way I interact” would suggest an imposed change and recalls the earlier point where James expressed feeling moulded and shaped by this environment.

The second part of this subordinate theme is the impact the work has on family. The participants describe how these negative emotions can be transferred to "the microsystem":

“I think with family I don't see them that much so I don't know what impact but with my girlfriend I can be a bit snappy sometimes if work is stressful. I think it was evident at the time I was assaulted by patient. I did not really talk about it initially. She was like I am not going to talk about it. And I said I was fine I am over it. I could see how it affected my relationship and we both became more distant to each other.” (Ayo: 131-134)

Ayo here describes how events at work directly informed his intimate relationship. Here he describes how he became somewhat distant after an assault and in return this had its effect on his relationship. Most of the participants express the feeling that the work has a direct impact on their relations. For example, James speaks about a more long-lasting impact on his children:

*“I think they do (*James’ children*), I think they have noticed I think one thing I noticed is that they actually worry for me coming to work because there was a time when I was assaulted, they knew I was actually assaulted at work, that was a difficult time for them as well to deal with as well because you don’t want your dad to come home assaulted with a black eye, no child want to see that to their dad, no child wants to see that, it is difficult for them but I think with time that has healed.” (James 80-83)*

The feeling that the job creates harm for this participant's children, which they had to heal from although they were not directly harmed, is powerful. It raises the notion of family members being affected by the events that occur for the participants (secondary trauma). This experience is highlighted by other participants where family members share a constant worry and apprehension that their loved one will be physically or mentally harmed at work:

"There is definitely an impact, they know what kind of risk is associated to working here, and so they are definitely worried about me, so yes in that sense yeah (Jamal: 126*) …it's my wife, is my parents as well."* (Jamal: 128).

3.3.2 Growth

The subordinate theme "**growth**" is closely interrelated with the theme "**microsystem**". Though this theme looks beyond the impact on the microsystem, it explores how participants have changed, evolved and grown in response to the stress and burnout regarding themselves and their close circles. It seemed appropriate to place this subordinate theme under the **PG** superordinate theme as it appeared that the participants were making sense of how the different dynamics informed their present self and how this had shaped them. In one case, the participant explored the feeling of powerlessness and the inability to control the unpredictability of his environment (emerging theme: PD unit as distorted/unpredictable):

"Whereas if you are doing like a clerical job, you know what you have deadline to meet, you can plan yourself but with this, you don't know what you are walking into on a daily basis." (James: 109)

Another participant shares a similar view:

"They can't see things differently (referring to PD patients) and then there is nothing you can do about this, it is not something you can change, it does happen you just have to take it on board." (Semedo: 79-80)

The language used in both quotes is not of surrender to the hostile environment observable in the previous superordinate theme. Instead, it tends towards an understanding that the FPD environment is chaotic and unpredictable. The participants were also able to explore the role that knowledge can play and, looking more critically into the data, it can be observed that the emerging theme "self as knowledgeable/ coping manner" is evidenced few times. This theme came up organically as there were no questions from the interview schedule that referred to knowledge. The frequent repetition of this theme in conjunction with the organic discovery of the theme could suggest that this is an aspect of the participants' experience that was significant. A more nuanced reflection of the interpretation can be developed by extrapolating further quotes:

"the whole of psychology opens your eyes…yes knowing what are your expectations, yes knowing that this could happen and that". (Semedo: 490)

Similarly, Jamal expresses how knowledge of the ward dynamics can help to reduce distress and manage difficult emotions:

"I think it gives you more insights into your emotional state and you know it allows you to become an observant more than you know, having to react on it." (Jamal: 88)

From these two extrapolations, the relation to power appears to be connected to knowledge. In this case, the participant regards having knowledge as a way to be able to better predict an environment that can, at times, be unpredictable. So, Ayo explores how he had gained some control and influence over his experiences by self-soothing:

"You know at what time don't say anything, don't make it worse try to de-escalate you know and then deal with yourself. Do not try to make their own worse (referring

to the PD patients) *because the more you heightened their own stress level the more it spreads, they could kick off and start throwing things and starting you know. And once it goes out others are also affected."* (Ayo: 112-116)

There is an acknowledgement by Ayo that he may not always be able to control his environment. However, there is also an acknowledgement that you can take control by regulating your responses. Although at first glance the interpretation of the emerging themes "PD unit as distorted/unpredictable" and "self as knowledgeable/ coping manner" may seem polarised, in reality they both highlight the challenge of and the coming to terms with the demanding nature of a PD forensic unit.

Furthermore, one of the most salient themes is the noticeably positive outlooks and behaviours developed whilst in the unit. These appear to be acquired behaviours that are now employed by participants in their personal lives outside of work and that others have observed. For example, one of the interviewees has experienced being more tolerant and accommodating of others outside of work as there is an emphasis on the chance that people in his personal life might not be "psychologically very normal" (Ayo: 361). Another interviewee stated:

“I think in terms of emotional intelligence, the way I relate to folks. I think that in terms of assertion, emotional regulation particularly because that is what we learn on the job. Yea, I think it changed me profoundly, I am naturally an introvert, natural introvert, socially anxious.” (Adam: 64-65)

Another participant expresses how they have developed a heightened sense of awareness:

"you are better at picking up signals which normally you wouldn't pick up, yeah that's in a different level, the tension maybe, the body language yeah I think there is something to it". (Jamal: 187)

Many more quotes and references from the participants describe feeling a greater sense of self-worth, confidence and assertiveness:

“Yes, I am definitely more assertive, like in this job, it increased my self-worth. Sometimes because I found it extra hard sometimes to speak but they need firm boundaries so it’s like encouraged me to be more like assertive when I say something and I have more self-confidence.” (Faye: 109-110)

Furthermore, interviewees express how they have developed an independent role in dealing with stressors as a matter of necessity. They underline the point that personal responses influence stress and burnout. For example, one of the participants describes how they have found it helpful to write reflective journals as a way to deal with constant aggression and hostility, and how this is a maturation and skill gained whilst working in this environment:

“I don’t do anything in excess. What I never used to do, was writing I found out it was helpful for me just to write a reflection and it just helps.” (James: 466)

As a result, some participants have expressed how the growth from their work environment has increased their level of openness as a way to reduce the impact on family members; empathy received through transparency. It appeared that sharing their traumatic events could create a level of openness in their relationships and increase intimacy with family members:

“*I do and I try to be as open as possible just to alleviate that anxiety especially with my kids, I try to be as open and just to tell them that mentally ill people can be violent*

and it can happen and that you can also be assaulted by a bus driver or you can be assaulted anywhere. I think it has made me to be having those conversations with them so next time I go home with a black eye they are not as worried." (James: 248-251)

Here, James sees openness as an important element to foster intimacy with his family and reduce the sense of anxiety in his children. Nevertheless, it appears that the openness underlines a sense of hypervigilance which perhaps is passed on his children.

The subordinate theme "growth" highlights a theme of endurance in the participants. It is remarkable that the same participants who describe and acknowledge adversities and hardship are also able to recognise and reflect upon their growth and how this has impacted them in their circles. During the interview, participants also began to acknowledge that their development has also influenced their outlook on PD and forensic units and, in return, has impacted their experience as a whole. There was a sense that this new outlook can increase a sense of empathy, sympathy and insight towards the patients but also others outside of work and increase work satisfaction. This outlook also seems to affect NHCP's experience of the outside world:

"I think I am more tolerant now, like people shouting doesn't even bother me one bit, I just see it as a behaviour now, I can't even put it into words before it used to terrify me but I have grown." (James: 163-164)

Although at first glance the sentence may highlight an acquired level of desensitisation, it also suggests an evolution of the participants' awareness of others and their own selves.

3.3.3 Summary of Post-traumatic Growth

By extrapolating the function and by contextualising this emerging theme, I was able to give the subordinate theme a higher and more nuanced meaning (Watson, 2017). Whilst the emerging theme for "winter jacket" was a more expressive experience of the "**microsystem**" (subordinate theme), the "developing skills" (emergent theme) is an awareness that the self is changing ("**growth**") in the context of experiences:

"Tolerance accommodating you know, looking at things from a different angle." (Ayo: 323).

The superordinate theme “microsystem” encapsulates how the difficulties from work harmed participants’ close circles and relations. Participants shared the experience that the work had somewhat increased a sense of isolation and inability to compartmentalise the struggles from work (fear of losing their job due to the nature of the ward). Furthermore, participants highlighted how they now have a heightened sense of paranoia and feel increasingly that the world is not safe (becoming more protective of their family members). The most striking aspect of the theme was how participants described their loved ones reacting to their experiences of working as NHCP. It showed striking similarities to those of secondary trauma.

Similarly, the rest of the emerging themes under the subordinate theme "growth" showcased how the participants expressed their changing selves and how they have become more aware of the impact of this:

"Because I have that patience, I hold back I try to find a different outlook of things so this is a skill I have developed that I have improved on.” (Adam: 253)

It appeared that through the various difficult experiences that the participants experienced they had begun to notice some positive change within themselves that affected their circles and their work. The most noticeable changes were those of becoming more assertive, confident, self-aware and tolerant. It also appeared that this informed their general outlook on their overall experience where there was a symbiotic acknowledgement of growth and hardship. As identified by Tedeschi and Calhoun, an aspect of PG is the acknowledgement that through suffering, knowledge and insight are gained (1995).

3.4 Theme 3: Reflection

This is the last superordinate theme highlighted in the study. This theme came up organically and seemed important to cluster due to the high relevance to the research question and how often this was highlighted by the participants. The theme showcases the different reflections of the participants regarding being interviewed and on their overall experience of working in this environment. Some of these perceptions appear to be positive and others highlight lacunas in the support available at a systemic level. The subordinate theme “experience of work” highlights how participants view the role of the NHCP and what they have come to expect from a systemic point of view.

3.4.1 Experience of Work

One of the expressed themes from participants with regard to their work in the FPD is the sense of pride associated with the job. Perhaps this is also a contributing factor to how some NHCP have managed the stress component of the job. Multiple

participants describe how rewarding and exciting the role can be at times, especially when this is acknowledged by other professionals in the mental health sector. There is a sense that the uniqueness of the role in itself contributes to the positive experiences:

"It's quite an elite place, special place to be and you know I am kind of proud about that." (Ayo: 187)

It can be observed that the use of the word "elite" would suggest that only a few have the privilege to carry out the role. The positive experience is clearly also shared by others when they state:

"I enjoy work and I love my job." (Adam: 15)

One of the participants also expressed a level of positivity about the very thing that generates psychological difficulties:

"I am questioning if I will get bored in my future profession whatever I am going to end up doing because every day is different here." (Jamal: 323)

Although Jamal has his mind set on a future profession, there is a felt ambivalence in the experience, where the elements of risk and stress are also what make the role of NHCP rewarding, fulfilling and exciting.

Moreover, participants also made a few references to the role of knowledge, experience and age with regard to coping in the FPD environment. The participants shared that age, gender, experience and personality are often good predictors of stress and burnout at work.

"You know security and kind of boundaries and it's really important and it comes with experience, you can't get it from you know from school or from books." (Jamal: 229)

"It's easier for females to de-escalate a male who is highly agitated, whereas if I am up and a male approaches it's probably gonna end up escalating." (James: 426)

There is a notion that experience, gender and age would serve as a protective factor from stressors even more than education at times. Nevertheless, some participants had a different experience where they observed experienced staff leaving:

"I think its stressful as well when you see all these experienced staff leaving, they can't take it anymore." (Anne: 433)

As mentioned in the introduction (Literature review chapter) and highlighted currently in the analysis, the high turnover is also a significant issue plaguing this sector (Eliacin et al., 2018). Furthermore, the impact of observing others trying to leave the environment is one that was highlighted by the participants. The notable point is that there seem to be multiple links made by different participants about the demographic features that appear to inform the difficulties of the role.

It also appears that participants associate the high turnover to their feeling of not being highly regarded by the organisation itself, and they are left with a feeling that NHCP's mental health is not considered half as much as the patients. Perhaps the expectation to self-soothe (highlighted in the previous superordinate theme) comes from a lack of perceived support from the mental health systems:

"it's just kind of it's just feels like everything is just about the patient and the staff and I think it should be balanced It should be 50-50 yes we have the duty of care". (Anne: 80-81)

There is a feeling that NHCP perceive that their health is seen as an afterthought or not of relevant concern.

3.4.2 Meta-reflection

This subordinate theme looks at the experience of the participants with regard to the interviews and what experiences and observable behaviours may have influenced the findings of the present analysis.

Throughout the text, there was a tentativeness to express difficult experiences that seemed to stem from how novel it was for participants to reflect upon the interview questions posed to them. There were deep pauses after questions and retractions that would indicate some sense of either novelty of the topic or cautiousness in answering. For example, Adam made the use of the words “you know” many times during the interview, in what would appear to be an attempt to gain acknowledgement and reassurance from the interviewer:

“I think you know if you have been targeted or singled out maybe you know if it's by one patient it’s usually manageable but if it’s collective it can be quite difficult you know.” (Ayo: 25-26)

There were more examples of dissonances that would suggest some sort of internal conflicts throughout all the interviews, which Adam brings to life in this quote:

“*I think for me, work, life and home life are very separate although, they cannot be completely separate.”* (Adam: 52).

Here, there is an almost immediate retraction of the statement, which would suggest some ambivalence. The ambivalence seems to suggest how new this question might

be for Adam. Possibly, this novelty might be due to participants' experience of never really having had a chance to reflect on the impact of their job because they had never been asked before, and had never paused to reflect on it themselves. During the interviews, a common question started to surface whereby participants would ask themselves why they chose to work in such an environment. For example, James (321) stated:

"I know they are going to be very scared (referring to his family members) because, who works with murderers?"

At times, the reflections bear resemblance to an expression of frustration and regret:

"Why are we here, why are we even working with this group of people, why do we have to stand and take their abuses." (Anne: 445)

It was thus no surprise that often participants appeared to avoid intrusive experiences. Participants were more willing to describe the experience of traumatic events through the experience of their colleagues:

"Threatens to slice his wrist. I witnessed it a couple of days ago, these chaps screaming: 'you are a liar', to this nurse who was trying to do his meds, was not lying he was trying to do his meds. He is been flustered by this anger and hostility." (Adam: 149-150)

Many other references from the data showed that participants found it easier to describe their experience through others. One wonders if there was a sense that those experiences were avoided due to the difficulties of re-experiencing but also due to an emerging theme whereby NHCP described highly personalising their sense of duty of care to the point of experiencing guilt. The participants appeared to

link the sense of guilt to incompetence or failure to provide what is perceived as rehabilitative care for the patient:

"I think as a team, I think well, I think we are failing occasionally." (Semedo: 337)

Finally, the participants expressed how deeply impacted they felt by the interview and how they realised that they would benefit from a space where they could process the impact of work on their lives readily, as they had not been able to accomplish this with the service available to them:

"I don't think we get enough time to speak about experiences here our difficult period, I think the more people speak about it, it will be beneficial, I think it's beneficial." (James: 558)

Furthermore, Faye highlighted in particular that often the space of reflection offered by organisations lacks a sense of safety to truly reflect on experiences:

"People are not talking about the support they need, support that will be really comfortable to talk about." (Faye: 413)

It appears that Faye in this case acknowledges the importance of having a true safe space as she realises through the interview that she had not experienced such.

3.4.3 Summary of Reflection

The first subordinate theme (experience of work) highlights how NHCP regard their work as invaluable and often an aspect of their life that is exciting and unique. Moreover, through their experience of work it appears that they have also experienced that different demographic factors can be good predictors of stress and burnout. Lastly, a reoccurring theme for some participants was the sense that

organisations have shown and continued to show poor regard for NHCP's mental health. These themes are relevant to the study as they highlight other external factors that contribute to the experience of stress and burnout.

On the other hand, the second subordinate theme (meta-reflection) highlights a reflection on the process of the interview. The interview highlighted a common thread whereby participants appeared new to the exploration of the possible impact of their work on their mental health and their close circle. Also, it appeared that participants avoided exploring their difficult experiences through their own personal experiences and rather veered towards the experiences of their colleagues to highlight or share difficult events. It appeared that participants began the process of exploration in the interview room and could identify that more reflection was needed for their care. This theme is interrelated with the reflexivity and ethics sections as it highlights the dynamics of power in the interview room with the interviewer, interviewee and the systems in place.

3.5 Reflexivity

During the initial interviews, I was particularly taken aback by the responsiveness of the participants. Although they showed a keen interest in participating in the study, it appeared that there was some difficulty for the participants to feel open enough to explore their experiences. I quickly returned to the drawing board with my supervisor as I explored what I could be bringing to the process that might influence the effective running of the interviews. Upon exploration, I was able to reflect on my naive skills and experience as a researcher and work through this. For example, I became more sensitive through the process to give cues to the participants and allow them the time to process the questions with more pauses. However, I was

advised later by my supervisor to keep account of these prompts during my initial analysis phase in order to look at subtleties and nuances in meaning, as the participants' own experience might be less overtly expressed. So, I paid much attention to not just the what, but also the how.

On a few occasions, I gave more prompts as it made the cagier participants open up more about their experiences. Nevertheless, it still appeared, as indicated in the reflection theme, that participants were still quite cautious in the way they answered questions. This could be a point to note for future studies, that perhaps the element of paranoia or cautiousness (highlighted in the PG superordinate theme) might be of relevance to the research process. Interestingly, although the participants appeared somewhat cagey at some stages, as a researcher, I have learnt and I am still learning that I can gather more robust and in-depth data by attuning my interview schedules more promptly and by being more reactive to answers given by participants. I think my usual stance in my day-to-day therapist life is such that it allows clients (in this case participants) to explore more freely with fewer questions and prompts, and I believe at times I might have struggled to switch out of this role and into my role of researcher. I have also found myself to be cautious in making interpretations as I am aware that this piece could be published and viewed by peers and professionals that I have worked with. My stance may have also been informed by the chance that a peer could read the findings and feel judged, as they may identify themselves in some of the findings.

Furthermore, I maintained close attention on my ability to bracket myself from the analysis of the data as I also work in a PD forensic unit (albeit in a different trust from the one in which I carried out my interviews). I realised that I sometimes identified with the data, and I endeavoured to identify what part of the interpretations were my

impositions. By doing this, I was then able to start to see clearly what the participant was trying to convey and tap into their real experiences. This is a continuous process that extends to the discussion chapter.

3.6 Ethical Considerations

The hermeneutic process was challenged during the generation of the subordinate themes as the relationship between researcher, text and context was tested, especially as I could identify with some of the experiences recounted by the participants. The data was combed through systematically in order to create a more sensitive analysis that considered the potential prejudice that I may have had on the data. I also ensured that I repeated the process of analysis months after the first one to ascertain that my interpretations were thorough and withstood my new outlook on the data collected.

I also realised that perhaps when the participants were interviewed, they might have felt a sense of cautiousness since I work in a similar environment. As such a sense of uneasiness or embarrassment might have been felt in sharing difficult experiences that they assumed I felt differently about. Although not fully aware of these dynamics at the time of the interview, I realised that I had assured the participants multiple times that answers would not be judged, and that I felt morally and ethically bound to treat their experiences with due regard.

4. Chapter Four: Discussion

4.1 Overview of Key Findings

This study aimed to fill a significant gap in the literature by exploring NHCP's experiences of stress and burnout whilst working in a medium forensic unit for patients with personality disorder. I employed a qualitative investigation using IPA to interview seven participants. The analysis of the interviews produced three main themes:

1. Operational trauma
    1.1 Mental Warfare (MW)
    1.2 The Affected Mechanical Body (AMB)
    1.3 Imposed Passivity (IP)

2. Post-traumatic Growth
    2.1 Microsystem (MS)
    2.2 Growth (G)

3. Reflection
    3.1 Experience of Work (EW)
    3.2 Meta-reflection (MR)

These themes and subthemes were the product of the analysis which was set out in the previous chapter. In the current chapter, I will draw significant conclusions from each theme and contextualise the findings where possible by linking to previous relatable studies. I will then move to the reflexivity segment and share subjective and conclusive thoughts on the research. This will be followed by a discussion of the

limitation of the study and possible venues for research to improve on the current literature. Finally, I will explore the implication of the findings with regard to counselling psychology.

4.2 Operational Trauma

One of the most frequent experiences highlighted by the participants during the interviews were those of experiencing intense and life-altering events that shaped their view of the world. The term “operational trauma” was employed as the experiences shared by the participants appeared to share significant features with this term (Keats, 2010). The term operational trauma was initially coined and used to describe soldiers who had been to war and who had not experienced physical trauma but experienced some sort of mental warfare that eventually impacted their mental and physical well-being (Keats, 2010). Similarly, the accounts of the participants in the current study were not rampant with events of physical aggression, although not devoid of them either.

The themes that mostly emerged in relation to the traumatic events experienced at work appeared to be psychological in nature rather than physical. This appears to sustain the previous accounts that perhaps the difficulties that would often arise with forensic patients with personality disorder tend to be more of a mental rather than physical nature (Fanning et al., 2019). Saverimuttu and Lowe (2010) found that patients with a personality disorder diagnosis are less likely to be involved in physical act of aggressions when compared to other mental health diagnosis such as schizophrenia. The study also suggested that females were more likely to engage in physical acts of aggression in inpatient wards than males. These findings appear to align with the current study whereby participants acknowledge the presence of

physical aggression but are more preoccupied with other components of the environment that feeds into the experience of stress and burnout. The three components that seemed to be relevant to creating stress and burnout for participants were subdivided into three subthemes, namely: **mental warfare**, **the affected mechanical body** and **imposed passivity**. As will be described below, the analysis suggests that the experience of stress and burnout in this study is in itself unusual due to the nature of the environment itself. The subthemes MW and IP explore the psychological difficulties encountered within the ward, whilst AMB explores the direct impact of stress and burnout.

4.2.1 Mental Warfare

The experience of the participants in this case highlights the mental discomfort and pervasive elements of the job. Participants describe how the role of NHCP creates a consistent experience of discomfort. From these themes, participants shared how intense the mental toll of the job can be. The participants mainly focused on four elements in this subtheme: the constant emotional taxing aspect of the role; the sudden experience of serious/disturbing incidents; the constant sense of hypervigilance; and the dread of de-escalating potentially serious events. The finding regarding hypervigilance shares similarities with the available research that suggests that general hypervigilance is linked to psychiatric settings with high violence index and that this is mediated by the level of care of staff towards patients (Forté et al., 2017). These are important elements to highlight as they give more sensitive context to the literature in respect of stress and burnout in mental health sectors and more specifically in highly specialised units like the one in this study. Though there is ample research suggesting that stress and burnout are linked to mental health units,

the dearth of research on the identification of what creates these phenomena for these units is still striking (Beryl & Völlm, 2018; Burgess et al., 2010). A close identification of the experiences of participants will help different support systems to move from a one-size-fits-all approach to more robust and case-sensitive care. For example, it is important to acknowledge hypervigilance as a major contributor in experiencing stress. This may have ramifications for the level of care that will be provided by NHCP to patients and can aid in understanding the long-term mental toll it may have. This study, however, shares a finer understanding of how such hypervigilance is created and perhaps offers a route to tackle it with more refined support and training. Nevertheless, the aim of the current study is also to use the findings of this theme to provide context to the experiences of NHCP outside of the work environment and how this shapes them. So, the subthemes in this current theme should provide some context and answers to the subsequent theme, **post-traumatic growth**, which looks at how NHCP are shaped by this experience and how it informs their close circle. The four elements mentioned in this subtheme are not the only evidence of stress factors highlighted in the transcripts. The next two themes tease out other aspects of the participants' experiences with regard to stress and burnout.

4.2.2 The Affected Mechanical Body

Similarly, to the previous subtheme, this highlights an aspect of the mental toll experienced in a FPD unit. Participants describe how the mental taxation of the job reflects physically on their health and body. One of the participants described how the experience of mental distress affected their sleep and appetite significantly. Another participant, on the other hand, described how they had noticed that by

dissociating and disconnecting from work, sometimes even physically disconnecting (i.e., not attending work or avoiding interaction with patients on the ward), they were able to safeguard themselves. The analysis segment highlighted how important this subtheme is in highlighting some of the participants' experiences regarding the physical expression of stress and burnout. The participants were able to identify significant links between their body and their mind. Where some saw their body as a barometer to indicate their experience of stress and burnout, one used it to disconnect and shut down, perhaps as a way of defending themselves from feeling the full impact of stress and burnout.

What is more striking is the level of awareness that is present with some of the participants in respect of the perceived impact of stress and burnout in the FPD unit. For example, one of the participants was able to identify and acknowledge that she suffered two chest infections as a result of her experience of burnout and that she had observed the frequency of similar psychosomatic features (Faye: 337-338). This is striking, as stress-linked sicknesses are often difficult to diagnose. It appears that there is a level of awareness present in the participants, and that perhaps they are identifying that the body is speaking for the mind and vice versa (Kane, 2009). Interestingly, Yousefzadeh and Ebrahimi (2020) published a recent paper indicating how self-differentiation training of psychosomatic illnesses in nursing roles can significantly reduce their occurrence and equip NHCP with the tools to manage these difficulties. This subtheme not only shows that stress-related illnesses are still a significant factor in FPD but also highlights that NHCP still feel powerless towards the phenomenon even though they are aware of it. From the analysis of the transcripts, it would appear that NHCP are still not equipped with the tools to deal with these difficulties and may just surrender to them as perhaps being an

unchanging feature of these environments, especially when it is indicated that suffering is part of the deal of working in challenging environments such as this (Beryl & Völlm, 2018).

The findings provide an initial outlook and a nuanced understanding of the impact of FPD units on bodily stress. However, the scope of these findings is to eventually contextualise how these might shape NHCP's lives outside of the work environment.

4.2.3 Imposed Passivity

This subtheme highlighted a concept of powerlessness, anger and repression. The analysis highlighted that NHCP experience intense verbal abuse, manipulation and threats. These feelings are aggravated by the experience of continuous splits in the multidisciplinary team. As a result, the participants describe having negative attitudes and feelings towards patients and themselves because they find it challenging to assert themselves and struggle to retain any power. This is a more distinctive and perhaps more specific phenomenon that appears to be associated with the nature of the FPD units. The participants acknowledge that the feelings experienced within this theme are specific to this environment due to the unique nature of patients in FPD units who present with a combination of personality disorder diagnosis, high intelligence and the potential to be violent (De Brito et al., 2013).

Literature has shown that splitting is a major contributing factor to stress and burnout in these environments and, as a result, staff often become cynical in their approach and care (Dickson & Wright, 2003). Nevertheless, there are some novel concepts highlighted by participants with regard to this subtheme. Participants were particularly keen to express how they often felt as if they had to hide their authentic self and take a passive stance in order to maintain peace and safety. This concept of

maintaining a passive stance in order to avoid violence bears striking similarities to some elements of domestic violence where there is a pattern of behaviours that is used to gain or maintain power and control (Johnson, 2019). There is a possibility that this power imbalance and struggle is partly linked to the concept of relational security. In this context, the basis of relational security is to maintain safety through the relationship built between the NHCP and patients. As described in the literature review, one of the most important forms of security in secured units is the relational security aspect (Tighe & Gudjonsson, 2012). Relational security is increasingly seen as a crucial factor in the maintenance of a safe and therapeutic environment in forensic secure units. The concept concerns the quality of therapeutic relationship that clinicians have with their patients and the way this relationship is used to maintain safety through the recovery process. Relational security mandate is one that could foster imposed passivity as a way to maintain a stable ward, especially when NHCP feel that they have limited resources to deal with the hostile environment.

Another point that surfaced within this theme was how participants described the passive mirroring of patients' negative attitudes and behaviours. Perhaps it would be of significant interest to explore how environments such as the one researched can impact on workers' behaviours and attitudes.

4.2.4 Summary of Operational Trauma

The term operational trauma was used in this context as participants' experiences appeared to mirror the experiences described by combat veterans (Keats, 2010). The analysis generated novel information by providing more refined context to what may cause the phenomena of stress and burnout. Two main novel ideas were

captured in this theme. Firstly, physical aggression is not the major concern for NHCP but rather the mental warfare at play. Secondly, participants described (imposed passivity) dynamics that bear a resemblance to those of domestic abuse and which seem to be perpetuated by the power imbalance and fear embedded within the relational security aspects of the unit.

The present theme also highlighted an ongoing issue that has been partly captured by previous literature with regard to the impact of stress and trauma in the workplace (Beryl & Völlm, 2018; Kane, 2009). The theme highlights how some of these issues are yet to be resolved even though this issue has a long history (Clarke & Sandra, 1998; Dickson & Wright, 2003). The theme shows that there may be ample room to support NHCP with targeted training and support to tackle these issues.

Imposed passivity is a concept that can be particularly detrimental to NHCP mental health as it poses the question of how these emotions and feelings are dealt with. It also poses the question of what impact this may have on long-term NHCP self-concept and self-esteem when they are met with such intense hostility without the resources to protect and assert themselves. Some of those answers are embedded in the next two themes as they show the transformations and reactions experienced by NHCP in response to the different aspects of stress and burnout highlighted throughout the subtheme of imposed passivity and in part of the main theme of operational trauma.

4.3 Post-traumatic Growth

This superordinate theme is perhaps the fulcrum of the study as it highlights two important aspects of participants' experiences outside of the work environment. Firstly, how the job has impacted NHCP's personal lives and close circles

(microsystem) and secondly how this job has changed or transformed them (growth). The analysis showed that the two themes are not mutually exclusive and that participants often expressed having experienced different aspects of both subthemes. The analysis has shown that participants can have both negative and positive experiences in their microsystem and still experience aspects of growth. Moreover, there are some experiences of growth that participants described as not finding positive but which still represent a development.

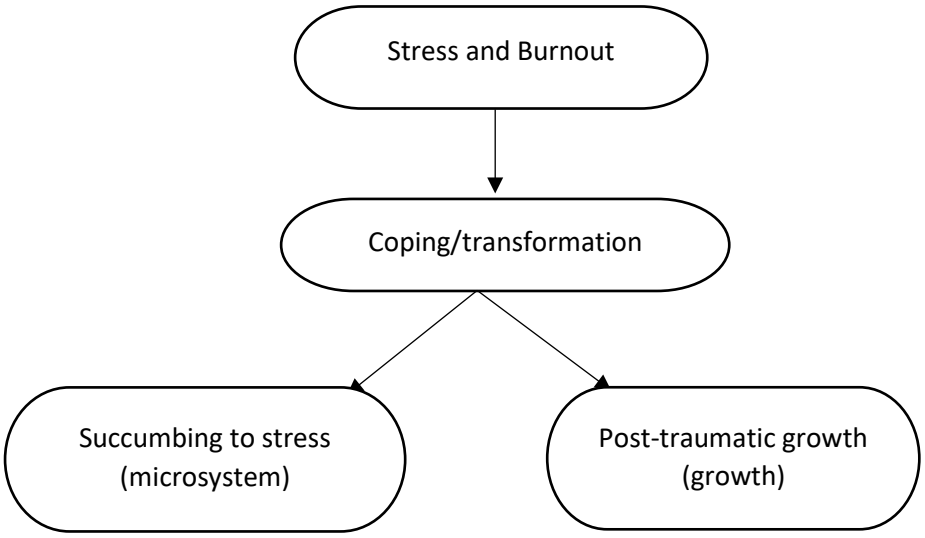


Figure 2. The outcome journey of stress and burnout

The term “post-traumatic growth” was employed as there are aspects of the participants’ experiences which showed that through stress and burnout there were elements of transformation and this had informed participants’ lives. As shown in Figure 2, this theme intends to expand on the journey of transformation that has revealed both the impact on the microsystem and the growth experienced by participants. IPA’s focus is not to generate models or directional flow. So, Figure 2 is

merely an illustration to conceptualise the experience of the participants with a visual representation. This theme is an important element to the study that sheds light on the impact the job has on people's lives and also serves to enrich research that suggests how social support offers protective properties in respect of stress and burnouts (Baird & Kracen, 2006; Canfield 2005). This theme looks at how participants make meaning of their experiences concerning their stressors and how such stressors have informed participants with regard to their family, friends, community and self.

4.3.1 Microsystem

This subtheme highlighted the difficulties that NHCP described experiencing in their personal lives as a direct link to the stressors experienced in their job. The analysis highlighted two aspects of this subtheme. The first one regards the self and the second extends to the participants' immediate environment.

The participants describe having different experiences regarding their personal lives. For example, one of the most striking aspects described by one of the participants was the difficulty in compartmentalising aspects of the job and separating these from their home and private life. This is an aspect that is linked to the previous theme (operational trauma) whereby participants expressed how pervasive the nature of the job is. From the information gathered in the analysis chapter it would appear that the pervasive nature of the job accompanies participants even beyond work. One of the participants used a metaphor (winter jacket) to describe this pervasive phenomenon. Participants expanded upon this emergent theme and described the difficulty to switch off from "work mode" as they find themselves constantly stimulated.

Participants described how they are often on constant lookout for risk to self and others.

The pervasive nature of the job appeared to also have other implications for participants whereby they recounted having dreams about work – something they had never experienced in previous jobs. Research has shown that perhaps when people struggle to deal with stress, this may manifest in their dreams as a way of attaining awareness (Nolan, 1993). Noticeably, the participants who described having high sleep disturbance were also who described having less explicit manifestation of stress and burnout. Perhaps this may suggest that stress and burnout are internalised by some more than others. This may be an avenue for future studies as it may help to understand how some people experience stress and burnout through the subconscious.

Furthermore, participants also described how they have developed a sense of paranoia towards people and feel as if the world is less safe. Perhaps the constant hypervigilance described by participants with regard to working on the wards has somewhat shaped their view of the outside world and they find it a challenge to see the world as being as safe as they used to. As described in one of the participant's self-reflections, the hypervigilance from work has transformed itself into paranoia in the outside world.

It may be significant to recognise the different experiences highlighted by participants regarding their self when the role is becoming challenging and potentially damaging. It is also remarkable how participants describe their changing view of the world due to their job. One of the participants alluded to this as a loss of innocence, and this is perhaps what fuels this experience of paranoia for other

participants whereby they describe seeing society as unsafe and unpredictable. Nevertheless, an apprehension was captured within the texts whereby participants seemed to struggle with the concept of how close to or far from reality their paranoia of the outside world is. Perhaps the ramification of this apprehension can be captured partially by participants experiencing the need to self-isolate in their personal lives as a way of not feeling constantly over-stimulated and to safeguard themselves. Studies have reported strong links between paranoid thoughts and the need to isolate from others (Kingston et al., 2019).

Looking closely at the different expressions of the emerging themes indicated above, it appears that participants are describing a sort of post-traumatic reaction that resembles vicarious trauma. Vicarious trauma is a phenomenon that occurs in helping professionals where they are in contact with traumatic material. Newell and MacNeil (2010) describe vicarious trauma as a shift in fundamental beliefs about the world where they are altered and possibly damaged by being repeatedly exposed to traumatic material. From the emerging themes described, it appears that participants experienced this difficulty through hypervigilance, difficulty in compartmentalising, and shifting views about the outside world. It appears that there has been a shift in the participants' heuristic cognitive bias, whereby they are being exposed to something beyond what is normal. This can lead to a cognitive bias in terms of overgeneralising and having a distorted view of the world; that is, anticipating similar levels of threat outside of the work environment. For example, a therapist hearing the atrocities of child abuse may become hypervigilant about their own children. Research has shown that the vast majority of patients in the FPD units have significant historical trauma which is usually a compounding factor in the forensic history of patients. As such, the staff in this environment are not only exposed to the

daily challenging aspects of a forensic unit but are also exposed to the historical trauma of the patients, especially when engaged in therapeutic work with them.

The latter part of this subtheme looks at how participants' immediate environment is affected. The interviews highlighted a constant sense of worry from family members with regard to the participants' mental and physical well-being. Apart from the constant worry from close relatives, participants described other experiences in their personal environment. One of the participants described how the stress of violent events from work can often impact their intimate relationships whereby the participant noticed that they became more distant and at times irritable towards their partner. There is a sense that stress and burnout from work, even when is not of a physical nature, can impact relationships. Participants describe how this does not only impact their partners, but at times, extends to their parents and children too.

Furthermore, participants also described how events from work can impact their relatives so intensely that they often require healing from it. One of the participants expressed how their children were greatly impacted by their own experience of violence and aggression. The feelings expressed by the participants highlighted how family members can be vicariously impacted. Not only did they allude to the possibility of secondary trauma but also highlighted how their perception of paranoia or hypervigilance can be passed on to loved ones. The concept of secondary trauma in family members is a subject that is gaining significant interest from researchers as there is an acknowledgement that most of the current research in the field is based on secondary trauma between patients and therapists (Motta, 2020). Although research in this regard is at an early stage, the finding gives ground to further explorations and may inform other related phenomena such as transgenerational trauma (Kellermann, 2001). This is a significant aspect of the study as it underlines

that the impact of the job does not stop at the individual but goes beyond and affects close circles.

4.3.2 Growth

This subtheme, differently from the previous one, highlights how participants found growth within their experiences in the FPD units. As mentioned earlier, the two subordinate themes did not appear to be mutually exclusive. The same participants who described negative experiences also expressed aspects of growth relating to developing emotional regulation, self-efficacy, knowledge, confidence, openness, acceptance, learning new skills and having a higher sense of self-expression. This growth is at the heart of the definition of post-traumatic growth where people find meaning, resilience and strength through adversity and via unexpected routes (Kaufman, 2020).

Participants expressed a myriad of positive outcomes from working in the FPD ward that had influenced their lives and the lives of others. Participants spoke of how they had developed different ways to self-regulate and manage their reactions as a response to an environment that would always pose risks and stressors. These bear striking similarities to the concept suggested by Haynos et al (2016) with regard to resolving conflict through Dialectical Behaviour Therapy. Similarly, to Haynos et al (2016), participants shared their experience of reducing stressors by integrating mindfulness, emotional regulation and self-validation into their practice. Furthermore, participants expressed how they had become more assertive in their private lives as a result of learning how to express themselves at work. These are important discoveries with regard to the research questions as they underline that the lived

experiences of NHCP outside of work is multifaceted and that for many, the role involves significant changes to their identity.

Participants underlined other positive aspects that they had developed and which eventually informed their relationship with their close circle. The available research arguably suggests that although nurses have a mandate to care for patients, they do not often offer much empathy and sympathy towards their patients (Morse et al., 1992; Reynolds & Scott, 2000). Even though the current research is based on participants' self-reports, there is an overwhelming expression that the NHCP role creates an environment where empathy and sympathy are developed and have informed participants' attitudes towards work and others in their lives. Participants expressed how the job has made them cognisant of the need for openness and intimacy with close relatives, and that this aspect of the job has made them more aware and attuned to other people's emotions and needs. Participants describe becoming more empathic, sympathetic and insightful with regard to people's needs. This appears to enrich and support Hall's (1997) idea regarding nursing roles, that through the process of recognising and healing personal wounds, transformation and self-knowledge are facilitated at a deep level. This newfound outlook towards people is one that participants particularly emphasised. There is a consensus from participants that their view of the world has been significantly shaped by their job and this has offered them avenues to thrive in some aspects of their lives where they feel more self-confident and possess a higher sense of self-worth.

One wonders whether the growth in this environment was made possible due to the participants' view and stance towards the patients. As suggested in the earlier theme of imposed passivity, participants expressed how differently they would respond in their personal lives if they were subjected to the level of hostility and pressure they

encounter on the ward. Perhaps the “professional role” is one that makes it possible to accept the degree of abuse as a means that leads to finding growth. Usually, if a person were to experience the level of stress and abuse from a family member or a close relative, it would be culturally acceptable to find a way to distance oneself, even through legal means. However, in the FPD unit, it is assumed that the environment is hostile and as a consequence, there is a level of acceptance expected from NHCP with regard to the stress and burnout and this is not comparable with the outside world. This creates a dissonance between the negative response created by the domestic abuse conditions and the concept of acceptance of the challenging environment. This dissonance in some way adds another layer to the concept of imposed passivity but interlinks with the growth theme. This concept of acceptance is not necessarily seen as a positive element to the growth theme; it rather highlights a form of adaption to an environment that is ever challenging. There is an acceptance that the patients in this FPD environment are always going to pose risks and challenges and that this is an unchanging part of the job. As such, there is a thin line that separates the concept of acceptance and surrender. Additionally, it is important to underline that there is also a significant difference between the domain of domestic abuse and what is seen within this research. This is because, usually, victims of domestic abuse do not have the same level of support as NHCP. Also, NHCP are not as bound to remain in the abusive environment as victims of domestic abuse may be.

Furthermore, it appears that participants were also able to have a positive outlook linked to acceptance, as one of the recurring themes in the subtheme of growth was that some participants’ views of growth enabled them to shift the view they had for patients to the outside world. For example, one participant expressed how much

more compassionate and understanding he had become of people, generally. He has started to have a different outlook in life where he perceives that people outside of hospital settings may just be as maladjusted as patients in the FPD unit due to childhood trauma or other indicative historical reasons:

"I think in terms of emotional intelligence, the way I relate to folks. I think that in terms of assertion, emotional regulation particularly because that is what we learn on the job. Yea, I think it changed me profoundly, I am naturally an introvert, natural introvert, socially anxious". (Adam: 64-65)

4.3.3 Summary of Post-traumatic Growth

This theme teased out the main aim of the study. The microsystem subtheme highlighted how participants' outlook towards the external world has been significantly affected by the job. Participants describe feeling that they were self-isolating more and having more dreams related to work. They describe feeling more paranoid about the outside world as a response to feeling constantly hypervigilant at work. Further exploration is being suggested regarding NHCP's family members experiencing secondary trauma and NHCP experiencing vicarious trauma and aspects of domestic violence.

The growth subtheme underlined participants' accounts of maturing and developing within a challenging environment. Participants' accounts appear to suggest that the atypical environment fosters growth in different areas. This subtheme accounts for participants experiencing a higher sense of emotional regulation, confidence, openness, acceptance, empathy and assertiveness. Findings from the analysis suggest that certain aspects of the growth subtheme can only be fostered by adopting a "professional role" stance.

Although the growth subtheme would appear to run counter to the microsystem sub-theme, the analysis has shown that participants have idiographic experiences embedded within time. Whereas some participants have described experiencing certain aspects of growth and microsystem simultaneously, others have suggested that they transitioned from one subtheme to another over time. Nevertheless, both themes are a result of participants either adapting or succumbing to an environment that appears unchangeable.

4.4 Reflection

This theme, unlike the other two main themes, focuses on the process undertaken. It appeared particularly relevant to the study as it offers insight into participants' reflexive view of their role as NHSP (experience of work) and their attitude towards the study (meta-reflection). The theme was an organic discovery as participants appeared to offer these experiences with little or no prompts. This account is particularly important to the study as it offers a starting point on how to expand on the current research.

4.4.1 Experience of Work

In this theme, participants describe their own reflexive observation of what it feels like to work in the FPD environment and elements that they believe had informed their experience. Participants describe how the notoriety of the role has often provided a sense of elitism due to the high risk and challenges the environment poses. This offers participants an increased sense of self-worth and pride that they can carry out a job that not everyone can withstand. This notion is supported further by participants experiencing and witnessing high turnover at work. As highlighted in

the introduction, high turnover in this field is quite common (Mason, 2002). It would appear that for those who remain in the role and witness others leave, a sense of resilience at being able to stay, accompanied by difficult emotions from witnessing the job taking its toll on colleagues.

In trying to make sense of the high turnover, participants offered their view on how different demographics and levels of experience can mitigate the experience of stress and burnout in FPD units. Though there is ample research regarding the experience of different genders in FPD, there are fewer studies focused on the role of experience and age, and the aspects of these that mitigate or may exacerbate the experience of working in FPD units (Mercer & Perkins, 2018; Mezey et al., 2005). Perhaps an exploration or further research into these aspects might serve to update the available knowledge in this field in order to support NHCP more meaningfully. Similarly, an element that emerged was a strong feeling from NHCP that their mental well-being comes second to that of patients. Participants expressed the importance of achieving self-care as a team. The theme underlined a belief that organisations and structures do not serve to help staff recuperate or feel valued due to the constant prioritisation of the patients over them. Participants believed that organisations and structures are also structured in a way that makes work pervasive and stressful, and does not allow the NHCP as well as the wider team (MDT) to prioritise their own well-being to a satisfactory standard. As suggested by Figley (2002), self-care is one of the key points stressed for the proficient functioning of a counselling psychologist. It is believed that self-care is essential for the prevention of burnout and for maintaining one's own psychological wellness (Barnett et al., 2007). Perhaps there is a need for a culture shift where self-care is also put at the forefront of the NHCP role both on an individual level and as a team.

4.4.2 Meta-reflection

This theme is particularly relevant with regard to understanding the limitations of the study and how to improve on it. This subtheme highlighted how participants were often tentative about answering questions and appeared to need validation from the researcher in describing some of their experiences. Perhaps participants felt scrutinised as they were aware of my experience within FPD units and may have thought that describing negative experiences might represent them badly. After all, nurses and frontline staff do not want to be perceived as non-caring or unempathetic as this is at the heart of the caring role (Smith, 2011). This notion was also supported by how participants at times leaned towards describing difficult experiences through the experiences of their colleagues rather than their own. This appeared to be an attempt from participants to distance themselves from the negative experiences, probably to avoid re-traumatisation.

Nevertheless, part of the tentativeness observed seems to be derived from participants' meta-reflection and the novelty of the topic being researched. Some of the participants described how they had never reflected on how their job impacted them outside of work and only ever thought of the immediate work-related impact of the violence and aggression. Participants described not having a safe space to reflect on these issues and this was reflected by how novel and difficult questions began to surface for participants in respect of their role as NHCP. Perhaps part of the future direction of the study could be to return to these same participants after some time has passed, to explore how they had integrated these novel thoughts and further developed their meta-reflections.

Furthermore, trusts could provide spaces to reflect deeper on the role that the Offender Personality Disorder (OPD) pathway has on staff. Since the introduction of the OPD pathway in 2012 in the United Kingdom, there has been a focus on offering supervision, training and reflective practice for staff working with this client group as an acknowledgement of the challenging environment (Webster et al., 2020). Nevertheless, there are still major concerns with these supports, especially with regard to the reflective practice being offered. For example, NHCP particularly had issues with the usefulness of the space offered and the logistics involved (Webster et al., 2020). In a previous study, nurses in FPD units reported that reflective practices can be useful but are not always used effectively. The reason is nurses' concerns about psychological safety and lack of attendance. This appears to chime with the current findings in this research whereby participants shared the feeling of a lack of safety with regard to the spaces of support provided (Liddiard et al., 2017). Liddiard et al. highlighted that perhaps better education about the nature of reflective practice might increase engagement and the improve sense of safety.

This study highlights that perhaps there is more that can be done aside from educating NHCP on reflective practice and other available supports. The current study highlights how important it is to focus on the lives of staff beyond work as this can be a protective factor and an indicator of how work is affecting staff's well-being. As part of a wider reflection on the topic of supports available, I wondered whether there is also a lack of understanding regarding the support provided to NHCP. For example, a significant portion of the nursing work force in the United Kingdom is composed of ethnic minorities. Yet, the available resources and support are based on the ethos and values instilled by the Eurocentric Westernised approach (Romaine & Kavanaugh, 2019). It may be important and perhaps an opportunity for future

studies to understand the implications of instilling supports that are devised from an individualistic culture to a staff group that is composed of different ethnic groups that may be aligned to a more collectivist culture. These cultures may have different values and needs within these working environments, hence the need for putting in place support systems to reflect that.

4.4.3 Summary of Reflection

The subtheme “experience of work” highlights how participants feel a high sense of worth due to their ability to stay employed in this challenging environment. Participants also highlighted how their experience has led them to believe that staff demographics can have a significant impact on the level of stress and trauma they are subjected to. More importantly, participants also described the feeling that part of the stress and burnout experienced is due to low self-care perpetuated by inadequate support provided within the mental health structure that does not seem to regard staff well-being as a priority.

