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Article in *Criminal Behaviour and Mental Health* · October 2011

DOI: 10.1002/cbm.796 · Source: PubMed

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'Everything contradicts in your mind': A qualitative study of experiences of forensic mental health staff in two contrasting services

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ABSTRACT

Background In the theoretical literature, there is growing recognition of the psychological impact on staff of working in challenging healthcare settings. In forensic mental health (FMH) services, powerful transference and counter-transference reactions in staff–patient relationships may emerge and may even play a role in contributing to incidents of malpractice, but there is little empirical research here.

Aim The exploration of the experiences of FMH staff in two contrasting services.

Method Thirteen in-depth interviews were carried out with staff from a range of clinical disciplines in a mainstream National Health Service (NHS) medium secure unit (MSU), and 12 interviews were undertaken with such staff from a Personality Disorder Unit (PDU) in an MSU. All interview data were analysed independently using the grounded theory method. To synthesise the two separate analyses, a thematic analysis of both data sets was carried out, in which 'thematic units' were defined as significant points of comparison between the analyses of the two sets of interviews.

Results The combined analysis yielded six main themes under two main headings. Themes under the first heading Experience of the Clinical Task were: 'difficulty in achieving task integration'; 'motivation to build relationships, work through difficulty and bring about change'; and 'minimal sense of risk and anxiety at the centre'. Themes under the second heading Experience of the Organisation were: 'a distant and difficult relationship with outside'; 'preoccupation with staff relationships'; and 'feeling unsafe'. The overarching concept of the combined analysis was encapsulated in the quotation: 'Everything contradicts in your mind'.

Conclusions and implications Clinical and organisational aspects of work seemed separate in the minds of staff, with the latter reported to be more stressful; staff support came in the form of close relationships with colleagues, who saw themselves as isolated

in the context of the wider environment. Promotion of the well-being and effectiveness of FMH staff should therefore take account of clinical, organisational and societal aspects of their situation. Copyright © 2011 John Wiley & Sons, Ltd.

Introduction

At the time of embarking on this research, we had, between us, 10 years of experience as clinical psychologists in four different forensic mental health (FMH) services. Both of us had been struck by the sometimes enmeshed, highly charged relationships among staff and the way in which experienced and able clinicians could find it hard to maintain a patient focus in such settings. In attempting to explain notorious incidents of malpractice, inquiry reports from the high security hospitals have tended to invoke systemic failure rather than mistakes by individual staff (Blom-Cooper, 1999; Fallon et al., 1999). We were curious to learn more about the factors involved in such systemic failures, and in particular about how the nature of the FMH task and the working environment in FMH services impact upon staff.

General healthcare and general mental health staff have reported simultaneously high levels of stress and job satisfaction in large-scale questionnaire studies (Carson et al., 1995; Onyett et al., 1997; Commission for Health Improvement, 2004). It has been recognised that it is difficult to identify a primary task in the 'human services', where desired outcomes vary greatly between individual staff and different staff groups (Menzies Lyth, 1979; Miller and Rice, 1990; Zagier Roberts, 1994). This may be especially true of FMH services, in which a complex clinical task is set against the background of inherent tension between therapeutic activity and management of risk (Kurtz, 2002, 2007).

We were interested in the question of the extent to which staff experience therapeutic and public protection tasks as mutually enhancing or in conflict with each other. Past studies of ward atmosphere have revealed contradictory findings. Caplan (1993) found an association between therapeutic atmosphere and patients' perception of the staff group as relatively controlling and conflict-avoidant, while Kirby and Pollock (1995) produced evidence of a link between therapeutic atmosphere and staff's comparatively relaxed attitude to patients' expression of aggression. In a more recent grounded theory study of experiences of staff in a secure unit for men with learning disabilities, Isherwood et al. (2006) found that staff were preoccupied with anxiety about risk. This was associated with passing dilemmas up the professional hierarchy and compromising staff's capacity to think through difficult situations on the ground. Presumably, a certain level of safety is necessary to support therapeutic activity, but it is not easy to get the balance right because therapeutic work can be stifled by anxiety about risk and the consequent need for control.

