The Lived Experience of Working with Female Patients in a High Secure Hospital

Abstract

Women's secure hospitals are often considered to be stressful and demanding places to work, with these environments characterised as challenging and violent. The staff experience of working in this environment is however not well represented in the literature. This study is the first to examine the 'lived experience' of seven nurses working in the National High Secure Healthcare Service for Women. Interview transcripts were analysed with the use of Interpretative Phenomenological Analysis, and the findings presented within four superordinate themes 'horror', 'balancing acts', 'emotional hard labour', and 'the ward as a community'. These themes all depict the challenges that participants experience in their work, the ways in which they cope with these challenges and how they make sense of these experiences. A meta-theme of 'making sense by understanding why' is also presented, which represents the importance for participants to attempt to make sense of the tensions and challenges by formulating a fuller meaning. The findings suggest the importance of workforce development, in terms of allowing sufficient protected time for reflection and formulation (for example within the format of group supervision or reflective practice), and for staff support mechanisms (e.g. clinical supervision, counselling, debriefs) to be inbuilt into the ethos of a service, so as to provide proactive support for staff 'on the frontline'.

INTRODUCTION

In the past 15 years, there has been considerable public scrutiny and organisational reform to the provision of care for women within secure hospitals in the UK (Tilt et al., 2000; Bartlett & Hassell, 2001; Department of Health, 2003; WISH, 1999). The promotion of gender-specific security needs, namely the emphasis of a greater need for relational security over physical security (Aitken & Noble, 2001; Department of Health, 2002), saw the introduction of Women's Enhanced Medium Secure Services. Alongside these, a single National High Secure Healthcare Service for Women (NHSHSW) was established to provide 50 beds for female patients from across the UK detained under the Mental Health Act, 1983 who require high secure care. Secure hospitals in the UK are designed to provide treatment and containment for men and women who are detained under the Mental Health Act (1983), who have a mental disorder and are considered to present risk of harm to others. In contrast to women detained in prisons, female patients in secure hospitals may or may not have been in contact with the criminal justice system or been charged with or convicted of a criminal offence. Indeed, an audit conducted within the service during 2005-2006 highlighted that 20% had no index offence, and were detained under section 3 of the Mental Health Act (Elcock, 2007). Nonetheless, patients in high secure hospitals "require treatment under conditions of high security on account of their dangerous, violent or criminal propensities." (NHS, 2013).

Female patients represent 5.3% of patients detained in high secure hospitals in the UK and 4.3% of the prison population in England and Wales (MoJ, 2016). The rate of imprisonment for women in England and Wales is 146 per 100,000, and 142 per 100,000 in Scotland; this is similar to the rate in Australia (152 per 100,000) but far lower than the rate of female imprisonment in USA (693 per 100,000) (Walmsley, 2016). Women who are detained in high secure hospitals typically have complex needs, histories of abuse and significant attachment difficulties. In addition they have often engaged in severe self-harm and/or significant offending/institutional violence (Elock, 2007; Uppal & McMurran, 2008). It has been proposed that female patients' experience of relationship difficulties are "often re-enacted, creating chaos in the system of care around them" (Clarke-Moore & Barber, 2009, p.202). Indeed, women's secure hospitals are considered to "have a 'reputation' within their wider organisational setting as highly stressful and demanding places to work" (Jeffcote & Watson, 2004; p.22), with staff recruitment and retention historically problematic, and "women's wards being characterized as chaotic and violent" (Parry-Crooke & Stafford, 2009; p.2). A

study into the frequency of violence and aggression by Uppal & McMurran (2009) found that the NHSHSW had the highest number incidents when compared to all other directorates within the organisation (i.e. services for men with learning disabilities, severe mental health problems or personality disorder). Of these incidents in the NHSHSW, 45.8% involved violence to others (staff and patients approximately equally), and 47.8% involved self-harm. The management of violence and aggression, and the prevention and response to self-harm, therefore appear to be important aspects of the roles and responsibilities of staff working in secure hospitals; perhaps most notably the nursing team who are positioned 'on the frontline' (Scanlon & Adlam, 2011).