The “meta-reflection” subtheme sheds light on participants’ tentativeness and cautiousness in expressing their views regarding their experience of stress and burnout. Participants resorted to describing difficult experiences through others’ experiences. The analysis suggests that perhaps NHCP’s stance towards the study was due to not wanting to be viewed negatively (unempathetic or unreflective). Lastly, participants narrated that they were not aware of structures put in place to enable them to safely explore and reflect. Thus, they found the study to be a novel exercise. The findings would benefit from a follow-up that explored how participants had made sense of this current study, since they have suggested that this is a novel process for them.

4.5 Reflexivity

Whilst carrying out the study I began to increasingly understand the different intellectual suppositions involved with reflexivity. As suggested by Haynes (2012), reflexivity is not just an attempt to examine and explore researcher/participant relationships and their impact on knowledge. Reflexivity also acknowledges the constitutive nature of the research through the construction of emerging practical theories rather than objective truths. It also pays dividend on research and life as a process of becoming rather than an already established truth (Alverson & Skoldburg, 2000; Oliver, 2012). This process is at the heart of what is named “double hermeneutic” (Alvesson & Skoldburg, 2000). As suggested by Charmaz (2020), reflexivity also encompasses the emotions of the researcher in that it recognises that these are crucial to how the social is reproduced and endured within a complex social world. Consequently, a researcher may effectively be both subject and object of the research and experience the tension of working between the dualities of public social knowledge and private lived experience. As Calás and Smircich (1999, p. 664) ask: “Can we do our writing in a way that is ‘self-conscious’ of our choices?”

As suggested by Haynes (2012), I answered this question by posing myself four important questions that accompanied and guided me throughout my research process:

- What is the motivation for undertaking this research?
- How am I connected to the research, theoretically, experientially, emotionally?
- What effect will this have on my approach?
- What underlying assumptions am I bringing to it?

This research project has made me reflect in many ways. I believe the study and I have been affected mutually. As described by Alvesson and Skoldberg (2000), there are two fundamental aspects to reflexivity: interpretation and self-reflection. Initially, I did not realise the impact the research had on me and I was focused on my role and how I interpreted the different stages of the study. As time passed, I realised that an in-depth interpretation can only be achieved through an in-depth self-reflection. Part of my drive for conducting this study was in response to what I perceived as a social injustice. I believed that the mental well-being of mental health professionals within the health care system is often overlooked especially with regard to frontline staff. I concentrated my effort and exploration on the well-being of the participants rather than the patients and organisations as a conscious attempt to focus on this specific group. I believe there is a need for a culture change where workers' health is given high priority without a sense of guilt or an apologetic stance. Interestingly, I was struck by one of the participants who highlighted that they felt that structures and organisations were often neglectful of mental health professionals' well-being and rather focused most of the resources on running units smoothly. This accentuated the sense of powerlessness that I had felt with regard to the socio-political and socio-economic system that often disregard, underappreciate and undervalue the work and impact of mental health professionals within society (Baum et al., 2009; Illovsky, 2013).

To my surprise, this research also gave me significant moments of pause and made me re-evaluate my experience in FPD units. The analysis and discussion chapters made me reflect on my post-traumatic growth and how the research had evidenced this for the participants. My fears as a novice researcher were lessened as I found myself with novel discoveries that I had not anticipated. As mentioned in the earlier

chapters, I held significant anxieties that my social justice agenda and past experience in the field would make it difficult for me to bracket my preconceptions. However, it appeared that notwithstanding these anxieties, participants were able to assert their views and hold on to what was true to them despite initially being tentative and cautious (described in the superordinate theme “reflection”). I believed that participants were able to move beyond the tentativeness and cautiousness due to addressing the power dynamics in the room and fostering a safe environment where they felt free to express themselves.

Reflecting back on all stages of the study, I endeavoured to continuously assess my influence on the study and minimise this in every way I could. I believe this helped me to steer away from producing a piece that focused on finding similarities between my experiences and those of the participants. I was able to monitor my influence on the work and bracket myself by constantly reflecting on my role in the research through personal therapy, supervision, journaling and transparent discussion with my supervisor about the doubts I had regarding the interviews and analytical process. Also, it was of notable help that I had my supervisor audit the analysis of one of my transcripts. As such, I saw myself evolve from a stance that went beyond advocating reflexivity as a means for more effective research towards a lived moral and ethical project (Cunliffe, 2016). I believe that this project was able to bring to life the lived experiences of participants and as such fulfil my social justice agenda without this interfering with the integrity of the study.

4.6 Limitations and Opportunities for Future Studies

This research was meticulously brought together by following the strict requirements dictated by the standards of City, University of London. Part of the process of holding

the research process and findings to a high standard is the ability to reflect on their limitations and highlighting possible pathways for future related studies.

Looking back at the process, there are a few limiting aspects from choosing to adopt IPA. As indicated in the study, the main objective of the research was to identify participants' experiences within their role of NHCP. As suggested by Tuffor (2017), this can be challenging when there are disparities within participants' skills to successfully communicate the nuances of their experiences. This disparity may cause one voice to be heard more than the other, especially when the interpretation is moderated by the researcher's experience. Reflecting on the data gathered, some participants' language was richer than others. This provided a denser level of interpretation for me as a researcher. Although steps were taken to ensure that all the voices were heard in a hermeneutic fashion and that the validity of the study was maintained (Vicary et al., 2016; Yardley, 2008), the critique posed by Hefferon and Gil-Rodriguez (2011) regarding lack of standardisation remains. This issue is raised as a concern because it is believed that IPA remains a subjective approach that would yield different interpretation in a scenario whereby two analysts were working with the same data (Tuffor, 2017).

Another limiting aspect of the study was regarding the challenging aspect of recruiting a homogenous sample. I acknowledge that despite my attempts, I resorted to an opportunistic sampling due to the high volume of turnover that is often experienced in FPD units and the limited pool of participants that eventually matched the selection criteria. Due to logistical and ethical constraints, participants were gathered from one unit. Perhaps future studies could reach out to other similar units in order to expand on the current findings. Another point to build upon is with regard to race and the role it plays in the study. Given the societal shift towards the

awareness of race and its implication within mental health sectors, I believe that I could have incorporated more race-sensitive elements within the design of the study, especially given that the work force was primarily composed of ethnic minorities, and given the risk and complexities associated with the racial component (Romaine & Kavanaugh, 2019). Some of the questions within my interview schedule could have explored the role of race in stress and burnout. This could have provided a broader and more inclusive account of the participants' experiences. It could have also shed light on another layer of stressors that might be present within this environment and brought this to the study. The omission of this element might have been due to my own personal reservation as a black researcher not to accentuate the role of race if this is not brought up organically by the participants during the interviews, and perhaps this was also why participants did not raise the issue. Also, participants may have felt that by bringing race into the equation, it might have influenced the way their experience was viewed and overshadowed other experiences that they believed had little or nothing to do with race. Nevertheless, this is an issue worth noting as the issue of race and racism is still of major concern within the mental health sector (Fernando, 2017). This line of reasoning expands to various "intersectionalities" that might be present within a therapeutic environment such as an FPD unit (Collins & Bilge, 2020).

Furthermore, there are a few more opportunities that appear relevant to the cause of psychology. Firstly, within the theme of operational trauma, it appeared that certain aspects of the relationship between participants and patients resembled those of domestic abuse. Particularly given the enclosed format of inpatient units, it would be beneficial for future studies to explore this phenomenon particularly within the context of relational security and the role that the wider multidisciplinary team plays

within these dynamics. Secondly, in researching the application of terms such as vicarious trauma and secondary trauma, it appears that there is a need for greater clarification of the construct of these terms, especially as the field of trauma is ever expanding and new concepts such as generational trauma and vicarious post-traumatic growth are entering the mix (Ben-Porat, 2015; Jacob, 2011). Lastly, an area to revisit would be in relation to longitudinal studies that explore the impact of working in environments such as the one proposed in this research. Such studies would serve to understand the long-term impact of stress, burnout and trauma work, and could be adapted to different mental health professional roles.

In summary, the current study provides a significant understanding of the experiences of NHCP with regard to their lives outside of the work environment. The study has also created a foundation upon which further studies can be built and expanded. The aspiration was to equip clinicians as well as individuals with the knowledge to support and promote the practice of well-being in sectors that may be overlooked.

4.7 Implications for Counselling Psychology

Over the years, the field of counselling psychology has attempted to find its own identity within the field of psychology (Corrie & Callahan, 2020). As a result, counselling psychologists have attempted to identify what makes counselling psychology stand out against other similar professions. The main pillars of counselling psychology lie within the existential-phenomenological and humanistic stance where the objective is to find meaning and understanding by focusing on the values and beliefs of the subjective experience (Galbraith, 2017). Furthermore, the emphasis is placed on the relational factors aligned with a constant curiosity to

understand the human life from different positions (Milton, 2010). This approach can be at odds with other fields of psychology such as clinical psychology, as it can be argued that the approach of the latter veers towards a more standardised outlook (Galbraith, 2017). Nevertheless, this does not preclude counselling psychology from carrying out scientific exploration and implementing findings within the practice of psychology as a whole.

The current study aligns with the ethos of counselling psychology as it emphasises three fundamental aspects suggested by Cooper (2009). Firstly, there was an emphasis on subjectivity, reflexivity and socio-political intricacies of the counselling psychology practice. Secondly, there was an understanding that participants are socially and relationally embedded being within the wider context of society. Lastly, the study kept in mind an appreciation that people are unique beings and in order to facilitate growth and an actualising potential, it acknowledged a fundamental need to veer away from claiming universal laws. This principle highlights how the findings from the current study can be adopted. The implications of the findings allow NHCP firstly to find self-empowerment through self-efficacy and, most importantly, provide counselling psychologists with the knowledge and tools to foster resilience and resources within a wider community (Palmqvist, 2016). This process has already begun with me as I have found that the current research has informed my role at work and has produced positive outcomes for people around me. For example, in my supervisory role at a forensic unit, I have been able to support my supervisee in a more significant manner. The knowledge gained through the current study has enabled me to better understand the nuances of stressors in this environment and as a result my supervisee has shared how they felt empowered, understood and even surprised about certain aspects of their physical and mental state whilst at work. The

hope is that the dissemination of the study's findings will provide a rationale for evidence-based plans to promote self-care and resources with a view to promoting well-being within the work environment. This would also inform the work of counselling psychologists as there is an increased requirement for them, within their role of seeing patients, to also provide psychological support for other staff members within the team (i.e. assistant psychologist, support workers, nurses and occupational therapists).

4.8 Conclusion

The study has provided several interesting insights regarding NHCP stress and burnout. The most striking aspects of the study relate to the different negative parallels that have been identified whereby some of the experiences shared by NHCP had significant similarities with central aspects of operational trauma and domestic violence. However, there were also important factors to suggest that participants also experienced significant growth within their experience of adversity (post-traumatic growth). The study provides clinicians as well as NHCP with rich information that offers a more fine-grained outlook on the stressors that arise from environments such as the one that has been presented.

As indicated in the introductory chapter, the aim of the study was to fulfil the five important values outlined by Levina (1969). The study aimed to develop an evidence base that goes beyond diagnosis and enhances responsiveness whilst maintaining the client's position (in this case participants) at the centre of their experience. Furthermore, part of the mandate for counselling psychologists is to divulge information that provides cultural, societal and context-based informed knowledge

that empowers and promotes well-being, increases agency and highlights the importance of individual differences (Corrie & Callahan, 2020).

Reference list

Alase, A. (2017). The interpretative phenomenological analysis (IPA): A guide to a good qualitative research approach. *International Journal of Education and Literacy Studies*, *5*(2), 9-19.

Alvesson, M., & Karreman, D. (2000). Varieties of discourse: On the study of organisations through discourse analysis. *Human Relations, 53*(9), 1125-1149.

Alverson, M., & Skoldberg, K. (2000). *Reflexive methodology: New vistas for qualitative research*. London: Sage*.*

Anderson, R. E, & Srinivasan, S. S. (2003). E-satisfaction and e-loyalty: A contingency framework*. Psychology & Marketing*, *20*(2), 123-138.

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders (DSM-5®)*. American Psychiatric Pub.

Archer, M., Bhaskar, R., Collier, A., Lawson, T., & Norrie, A. (Eds.). (2013). *Critical realism: Essential readings*. Routledge.

Archibald, S., Campbell, C., & Ambrose, D. (2014). Prediction of treatment outcomes for personality disordered offenders. *The British Journal of Forensic Practice*, 16(4), 281–294.

Azam, K., Khan, A., & Alam, M. T. (2017). Causes and adverse impact of physician burnout: a systematic review. *J Coll Physicians Surg Pak*, *27*(8), 495-501.

Bach, B., & First, M. B. (2018). Application of the ICD-11 classification of personality disorders. *BMC Psychiatry*, *18*(1), 351.

Baird, K., & Kracen, A. C. (2006). Vicarious traumatization and secondary traumatic stress: A research synthesis. *Counselling Psychology Quarterly*, *19*(2), 181-188.

Barnett, J. E., Baker, E. K., Elman, N. S., & Schoener, G. R. (2007). In pursuit of wellness: The self-care imperative. *Professional Psychology: Research and Practice*, *38*(6), 603-613

Baum, A. (1990). Stress, intrusive imagery, and chronic distress. *Health Psychology, 9*(6), 653-659

Baum, F. E., Bégin, M., Houweling, T. A., & Taylor, S. (2009). Changes not for the fainthearted: reorienting health care systems toward health equity through action on the social determinants of health. *American Journal of Public Health*, *99*(11), 1967-1974.

Beck, C. T. (2011). Secondary traumatic stress in nurses: A systematic review. *Archives of Psychiatric Nursing*, *25*(1), 1-10.

Ben-Porat, A. (2015). Vicarious post-traumatic growth: Domestic violence therapists versus social service department therapists in Israel. *Journal of Family Violence*, *30*(7), 923-933.

Berger, R. (2015). Now I see it, now I do not: Researcher's position and reflexivity in qualitative research. *Qualitative Research, 15*(2), 219-234.

Beryl, R., & Völlm, B. (2018). Attitudes to personality disorder of staff working in high-security and medium-security hospitals. *Personality and mental health*, *12*(1), 25-37.

Bhaskar, R. (2013). *A realist theory of science.* Routledge.

Biggerstaff, D., & Thompson, A. R. (2008). Interpretative phenomenological analysis (IPA): A qualitative methodology of choice in healthcare research. *Qualitative research in psychology*, *5*(3), 214-224.

Birks, M., & Mills, J. (2015). *Grounded theory: A practical guide.* Sage.

BPS code of ethics and conduct (updated July 2018). British Psychological Society. (2018). Code of ethics and conduct., 1-10. Retrieved from https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Ethics%20and%20Conduct%20%28Updated%20July%202018%29.pdf

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Braun, V., & Clarke, V. (2015). Using Thematic Analysis in Psychology*. Qual Res Psychol.2006; 3: 77–101,*

Braun, V., Clarke, V., & Weate, P. (2016). Using thematic analysis in sport and exercise research. *Routledge Handbook of Qualitative Research in Sport and Exercise*, 191-205.

British Psychological Society. (2018). Code of ethics and conduct., 1-10. Retrieved from https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Ethics%20and%20Conduct%20%28Updated%20July%202018%29.pdf

Bronfenbrenner, U. (1992). *Ecological systems theory*. Jessica Kingsley Publishers.

Burgess, L., Irvine, F., & Wallymahmed, A. (2010). Personality, stress and coping in intensive care nurses: a descriptive exploratory study. *Nursing in critical care*, *15*(3), 129-140.

Calás, M. B., & Smircich, L. (1999). Past postmodernism? Reflections and tentative directions. *Academy of management review*, *24*(4), 649-672.

Canfield, J. (2005). Secondary traumatization, burnout, and vicarious traumatization: A review of the literature as it relates to therapists who treat trauma. *Smith College Studies in Social Work*, *75*(2), 81-101.

Charmaz, K. (2000). Experiencing chronic illness. *Handbook of Social Studies in Health and Medicine,* 277-292.

Charmaz, K. (2020). “With constructivist grounded theory you can’t hide”: Social justice research and critical inquiry in the public sphere. *Qualitative Inquiry*, *26*(2), 165-176.

Clark, M. L., & Sandra, G. (1998). Nurses, indirect trauma, and prevention. *Image: The Journal of Nursing Scholarship, 30*(1), 85-87. 10.1111/j.1547-5069.1998.tb01242.x Retrieved from https://doi.org/10.1111/j.1547-5069.1998.tb01242.x

Clark, S., & John Chuan, S. (2016). Evaluation of the impact personality disorder Project–A psychologically-informed consultation, training and mental health collaboration approach to probation offender management. *Criminal Behaviour and mental Health, 26*(3), 186-195.

Clegg, S. (2016). Critical and social realism as theoretical resources for thinking about professional development and equity. *Theorising Learning to Teach in Higher Education, 3(1),* 141-156.

Coffey, M. (1999). Stress and burnout in forensic community mental health nurses: An investigation of its causes and effects. *Journal of Psychiatric and Mental Health Nursing, 6*(6), 433-443.

Cohen, K., & Collens, P. (2013). The impact of trauma work on trauma workers: A metasynthesis on vicarious trauma and vicarious post-traumatic growth. *Psychological Trauma: Theory, Research, Practice, and Policy, 5*(6), 570-577.

Collins, S., & Long, A. (2003). Working with the psychological effects of trauma: Consequences for mental health-care workers–a literature review. *Journal of Psychiatric and Mental Health Nursing, 10*(4), 417-424.

Collins, P. H., & Bilge, S. (2020). *Intersectionality*. John Wiley & Sons.

Cooke, D. J. (2018). Psychopathic personality disorder: Capturing an elusive concept. *European Journal of Analytic Philosophy*, *14*(1), 15-32.

Cooke, E. (2016). *Working with offenders with personality disorder: it is more than just the offender* (Doctoral dissertation, University of Birmingham).

Cooper, M. (2009). Welcoming the Other: Actualising the humanistic ethic at the core of counselling psychology practice. *Counselling Psychology Review-British Psychological Society*, *24*(3/4), 1-27.

Corrie, S., & Callahan, M. M. (2000). A review of the scientist--practitioner model: reflections on its potential contribution to counselling psychology within the context of current health care trends. *Psychology and Psychotherapy*, *73*, 413-418.

Craissati, J., Joseph, N., & Skett, S. (2015). Working with offenders with personality disorder: A practitioners' guide. London: Department of Health.

Creswell, J. W., & Poth, C. N. (2017). *Qualitative inquiry and research design: Choosing among five approaches*. Thousand Oaks, CA: Sage.

Crocq M. A. (2013). Milestones in the history of personality disorders. *Dialogues in clinical neuroscience*, *15*(2), 147–153.

Cunliffe, A. L. (2016). “On becoming a critically reflexive practitioner” redux: What does it mean to be reflexive? *Journal of Management Education*, *40*(6), 740-746.

De Brito, S. A., Viding, E., Kumari, V., Blackwood, N., & Hodgins, S. (2013). Cool and hot executive function impairments in violent offenders with antisocial personality disorder with and without psychopathy, *8*(6), 555-566.

Devilly, G. J., Wright, R., & Varker, T. (2009). Vicarious trauma, secondary traumatic stress or simply burnout? Effect of trauma therapy on mental health professionals. *Australian & New Zealand Journal of Psychiatry*, *43*(4), 373-385.

Department of Health (2006). *The Mental Health Bill Plans to Amend the Mental Health Act 1983.* London: The Stationery Office; Available at: http://www.dh.gov.uk/assetRoot/04/13/42/33/04134233.pdf (accessed 4 May 2020).

Dickinson, T., & Wright, K. M. (2008). Stress and burnout in forensic mental health nursing: A literature review. *British Journal of Nursing, 17*(2), 82-87.

Dixon-Woods, M., Shaw, R. L., Agarwal, S., & Smith, J. A. (2004). The problem of appraising qualitative research. BMJ Quality & Safety, 13(3), 223-225.

Duquette, A., Kérouac, S., Sandhu, B. K., Ducharme, F., & Saulnier, P. (1995). Psychosocial determinants of burnout in geriatric nursing. *International Journal of Nursing Studies, 32*(5), 443-456.

Edwards, D., Burnard, P., Coyle, D., Fothergill, A., & Hannigan, B. (2000). Stress and burnout in community mental health nursing: A review of the literature. *Journal of Psychiatric and Mental Health Nursing, 7*(1), 7-14.

Eisikovits, Z., & Koren, C. (2010). Approaches to and outcomes of dyadic interview analysis. *Qualitative Health Research, 20*(12), 1642-1655.

Eliacin, J., Flanagan, M., Monroe-DeVita, M., Wasmuth, S., Salyers, M. P., & Rollins, A. L. (2018). Social capital and burnout among mental healthcare providers. *Journal of Mental Health, 3*, 1-7.

Elliott, K. A., & Daley, D. (2013). Stress, coping, and psychological well-being among forensic health care professionals. *Legal and Criminological Psychology, 18*(2), 187-204.

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *The British Journal of Clinical Psychology, 38 (Pt 3)*(3), 215-229. doi:10.1348/014466599162782

Ellis, S., & Moss, G. (2014). Ethics, education policy and research: The phonics question reconsidered. *British Educational Research Journal, 40*(2), 241-260.

Fanning, J. R., Coleman, M., Lee, R., & Coccaro, E. F. (2019). Subtypes of aggression in intermittent explosive disorder. *Journal of psychiatric Research*, *109*, 164-172.

Feeney, A. (2003). Dangerous severe personality disorder. *Advances in Psychiatric Treatment*, **9**(5), 349–358.

Fernando, S. (2017). Struggle against Racism in the UK. In *Institutional Racism in Psychiatry and Clinical Psychology*. London: Palgrave Macmillan, Cham.

Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self-care. *Journal of clinical psychology*, *58*(11), 1433-1441.

Fink, G. (Ed.). (2016). *Stress: Concepts, Cognition, Emotion, and Behavior: Handbook of Stress Series* (Vol. 1). Amsterdam: Academic Press.

Finlay, L. Phenomenology for Therapists. Researching the Lived World. 2011. *Hoboken, NY: Wiley*.

Fletcher, A. J. (2017a). Applying critical realism in qualitative research: Methodology meets method. *International Journal of Social Research Methodology, 20*(2), 181-194.

Fletcher, A. J. (2017b). Applying critical realism in qualitative research: Methodology meets method. *International Journal of Social Research Methodology, 20*(2), 181-194.

Forté, L., Lanctôt, N., Geoffrion, S., Marchand, A., & Guay, S. (2017). Experiencing violence in a psychiatric setting: Generalized hypervigilance and the influence of caring in the fear experienced. *Work*, *57*(1), 55-67.

Fugard, A. J., & Potts, H. W. (2015). Supporting thinking on sample sizes for thematic analyses: A quantitative tool. *International Journal of Social Research Methodology, 18*(6), 669-684.

Glaser, B. G., & Strauss, A. L. (1967). The discovery of grounded theory: Strategies for qualitative theory. *New Brunswick: Aldine Transaction.*

Godoy-Izquierdo, D., Sola, H. C., & García, J. F. G. (2011). Assessing coping with stress self-efficacy: English validation of the CSSES. *Health Outcomes Research in Medicine*, *2*(2), e105-e118.

Goffman, E. (2009). *Stigma: Notes on the management of spoiled identity.* NY: Simon and Schuster.

Golafshani, N. (2003). Understanding reliability and validity in qualitative research. *The Qualitative Report, 8*(4), 597-606.

Gould, N. (2006). An inclusive approach to knowledge for mental health social work practice and policy. *British Journal of Social Work*, *36*(1), 109-125

Greenberg, S. A., & Shuman, D. W. (1997). Irreconcilable conflict between therapeutic and forensic roles. *Professional Psychology: Research and Practice, 28*(1), 50.

Gregor, S. (2006). The nature of theory in information systems. *MIS Quarterly,* 611-642.

Grenier, S., Darte, K., Heber, A., & Richardson, D. (2007). The Operational Stress Injury Social Support Program: A peer support program in collaboration between the Canadian Forces and Veterans Affairs Canada. In *NATO Research and Technology Organization, Human Factors and Medicine Panel Symposium, Apr, 2006, Brussels, Belgium; A portion of this chapter was presented at the aforementioned symposium.*. Routledge/Taylor & Francis Group.

Grondin, J. (1997). *Introduction to philosophical hermeneutics* Yale University Press.

Grossi, G., Perski, A., Osika, W., & Savic, I. (2015). Stress-related exhaustion disorder–clinical manifestation of burnout? A review of assessment methods, sleep impairments, cognitive disturbances, and neuro-biological and physiological changes in clinical burnout. *Scandinavian Journal of Psychology*, *56*(6), 626-636.

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. *Handbook of Qualitative Research, 2*(5), 105-117.

Guest, G., Bunce, A., & Johnson, L. (2006). How Many Interviews Are Enough?: An Experiment with Data Saturation and Variability. *Field Methods*, *18*(1), 59–82.

Guest, G., MacQueen, K. M., & Namey, E. E. (2012). *Applied thematic analysis*. Thousand Oaks, CA: Sage

Hage, S. M. (2003). Reaffirming the unique identity of counseling psychology: Opting for the “Road Less Traveled By”. *The Counseling Psychologist*, *31*(5), 555-563.

Halfer, D., & Graf, E. (2006). Graduate nurse perceptions of the work experience. *Nursing Economics, 24*(3), 150-156.

Hall, L. M., & Donner, G. J. (1997). The changing role of hospital nurse managers: a literature review. *Canadian Journal of Nursing Administration*, *10*(2), 14-39.

Hassard, J., Teoh, K. R., Visockaite, G., Dewe, P., & Cox, T. (2018). The cost of work-related stress to society: A systematic review. *Journal of Occupational Health Psychology, 23*(1), 1-49.

Haynes, K. (2012). Reflexivity in qualitative research. *Qualitative organizational research: Core methods and current challenges*, 72-89.

Haynos, A. F., Fruzzetti, A. E., Anderson, C., Briggs, D., & Walenta, J. (2016). Effects of dialectical behavior therapy skills training on outcomes for mental health

staff in a child and adolescent residential setting. *Journal of hospital administration*, *5*(2), 55-61.

Health and Care Professions Council. (2016). *Guidance on conduct and ethics for students*. HCPC.

Health and Safety Executive. (2017). Work-related stress, depression or anxiety statistics in Great Britain 2017.

Hefferon, K., & Gil-Rodriguez, E. (2011). Interpretative phenomenological analysis. *The Psychologist*, *24*(10), 756–759.

Heidegger, M. (1999). *Ontology: The hermeneutics of facticity.* Indiana University Press.

Ho, K. H., Chiang, V. C., & Leung, D. (2017). Hermeneutic phenomenological analysis: the 'possibility' beyond 'actuality' in thematic analysis. *Journal of advanced nursing*, *73*(7), 1757-1766.

Holland, D. (2013). *Integrating knowledge through interdisciplinary research: Problems of theory and practice*. London: Routledge.

Home Office and Department of Health (1999). *Managing dangerous people with severe personality disorder: Proposals for consultation*. London: Home Office

Horgan, H., Charteris, C., & Ambrose, D. (2019). The Violence Reduction Programme: An exploration of posttreatment risk reduction in a specialist medium-secure unit. *Criminal behaviour and mental health*, *29*(5-6), 286-295.

Husserl, E. (1954). *The crisis of European sciences and transcendental phenomenology* (D. Carr, Trans.). Evanston, IL: Northwestern University Press. (Original work published 1939)

Husserl, E. (1999). *The essential Husserl: Basic writings in transcendental phenomenology* Indiana University Press.

Iliceto, P., Pompili, M., Spencer-Thomas, S., Ferracuti, S., Erbuto, D., Lester, D., ... & Girardi, P. (2013). Occupational stress and psychopathology in health professionals: an explorative study with the multiple indicators multiple causes (MIMIC) model approach. *Stress*, *16*(2), 143-152.

Illovsky, M. E. (2013). *Mental Health Professionals Minorities and the Poor*. London: Routledge.

Jacob, J. D. (2012). The rhetoric of therapy in forensic psychiatric nursing. *Journal of Forensic Nursing*, *8*(4), 178-187.

Jacob, J. D., & Holmes, D. (2011). Working under threat: Fear and nurse–patient interactions in a forensic psychiatric setting. *Journal of Forensic Nursing, 7*(2), 68-77.

Jacobowitz, W. (2013). PTSD in psychiatric nurses and other mental health providers: a review of the literature. *Issues in Mental Health Nursing*, *34*(11), 787-795.

Johnson, S. A. (2019). Understanding the violent personality: Antisocial personality disorder, psychopathy, & sociopathy explored. *Forensic Research & Criminology International Journal*, *7*(2), 76-88.

Jones Nielsen, J. D., & Nicholas, H. (2016). Counselling psychology in the United Kingdom. *Counselling Psychology Quarterly*, *29*(2), 206-215.

Joseph, N., & Benefield, N. (2012). A joint offender personality disorder pathway strategy: An outline summary. *Criminal Behaviour and Mental Health*, 22, 210–217.

Kane, P. P. (2009). Stress causing psychosomatic illness among nurses. *Indian Journal of occupational and environmental medicine*, *13*(1), 28-32.

Kaufman, S. B. (2020). Transcend: The new science of self-actualization. New York, NY: JP Tarcher US/Perigee Bks.

Kavka, J. (1949). Pinel's Conception of the Psychopathic State: An Historical Critique. *Bulletin of the History of Medicine*, *23*(5), 461-468.

Keats, P. A. (2010). Soldiers working internationally: Impacts of masculinity, military culture, and operational stress on cross-cultural adaptation. *International Journal for the Advancement of Counselling*, *32*(4), 290-303.

Kellermann, N. P. (2001). Transmission of Holocaust trauma-An integrative view. *Psychiatry: Interpersonal and Biological Processes*, *64*(3), 256-267.

Kennedy, H. G. (2002). Therapeutic uses of security: mapping forensic mental health services by stratifying risk. *Advances in Psychiatric Treatment*, *8*(6), 433-443.

Kim, S. R., Kim, H. Y., & Kang, J. H. (2014). Effects of type D personality on compassion fatigue, burnout, compassion satisfaction, and job stress in clinical nurses. *Journal of Korean Academy of Nursing Administration*, *20*(3), 272-280.

Kingston, J., Lassman, F., Matias, C., & Ellett, L. (2019). Mindfulness and Paranoia: A Cross-Sectional, Longitudinal and Experimental Analysis. *Mindfulness*, *10*(10), 2038-2045.

Kline, R., & Lewis, D. (2019). The price of fear: estimating the financial cost of bullying and harassment to the NHS in England. *Public Money & Management*, *39*(3), 166-174.

Koocher, G. P., & Keith-Spiegel, P. (2008). *Ethics in psychology and the mental health professions: Standards and cases.* Oxford: Oxford University Press.

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology, 3*(2), 102-120.

Larsson, P., Brooks, O., & Loewenthal, D. (2012). Counselling psychology and diagnostic categories: A critical literature review. *Counselling Psychology Review*, *27*(3), 55-67.

Laverty, S. M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods, 2*(3), 21-35.

Levinas, E. (1969). *Totality and Infinity: An Essay on Exteriority* (A. Lingis, Trans.). Pittsburgh, PA: Duquesne University Press

Levin, A. P., & Greisberg, S. (2003). Vicarious trauma in attorneys. Pace L. Rev., 24, 245-252.

Liddiard, K., Sullivan, J., & Chadwick, A. (2017). Nurses' views on reflective practice sessions in a medium secure unit. *Mental Health Practice*, *20*(10), 19-24.

Lincoln, Y. S., Lynham, S. A., & Guba, E. G. (2011). Paradigmatic controversies, contradictions, and emerging confluences, revisited. The Sage handbook of qualitative research, 4, 97-128.

Lipke, H. (1995). Eye movement desensitization and reprocessing (EMDR): A quantitative study of clinician impressions of effects and training requirements. *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures*, 376-386.

Lloyd, C., King, R., & Chenoweth, L. (2002). Social work, stress and burnout: A review. *Journal of Mental Health, 11*(3), 255-265.

Maguire, M., & Delahunt, B. (2017). Doing a thematic analysis: A practical, step-by-step guide for learning and teaching scholars. *AISHE-J: The all-Ireland Journal of Teaching and Learning in Higher Education, 9*(3), 3351-3364.

Maslach, C., Jackson, S. E., & Leiter, M. P. (1996). *MBI: Maslach burnout inventory* CPP, Incorporated Sunnyvale (CA).

Maslach, C., Jackson, S. E., Leiter, M. P., Schaufeli, W. B., & Schwab, R. L. (1986). *Maslach burnout inventory*. Palo Alto, CA.

Mason, T. (2002). Forensic psychiatric nursing: A literature review and thematic analysis of role tensions. *Journal of Psychiatric and Mental Health Nursing, 9*(5), 511-520.

Maxwell, J. A. (2012). *A realist approach for qualitative research* London: Sage.

McLeod, J. (2011). *Qualitative research in counselling and psychotherapy*. London: Sage.

McVicar, A. (2003). Workplace stress in nursing: A literature review. *Journal of Advanced Nursing, 44*(6), 633-642.

Mealer, M., & Jones, J. (2013). Posttraumatic stress disorder in the nursing population: a concept analysis. In *Nursing forum*, 48(4), 279-288).

Meier, L. L., & Cho, E. (2018). Work stressors and partner social undermining: Comparing negative affect and psychological detachment as mechanisms. *Journal of Occupational Health Psychology,* 24(3), 359–372.

Mercer, D., & Perkins, E. (2018). Sex, gender and the carceral: Female staff experiences of working in forensic care with sexual offenders. *International journal of law and psychiatry*, *59*, 38-43.

Mezey, G., Hassell, Y., & Bartlett, A. (2005). Safety of women in mixed-sex and single-sex medium secure units: staff and patient perceptions. *The British Journal of Psychiatry*, *187*(6), 579-582.

Mingers, J., Mutch, A., & Willcocks, L. (2013). Critical realism in information systems research. *MIS quarterly*, *37*(3), 795-802.

Minoudis, P., Shaw, J., & Craissati, J. (2012). The London Pathways Project: Evaluating the effectiveness of a consultation model for personality disordered offenders. *Criminal Behaviour and Mental Health*, 22(3), 157–232.

Moran, D., & Husserl, E. (2005). Founder of phenomenology. *Cambridge: Polity*.

Morse, J. M., Anderson, G., Bottorff, J. L., Yonge, O., O'Brien, B., Solberg, S. M., & McIlveen, K. H. (1992). Exploring empathy: a conceptual fit for nursing practice?. *Image: The journal of nursing scholarship*, *24*(4), 273-280.

Motta, R. (2020). Secondary trauma in children and school personnel. In *Addressing Multicultural Needs in School Guidance and Counseling* (pp. 65-81). IGI Global.

Nathan, R., Brown, A., Redhead, K., Holt, G., & Hill, J. (2007). Staff responses to the therapeutic environment: A prospective study comparing burnout among nurses working on male and female wards in a medium secure unit. *The Journal of Forensic Psychiatry & Psychology*, *18*(3), 342-352.

National Health Service (2016). *HRA Approval: Assessment Criteria and Standards Document.* Retrieved from https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&cad=rja&uact=8&ved=2ahUKEwiU96DP8bThAhXbVBUIHSSEA_gQFjABegQIBRAC&url=https%3A%2F%2Fwww.hra.nhs.uk%2Fdocuments%2F217%2Fhra-approval-assessment-criteria-standards-document.pdf&usg=AOvVaw0MFa5L1ZjdUAI6v2ApCTeK (accessed 4 May 2020).

Neff, L. A., & Karney, B. R. (2004). How does context affect intimate relationships? Linking external stress and cognitive processes within marriage. *Personality and Social Psychology Bulletin*, *30*(2), 134-148.

Newell, J. M., & MacNeil, G. A. (2010). Professional burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue. *Best Practices in Mental Health*, *6*(2), 57-68.

Nolan, B. (1995). Sleep events among veterans with combat-related posttraumatic stress disorder. *American Journal of Psychiatry*, 52(1), 110-115.

O'Connor, K., Neff, D. M., & Pitman, S. (2018). Burnout in mental health professionals: A systematic review and meta-analysis of prevalence and determinants. *European Psychiatry*, *53*, 74-99.

Ogińska-Bulik, N. (2006). Occupational stress and its consequences in healthcare professionals: the role of type D personality. *International Journal of Occupational Medicine and Environmental Health*, *19*(2), 113-122.

Oliver, C. (2012). Critical realist grounded theory: A new approach for social work research. *British Journal of Social Work*, *42*(2), 371-387.

Olszewski, T. M., & Varrasse, J. F. (2005). The Neurobiology of PTSD: implication for nurses. *Journal of psychosocial nursing and mental health services*, *43*(6), 40-47.

Onweugbuzie, A. J. (2002). Why can't we all get along? towards a framework for unifying research paradigms. *Education, 122*(3), 518-531.

Overgaard, S. (2003). Heidegger's early critique of Husserl. *International Journal of Philosophical Studies: IJPS, 11*(2), 157-175.

Palmqvist, O. (2016). *Towards Empowerment: Narrative Study of Counselling Psychology Trainees and How They Make Sense of Their Personal and Professional Development in the Context of Their Past Experiences* (Doctoral dissertation, University of East London).

Paris, M., & Hoge, M. A. (2010). Burnout in the mental health workforce: A review. *The journal of behavioral health services & research*, *37*(4), 519-528.

Pearlman, L. A., & Saakvitne, K. W. (1995). Treating therapists with vicarious traumatization and secondary traumatic stress disorders. *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*, *23*, 150-177.

Peat, G., Rodriguez, A., & Smith, J. (2019). Interpretive phenomenological analysis applied to healthcare research. *British Medical Journal,* 22(1), 7-9.

Penny, C., & Exworthy, T. (2015). Human rights in secure psychiatric care. *Handbook of secure care. London: RCPsych Publications*, 269.

Polkinghorne, D. E. (2005). Language and meaning: Data collection in qualitative research. *Journal of Counseling Psychology, 52*(2), 137–145.

Pritchard, D. (2010). Epistemic relativism, epistemic incommensurability and Wittgensteinian epistemology. *S. Hales, Blackwell Companion to Relativism*, 266-285.

Reed J. The development of forensic psychiatric services. In: Clark T, Rooprai DS, editors. *Practical forensic psychiatry.* London: Hodder Arnold; 2011. 3–4.

Reynolds, W. J., & Scott, B. (2000). Do nurses and other professional helpers normally display much empathy? *Journal of advanced nursing*, *31*(1), 226-234.

Roberts, J. M. (2014). Critical realism, dialectics, and qualitative research methods. *Journal for the Theory of Social Behaviour*, *44*(1), 1-23.

Romaine, C. L., & Kavanaugh, A. (2019). Risks, benefits, and complexities: Reporting race & ethnicity in forensic mental health reports. *International Journal of Forensic Mental Health*, *18*(2), 138-152.

Rössler, W. (2012). Stress, burnout, and job dissatisfaction in mental health workers. *European Archives of Psychiatry and Clinical Neuroscience, 262*(2), 65-69.

Ryan, F., Coughlan, M., & Cronin, P. (2009). Interviewing in qualitative research: The one-to-one interview. *International Journal of Therapy and Rehabilitation, 16*(6), 309-314. doi:10.12968/ijtr.2009.16.6.42433

Sabin-Farrell, R., & Turpin, G. (2003). Vicarious traumatization: implications for the mental health of health workers? *Clinical psychology review*, *23*(3), 449-480.

Ruiz, P. (2000). *Comprehensive textbook of psychiatry* (Vol. 1, pp. 938-950). B. J. Sadock, & V. A. Sadock (Eds.). Philadelphia, PA: Lippincott Williams & Wilkins.

Saverimuttu, A., & Lowe, T. (2000). Aggressive incidents on a psychiatric intensive care unit. *Nursing Standard (through 2013)*, *14*(35), 33-39.

Schulz, K. F., & Grimes, D. A. (2005). Sample size calculations in randomised trials: Mandatory and mystical. *The Lancet, 365*(9467), 1348-1353.

Seebohm, T. M. (2007). *Hermeneutics. method and methodology.* Springer Science & Business Media.

Seppänen, A., Törmänen, I., Shaw, C., & Kennedy, H. (2018). Modern forensic psychiatric hospital design: clinical, legal and structural aspects. *International journal of mental health systems*, *12*(58), 1-12.

Sgier, L. (2012). Qualitative data analysis. *An Initiat.Gebert Ruf Stift,* 19-21.

Skodol, A. E., Bender, D. S., Morey, L. C., Clark, L. A., Oldham, J. M., Alarcon, R. D., & Siever, L. J. (2011). Personality disorder types proposed for DSM-5. *Journal of personality disorders*, *25*(2), 136-169.

Smith, J. A., & Osborn, M. (2004). Interpretative phenomenological analysis. *Doing Social Psychology Research*,1(1), 39-54.

Smith, J. A., & Osborn, M. (2007). Pain as an assault on the self: An interpretative phenomenological analysis of the psychological impact of chronic benign low back pain. *Psychology and Health, 22*(5), 517-534.

Smith, J. (2009). A., Flowers, P., & Larkin, M. (2009) Interpretative Phenomenological Analysis. Theory, Method and Research. *Qualitative Research in Psychology*, *6*(4), 346-347.

Smith, P. (2011). *The emotional labour of nursing revisited: Can nurses still care?*. Macmillan International Higher Education.

Solovieva, N. (2015). *A mixed method Delphi study to determine professional consensus on the key elements of outpatient Psychodynamic Group Psychotherapy (PGP) for psychosis* (Doctoral dissertation, University of Essex). Retrieved from

Speer, S. A. (2000). Let us get real? feminism, constructionism and the realism/relativism debate. *Feminism & Psychology, 10*(4), 519-530.

Sprang, G., Clark, J. J., & Whitt-Woosley, A. (2007). Compassion fatigue, compassion satisfaction, and burnout: Factors impacting a professional's quality of life. *Journal of Loss and Trauma, 12*(3), 259-280.

Steffen, E., Vossler, A., & Stephen, J. (2015). From shared roots to fruitful collaboration: How counselling psychology can benefit from (re) connecting with positive psychology. *Counselling Psychology Review*, *30*(3), 1-11.

Strawbridge, S., & Woolfe, R. (2010). Counselling psychology: Origins, developments and challenges. *Handbook of counselling psychology*, *3*, 3-22.

Taylor, B., & Barling, J. (2004). Identifying sources and effects of carer fatigue and burnout for mental health nurses: A qualitative approach. *International Journal of Mental Health Nursing, 13*(2), 117-125.

Tedeschi, R. G., & Calhoun, L. G. (1995). *Trauma and transformation*. London: Sage.

Tighe, J., & Gudjonsson, G. H. (2012). See, Think, Act Scale: preliminary development and validation of a measure of relational security in medium-and low-secure units. *The Journal of Forensic Psychiatry & Psychology*, *23*(2), 184-199.

Trebilcock, J., Jarrett, M., Weaver, T., Campbell, C., Forrester, A., Walker, J., & Moran, P. (2019). A more promising architecture? Commissioners' perspectives on the reconfiguration of personality disorder services under the Offender Personality Disorder (OPD) pathway. *Mental Health Review Journal*.

Treloar, C., Champness, S., Simpson, P. L., & Higginbotham, N. (2000). Critical appraisal checklist for qualitative research studies. The Indian Journal of Paediatrics, 67(5), 347-351.

Tuffor, I. (2017). A critical overview of interpretative phenomenological analysis: a contemporary qualitative research approach. *Journal of Healthcare Communications*, *2*(4), 52.

Turpin, G., Barley, V., Beail, N., Seaire, J., Slade, P., Smith, J. A., & Walsh, S. (1997). Standards for research projects and theses involving qualitative methods: Suggested guidelines for trainees and courses. Paper presented at the *Clinical Psychology Forum,* 3-7.

Turpin, G. (2009). The future world of psychological therapies: Implications for counselling and clinical psychologists. *Counselling Psychology Review, 24*(1), 23-33.

Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing & Health Sciences, 15*(3), 398-405.

Van Niekerk, W. J. (2005). No title. *Emotional Experiences of Incestuous Fathers: A Social Constructionist Investigation.*

Wahyuni, D. (2012). The research design maze: Understanding paradigms, cases, methods and methodologies. *Journal of applied management accounting research*, *10*(1), 69-80.

Walsh, R. (2003). The methods of reflexivity. *The Humanistic Psychologist, 31*(4), 51-66.

Watson, I. R. (2017). *Eastern and Western learning theories in transnational higher education: An interpretive phenomenological analysis case study of a Malaysian college* (Doctoral dissertation, Northumbria University).

Weaver, K., & Olson, J. K. (2006). Understanding paradigms used for nursing research. *Journal of Advanced Nursing, 53*(4), 459-469.

Webster, N., Doggett, L., & Gardner, S. (2020). If you want to change the world you have to start with yourself: The impact of staff reflective practice within the Offender Personality Disorder pathway. *Probation Journal*, *67*(3), 283-296.

Willig, C. (2013). Introducing qualitative research in psychology. McGraw-Hill Education (UK).

Willig, C. (2017). Interpretation in qualitative research. The SAGE Handbook of Qualitative Research in Psychology, UK.

Willig, C., & Billin, A. (2012). Existentialist-informed hermeneutic phenomenology. *Qualitative research methods in mental health and psychotherapy*, 1(9), 117-130.

Wilson, S., Guliani, H., & Boichev, G. (2016). On the economics of posttraumatic stress disorder among first responders in Canada. *Journal of Community Safety and Well-Being*, *1*(2), 26-31.

Wilson, S., Stroud, C. B., & Durbin, C. E. (2017). Interpersonal dysfunction in personality disorders: A meta-analytic review. *Psychological Bulletin*, *143*(7), 677-734.

Wong, P. T. (2012). From logotherapy to meaning-centered counselling and therapy. *The Human Quest for Meaning: Theories, Research, and Applications, 2*, 619-64.

Yardley, A. (2008). Piecing together-A methodological bricolage. *Forum: Qualitative Social Research, 9*(2), 1-11.

Yardley, L. (2008). Demonstrating validity in qualitative psychology. *Qualitative Psychology: A Practical Guide to Research Methods, 2*, 235-251.

Yousefzadeh, P., & Ebrahimi, A. (2020). The Effectiveness of Self-Differentiation Training on Cognitive Emotion Regulation and Psychosomatic Symptoms of Nurses. *International Journal of Body, Mind and Culture*.

Yucel, R. (2018). Scientists' Ontological and Epistemological Views about Science from the Perspective of Critical Realism. *Science & Education*, *27*(5-6), 407-433.

