WORKING WITHIN PROFESSIONAL BOUNDARIES IN FORENSIC MENTAL HEALTH SETTINGS: AN ADULT ATTACHMENT PERSPECTIVE

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Abstract

Background - Boundary maintenance within any healthcare context is important, due to the potential adverse impact on patients. The criminogenic nature of forensic patients means that boundary maintenance is pertinent for the safety of patients, staff and members of the public alike. Individual precursors of boundary crossings are relatively well studied. However, interpersonal risk factors which may affect employee perceptions about the seriousness and acceptability of boundary crossing behaviour within forensic settings has received less research attention.

Aims and Objectives - The main aim of this thesis was to explore perceptions of boundary crossings and violations within forensic hospitals and the role which attachment tendencies may play in this relationship.

1. What does the literature suggest about the role of attachment tendencies on an individual's workplace behaviour? (Chapter 2).
2. Is the Revised Experiences in Close Relationships (ECR: Fraley et al., 2000) a suitable measure for assessing attachment tendencies within the workplace? (Chapter 3).
3. What are the individual employee factors which may be associated with the perceptions of the acceptableness and seriousness of boundary crossings and violations within forensic mental health settings? (Chapter 4).
4. What is the impact of adult attachment tendencies upon the perceptions of the acceptableness and seriousness of boundary crossings and violations within forensic mental health settings? (Chapter 5).

Method – To answer the first question, a systematic review was completed to explore the current literature regarding the role of attachment tendencies upon employees work performance (Chapter 2). A psychometric review was conducted to assess the reliability and validity of the ECR-R and its suitability for measuring attachment in the workplace (Chapter 3). Two pieces of empirical research using qualitative methods aimed to explore the relationship between perceptions of boundaries on organisational and interpersonal employee characteristics (Chapters 4 & 5).

Overall Findings – The systematic review (Chapter 2) demonstrated that secure attachment tendencies were associated with professional and "help giving" behaviours at work; whilst anxious tendencies were associated with unprofessional and unethical behaviours which may have a negative impact on both the organisation involved, as well as individuals associated with that work place. The psychometric review of the ECR-R (Chapter 3) confirmed the validity and reliability of the tool for measuring adult attachment tendencies, both within romantic and occupational contexts. Empirical research demonstrated significant relationships between individual employee factors (Chapter 4), attachment tendencies (Chapter 5) and the perceived acceptability of boundary crossings, using vignettes, within a forensic setting. Employees who were either working within a therapy role or had more experience were more likely to view boundary crossings and violations as unacceptable compared to their colleagues. Additionally, the perceived acceptableness of boundary crossings and violations was higher in anxiously attached rather than avoidant attached employees.

Conclusions – Healthcare professionals perceptions towards boundary crossings and violations is mediated by individual and organisational factors. Employees

who have anxious attachment tendencies are more likely to perceive boundary crossings as acceptable. Additional research is needed to identify if this relationship applies to the actual engagement of boundary crossings or violations. Findings may help to support individuals through additional training in boundary maintenance and highlight the importance of regular supervision.

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Chapter One: Introduction

This thesis aims to explore the role of attachment tendencies upon employee's perceptions of boundary crossings within forensic hospitals. Professional boundaries can be defined as "An edge of appropriate behaviour at a given moment in the relationship between a patient and therapist, as governed by the therapeutic context and contract. They may be defined by the physical, psychological and/or social space occupied by the patient in the clinical relationship" (Gutheil & Brodsky, 2011). The literature in this area has broadly distinguished between two types of boundaries; boundary crossings and boundary violations (e.g. Glass, 2003; Gutheil & Brodsky, 2011, & Zur, 2007).

Boundary crossings are considered to be small deviations from standard practice, which are generally "harmless, non-exploitative and may support or advance therapy" (Gutheil & Brodsky, 2011; Sude, 2013). They usually occur in isolation and may be considered minor in severity (Cooke, Hall, Friedman, Jain, & Wagoner, 2019). Comparatively, boundary violations are considered to cause harm to the patient and can range from engaging in social or financial exploitation to having a sexual relationship with the patient (Gutheil & Brodsky, 2011). Unlike boundary crossings, violations are likely to be exploitive and repetitive (Cooke et al., 2019).

Although many, if not all, organisations provide staff with policies regarding appropriate behaviour and boundaries with patients, the issue of boundary maintenance is not based on clear black and white rules. This can lead to confusion regarding what the correct thing to do is in any given boundary dilemma. Subsequently, a flexible, rather than a rigid approach has been recommended in order to aid the therapeutic relationship (Ljungberg, Denhov, &

Topor, 2017; Llewelyn & Gardner, 2009). However, boundary crossings or violations are increasingly imperative for staff working in forensic settings, especially since they can provide a threat to institutional security (Adshead 2012a; Worley & Worley, 2011). This view, however, is not necessarily supported by those individuals working within forensic environments. For example, fewer staff working in the highest level of secure hospitals consider the maintenance of professional boundaries to be an element of their job role; in comparison to professionals working in medium and low secure hospitals (59.7%, 84.2% and 76.7% respectively; Dale & Storey, 2004). Thus suggesting further exploration into employee's perceptions of boundaries is important. The remainder of the relevant literature will now be discussed.

Employee Behaviour

Employee behaviour describes the manner in which an individual behaves in a given work situation. Professionals studying employee behaviour have made distinctions between various different employee behaviours, many of which concentrate on performance. Two common contrasting forms of employee behaviour are organizational citizenship behaviours (OCBs) and counterproductive work behaviours (CWBs). OCBs are considered to be 'discretionary behaviours' which positively contribute to an organisation (Organ, Podsakoff, & MacKenzie, 2005). Conversely, CWBs are referred to as "the dark side of employee behaviour" (Raver, 2013).

CWBs include a range of employee behaviours which can include deviant, dysfunctional, aggressive or abusive behaviour (Raver, 2013). Theorists have generally made a distinction between those behaviours which are aimed at the organisation and those which are aimed towards a specific individual (Berry,

Carpenter & Barratt, 2012). Due to the negative impact that CWB's can have on an individual, for the purpose of this thesis, it is argued that professional boundaries are a form of CWB.

More specifically, researchers such as Spector et al. (2006) and Gruys and Sackett (2003) have provided various definitions of CWBs. When these definitions are analysed the relationship with professional boundaries can be observed. For example, Spector et al's. (2006) dimensional model of CWB contains a sub category of 'abuse', (which they define as harmful behaviours directed towards another causing physical and psychological impact). The connection to professional boundaries with patients is supported by the fact that many patients involved in boundary violations often suffer psychological distress. Furthermore, although aimed at the organisation, it could be argued that Spector et al's (2006) aspect of 'production deviance', which they define as "an intentional failure to complete aspects of the job properly," is related to not upholding professional boundaries.

In a more elaborate model of CWB's, containing 11 items, (e.g. Gruys & Sackett, 2003), the following examples are connected to professional boundaries; misuse of information (e.g. breaching patient or staff confidentiality), unsafe behaviour (potentially related to any boundary breach within forensic settings e.g. bringing in contraband for patients, not following procedural security) inappropriate verbal actions (e.g. excessive self disclosure) and inappropriate physical actions (e.g. touching patients inappropriately, intimate relationships). A further parallel between CWBs and boundary violations is that both behaviours are more likely to occur within demanding work environments (Bowling & Eschleman, 2010); with work stressors (Berry, Ones, &

Sackett, 2007) and interpersonal conflict (Fox, Spector, Goh, Bruursema, & Kessler, 2012), being strong predictors of CWBs. Employees within forensic mental health settings are likely to be exposed to both of these factors. Professional boundaries, a specific CWB, will now be discussed in more depth.

Professional Boundaries

As defined previously, the literature in this area broadly distinguishes between smaller deviations from standard practice; boundary crossings and more serious deviations; boundary violations (Gutheil & Brodsky, 2011).

Although it is usually sexual boundary violations which are exposed to the public domain, through media attention, it has been argued that non-sexual boundary violations are actually far more pervasive (Gutheil & Brodsky, 2011). It is further suggested that a number of boundary crossings commonly predispose a major boundary violation, a concept which has been termed the "slippery slope" (Galletly, 2004). This process usually occurs over a length of time and can include giving a patient preferential treatment, spending more time with them, engaging in personal disclosure or making physical contact with them (Galletly, 2004). These acts of boundary crossings are perhaps more problematic as they are often subtle behaviours which are difficult to distinguish (Glass, 2003).

Whilst it is broadly accepted that professional boundaries established with patients are designed with patient's best interest in mind, it is recognised that such boundaries are often difficult to define. Whether or not a given behaviour crosses or violates a boundary is often subject to the judgment and interpretation of the individual healthcare worker involved (Gutheil & Brodsky, 2011). Whilst functioning boundaries typically go unnoticed, it is usually clear to

see when a boundary violation has occurred (Schafer & Peternelj-Taylor, 2003). It is perhaps this somewhat elusive nature of boundaries which can leave professionals unsure about what the "right" thing to do is (Gutheil & Brodsky, 2008; Gutheil & Brodsky, 2011). Furthermore, many staff hold ambivalent attitudes towards boundaries; often believing they will be invincible from being involved in such behaviour (Norris, Gutheil, & Strasburger, 2003).

Previous research has demonstrated the importance of professional boundaries as well as considering the process behind how boundaries are broken (through crossing or violation) and the consequences of such actions (Coe, 2008; Glass, 2003; Gutheil & Brodsky, 2011). However, as discussed previously, the concept of professional boundaries is often difficult to define since they are usually context dependent (Gutheil & Brodsky, 2011). Others have suggested that professional boundaries are something employees distinctively know (Gutheil & Gabbard, 1993); however, this cannot explain why individuals from all professional backgrounds continue to breach boundaries (Wachtel, 2007).

In an attempt to discover reasons for professional boundary crossings, a recent review explored individual factors which may increase the likelihood of a boundary crossing occurring, e.g. inexperience (Ashton, 2016); especially those with less than 5 years' experience (Bachmann et al., 2000), however, those nearing the end of their professional career are also considered at high risk (Baca, 2009; Coe, 2012). Furthermore, age has been suggested as an important variable. For example, it has been suggested that younger professionals may experience high levels of emotional exhaustion and depersonalisation which were found to increase the risk of boundary crossings and violations (Johnson, Worthington, Gredecki, & Wilks-Riley, 2016). It is also thought that, specifically

within forensic settings, female professionals are more likely to be the perpetrators of boundary crossings or violations, despite accounting for a smaller proportion of the overall workforce (Guerino & Beck, 2011).

Other risk factors which have been considered include various personal problems (Worley & Worley, 2013) such as life crises, job changes, illness, loneliness, pride (which can reduce the likelihood of seeking help), lack of training, substance use and counter transference (Baca, 2009; Norris et al., 2003). Additionally, those who were involved in an abusive relationship, affiliated with antisocial individuals or experienced financial difficulties were thought to be at greater risk of boundary violations (Worley & Worley, 2013). Conversely, others suggest that since anyone is vulnerable, no individual factors are relevant (Norris et al., 2003); instead, it may be the unique interaction between two individuals which is the catalyst for boundary crossings.

Factors which may affect this unique interaction are transference and counter-transference. These two processes are generally thought to have the potential to disrupt therapy (Hayes, Gelso, & Hummel, 2011). Transference is a term in psychoanalysis whereby there is an unconscious redirection of feelings from a patient to a therapist (Prasko et al., 2010). Within the psychoanalytic literature, these feelings are often portrayed as erotic; however other emotions including hate, mistrust and dependency are also relevant. For example, if an individual experienced particularly strict parenting, which they found difficult, these emotions may be transferred to individuals who they feel are in a position of power later in life. Counter-transference on the other hand, relates to transference of feelings from therapist to patient (Prasko et al., 2010). For

example, if a patient reminds the professional about a loved one or previous romantic partner, then they may develop intimate feelings for them.

From these definitions it is easy to see how transference and counter-transference may be important for boundary crossings and violations, especially given the degree of emotions which are involved from both the professional and the patient. Whilst the transference/counter-transference concept is most frequently associated with therapists and their clients, it is reasonable to assume that these concepts are also significant between any professional-patient relationship, especially in forensic settings where staff, especially nurses, are often in the company of patients for many hours at a time, sometimes across years (Adshead, 2012a; Kelly & Wadey, 2012).

Furthermore, an individual's attachment tendency may underlie the process of transference (Anderson & Cole, 1990; Goodwin, 2003). Both theoretical concepts relate to a strong emotional connection with another individual, whereby patterns of relating are repeated from early childhood experiences (Obegi & Berant, 2012; Parish & Eagle, 2003; Prasko et al., 2010). This causes representations of previous relationships to be activated, resulting in both positive and negative emotions from which we go on to form an impression regarding that individual (Brumbaugh & Fraley, 2006; Prasko et al., 2010). It is therefore plausible to consider attachment tendency as a factor which may be partly responsible for explaining individual characteristics in those who cross or violate boundaries with patients, attachment theory will therefore now be discussed in more detail.