Recent research has focussed on the needs of those detained within such settings (e.g. Parkes & Freshwater, 2012), however the needs and experiences faced by those who work in such settings remains elusive. Such insight might be helpful in order to inform staff training, support and supervision and to enhance the resilience of the workforce whilst minimising burnout and stress. It might also enable the impact of the work on individual staff to be better anticipated and understood and provide a language with which to begin to discuss the approaches used and challenges faced in such highly specialist environments. Therefore, this study seeks to understand the experience of providing nursing care to women patients in a high secure hospital.

METHOD

Interpretative Phenomenological Analysis (IPA) is a qualitative approach specifically focused on exploring " in detail how participants are making sense of their personal and social world" (Smith & Osborn, 2008; p.53). The approach seeks to understand how participants make sense of specific experiences. The IPA researcher is said to engage in a 'double hermeneutic', whereby they attempt to make sense of the participants' account, which reflects the participants attempt to make sense of their own experience. An important feature is the maintenance of the connections between this personal meaning and its context (Larkin, Eatough & Osborne, 2011; p.321). It is because of these qualities that IPA has been used in current study.

Participants

Purposive sampling was employed in order to recruit a sample of nursing staff currently working within the NHSHSW. Following the receipt of ethical and governance approvals from university and National Health Service committees, information was sent to the nursing teams via Ward Managers, and the first author attended staff meetings to introduce the research. Written informed consent was gained from all participants. The resultant sample comprised seven members of nursing staff, two of whom were male and five female. Two were Team Leaders, two were Nursing Assistants, and three were Staff Nurses. The length of time participants had worked in the hospital ranged from 3 to 30 years (median 8 years). Three had worked on male wards in the same hospital, while four had only worked within the women's service.

Data collection

Interviews were guided by a schedule[1] of open ended, non-leading questions covering the following main areas: how they came to their current career; what expectations they had beforehand and how their experience has compared; the feelings they have about their work (positive and negative), the impact of the negative aspects, and the advice they would give to others considering applying to work in the NHSHSW. Interview duration ranged from 40-75 minutes (mean 55 minutes) and were audio-recorded, and transcribed verbatim. Identifying material (in relation to the participant, patients[2], or the ward) was removed at the point of transcription.

Analysis:

Data were analysed using Interpretative Phenomenological Analysis (Smith, Flowers & Larkin, 2013) using a set of guiding principles (Smith & Osborn, 2008). Transcripts were read and re-read several times, with and then without the audio. Sections of particular interest were highlighted, and initial annotations and extractions were made, line by line throughout

[1] Interview schedule available from the first author upon request

[2] The term patient has been used to reflect the terminology used in the Mental Health Act under which these service users are detained

the transcript. Emergent themes were noted, capturing an interpretation of the essence of the exploratory comments and the data behind them. The first completed transcript was reviewed in full by the second author. Although the process is described in linear form, the analysis was iterative and stages were returned to and expanded upon within each case, and following the initial analysis of other cases. Index cards of each emergent theme were made, with example participant extracts noted and coded. This process assisted further abstraction, and examination of the validity of the emergent themes, resulting in some themes being relabelled or joined together. A process of clustering the themes was then undertaken, with numerous formations tested, culminating in the construction of super-ordinate themes which encompassed related subthemes. Throughout the research process, a reflexive log was kept and regular discussions took place between the authors about the process and emergent ideas and themes. The research process was informed by the principles of conducting and reporting rigorous qualitative work which have been outlined by Yardley (2000); the COREQ (Tong, Sainsbury and Craig, 2007) was also consulted.

RESULTS

Four super-ordinate themes were identified: Horror, Balancing Acts, Emotional Hard Labour, and Community. Each of the superordinate themes contain a number of subthemes as summarised in Table 1. Within the text the subthemes are denoted in bold and text from participants presented in italics to support and elucidate the theme.

TABLE 1

ABOUT HERE

Each of the themes are discussed below before a meta-theme of 'making sense by understanding' which links together each of the concepts presented (see figure 1). Throughout, italics are used to denote direct quotations from participants with ^{P} used to denote the transcript from which the quote is drawn.

FIGURE 1

ABOUT HERE

Horror

Descriptions of perceived and experienced 'horror' were evident with physical and psychological aspects discussed. This superordinate theme comprises of four subthemes: **horror stories**, **self-harm**, **danger** and **not being able to help**; the latter two describing the psychological horror of their emotional experiences, and the former two depicting descriptions of more physical representations of horror.