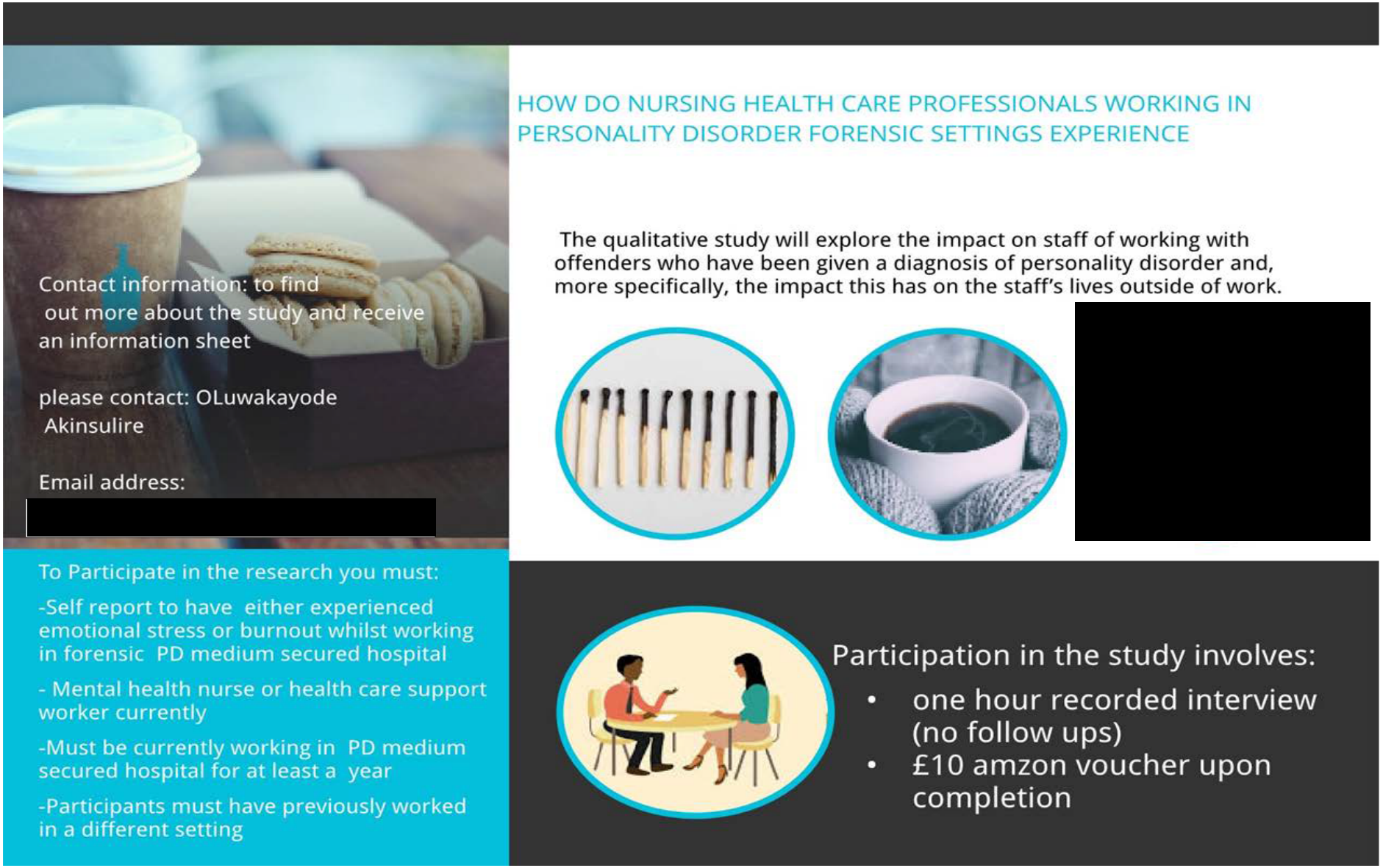
Appendices

APPENDIX A: Interview Schedule

- How long have you worked in a forensic unit for?
- What are your understanding of burnout and emotional stress?
- What are your experience of burnout and emotional stress in regards to the patients you currently work with?

- How different is your experience to your previous jobs regarding stress and burnout?
- Is the emotional stress and burnout in the forensic unit different from what you have experienced outside of work? If yes do you have an idea why?
- What changes have you noticed outside of work (external)? How do you feel about these changes?
- How has it impacted your relationship with your family?
- How has it impacted your relationship with others?
- What is the most significant change you observed in yourself outside of work (internal)?
- How would people describe you since you started working in on the ward?
- What do you do for self-care outside of work?
- How do you feel about your work? In regards to the crimes the clients have committed
- How do you feel about working with your clients?
- What support can the staff receive?
- How do you feel about your colleagues leaving the job? Is this frequent?
- How do you think you are perceived by people who know you work in a forensic personality disorder unit?
- What do you think about this process overall?

APPENDIX B: Recruitment Flyer



APPENDIX C: Participant Information Sheet

IRAS number: 256543

Date: 02/01/2019

Version number: 2

PARTICIPANT INFORMATION SHEET

Title of study: How do nursing health care professionals working in Personality disorder forensic settings experience emotional stress and burnout.

Name of principal investigator: Akinsulire Oluwakayode; **supervisor:** Jacqui Farrants

We would like to invite you to take part in a research study. Before you decide whether 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. Please take your time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

The following study is undertaken as a part of an educational program in counselling psychology. The aim of the study is to explore how burnouts and emotional stress affects nurses and a health care assistant in their personal life. It is has been researched that the level of emotional strain experienced in forensic settings has a unique effect on health care professionals in this field. Past studies have shown the impact this might have in the workplace (Staff shortage, staff falling ill, conflicts and poor empathic response towards patients) however very little has been researched on how this affects the personal life of Nurses and health care assistants who spend a significant time alongside clients with extensive criminal History and current challenging behaviour. The implications of this phenomenon find ground for research as it would aid counselling psychology to understand the impact and possible support that can be provided for this subset being studied.

Why have I been invited?

You have been invited to give your unique perspective on your experience of working in a medium secure forensic unit. As you would have spent a significant amount of time working alongside patients in this setting you have a unique experience to share through the following interview and study. The inclusion criteria are as follows:

- Participants must self-report to have experienced either emotional stress or burnout whilst working in the forensic medium secure hospital.

- Participants must be a Mental Health Nurse or a Forensic Health Care Assistant working in a Forensic Medium Secure Hospital.
- Participants must have worked in a Forensic Medium secure Hospital for at least a year.
- Participants must have previously worked in a Non-Forensic Mental Health Setting for at least a year.

Do I have to take part?

Participation is voluntary at every stage of the interview. The participant can withdraw at any stage or avoid answering any question that they do not feel comfortable with as they might find it intrusive or too personal to answer. You can withdraw at any stage of the project without being penalised or disadvantaged in any way.

It is up to you to decide whether to take part. If you do decide to take part, the participant will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason, however*, once the data has been anonymised and analysed participants will no longer be able to withdraw their data.*

What will happen if I take part?

Once consent is being given, the participant will be interviewed, and audio recorded for approximately 60 minutes in one sitting. The research study will last two years in order to give time to gather data, analyse and write up the findings. Participants will meet researcher once, on the day of the interview after the participant has been informed of the study and has agreed to participate. The participant will complete a short questionnaire before the audio interview takes place. The research method that will be adopted is a form of qualitative research namely Interpretative phenomenological Analysis where the research will try and identify a reoccurring pattern that can give a better understanding of the phenomenon being studied. The research will take place in the hospital.

Expenses and Payments (if applicable, delete otherwise)

An Amazon voucher of £10 pounds will be given upon completion as a token of the participant's time.

What do I have to do?

Please answer the questions in the questionnaire and interview. There are no other commitments or lifestyle restrictions associated with participating.

What are the possible disadvantages and risks of taking part?

Participating in the research is not anticipated to cause you any disadvantages or discomfort. The potential physical and/or psychological harm or distress will be the same as any experienced in everyday life.

What are the possible benefits of taking part?

Whilst there are no immediate benefits for those people participating in the project, it is hoped that this work will have a beneficial impact on how Health care professionals are supported in this ambit of work. Results will be shared with participants in order to inform their professional work.

What will happen when the research study stops?

Should the research stop earlier than planned and you are affected in any way we will tell you and explain why. Any gathered data at this point will be destroyed following the data protection laws.

Will my taking part in the study be kept confidential?

City, University of London will keep your name, and contact details confidential and will not pass this information to any other organisation. City, University of London will use this information as needed, to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. Certain individuals from City, University of London and regulatory organisations may look at the research records to check the accuracy of the research study. City, University of London will only receive information without any identifying information. The people who analyse the information will not be able to identify you and will not be able to find out your name or contact details.

City, University of London will keep identifiable information about you from this study for 10 years after the study has finished.

All the information that the researcher will collect about you during the research will be kept strictly confidential. The participants will not be identifiable in any reports or publications. Your institution will also not be identifiable. Data collected may be shared in an anonymised form to allow reuse by the research team and other third parties. These anonymised data will

not allow any individuals or their institutions to be identifiable. The audio recording and data gathered will solely be accessed by me and my supervisor if need be.

Information obtained in the course of a research project would be considered privileged information and should under no circumstances be publicly disclosed in a fashion that would identify any individual or organisation. However, Exceptions to this duty of confidentiality occur where there is a disclosure of the information made 'in the public interest'.

The transcription and any other research data will be kept in a password protected computer only known and accessible to the chief investigator. The data will only be available to the Chief investigator at all times.

The records of the study will be kept securely in an encrypted device and safely destroyed after 10 years following the statutory requirement at City University of London under the data protection act 2018.

What should I do if I want to take part?

If you decide to take part in the following study a consent form will be obtained, and the data will be gathered as described above.

What will happen to the results of the research study?

Results of the research will be published. The participant will not be identified in any report or publication. Your institution will not be identified in any report or publication. If you wish to be given a copy of any reports resulting from the research, please ask us to put you on our circulation list.

What will happen if I do not want to carry on with the study?

If you withdraw from the study all the information and data collected from you, to date, will be destroyed and your name removed from all the study files. The participant does not incur any penalty for withdrawing at any point.

.

Who has reviewed the study?

This study has been approved by the City, University of London, the Department of Psychology and Research Ethics Committee and the

Further information and contact details.

Researcher: OluwakayodeAkinsulire, City University of London, Email: [redacted]

Supervisor: Dr Jacqui Farrants, Consultant Psychologist, City, University of London, Northampton Square London, EC1V 0HB, United Kingdom. [redacted]

Data Protection Privacy Notice:

City, University of London is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. City, University of London will keep identifiable information about you for 10 years after the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information dataprotection@city.ac.uk.

City, University of London is the data controller for the personal data collected for this research project. Your personal data will be processed for the purposes outlined in this notice. The legal basis for processing your personal data will be that this research is a task in the public interest, that is City, University of London considers the lawful basis for processing personal data to fall under Article 6(1)(e) of GDPR (public task) as the processing of research participant data is necessary for learning and teaching purposes and all research with human participants by staff and students has to be scrutinised and approved by one of City's Research Ethics Committees.

What if I have concerns about how my personal data will be used after I have participated in the research?

As a university, we use personally identifiable information to conduct research to improve health, care and services. As a publicly-funded organisation, we have to ensure that it is in the public interest when we use personally-identifiable information from people who have agreed to take part in research. This means that when you agree to take part in a research study, we will use your data in the ways needed to conduct and analyse the research study. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

Health and care research should serve the public interest, which means that we have to demonstrate that our research serves the interests of society as a whole. We do this by following the UK Policy Framework for Health and Social Care Research.

If you wish to raise a complaint on how we have handled your personal data, you can contact our Data Protection Officer who will investigate the matter. If you are not satisfied with our response or believe we are processing your personal data in a way that is not lawful you can complain to the Information Commissioner's Office (ICO).

Our Data Protection Officer [redacted] and you can contact them at dataprotection@city.ac.uk**.**

What if there is a problem?

If the research is undertaken in the UK if you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through City's complaints procedure. To complain about the study, you need to phone [redacted] You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: Impact of emotional stress and burn out on Forensic Nursing Healthcare Professionals' personal lives.

You could also write to the Secretary at:

[redacted]
Research Integrity Manager

Research & Enterprise
City, University of London
Northampton Square
London
EC1V 0HB

[redacted]

City holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study, you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Thank you for taking the time to read this information sheet.

APPENDIX D: Consent Form

IRAS number: 256543

Date: 02/01/2019

Version number: 2

Title of Study: *How do nursing health care professionals working in Personality Disorder forensic settings experience emotional stress and burnout.*

Please initial box

1	I confirm that I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records.	
	I understand this will involve:	
	• being interviewed by the researcher	
	• allow the interview to be audiotaped.	
	• Complete interview asking me about the impact of burnout and stress in participants.	

2	This information will be held by City as the data controller and processed for the following purpose(s): *lawful basis for processing under General Data Protection Regulation (GDPR) for personal data.* Public Task: The legal basis for processing your personal data will be that this research is a task in the public interest, that is City, University of London considers the lawful basis for processing personal data to fall under Article 6(1)(e) of GDPR (public task) as the processing of research participant data is necessary for learning and teaching purposes and all research with human participants by staff and students has to be scrutinised and approved by one of City's Research Ethics Committees.	
4	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way.	
5	I agree to City recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on City complying with its duties and obligations under the General Data Protection Regulation (GDPR).	
6.	I agree to the arrangements for data storage, archiving, sharing.	
7	I would like to be sent the summary of the outcomes and findings after the study has been completed.	
8	I agree with the use of anonymised quotes in publication.	
9	I agree to take part in the above study.	

_____	_____	_____
Name of Participant	Signature	Date
_____	_____	_____
Name of Researcher	Signature	Date

When completed, 1 copy for the participant: 1 copy for researcher file.

APPENDIX E: Research Debrief Information

Impact of emotional stress and burn out on Forensic Nursing Healthcare Professionals' personal lives.

The aim of the study is to explore how to burnouts and emotional stress affects nurses and a health care assistant in their personal life. It is has been researched that the level of emotional strain experienced in the forensic setting has a unique effect on health care professionals in this field. As it has been shown extensively the impact this might have in the workplace (Staff shortage, staff falling ill, conflicts and poor empathic response towards patients) very little has been researched on how this affects the personal life of Nurses and health care assistant who spend a significant time alongside clients with extensive criminal History and current challenging behaviour. The implications of this phenomenon find ground for research as it would aid counselling psychology to understand the impact and possible support that can be provided for this sub-set being studied.

The research aims to answer the following question: How and in what areas are the personal lives of Nursing Health Care professionals (NHCPs) affected by the emotional stress and burnouts? The question was informed by the literature gathered below, the available material covering the topic of emotional stress and burnout in forensic hospitals. The term NHCP, adopted in this thesis, refers to roles where workers are required to spend a significant amount of time with patients on a daily basis. This is supported by the available research which categorises the two main roles those require long periods of contact with patients as being the Mental Health Nurses and Health Care Assistants.

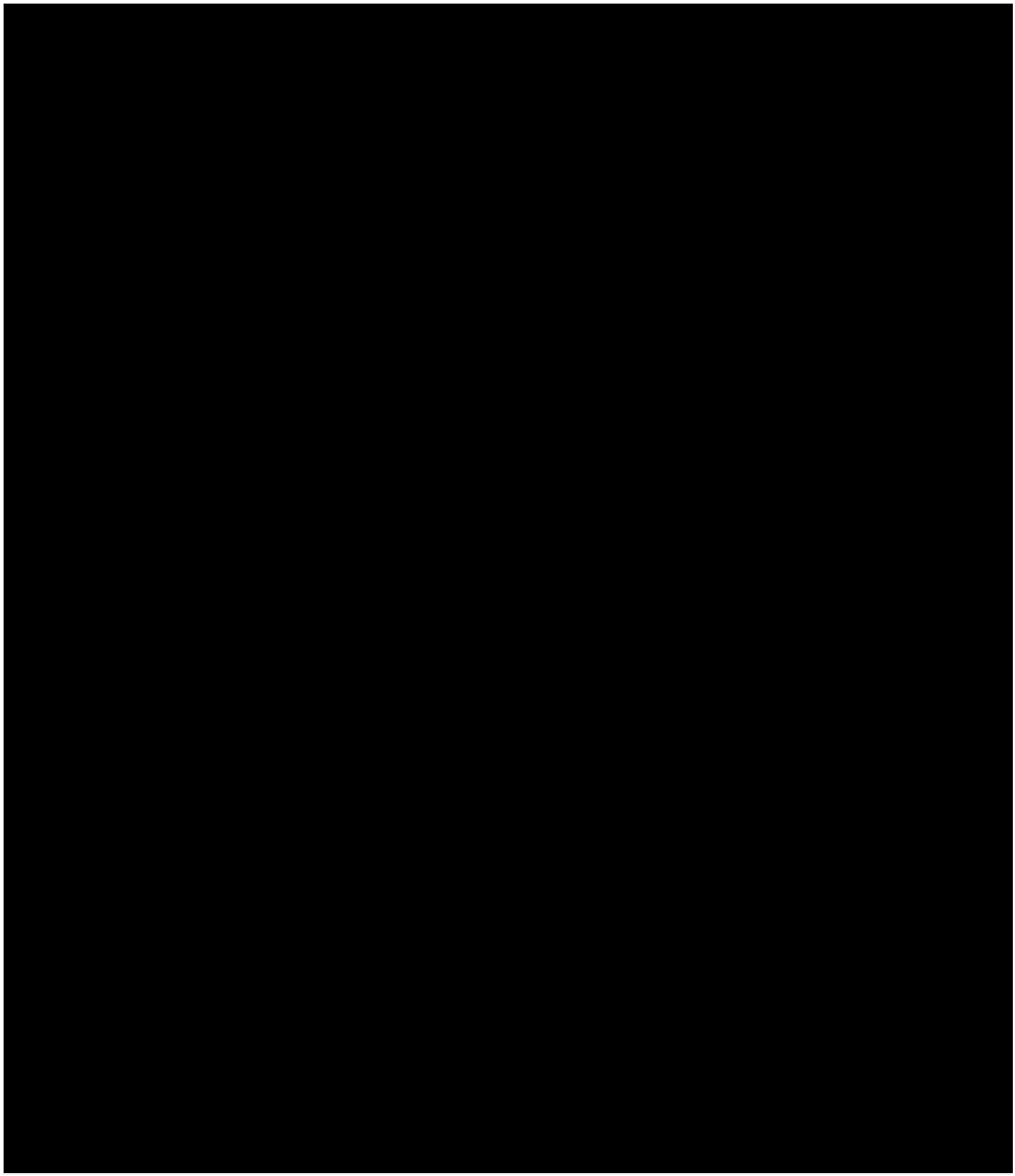
The analysis is carried through a semi-structured IPA. The interview would typically last approximately 60 minutes. 12 individuals working in a medium secure hospital will be recruited for the study.

Thank you for your time.

suggested relevant up to date reading can be found with the following articles:

- *Eliacin, J., Flanagan, M., Monroe-DeVita, M., Wasmuth, S., Salyers, M. P., & Rollins, A. L. (2018). Social capital and burnout among mental healthcare providers. Journal of Mental Health, 1-7.*
- *O'Connor, K., Muller Neff, D., & Pitman, S. (2018). Burnout in mental health professionals: A systematic review and meta-analysis of prevalence and determinants//doi.org/10.1016/j.eurpsy.2018.06.003 Retrieved from http://www.sciencedirect.com/science/article/pii/S0924933818301275*

APPENDIX F: Transcript example (line by line coding)



APPENDIX G: Table listing the emerging themes.

Emergent themes	Transcripts line	Explanatory comments of the emergent themes
“winter jacket.” (protection)	Line 413-415, 425, 426-428, 432, 433, 501, 556, 570, 627, A52, A56, A68, A87, B7, B126, B136, B138, B156, B158, E150, E401, E459, E470, E528, F108, F339	The use of the imaginary water dripping winter jacket is a metaphor used by one of the interviewee to indicate that there is a need to use a winter jacket in a PD forensic unit as a form of protection from stressful nature of the environment and work. This is an element sustained with other participant who describes the difficult nature of compartmentalising work. For example, In line 414 there is an indication that the stress can often be so pervasive to cause the winter jacket to “be dripping of water”. Later on the interviewee refers back to the winter jacket and emphasises on the importance to leave this jacket somewhere away from his family as this could impact his microsystem negatively. As he describes in line 416 the winter jacket belongs to the unit he works in, it is not his possession. in line 413 bringing the “dripping winter jacket “to the doorstep of his house appears to be an attempt to describe the pervasive element of the job, however in line 416 the interviewee changes the narrative where he states that he leaves the jacket at work, this might indicate the struggle encountered in succeeding with separating his work from his family. The repetition and mannerism of how the words ***“you don’t take it”*** (referring to the difficulties from work) would suggest that there is an internal struggle, perhaps a difficulty at succeeding at the task of compartmentalising that is has been experienced by the participants. Uses the word equip in line 501, 556 and 627 in a manner that there is something to protect the self and others from. Also used as a metaphor of armouring self against a war.
Impact on microsystem	50, 51, 285, 426, 356-359, 361, 413-416, 450, 451,	This emergent theme describes how the participants have experienced and observed the direct impacts of the job on their intimate relations. Some Participants describe how negative emotions can be transferred to ***“the microsystem”*** **(426)**

	460, 461, B128, B132, B154, C53, E201, E204, E206, E208, E215, E216, E222, E226, E230, E244, E245, **E247, E248,** E255, E279, E570, F68, F244, F272	experiencing the world as more unpredictable and dangerous which has led to higher level of vigilance and sense of protection of close relatives (356-358) More so, the experience of family worrying about the mental and physical impact of the job in relation to risk for the participants. "**all sort of harms**" **(C53).** For example (**E247-248)** describes the impact of the job on his children: "**no child want to see that to their dad, no child wants to see that, it is difficult for them but I think with time that has healed".** It is particularly powerful the concept that the job creates harm to participant's children which they had to heal from
Denying self to feel	509, 513, 630, 672-674, B303, E06, E10, E42, E44	Line 630 indicates the need to ***"change your life"*** to work in the PD unit The strong sense that If you ***"shed off"*** your identity, you might avoid conflict. The notion that having an identity creates a problem (614).
Transferable behaviour/ Developing skills	334, 340, 346, 354, 361-365, 388, A65-66, B101, B177, B300, B305, B350, E163, E296485, 508, 510-513, 518, B177, B295, B300, B306, C28, E198, E201, E216, E231, E296, E378, F193, F218, F229, F238, F251, F254, F256, F258, F310	This concern noticeable behaviours developed whilst in the unit. This appear to be acquired behaviour used in their personal lives outside of work. For example, one of the interviewee has experienced to be more tolerant and accommodating of others outside of work as there is an emphasis on the chance that people in his personal life might not be ***"psychologically very normal"*** *(361). Another interviewee stated* ***"I think it changed me profoundly, I am naturally introvert, natural introvert, socially anxious" (A65).*** ***"you are better at picking up signals which normally you wouldn't picked up, yeah that's in different level , the tension maybe, the body language yeah I think there is something to it" (B177).*** The participants narrate of acquired positive changes that they have associated to working in the environment. There is an acknowledgement that experience a higher general sense of confidence, conflict resolution skills and assertiveness in their personal lives.
Unsafe outside world/ Self awareness	B103, B108, 361, 365, B110, B111, B115, B166, B168, B175, B180, B332, E363, E369, E371, F198, F205, F209, F286	This describes how participant have noticed how increasingly hypervigilant they have become of the outside world. Describing that since working in this environment the world is perceived as unsafe. The reflection from participants underline worry that this heightened state can feel like paranoia. For example E362 goes as far as to say "**but where is the line and what you define careful I think is probably sometimes I feel I think its just paranoia"**.

		“It is a change that raises concerns, always being aware” (F205)
Isolation	B168, E383, E385, E388, E398, F220, F283, F294	This is a theme where participants have described feeling that they have experienced feeling alone and seeking isolation **(“like going out doesn't excite me as much” E388; yea yea, I think that is one element where I do not enjoy, going out in a group as much E398)** in their personal lives as a result of the changes they have experienced since working in the FPD units.
changing viewing lens/ internal dialogue of reconstructing self - experience	142, 144-146, 148-149, 159, 163-165, 172-174, 180- 182, 351, 352, 354, A47, A124, E163, E165, E175, E342, E373, F390	The experience that the change of viewpoint can increase a sense of empathy, sympathy and insight towards the patients and increase work satisfaction. The use of a story/metaphor to describe how holding a different perspective can make you ***“lose grip of anger”*** towards the patients**.** (150-159)
Work as rewarding and Acknowledged by others	380, 388, 389, 391, 392, 563, 567, A15, A25, A27, A129, A164-165, B4, B105, B187, B185, B189, B307, B318, E181	This an experienced share by different participants where they describe the difficult nature of the job but at the same time they are able to express how rewarding the role can be at times, especially when this is acknowledged by other professionals in the mental health world The rewards go beyond money and profit (391), **“I enjoy work and I love my job” (A15); “its quite an elite place, special place to be and you know I am kind of proud about that” B187**
Self as impactful/powerful on others	78, 256, 306, 333, B185, C32, E169-170, E173, E178, E182	The experience that the role can often come with the perception that there is power exerted, and this has a significant impact on patients but also the society. The idea that rehabilitating forensic patients with personality disorder can make the society safer. **“somebody whose high risk and been able to manage and bring him down to a point where you are having a conversation” B182-183**
Self as knowledgeable/ coping manner/ insight	Line 48-49, 121-125, 308, 315, 328-330, 333-334, 341-343, 404, 490, B88	The interviewees expressed how important the role of knowledge is in coping with stressful nature of the environment. There is a particular importance given to role of insight as a skill used to manage the environment.

Self-soothe/ autonomous role in coping.	113, 415, 417, B78, B84, C5, C6, C10, C53, E44, E416, E457, E466, E507, E539, F53	Interviewees expresses how they had developed an independent role in dealing with stressors as a matter of necessity. But also an emphasis that stress and burnout are influenced by personal responses. For example in C10 **"then there is a stage where you have pushed yourself too much"** Referring to burnout. More importantly there is an emphasis on that in conjunction to the support available one has to be able to form his own skills to self-soothe in order to avoid constant burnouts. For example one of the participants describes how he has find it helpful writing on a reflective journal as a way to deal with constant aggression and hostility (E466)
Powerlessness on others perception/frame of mind	79, 80, 100, 103, 226, 233, 258-260, A107, A148	Describing the interviewees experience in relation to how he feels in relation to the patients and colleagues. They emphasise mostly on the powerlessness of working with rigid view points
PD unit as distorted/unpredictable, Chaotic	220, 225, 238, 239, 255, 258, 269, 317, 323, 471, 531-532, 534, 535, A32, A45, A49, A68, A139, B30, B35, B89, B229, B328, B344, B348, C71, E91, E108, E110	Interviewees share their experiences of how the PD environment is unique how often the conventional rules do not apply. **"you come to expect a different set of behaviour" (A45)**
Psychological ailment/ link to intelligence and capacity	250, 258, 268, 348-350, 472, A32, B30, A64, A76, A79, A135, B53, E139, F147, F176, F180	Participants explores how patients in this environment can use their intelligence as a means to exert control and how this becomes an internal conflict between personality disorder (mental illness) and intentionality. For example, F148-149 **"a lot of their behaviours…I feel like they know that is not acceptable in the general population."** The participant tried describing that the hostility and aggression shown by patients indicates the intentionality as these same patients would not conduct themselves in the society (general population) the same way for fear of more severe consequences. ***"the burnout rate I think its high in this ward than other wards in forensic, the guys are much demanding , the patients we work for are much more***

		challenging they are bright, they are articulate , they are highly hypercritical , they've got personality disorders" A31-32
Reflection/Regret	687-690, 10, 11, 12, 87, 94-95, 149, 257, 366, 654-656, 665, A52, B4, B16, B23, B48, B74, C14 B170, B298, B318, B358, C69, C86-87, E128, E263, E321, E533, F51, F242, F440, F446	Throughout the text, there was a tentativeness to express difficult experiences that seemed to stem from the participants novelty in reflecting on questions that were posed to them. The participants described how they had never really reflected on the impact of their job because no one had ever asked before and they had never paused to reflect on it themselves. During the interviews a common question started to surface where participants would ask themselves why they chose to work in such environment. For example, **E321 "I know they are going to be very scared (referring to his family members) because, who works with murderers?"**

Emergent Themes	**Original transcript (Line Numbers)**	**Explanatory comments of the emergent themes**
Emotional force/ negative impact, Fear	10, 40,41, 53, 237, A31, A48, A148, A87, A161, A166, A168, B12, C21, C46, C52, C69, E105, E168, F94, F137	This theme speaks of a negative impact of working in the FPD ward. This has been described by one of the participants as the ***"emotional pressure." (41)*** stress as exhausting taking energy or ***"hungry"*** (51) **"see someone on the floor cold (a patient who died)" C52**
behavioural consequences of stress/ Window of tolerance	21, 22, 26, 179, 191-192, 206-208, 230, 241, 283, 286, C11, E19, E163, E166	An emerging theme emphasising different stressors and how the participant explore how his whole system is been challenged. **C11 "but then there is a stage where you have pushed yourself too much out of your comfort zone and then it becomes a bit stressful".**

Breaking point/inability to cope/ Trauma	21-23, 25, 27, 28, 29, 44-45, 52, 53, 284-287, 449, A22, B338, C8, C52, E515	Showcases how the window of tolerance has been tested to its breaking point. ***"could not take the pressure anymore it snaps" (28)***
Shutting down/broken body	29-30, 33, 287, 288, 291, 292, C21, C23, C54, E403, E548, F117, F189	"***no, no, no, I can't take it anymore***" (287), where previous resources are no longer effective and the whole system shuts down. This sometimes can be in the form of call sick at work.
Shutting down as coping/ forms of coping/ absence of Motivation	53, 54, 55, 56, 414, 432, 433, C28, C38, C40, C58, C60, E12, F122, F125	The previous theme on shutting down was as a consequence of stress while this theme describes an informed decision to disconnect as a way to protect oneself. ***"time to shut-down to re-energise myself"* (53).** ***"I was just disconnected So that's my stepping back" (F128)***
The mechanical whole Body/ psychosomatic	Line 14, 18, 26, 27, 33, 115, 4492, 1, 22, 76, 174, 175, 179, 193, 198, 284, 328, 488, 624, 665-667, A9, A161, B19, C10, C31, C35, C39, C338, E55, F52	The often comparison of the body to machinery where there is a sense that stress and burnout would impact the organism as a whole. The often use of physics to make sense of the experience, maybe an attempt to make the experience abstract or to disconnect and distance the self. However there is also a theme where the experiences are somatised where they can be felt physically. ***"the stress took a turn on my body because I had two chest infections and that is the first ever had two Chest infection in 6-months" (C337-C338)***
Hypervigilance at work	489-491, 496-497, 540-542, A20, B295, C31, C68, E18, E44, E49, E110, E350, E359	The experience of being on the constant lookout for a threat to self and others "**stress is those things you are actually dreading**" E18.
Impact livelihood and career	458, 477-478, A73, A140-141, A145	Experiencing apprehension on job security and possible impact it can have on their personal livelihood and the family's. For example, the constant fear of losing your job due to a lie from a patient (458) or facing litigation: ***"which is***

		part of personality disorder but it frustrating to have a solicitor come around telling you why are you not doing this" A145
Anger embedded with stress, Apathy	Line 158-160, 165, 175, 177, 309, A19-21, B266, E20, E36, E57, E116, E120, E126, E135	Participants recounting how often the feeling of anger is felt and how it inter-relates with stress. Participants describe how at times they feel apathy at work and they are often able to relate this to the stress experienced **"snappy, irritable, rigid, almost been sadistic with patients on an emotional level" (A19).**
Manipulation	261, 265, 301-303, 458, 459, 471, 472, A32, B278, E139, E351	Showing a level of acceptance that the PD environment is not void of experiences where patients will deliberately influence or control the behaviour of others. ***"that will try to mould you, manipulate you. And you always have to be aware of when you are being manipulated" E351***
Collusion/ Splitting	308-311, 314, 323, A8, A12, 641, 301, 303, A19, A88, A97, A141, A149, B245, B250, B252, B254, B270	The experience of frustration and disunity with colleagues when a ***"serial liar"*** (referring to the PD patients) (309) are often believed over him. **"the staff group are playing out some of the things that we are very here to treat in patients and yea" (A97)** **"there is quite a lot of confusion, the split here is permanent" (B270)**
Problematic relational dynamics	Line 40, 41, 45, 46, 47, 67-71, 203, 204, 223, 228, 299, 578, 579, 607-610, 614, 638-641, A33, A74, A88, B12, F42, F57, B60, C66, C86, C87, E18, E72, E107, E123, E125, E391, E414, E436, E445	The experience that the different relationship dynamics with patients and colleagues at work may be at the base of the experience of stress and burnouts. ***"I think it is a constant kind of dilemma of how much there is on our part and how much in the patient" B60.*** ***"I guess, I guess with this job because its inpatients I guess you really have a bond with them as well and I think you work closer with them" C86***

Lack of emotional reciprocity	41, 69, 249-251, 299, E48	The interviewee describes the lack of understanding of the negative impact exerted by the PD patients on others (249-251)
Inevitable, continuous, constant stress, prolonged, imprisoned	38, 94, 104-105, 146-147, 180, 197, 199, 200, 233, 240, 242, 257, 414, 432, 447, 612, A45, A49, A110-111, A114-115, A118, B27, B29, B47, B199, B201, B203, B289, B323, C14, C16, C29, C34, C49, E27, E38, E51-52, E67, E74, E84, E90, E251	The experience that stress in this environment is always present. Emphasis on the need to use psychological interventions over a pharmaceutical model and linking this to the experience that positive change in patients ***"take longer to take effect"*** (240). evidences how the perspective of leaving the PD unit is comparable to being ***"a free man"*** (432) **"and it was daily so throughout that whole week, I think every time I was on shift I had to deal" C34**
No validation/ acknowledgement	219-222, 226, 309, A34, A107	The experience that on some occasions, merit is often withheld or unseen.
Unwilling Subservience	41,45, 69,74, 88-90, 95, 103, 112, 121, 132, 155, 217, 218, 241, 291, 485, 541, 607, A87, A135, A140, B88, B350, C27, E48, E131, F89, F139, F150, F156, F169	interviewee emphasises on the experience of being unwillingly subservient and reconciling with the notion that certain actions, feelings, behaviours are reluctantly experienced and forced upon. enforce passivity to abuse because of the fear of more aggression **"*is going to escalate the situation? That is a lot to think about" (F150)***
Reluctance to experience and desensitization	Line 127, 129, 130, 426-428, A52, A149, A160, A169,	These theme underlines an effort to avoid intrusive experiences especially those visual experience. Participants were more willing to describe the experience of traumatic events through the experience of their colleagues.

	B172, B196, B199, B286, C46, E163, E184, E289, E328, E331, E479, E518	***"threatens to slice his wrist . I witnessed it a couple of days ago, this chaps screaming 'you are a liar' to this nurse who was trying to do his meds, was not lying he was trying to do his meds. He is been flustered by this anger and hostility" A149-150.*** the context at which the reluctance of the experience is being expressed it appears that participants experience internal dissonance of danger vs desensitization (familiarity). ***B199 "don't get me wrong, there is level of desensitization, maybe it come with the burnout".*** ***"evoke those emotions and anxiety of feeling afraid I don't feel I don't have I don't feel afraid anymore" E289.***
Stress is infectious/ Stress as transferrable	Line 98-99, 114-115, 116, 237, 413, 448, A82, A150, B138, B141, B330, E243, E289, E323, F41	Use of the word ***"spread"*** (115) in the context of stress and that stress can be "transferred" (98) just like a virus. Participant share the experience where they emphasize how the stress can spread very quickly to other colleagues, patients and even people outside of work.
Different sources of stress	291, 297, 303, 314, 375, 457, A31-32, A66, B12, B29, B123, B229, C32, C33, C46, C51, E105, E106	Interviewees speaks of different source of stress and burnout. One of which is encapsulated by an interviewee stating, **"if a patient is going to die on your shift and everyone is safe and alive" (C33)**
Accepting defeat/ compromise/ helplessness	56-61, 257, A17, B342, E27, E97, E99, E101	Interviewees share how the feeling of helplessness turns into defeat in order to cope with stressful demands of the job. To avoid further distress, avoid getting ***"into a state" (59)*** ***"you know powerless sometimes and hopeless in those situations there is not much you can do really" (B342)***

Stimulating /exciting	A70-71, A101, A164-165, B192, B323, B352, B354, E481, F370	Participants expressed how their role can be stimulating due to the level of risk and unpredictability of the environment. ***"I am questioning if I will get bored in my future profession whatever I am going to end up doing because every day is different here" B323***
Disempowerment/ not valued	Line A4-6, A8, A17, A107, B42, B47, B259, B272, E93, E95, E104, E245, F59, F139, F150, F422, F80	Interviewees expressed that the experience of burnout often perpetuate the feeling of not been able to contribute positively at work. "**like they are not making any difference" (A6)** high turnover due to unhappiness as mental health of workers are not considered half as much as the patients. The expectation of self-soothing perhaps comes from lack of support. ***"it's just kind of It's just feels like Everything is just about the patient and the staff and I think it should be balanced It should be 50-50 yes we have the duty of care" F80-81.***
Hierarchical split	596, 45-46, A15, A36, A38, A40-41, B272, B280, B284, F71, F55, F74, F139	These is a common experienced shared by different interviewees. It appears that often conflict arises within the ranks in regard to modes of care for the FPD

		patients and this is a significant source of contention but also stress especially when nurses' abilities to care are been questioned. ***"the decisions are made as a team and sometimes it doesn't always, that brings division" B284***
Experience, and personality (protection)	554,556, A55, A62, A65, A124, B229-B230, B233, B314, B315, E156, E311, E353, E419, F432	The participants share that age, experience and personality are often good predictors to determine stress and burnout at work. ***"you know security and kind of boundaries and its really important and it comes with experience you can't get it from you know from school or from books" B229***
Failure, bad carer, lack of results	675, A34, A107, A118-119, A146, A148, B12, B42, B44, B47, B58, B65, B254, B292, B337, C77, C79	Participants highly personalise their sense of duty care to the point of feeling guilt. The guilt appears to be perpetuated from the sense of failure to provide what is perceived as rehabilitative care for the patient. There is also an emphasis on not managing well these feelings. ***"I think as a team, I think well, I think we are failing occasionally" B337.***
Duty of care/ Feeling neglected	A21, A34, A46-47, A32, B69, B292, B339, C52, E67, E71, E92, E94, E271, E340, F80	Participant express the experience of feeling that their duty of care often makes them feel neglected but also experience a s sense of compulsion to behave in certain ways. ***"permissiveness which is expectation that we will see a range of behaviour that would not be socially acceptable" (A47)***

Invasiveness/pervasive/Vicarious	A73-74, B151, B158, C84, E228, E549, E577, F69, F163, F411	Participants express how the role can create a sense of trauma through the vicarious and the personal experiences. **“it’s just all consuming” (F411)**
Lack of safe space	E558, E582, F413, F474	The participants share the experience that there has been a space where they have felt it was safe to process their work struggles. ***“people are not talking about the support they need support that will be Really comfortable to talk about” F413***
Insufficient support/staff shortage	E65, E73, E75, E83, E87-E88, E510, E511, E522, F102	This is the constant experience of high work turnover and the mental and physical impact of this. Furthermore the impact of observing others trying to escape the environment. ***“think its stressful as well when you see all these experienced staff leaving, they can’t take it anymore” E511***
Intimacy	E253, E284	Openness as a way to reduce impact on family members, empathy received through openness. Shared trauma creates openness in relationship.
Irritability	E390	The interviewee express feeling significantly more irritable since working in the FPD environment with family members and friends.

APPENDIX H: Table of Subordinate Themes

Subordinate themes	Emergent theme
The affected mechanical body	• Emotional force/ negative impact • behavioural consequences of stress/ Window of tolerance • Breaking point/inability to cope/trauma. • Shutting down/broken body • Shutting down as coping/ forms of coping/absence of motivation • The mechanical whole Body/ psychosomatic • Hypervigilance at work
Imposed passivity	• Anger embedded with stress (apathy) • Manipulation • Collusion/ Splitting • Lack of emotional reciprocity • Inevitable, continuous, constant stress, prolonged, imprisoned. • No validation/ acknowledgement • Unwilling Subservience • Stress is infectious/ Stress as transferrable. • Different sources of stress • Accepting defeat/ compromise/ helplessness • Invasiveness/pervasive/Vicarious • Hierarchical split • Problematic relational dynamics
Power/Changing self	• Work as rewarding (acknowledgment) • Self as impactful/powerful on others • Self as knowledgeable/ coping manner • Self-soothe/ autonomous role in coping. • Powerlessness on others perception/frame of mind • PD unit as distorted/unpredictable Psychological ailment/ link to intelligence • Problematic relational dynamics • Intimacy • Changing viewing lens/ internal dialogue of reconstructing self - experience
Microsystem (Impact outside of work)	• Winter Jacket • Impact on microsystem

	• Denying self to feel • Transferable behaviour/developing skills. • Impact livelihood and career • Isolation • Unsafe outside world/ Self awareness • Irritability
Experience of work	• Stimulating /exciting • Failure, bad carer, lack of results • Duty of care/ Feeling neglected. • Insufficient support/staff shortage
Reflection	• Disempowerment/ not valued. • Experience, and personality (protection) • Reluctance to experience (desensitization) • Lack of safe space • Reflection

APPENDIX I: Superordinate Themes

Superordinate Themes	Subordinate Themes
Operational trauma	• The affected mechanical body • Imposed passivity
Post-traumatic growth	• Microsystem • Power
Reflection	• Experience of work • reflection

APPENDIX J: Ethical Approval

Mr Oluwakayode Akinsulire

Trainee Counselling Psychologist

City, University of London

Northampton Square

London EC1V 0HB

The 15th of January 2019

Dear Mr Akinsulire

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title: **How do nursing health care professionals working in Personality Disorder forensic settings experience emotional stress and burnout**

IRAS project ID: **256543**

Sponsor **City, University of London**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above-referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales? You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Following the arranging of capacity and capability, participating NHS organisations should **formally confirm** their capacity and capability to undertake the study. How this will be confirmed is detailed in the "*summary of assessment*" section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed here.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The attached document *"After HRA Approval – guidance for sponsors and investigators"* gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including Registration of Research.

- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?

You should work with the applicant and sponsor to complete any outstanding arrangements, so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

[redacted]

Whom should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below.

[redacted]

Yours sincerely

[redacted]

Email: hra.approval@nhs.net

[redacted]

Mabel Saili, NOCLOR, Lead NHS R&D contact

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Copies of advertisement materials for research participants [Flyer]	1	The 09th of November 2018
Evidence of Sponsor insurance or indemnity (non-NHS Sponsors only) [Public liability cover]		The 29th of June 2018
HRA Schedule of Events [Validated SOE]	1.0	14 January 2019
HRA Statement of Activities [Validated SOA]	1.0	07 January 2019
Interview schedules or topic guides for participants [Interview schedule]	1	The 09th of November 2018
IRAS Application Form [IRAS_Form_30112018]		The 30th of November 2018
Letter from sponsor [letter of sponsor]		The 08th of November 2018

Participant consent form [Consent Form]	1	09 November 2018
Participant information sheet (PIS) [Information sheet]	1	09 November 2018
Research protocol or project proposal [Protocol]	3	14 January 2019
Summary CV for Chief Investigator (CI) [Chief investigator CV]	1	
Summary CV for student [Student CV]		The 09th of November 2018
Summary CV for supervisor (student research) [Supervisor's CV]		The 12th of November 2018

Summary of assessment

The following information provides assurance to you, the sponsor and the NHS in England and Wales that the study, as assessed for HRA and HCRW Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England and Wales to assist in assessing, arranging and confirming capacity and capability.

Assessment criteria

Section	Assessment Criteria	Compliant with Standards	Comments

1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	A statement of activities has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.
4.2	Insurance/indemnity arrangements assessed	Yes	No comments
4.3	Financial arrangements assessed	Yes	No application for external funding has been made.

			The statement of activities confirms there are no funds available to site from the sponsor.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
Section	**Assessment Criteria**	**Compliant with Standards**	**Comments**
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Not Applicable	No comments

6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England and Wales

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.
All study activities will be conducted at participating NHS organisation by the researcher. The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England and Wales in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. Where applicable, the local LCRN contact should also be copied into this correspondence.

If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England and Wales which are not provided in IRAS, the HRA or HCRW websites, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net or HCRW at Research-permissions@wales.nhs.uk. We will work with these organisations to achieve a consistent approach to information provision.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and Wales, and the minimum expectations for education, training and experience that PIs should meet (where applicable).
A local collaborator is expected at participating NHS organisation. GCP training is not a generic training expectation, in line with the HRA/HCRW/MHRA statement on training expectations.