Attachment Theory

Attachment theory suggests that babies are born with an instinctive drive to seek and maintain proximity to relevant caregivers. It is suggested that this innate ability helps protect the individual from psychological or physical threat (Mikulincer & Shaver, 2005). All children have the capacity to form attachments, however the nature of such attachments depend on the "parental environment" to which they are exposed (Holmes, 2014).

It is generally suggested that individual differences in attachment form from early experiences with attachment figures (Bowlby, 1973); with a consistent, available and responsible caregiver providing security for the individual, whilst an inconsistent, absent, neglectful or unresponsive caregiver being more likely to create an insecure attachment with the infant (Mikulincer & Shaver, 2005). More specifically, it is thought that an individual who experiences inconsistent availability is likely to develop an anxious attachment style, whilst those who experience a consistent, unavailable caregiver are likely to develop an avoidance attachment style (Hazan & Shaver, 1990).

The original conceptualisation of attachment theory, and indeed attachment styles, was supported by empirical research known as The Strange Situation (Ainsworth, Blehar, Waters, & Wall, 1978) where three patterns of attachment were identified, secure, avoidant and anxious/ambivalent (see table 1).

Table 1

Ainsworth et al.'s (1978) Strange Situation findings

Behaviour when the caregiver left	**Behaviour when the caregiver returned**	**Attachment Style**
Engaged in attachment behaviours and/or became upset.	Easily soothed.	Secure
Engaged in attachment behaviours and/or became upset.	Not easily soothed and continued to display signs of distress.	Anxious (Insecure)
Failed to show much distress on separation.	Actively avoided contact with their caregiver.	Avoidant (Insecure)

The various attachment patterns which are formed with caregivers during the early period of a child's life are very likely to influence close relationships and social interactions within adulthood, and passed to the following generation due to the formation of an internal working model (Mikulincer & Shaver, 2007). Thus available and responsive others support a sense of security; resulting in secure attachment and unavailable and un-responsive others provoke a sense of insecurity within interpersonal relationships, which likely results in an insecure attachment style in adulthood (Mikulincer & Shaver, 2005).

Attachment behaviour has been conceptualised via different models, ranging from three (Hazan & Shaver, 1987), four (Bartholomew & Horowitz, 1991) and most recently, a two dimensional model (Brennan, Clark, & Shaver, 1998; Mikulincer & Shaver, 2005). For the purpose of this thesis, this latter, two dimensional approach is taken to represent the two main insecure categories (anxious and avoidant) as research has indicated this approach accurately represents the structure of attachment (Fraley & Waller, 1998).

The different attachment styles affect how an individual behaves in interpersonal relationships throughout their life. For example, individuals with anxious attachment styles are likely to have a negative view of self which can lead to "hyperactivating" whereby they become overly dependent upon others (Mikulincer & Shaver, 2005). Such individuals may also become hypervigilant of social and emotional cues which they receive from others (Fraley, Niedenthal, Marks, Brumbaugh, & Vicary, 2006) due to a fear of being rejected. They may perceive themselves to be unworthy and unlovable and have a strong need for attention from others (Geller & Bamberger, 2009).

Alternatively, those with avoidant attachment styles are likely to view others as unavailable, unresponsive or punishing (Bowlby, 1973; Mikulincer & Shaver, 2005). As opposed to hyperactivating, avoidant individuals are likely to use deactivating strategies whereby they may minimise the importance of relationships and attempt to avoid emotional intimacy (Mikulincer & Shaver, 2005) due to a fear of becoming dependent on others (Geller & Bamberger, 2009). Avoidant individuals may therefore experience a discomfort with closeness to others and experience a strong desire for autonomy.

Conversely, securely attached individuals are more able to view themselves as worthy and others as trustworthy as well as being comfortable in relationships. It is suggested that these traits help to build resilience and help to manage challenging situations by using internal coping strategies and seeking the support of others (Mikulincer & Shaver, 2005).

Initially, during infancy, various attachment related behaviour, as outlined above, is activated by separation from an attachment figure (Bowlby, 1973). Within adulthood, a similar process occurs, but the threshold for the activation of

the attachment system is higher than in childhood. This is thought to be due to various coping skills which the adult has acquired; such as problem solving, self-soothing and the regulation of emotions (Bowlby, 1973). However, an individual's ability to use appropriate and adaptive rather than maladaptive coping strategies still relate to an individual's attachment style from infancy (Feeney & Thrush, 2010), thus, an insecure infant is likely to develop into an insecure adult (Collins, Guichard, Ford, & Feeney, 2004; Mikulincer, Shaver, & Pereg, 2003). Whilst an individual is likely to possess a dominant attachment style, some attachment strategies do differ across different contexts (Brumbaugh & Fraley, 2007; Klohnen, Weller, Luo, & Choe, 2005). Furthermore, securely attached individuals may possess avoidant or anxious tendencies, just as anxiously or avoidant attached individuals may possess some secure tendencies.

Measuring Adult Attachment

An individuals working model consists of mental representations regarding how we understand ourselves and others. These working models are established in infancy and continue to influence our interpersonal relationships throughout life (Bowlby, 1982; Fraley & Brumbaugh, 2004; Fraley & Shaver, 2008; Harms, 2011). Tendencies of adult attachment have largely been assessed via romantic relationships, since it is argued that these relationships are functionally similar to those between a child and parent (Shaver, Hazan, & Bradshaw, 1988). These assessments have been conducted by either semi structured interviews or self-report questionnaires.

The main example of the interview approach is The Adult Attachment Interview (AAI; George, Kaplan & Main, 1985) which remains the most prevalent measure of this type, leading it to be referred to as the "gold standard" for

measuring adult attachment tendencies. However, due to this assessment being lengthy, it is not practical to complete the AAI in every situation where one wishes to assess attachment tendencies. Self-report measures can alleviate some of the problems associated with lengthy interview style questionnaires.

There are a range of self-report assessments of adult attachment tendencies. These assessments initially involved categorizing individuals into groups (e.g. Ainsworth, 1978; Bartholomew & Horowitz, 1991; Griffin & Bartholomew, 1994; Hazan & Shaver, 1987). The prevalence of individuals classifying themselves into each category has generally been consistent with those attachment tendencies observed in infancy (Hazan & Shaver, 1987). However, other researchers have preferred to measure adult attachment tendencies as a dimensional construct, consisting of two categories; attachment anxiety and avoidance (e.g. Brennan, Clark, & Shaver, 1998; Fraley, Waller, & Brennan, 2000). This is due to the belief that attachment tendency is a variable which people vary on, rather than being classified as one or the other (Fraley & Waller, 1998).

Attachment theory within the Workplace

Despite its presumed relevance to interpersonal relationships within adulthood, attachment theory has only been applied to the workplace since the 1990s, with a particular resurgence since 2010. Hazan and Shaver (1990) were the first to investigate attachment styles within the workplace; arguing that working environments in many ways are similar to the "exploration" concept within the original conceptualisation of attachment theory. The first review into attachment within the workplace reviewed associations between attachment tendencies and the following variables: leadership, trust, job attitudes, stress, coping and job performance (Harms, 2011).

Generally, the findings suggest that an individual's attachment tendency, and consequently their model of self and others, has been found to predict work place behaviours (Richards & Schat, 2011). Overall, individuals with secure attachment tendencies have been found to be satisfied with workplace relationships, job outcomes and have increased wellbeing. As these individuals are likely to have positive working models of themselves and others, they are more likely to be comfortable in their relations with colleagues and be successfully able to deal with stress (Johnstone & Feeney, 2015; Mikulincer & Florian, 1995). Conversely, those with anxious tendencies have little satisfaction with their roles or their relationships within the workplace. They are likely to have a negative view of themselves and be hypersensitive to signs of rejection (Mikulincer & Florian, 1995; Miller, 2007) which is likely to impact upon work place behaviours. Finally, those with avoidant tendencies also report dissatisfaction with work based relationships, but are generally satisfied with their job outcomes (Hazan & Shaver, 1990).

In sum, attachment theory has only recently been applied to the working environment. However, important differences between attachment tendencies, workplace behaviours and interpersonal relationships have been identified. Due to the mechanisms of boundary crossings being based on interpersonal relations, as well as their connection to transference and counter-transference processes, the exploration between attachment tendencies and boundary crossings is warranted. However, firstly, the additional impact of forensic environments should be considered.

Forensic working environments

Given that in adults, attachment behaviour is commonly activated during times of illness, stress and unknown environments (Bowlby, 1979; Goodwin,

2003); it is conceivable that forensic psychiatric units have the propensity to dramatically increase the chance of attachment behaviours being acted out on a day to day basis. This is likely to be the case for both patients and staff.

Additionally, when considering boundary crossings and violations specifically within forensic institutions, much of the literature suggests that three key factors are likely to result in professional boundaries being broken; the uniqueness of the environment and the characteristics of both the staff and patients within these environments. Forensic environments are intense, with employees being exposed to danger and frequent confrontations by inmates or patients (Griffin, Hogan, & Lambert, 2012; Lamber, Cluse-Tolar, & Hogan, 2007; Micieli, 2008); often resulting in complicated relationships between staff and patients. This can cause a "ripe" environment for problematic therapeutic relationships (Peternelj-Taylor & Johnson, 1995) in which retaining professional boundaries is more challenging (Darnley, Brian, Reiss, & Kirtchuk, 2012; Peternelj-Taylor, 2003).

Forensic clients are more likely to present professionals with challenges to boundaries, compared to general psychiatric patients (Kelly & Wadey, 2012). One reason for this is because they are more likely to have developed negative behavioural strategies or poor coping strategies in order to have their needs met. In some cases, this has led others to believe there is a "blurring of lines" when considering the responsibility of crossings and violations (Faulkner & Regehr, 2011). However, forensic clients are vulnerable (Fischer, Houchen, & Ferguson-Ramos, 2008; Regehr, Edwardh, & Bradford, 2000) and it is always the professional's responsibility to uphold boundaries with patients (Celenza, 2007; Gutheil & Brodsky, 2011).

Nevertheless, boundary maintenance is not always an easy task, since patients present with their own unique problems, namely their inability to comply with social norms (Darnley et al., 2012; Evershed, 2011), which further complicates the relationship with professionals (Aiyegbusi & Clarke-Morre, 2009). Particular challenges to boundaries are posed by individuals with personality disorders (Evershed, 2010); a sub group of individuals who account for up to 70% of the forensic population (Adshead, 2012a). Such individuals may tempt nurses to violate boundaries by using techniques such as splitting (Townsend, 2015). Thus it has been suggested that some professionals may collude with forensic clients out of fear of being attacked (Adshead, 2012a), or due to the exposure to "hardened and manipulative offenders", leading professionals to "break under pressure" (Worley & Worley, 2011). Other issues may also complicate professional behaviour within secure settings. For example, the length of time which an individual is likely to spend in a forensic setting may increase the intensity of the relationship between client and professional (Adshead, 2012a; Evershed, 2011; Fischer et al., 2008; Kelly & Wadey, 2012).

The risk of boundary crossings and violations in such environments may be particularly high for psychiatric nurses, since patients spend the majority of their time in the contained space of the ward which acts as the client's domestic and social environment (Kelly & Wadey, 2012). Indeed, it is suggested that weekend and evening shifts are particularly 'risky' since nursing staff are required to facilitate unstructured activities with little supervision; which can lead to small talk and subsequently self-disclosure (Love & Heber, 2002). Psychiatric nurses therefore have to manage the balance of providing security and care (Peternelj-Taylor, 2003) which can be particularly problematic when considering the maintenance of boundaries.

It is noteworthy that boundary violations in forensic mental health settings often differ from those in other psychiatric services (Adshead, 2012a); requiring research and development of theories specific to this area. For example, perhaps due to the gender of the majority of the patients who reside in secure services, male patients are more likely to be victims of boundary violations, with female staff being the perpetrators (Adshead, 2012a; Thomas-Peter & Garrett, 2000).

Overview

Boundary crossings and violations occur across all types of professionals, within a wide range of health care settings. Boundary maintenance is particularly challenging in forensic settings due to some of the characteristics of the patients, the length of time they spend within a secure hospital and the balance which needs to be maintained between care giving and security. Serious boundary violations, such as sexual relationships between professionals and patients have previously been broadcasted in the media. However, it is suggested that smaller boundary crossings are much more pervasive and may in fact lead to more serious violations. This, coupled with the fact that employees do not always recognise the seriousness of boundary maintenance, reveals an important area of research which has not been explored previously; employee perceptions of boundary crossings.