Participants described their experience of being confronted with, and growing accustomed to, a negative discourse of **horror stories** which surrounded female patients. Participants recounted discussions during their hospital induction training: *'where are you going?' If you say 'Women's Service's it was kinda like 'ohhhhhh, Oh God you're not going on Women's Services, oh God it's horrendous!'*[P5]. Participants described the impact that these reactions had on them, and on their expectations: *Oh my God I'm gonna be wading through blood every day and fighting* and *'oh god' you know it's scary it's like a bear pit you know and you just think 'oh God'*[P5].

Participants described the challenges that participants associated with witnessing and responding to **self-harm.** Self-harm was portrayed as being almost synonymous with the women's service: *Women's services stroke self-harm! [laughing]; the first thing that I thought of was [whispered] self-harming*[P1]. This whispered statement seems to speak of the taboo of this association, and indeed perhaps of the act of self-harm itself.

Participants provided graphic descriptions of the self-harm they have witnessed, depicting the horror of self-harm;

> *vein popping, people bloodletting, you find them with three or four pint of blood gone . . . one more nick and you're into life threatening stuff*[P2]

> *we had 3 incidents earlier simultaneously, and you just don't know which way to run first, . . . life threatening self-harm . . quite horrific, quite horrific*[P7]

In addition to self-harm being a challenge for staff, it is described as having an impact on the whole ward, creating a *ripple effect*[P7] which results in staff *constantly fire-fighting all the time*[P7]. The descriptions paint the picture of a stressful environment; participants spoke of feeling 'trepidation', 'apprehension' and being 'scared' about being required to respond to incidences of self-harm. For some this culminated in an anxiety *when you're ultimately in charge* and are *making sure you're keeping somebody alive*[P7]*;* a pressure and responsibility that is felt by nurses when faced with life-threatening self-harm.

Not being able to help captures the experience of feeling unable to help, despite desperately trying to do so. One participant described her experience of managing risk but not being able to remove the risk entirely, and reflected on the emotional strain of this:

> *you can do as much as you can to prevent it…but we have women who you could sit in an empty room and they would still life threateningly self-harm…waiting is draining because you know it's going to happen, you've done as much as you possibly can to prevent it but you still know it's coming, …that's..probably the worst bit, more than the actual event itself*[P7]

Participants described the **danger** of staff being assaulted or threatened with assault and the need *to be vigilant.* Such vigilance was noted to have an emotional toll on staff, especially when a patient is unsettled:

> *I can feel quite nervous, on edge…..made me on edge and,…when she got up and walked around, I were just watching her because she'd she'd she'd pick things up and secrete [hide] things, and it made me a nervous wreck [pause] it really did*[P1].

Balancing acts

This super-ordinate theme describes the dilemmas that participants encounter, with the challenges presented through dialectics (i.e. **offence vs. person**; **security vs. therapy**). The participants' attempts to make sense of these dialectics are demonstrated through mechanisms (e.g. understanding the patient; boundaried caring nursing) which allow the dialectics to reach a point of synthesis (offence and person; therapeutic security).

The dilemma of seeing the **Offence vs. person** reflected opposing positions adopted towards the women as perpetrator or victim**.** Participants described the need to *separate the offence from the person*[P3]*;* of focusing on patients as victims: *I just think 'oh that poor girl, that poor girl*[P1]. They also noted punitive responses from those who focused on offences: *[they say] she murdered her kids, what does she expect?*[P6]. Integrating these elements was seen as a challenge and an emotional task:

> *children, male female, whoever, myself, you, the girls on here..whatever they've learnt they've learnt from people that were there at the beginning, and sometimes, they've not had a hope in hell …. And part of you thinks, well how can we blame them for what they've done, on the other side of the coin, is you can't not blame them, because they've done it as an adult..it's inacceptable [sic]. So it's, it's…it does bring a lot of feelings out in you!*[P3]

Understanding through linking and formulating, for example considering the patients' offences in the context of their negative life experiences, helped with making sense of these tensions: knowing a person's past *doesn't condone perhaps what they've done as adults, but it kinda goes a long way to showing what they've had to deal with*[P3]. Additionally, the fact that the patients are deemed to have a 'mental disorder' was considered to assist participants in addressing the tensions: *They're deemed mentally ill under the Mental Health Act. So…you kind of…[pause] are more accepting of them as people*[P3]. Consideration of the whole individual requires the nurse to engage in a constant balancing act, to maintain a position where one sees the offence and the vulnerability of the person allowing integration or synthesis of this dialectic.