We were curious to learn about the relationship between, on the one hand, external factors and aspects of staff's experiences determined by the nature of

the organisation and, on the other hand, aspects resulting from the nature of the clinical task and contact with patients. Psychoanalytic theory has provided a rich account of the ways in which mental contact with dangerous and distressed patients can provoke unconscious counter-therapeutic responses in staff, such as splitting within a multidisciplinary team or enactment by the staff group of an aspect of the patient's inner world (Winnicott, 1949; Davies, 1996). Empirical studies, however, consistently show that mental health service staff are more likely to attribute stress and burnout to organisational factors, such as a perceived lack of support from managers, than to the nature of the patient group or contact with patients (Cole et al., 2000; Garland, 2004). Lavender (2002) has suggested that forensic services face a particular organisational challenge because society is so ambivalent towards offender-patients, and unsure of what it wants from FMH staff. So, in addition to considering the impact of patients on staff, it seemed important to reflect on the effects on staff of dynamics of the wider environment.

The areas for exploration were thus potentially wide ranging and the relationships between them complex. A qualitative approach was considered most helpful in allowing an open approach to the generation and analysis of interview data. In addition, there was little previous research into the experiences of FMH staff, and we wanted participants to define their own terms as far as possible.

Method

Participants

Twenty-five interviews were conducted with staff working in two contrasting NHS FMH services: 13 were with staff from a typical medium secure in-patient unit (MSU) and 12 with staff from a personality disorder unit (PDU) within an MSU. The MSU was chosen as the most common FMH setting in the UK. A typical patient group consists of offenders with a range of psychotic symptoms, often in combination with long-term personality difficulties and problems of addiction. The PDU was selected because services for offenders with a diagnosis personality disorder constitute a growth area in response to initiatives such as Personality Disorder: No Longer A Diagnosis of Exclusion (National Institute for Mental Health in England, 2003). There is recognition of the complex therapeutic needs of this patient group and the particular pressures such patients exert upon staff to act counter-therapeutically. Key characteristics of the services are shown in Table 1.

The interview sample was chosen to represent the range of professionals working with FMH patients as closely as possible. Participant information sheets were given to all staff on both units. Selected staff were approached by a senior member of staff to seek informed consent for participation in the research. In the MSU, a representative of each main professional group was sought, together

Table 1: Service characteristics

Service	General description	Patient group	Activity & approach	Average length of stay	Destination at discharge
MSU	60-bedded NHS medium secure unit	Male and female offenders with a primary diagnosis of mental illness	Assessment, treatment and rehabilitation within a biopsychosocial model	2 years	Usually conditions of lower security or hostel/community placements
PDU	12-bedded PDU within an NHS medium secure unit	Male offenders with a diagnosis of personality disorder	3–4 month assessment followed by structured group programme based on social problem-solving approach	2 years	Usually prison, although occasionally directly into the community

with a randomly selected nurse from within each graded nursing band. In the PDU there was only one multi-disciplinary team, so if there was one member of staff from a particular professional group they were invited to participate; where there was a choice the member of staff more substantially involved in the work of the Unit was chosen, except in the case of the two doctors, one a Consultant and the other a Specialist Registrar, who were both approached. In the PDU nurses were again selected randomly from within graded bands. Basic information about the demographic characteristics and professional experience of participants was collected and is given in Table 2.

Semi-structured interview

A semi-structured interview aimed at exploring staff's experiences of work was developed and piloted within the MSU. The interview included requests for a definition of the participant's main functions and of the service as a whole, and for an example of recent clinical work, including a follow-up question about its personal impact; it also asked about supervision and support and contained questions designed to aid reflection on experiences of successful and unsuccessful teamwork, satisfaction and dissatisfaction in the job, general impact of work and safety issues, and perceptions of people external to the units. The interview combined open questions with probes for specific examples of experience. Interviews were tape recorded, transcribed and anonymised.