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken

No Honorary Research Contracts, Letters of Access or pre-engagement checks are expected for local staff employed by the participating NHS organisations. Where arrangements are not already in place, research staff not employed by the NHS host organisation undertaking any of the research activities listed in the research application would be expected to hold Letters of Access.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales to aid study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

This content has been removed for copyright protection reasons

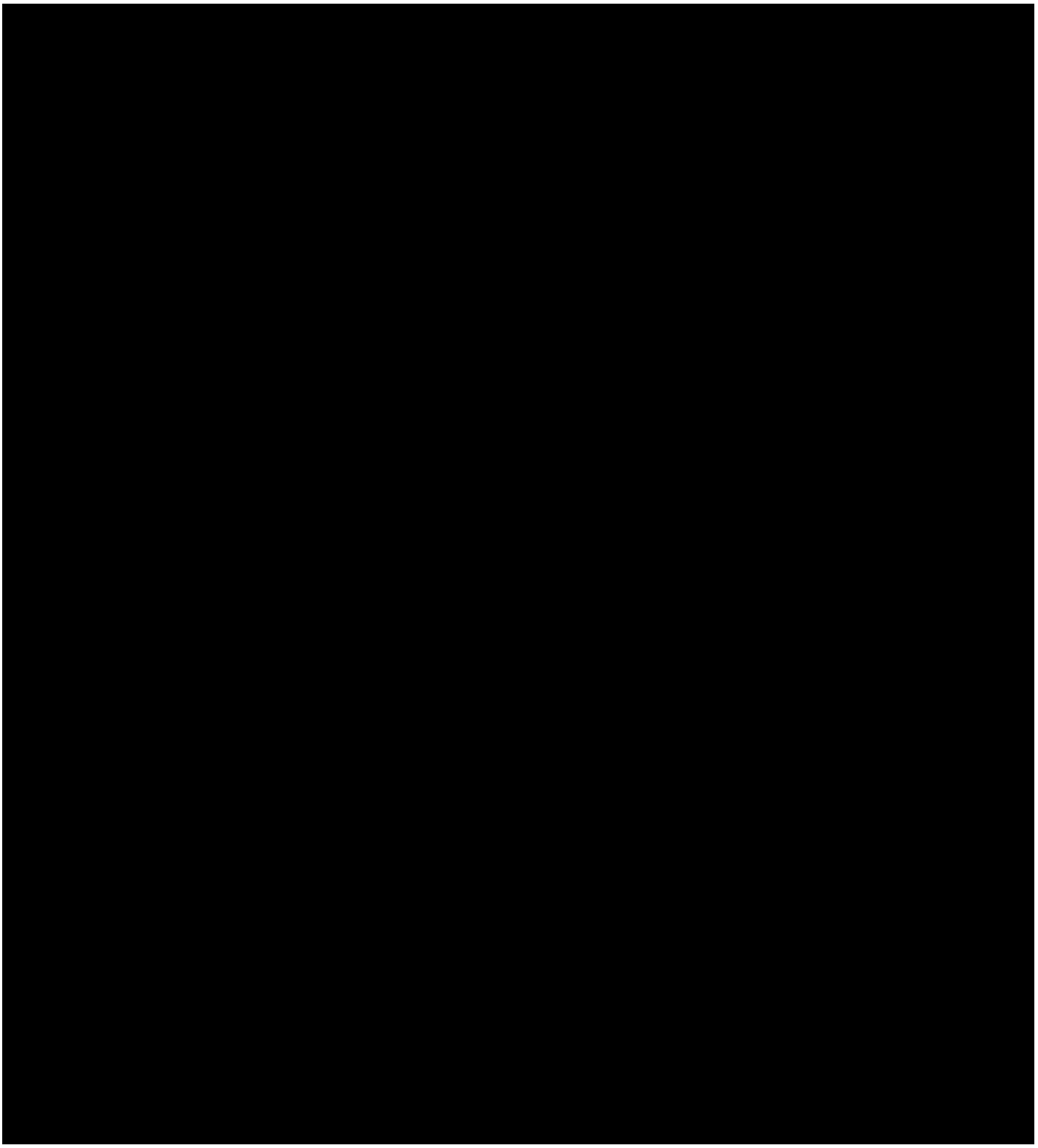
PART B: Journal Article

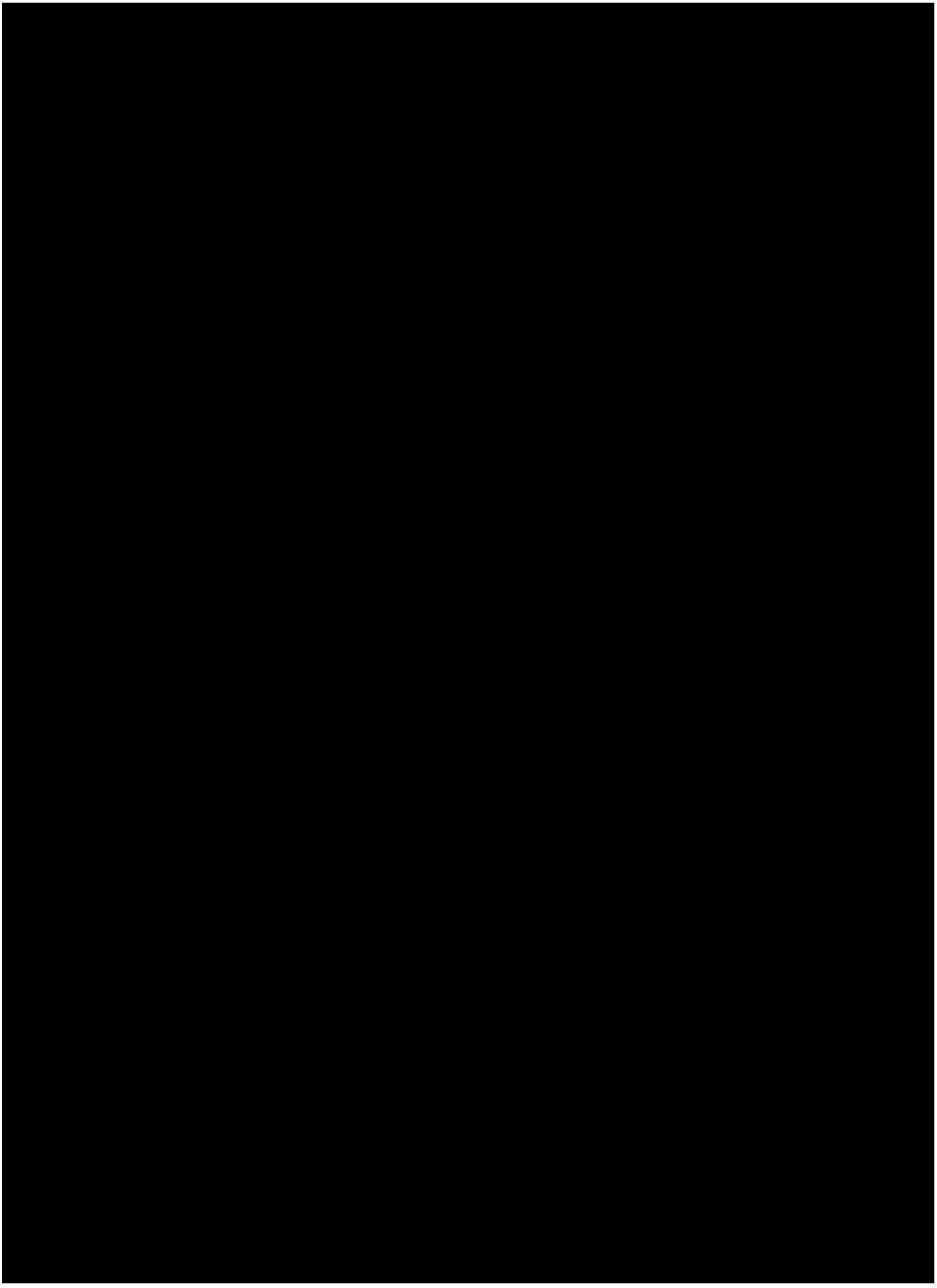
Post-traumatic growth within the experience of emotional stress and burnout in Nursing Health Care Professional (NHCP) working in Personality Disorder forensic settings.

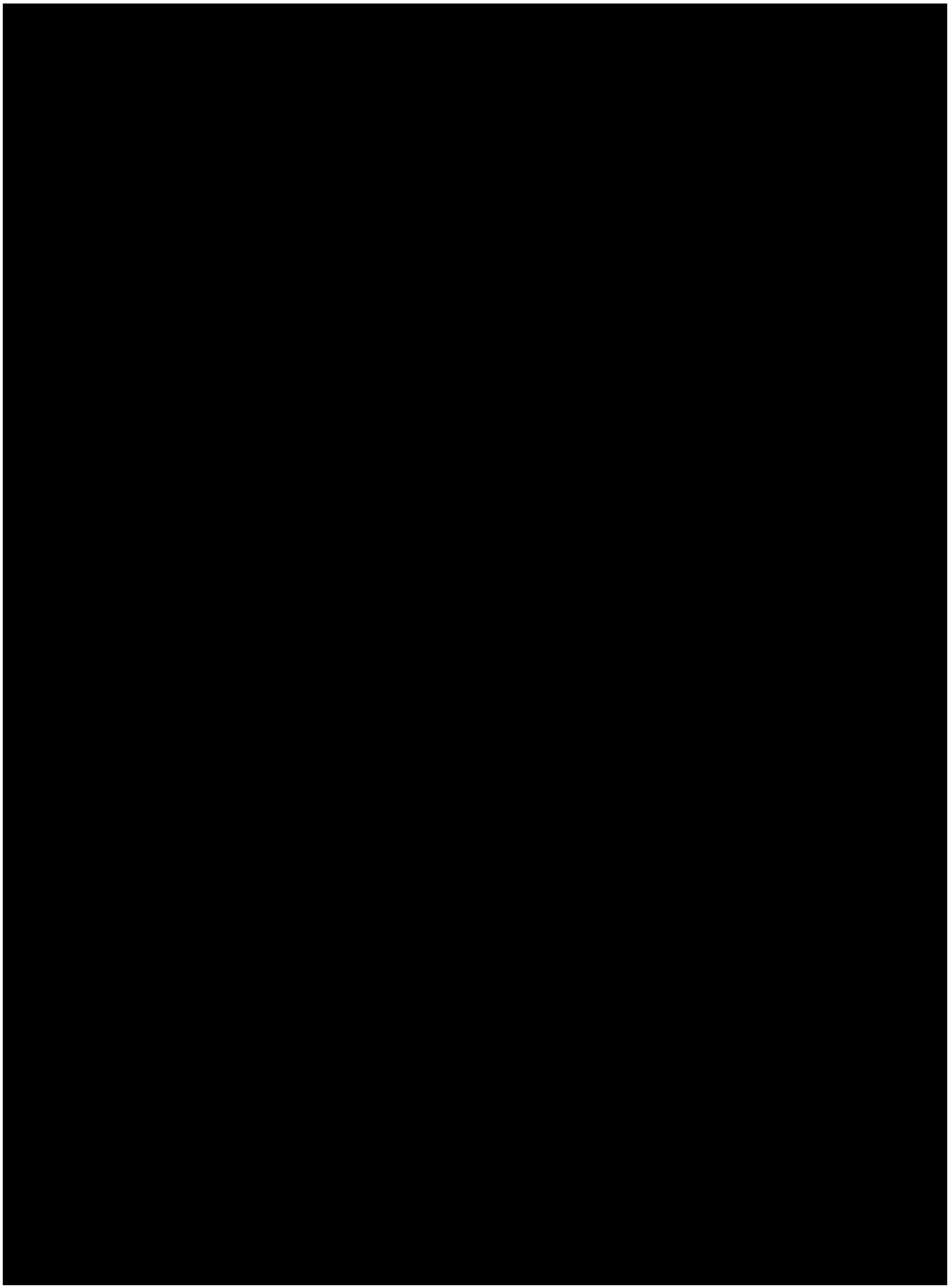
To be submitted to the Journal of Occupational Health Psychology

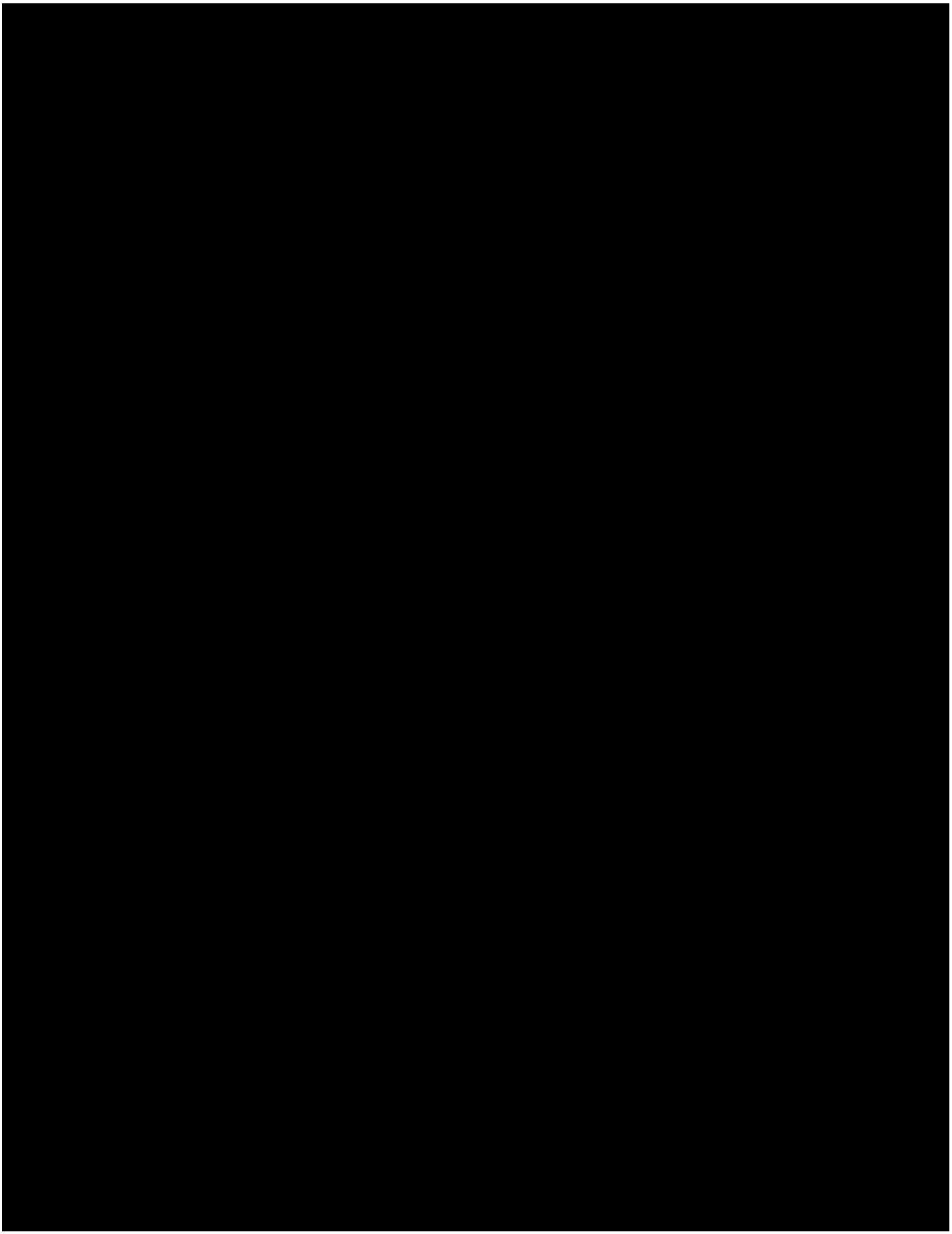
(Following the guidelines from: Chen.Y.P. (2020). Journal of occupational health psychology. *American Psychological Association.* Retrieved from https://www.apa.org/pubs/journals/ocp?tab=1)