The tension of **security vs. therapy** reflects a spectrum between a risk focus and a therapy focus: *There's always two sides int [sic] there. There's always 'you're too soft' and there's always 'you're too hard', and you'll always find you've got people here that'll shout to you for whatever 'what you doing that for, you're too soft'*[P6]. While acknowledging a *need for security,* participants considered it to have a *stifling effect, restricting imagination, holding staff back*[P6]. For some this led to frustrations about the focus on security: [security is] *the be all and end all here. It' like, risk assessment. Ooh it's a risk, 'well f**k it we won't bother with that then'*[P6]. *Battles* between perspectives were noted:

there have been some major battles..err..with the approaches, because people think erm that risk aversion is..is the way, but people have to take risks, you know? We have to, have to, as safely as possible, allow people to grow, and take risks in a safe environment. They're gonna move on from here one day, and out there's a risky place, you know?[P2]

Such *therapeutic risk taking* was seen as one synthesis to the dialectic. Another approach was the creation and maintenance of boundaries: *they need to know where the boundaries are and then they feel contained, and then we can start working*[P2]. Boundaries were also presented as essential for staff, for their wellbeing and safety.

Emotional hard labour

The 'emotional hard labour' that nurses engage in carries a personal cost for the nurse – a **cost to self** - and necessitates the adoption of a mechanism for managing the emotional toll of the work – **self-care**.

The **cost to self** resulting from their work was manifested in a variety of ways, such as the emotional impact of *taking the work home* and of being emotionally drained: *She drained me. Absolutely drained me … When I do have bad days I really don't want to come the next day 'cause I feel drained, I feel absolutely drained*[P1]. Another participant described a *bottomless pit that you keep throwing into that you just never gets full*[P3].

Others described consequences of being assaulted at work:

I was assaulted quite badly… and I didn't realise how much it affected me until this patient came back again…and I really really struggled for a long time…I lost a lot of confidence in me [sic] job and what I was doing…I think that was probably one of the lowest [pause] times I've ever felt really[P4]

and the sense conveyed by another participant that being assaulted is seen as part of the job:

when you go into like work it's not normal coming home after being battered by a patient and then carrying on like nothing's happened[P5].

Concerns were expressed about the lasting impact of becoming 'desensitised' and accustomed to traumatic or unusual circumstances – the once *abnormal becoming normal*. This process is described in participants' reaction to managing violence and aggression, self-harm, and aspects of security: I used to think *'oh my goodness..I couldn't deal with that I couldn't'. And now, to me it's just…it's just..it's normal. How strange!* [P1]. Concerns were also raised about the impact of such desensitisation extending beyond the workplace: *I think after a while you do get get kind of desensitised from it…it's scary because if you're outside of work and some situations you might just might just go over your head*[P5].

The notion of **self-care** encompassed a wide range of ways in which participants sought to look after themselves. Self-care was seen as very important by participants: *at the end of the day, you've gotta look after yourself, otherwise you're…well you can't do the job if you're not well*[P3]. Engaging in *gallows humour*[P2] or *black humour*[P3] was one indirect way of managing the emotions evoked from witnessing and experiencing traumatic events within their work. One participant described it as *a bit of a defence mechanism against the horrendous things that ya have to deal with*[P2]. Similarly, another participant recognised some of the functions of such humour whilst accepting the negative way this process could be received by others outside of the group:

> *it's not meant maliciously or anything like that, it's just that sometimes, it's just a way of venting I suppose…what you've just seen and what you've just had to deal with..and then it stays in these walls, it never goes any further … It sounds terrible doesn't it [laughs]*[P3]

Compartmentalising home and work life was a common practice: *work is work, and home is home….. and when I'm here, no matter what's going on at home I give it 100% and you know get the job done. Equally, when I'm at home, I give that 100%* [P7]. For some, compartmentalising was described as a learned process:

> *you learn to put up a face. You kind of leave yourself at the gate I suppose, you come through the gate, pick your keys up, and you leave part of yourself outside, … and when you go outside you pick that person up and go on*[P3].