Not all individuals have difficulties maintaining boundaries. However, the implications of boundary crossings can be significant, especially in forensic settings where other people's lives may be placed in danger. Therefore, it is important to investigate differences across individuals which may predispose them to engaging in such acts. As boundary maintenance, crossings and violations are interpersonal in nature, it seems logical to explore an

interpersonal characteristic which may lead to differing perceptions in the acceptability and seriousness of such acts. An important interpersonal variable which has not previously been explored in the relation to boundary crossings and violations is adult attachment tendencies.

Aims of the Thesis

The main aim of this thesis is therefore to explore employee perceptions regarding the seriousness and acceptability of boundary crossings and violations in employees who work within forensic hospitals. The potential role of individual employee factors, such as attachment tendencies, may play in this relationship, are also explored.

Specific objectives are:

1. To review the current evidence on the association between attachment and workplace behaviour including boundary maintenance (Chapter 2)
2. To evaluate a widely used adult attachment tool, the ECR-R, and explore the feasibility of accurately measuring attachment of employees (Chapter 3)
3. To explore individual staff factors associated with employee perceptions regarding the seriousness and acceptability of boundary crossings and violations within forensic mental health settings (Chapter 4)
4. To assess the association between attachment styles and perceptions regarding the seriousness and acceptability of boundary crossings and violations within forensic mental health settings (Chapter 5)

Chapter Two: The Relationship between Counterproductive Work Behaviour, Organizational Citizenship Behaviours and Attachment: A Systematic Review

Chapter Rationale

The purpose of this chapter was to map the evidence base in the area of adult attachment tendencies and workplace behaviours. There are no direct pieces of research investigating the impact of attachment tendencies and boundary maintenance/crossings. However, the basic concepts of counterproductive work behaviours (CWBs) and organizational citizenship behaviours (OCBs) overlap with boundary crossings, violations and maintenance, as discussed in more depth within chapter one. For example, OCBs involve working within professional guidelines and generally having positive interpersonal relationships within the workplace. Conversely, CWBs involve deviant, dysfunctional and even abusive behaviours (Raver, 2013) which can endanger others (Sackett & Devore, 2001); demonstrating the parallels to poor boundary maintenance. The findings of this chapter would therefore guide subsequent chapters which focus on boundary crossings.

Abstract

Introduction

The interest in the antecedents of OCB and CWB has grown vastly over the last decade due to the economic impact that CWBs can have upon organizations. However, attachment tendencies and their impact within the workplace have only recently been studied.

Aims

This systematic review aims to examine the role of attachment tendencies as a potential antecedent of OCBs and CWBs. This review was aimed to synthesise research findings on the relationship between attachment styles and deviant (CWB) and/or non-deviant (OCB) behaviours in adults aged 18+ who are employed.

Method

A total of eight online databases were searched on the 27th August 2017, including four databases which were intended to discover grey literature (PsychINFO, Medline, ABI/INFORM Global, Business Premier Source, Proquest, Web of Science, EThOS and Open Grey). Additionally, searches of reference lists from key articles were completed. Key authors in the field were also contacted. The contents pages of the following journals were hand searched for the past 5 years: International Journal of Human Resource Management, The Journal of Academy of Management, Journal of Applied Social Psychology and Journal of Management.

Results

This search yielded 3492 hits, of which 169 duplicates, 3323 irrelevant references and 37 not meeting inclusion criteria were removed. The remaining 8 studies were quality assessed and analysed. Results indicated a positive relationship between secure attachment and OCB and a positive relationship between anxious attachment and CWB. The quality of studies varies and is discussed throughout the quality assessment.

Conclusions

Attachment styles can impact upon an employee's behaviour at work. Future research would benefit from exploring wider populations as well as considering other control variables.

Key Words: attachment, counterproductive work behaviour, organizational citizenship behaviour

Introduction

Organizational Citizenship Behaviours and Counterproductive Work Behaviours

Employee work behaviours can "shape the organizational, social and psychological context" (Borman & Motowidlo, 1997). One of the main ways employee work behaviours have been studied is through performance, which can include task performance, organisational citizenship behaviour (OCB) and counterproductive work behaviour (CWB) (Rotundo & Sackett, 2002). OCBs are discretionary behaviours that do not necessarily lead to reward but aid the effective functioning of a given organization (Organ & Konovsky, 1989). OCBs include, and are not limited to, volunteering for tasks which have not been assigned to the individual and helping other colleagues with work without being asked to do so (Schnake, 1991). OCB is mainly considered as a multidimensional construct with some researchers suggesting it is comprised of the following five components; altruism, courtesy, sportsmanship, conscientiousness and civic virtue (Podsakoff, MacKenzie, Paine, & Bachrach, 2000). Other researchers have also made a distinction between OCBs which are aimed at other individuals (OCB-I) and those aimed at the organization (OCB-O; Williams & Anderson, 1991).

Conversely, CWBs have been described as "the dark side of employee behaviour" including deviant, dysfunctional, aggressive, uncivil or abusive employee behaviours which occur within organizational contexts (Raver, 2013). These are usually intentional employee behaviours which can be harmful to the organisation e.g. theft, misuse of time, resources or information and the destruction of property (Gruys & Sackett, 2003). CWBs can also be harmful towards individuals within the organization e.g. instances of bullying, sexual

harassment and endangering others (Sackett & Devore, 2001). For example, it has been suggested that up to 50% of employees may have been involved in theft within the workplace (Center for Retail Research, 2010). A subsequent, more recent study has confirmed similar estimates, with 52% of employees admitting to a form of CWB, with interpersonal and minor CWB's being more prevalent than serious organizational CWB (Pecker & Fine, 2015). Despite this prevalence, much deviant employee behaviour is said to go unnoticed; resulting in the true prevalence rates being largely unknown (Fine, Horowitz, Weigler, & Basis, 2010).

As mentioned previously, CWB covers a wide range of acts and these often overlap with other concepts such as workplace retaliation and incivility (Marcus, Taylor, Hastings, Sturm, & Weigelt, 2016; Spector et al., 2006). Specifically, retaliation has been referred to as "adverse reactions" individuals express towards their employers or organizations in response to injustice or perceived unfairness (Folger & Skarlicki, 2005; Skarlicki & Folger, 1997). Alternatively, workplace incivility refers to rude or discourteous behaviour which are in violation to workplace norms (Anderson & Pearson, 1999). Some suggest that these acts of incivility are not necessarily malicious and are generally "milder" forms of a given behaviour (Anderson & Pearson, 1999). Whilst retaliation and CWBs are thought of by some as intentional behaviours (Anderson & Pearson, 1999; Martinko, Gundlach, & Douglas, 2002), other research has discovered that CWBs are not necessarily intentional (Spector & Fox, 2005) and they have been positively associated with incivility constructs (Penny & Spector, 2005).

Hollinger and Clark (1983) were some of the first authors to explore CWB's and they made distinctions between property and production deviance; the latter including rule breaking and not abiding to work based policies and procedures. Further classifications have included interpersonal deviance (Robinson & Bennett, 1995 & 1997). As the literature has developed in this area, various models of CWBs have been suggested. For example, a 5-factor model comprising of abuse towards others, production deviance, theft, sabotage and withdrawal has been developed (Spector, 2006). Further, an 11-factor model consisting of theft, destruction of property, misuse of information, misuse of time and resources, unsafe behaviour, which includes putting others at risk, poor attendance, poor quality work, alcohol use, drug use, inappropriate verbal action and inappropriate physical actions, such as physical and verbal abuse has been devised (Gruys & Sackett, 2003). More recently, there has been a drive for a singular construct of CWB (Berry et al., 2007; Dalal, 2005; Sackett, 2002), which is considered a more robust method of measuring CWB (Fine et al., 2012).

Due to the high economical and psychological cost associated with CWBs (Bennett & Robinson, 2003), it is important to identify the antecedents (Germeys, & De Gieter, 2017). Both individual and situational factors can impact upon an individual's propensity to commit CWB's and OCB's (Murphy, 1993; Robinson & Greenberg, 1998). However, within the research literature, these constructs are often analysed separately; subsequently, the combined effect of these factors is largely unknown (Sackett & Devore, 2001).

In terms of individual factors, being younger, working part time (Hollinger & Clarke, 1983) or being male (Henle, 2005) may increase the likelihood of CWBs. Conversely, more recent research has failed to discover an association

between gender and OCB and proposed only a weak relationship between gender and CWB (Ng, Lam, & Feldman, 2016). With regards to individual traits, research has indicated that higher levels of self-esteem are likely to lead to lower levels of CWB (Whelpley & McDaniel, 2016). However, the main individual difference within the OCB/CWB literature has focussed on personality traits being antecedents (Dalal, 2005). For example, it is suggested that higher levels of conscientiousness are associated with OCB's (Organ & Ryan, 1995; Sackett & Devore, 2001). In comparison, lower levels of conscientiousness and agreeableness (Berry et al., 2007) as well as the "dark triad" of personality dimensions (Machiavellianism, narcissism and psychopathy) have been correlated with CWB's (Forsyth, Banks, & McDaniel, 2012).

In addition to individual factors, the type of environment can also affect the likelihood that OCB's or CWB's will occur. For example, the stressor-emotion model (Spector & Fox, 2005) was developed to illustrate that stressful working contexts can illicit "uncharacteristic" CWB's, such as theft (Searle, Rice, McConnell, & Dawson, 2017). Furthermore, healthcare settings may be particularly stressful for employees, resulting in employees being less able to regulate negative emotions (Kiefer & Barclay, 2012). They may also be subject to poor sleep quality due to shift work (Spector et al., 2006); subsequently increasing risks of CWB's whilst simultaneously decreasing OCB's due to emotional exhaustion (Bolton et al., 2012) or moral disengagement (Fida et al., 2015). Furthermore, it is considered that negative emotional reactions, occurring either due to individual differences or the workplace environment can lead to CWB's (Colbert et al., 2004; Fox et al., 2001) which may be impulsive in nature (Fox et al., 2001, Spector & Fox, 2010); in order to alleviate negative feelings or experiences (Searle & Rice, 2018).

Interpersonal factors can also act as antecedents or disinhibitors of CWB's and OCB's. For example, if there is a negative working relationship between supervisors and employees then they are likely to have poor working attitudes and subsequently engage in more CWB's (Yang, Liu, Nauta, Caughlin, & Spector, 2016). Furthermore, abusive supervision can lead to less OCB's (Zellars, Tepper, & Duffy, 2002). More specifically, the CBW's connected with poor supervisor-employee relationships are likely to be aimed at the organization (Bruk-Lee & Spector, 2006). Additionally, the relationships between co-workers are also of relevance; since conflict between co-workers is likely to result in CWB's aimed at other people within the organization (Bruk-Lee & Spector, 2006).

A further factor connected with interpersonal relations is the perceived culture within a given workplace; employees generally respond positively to satisfying and fair workplaces (Kish-Gephart, Harrison, & Trevino, 2010) and retaliate against unjust workplaces (Dalal, 2005). Such retaliation usually includes a lack of commitment, which harms other employees or the organization itself (Dalal, 2005).

In sum, despite individual and organization factors being contributing factors of OCB's/CWB's within the workplace (Sackett & Devore, 2001), there is evidence to suggest that each of the factors discussed above can in fact be mediated by various means. For example, emotional reactions can be mediated by personality characteristics (Spector & Fox, 2002). Additionally, higher levels of agreeableness and conscientiousness can protect against a negative working climate (Bollmann & Krings, 2016). Finally, high levels of organizational support can act as a buffer against CWB's, even if individual factors predispose that

individual to a greater risk of such behaviours (Palmer, Komarraju, Carter, & Karau, 2017).

Attachment theory and CWB/OCB

Attachment theory denotes that an individual's relationship with their primary caregiver in infancy provides a template of how they view social interactions and form relationships (Bowlby, 1969). This leads to an attachment style, which, more recently has been viewed as a two-dimensional state (Brennan et al., 1998); the two dimensions being attachment anxiety and attachment avoidance. Individuals who are anxiously attached are likely to be preoccupied with rejection and abandonment. They will therefore be concerned with others being responsive and available to them. Conversely, those individuals who are assumed to be avoidant are likely to experience discomfort with closeness and dependency. Thus, there are less likely to rely on others for support (Brennan et al., 1998; Fraley et al., 2000). As opposed to these two concepts, securely attached individuals are those who find it easy to become emotionally close to others, are not concerned with depending on others, or vice versa, and are not preoccupied with others accepting them (Bowlby, 1969). These attachment styles generally persist into adulthood. Attachment theory is therefore considered to be a key framework for understanding interpersonal interactions throughout the life span (Hazan & Shaver 1987).

Until recently, the impact of attachment styles within the workplace has largely been undervalued. Hazan and Shaver (1990) were the first researchers to examine this topic. They discovered that securely attached individuals were focussed on their relationships with co-workers and broadly appeared satisfied with their working relationships. Secure attachment styles have further been

associated with career exploration (Littman-Ovadia, 2008), ability to negotiate (Ketterson & Blustein, 1997), work related adjustment, (Blustein, Prezioso, & Schultheiss, 1995) decision making (Hazan & Shaver, 1990) and confidence (Blustein et al., 1995).