Table 2: Participant characteristics

Characteristic	MSU (N = 13)	PDU (N = 12)
Profession		
Nurse	6	5
Other ^a	7 ^b	7 ^c
Gender		
Male	5	5
Female	8	7
Age (band)		
20–30	1	3
31–40	5	4
41–50	5	3
51–60	2	2
Ethnicity		
White UK (+2 other)	8	12
Black African-Caribbean	1	0
Black African	1	0
Mixed race	1	0
Other	2	0
Years in Profession		
Average (range)	12 (2–22)	14 (2–27)
Years in Current Job		
Average (range)	4.25 (0.5–11)	2.8 (0.16–4.5)

^apsychiatrist, ward doctor, social worker, psychologist, occupational therapist, art therapist, probation officer, ward administrator, teacher.

^bone from each discipline except no probation officer or teacher.

^ctwo psychiatrists, otherwise one from each discipline except no art therapist or ward administrator.

Analysis

Grounded theory was chosen as a method for initial analysis of the interviews because this approach was designed to study social processes and offers a way of developing understanding of staff experiences within an organisational context (Strauss and Corbin, 1998; Charmaz, 2003). Data from the PDU were analysed by the first author and data from the MSU by the second. During the period of these analyses the authors did not confer. Interviews were line-coded before summary codes for blocks of 3–8 lines were developed. These were used to build categories and the method of constant comparison, in which transcripts are checked retrospectively and prospectively as analysis proceeds, was used to generate lower and higher order categories (Pidgeon and Henwood, 1996). A further stage of analysis was necessary to synthesise the two analyses. Thematic analysis was selected because grounded theory is regarded as a type of thematic analysis, and therefore there was, a high degree of congruence between the two analytic

Table 3: Emerging themes

Overarching Theme: 'Everything contradicts in your mind'	
Experience of the Clinical Task	Experience of the Organisation
Theme 1: Difficulty in Achieving Task Integration	Theme 4: A Distant and Difficult Relationship with Outside
Theme 2: Motivation to Build Relationships, Work Through Difficulty and Bring About Change	Theme 5: Preoccupation with Staff Relationships
Theme 3: Minimal Sense of Risk and Anxiety at the Centre	Theme 6: Feeling Unsafe

stages. The approach to thematic analysis described by Braun and Clarke (2006) allowed the researchers to identify points of comparison between the two analyses as 'thematic units', which could then be used to develop overall themes.

Results

The combined analysis of staff interviews yielded six main themes and an overarching, summarising theme. The latter is described first, followed by the six main themes, which are presented according to whether they relate to staff's experience of the clinical task or the organisation. The way in which the analysis is organised is presented in Table 3.

Overarching theme: 'Everything contradicts in your mind'

A quotation from a participant is used to describe the impression of organisational fragmentation conveyed by the analysis as a whole. We struggled to integrate the material into a coherent single model and ended up dividing the themes, numbered 1–6 below, into two groups under the headings: Staff's experience of clinical work and Staff's experience of the organisation. At ground level, staff reported difficulty in integrating their perceptions of individual patients. They presented therapeutic and custodial tasks as distinct. Staff perceived different groups in the organisation as isolated from each other and as varied in their understanding of what constituted the main task of the service.

Staff's experience of the clinical task

1. Difficulty in achieving task integration

Participants described managers' agenda as different from their own, seeing managers as commercially driven and concerned with '*getting people through and out*' (MSU, Nurse 2) and '*producing the goods*' (MSU, Nurse 5).