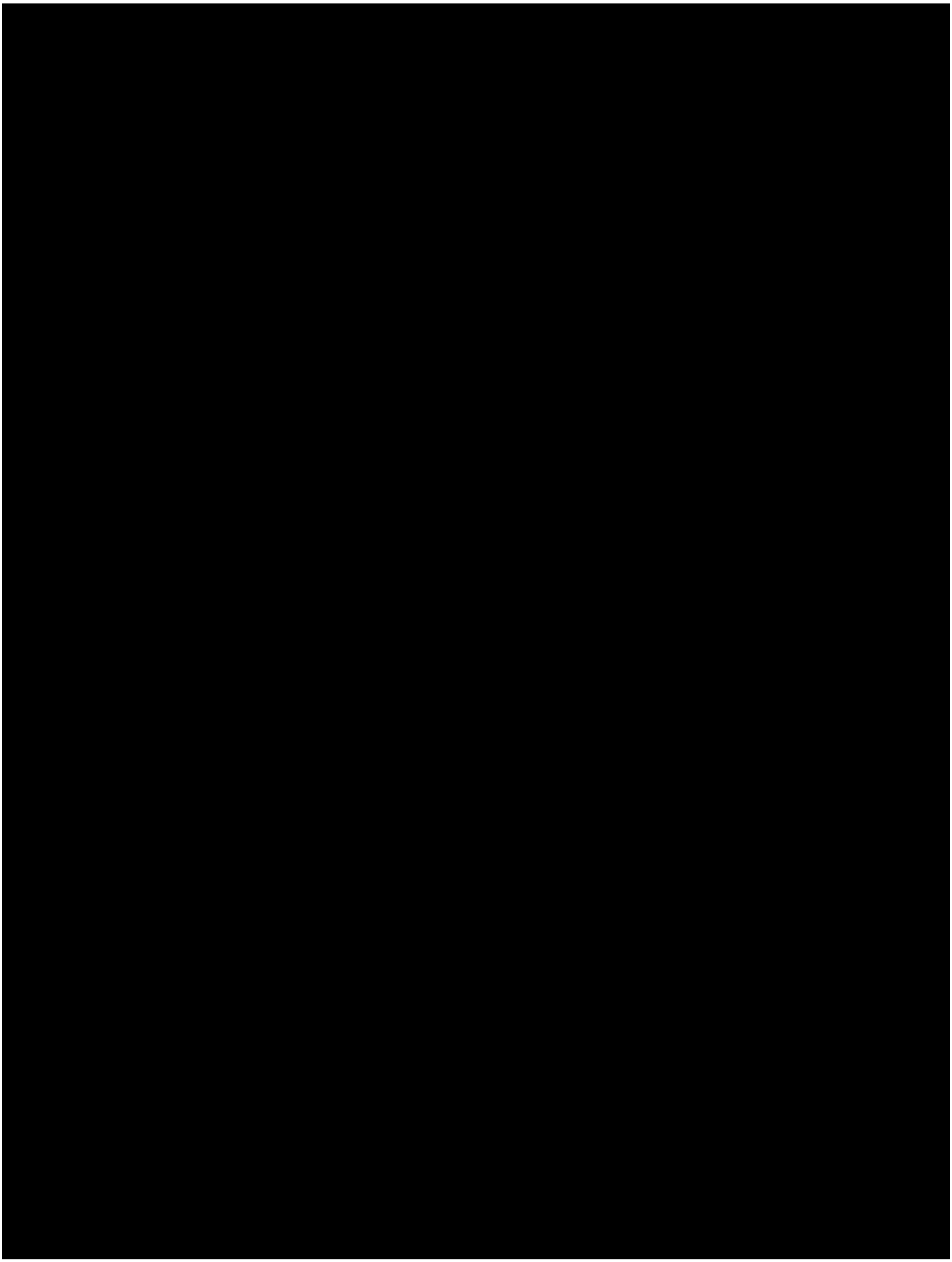
Word count: 9794

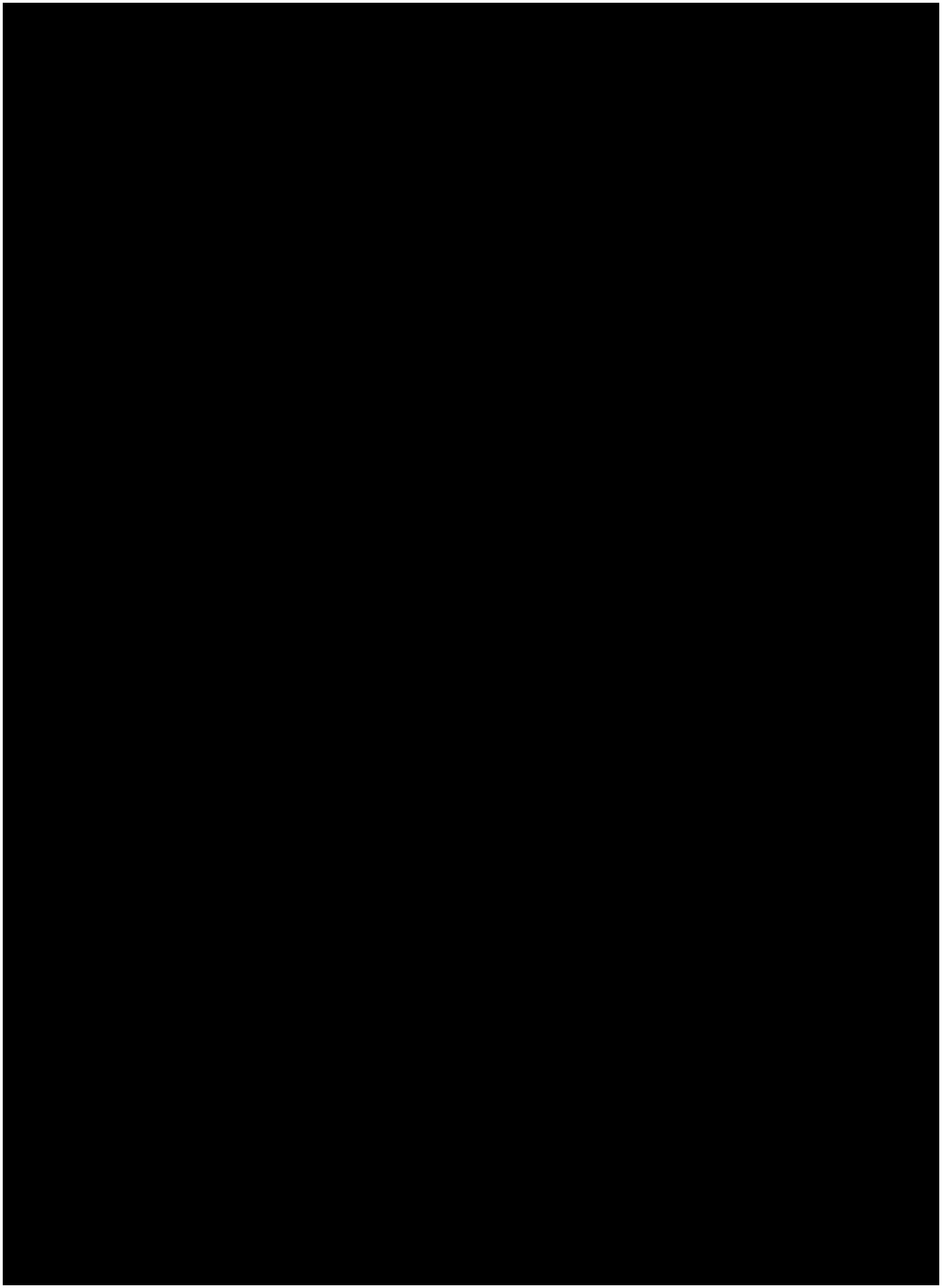


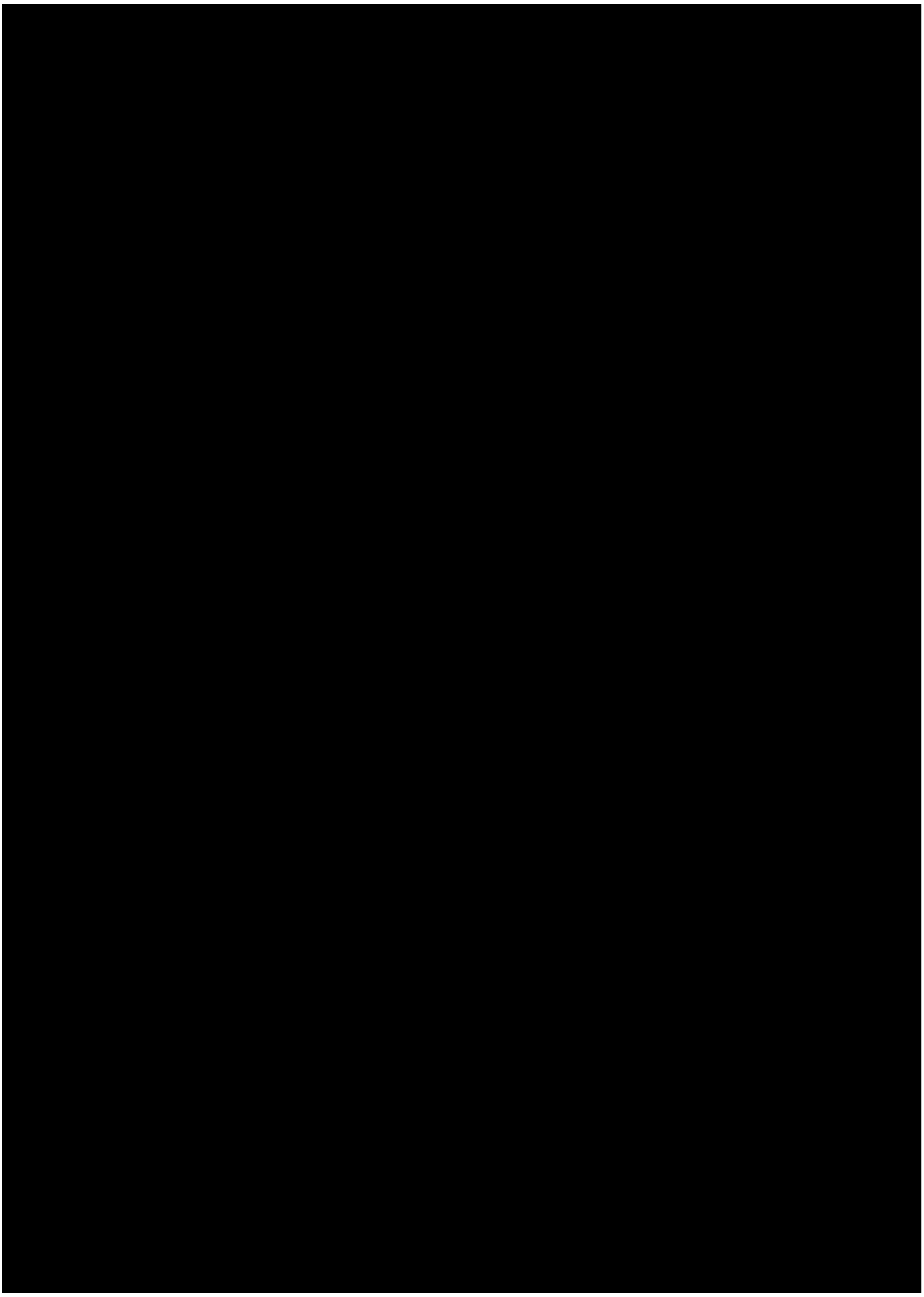


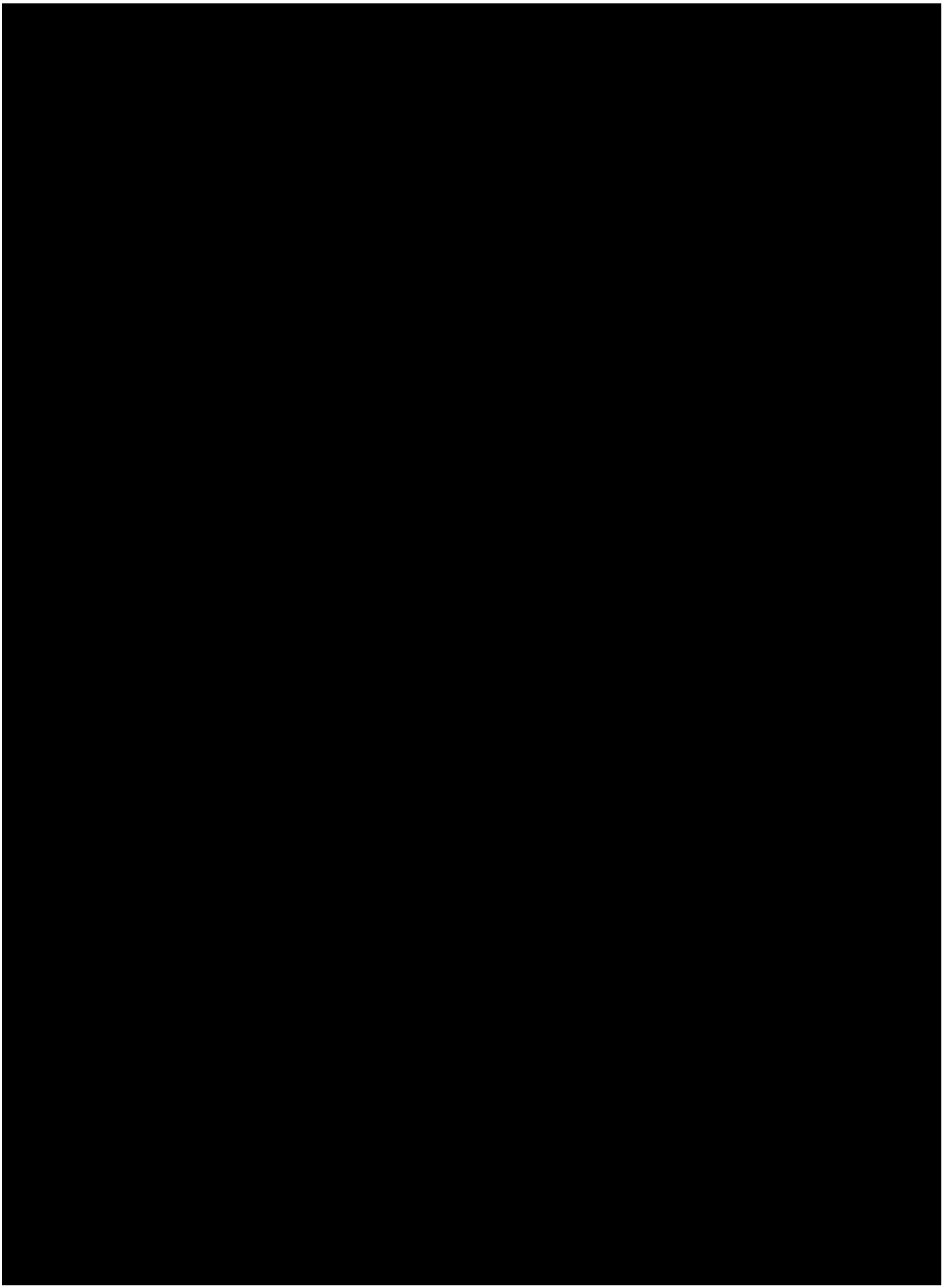


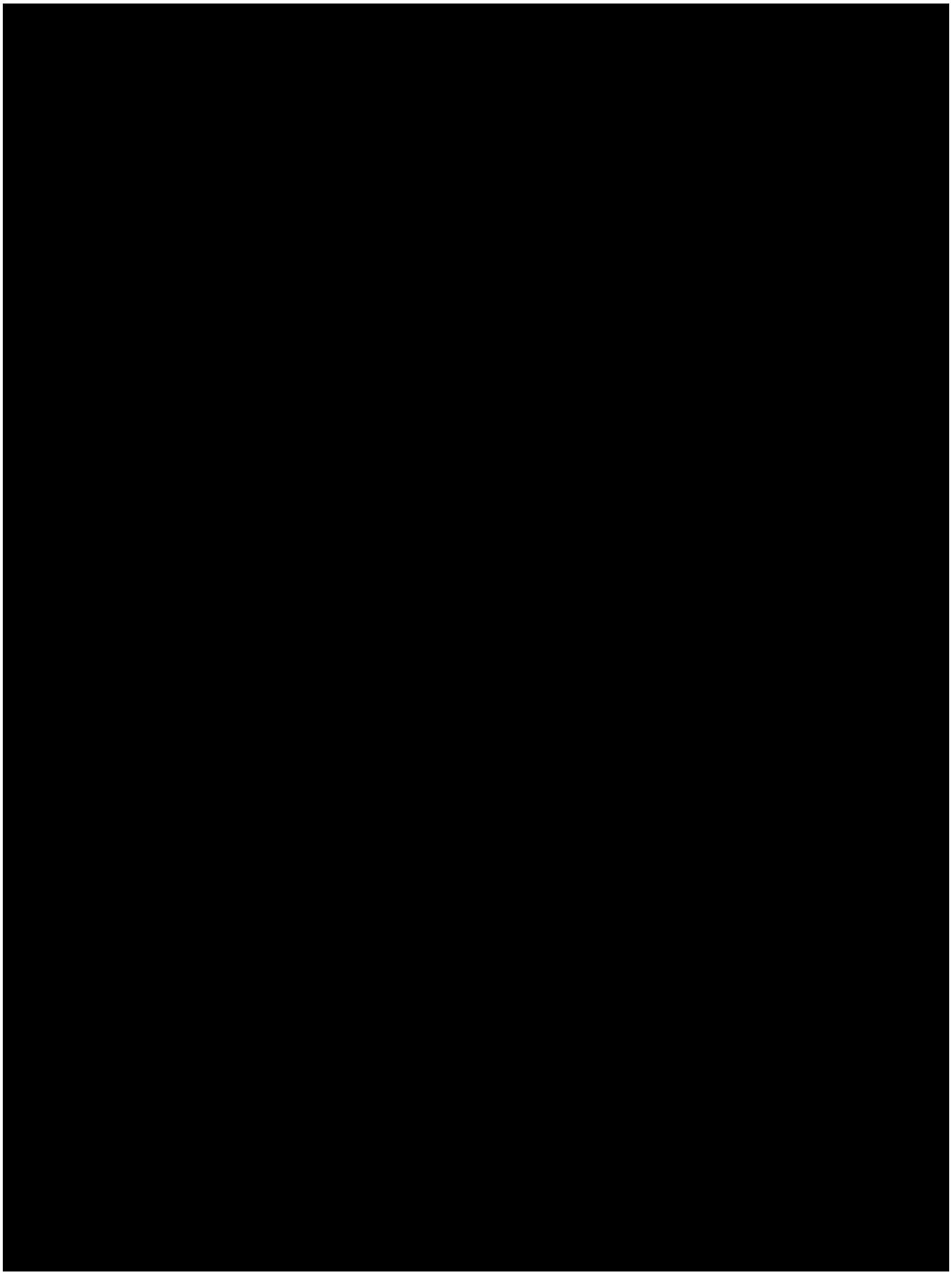


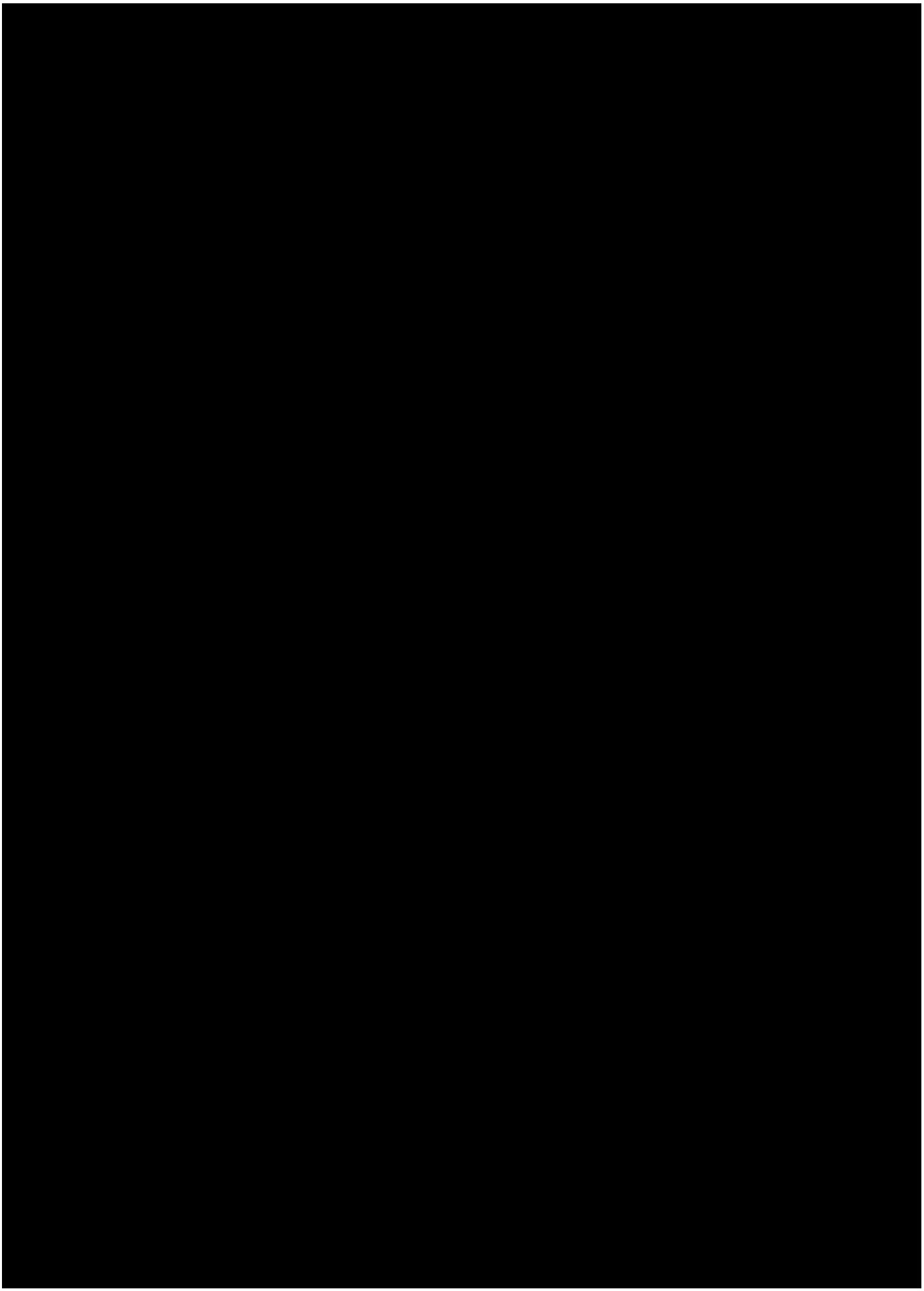


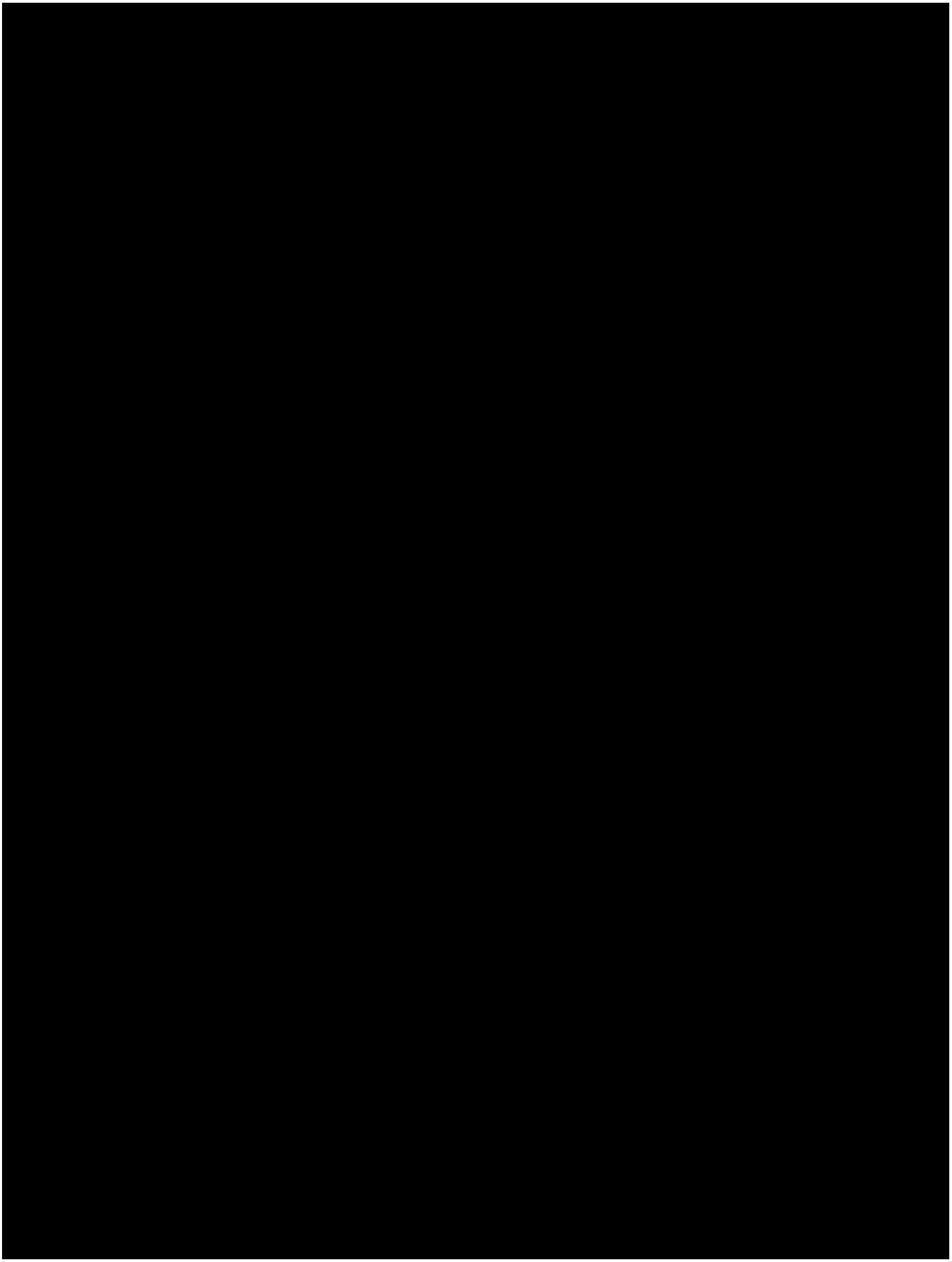


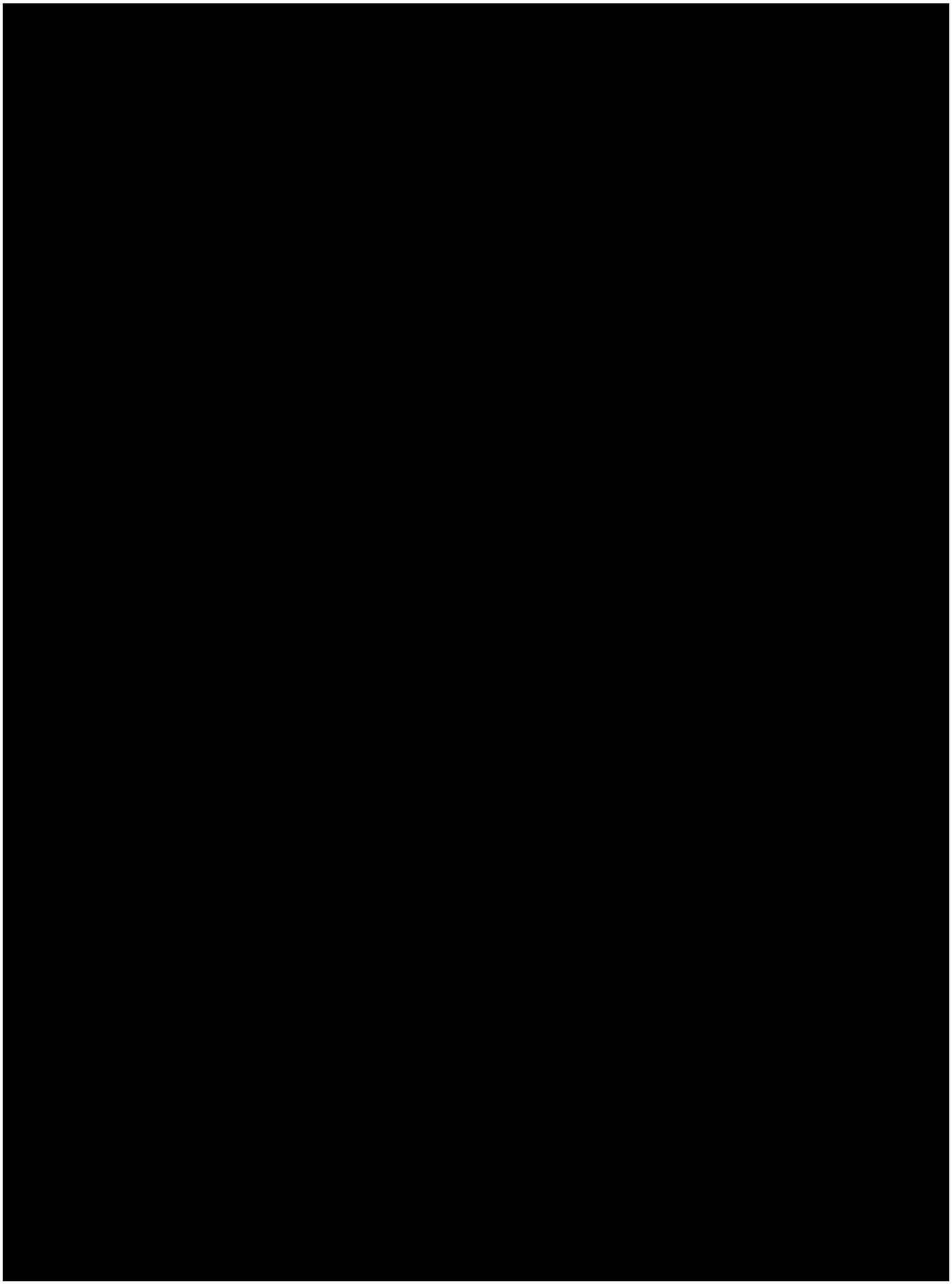


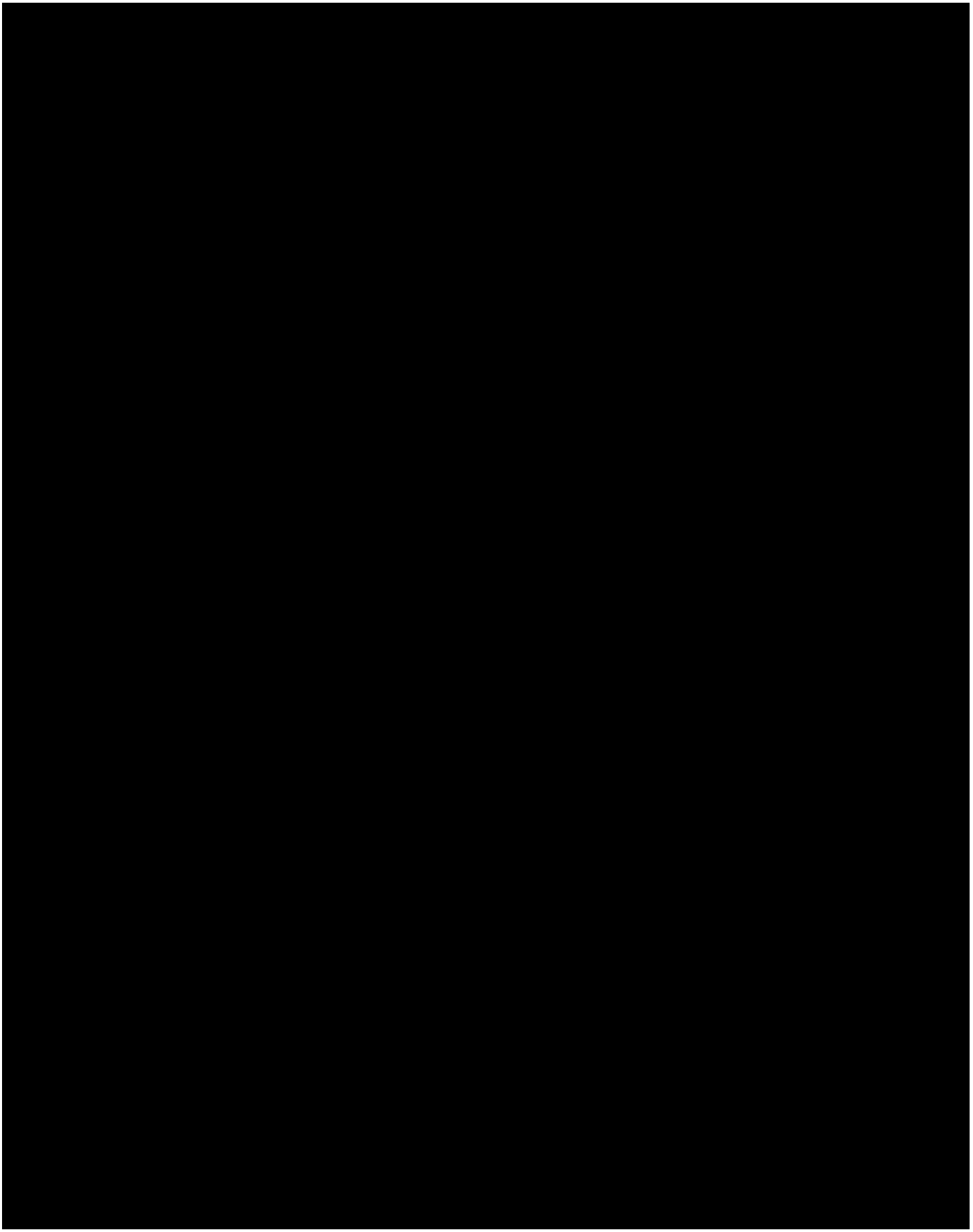


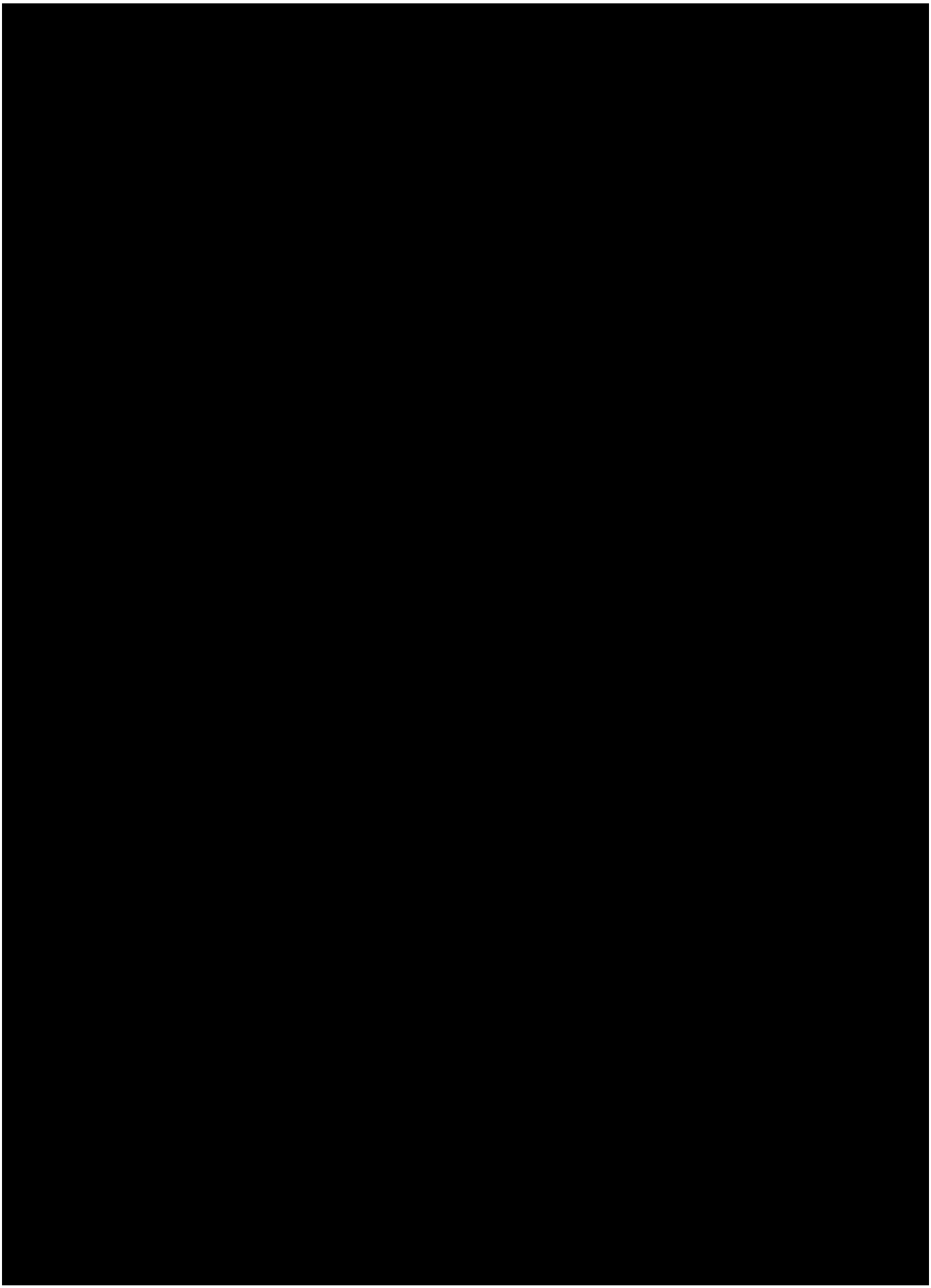


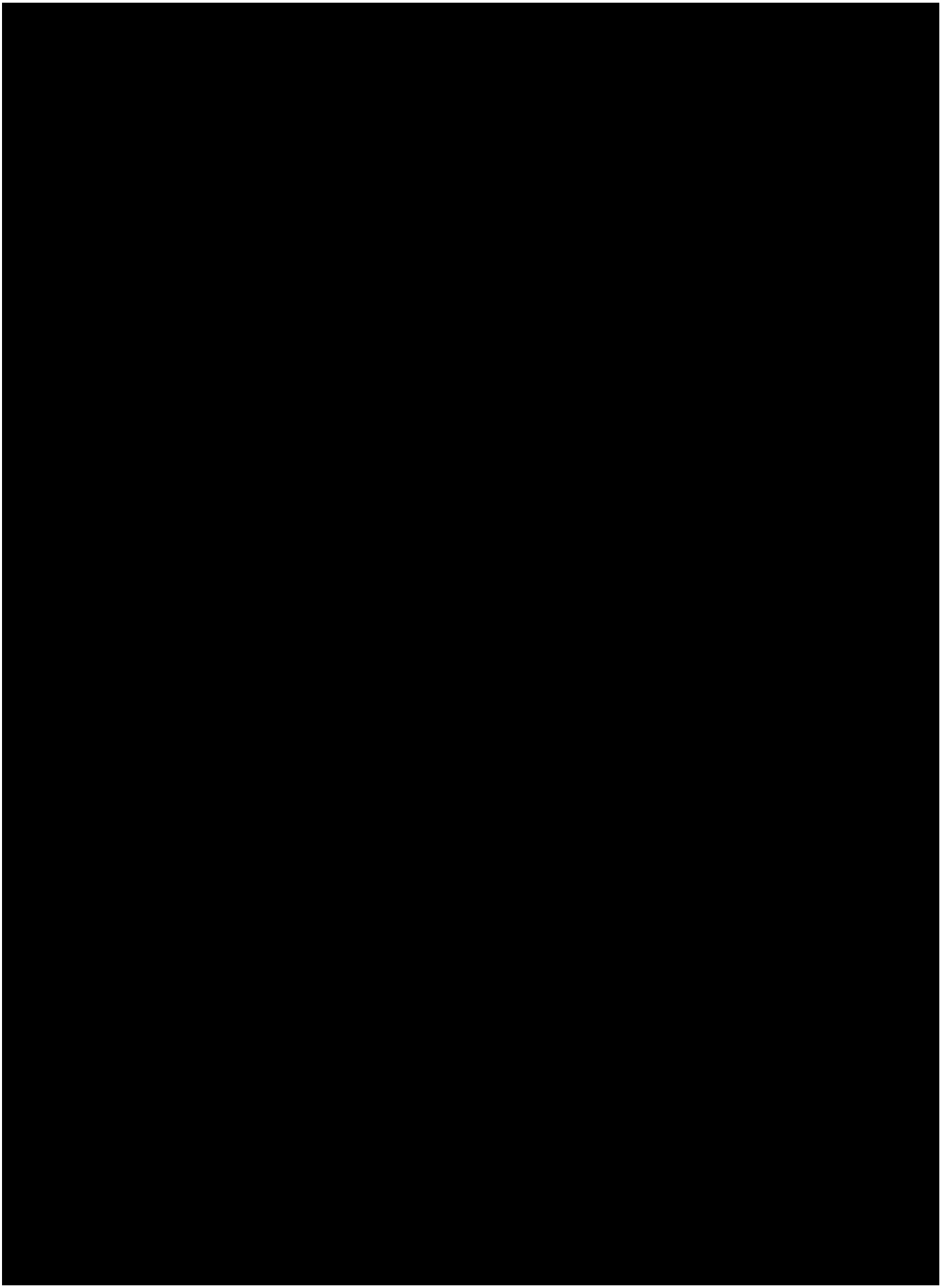


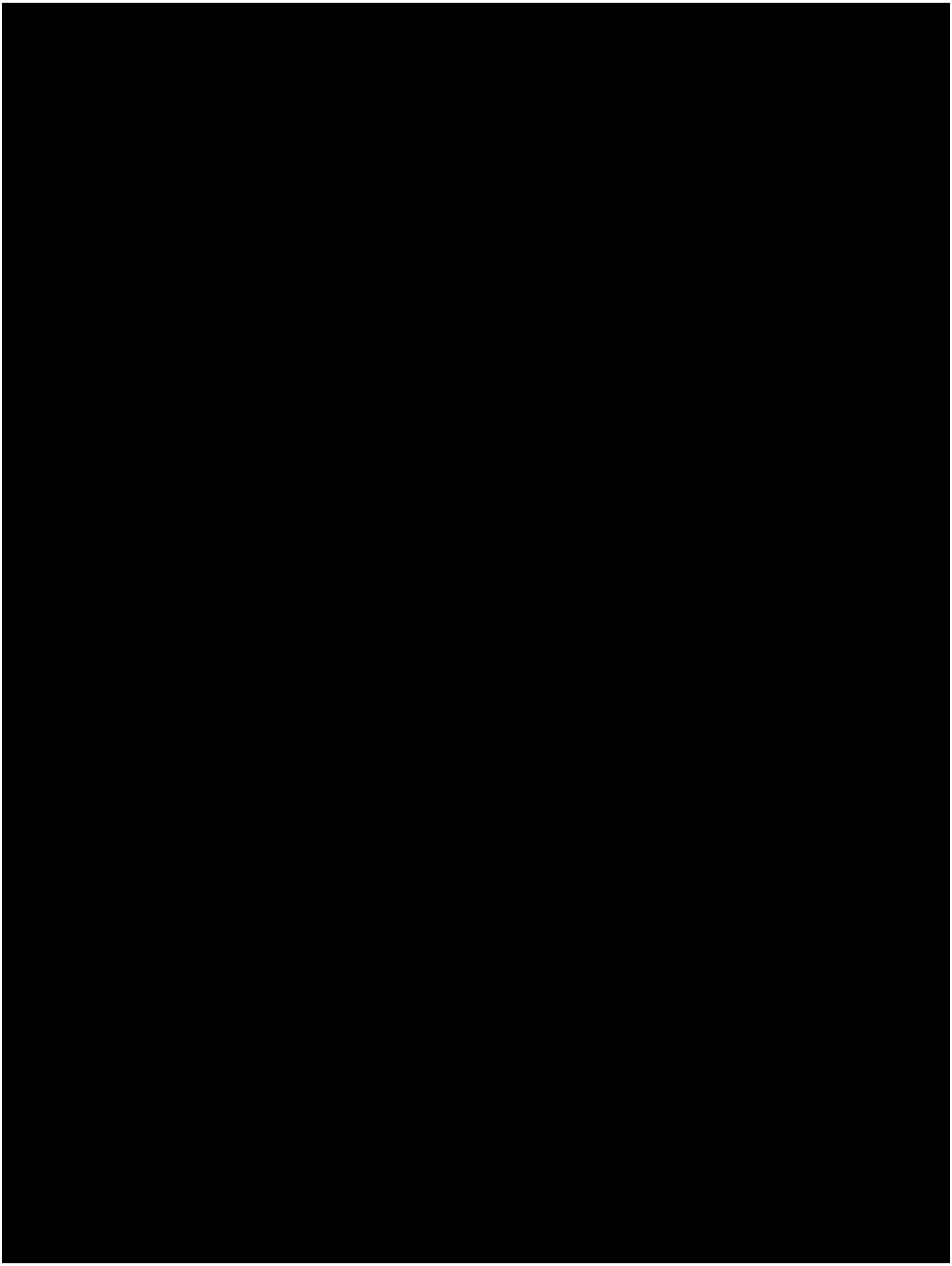


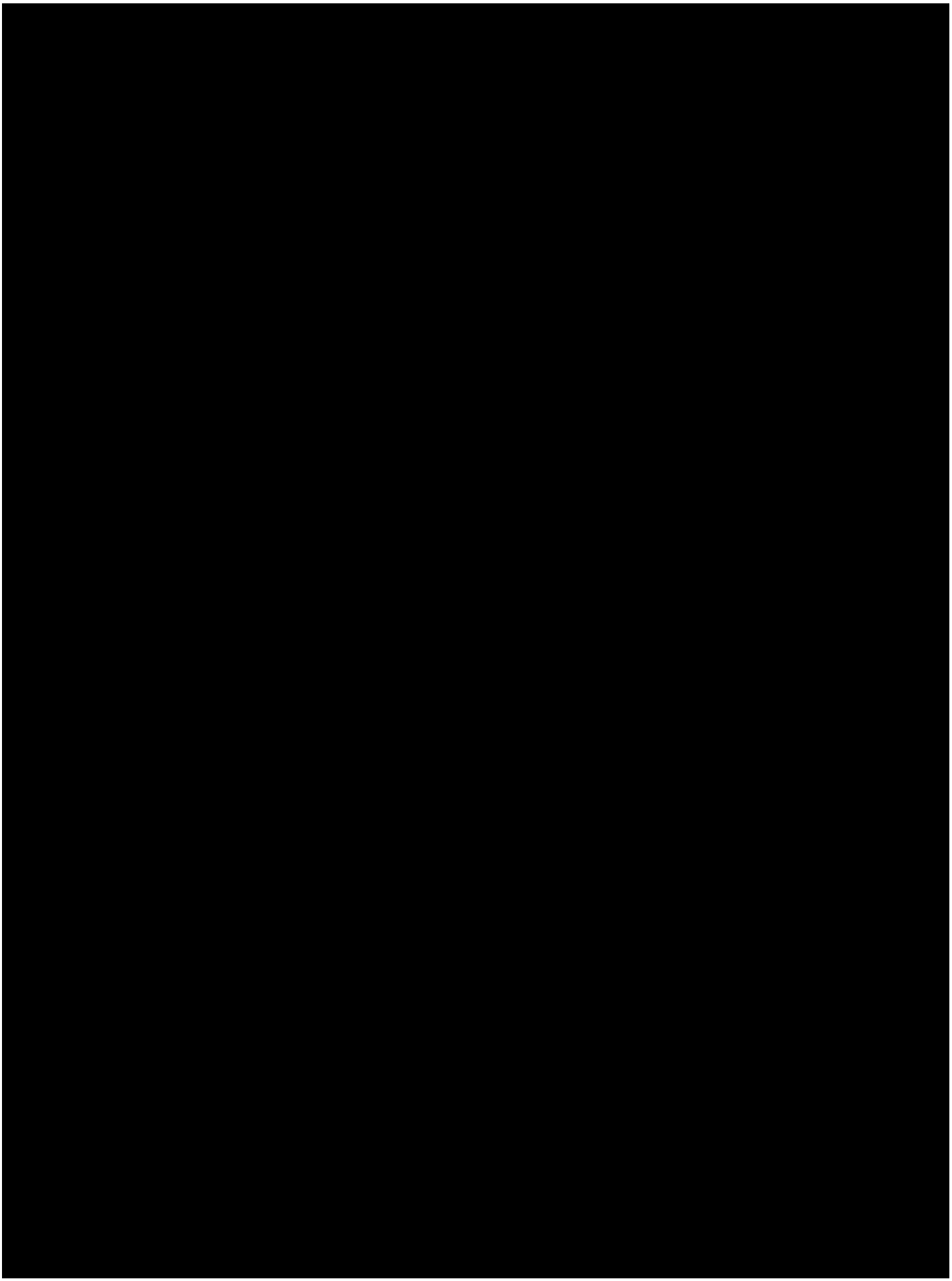


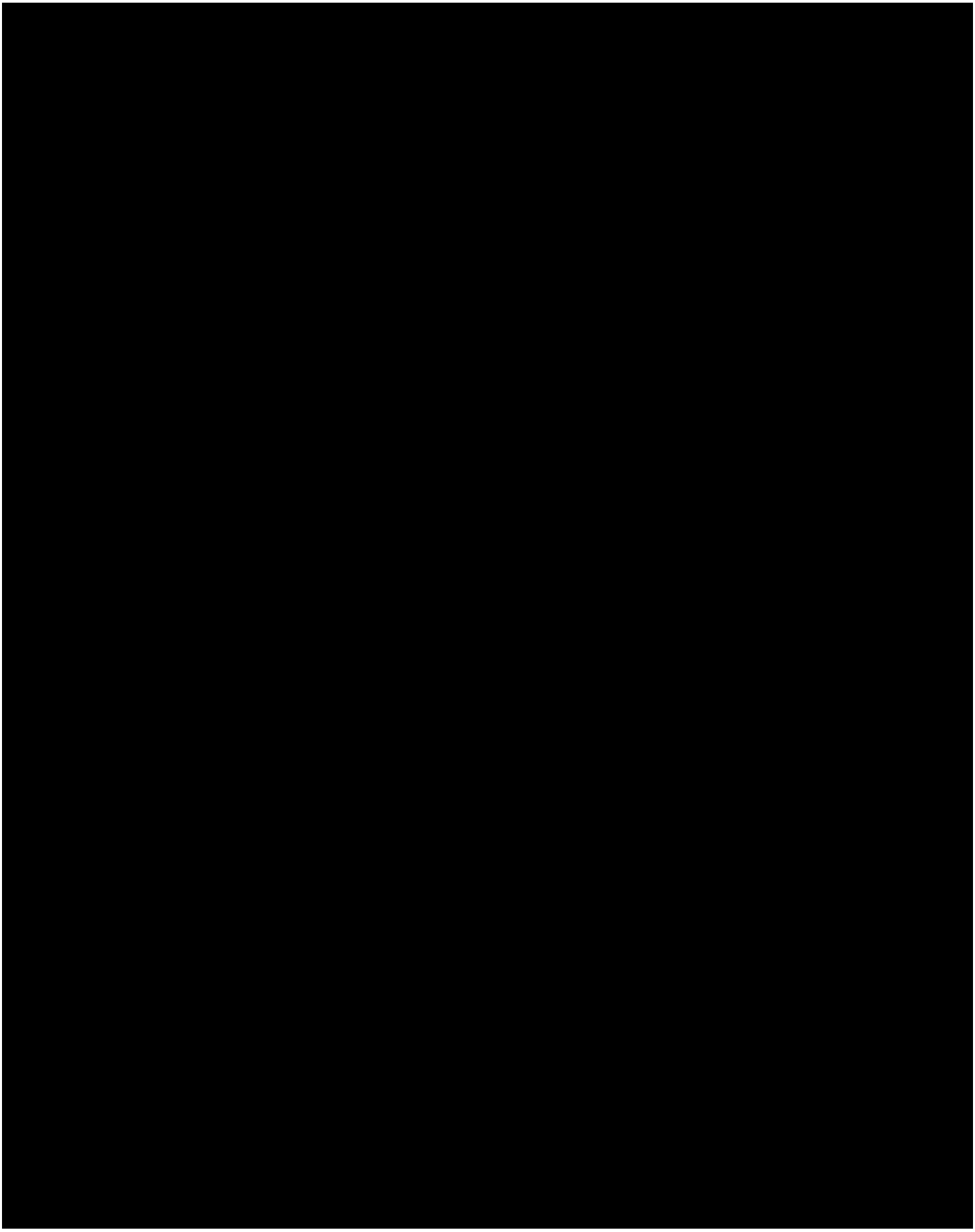