On the other hand, anxiously attached individuals have a negative self-model and a positive model of others (Bartholomew & Horowitz, 1991); leading them to demonstrate insecurity within the workplace and seek constant approval (Hazan & Shaver, 1990). It is suggested that such individuals may be more likely to misinterpret social situations because of fears of being rejected or criticised and are also more likely to perceive others' (e.g. co-workers') acts as uncivil (Leiter et al., 2015). Anxiously attached individuals are also more likely to experience distress when exposed to incivility (Little et al., 2011). They are more likely to be preoccupied with relationships and meeting unreasonable expectations at work, as well as having thoughts of being undervalued (Hazan & Shaver, 1990). Such individuals have also demonstrated higher levels of emotional support seeking (Richards & Schat, 2011). A negative correlation of anxious attachment and helping co-workers has been found (Geller & Bamberger, 2009), suggesting that such individuals may be less likely to demonstrate OCB's within the workplace (Hazan & Shaver, 1990; Mikulincer & Shaver, 2007b).

Alternatively, individuals with avoidant attachment styles have a positive model of themselves and a negative 'other' model (Bartholomew & Horowitz, 1991); leading them to be self-reliant and avoid emotional involvement with others (Bartholomew, 1990). Furthermore, several avoidant attachment traits may be observed in the workplace, including individuals who have a perceived

negative judgment of job performance (Hazan & Shaver, 1990), increased levels of conflict with co-workers (Hardy & Barkham, 1994), stronger intentions to leave their job (Mikulincer & Shaver, 2007b) lower levels of emotional support-seeking (Richards & Schat, 2011) and higher levels of self-reliance (Bartholomew, 1990). Additionally, it is suggested that avoidant individuals may not greatly value relationships with others and may therefore see little relevance of OCB's (Little et al., 2011).

In sum, it is suggested that attachments formed in our early childhood go on to affect our interpersonal relationships throughout adulthood (Bowlby, 1969). Furthermore, research over the past two decades has established a connection between adult attachment styles which have various impacts within the workplace. More specifically, this review seeks to find research evidence which has examined the relationship between adult attachment styles and specific behavioural acts which occur within the workplace, namely OCB's and CWB's. Prior to this review being conducted, a scoping review was completed on the 9th June 2017. To the author's knowledge, there have been no existing systematic reviews examining the role of attachment tendencies and OCB's/CWB's.

Method

Aims & objectives

The aim of this systematic review was to explore the relationship between deviant (CWB) or non-deviant (OCB) behaviours and attachment in adults aged 18+ who are employed.

Sources of Literature

A total of eight online databases were searched on the 27th August 2017, including four databases which were intended to discover grey literature (PsychINFO, Medline, ABI/INFORM Global, Business Premier Source, Proquest, Web of Science, EThOS and Open Grey). Searches were also conducted via Google Scholar to capture any further research which may have been missed. After retrieving sources from the online databases, the reference lists of key studies were scanned. Key articles are listed in Appendix A. Five key professionals in the field were contacted to retrieve any additional studies; however, this did not generate any further papers. Finally, the contents pages of the following journals from the last 5 years were hand-searched: International Journal of Human Resource Management, The Journal of Academy of Management, Journal of Applied Social Psychology and Journal of Management.

Search Strategy

The search terms used are in Table 2. The full syntaxes are in Appendix B.

Table 2

Search terms used for the systematic review.

Experience – Attachment	**(attachment* or attachment theor* or attachment behavio* or attachment style*).**
Outcome 1 – OCB	(organizational citizenship behavio* or OCB* or extra role performance or employee motivation or work ethic or employee attitude* or work* performance).
Outcome 2 – CWB	(counterproductive work behavio* or CWB* or dysfunctional work behavio* or employee devianc* or work* bully* or work* harass* or work* aggress* or work* abuse* or work* violence).

Eligibility Criteria

Population: Adults (18 years+) employed or contracted to work on a full or part time basis in any form of workplace.

Experience: Attachment styles or tendency

Comparator: Different attachment types or tendencies

Outcomes: CWB or OCB.

Study Type: Cohort, case control or cross-sectional studies and case series.

Language: All

Exclusion: Studies which investigate attachment styles and CWB/OCB in contexts other than the workplace, studies which investigate attachment *to* the work place rather than attachment styles of the individual. Commentaries, opinion papers, letters and editorials were excluded.

Please refer to Appendix C for the inclusion/exclusion form.

Results

Figure 1 illustrates the search and selection process. This process was also independently completed by another individual to minimise errors and biases. This individual was a trainee clinical psychologist. The study selection procedure resulted in 8 studies which met the inclusion/exclusion criteria.

Data Extraction

Information was extracted from each of the included studies. The data extraction form used is in Appendix D. The characteristics and findings of all the included studies are in Table 3.

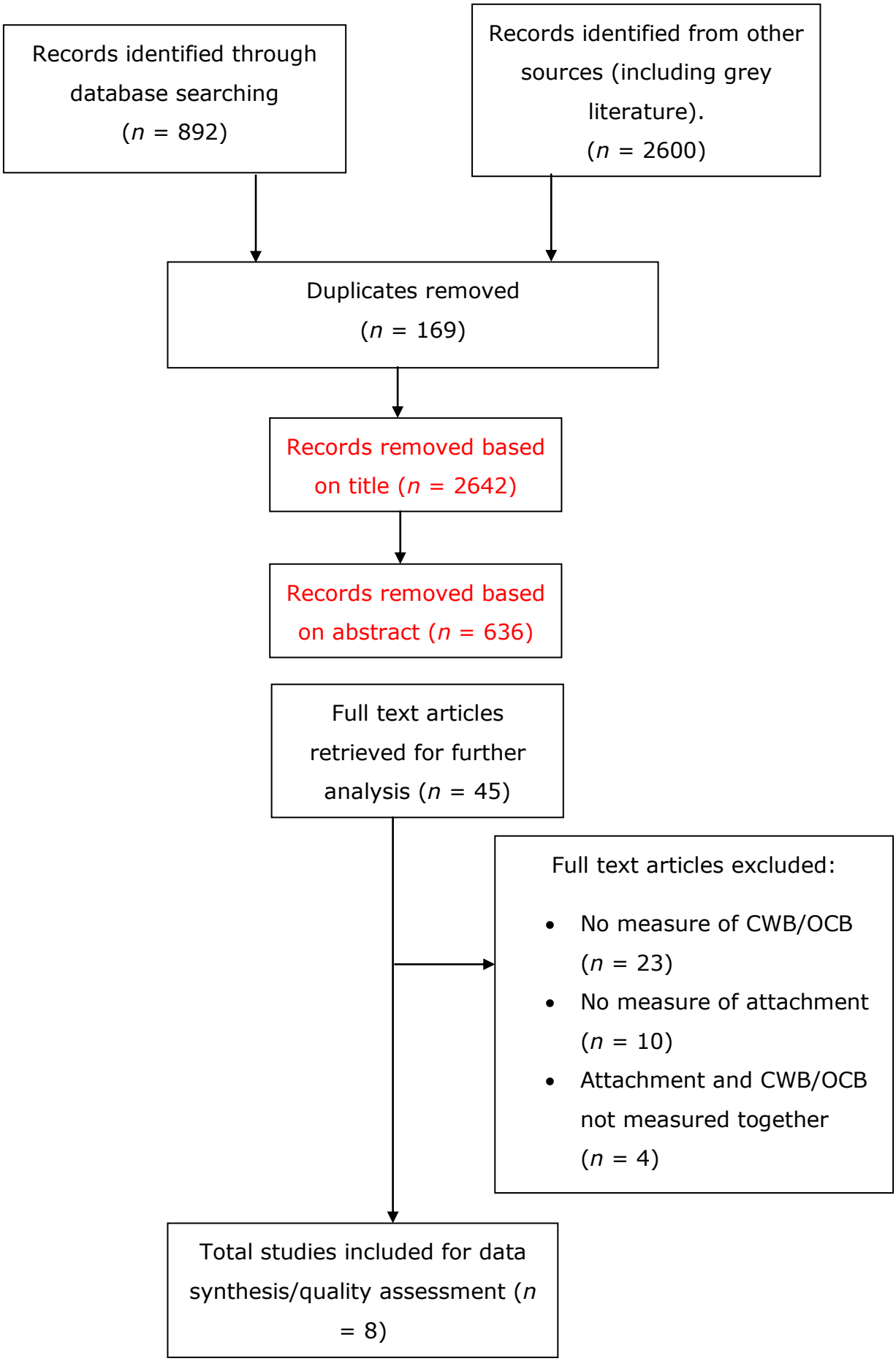


Figure 1. Adapted from: Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & Prisma Group. (2009).

Table 3

Characteristics and findings of included studies

Reference, Country	Population	CWB/ OCB	Attachment Measure	Performance Measure	Results
Syna Desivilya, Sabag, & Ashton (2006)[1] **Israel**	*N*= 212 (165 female & 47 male) Undergraduate students but were employed within four departments of the college. Mean age 36.6 years	OCB	Experience in Close Relationship (ECR) – Hebrew version developed by Mikulincer and Florian (2000).	Scales adapted from the questionnaire in Niehoff and Moorman (1993)	Secure attachment was positively related to OCB. R^2 [F (9, 194) = 7.35, p <0.001] ***S**
Geller & Bamberger (2009)[2] **Israel**	*N* = 308, participants were call centre employees. *Age and gender are not detailed within paper.*	OCB	Experiences in Close Relationships Scale (ECR Scale – Brennan et al., 1998; Hebrew version by Mikulincer & Florian, 2000)	Peer rating method based on Bowler and Brass (2006) to assess instrumental co-worker helping.	Individuals who were higher in attachment anxiety were viewed by peers as providing less help to colleagues, compared to those lower in attachment anxiety. Inverse association between anxiety and instrumental helping behaviour (r = -.18, p < .01). No relationship was found between avoidance and helping (r = -.04, p >.5). ***S**
Little, Nelson, Wallace, & Johson (2011)[3]	*N* **=** 331 (63% male, 37% female) employees from a building facilities	OCB & CWB	Modified version of the Self Reliance Inventory (SRI; Joplin, Nelson & Quick, 1999). The	Williams and Anderson's (1991) OCB-I and OCB-O measure. The Hollinger and	Significant positive correlations between counter dependence and deviance (r = 0.12, p < 0.05) and significant negative

USA	& maintenance organization. Mean age: 36.28 years.		scale was modified to represent an individual's attachment style in the workplace (Frazier, Johnson, & Bolton, 2007)	Clark's (1982) production deviance measure.	correlations between secure style and deviance (r = -0.11, p < 0.05). Significant positive correlations between secure attachment and OCB-I (r = 0.12, p < 0.05) and overdependence and OCB-I/ O, (r = -0.19, p <0.05 and r = 0.23, p < 0.05) respectively. The only relationship to remain significant when the mediator was in the model was that between over dependent attachment style and OCB-O (Direct effect = -0.09, t = -2.67, p <0.05).
Richards & Schat (2011)[4] **Canada**	N = 146, from various sectors: manufacturing (28.1%), technology (9.8%), banking (8.5%), retail (8.5%), health care (7.8%), government and public service (5.9%), construction (5.2%), travel and transporta- tion (4.6%),	OCB & CWB	ERS, an adapted version of Brennan et al.'s (1998) measure in which we replaced references to roman- tic partners in the items with "other people" or "others."	CWB was measured with 10 items from Bennett and Robinson's (2000) measure, which includes five items for CWB-I and five items for CWB-O The OCB was measured by the Organizational Citizenship Behaviour Scale (Podsakoff, MacKenzie, Moorman, & Fetter,	Attachment anxiety was significantly correlated with CWB (r = .33, p < .001) ***P.** Attachment avoidance was not significant with CWB (r = . 09) ***P.** Relationship between attachment anxiety and OCB-O; F(1, 134) = 3.84, p = .05. ***S** A negative relationship was found between avoidance and OCB-O (r = -.16, p < .05). Anxiety was related to OCB-I (r = -.30, p < .001) but not avoidance (r = -.13, p > .05).