In contrast, participants saw themselves as having a human focus. They emphasised the clinical aspect of their task and their role in helping patients. They discussed public protection duties uneasily and sometimes with frank ambivalence. They usually described their role in helping patients first and then mentioned the need to reduce risk as an add-on, seldom integrating the two aspects. For example:

It's not to reduce reoffending . . . This is about helping people address the problems that they . . . have in life and maybe one of the results will be that they don't reoffend. (PDU, Nurse 2)

Staff in the PDU talked of a difficulty in bringing together awareness of patients' vulnerability with knowledge of their potential to abuse others. Here one communicates the resulting state of mind:

Everything contradicts in your mind the behaviours you see in him, knowing what they've actually done, how violent their offending can be and how they're actually presenting to you . . . it was almost like playing games nothing seems real on the ward . . . (PDU, Nurse 2)

2. Motivation to build relationships, work through difficulty and bring about change

Staff were strongly invested in bringing about positive changes in patients' lives and saw the development of relationships with patients, often in the face of considerable difficulty, as pivotal. Occasions when staff succeeded in building rapport with patients who were initially inaccessible or hostile were described with pride:

Over about 9 months of one-to-ones and playing them back and showing them to him, he actually was really good he spoke far slower, he actually sat and listened to what people were saying . . . to get into that stage I thought was really good because . . . we hated the sight of each other when we (sic) came in (laughing) we did not get on at all. (PDU, Nurse 3)

More senior staff who had less contact with patients saw this as a source of frustration:

I don't do any clinical work any more so I find that terribly unsatisfying . . . (PDU, Psychiatrist 2)

Staff spoke of a sense of shared humanity and a belief that external circumstances could make the difference in determining whether someone goes down a criminal route or not:

There but for the grace of God goes I, you know, different upbringing, different social circumstances, different life events, who knows? (MSU, Psychiatrist)

3. Minimal sense of risk and anxiety at the centre

Perhaps contrary to expectation, staff described forensic wards as physically safe places. The following quotation is fairly typical:

Particularly in the secure hospitals you actually go 'oh we're safer than any open psychiatric ward' because . . . people are just more aware, there's less drugs and . . . staff tend to be more in control. (PDU, Psychiatrist)

Mention of patients' index offences was rare and episodes of violence on the wards were downplayed. For example, a nurse referred to an assault which led to 2 weeks' sick leave as '*that little incident*' (MSU, Nurse 4). Staff talked about a lack of stress and worry in their direct work with patients compared with what people might imagine:

It's not a scary job in the way that people perhaps think it is. (MSU, Social Worker)

Only two members of staff talked about being directly affected by the risk presented by patients, both suggesting such sensitivity was more of a feature on entry to the work environment than as an established staff member. One, a fairly new staff member, commented:

You live in the gutter you start to smell of the gutter and I think it's started to affect me. (MSU, Social Worker)

The other considered it important to retain a freshness of response to aggression because it is possible to develop a false sense of security in such environments:

I don't think you should become blasé . . . if there is a patient who's effing and blinding and blowing their top . . . I get butterflies and I feel nervous and God what could happen here? (PDU, Occupational Therapist)

Staff's experience of the organisation

4. Distant and difficult relationship with outside

The work environment was seen as closed and deeply absorbing:

It's easy to get sucked in here because . . . the whole thing's so closed, it's all locked in. (MSU, Occupational Therapist)

There was only a vague, general sense of preparing patients for a future environment and little clear idea of what life might be like for patients after discharge. Family and friends provided much needed support to staff, but were cut-off from the work setting. For example, a nurse was struck by the fact that she turned into

a 'different person' (PDU, Nurse 4) outside work; another talked of her family knowing very little about her work. The media was regarded as hostile to patients, portraying them as monstrous, 'Hannibal Lecter' (PDU, Nurse 4) types, and the general public as wilfully ignorant of FMH issues:

Forensic patients are the patients that the world would like to forget exist ... (PDU, Psychiatrist 1)

Colleagues outside the immediate work environment, particularly senior ones, were often described as threatening and undermining. They were seen to conduct envious attacks on staff in the PDU, putting good results down to 'cherry picking' patients (PDU, Psychiatrist 2). They were regarded as out-of-touch and at odds with MSU clinicians. An example was given of managers moving patients between clinical areas for financial reasons. The potential threat of a homicide inquiry permeated doctors' interviews from both services. Such a threat was described in personal as well as professional terms:

If we still had, a major inquiry, i.e. if someone committed homicide under my care and we went through everything we'd written or hadn't written for the last ... 3 to 4 years ... I think that's an absolutely devastating experience. I'm not sure that I could survive that ... (PDU, Psychiatrist 2)

5. Preoccupation with staff relationships

In contrast to the relative lack of anxiety in representations of direct work with patients, accounts of relationships with colleagues were full of emotion, both positive and negative. In the MSU, intra-professional allegiances were seen not only to provide vital support but also to lead to hostility towards other professional groups. In the PDU, emotional statements were made about the positive impact of the multidisciplinary team on individual members of staff; it produced a feeling of 'being wanted' and an 'overwhelming' sense of welcome (PDU, Occupational Therapist). Staff across both services spoke of the extreme importance of close support from colleagues in everything from direct work with patients, through talking through complicated clinical issues, to dealing with external agencies. Indeed the absence of such support was felt to result in almost unbearable isolation:

It's about knowing that there are at least a few people in the same clinical team who share some of my angst and annoyance at certain things, which is very supportive and reassuring, because you know otherwise you'd think you're going mad ... (MSU, Social Worker)

There was acknowledgement that close support networks functioned sometimes to exclude others, making relationships closer with some colleagues and more distant with others:

The disadvantages are that people may see them as a clique ... (PDU, Psychologist)

Although episodes of violence by patients were downplayed, where negative emotion was expressed in relation to such incidents it was directed at the perceived incompetence of colleagues, which are described further below.

6. Feeling unsafe

Lack of emotional safety in professional relationships was a theme throughout. It was considered too risky to speak directly with colleagues about important issues:

I sometimes feel unsafe when I say things in meetings. (MSU, Arts Therapist)

This problem was experienced with close colleagues out of fear of losing a positive team image or vital source of support, as well as with those with whom relationships were considered less good.

Episodes of conflict and difficulty between colleagues were described in intense and emotional terms. Here is one participant talking about the effect of a complaint being made by colleagues about her:

I found that situation exceptionally difficult and an absolute emotional strain to the point where I . . . did for a while feel very paranoid about the staff team. (PDU, Nurse 4)

Summary of findings

Clinical and organisational aspects of experience seemed separate in the minds of staff and differed in the type and range of emotion they evoked. Staff appeared motivated by the desire to bring about positive change for patients and to achieve some satisfaction in this regard. They reported relatively little stress from contact with patients and greater stress from relationships with colleagues and their experience of the organisation. Staff represented themselves as isolated from the wider environment, which was characterised as uncomprehending and often hostile. The picture presented was of organisations divided into different groups with somewhat contradictory ideas about the nature of the work being undertaken. Within services, support from small groups of colleagues (the multidisciplinary team in the PDU, professional groups in the MSU) was seen as crucial and a sense of crisis accompanied its loss or absence. However, positive experiences of collegial relationships came with an awareness of the risk of alienating others and a difficulty in addressing issues directly for fear of 'rocking the boat'.

Discussion

Our study suggests that aspects of organisational life can present considerably more of a problem for FMH staff than contact with their patients, which is in

line with previous research into stress and burnout in healthcare staff and mental health nurses (Carson et al., 1995; Schulz et al., 1995; Onyett et al., 1997). This finding was more pronounced than might be expected given the particular challenges presented by the patient group. Psychoanalytic organisational theory indicates that mental contact with the distress and disturbance of forensic patients is especially difficult, and staff are likely to resort to highly defended ways of dealing with it unless they are highly trained and the working environment is very supportive and containing (Winnicott, 1949; Hinshelwood, 1993, 2004). A degree of organisational dysfunction may, therefore, be attributable to the displacement and projection onto colleagues of what are felt to be unmanageable feelings towards patients and the clinical task. But it would almost certainly be reductive not to also give serious consideration to the possibility of a strong and independent influence of organisational difficulties upon staff and patients. Bearing this in mind, what do previous research and our findings collectively tell us about which organisational characteristics may be most important in contributing to staff well-being and clinical outcomes?