Formal support systems such as *counselling* and *clinical supervision* were also seen as ways to look after themselves emotionally. Supervision was described as an opportunity to *talk about what's happened, how it's made me feel*[P3] and to avoid being *drawn in all the time*[P3]. In

addition to formal support systems, participants described *supervising each other*: *we look out for each other, and we just kind of protect each other…I suppose..keep each other safe, keep the patients, everybody*[P3].

Finally, seeing a patient progress and move on was consistently described as giving meaning to their work and of this positive putting negative aspects into perspective: *you look back and you think 'Ooh you were part of that!' … and feel…[pause]… makes [you] sort of [forget] the bad days*[P4].

The Ward as a Community

In this super-ordinate theme, the ward is conceptualised as a community, and the dynamics, roles and identities within this community are illustrated. Whilst recognising the **importance of the team**, **conflicts in the community** did arise. Perceived **roles and identities** could lead to marginalisation, and to parallels with other relationships such as that of teacher and family member.

The **importance of team** was emphasised: *you can't do it on your own. There's no way you could, you need people right around you*[P3]. The team was said to *work together and we utilise each other's strengths and weaknesses*[P3]. Additionally, one participant compared the ward team to the close-knit teams within emergency services:

> *Other than places like the fire service, and the army, you don't get the sort of same level of intense experience that you get here, and people get really close, and I quite enjoy the sort of camaraderie and banter and things*[P2]

This theme has clear overlap with the functions of the team in relation to self-care outlined earlier, and reinforces the importance of the team with camaraderie and banter used as the "social glue" (Charman, 2013; p.157).

Conflicts in the community, especially within the staff-team, were described by some as the most challenging aspects of their work. Participants described *team-splitting* that arises when some staff follow policies and procedures, and others do not, when a colleague decides to *do their own thing*[P7] contrary to the prior consensus of the team and when *people are*

challenging your decisions all the time[P5]. Actual and symbolic **roles and identities** feature in the participants' accounts of working within this 'ward community'. Gender for example had practical and interpersonal impacts reflected in the need for an appropriate *gender mix* on the ward and an awareness of *gender sensitivity issues*. Recognition of what gender can represent to a patient was shown by a male participant:

> *there's a patient this evening that's said 'don't come into me room please' erm she was sat on the floor with her head in her hands. And I went 'okay I'll go and fetch a female, ... '. She says 'it's not you' she says 'It's just I'm having a bad time'. She was having a flashback about her abusers*[P2]

The influence of occupational role was important for some. Being a Nursing Assistant (NA: non-registered nurse) was seen by one participant to define what input she could offer: *I mean I try not to say too much because I think, well I'm not qualified and I'm not a, you know, a registered nurse ... I wouldn't do anything without asking somebody else senior to me or whoever is in charge*[P4]. However, this position was sometimes difficult: *I think sometimes you know, wish they would listen a little bit more to what we've got to say. So I do and I find that annoying....really*[P4]. Other participants described the satisfaction of being able to mentor and pass on their knowledge to other more junior members of staff: *passing on the skills really as well to the rest of the staff, 'cause they, they learn from watching and taking part. And knowing that when I do retire, that some of the skills I've learnt over the years I've passed on to the younger staff*[P2]. Symbolically, taking on a role of 'teacher', contributes to the identity of some staff within the ward community.

Meta-Theme: 'Making Sense by Understanding'

Connecting together the super-ordinate themes was a common desire to make sense of experiences through developing a fuller understanding. In relation to the horror and emotional challenges, making sense afforded participants the motivation and strength to continue to engage in the work. When participants cannot understand or find meaning in behaviour or processes they described an increased sense of challenge. Evidence of learning and growing even from the most challenging of situations (e.g. being assaulted) illustrates the function of this 'sense-making' process. In 'Balancing Acts', this meta-theme is most strongly depicted within participants' attempts to synthesise the two dialectics, by gaining an

understanding of the wider context surrounding specific acts. Within the 'Ward as a Community', attempts are made to try to understand the conflicts that arise in the team. The 'emotional hard labour' that participants are faced with, and the mechanisms of self-care that they engage in to manage this 'emotional toll', appears to be made sense of through processes such as humour and acknowledging progress.