	education (4.6%), and hospitality and food services (3.3%) 50.3% male, mean age: 37.5 years.			1990).	
Falvo, Favara, Di Bernardo, Boccato, & Capozza (2012)[5] **Italy**	*N* = 161 (36 male & 124 female) Nurses who worked in a hospital. Age ranges as follows: 21-30 (17.4%), 31-30 years (37.9%), 41 – 50 years (34.2%), and 50+ (9.9%)	OCB	16 item scale adapted from Hazen and Shaver's (1987) distinction of 3 attachment styles. Also used the Italian version of the Attachment Style Questionnaire (Feeny, Noller & Hanrahan, 1994; Fossati et al., 2003).	Six items from Pond , Nacoste, Mohr, & Rodriguez (1997) scale were used to measure OCB Altruism	Secure attachment directly associated with altruism. $\chi 2$ (2) = 0.82, p = .005; SRMR = 0.16; CFI = 1.00. ***S**
Leiter, Day, & Price (2015)[6] **Canada**	*N* **=** 1781 healthcare providers (157 first-line managers – mean age: 47.35 years and 1624 frontline staff – mean age: 43.14 years) *Gender not detailed in paper.*	OCB & CWB	Brief Attachment Questionnaire/ Short Workplace Attachment Measure (Leiter, Price, & Day, 2013)	Straightforward Incivility Scale (Leiter & Day, 2013) Workgroup Civility was measured with the CREW civility scale (Osatuke, Moore, Ward, Dyrenforth, & Belton, 2009)	Anxiety was more strongly association will all types of incivility than avoidance: • Supervisor (t = 1.78, p <.001) • Co-worker (t = 5.06, p <.01) • Instigated (t = 3.49, p < .001). Anxiety was positively correlated with supervisor incivility (r = .13, p <.0001), co-worker incivility (r = .26,

					p <.0001), and instigated incivility (r = .17, p <.001). Avoidance was significantly correlated with supervisor incivility (r = .07, p <.01) and co-worker incivility (r = .09, p <.001) ***S.** Avoidance was negatively correlated with civility (r = -.25, p < .001). ***S**
Harms, Bai, & Han (2016)[7] **USA**	152 employees (52% female) and supervisor (75% male) sets working in restaurants. *Age not detailed in research paper.*	OCB	Bartholomew and Horowitz's (1991) self-report relationship questionnaire (RQ)	OCB-I was measured by the Williams & Anderson (1991) scale	Significant relationship found between avoidance and OCB-I. Avoidant attachment was negatively related to OCB-I (β = - .05, p <.05). ***S**
Schusterschitz, Stummer, & Geser (2014) [8] **Germany**	132 employees (43 % female, 57% male) Various employment sectors: 20% banking and finance, 20% marketing and sales employers, 20% product management, logistics and IT, 30 % health care.	OCB	"Scales to measure two dimensions of attachment insecurity" (Grau, 1999)	German-speaking OCB questionnaire (Staufenbiel & Hartz, 2000)	Employees high in anxiety show higher ratings of OCB-conscientiousness (β = .21, p <.05) ***S** Employees high in avoidance show high ratings in OCB-civic virtue (β = 0.12) ***NS** and less likely to engage in OCB-altruism (β = 0.17) ***S**

										Mean age: 32 years.	

Table Notes: S = Significant/NS = Non-significant/P = Partial

Characteristics of included studies

All studies in the review were cross-sectional, published in English. Four studies [1,5,6,8] relied on self-report measures to obtain information regarding OCB's/CWB's. A further three studies [3,4,7] relied on supervisors to give this information. Finally, one study [2] used co-workers to report on each other regarding OCB's and/or CWB's.

The included studies involved 3223 participants. All participants were aged over 18 and were in employment. Four [4,5,6,8] of the included studies involved individuals who worked in healthcare settings. Other employments included call centres [2], restaurants [7], college departments [1], banking and finance [8], marketing and sales [8], product management and IT [8], and a building facilities organization [3]. Participants were recruited across several different countries including Canada [4,6], America [3,7], Israel [1,2,] Germany [8] and Italy [5].

In terms of attachment, two studies [1, 2] used the Experience in Close Relationship questionnaire (ECR; Brennan et al., 1998); both these studies used the Hebrew version (Mikulincer & Florian, 2000). An Italian version of the Attachment Style Questionnaire (Feeny et al., 1994; Fossati et al., 2003) was also used [5]. Other measures used were the Relationship Questionnaire [7] (RQ; Bartholomew & Horowitz, 1991), The Short Workplace Attachment Measure [6] (SWAM; Leiter et al., 2013), the scales to measure two dimensions of attachment insecurity [8] (Grau, 1999) and the ERS [4] (Brennan et al, 1998). Finally, some measures were adapted by researchers. These were the Self Reliance Inventory [3] (SRI; Joplin et al., 1999); this was adapted by authors in order to capture attachment styles within the work place as suggested by Frazier

et al. (2007) and a 16-item scale [5] was adapted from Hazan and Shaver's (1987) measure.

In terms of OCB's or CWB's, five studies [1,2,5,7,8] measured OCB's only, the remaining three [3,4,6] measured both OCB's and CWB's. The studies used a range of tools to measure these variables; four studies used measures in their original forms [3,6,7,8]. These measures were the Production Deviance Measure (Hollinger & Clark, 1982)[3], the OCB-I and OCB-O measure (Williams & Anderson, 1991)[3], Straightforward Incivility Scale (Leiter & Day, 2013)[6], the CREW civility scale (Osatuke et al., 2009)[6,] and a German-speaking OCB questionnaire (Staufenbiel & Hartz, 2000)[8]. Other studies [1,2,4,5] opted to adapt their measures. Adapted measures were Pond et al's (1997) scale for altruism and a questionnaire which was developed by Niehoff and Moorman (1993)[1], a further study also used Pond et al's (1997) scale but chose to only include 6 items[5]. Further adapted measures were a peer rating method; used to assess instrumental co-worker helping (Bowler & Brass, 2006)[1], Bennett and Robinson's (2000) measure which includes CWB-I and CWB-O items [2]; whereby only ten items were used, and finally the Organizational Citizenship Behaviour Scale (Podsakoff et al., 1990)[5].

The overall results of the included studies indicate that secure attachment was associated with more OCB's in the form of pro-social tendencies and helping behaviours. Attachment anxiety was generally associated with fewer citizenship behaviours and higher prevalence of workplace incivility (CWB's). Avoidant attachment was negatively related to OCB's, one study also found avoidant attachment to be uncorrelated to CWB's [4]. However, a further study suggested that anxious attachment is positively correlated to OCB-conscientiousness and avoidant attachment is correlated with OCB-civic virtue [8].

Quality assessment

A quality and risk of bias assessment was completed by the author and independently conducted by a second independent reviewer. The quality assessment form can be seen in Appendix E. This tool was adapted from the Critical Appraisal Skills Programme (CASP) case control study checklist (CASP, 2018). The checklist criteria used included the following areas:

- Selection and attrition bias
- Study design
- If a valid and reliable method was used to assess attachment style and CWB and OCB.
- Appropriateness of the analysis.

Participants and Selection Bias

The number of participants included in research is relevant as it helps readers gain an understanding of how reliable the results are (Marczyk, DeMatteo, & Festinger, 2017). The subject area of the current review is relatively new; as demonstrated by the small number of articles discovered in this area. Due to the novelty of the research area, participant samples were compared across studies. Participant numbers ranged from 132 [8] – 1781 [6.] The largest participant sample was significantly larger than most of the studies. An average of the rest of the studies [1,2,3,4,5,7,8] was 219 and all included studies include acceptable participant numbers.

As is the case with any research, it is important, where possible, that the included participants are representative of the general population; since this is an indicator of external validity. Of the included studies, six [1,2,3,5,6,7,8] studies

were deemed to be representative of the wider target population. Of these, four [3,5,6,7,] were moderately representative, the further two [1,2,] although considered representative, were thought to be less generalisable to other adult populations who are employed. This is because studies included students who were also employed [1], participants who had been newly hired [2,] and those attending a course on professional development [8].

Any of these aspects may cause a bias within the specific types of responses which were given on the measures. For example, students from a specific sub section of the general population. Additionally, newly appointed employees may provide socially desirable responses or may be less likely to exhibit CWB's during the early stage of their employment. Only one study was deemed un-representative of the broader population [4.] This was because the participants were selected from a "study response project". It is probable that individuals whom belong to such a project may have specific individual traits which make them distinctive to other population groups. However, the same point could be made about the other studies since all studies used specific occupation types, as outlined in table 3.

Response Rate and Missing Data

Response rate is another important aspect of study validity and bias since the results are only representative of those individuals who completed the full study. Some strategies can be employed in order to retain participants; however, these are often costly, so the benefits of using these should be measured against any potential costs to validity (Morton, Bandara, Robinson, & Carr, 2012). Conversely, other studies have suggested that there is no direct correlation between response rate and validity (Holbrook, Krosnick, & Pfent,

2007); whilst a low response rate doesn't necessarily result in lower validity, rather a greater *risk* of lower validity (Morton et al., 2012).

Although it is almost impossible to suggest a finite number for an appropriate response rate, for the purpose of this review, organizational research norms were reviewed in order to have an appropriate figure to use for the purpose of validity assessment. Based on this research, a figure of 52.7% was selected as this has been suggested an average response rate in organizational research (Baruch & Holtom, 2008). Of the studies reviewed, four [1,2,3,7] reached or exceeded this benchmark. A further three studies did not list the response rate of participants [4,6,8]. The final study had a response rate of 40.25%, however, it should be noted that this study used postal surveys which are known to have lower responses rates (Cook, Dickinson, Eccles, 2009). None of the studies reported the details of those who didn't take part, which may have increased the generalisability of the results (Morton et al., 2012). However, due to the methodological nature of the studies included in this review, such an observation may not have been possible since participants either volunteered to participate, or did not, rather than dropping out of the study per se.

The process by which missing data is dealt with is also an important aspect which can potentially bias the results of a study. Some individuals may simply delete cases for whom there is not a full data set for. However, this can skew data and may result in the data no longer being random (Clarke & Hardy, 2007). Common methods are list-wise and pair-wise deletion which were used in two of the studies, respectively [2,4]. Maximum likelihood estimation and multiple imputation are deemed as "modern approaches" to deal with missing data (Enders, 2013). Such approaches are deemed as being more reliable since they

result in less restrictive assumptions and thus less potential for bias (Enders, 2013). However, since none of the included studies used these methods, those who used any method [2,4] are deemed more reliable within this review since they indicate attempts have been made to account for the missing data.

Furthermore, none of the included studies provided a description of participants who withdrew from the study. It could be argued that due to the methods included within the studies in this review, there was less chance for participants to withdraw since most studies involved the participants being involved at just one time point. Again, due to the study design, it is apparent that the response rate relates to the number of people who took part out of a larger number of those who were invited to take part and did not respond, rather than dropped out of the study altogether. This may therefore account for the unavailability of such data. However, two of the studies included different time points to collect responses on the measures; either 2 [2] or 3 [3] month lags. For these studies, it is possible that people who took part initially may not be available to complete the second part of the study, resulting in participants who dropped out of the research, leading to attrition bias. Although one study [2] used list-wise deletion to deal with missing data, a further study [3] did not state how they dealt with missing data, potentially resulting in less reliable results.

In sum, having information regarding the characteristics of those individuals who didn't participate would have made it possible to establish if this group were comparable to those who did participate (Kelley, Clark, Brown, & Sitzia, 2003). Whilst this may have provided useful information to aid the validity of the studies, it appears that due to the study design, such a comparison was not possible.

Study Design

The study designs were independent, correlation designs. Whilst this is the most suitable design for the aims of the studies, many extraneous variables within the environments the studies took place in are unlikely to have been fully controlled; resulting in less validity. Two studies [1,2] attempted to eradicate such issues by standardising the way in which participants completed measures. However, a further six [3,4,5,6,7,8] failed to do this. Due to the nature of the research topic being explored, none of the studies included a truly random sample. Most of the studies used either single [1,2,3,5,6,7] or multiple [4,8] workplaces or sectors; both of which limit the potential for the findings to be applied to other employment sectors. Additionally, the participants within each of these specific sectors were not chosen at random. Three of the studies [3,4,5] required participants to respond to requests to take part on a voluntary basis. It appears that this may have also been the case for a further study [1] however; the authors did not explain the recruitment process.

One study [7] sent postal surveys to several employees. The difference between this method and being asked to participate in person is likely to have affected who took part. For example, those asked in person may have felt less able to decline. Additionally, although the response rate was lower in the study involving postal surveys, perhaps the responses were less biased since responders may have felt more anonymous. Finally, one study [2] recruited a very specific group of employees; new employees joining the organization. This group of participants are particularly at risk for providing biased responses due to potentially wanting to provide responses which placed them in a positive light. Additionally, research has shown that OCB/CWB's may be more likely to occur

when individuals have been in a workplace for a significant amount of time (E.g. Kegans, McCamey, & Hammond, 2012); suggesting this particular study may have captured a skewed association between the study variables. Such implications were confirmed by the authors who indicated some participants felt unsure about leaving their tasks in order to help others. This was due to them being new in their role rather than not necessarily wanting to help others.

Finally, none of the included studies clearly indicated if participants were aware of the research objectives. It is likely that since the included questionnaires required participants to indicate behaviours involved in their job role, that there would be a degree of socially desirable responding which occurred leading to biased responses. However, if participants were also aware of the research hypothesis, it is possible that some of their responses may have changed in concordance with the expected outcomes of the research.