Earlier research highlighted the significance of the extent to which staff feel supported in their work and have a clear sense of purpose in determining levels of stress and burnout. A study of staff working with older adults, for example, found that the degree to which staff perceived themselves to be supported was positively correlated with psychological wellbeing at work (Cole et al., 2000). Two more recent studies found that clarity of purpose was significant: palliative care nurses' sense of meaning and purpose were associated with comparatively low levels of stress and burnout (Ablett and Jones, 2007), while a relative lack of clarity of 'agency mission' was identified as the most important organisational factor associated with burnout in prison staff (Garner et al., 2007).

FMH staff in the current study saw support as coming from small groups of close colleagues, which were often isolated from other groups and from the wider institution and the outside world. These close relationships with colleagues were described as, at least in part, a response to a sense of external threat, which was made up of perceived hostility towards the patient group, a lack of sympathy by outsiders towards those who are motivated to help forensic patients rebuild their lives and a risk-obsessed culture, which subjects staff to unyielding scrutiny. While such collegial relationships may have been necessary to bolster staff at a personal level, they were limited in the extent to which they supported the work. The value placed upon close relationships with small groups of colleagues, for example, made it difficult to address areas of professional conflict and further isolated staff from others in different professional groups (in the MSU) and the wider hospital environment (in the PDU).

Psychoanalytic accounts would indicate that there is potential in FMH services for the build-up of both conscious and unconscious anxiety; this is likely to emanate from primitive feelings stirred up by the task of having to care for such vulnerable and challenging patients in a complicated and fragmented work

environment (Menzies Lyth, 1960; Hinshelwood, 1993). It is hardly surprising that without ongoing attention to the question as to how to help staff reflect on the difficulty of their task, and in particular direct work with psychological disturbance in the face of organisational and social ambivalence towards the patient group, staff find ways of surviving that are less than satisfactory.

Our study also suggested that FMH staff found it difficult to achieve a clear sense of purpose, largely because of a lack of integration between therapeutic and custodial aspects of the task at ground level and the perception that different groups within the organisation had contradictory ideas about the nature of the work. In a recent study of staff relationships in an MSU, Davies et al. (2006) focused on the plurality of perspectives contained within a single organisation, attributing this to formal and informal structures that divide staff into different professional groups. Another study concluded that multidisciplinary team working is hard to achieve in secure FMH services, which are characterised by perceived power differences between staff and patients on the one hand and medical and non-medical staff on the other (Shaw et al., 2007). This analysis suggested that it may be helpful to try to achieve a coherent understanding of the task across different levels of the organisation, including managers and stakeholders, rather than just at the level of the clinical team.

Lastly, we turn to the question of understanding FMH staff's fragmented experience of work. Psychoanalytic accounts have tended to consider the impact of patients' use of primitive defences to deal with distress and anxiety on individual staff and staff groups. In contrast, a systemic narrative such as Lavender's (2002) has emphasised the way in which society's ambivalence towards forensic patients affects both staff and patients in turn. There are likely to be mutually reinforcing relationships between patients who use powerful and primitive defensive mechanisms, staff who struggle to bring together contradictory aspects of their relationships with patients, an organisation in which understanding of the task is divided and distributed rather than held coherently in mind and a society that is highly ambivalent towards the FMH task. Our study suggests that any meaningful formulation of the experiences of FMH staff will need to consider these various clinical, organisational and social aspects of the overall situation rather than adopt an overly simplistic view.

Acknowledgements

The authors would like to thank Dr. Keith Turner and Prof. Stephen Frosh, who supervised, respectively, the individual studies on the PDU and the MSU.

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