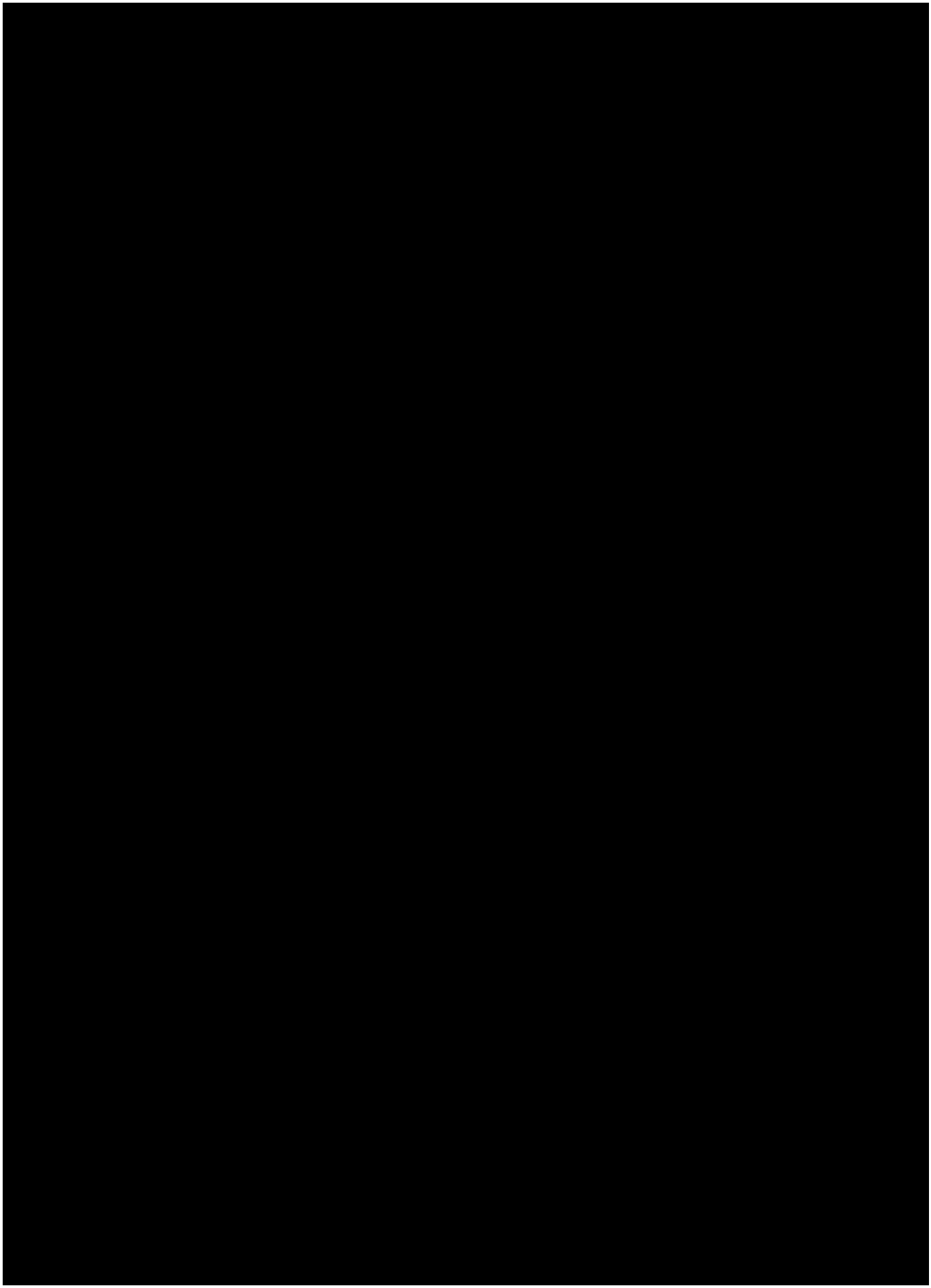


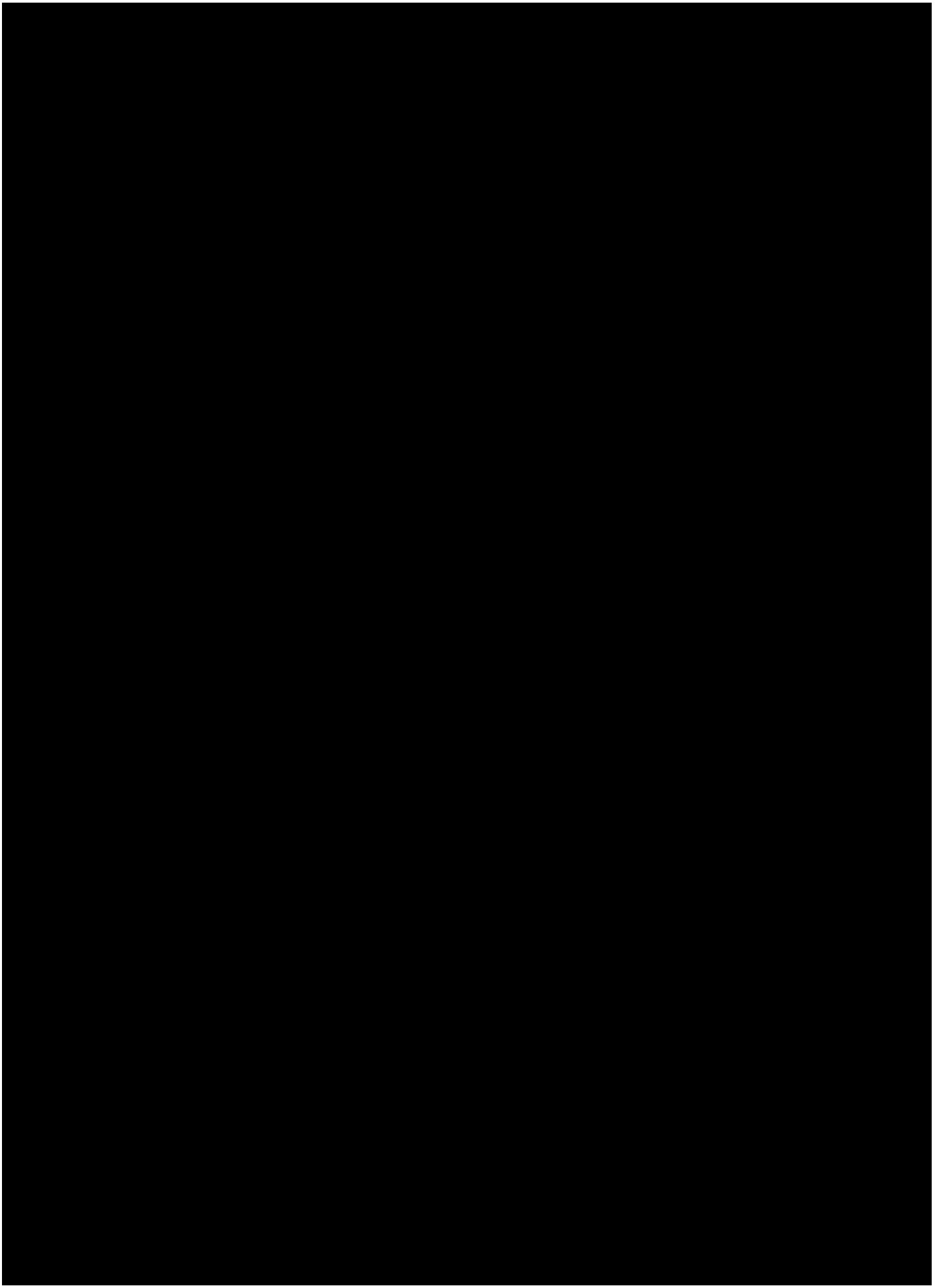


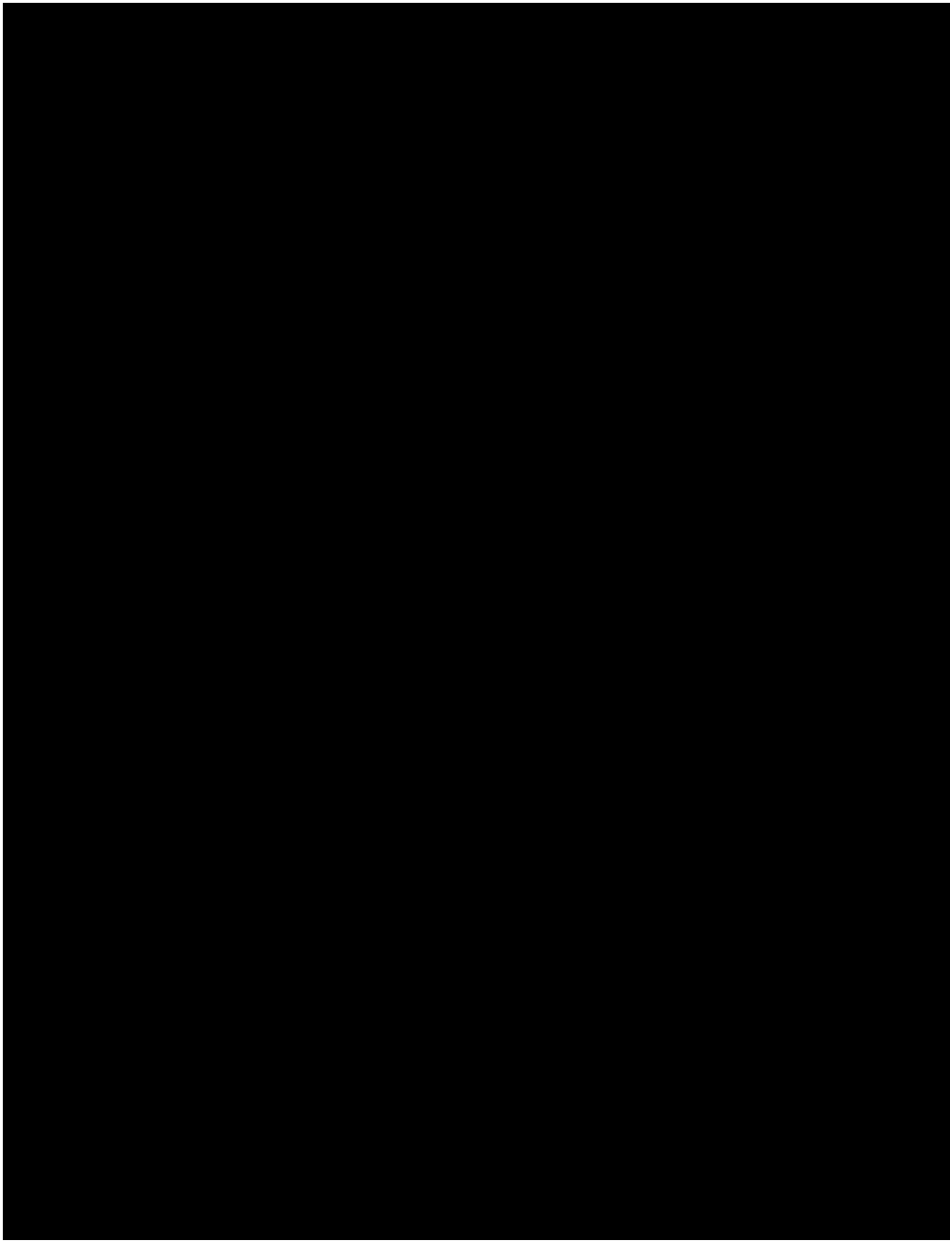


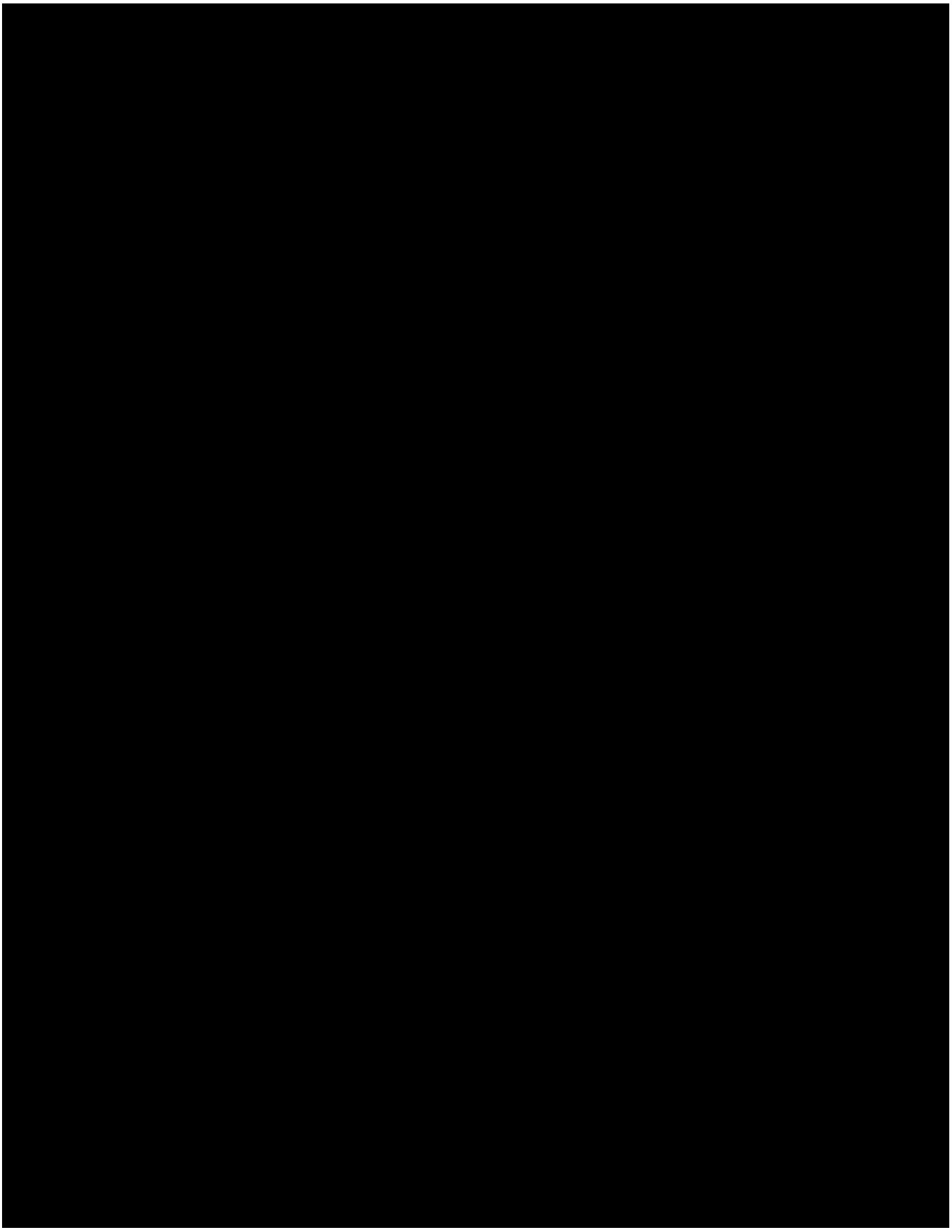


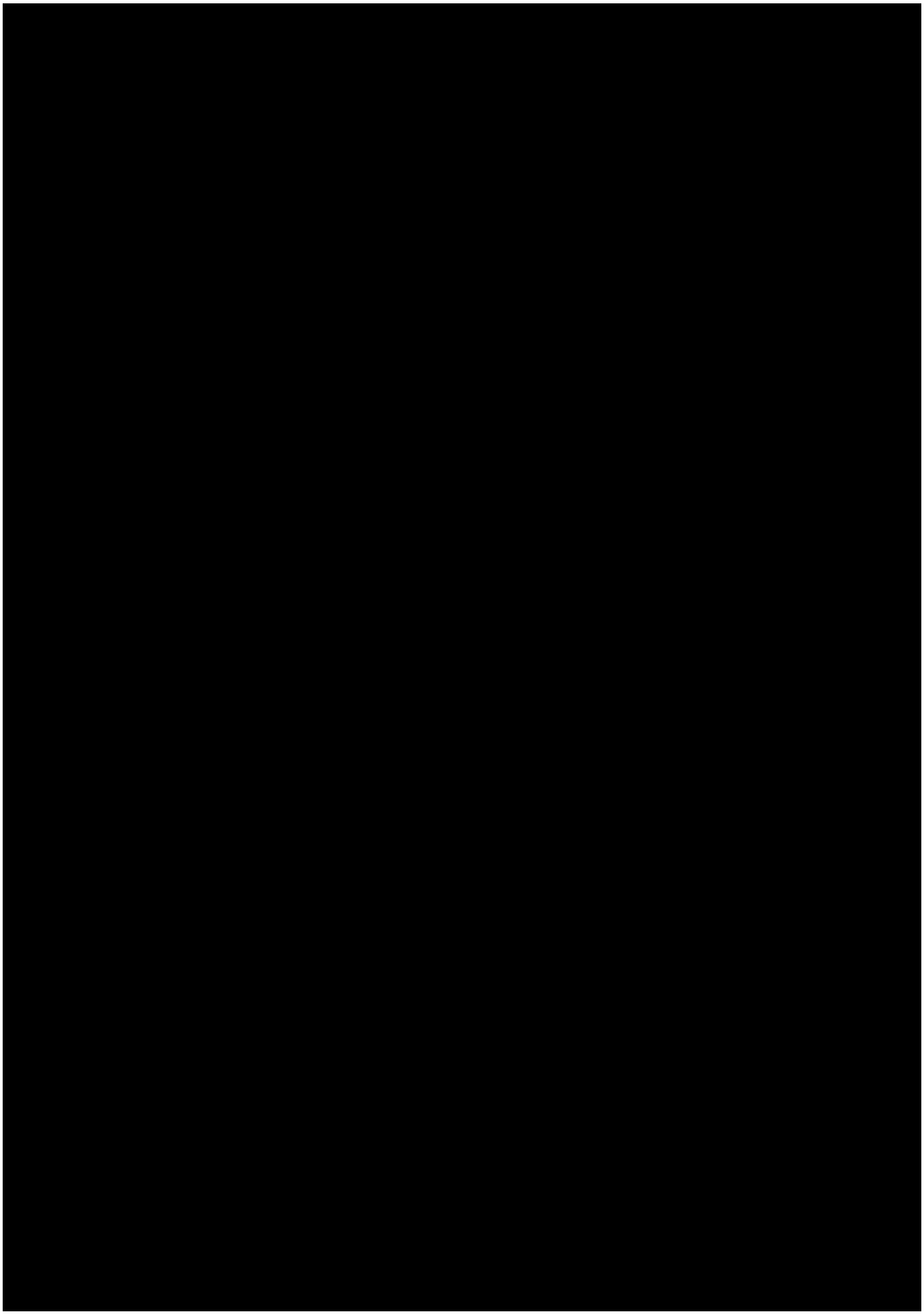


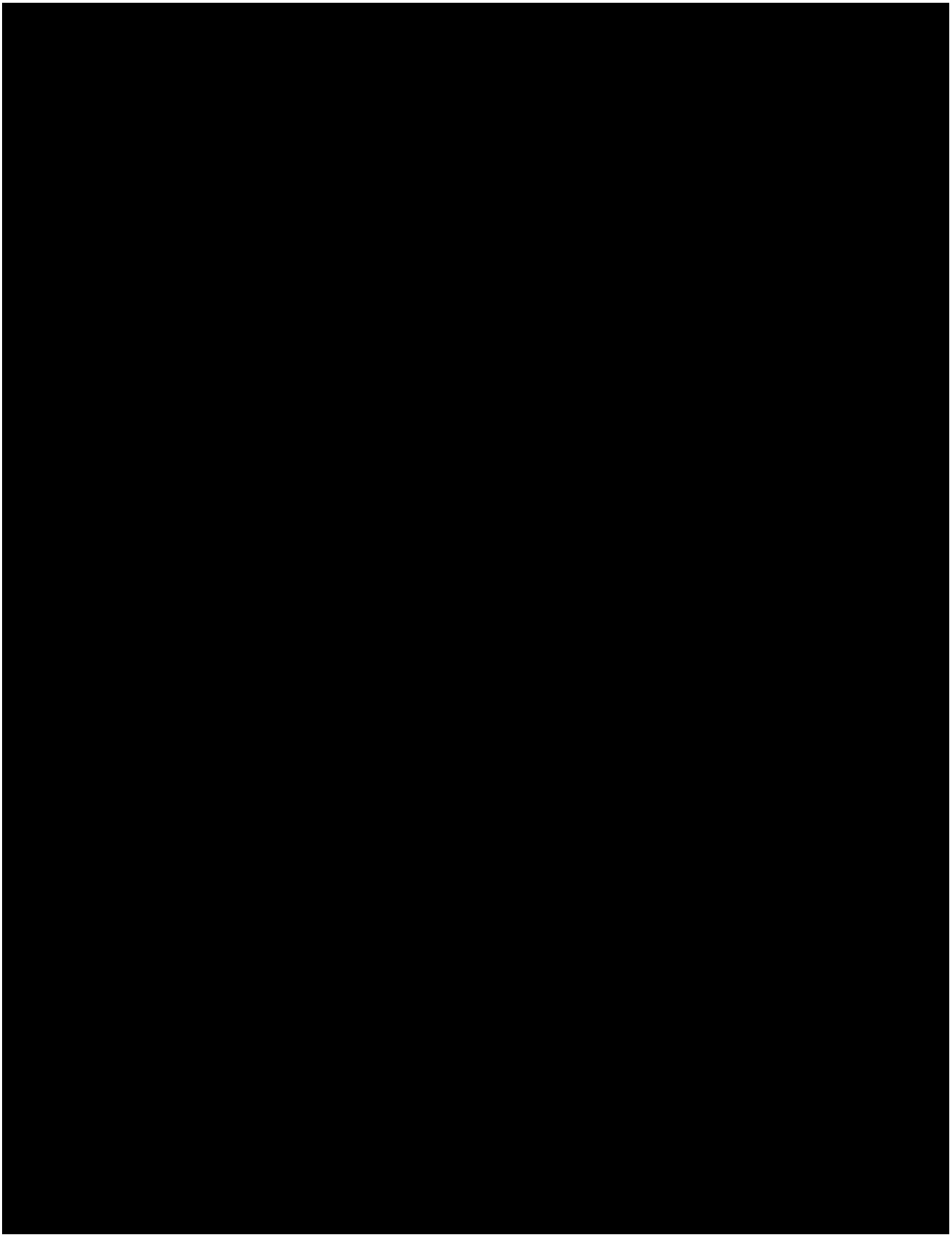


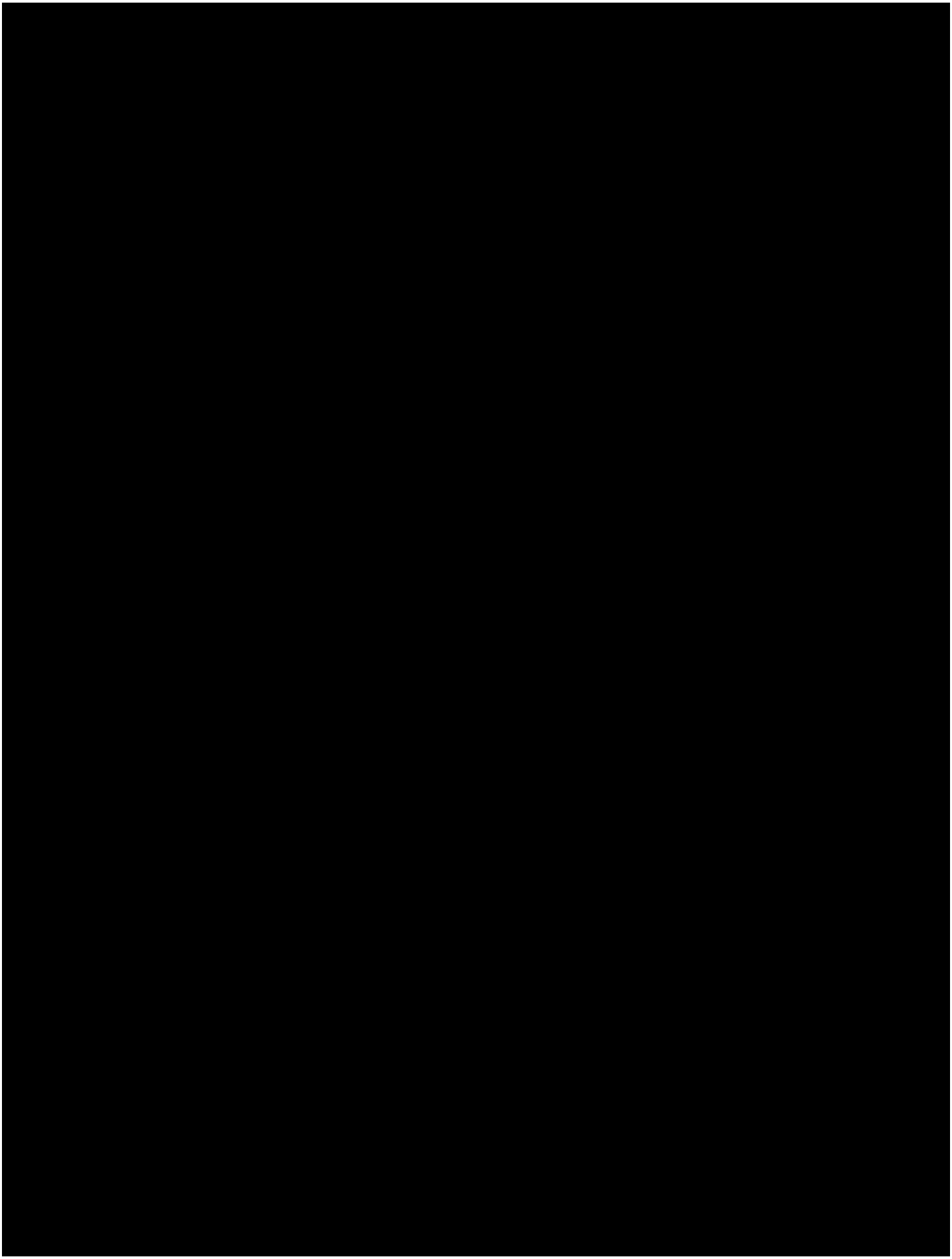


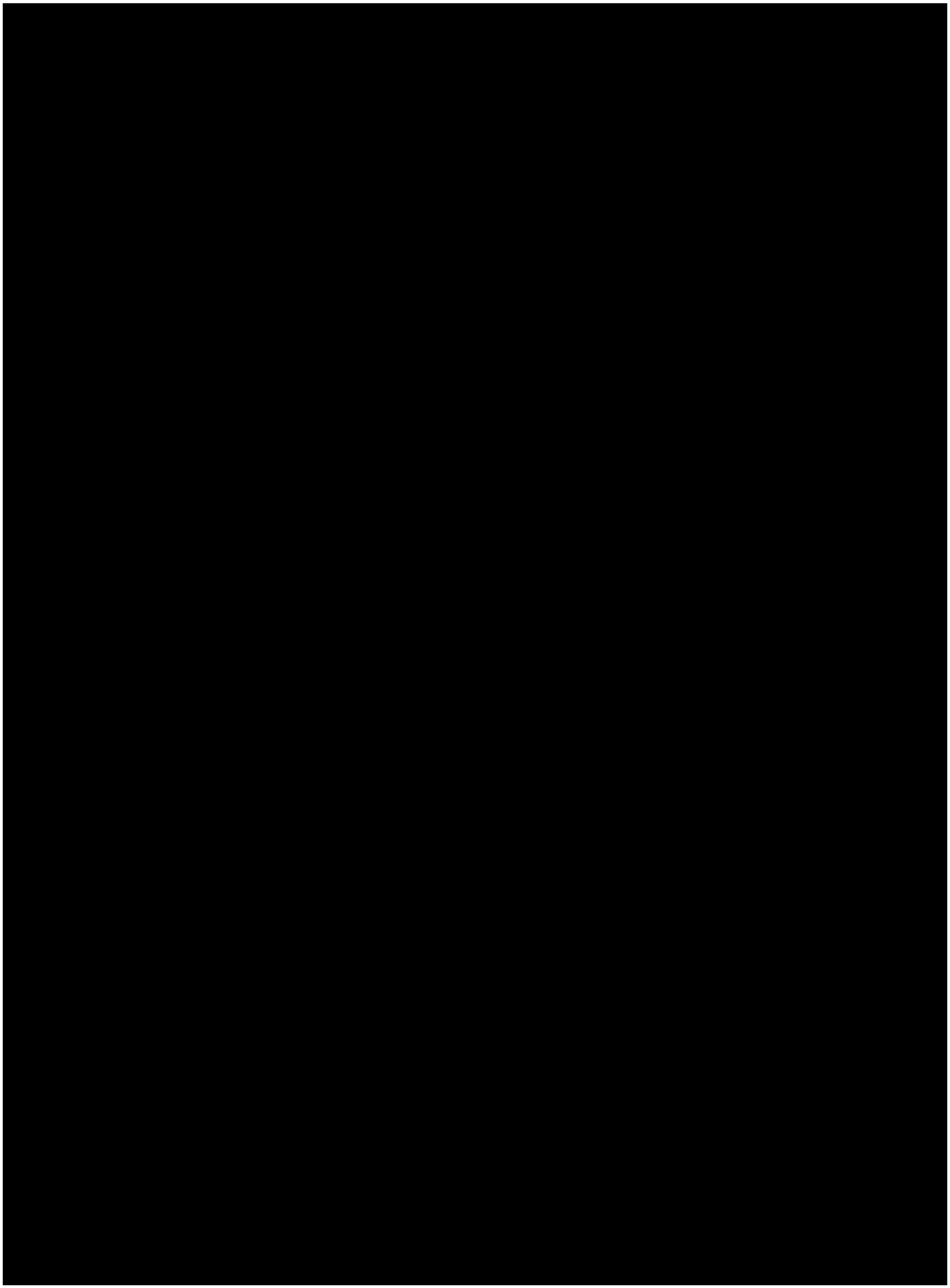


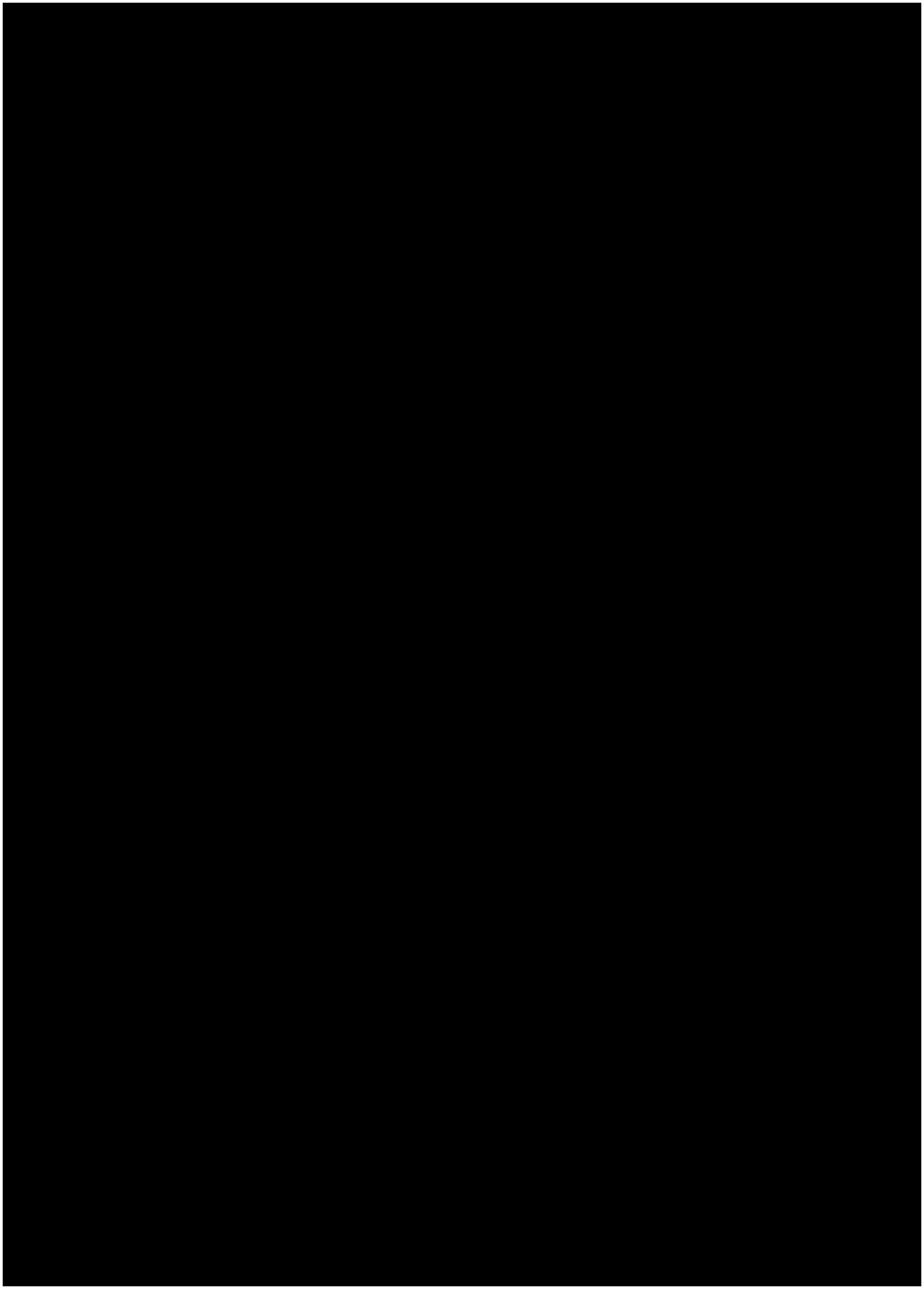


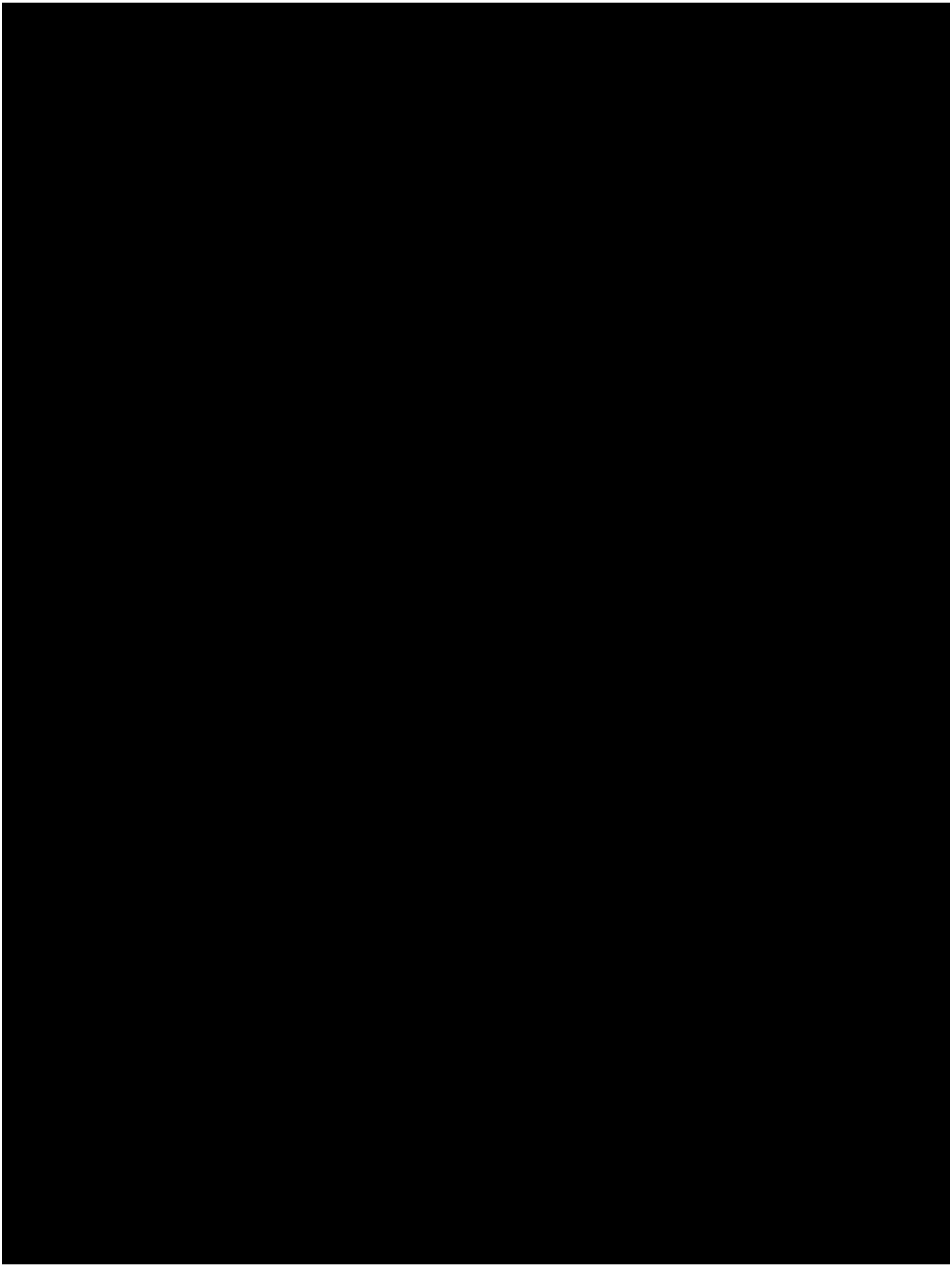


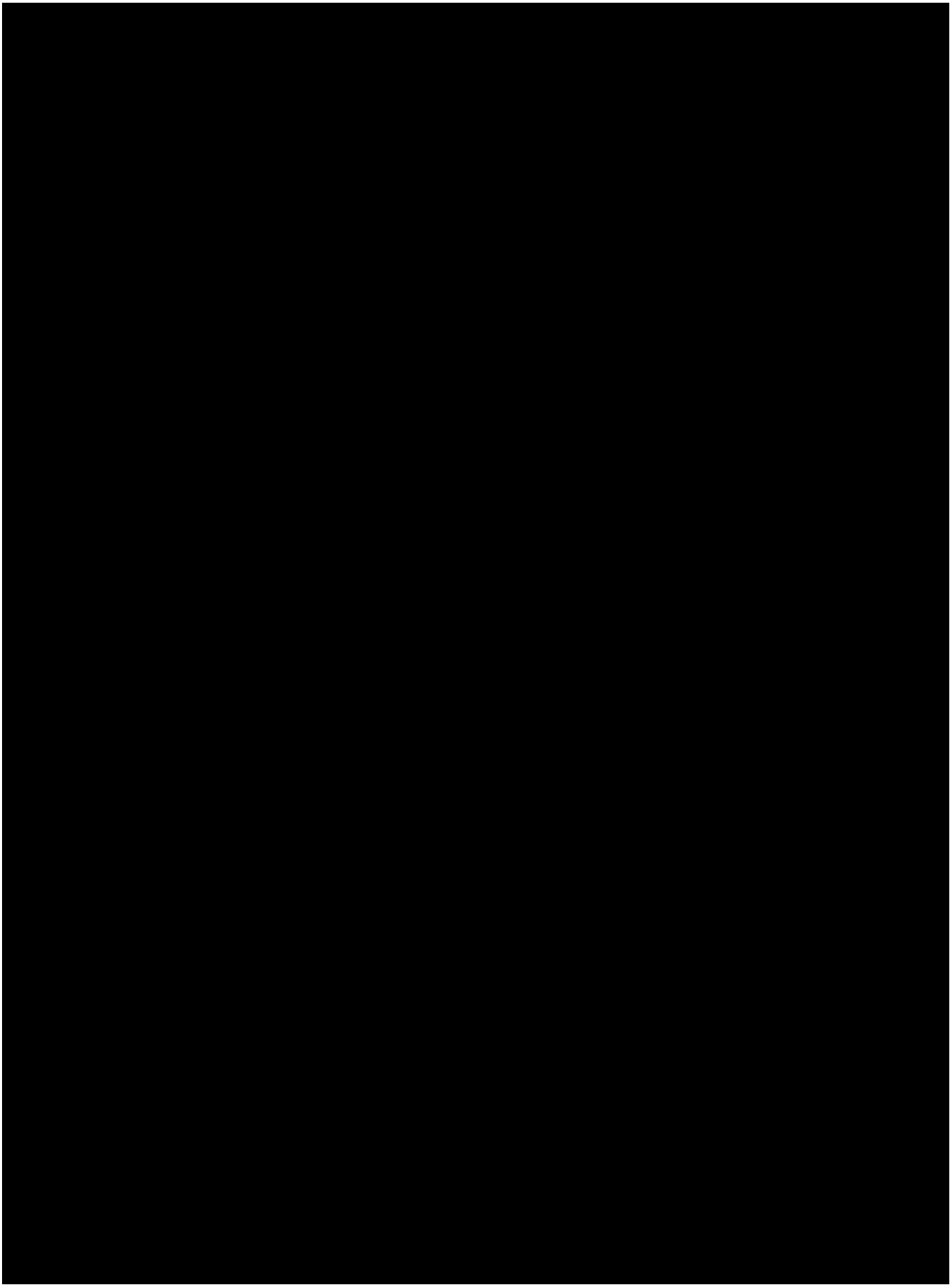


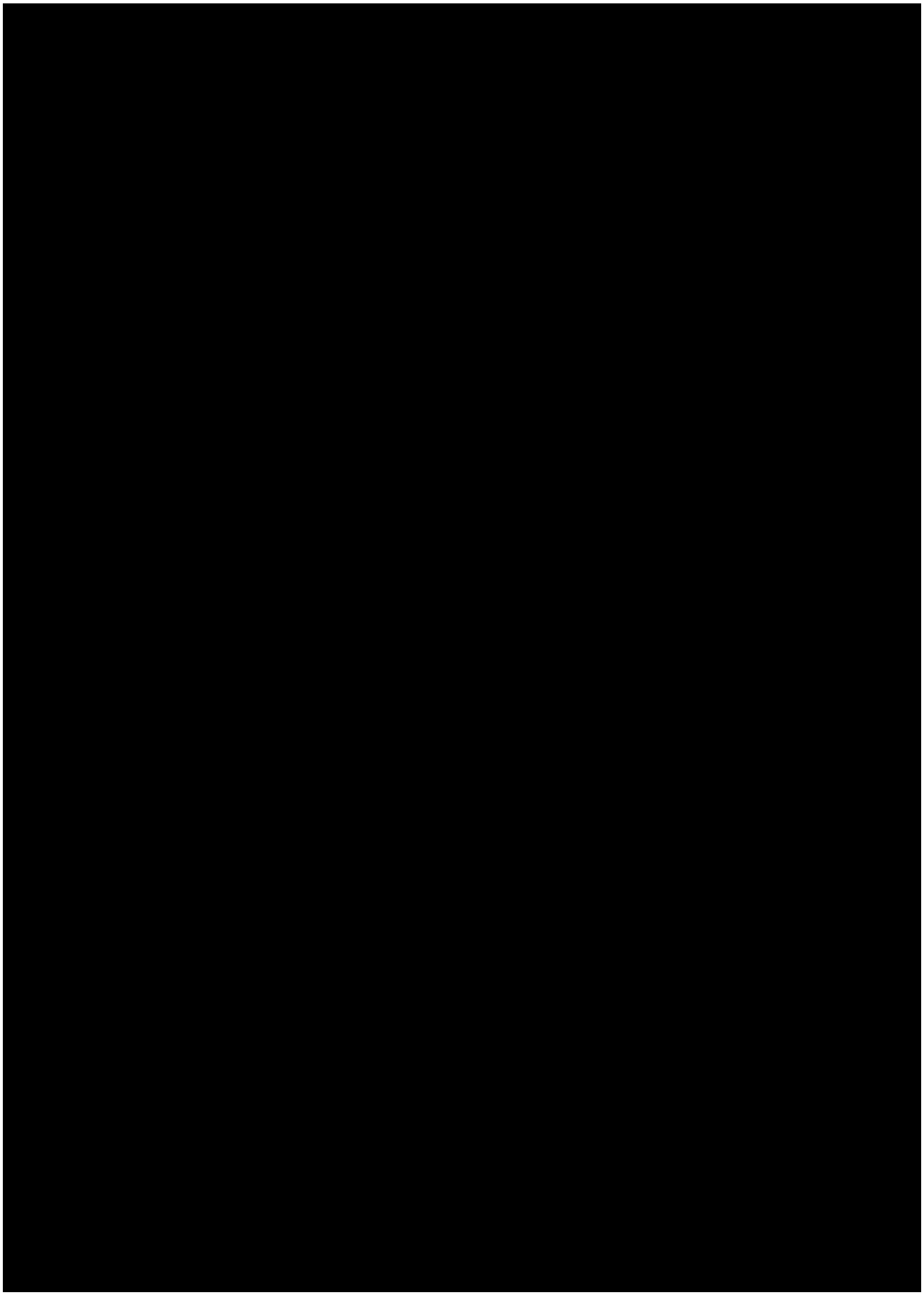


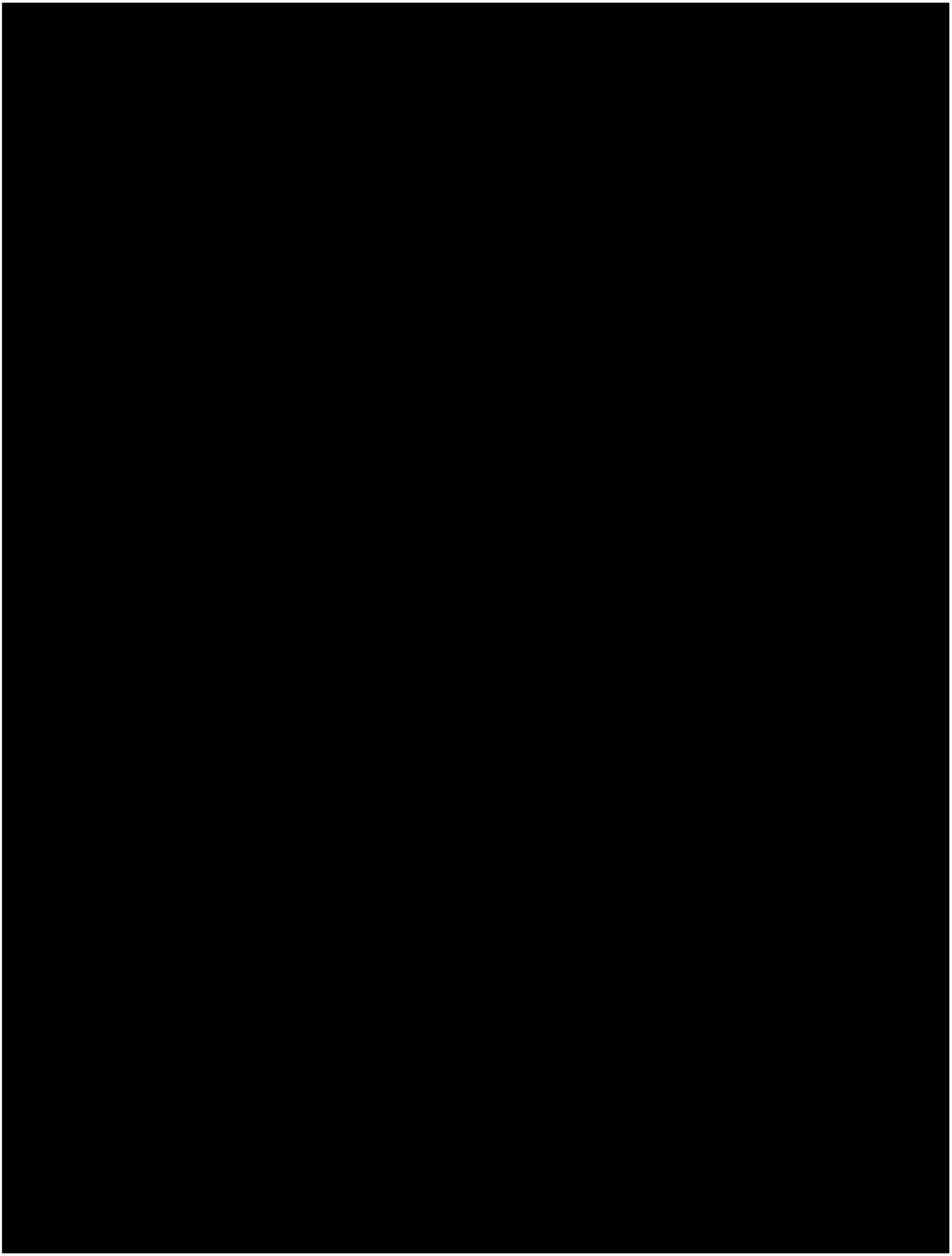


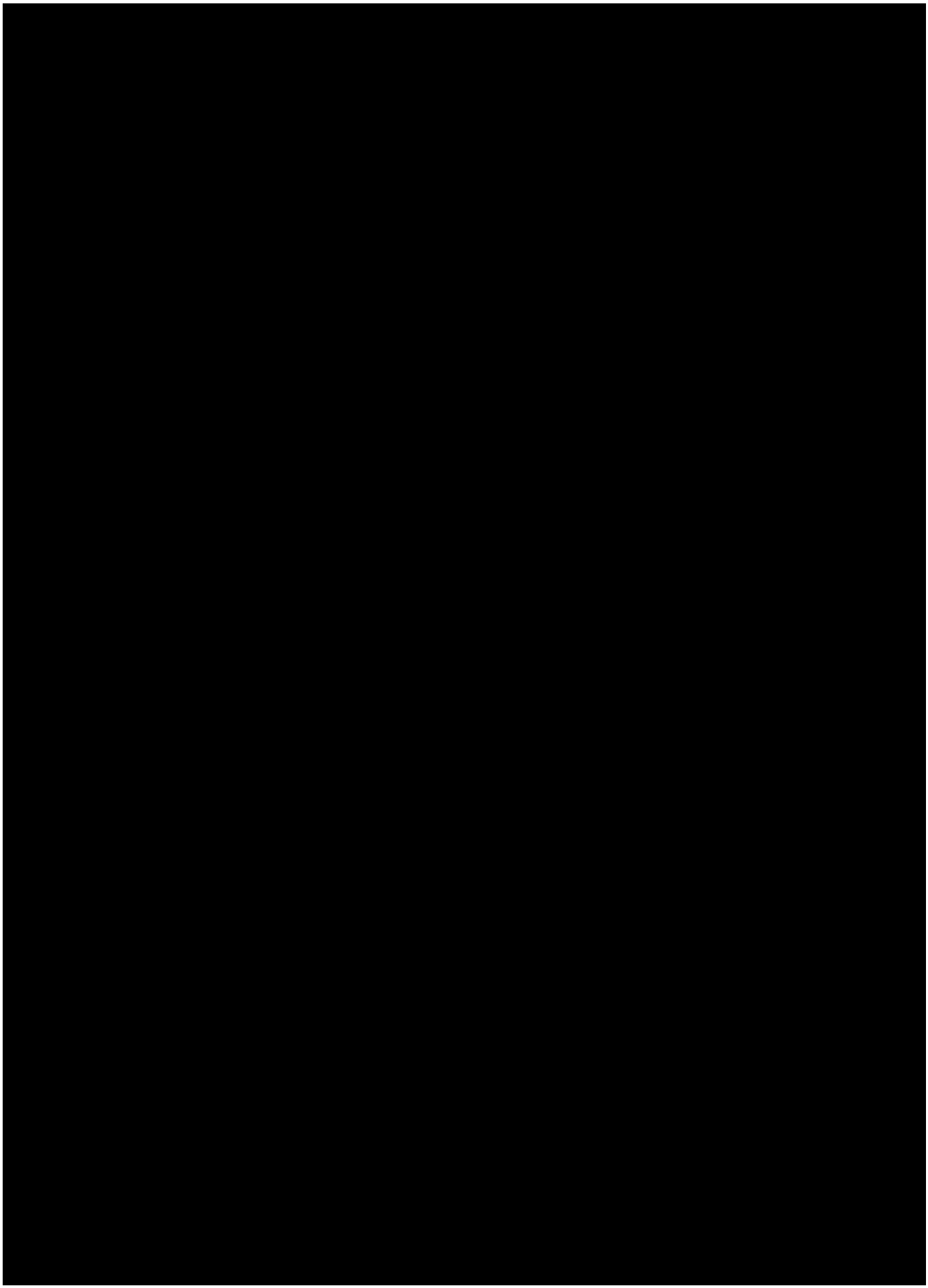


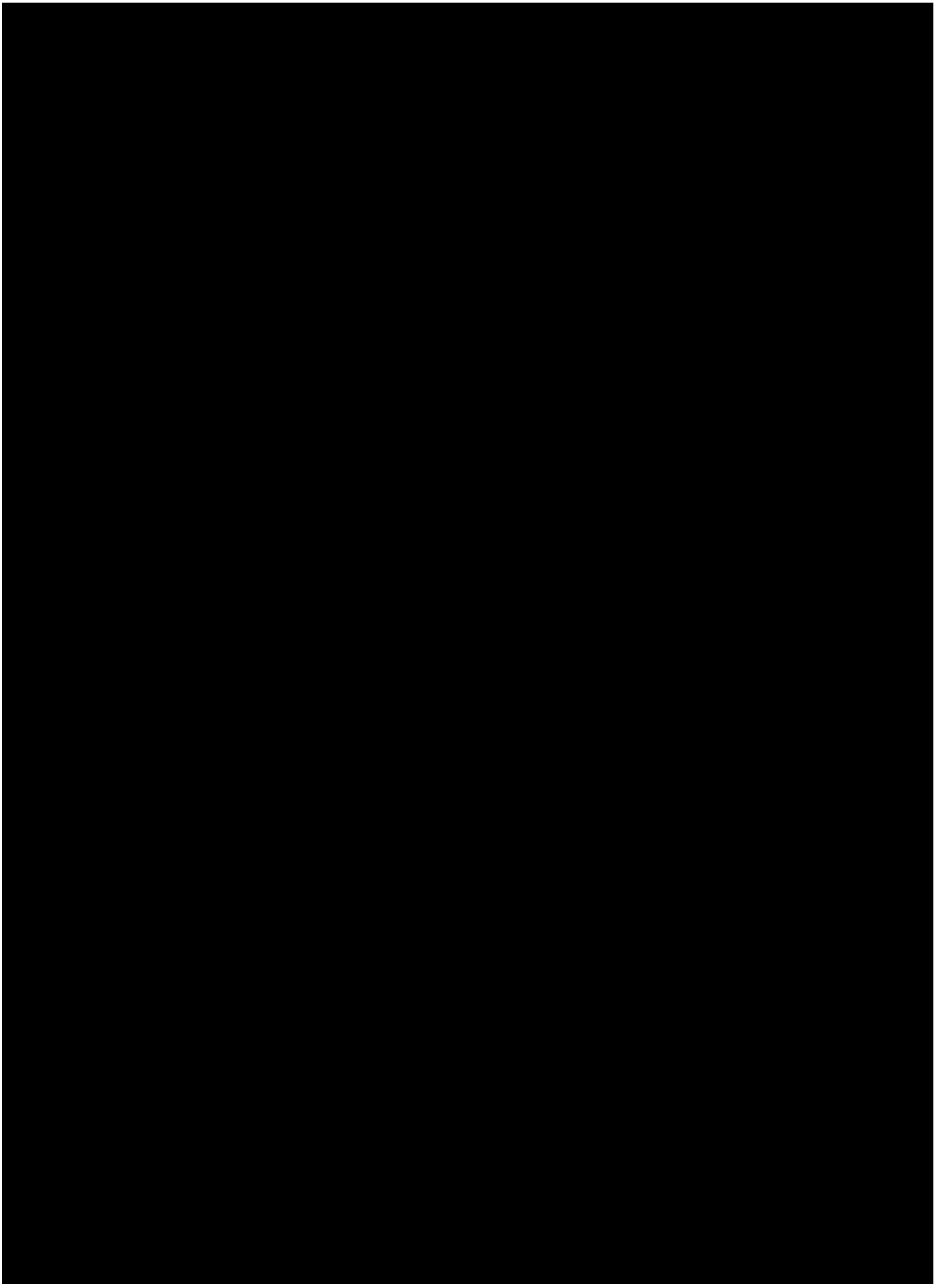