Validity and reliability of the included tools

An overview of the validity and reliability of the tools used within the studies is provided below. Please refer to Appendix F for a complete overview. In terms of reliability, all the included studies used attachment measures which had acceptable or good levels of reliability ($\alpha > .7$). Only three of the studies [6,7,8] did not alter the attachment measures which were used. Some of the adaptations involved changing the language to make them appropriate for the countries in which they were used [1,2]. Such an approach is generally deemed as acceptable as it allows for increased reliability and validity for the measure to be used with populations outside of the country it was developed in (Mikulincer & Florian, 2000).

Other adaptations have occurred to address the fact that romantic references in adult attachment measures can limit their applicability to other contexts (Wei, Russell, Mallinckrodt, & Vogel, 2007). Two studies in this review [4,6] used measures which were adapted to create a "context independent" measure (Richards & Schat, 2011). The authors who created the ECR (Fraley et al., 2000) have endorsed such adaptations. However, others suggest that the "fundamental content" of original items included in adult attachment measures are suitable for a range of environments (Wei et al., 2007). Yet, some argue attachment styles remain relatively stable across the life span and across multiple contexts (Fraley & Brumbaugh, 2004); indicating that such adaptations may not be necessary.

Other scales used within this review were altered to make them more concise [4,5]. Whilst this may be useful to eradicate effects of fatigue or lack of concentration, briefer scales may result in reduced reliability and validity of results (Richards & Schatt, 2011). A final adaptation involved merging two measures together [5]. The validity of such an approach is less acceptable and could indicate concerns with the reliability of the results. However, authors included revised cronbach alpha scores for the adjusted measures within this review, which remained within acceptable ranges; thus, suggesting reliability was sustained.

In terms of validity, two studies used the ECR (Brennan et al., 1998), [1, 2] this measure has good construct and discriminate validity (Shaver & Mikulincer, 2004). Further research has also confirmed the two-dimensional structure, indicating that the scale successfully distinguishes between attachment anxiety and avoidance (Brennan et al., 1998), which has also been the case for the

Hebrew version which was used in these two studies (Mikulincer & Florian, 2000). A further study [4] adapted the ECR to form the ERS scale (Fraley, Hefferman, Vicary, & Brumbaugh, 2011) which assesses generalised attachment tendencies as opposed to only romantic partners. This approach has been shown to increase the external validity of such a tool (Jan Conradi, Gerlsma, Duijn, & Jonge, 2006), allowing it to be used successfully within employment contexts. Factor analysis has demonstrated that a further two tools used within this review [3, 6] have been validated in terms of their factor structures; the SRI (Joplin, Nelson, & Quick, 1999) with three factors (Frazier et al., 2007), and the SWAM (Leiter et al., 2013) with two factors which were weakly correlated; $r = .02$ (Leiter et al., 2015). Construct validity has also been confirmed with another measure, RQ [7] (Bartholomew & Horowitz, 1991) when used with Swedish research participants (Bäackström & Holmes, 2001), suggesting this measure has validity outside of the population it was designed to assess. Finally, validity has been indicated for the Hazen and Shaver (1987) scale [5] (Feeney, Noller, & Hanrahan, 1994), however this study used two attachment measures, the validity of such an approach being more questionable since this is a less standardised method.

When considering the OCB/CWB scales, whilst in the original form, the tools are deemed to be reliable ($\alpha > .7$). However, this reliability may have been compromised due to the majority of the included studies adapting the tool they used [1,2,4,5]. Some of the studies made adaptations to make the questionnaires shorter, in an attempt to reduce the amount of questions an individual has to answer which may lead to boredom, resulting in less accurate responses [1,4,5]. However, the process of making a measure abbreviated have been criticised for lacking breadth of information (Crede et al., 2012) which could ultimately affect

the validity and applicability of the results. However, it should be noted that where tools have been adapted, the authors have generally completed additional Cronbach Alphas of the revised tools [1], the reliability of which has generally remained within acceptable to good ranges.

In terms of validity, factor analysis has confirmed the original dimensions of the tools which have been used in the included studies [1,4,6,8] which is indicative of good construct validity. However, authors have suggested that the tool designed to measure Altruism and generalised compliance [5] may include concepts which are not statistically distinct (Smith, Organ, & Near, 1983); indicating lower construct validity. Furthermore, the OCB-I scale (Williams & Anderson, 1991) which was used in two of the included studies [7, 3] has been criticised in terms of the constructs it measures. In particular, it is suggested that a four-factor model is more relevant for this particular measure, due to the inclusion of several items which appear to measure CWB (e.g. "takes undeserved work breaks"), rather than OCB constructs (Lee & Allen, 2002; Blaich, Rodwell, & Noblet, 2008). Although the Organizational Citizenship Behaviour Scale (Podsakoff et al., 1990)[4] demonstrated acceptable construct validity, it was only found to demonstrate discriminant validity (Mahembe, Engelbrecht, Chinyamurindi, & Kandekande, 2015). Finally, the Production Deviance Measure (Hollinger & Clark, 1982) [3] has been specifically designed to assess occupations in retail, hospitals and manufacturing environments (Bennett & Robinson, 2000) which limits the external validity of this measure. Furthermore, critics have highlighted that this measure fails to address interpersonal deviant behaviours which is a relevant aspect of CWB (Robinson & Bennett, 1995) and may lower the validity of such a measure; since it may have limited ability to capture relevant aspects of a construct.

Practical methodological considerations

All the included studies used self-report questionnaires to measure attachment. Some authors question the intrinsic validity of self-report measures (Bateman & Fonagy, 2010), with the Adult Attachment Interview (AAI; George et al., 1996) historically being considered the gold standard of measuring adult attachment. However, it is not always realistic to use the AAI in research, due to time constraints. Furthermore, it is likely to present with its own validity issues since an individual may be more likely to provide altered responses when asked certain questions in person. Additionally, further bias for interview style measures concern the subjective nature of the scoring involved.

Considering whether the completion of measures took place in a standardised format was important as it could impact upon the reliability. The way in which completion took place in three of the studies was unclear [4,7,8]. Two of the included studies appeared to have a standardised method for participants completing the measures. One required participants to complete them at the start of their lecture [1,] another required participants to complete the measures across two time points, on their first day and at the end of the first month, both of which were completed within the workplace [2] . Whilst the time difference may have created bias, Leiter et al. (2015) suggest that this process was to avoid same source bias between the attachment and OCB/CWB measures; a process which has been previously recommended (Podsakoff, Mackenzie, Lee, & Podsakoff, 2003).

A further four of the studies did not include standardised methods of completing measures. In one study, the location of completion was not detailed [3] furthermore, the time scale in which participants completed different measures

was based on approximation [5,8]. A further study asked participants to complete the measures at home. Whilst participants may have preferred the anonymity of this method and thus provided more honest answers, there is no way of controlling the environment in which these were completed which may affect the reliability. A further study invited participants to complete their responses via either paper or electronic methods [6]. Some have suggested that online questionnaires may be "superior" to their paper counterparts due to increased accessibility (Miller et al., 2002). However, further research has suggested online studies are less likely to be monitored during admission which could decrease validity (Musch & Reips, 2000). Conversely, other research has suggested that online data collection does not compromise the integrity of the measure used or enhance results; researchers have found similar results have been discovered using both electronic and paper methods (Riva, Teruzzi, & Anolli, 2003).

A further area of variation within the methodology of studies was who completed the OCB/CWB measures. Some studies relied on individuals to self-report these traits [1,5,6,8,] whilst others relied on either supervisors [3,4,7] or peers [2] to complete the ratings. Some critics have suggested that for work behaviours to be measured accurately, the employee needs to complete the scale themselves; since distinct differences have been found between self-report and managers report of employee work behaviours (Lam, Hui, Law, 1999). One of the reasons this could be the case is that some supervisor ratings of OCB can be biased due to ratings being based on general opinions rather than factual information (Dalal, 2005).

Analysis

All the studies included in this review were deemed to have used appropriate statistical analysis, given the design and aims of the research. All studies used a form of regression analysis which was appropriate for assessing the relationship between different variables. For this review, it was deemed important if authors controlled for specific variables or not. Specifically, this review assessed if authors controlled for the age of participants and the length of time an individual had been working for the organization. This was deemed as important since both these factors have been demonstrated to affect an individual's likelihood to commit OCB's or CWB's (Chahal & Mehta, 2010; Hollinger & Clarke, 1983). Four of the studies successfully controlled for age [1,3,4,7]. None of the included studies specifically controlled for the length of time an individual had been working for an organization before the study was conducted; however two studies included comparable variables, seniority [1] and tenure [7].

Discussion

This review has demonstrated that there is a relationship between workplace behaviour (OCBs/CWBs) and an individual's attachment style; securely attached individuals are more likely to endorse OCB's [1,3,5]. This relationship is further supported by other researchers finding a negative relationship between attachment anxiety and OCB's, in that such individuals typically engaged in fewer helping behaviours [2,4,6]. This relationship was also replicated with individuals who had avoidant attachment styles, who were specifically less likely to engage in OCB-I's [7]. However, in a study where anxious and avoidance styles were compared, anxiously attached individuals were

significantly more likely to engage in CWB's [6]. Furthermore, anxiously attached individuals appear particularly less likely to engage in OCB's aimed at the organization [3,4]. One piece of research did demonstrate a positive relationship between anxiety and avoidance attachment types and OCBs [8.] However, it is likely this is because researchers used a scale which measured OCBs on a 5-level construct. It is therefore possible, that anxiously and avoidant attached individuals may demonstrate specific OCBs rather than no OCBs at all; namely civic virtue. This finding of a positive relationship between anxiously attached individuals and conscientiousness was not expected and not in line with the other study findings. This may be due to the client group involved, or the measure used to assess the variables.

It is likely that the general relationship found within this review exists because securely attached individuals are likely to have developed pro social values and a positive working model for the organizational setting (Mikulincer & Shaver, 2007b) which lead to OCB's and a decreased likelihood in committing CWB's (Syna Desivilya et al., 2006).

Alternatively, it has been suggested that feelings of attachment anxiety are likely to transpose into the workplace; leading them to seek approval for others (Hazan & Shaver, 1990). More specifically, some suggest that anxiously attached individuals may be predisposed to offer "compulsive care giving" due to a fear that others may leave them (Kunce & Shaver, 1994; Carnelley, Pietromonaco, & Jaffe, 1996; Feeney & Collins, 2001). This may lead to the assumption that anxiously attached individuals would demonstrate OCBs as a method to avoid rejection. However, this was not the case in this review, whereby the findings may concur with the view that anxiously attached

individuals exhibit fewer helping behaviours towards co-workers because they have a less intimate relationship with them, and thus are less preoccupied with securing their love (Feeney & Collins, 2001). Instead, they may be more focussed on investing their resources into their romantic relationships, due to a fear of abandonment; leaving little resources to invest in a similar manner to working relationships (Rom & Mikulincer, 2003; Gillath et al., 2005).

Alternatively, avoidant individuals are considered to have a working model which is based on threat (Bartholomew, 1990). Consequently, they may consider closeness to individuals as increasing the likelihood of rejection and abandonment (Geller & Bamberger, 2009). Such individuals may therefore avoid social contact, disengage from others and be less likely to seek support. Combined, it's possible that these factors lead to a "distant" approach leading to less OCBs but also less CWB's (Leiter et al., 2015; Richards & Schat, 2011; Mikulincer & Nachshon, 1991). Alternatively, such individuals may be more cautious of other intentions and may subsequently develop a negative view of their organization and the individuals within it; leading to less OCBs (Little et al., 2011).

It is noteworthy that the general findings of this review are different to what has previously been discovered within romantic relationships. For example, whilst the majority of the reviews discovered an inverse relationship between attachment anxiety and helping behaviours, a positive relationship has been found within romantic contexts (Feeney & Collins, 2001; Kunce & Shaver, 1994). Such findings may be explained by anxiously attached individuals needing to use resources to cope with individual factors such as low self-esteem, or by investing all their energy into securing their own romantic relationships, leaving them no,

or little capacity to execute similar helping behaviours within other contexts, including their workplaces (Collins & Read, 1990; Rom & Mikulincer, 2003).

It is therefore reasonable to speculate that there is variability within individuals working models from one context to another (Brumbaugh & Fraley, 2007; Klohnen et al., 2005). Consequently, individuals are likely to report a mix of attachment tendencies, both across time and different relationships (Bartholomew & Horowitz, 1991). Indeed, some authors have suggested that adults may be best characterised as a combination of two or more attachment styles, depending upon the context (Simpson, 1990). Combined, such research helps illustrate the complexity of attachment and may explain some of the results found in this review. This could have implications for those studies who used romantic attachment style measures [1,2,5,8], since this may not be an accurate representation of their attachment style within the workplace.