DISCUSSION

This is the first study to provide a detailed account of nurses' experience of working in a high secure mental health setting for women. Whilst the focus of IPA is to provide an interpretation of the experiences from a homogenous group, the frank and detailed accounts offered by participants in this study offer insights into this unique service and may reflect experiences of working with women with highly complex mental health and forensic needs more widely.

Nurses in this study described various personal costs of working in this setting. The difference between participants' private emotional responses and public behavioural response is described in previous literature as 'emotional labour' (Hochschild, 1983), where this emotion management can benefit the organisation but presents costs to the individual (Grandy, 2000). As noted by Hinshelwood (2008) "it is as if we assumed that because they are professionals they will only have the proper caring feelings" (p.xix).

The separating or 'splitting' reflected in the balancing acts theme appears to be employed as a mechanism to tolerate the dilemmas associated with accepting the offence and the person. Although difficulties integrating the 'acceptable and unacceptable' are widely recognised (Bienenfeld, 2005; Clarkin, Fonagy & Gabbard, 2010); formulation was one mechanism used to facilitate this integration although this itself can be a complex task (Davies et al, 2013). Further, the balance between security and therapy is similar to the concept of 'carers vs. controllers' identified by Clarke (1996), and to the 'Boundary Seesaw Model' developed by Hamilton (2010). In the present study, the emphasis participants placed on 'boundaries' and on 'therapeutic risk taking', were ways to resolve the tension and find some synthesis.

Risqué humour was reported as a way of coping with the emotional toll, but was recognised as having the potential for negative evaluation from those outside the group. The use of dark

humour has been recognised in others who face highly stressful situations such as emergency service personnel (Charman, 2003) where it has been noted to help individuals persevere with challenging work (Young, 1995), to normalise the experience (Myers, 2005) and to mask feelings of vulnerability (Tracy et al., 2006). It is likely that the use of black humour in the current study serves a similar function for the participants. Participants also spoke of the importance of formal mechanisms such as supervision, which is increasingly being recognised as critical for forensic practitioners (Davies, 2015).

The role of gender reported by participants parallels issues raised in UK policy guidance concerning appropriate gender mix and the importance of female patients having choice with regard to workers providing them with support (DoH, 2003). As noted by one of the participants in this study, this may be particularly important for those who have experienced trauma.

In this study, 'making sense by understanding' shows the way in which staff coped with the challenges they are faced with: "The answer…is that we must make meaning of the experiences, both meaning in our own terms as carers and meaning in terms of those we care for" (Hinshelwood, 2008; p.xx).

The limitations of this study are inherent with the approach taken to this research. Whilst the select nature of the setting and participants facilitates a coherent understanding, this limits the generalizability of the findings to other settings. Despite this, the themes in this study are both powerful and share commonalities with findings from other settings. In addition they lend weight to arguments about the mechanisms that may support staff working in highly complex inpatient settings for women.

CONCLUSION

Working with women with complex forensic and mental health needs raises challenges for staff, who in turn deploy a range of coping methods to manage these. In this study, themes of horror, balancing acts, emotional hard labour, and the ward as a community were evident; with the meta-theme of 'making sense by understanding' linking these together.

IMPLICATIONS FOR CLINICAL PRACTICE

The emotional toll and horror that participants described being exposed to were addressed through a range of self-care and external support mechanisms. The importance of fostering these through a coherent and systematic approach to staff supervision and support is essential (Davies, 2015). This should include peer supervision and facilitated reflective practice to encourage the use of the wide range of self-care strategies reported. Indeed, Neath (2010) promotes the need to generate a holistic staff wellbeing strategy that incorporates a range of mechanisms for workforce development including multidisciplinary clinical discussion and post-incident reviews and debriefs. In addition, training in and appropriate time to focus on boundary management (Vamos, 2001) and case formulation (e.g. Davies et al, 2013) are essential to allow staff-support to serve a preventative, and not purely reactive, function.