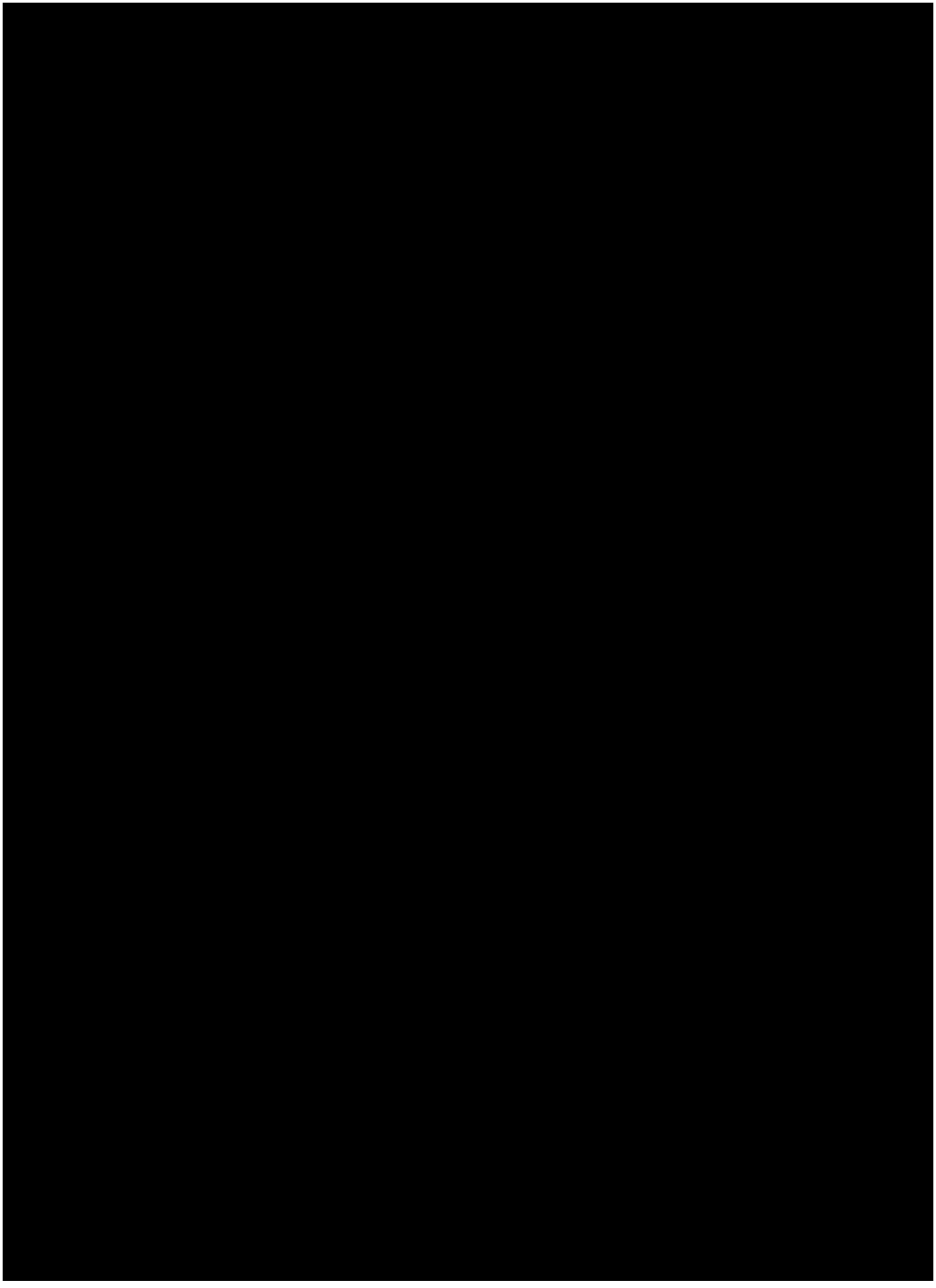


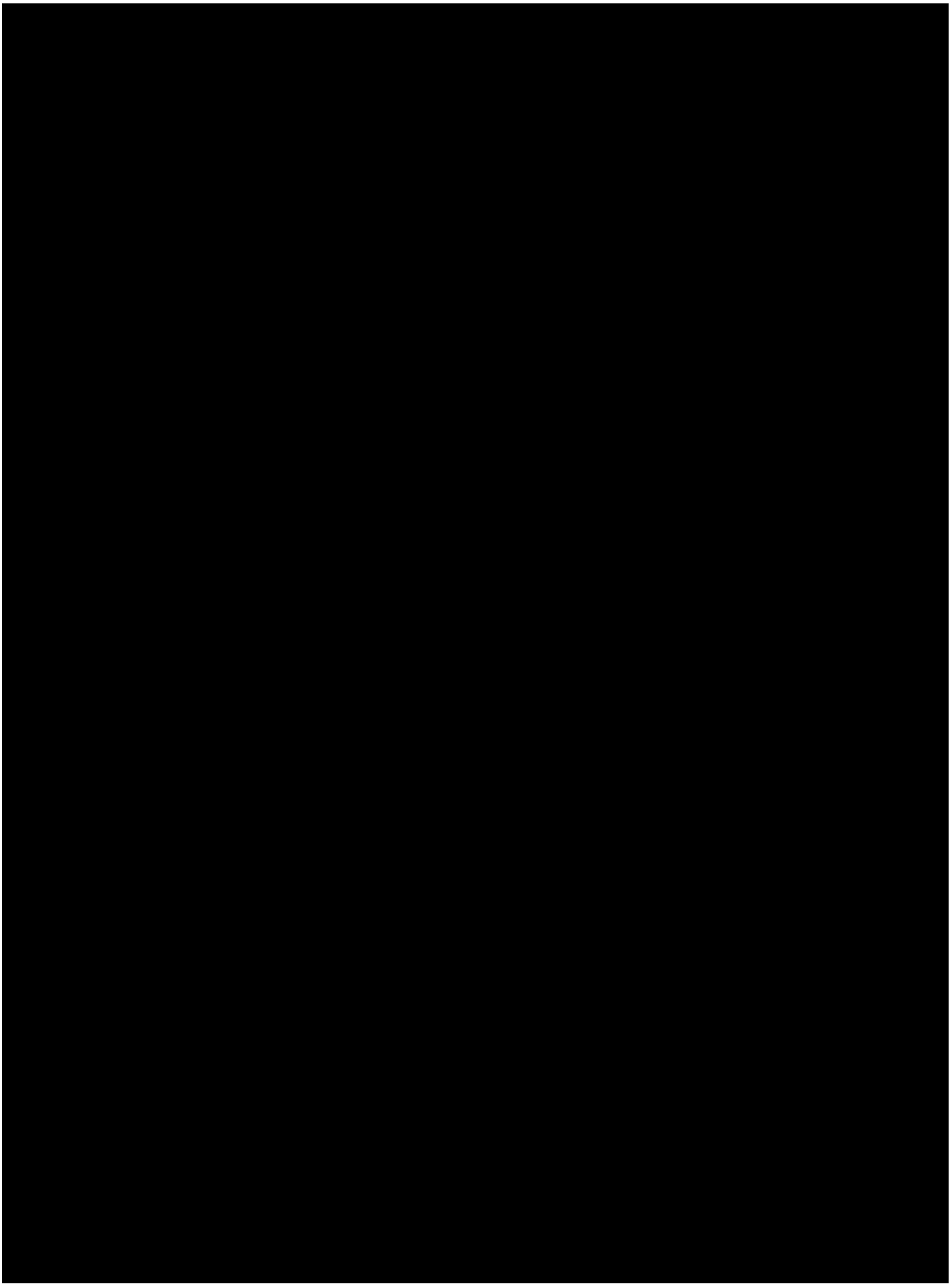


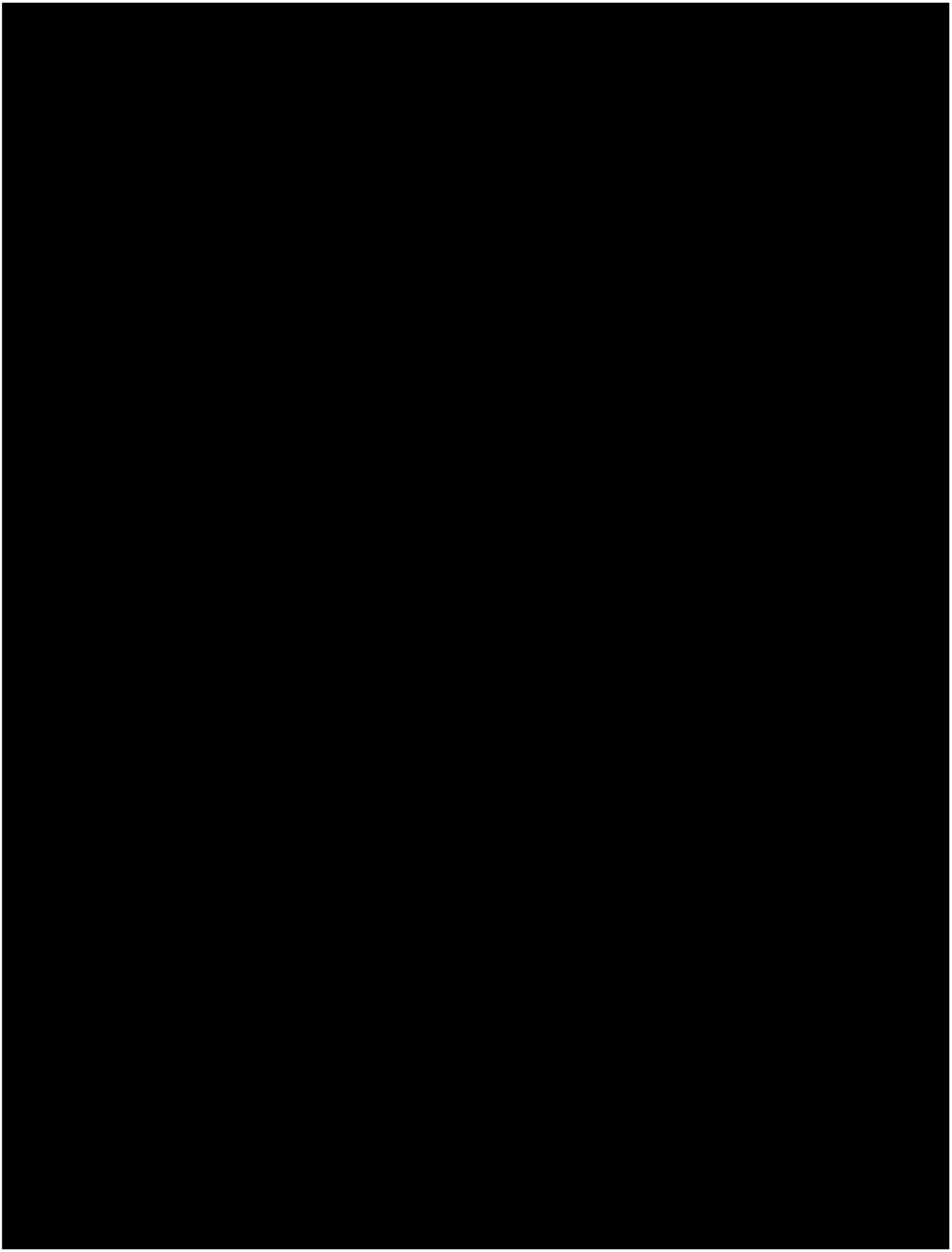


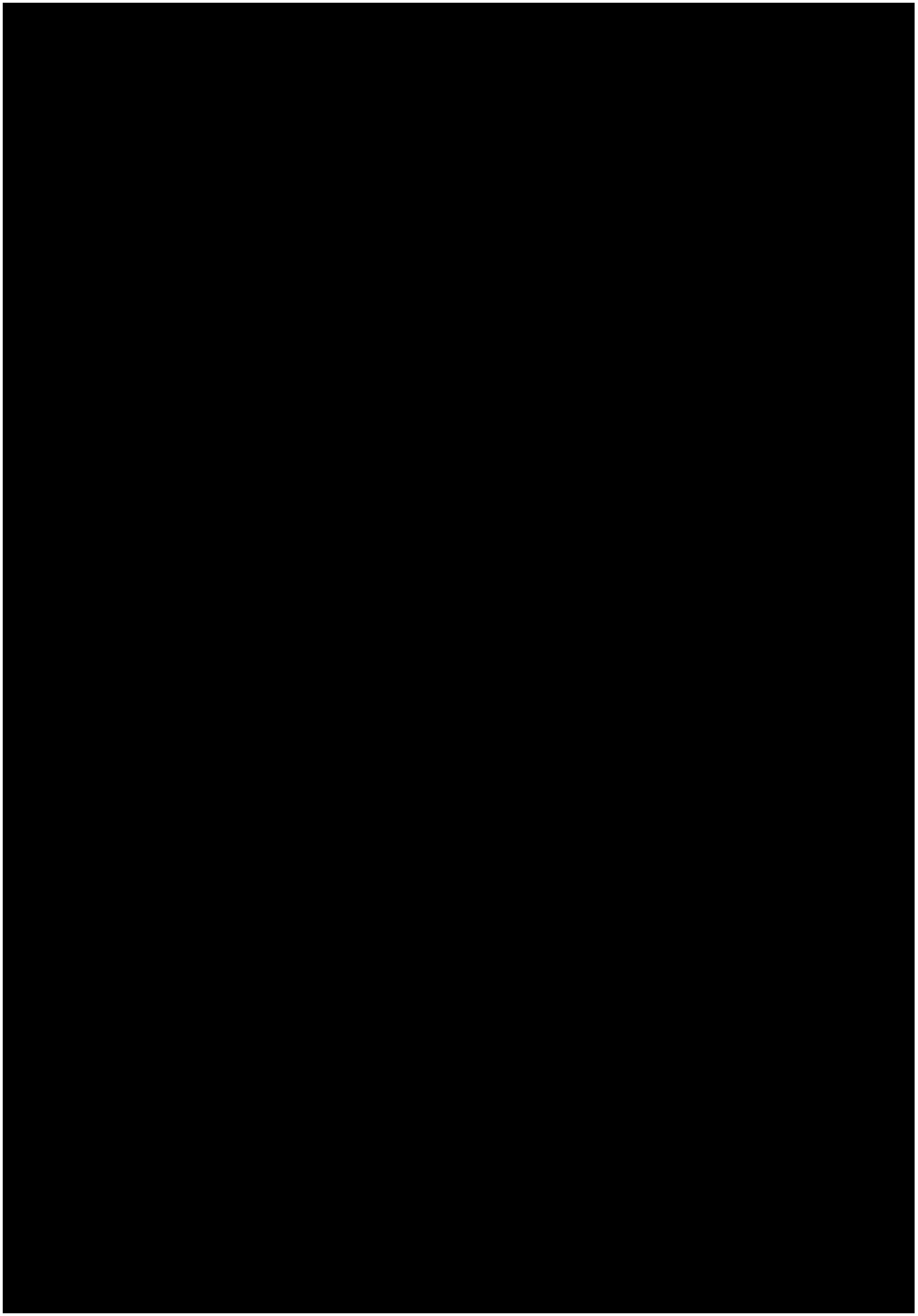


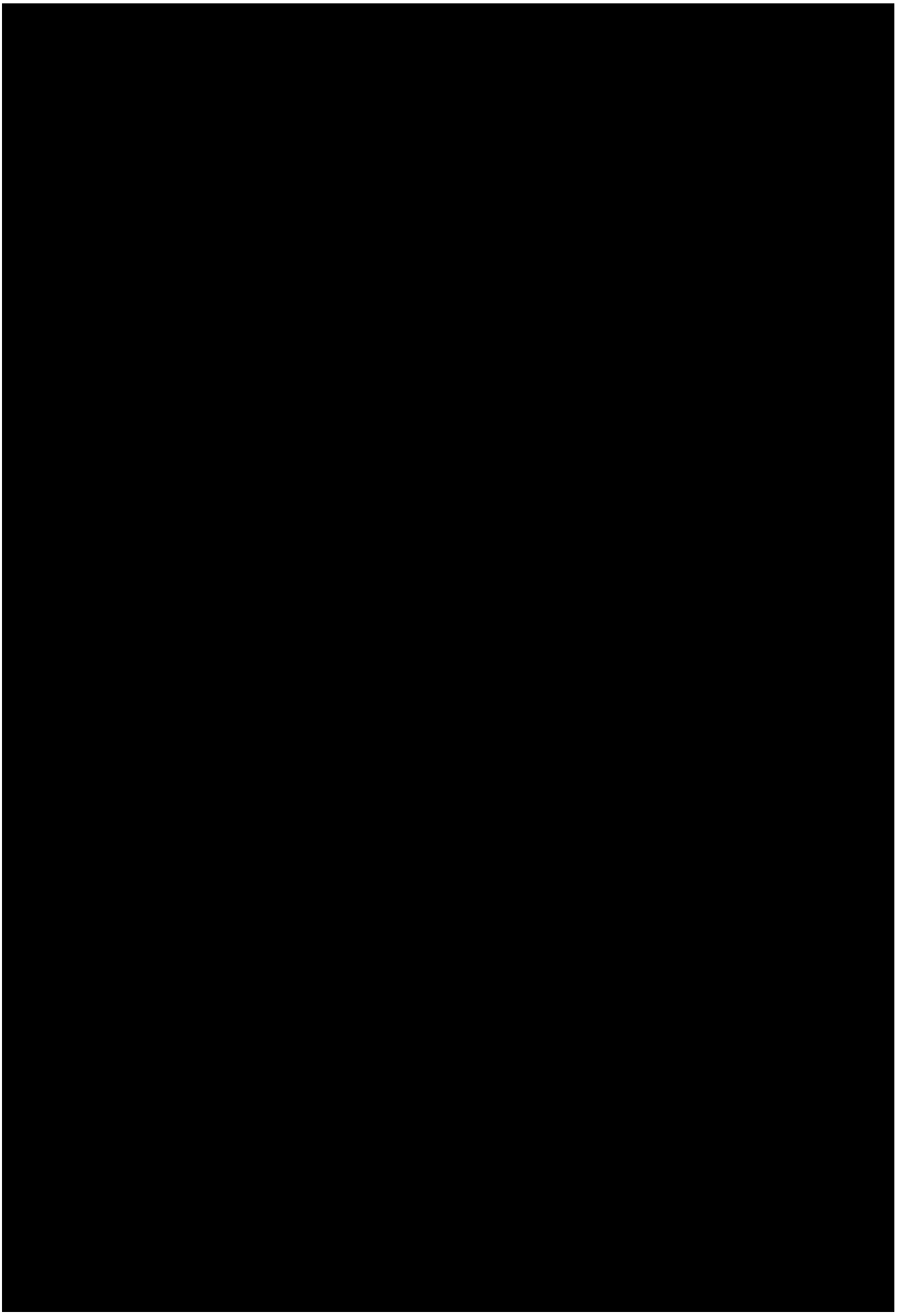


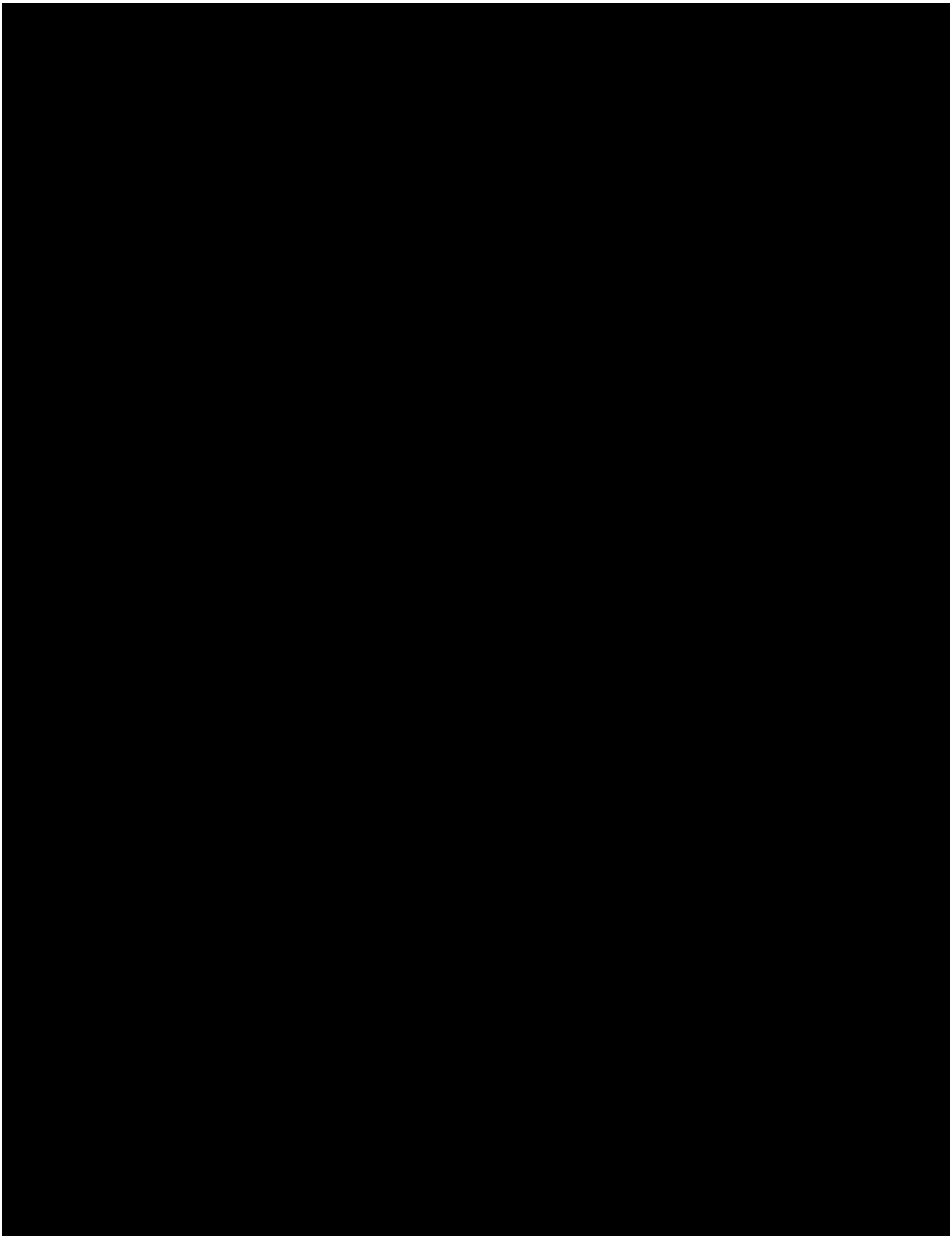


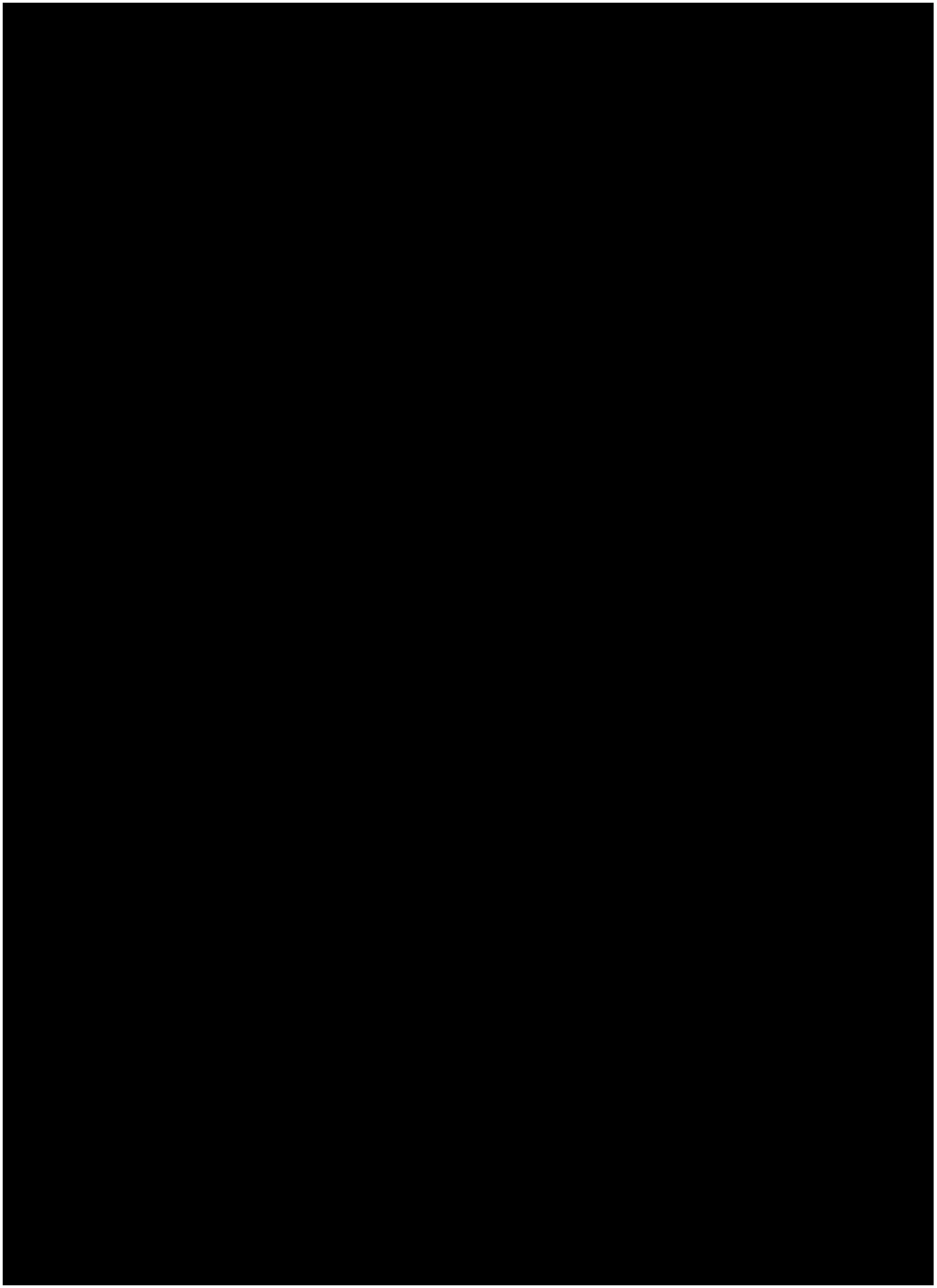


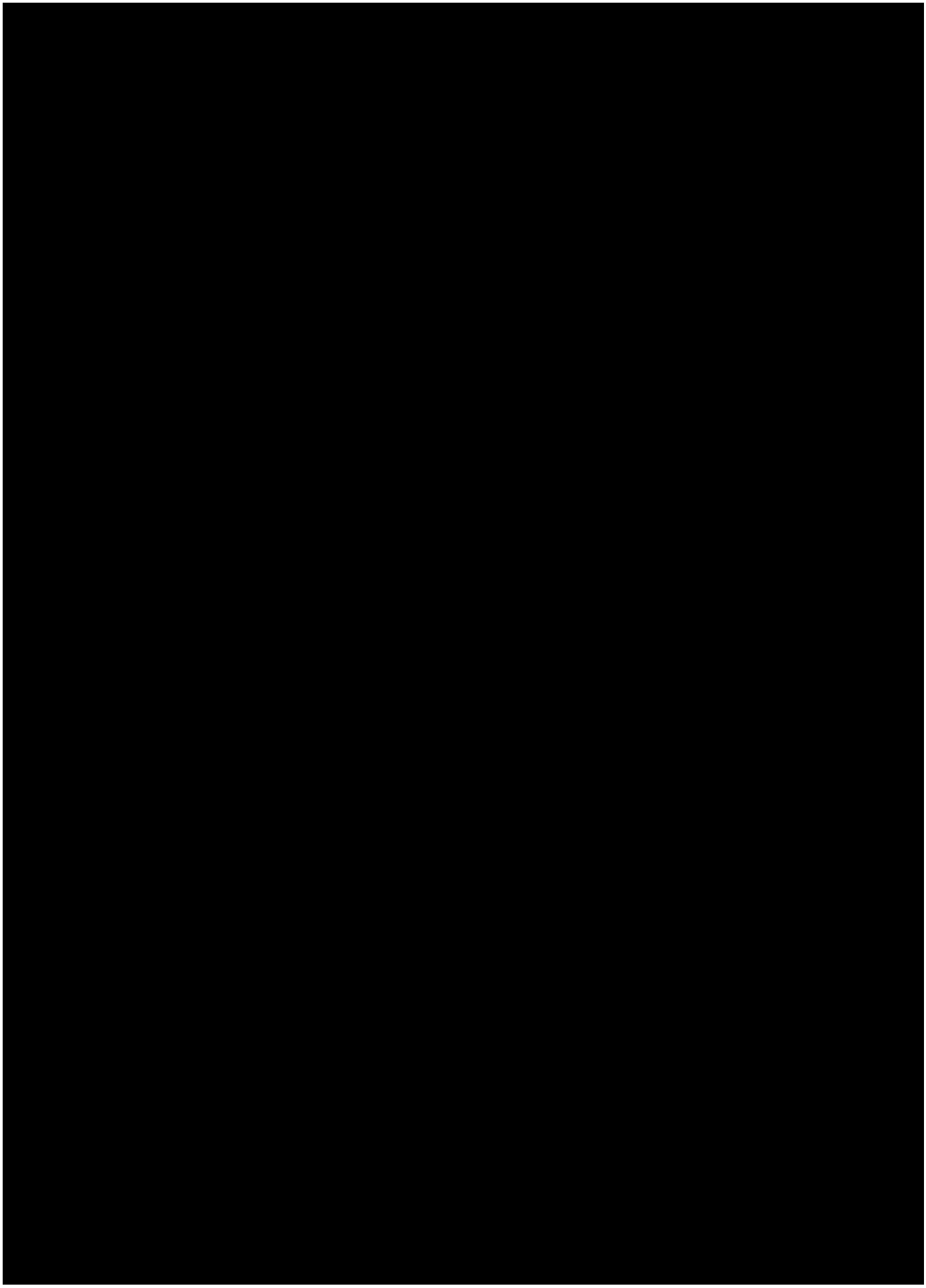


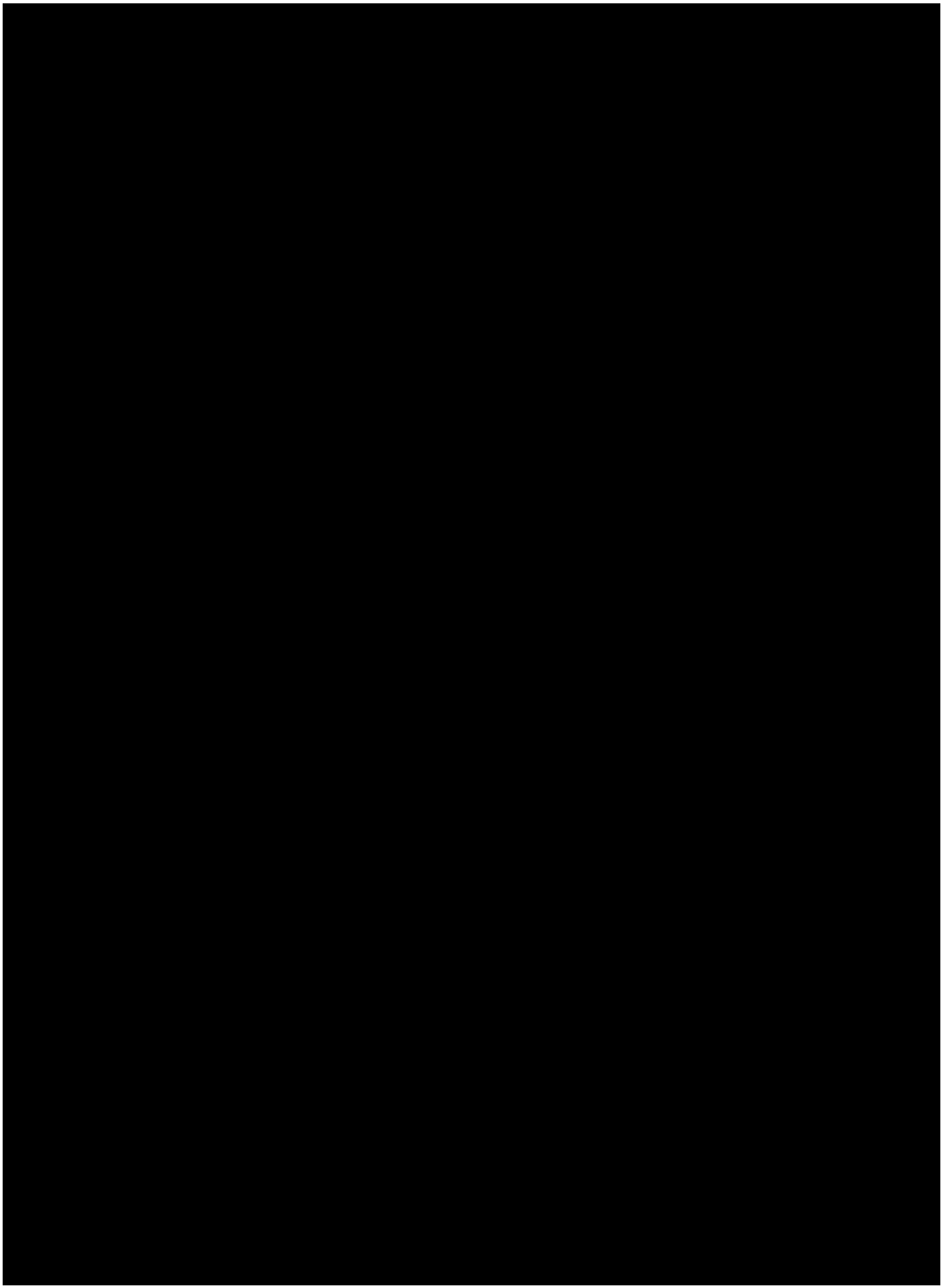




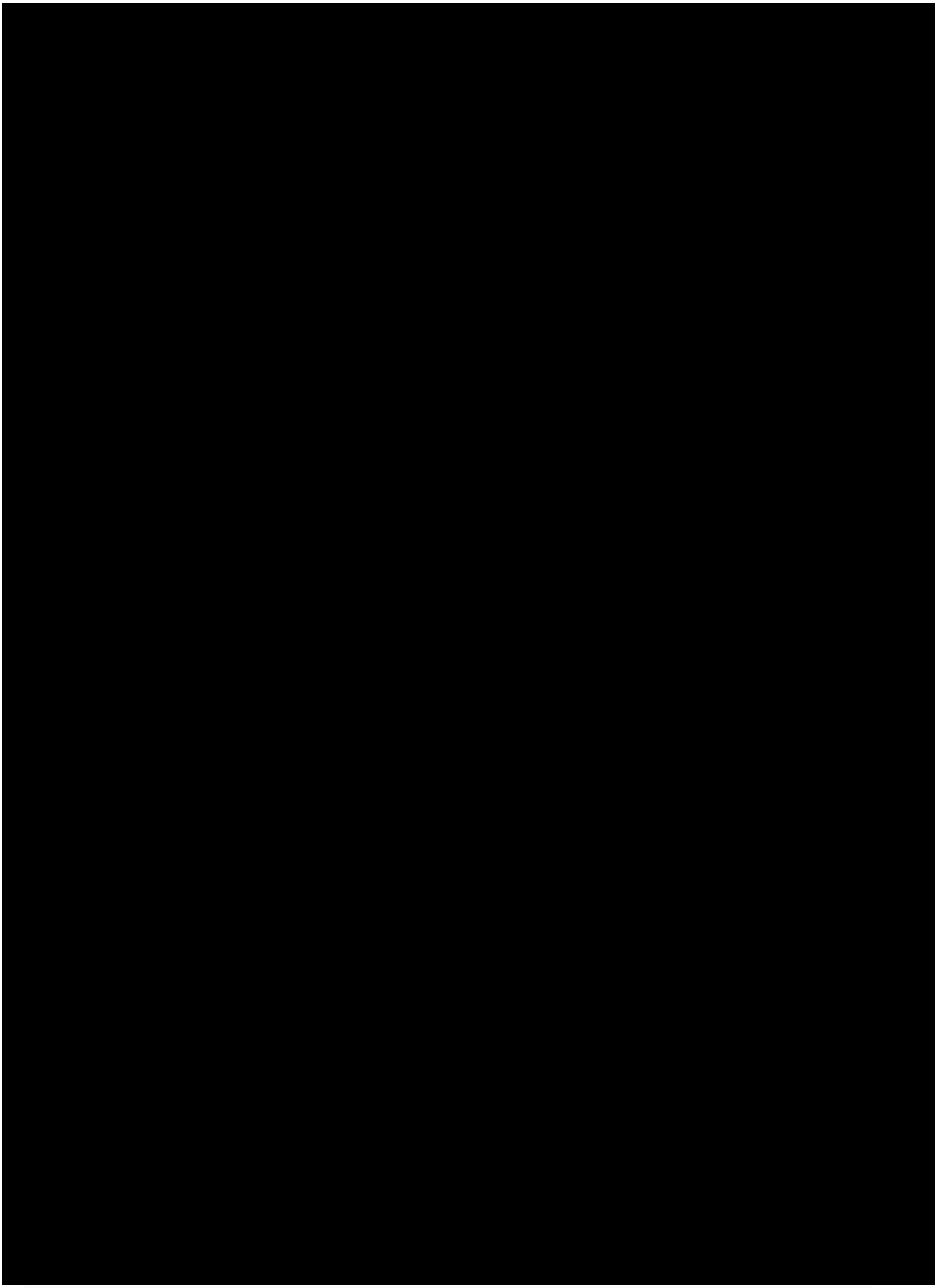


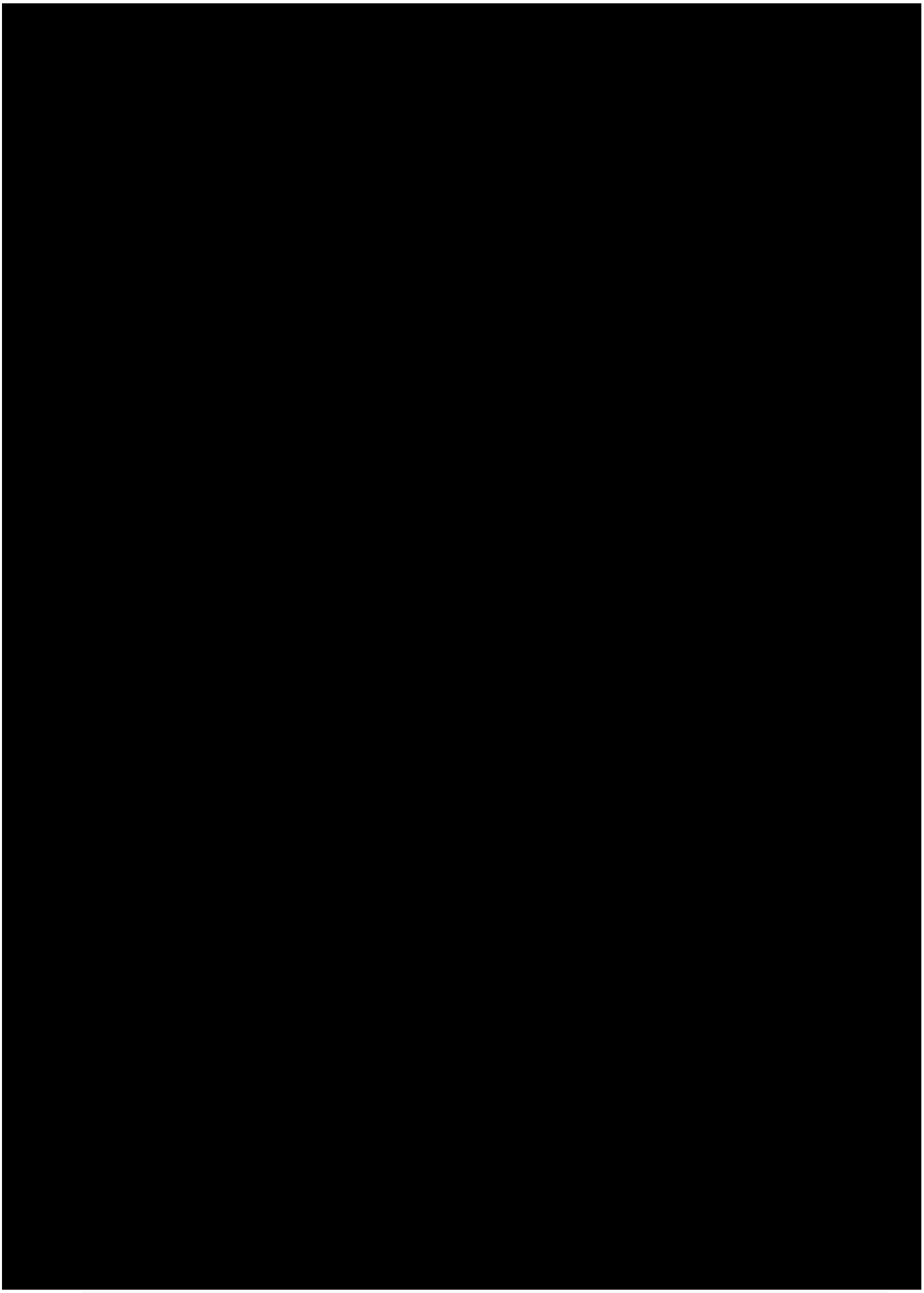


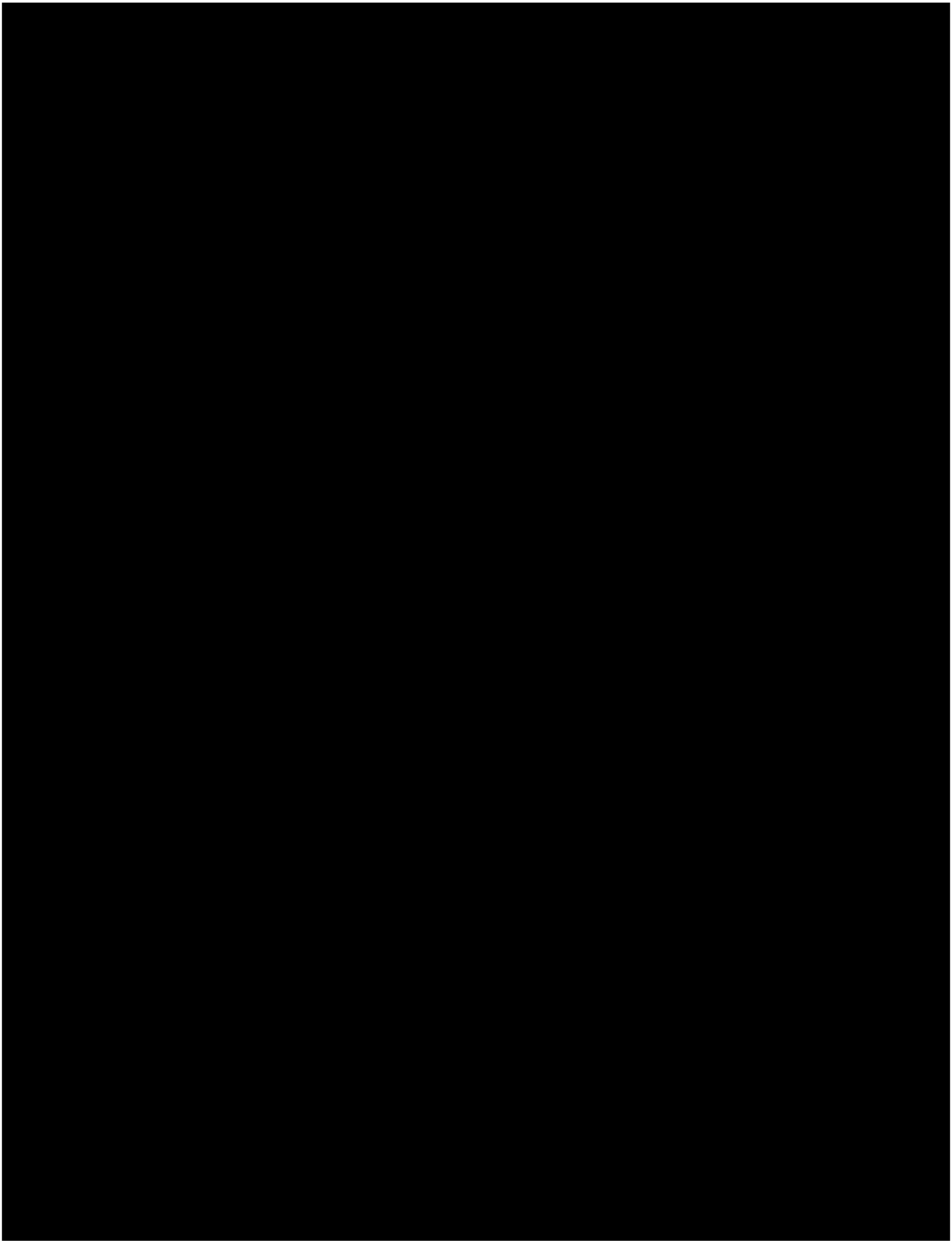


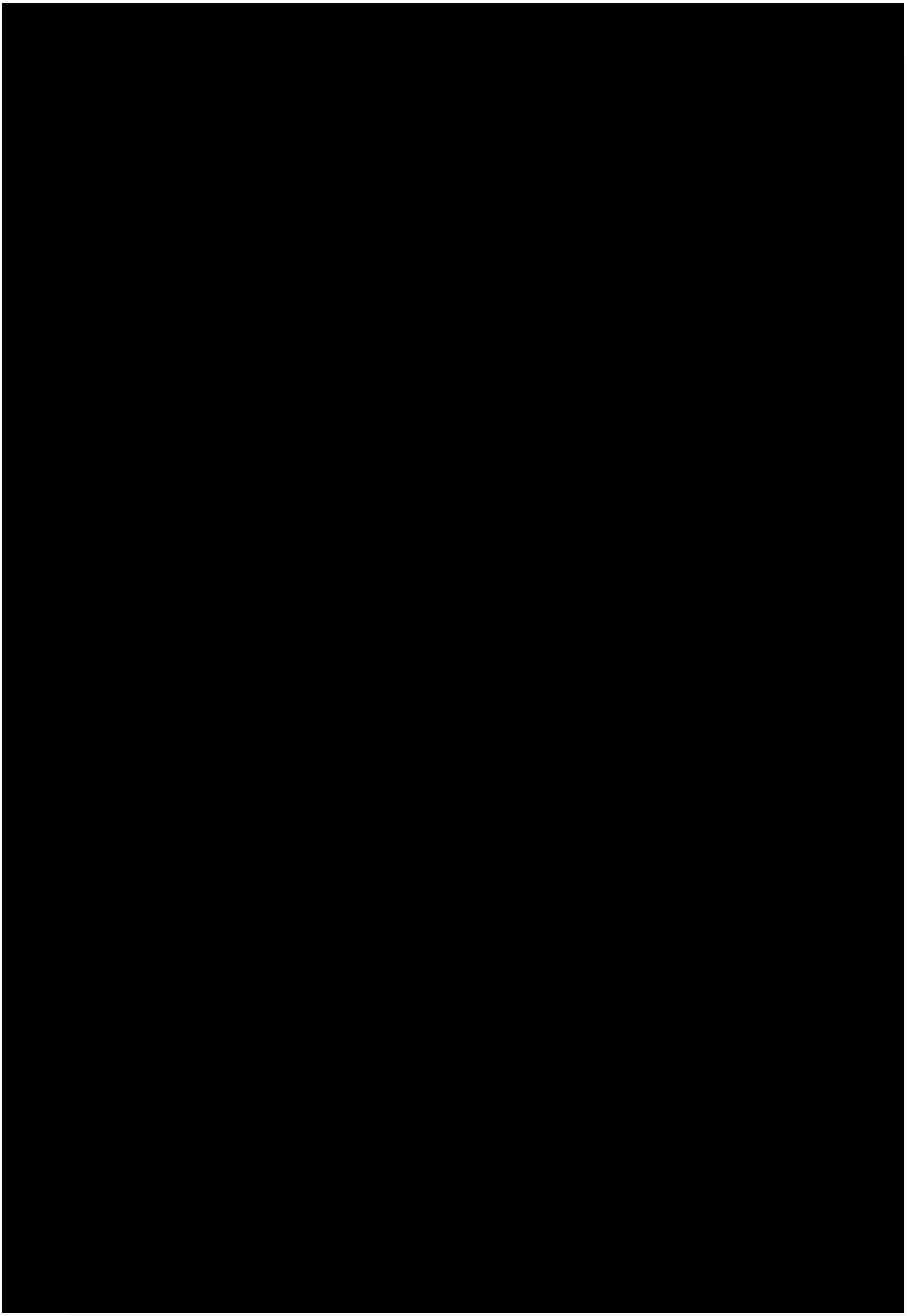


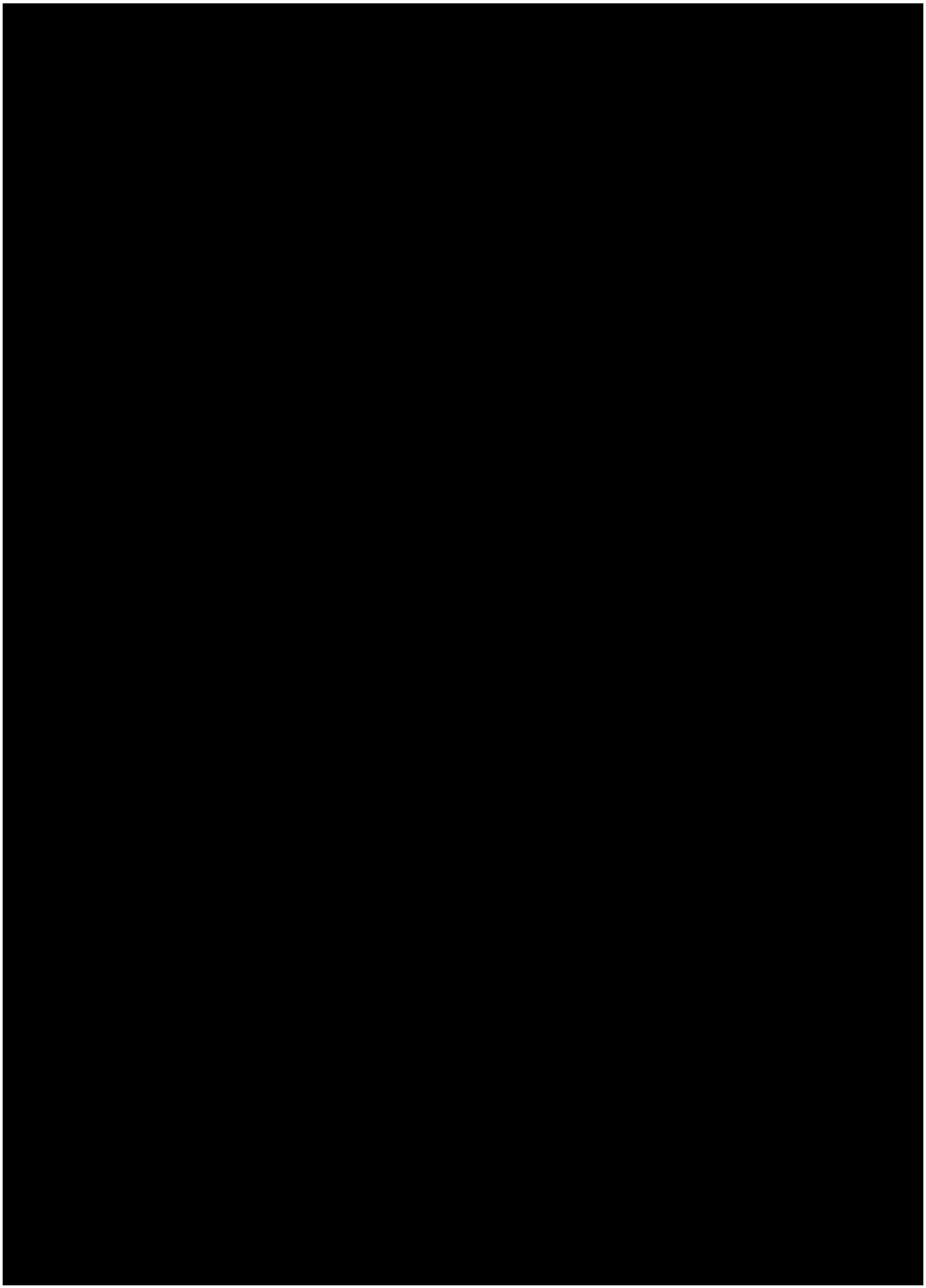
[redacted]