Limitations

There were several limitations regarding this review. Due to the nature of this review and the limited resources available, only a small number of databases were searched. Although these were deemed the most relevant for this review topic, it is possible that searching of additional databases may have retrieved additional results. Furthermore, although thorough attempts were made to establish all search terms, OCBs, and particularly CWBs have only relatively recently been explored within academic literature. Consequently, it is possible that some of the search terms failed to capture all the conceptualisations of these terms. Again, this may have resulted in some studies being undiscovered.

To extend future reviews in this area, it would be beneficial to include reviews which have measured attachment *to* organisations, since a number of these were discovered during the search process. These were not included in the current review, due to inclusion criteria which was quite specific due to the scope of the review. Research in this area is likely to supplement the current findings.

Future Research

The results of this review have provided justification for the importance of adult attachment style within the work place. This review illustrated that there are a number of, although limited, pieces of research that have investigated the impact of attachment styles upon specific workplace behaviours, OCBs and CWBs. However, most of the results focussed on OCB's, with only three studies including CWB's [3,4,6]. Due to the suggested impact of CWB on businesses and indeed other individuals within the workplace, it would be beneficial for future research to specifically focus on CWB's and the relationship to attachment styles. Additionally, future research would benefit from wider participant samples, across several different working contexts and within different cultures.

It is hoped that this review may provide an understanding about why certain individuals engage in various workplace behaviours. Although attachment styles generally remain stable across the lifespan (Fraley & Brumbaugh, 2004; Fraley & Shaver, 2008; Harms, 2011), others have suggested that there may be variation in styles across contexts (Simpson, 1990). Therefore, knowledge of the impact which attachment styles have on employee's behaviour within the workplace is likely to be useful to implement support for them. For example, those with anxious attachment styles may require additional emotional support from line managers due to potential issues of distrust (Harms et al., 2016).

Furthermore, specific employment contexts may require more exploration. For example, research has used the stressor-emotional model (Spector & Fox, 2005) to explain how stressful working contexts can lead to "uncharacteristic" CWBs (Searle et al., 2017). It is therefore proposed that the conditions within healthcare settings may make people in these environments particularly vulnerable to committing CWBs; due to stress and emotional exhaustion (Bolton et al., 2012; Kiefer & Barclay, 2012) or the process of moral disengagement (Fida et al., 2015).

It could be argued that the implications of CWBs within the healthcare setting are paramount due to the potential implications for patients within their care. As interpersonal interactions and therapeutic relationships are likely to be established within patient focussed roles, the role of attachment styles is likely to be very relevant. Although one of the studies in this review focussed on staff from healthcare settings alone[6], additional research in this area is warranted due to the issues outlined above.

Highly anxious attached individuals may be prone to provide compulsive care giving (Kunce & Shaver, 1994) or egoistic care giving; aimed at making the caregiver feel better about themselves. This can be at the expense of addressing the needs of those who the care giving was originally aimed at (Erez et al., 2008; Gillath et al., 2005). Therefore, even if indirectly, it is possible that caregivers may neglect the needs of others whilst putting their own needs first. Furthermore, it is likely that, within a healthcare setting, this could lead to endangering others, which has been classified as a type of CWB (Sackett & Devore, 2001); especially since such individuals have been shown to demonstrate limited and ineffective care giving (Collins & Feeney, 2000; Gillath

et al., 2005; Mikulincer, Shaver, Gillath, & Nitzberg, 2005). These individuals may even demonstrate inappropriate physical actions or verbal and/or physical abuse (Gruys & Sackett, 2003).

Alternatively, it is suggested that avoidant individuals may lack the necessary skills or motivation to become good caregivers; thus, resulting in less OCBs (Feeney & Collins, 2001). This is likely due to their unwillingness to create open relationships with others (Mikulincer & Nachshan, 1991). Given these proposed relationships between attachment tendencies and differences in workplace behaviour, particularly within healthcare settings, it would be beneficial for future research to focus in this area.

Finally, given that in chapter one it was argued that boundary violations are a form of CWB due to the psychological impact which boundary breaches can have upon patients, amongst other parallels; it is important to examine if similar relationships found in this review extend to perceptions of boundary crossings and violations (Chapter 5).

Chapter Three: Assessing Attachment Tendencies within Organizational Settings – A review of the Experiences in Close Relationships - Revised

Chapter Rationale

The emergence and relevance of attachment theory within the workplace and its relevance to workplace behaviours has been discussed (Chapters 1 & 2). However, before embarking on primary research focussing on attachment tendencies and perceptions of boundaries within forensic mental health settings, it was important to review the psychometric properties of a measure of adult attachment tendencies (ECR-R). Furthermore, it is appropriate to assess its potential to accurately measure attachment tendencies outside of romantic contexts. Combined, this would allow the results of the empirical research in this thesis to be interpreted reliably.

Abstract

The Revised Experiences in Close Relationships (ECR-R) is a psychometric assessment measure, designed to measure self-reported adult attachment tendencies across two dimensions: anxiety and avoidance. The ECR-R is a widely used measure, demonstrating good psychometric properties. However, its focus on romantic connotations has led researchers to question its applicability of assessing constructs outside of romantic relationships. Measuring attachment within organizations is a growing trend, however the reliability and validity of applying the ECR-R to this context has not previously been assessed. Practical implications are discussed throughout.

Key Words: Experiences in Close Relationships–Revised, ECR-R, attachment, assessment.

Introduction

Attachment styles have been historically studied in the context of an infant's attachment to primary caregivers, and thus within the realms of developmental psychology. However, since working models persist into adulthood, there is a growing body of research which uses attachment styles to explain the quality of adult relationships across broader social contexts, (Collins & Feeney, 2004; Falvo, et al., 2012), such as within organizations (Collins & Read, 1990; Hazan & Shaver, 1990). It is suggested that the working environment is comparable to the exploration process in infants (Hazan & Shaver, 1990); with the model of self and others predicting behaviours which individuals adopt in their employment relationships (Richards & Schat, 2011). This area remains under researched (Littman-Ovadia, Oren, & Lavy, 2013), with most papers in this area being published after 2010 (Yip, Ehrhardt, Black, & Walker, 2018).

The impact of attachment styles within the workplace

Research has begun to recognise the value of using attachment styles to assess important individual differences within the workplace (Harms, 2011; Hazan & Shaver, 1990; Richards & Schat, 2011; Mikulincer & Shaver, 2007a; Nelson & Quick, 1991; Joplin et al., 1999; Quick, 1999), rather than the historic emphasis which has been placed on personality traits (Noftle & Shaver, 2006; Roisman et al., 2007). Existing research has revealed that secure attachment styles predict good performance at work including positive relationships with colleagues (Falvo et al., 2012), good problem solving and negotiation skills

(Ketterson & Blustein, 1997; Lee & Thompson, 2011; Mikulincer, Shaver, & Rom, 2011) as well as greater career exploration (Littman-Ovadia, 2008).

Conversely, anxious and avoidant attachment tendencies are associated with an inability to manage stress (Falvo et al., 2012; Johnstone & Feeney, 2015; Pines, 2004; Simmons, Gooty, Nelson, & Little, 2009), leading to burnout (Littman-Ovadia et al., 2013), increased employee sickness rates, and higher rates of turnover (Tziner, Ben-David, Oren, & Sharoni, 2014). Additionally, correlations have been established with difficulties within interpersonal relations at work. These have included colleagues and authority figures alike (Hardy & Barkham, 1994; Hazan & Shaver, 1990; Kahn & Kram, 1994; Rom & Mikulincer, 2003), with individuals struggling to follow instruction, work productively or accept constructive feedback (Hardy & Barkham, 1994) and often having stronger intentions to leave their job (Mikulincer & Shaver, 2007a).

Implications of working in Secure Forensic Environments

In relation to the current thesis, it is crucial to reflect on how the aforementioned associations of attachment styles on various work behaviours may affect staff working within secure forensic environments. Research suggests individuals with avoidant tendencies may struggle to find job satisfaction and fulfilment in their work (Krausz, Bizman, & Braslavsky, 2001; Sumer & Knight, 2001), particularly those which involve working with patients (Savickas, 2001). In part, this is likely due to a desire to be compulsively self-reliant and avoid emotional involvement with others (Bartholomew, 1990). These individuals also often experience difficulties trusting others, including work colleagues (Simmons et al., 2009); all of which could be argued as necessary skills for working within healthcare contexts.

Individuals working within forensic environments are likely to be regularly exposed to strained social interactions, leading to burn out (Laschinger, Leiter, Day, Gilin-Oore, & Mackinnon, 2012; Pearson & Porath, 2009), with insecurely individuals being particularly vulnerable (Littman-Ovadia et al., 2013). Other deficits which are likely to be relevant to forensic environments include difficulties in decision making (Hazan & Shaver, 1990), helping behaviours (Geller & Bamberger, 2009), work related adjustments (Blustein et al., 1995), emotional support seeking (Richards & Schat, 2011), and ethical decision making (Chugh, Kern, Zhu, & Lee, 2014). Finally, the patients whom employees within forensic environments encounter on a daily basis are likely to have their own attachment insecurities (Adshead, 2012a), which only adds to the complexity of this dynamic. This literature has highlighted the importance of measuring attachment within organizations, especially forensic mental health settings. However, the best way to measure this construct requires an analysis of a tool.

A specific tool, the ECR-R (Fraley et al., 2000) was chosen for evaluation since it is the most widely used self-report measure of adult attachment (Mikulincer & Shaver, 2007a). This critique will therefore focus on a review of the relevant psychometric properties of the tool as well as its applicability to organizational settings.

Overview of the ECR-R

The ECR-R was developed from the original Experiences in Close Relationships tool (ECR; Brennan et al., 1998), to improve the tools ability to accurately measure secure individuals e.g. those scoring low on the anxiety and avoidance dimensions, resulting in improvements in measurement precision and

good item functioning (Fairchild & Finney, 2006). Normative data of the original tool (ECR) was based on a sample of psychology undergraduate students from the University of Texas (*N* = 1085, 682 women and 403 men), aged between 16-50 years (*Median* = 18). Of the total sample, 487 indicated they were "seriously involved in a relationship", 220 indicated they were "casually dating" and a final 376 were not romantically involved in any way. The median relationship length for the sample was 15 months. Brennan et al. (1988) created the ECR by combining the items of "virtually all" of the previously developed self-report adult romantic attachment measures; resulting in 482 items, 323 after duplicates were removed. Participants rated their responses on a 7-point likert scale, "not at all like me" to "very much like me". A total of 36 items were deduced by selecting the highest absolute-value correlations.

An item response theory (IRT), using a graded response model was established to include the ECR, Adult Attachment Scales (Collins & Read, 1990), Relationship Styles Questionnaire (Griffin & Bartholomew, 1994) and Simpson's (1990) Attachment scales. Fraley et al. (2000) discovered that out of the four scales, the ECR had the best psychometric properties. However, they suggested that the scale could be further improved by using IRT to select the items with the best psychometric properties. As a result, it is suggested that measurement precision was increased by 50-100%; 13 of the original 18 items on the anxiety dimension and 7 of the 18 avoidance items (Fraley et al., 2000). Norms for the ECR-R are based on over 17,000 people who have completed the ECR-R online. Of this group, 73% were female, with an average age of 27 and 21% of the sample were married, see table 4.

Table 4

ECR-R Normative Data (Fraley et al., 2000)

	Avoidance *M(SD)*	Anxiety *M(SD)*
Overall Sample	2.92 (1.19)	3.56 (1.12)
Male	2.94 (1.13)	3.57 (1.10)
Female	2.92 (1.17)	3.56 (1.13)
Married	2.86 (1.26)	3.26 (1.15)
Single	2.94 (1.17)	3.64 (1.10)
20 – 29 years	2.88	3.59
30 – 39 years	2.96	3.55
40 – 49 years	3.04	3.51
50 – 59 years	3.12	3.47
60 – 69 years	3.20	3.43

The ECR-R measures anxiety and avoidance on a dimensional framework. There has been a drive towards the dimensional approach in recent years due to the belief that individuals vary continuously regarding attachment security (Fraley & Waller, 1998). However, categorical models remain dominant in the research field and there continues to be a lack of consensus about whether attachment is a categorical or dimensional construct (Ravitz, Manuder, Hunter, Sthankiya, & Lancee, 2010). Problems with a categorical model include the assumption that individual differences in attachment can be reduced to "types" which are assumed to be distinctive from one another (Fraley, Hudson, Heffernan, & Segal, 2015). Conversely, a dimensional approach reflects the complexity of the attachment construct which involves a wide range of interpersonal experiences from all areas of life, which, it is felt highlights a richness that cannot be provided by categorical approaches (Fraley, Roisman,

Booth-LaForce, Owen, & Holland, 2013; Fraley et al., 2015; Gillath, Shaver, Baek, & Chun, 2008; Ravitz et al., 2010).