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Superordinate theme	Subtheme	Examples
Horror	Horror stories	*People were saying 'Oh no, don't apply for Women's, you don't want to go over there'. And then I thought hmmm, because you hear horror stories don't you*[P1]
	Self-harm	*vein popping, people bloodletting, you find them with three or four pint [sic] of blood gone..* [P2]
	Not being able to help	*When it gets to a certain point and they completely shut you off its quite challenging because you're just so desperately trying to help them and make them feel better and they won't let you! [laughing] So that's quite, can be quite challenging*[P7]
	Danger	*you are constantly aware of what's happening around you. You see you never really, you never really relax in that respect* [P3]
Dilemmas & Balancing Acts	Perpetrator vs. Victim / Offence vs. Person	*I was..was able to separate the two, but I didn't know at the time how I was gonna do it..it just happens. You see..you see the person, you don't see the offence* [P3]
	Security vs Therapy	*the tension between security and therapy... that's what makes the job interesting for me* [P2]
Emotional Hard Labour	Cost to Self	*...even at night sometimes I'm having dreams and I wake up and you know when ya feel really anxious in ya stomach, that's how I've been feeling these last couple of weeks.*[P1]
	Self Care	*works work and home time is at home and I think you know you've just got to leave it, you've got to have something separate and I think that's one thing I did learn*[P4]
Community	The importance of team	*I think when you've got a good team with ya, and there are unsettled patients, you know, and ya, ya work together with them*[P1]
	Conflicts in the community	*if there's a situation and you do what you think is the right way, and then you'll have somebody say 'no we don't do it like that, so...we're not gonna do it that way'* [P5]
	Roles and Identities	*Gender: it's a fact that if you've got too many men on the ward, things can't get done.* [P2] *Occupational role/grade: I mean I try not to say too much because I think, well I'm not qualified and I'm not a, you know, a registered nurse* [P4]

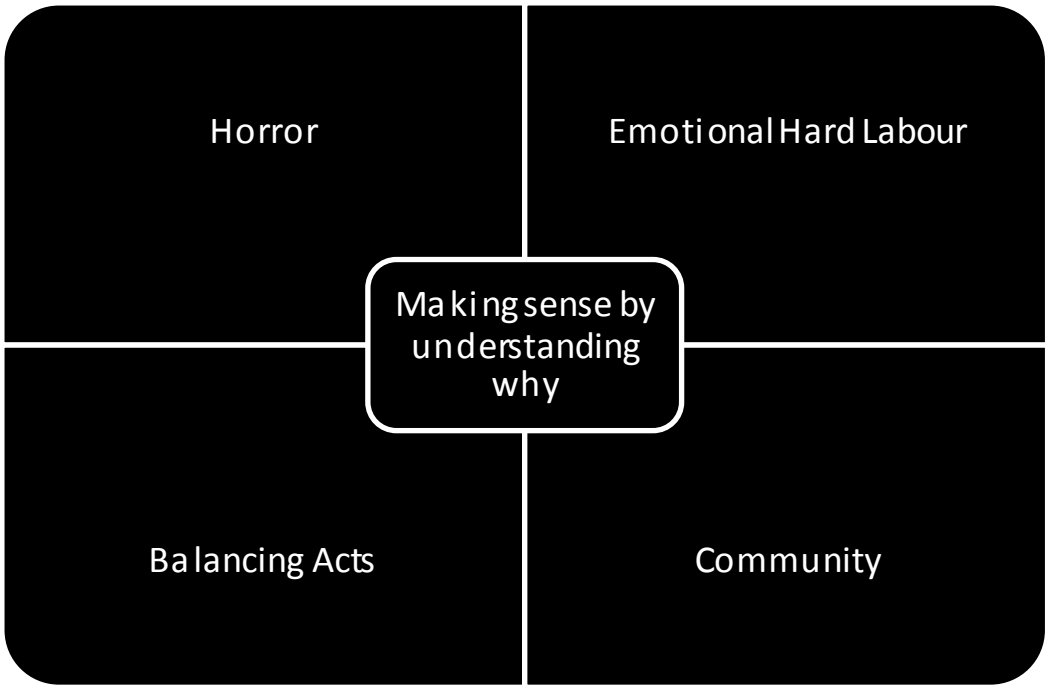

Figure 1: Visual Representation of Super-ordinate and meta-themes