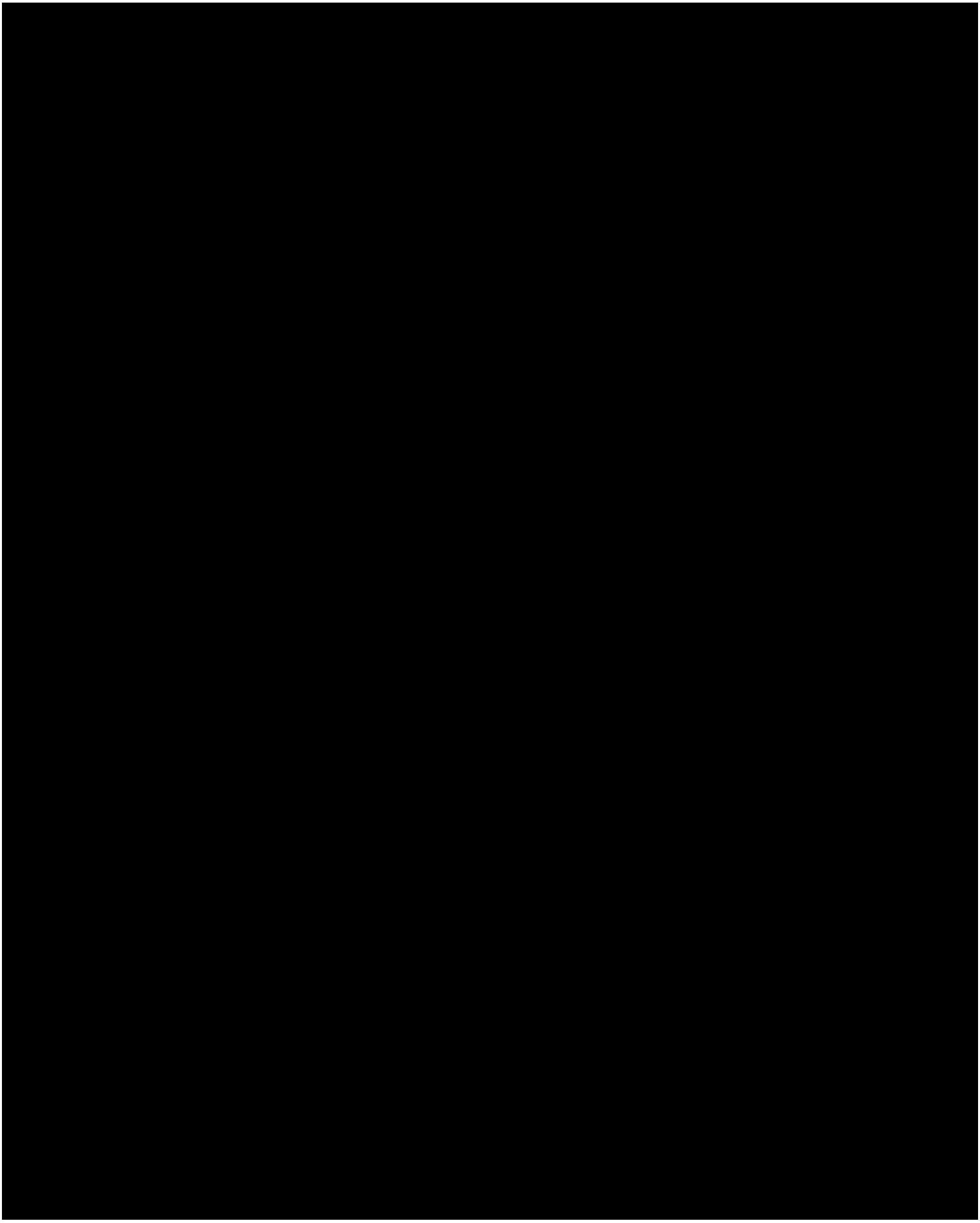


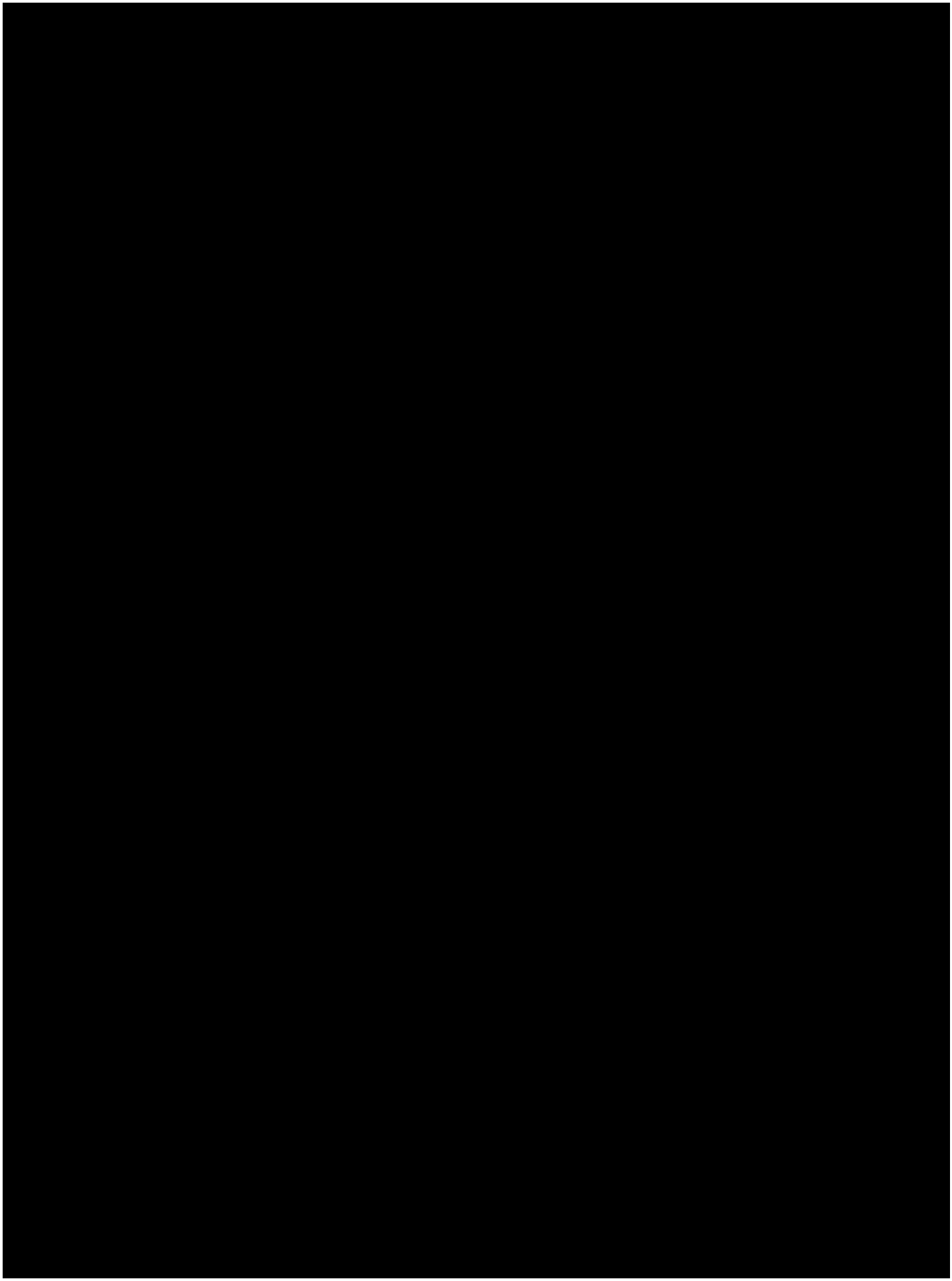


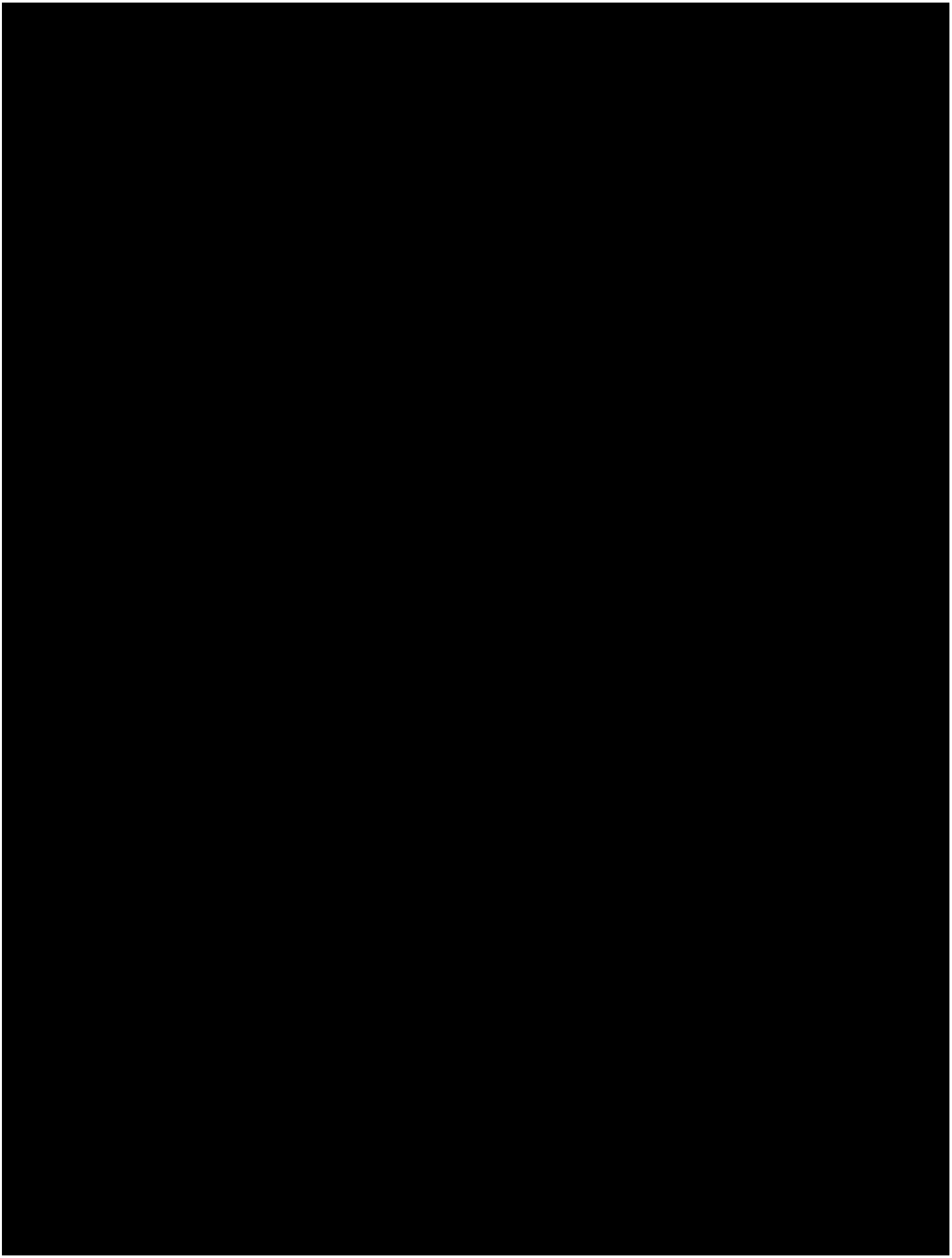


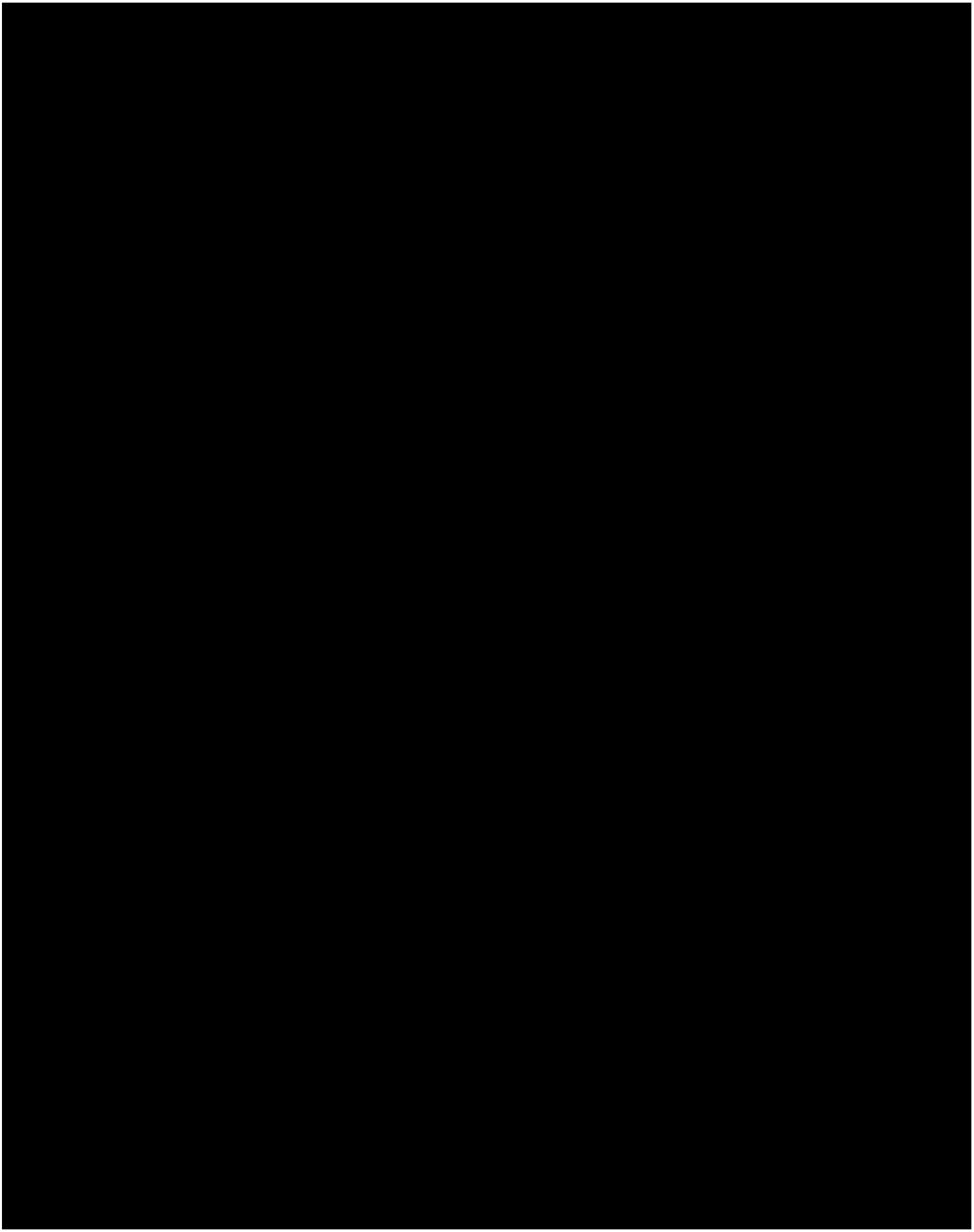


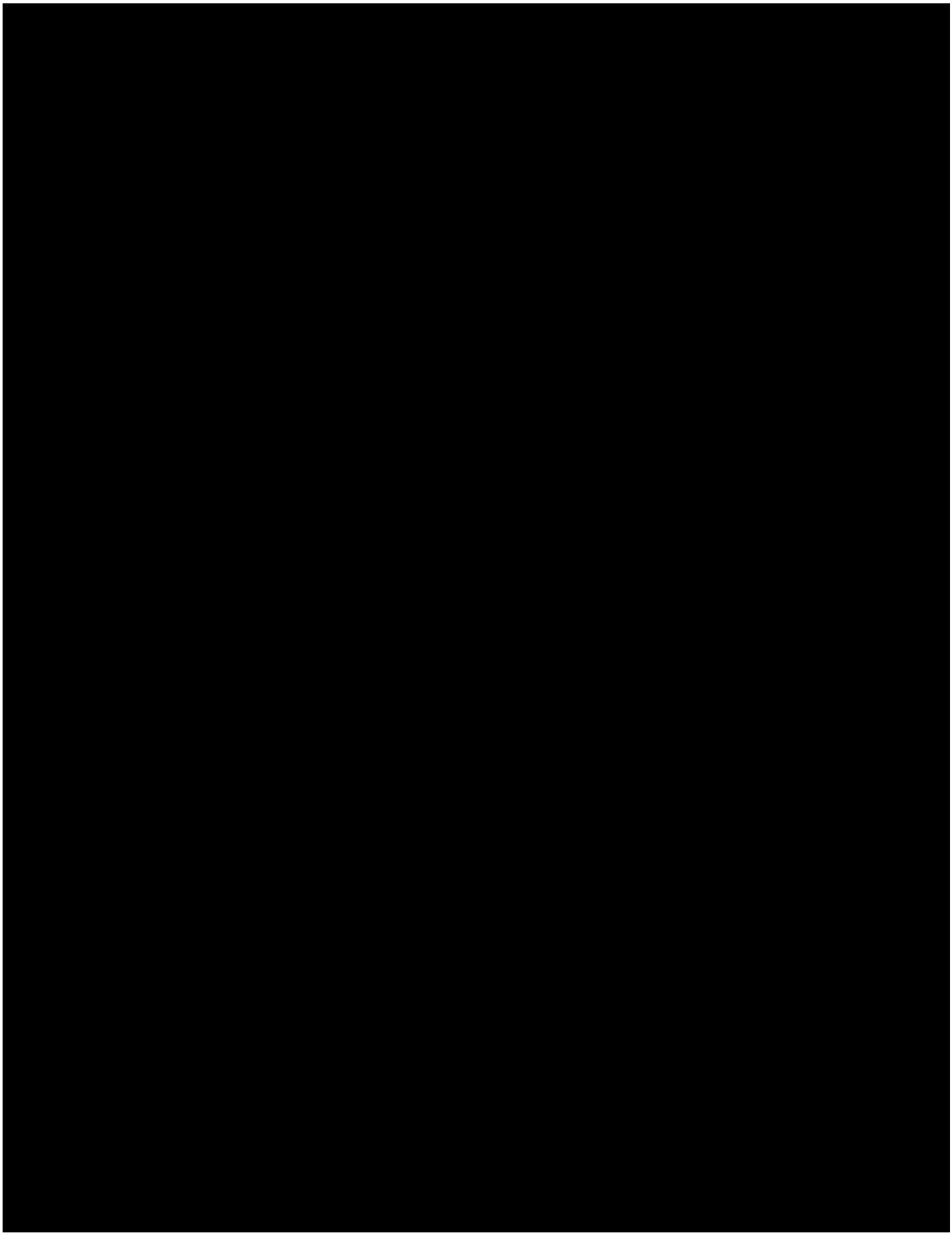












This content has been removed for data protection reasons

Part C: Case Study

Case Study Assimilative Integration

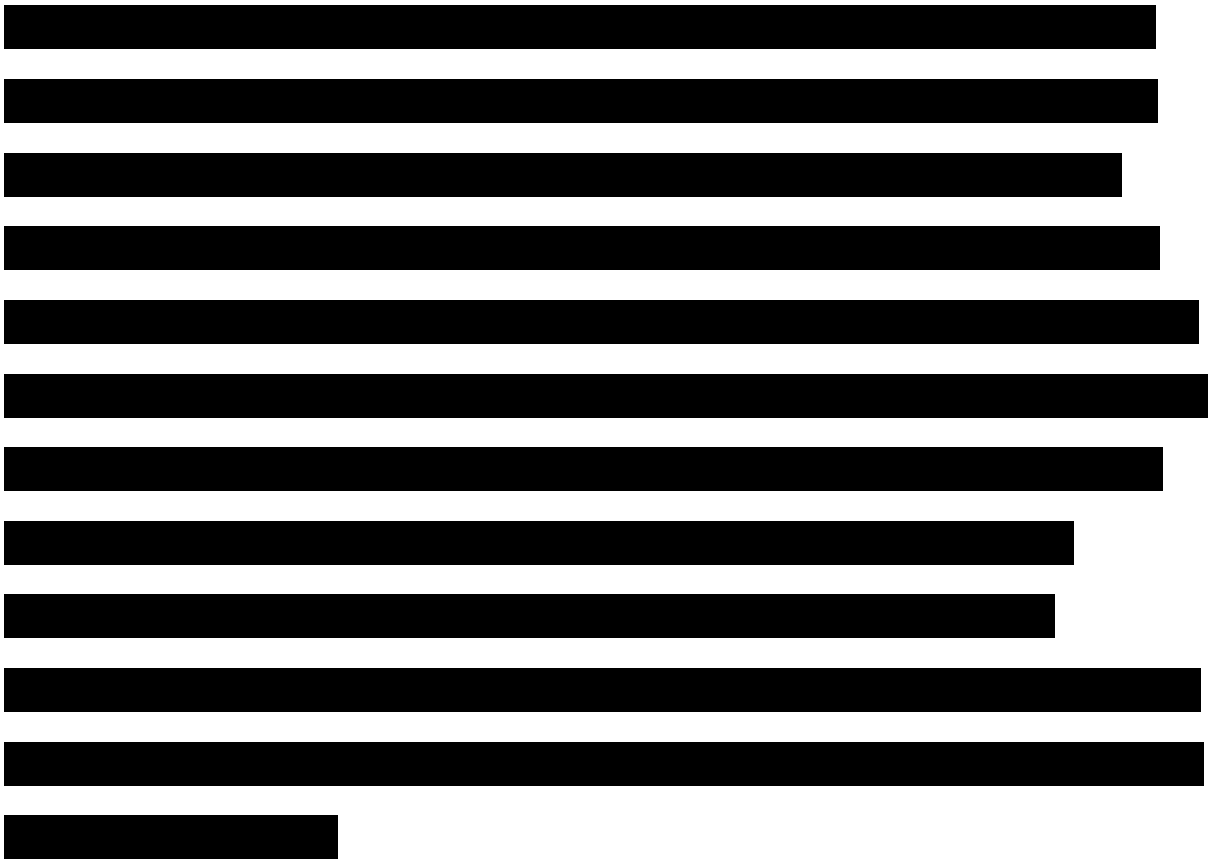
Word Count: 6585

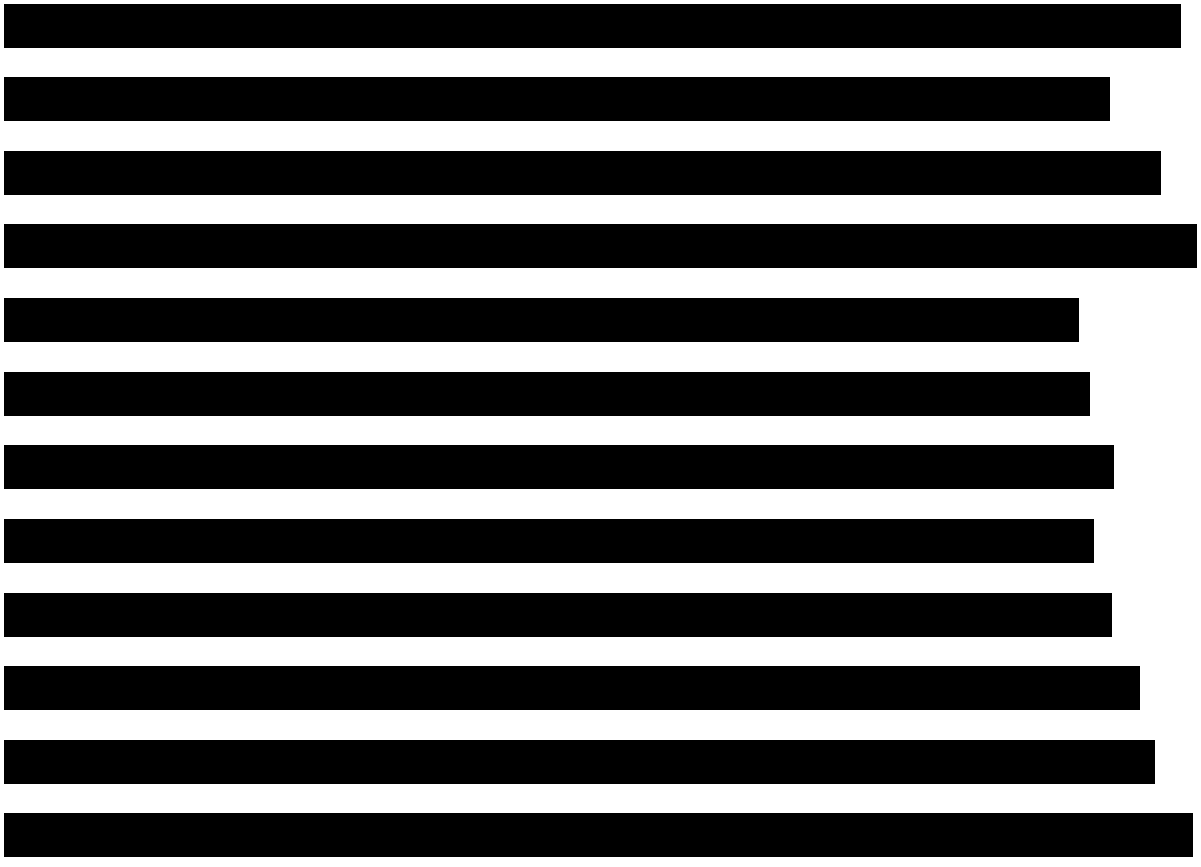
Title: Posttraumatic Growth: Trauma and the concept of Holism through Assimilative Integration

[redacted]

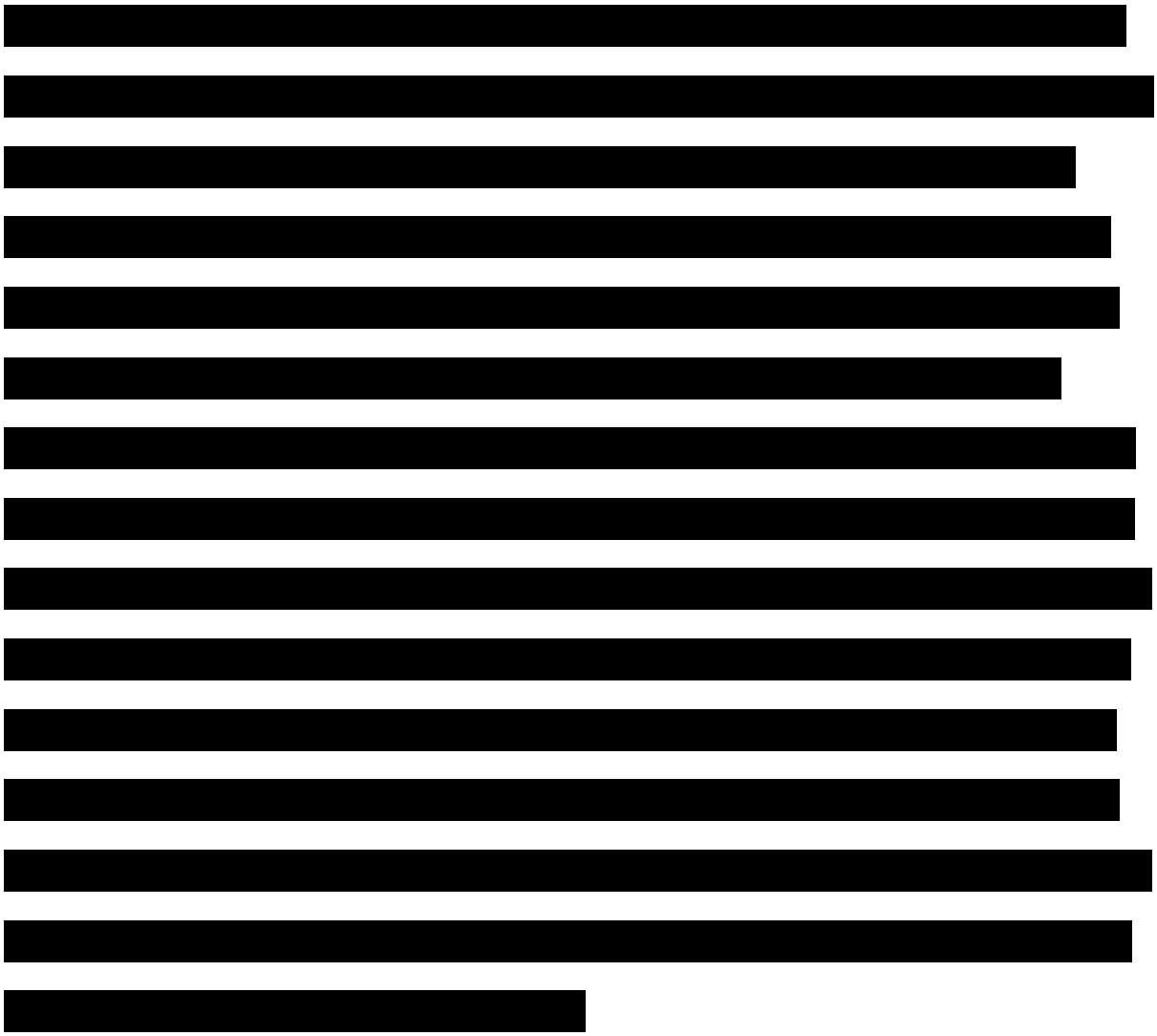
[redacted]

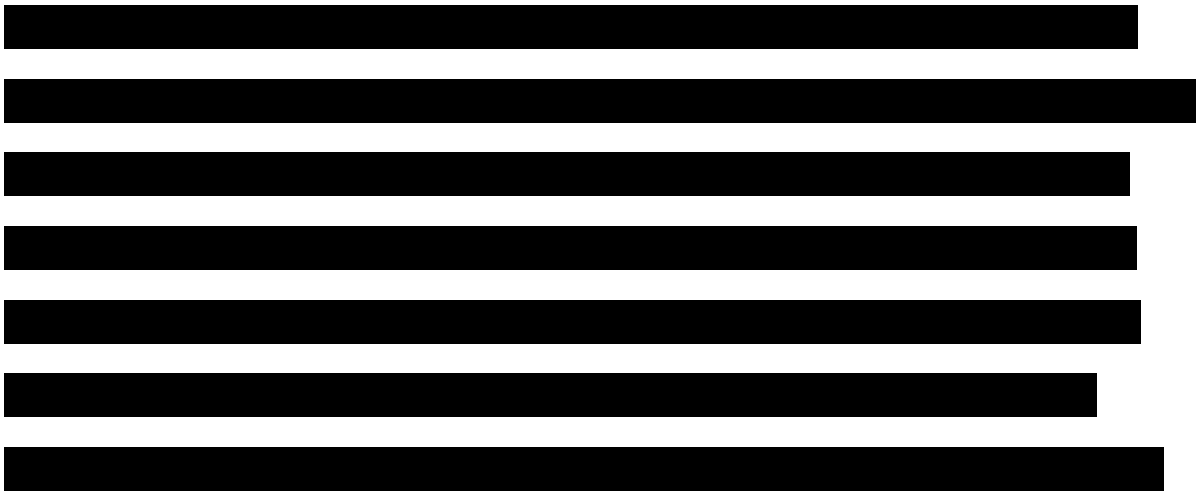
[redacted]





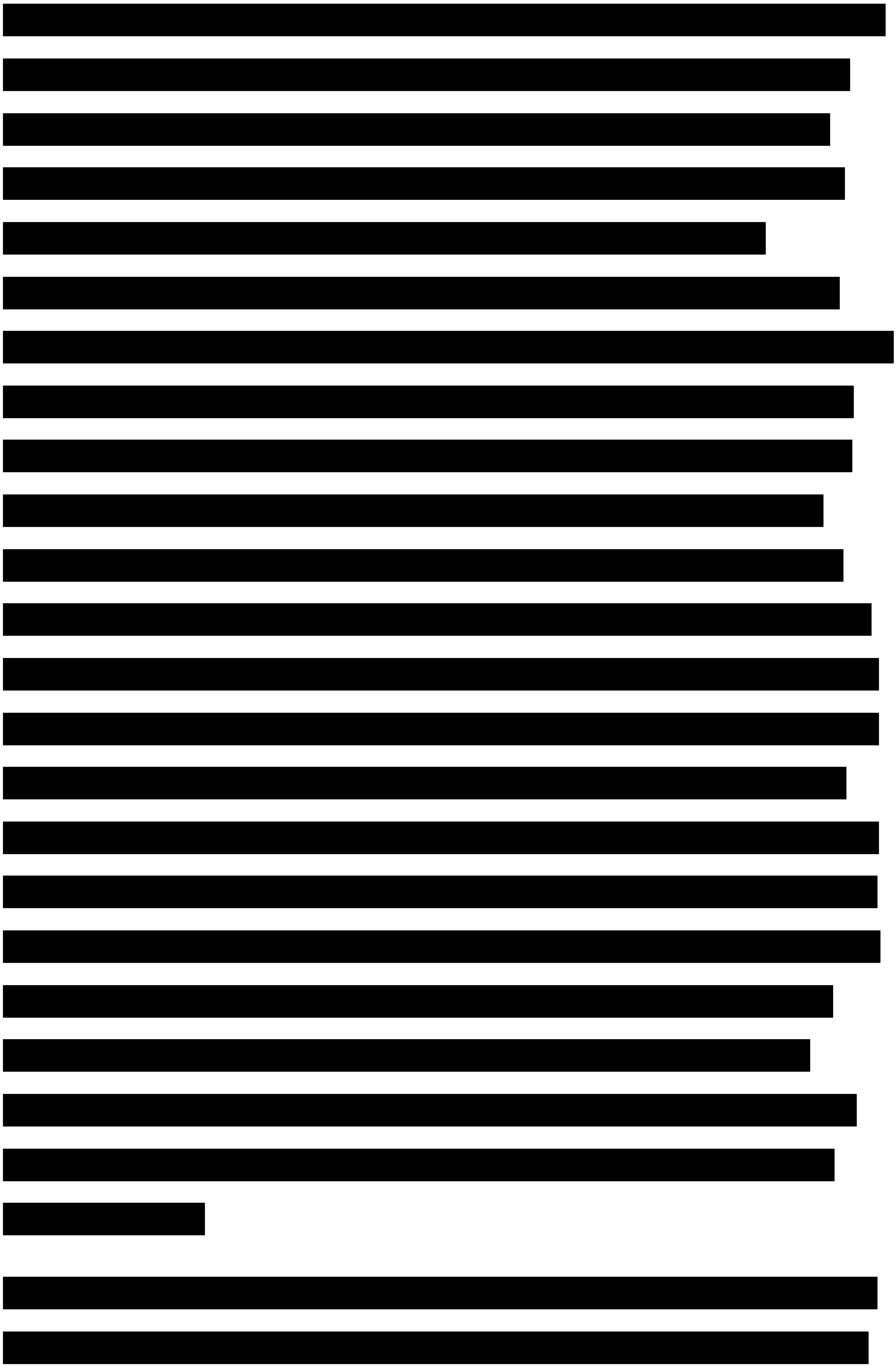
[redacted]





[redacted]

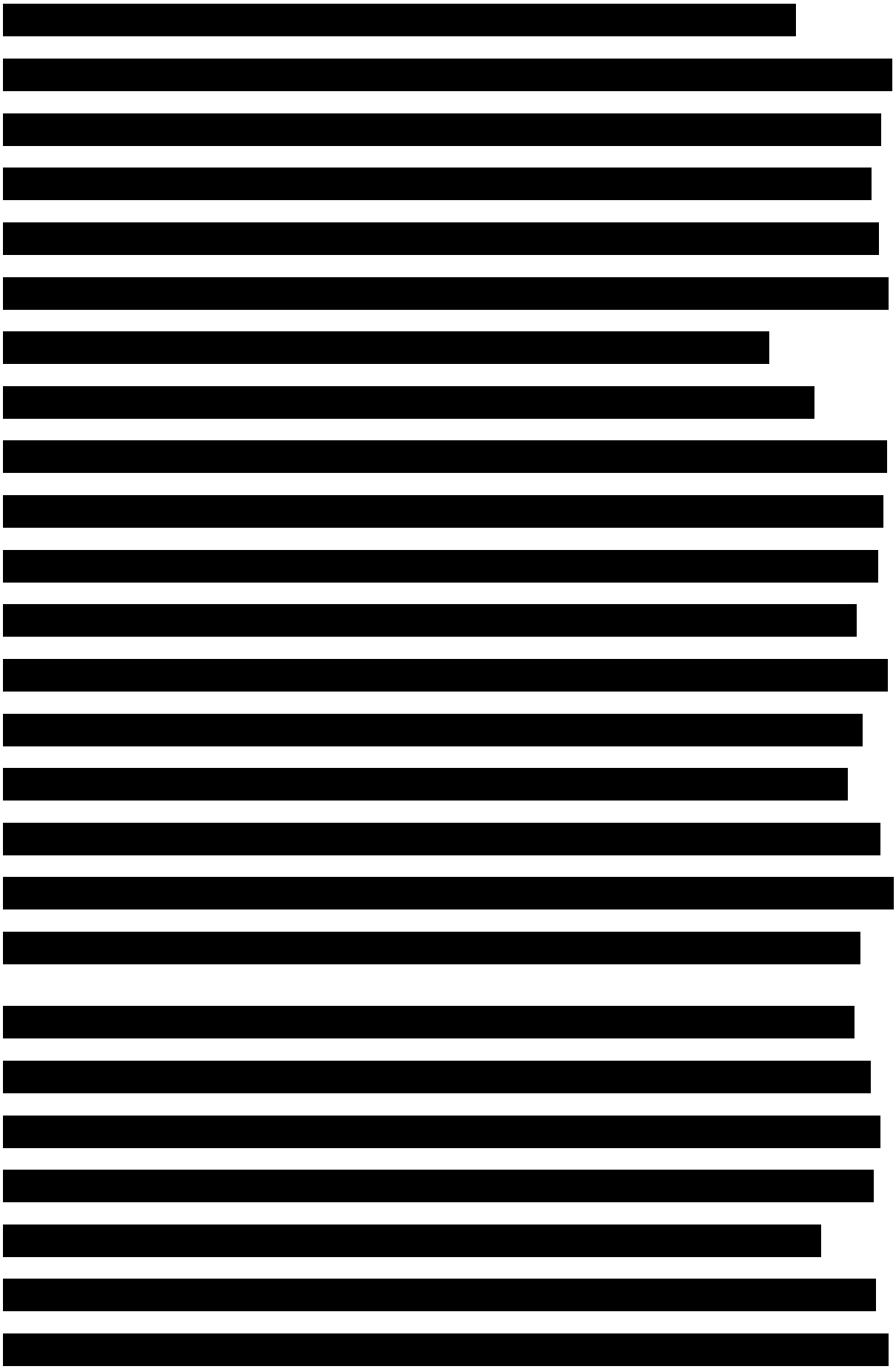
[redacted]



[redacted]

[redacted]

[redacted]



[redacted]

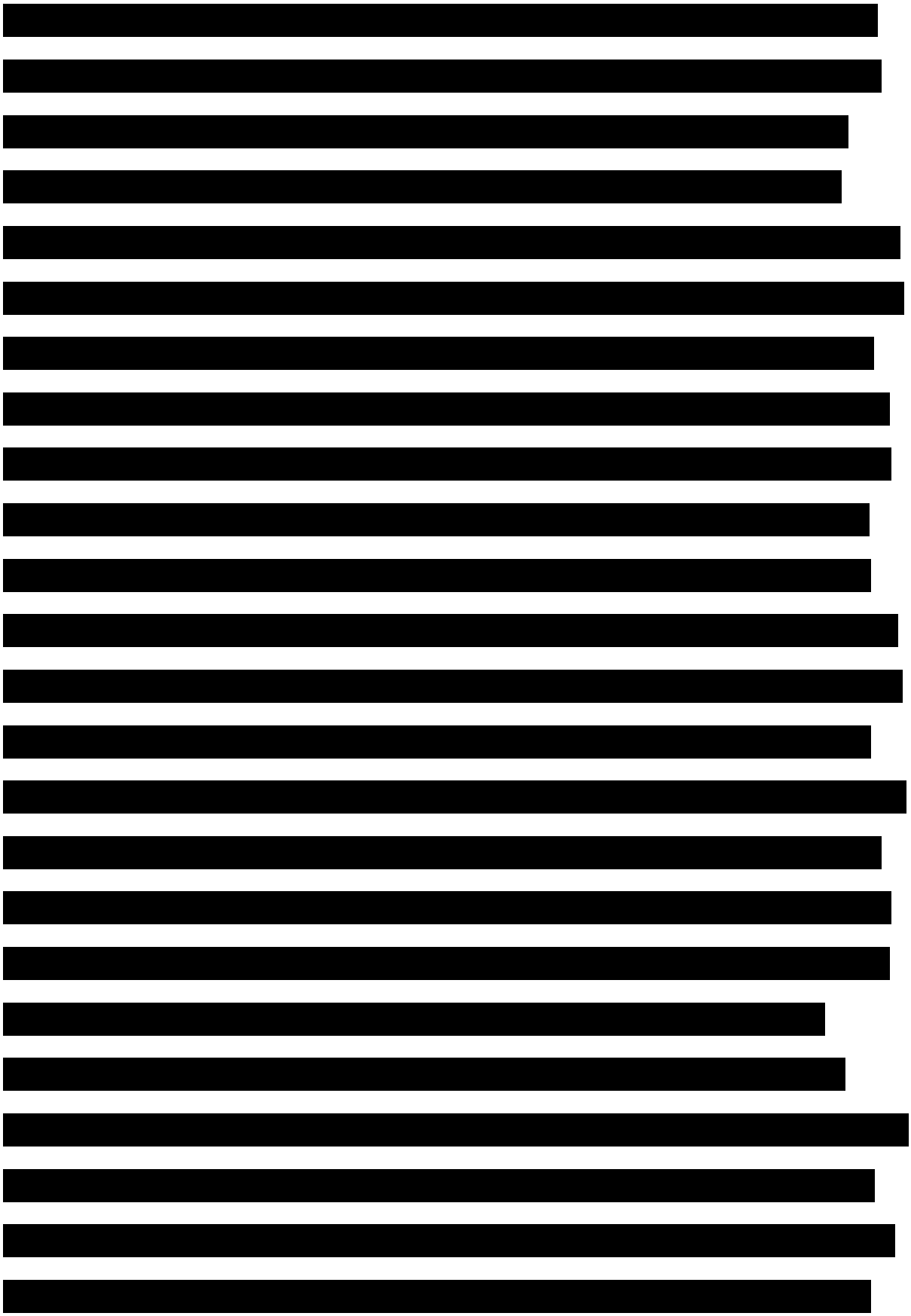
[redacted]

[redacted]

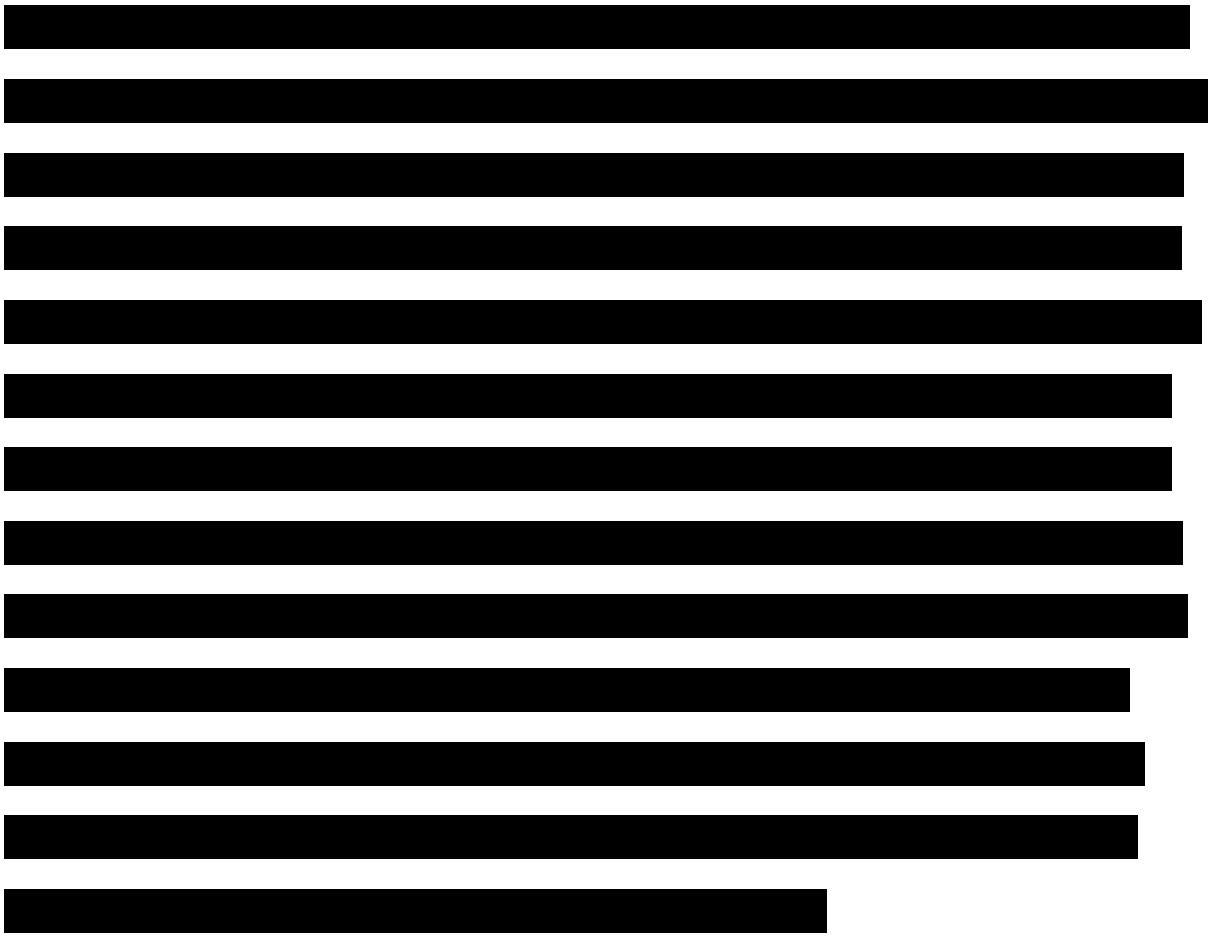
[redacted]

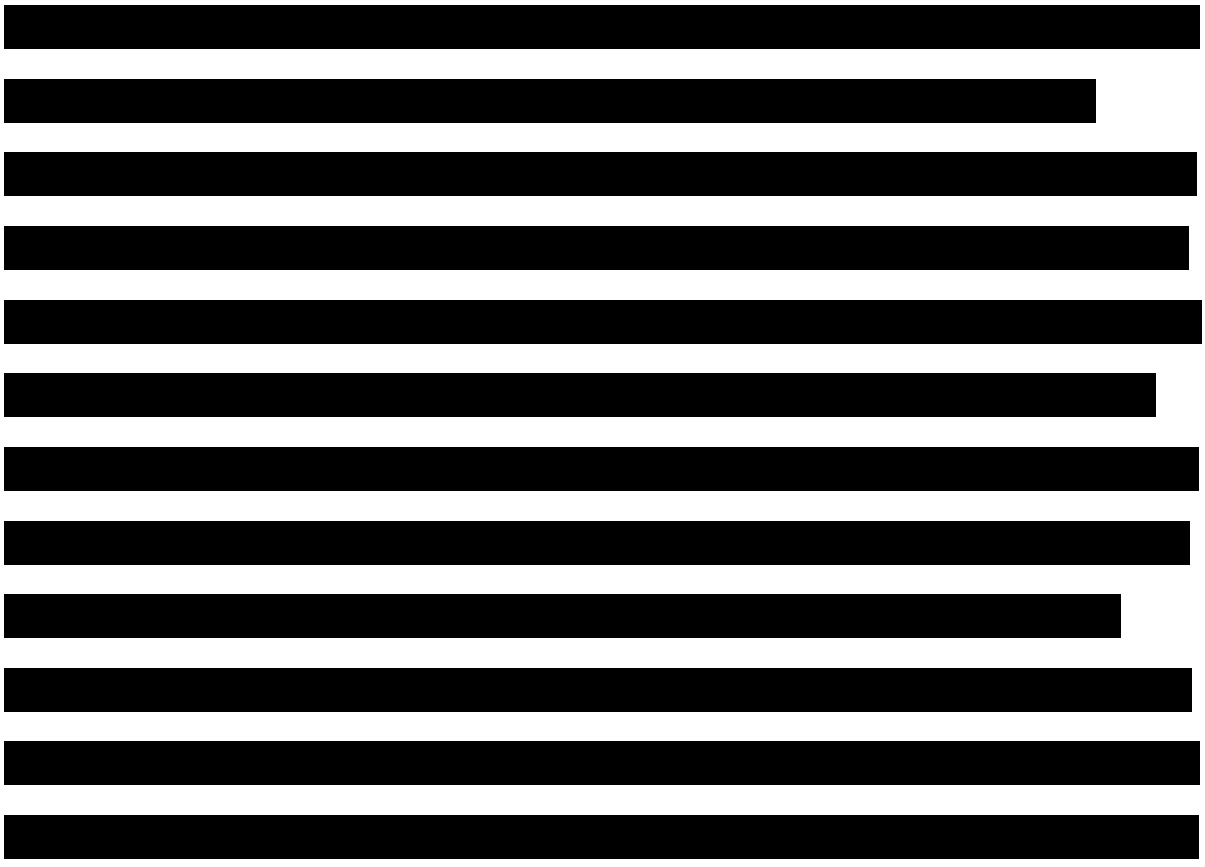
[redacted]

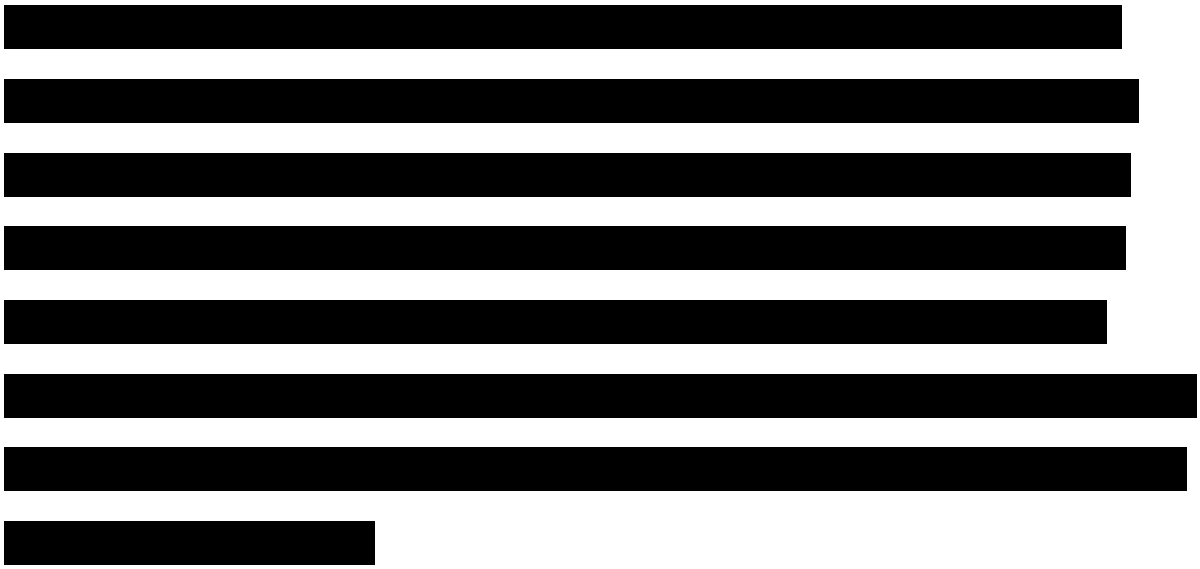
[redacted]

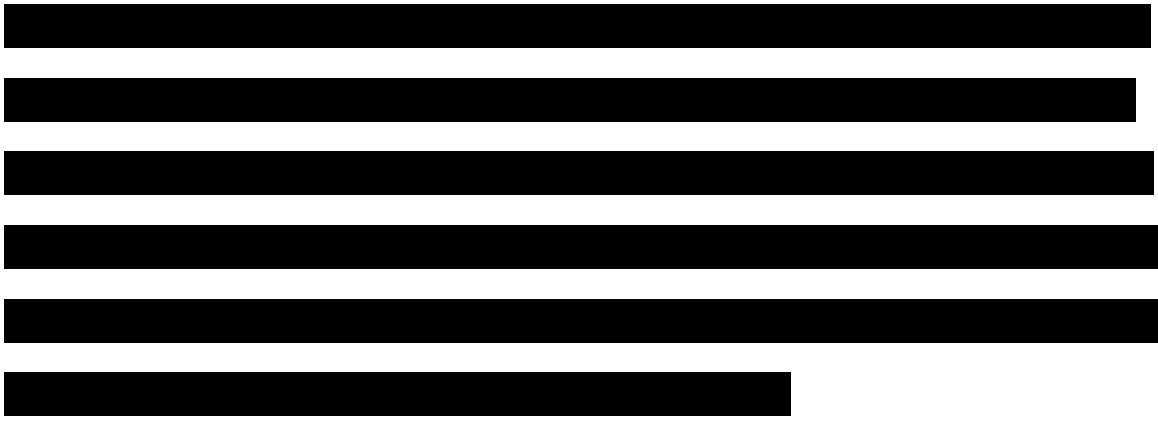


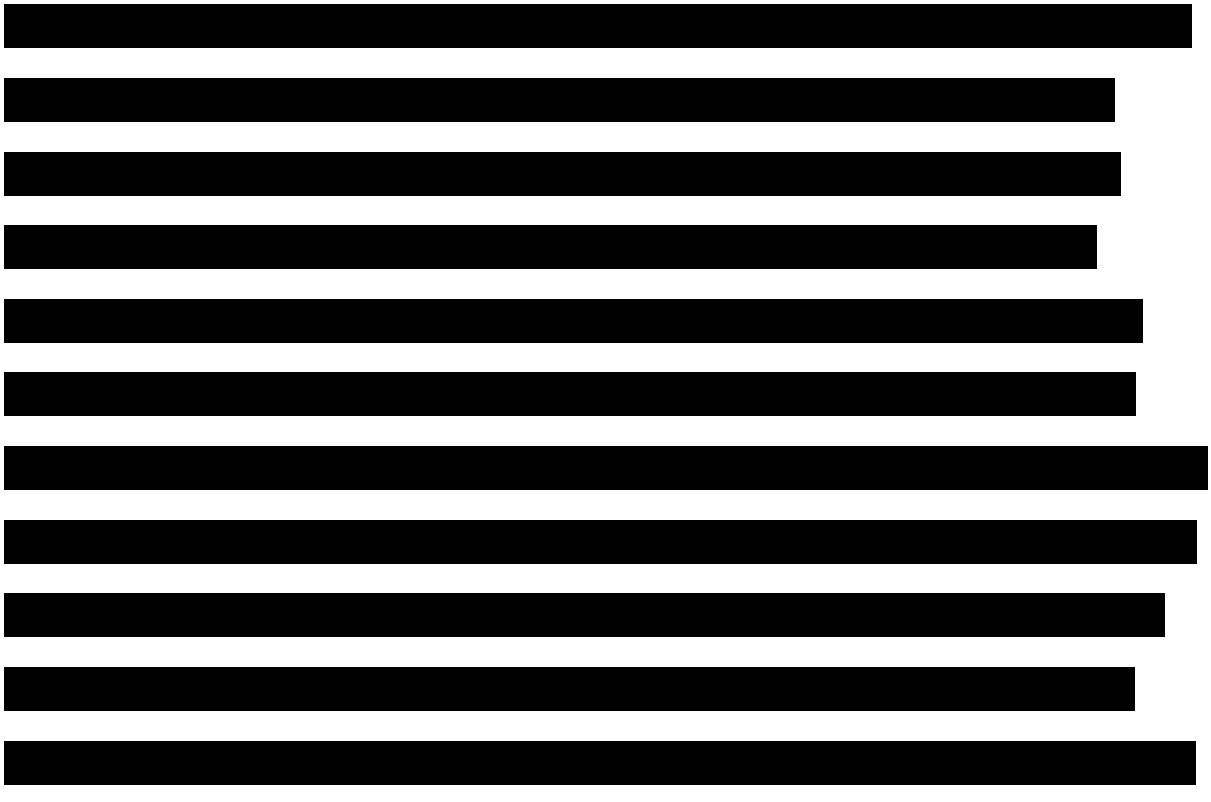
[redacted]

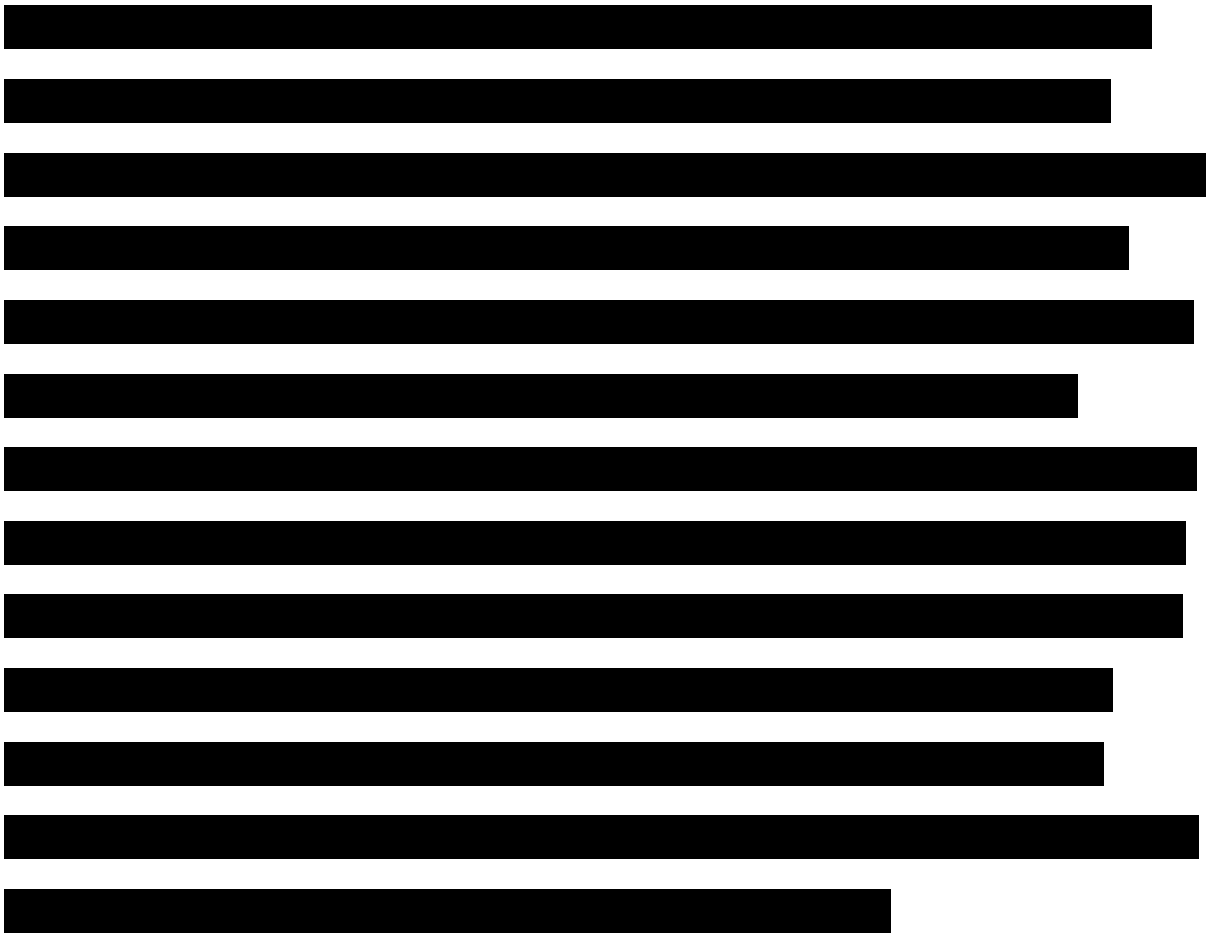












References

Bohart, A. C. (2013). The actualising person. *The Handbook of Person-Centred Psychotherapy and Counselling, 2*, 84-101.

Boy, A. V., & Pine, G. J. (1999). *A person-centered foundation for counseling and psychotherapy* Charles C Thomas Publisher.

Cepeda, L. M., & Davenport, D. S. (2006). Person-centered therapy and solution-focused brief therapy: An integration of present and future awareness. *Psychotherapy: Theory, Research, Practice, Training, 43*(1), 1.

Cohen, A. (2003). Gestalt therapy and post-traumatic stress disorder: The irony and the challenge. *Gestalt Review, 7*(1), 42-55.

Cooper, M., & McLeod, J. (2011). Person-centered therapy: A pluralistic perspective. *Person-Centered & Experiential Psychotherapies, 10*(3), 210-223.

Edwards, D. (2013). Responsive integrative treatment of clients with PTSD and trauma-related disorders: An expanded evidence-based model. *Journal of Psychology in Africa, 23*(1), 7-19.

Glauser, A. S., & Bozarth, J. D. (2001). Person-centered counseling: The culture within. *Journal of Counseling & Development, 79*(2), 142-147.

Honos-Webb, L., & Stiles, W. B. (2002). Assimilative integration and responsive use of the assimilation model. *Journal of Psychotherapy Integration, 12*(4), 406.

Joseph, S. (2015). A person-centered perspective on working with people who have experienced psychological trauma and helping them move forward to post-traumatic growth. *Person-Centered & Experiential Psychotherapies, 14*(3), 178-190.

Joyce, P., & Sills, C. (2018). *Skills in gestalt counselling & psychotherapy* Sage.

Kinsler, P. J., Courtois, C. A., & Frankel, A. S. (2009). Therapeutic alliance and risk management.

Levine, T. B. (2012). *Gestalt therapy: Advances in theory and practice* Routledge.

McCann, I. L., & Pearlman, L. A. (1990). *Psychological trauma and the adult survivor: Theory, therapy, and transformation* Psychology Press.

McLeod, J., & McLeod, J. (2015). Assessment and formulation in pluralistic counselling and psychotherapy. *The Handbook of Pluralistic Counselling and Psychotherapy,,* 15-27.

Messer, S. B. (2012). Assimilative and theoretical integration in the treatment of a trauma survivor. *Pragmatic Case Studies in Psychotherapy, 8*(2), 113-117.

Norcross, J. C., & Goldfried, M. R. (Eds.). (2005). *Handbook of psychotherapy integration*. Oxford University Press.

Pack, M. (2008). "Back from the edge of the world": Re-authoring a story of practice with stress and trauma using gestalt theories and narrative approaches. *Journal of Systemic Therapies, 27*(3), 30-44.

Payne, M. (2006). *Narrative therapy* Sage.

Perera-Diltz, D. M., Laux, J. M., & Toman, S. M. (2012). A cross-cultural exploration of post-traumatic stress disorder: Assessment, diagnosis, recommended (Gestalt) treatment. *Gestalt Review, 16*(1), 69-87.

Ramos, C., & Leal, I. (2013). Post-traumatic growth in the aftermath of trauma: A literature review about related factors and application contexts.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*(2), 95-107.

Rogers, C. R. (1965). The therapeutic relationship: Recent theory and research. *Australian Journal of Psychology, 17*(2), 95-108.

Rutherford, M. C. (2007). Bearing witness: Working with clients who have experienced trauma—Considerations for a person-centered approach to counseling/*Person-Centered & Experiential Psychotherapies, 6*(3), 153-168.

Sanderson, C. (2010). *The warrior within: A one in four handbooks to aid recovery from childhood sexual abuse and violence* One in Four.

Schneider, K. J. (2008). From segregation to integration.

Steiner, A. (2007). The empty chair: Making our absence less traumatic for everyone. *New Therapist, 48*, 11-22.

Tedeschi, R. G., & Calhoun, L. G. (1995). *Trauma and transformation* Sage.

Tudor, K. (2008a). *Brief person-centred therapies* Sage.

Wilkins, P. (2015). *Person-centred and experiential therapies: Contemporary approaches and issues in practice* SAGE.

Willig, C. (2019). Ontological and epistemological reflexivity: A core skill for therapists. *Counselling and Psychotherapy Research, 19*(3), 186-194.

Wilson, J. P. (2007). The posttraumatic self. *The posttraumatic self*. London: Routledge.

Yontef, G., & Jacobs, L. (1989). Gestalt therapy. *Current Psychotherapies, 4, 1-30.*