Psychometric properties

Face validity

Face validity is concerned with whether an assessment tool measures what it states it does. When reviewing the items of the ECR-R, one can surmise that the tool measures the relevant constructs of interpersonal attachment. The ECR-R is designed to measure attachment in romantic relationships and the items are suggestive of this (see Appendix G). Additionally, participants are not explicitly told that their attachment styles are being assessed. Instead, participants are given the instructions which summarise the purpose as assessing how they generally experience relationships.

Face validity of the ECR-R is likely to depend on the individual completing the measure; whilst it is obvious that the questions enquire about relationships in some manner, a non-psychologist is likely to be less familiar with the theoretical concepts the questionnaire aims to evaluate. This may be advantageous since participants are less likely to manipulate their answers to respond in a socially desirable manner. However, it is likely that participants may still provide socially desirable responses to self-report measures in general (Bateman & Fonagy, 2010), thus their understanding of the theoretical underpinnings is likely to be irrelevant.

Content validity

Content validity considers the extent a measure represents the construct of attachment. It is recommended that the development of an instrument should contain the largest pool of potential items assessing a construct (Netemeyer,

Bearden, & Sharma, 2003). The content validity of the ECR-R is strong, since it was developed from the ECR, the items of which were selected from the largest possible pool of items assessing attachment from all known existing self-report attachment measures, including those from unpublished studies.

However, a criticism of the ECR-R remains its relative weakness at measuring attachment security (Fraley et al., 2000). Additionally, others have suggested that rather than separate constructs, the dimensions of anxiety and avoidance may be correlated and thus not orthogonal (Ronen & Mikulincer, 2009). Therefore, whilst attachment literature often assumes anxiety and avoidance constructs should be orthogonal (Mikulincer & Shaver, 2003; Mikulincer, Shaver, Sapir-Lavid, & Avihou-Kanza, 2009), not all theoretical perspectives are based on this assumption of independency.

For example, within the very early conceptualisation work of attachment, it was suggested that anxiety and avoidance may be theoretically orthogonal but correlated with one another in practice (Bowlby, 1973); with anxiety being likened to a monitoring system and avoidance more of a behavioural system (Fraley & Shaver, 2000). Such variance appears to depend on the measures used, with the ECR-R demonstrating higher rates of correlation than the ECR (Cameron, Finnegan, & Morry, 2012; Mikulincer & Shaver, 2007a); r = .35 and r = .11 respectively (Brennan et al., 1998; Fraley & Shaver, 2000). Theoretically, it is proposed that relationship status is a variable highly likely to increase the correlation between these two dimensions (Mikulincer & Shaver, 2007a).

Finally, others argue that the construct of attachment may be best measured by interviews which assess an individual's attachment as a child, as the intrinsic validity of self-report questionnaires has been questioned (Bateman

& Fonagy, 2010). Measures of this kind include the Inventory of Parent and Peer Attachment (IPPA; Armsden & Greenberg, 1987); the Attachment History Questionnaire (AHQ; Pottharst 1990) with the Adult Attachment Interview (George et al., 1996) often being referred to as the "gold standard".

However, these types of assessment are more time consuming to complete, especially when considering the practical implications of employees engaging in research. Furthermore, they may give the impression to recipients that they are less confidential, with people being willing to give more honest answers in self-report questionnaires. It has also been argued that there are parallels between child-parent and romantic relationships, thus assessing attachment via adult romantic relationships is acceptable (Shaver et al., 1988). Consequently, this appears the best method for measuring employee's attachment styles.

Construct Validity

Construct validity assesses whether a tool measures an intended construct. Construct validity was evaluated by assessing the convergent and discriminant validity of the ECR-R. Many researchers have assessed these areas of validity via a comparison to the Relationship Questionnaire (RQ; Bartholomew & Horowitz, 1991). The RQ is a self-report questionnaire which consists of four paragraphs aimed at depicting one of the following four attachment types: secure, preoccupied, fearful and dismissing. Participants are required to rate how well each paragraph describes their experiences in romantic relationships on a 7-point likert scale, where 1 = not at all like me and 7 = very much like me.

Findings have generally demonstrated positive correlations between ECR-R avoidance and RQ dismissing items, as well as negative correlations between

ECR-R anxiety and avoidance, with RC secure subscales correlating positively with the fearful subscales (Busonera, Martini, Zavattini, & Santona, 2014; Tsagarakis, Kafetsios, & Stalikas, 2007), please see table 5.

Table 5

Correlations between ECR-R and RC items (Busonera et al., 2014)

ECR-R Subscale	RQ Subscale	*R* Value
Anxiety	**Preoccupied**	***r*. 41**
Avoidance	Dismissing	*r.* 19
Avoidance	Preoccupied	*r.* 15
Anxiety	Secure	*r*. -31
Avoidance	Secure	*r.* -31
Anxiety	**Fearful**	***r*. 44**
Avoidance	Fearful	*r*. 35
Anxiety	**Model of Self**	***r.* -54**
Anxiety	Model of Other	*r*. -29
Avoidance	Model of Other	*r*. -35
Avoidance	Model of Self	*r*. -15

Note. Moderately correlated variables are in boldface.

However, many of these correlations provided weak to moderate effect sizes and there has been no support between the ECR-R anxiety and dismissing items (Busonera et al., 2014; Tsagarakis et al., 2007). Some have argued that this may be due to the two scales not being comparable in structure (Tsagarakis et al., 2007).

Since it has been proposed that model of self and model of other should theoretically correspond to the attachment anxiety and avoidant constructs

respectively (Bartholomew & Horowitz, 1991; Brennan et al., 1998), authors have attempted to resolve the potentially incompatible structure by forming indices of model of self and other from the RQ items. Results suggest that the model of self-construct is significantly positively correlated with the ECR-R anxiety construct and the model of other with ECR-R avoidance; thus, indicating convergent validity of the ECR-R (Busonera et al., 2014; Rotaru & Rusu, 2013; Tsagarakis et al., 2007).

Convergent and divergent validity has also been examined by comparing the ECR-R to tools which measure traits considered to underlie the theoretical concepts. For example, attachment anxiety and the negative model of self (Brennan et al., 1998) as well as hyper activating strategies and neuroticism (Brennan & Shaver, 1995; Mikulincer & Florian, 1998; Shaver & Mikulincer, 2002). Positive correlations have been observed between the State-Trait Anxiety Inventory (STAI; Spielberger, 1970) and The Penn State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Borkovec, 1990) with ECR-Anxiety (e.g. β = -.57, p <.001; Tsagarakis et al., 2007 & r = 0.42, p < 0.01; Wongpakaran et al., 2011). Whilst negative correlations have been found with measures of self-esteem, when using the Rosenberg self-esteem scale (RSES; Rosenberg, 1965; Tsagarakis et al., 2007; Wongpakaran et al., 2011).

Positive correlations have also been found between both the anxiety and avoidance dimensions and other measures, for example, the UCLA Loneliness Scale (Version 3; Rusell, 1996), the Brief Symptom Inventory (BSI; Derogatis & Spencer, 1993), with the exception of somatic complaints, and the Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988), with the exception of any relationship between avoidance and the

intrusiveness/neediness scales (Fairchild & Finney, 2006; Kooiman, Klaassens, van Heloma Lugt, & Kamperman, 2013).

Conversely, negative correlations have been discovered between the Dyadic Adjustment Scale (DAS; Spanier, 1976), the Social Provisions Scale (SPC; Russel & Cutrona, 1987) and a comparison with The Touch Scale (Brennan, Wu, & Loev, 1998) produced mixed results, suggesting that both attachment anxiety and avoidance, as measured by the ECR-R share dissimilar constructs (Busonera et al., 2014; Russell & Cutrona, 1987; Spanier, 1976).

Predictive Validity

Predictive validity assesses the extent a particular score on one measure can predict a score on another measure. Attachment styles have been linked to several different predictable criterions. Since the ECR-R is designed to measure adult attachment within the context of a romantic relationship, it is unsurprising that it has predictive validity for various aspects of relationships. For example, significant associations have been discovered between high levels of attachment anxiety and avoidance and low levels of relationship quality, including lower levels of sexual satisfaction (Brassard, Shaver, & Lussier, 2007; Butzer & Campbell, 2008; Mallinckrodt & Wei, 2005) and marital satisfaction (Mikulincer & Shaver, 2007a; Saavedra, Champman & Rogge, 2010; Treboux, Crowell, & Waters, 2004; Williams & Riskind, 2004).

Research has also reflected on the ECR-R's ability to predict other variables which are likely to be more relevant to the workplace. Namely, secure attachment generally provides an individual with increased abilities to deal with stressors (Ditzen et al., 2008), as well as predicting the relationships between self-efficacy and emotional awareness (Mallinckrodt, & Wei, 2005) and shame,

depression, and loneliness (Wei, Shaffer, Young, & Zakalik, 2005). This demonstrated predictive validity in importance since these variables may affect an individual's performance within the work place. Whilst some have highlighted the benefits of measuring an employee's attachment tendency, particularly to implement support and interventions (Hardy & Barkman, 1994; Manning, 2003), their use for selection purposes is deemed questionable (Harms, 2011) due to potential ethical implications.

Internal Reliability

Internal reliability considers how consistent a tool is. Internal reliability of the ECR-R, as assessed by Cronbach Alpha scores, have been deemed excellent, ≥ 0.9 (Fairchild & Finney, 2006; Sibley & Liu, 2004; Brennan et al., 1998; Fraley et al., 2000; Wongpakaran et al., 2011). Internal reliability has also been found in studies using the ECR-R within the work place, the Cronbach Alpha's remaining in the ≥ 0.9 range (e.g. Dahling, & Librizzi, 2015; McMahon, 2007); thus, suggesting that the scale retains its reliability across contexts, including organizational settings.

Test- retest reliability

Test-retest reliability measures stability over a period of time. Theorists disagree about whether attachment is a constant (e.g. Fraley & Brumbaugh, 2004; Fraley & Shaver, 2008; Harms, 2011) or variable construct (Collins & Read, 1990; Feeney et al., 1994; Shaver & Brennan, 1992). However, the majority of authors agree that some change over prolonged periods of time is to be expected (Bowlby, 1973; Crowell, Treboux, & Waters, 2002; Fraley, Vicary, Brumbaugh, & Roisman, 2011). In practice, relatively short-term instability has been observed across adult attachment styles which have been attributed to

changes within personal circumstances as well as individual differences (Baldwin & Fehr, 1995; Shaver & Brennan, 1992; Scharfe & Bartholomew, 1994); with the largest changes occurring in anxious-ambivalent individuals (Baldwin & Fehr, 1995). Others suggest that observed differences are due to unreliable measurement (Fraley & Waller, 1998; Fraley et al., 2000), leading to some recommending the use of multiple assessment tools, with interview style tools providing the greatest stability (Scharfe & Bartholowmew, 1994).

Test-retest reliability for the ECR-R has demonstrated varying levels of reliability, all of which have been deemed acceptable; either excellent, $r \geq 0.9$ (Sibley & Liu, 2004; Fraley et al., 2000; Sibley et al., 2005) good, $r \geq 0.8$ (Kooiman, et al., 2013; Tsagarakis et al., 2007) or acceptable levels of reliability, $r \geq 0.7$, (Wongpakaran et al., 2011). Demonstrated variability may be attributed to varying retest periods ranging from 6 (Wongpakaran et al., 2011) to 3 weeks (Sibley et al., 2005). Furthermore, Kooiman et al. (2013) did not have a standardised time frame with the range of test-retest period being 33-75 days.

Whilst longer periods of stability have not been assessed with the ECR-R, the ECR has demonstrated test-retest stability of ≥.68 (Lopez & Gormley, 2002) across a six month period. Additionally, research using the Experiences in Close Relationships-Relationship Structures (ECR-RS; Fraley, Heffernan, Vicary, & Brumbaugh, 2011), demonstrated the potential importance of relationships specificity and stability; with attachments to parents remaining stable across twelve months (.90) and romantic partners being just .50 (Fraley et al., 2011). Since these tools are all variations of the ECR-R, it appears reasonable to assume that similar levels of stability may be observed in the ECR-R across

longer time frames. This is particularly important for organizational contexts, since employee's employment lengths are likely to vary. Additionally, much organizational research focussing on attachment styles is likely to benefit from being conducted over a longer period of time.

The adaptation of attachment tools for the workplace

As an emerging area of research, there has been some debate about how best to measure attachment within the organizational context. Critics have suggested that the reference to romantic relationships within both the ECR and ECR-R limits its applicability to other contexts (Wei, et al., 2007). Others have acknowledged the fundamental contents of the items are suitable for various environments (Wei et al., 2007). An adaptation of the ECR, the ECR-RS, was developed to assess attachment patterns in a variety of close relationships. However, authors also readily promote the modification of the ECR-R for research purposes (Fraley et al., 2000).

Richards and Schat (2011) adapted the ECR by replacing the word "partner" with "other(s)" to create a "context independent" measure and discovered that the factor structure and psychometric properties remained intact. In a similar fashion, Davidovitz, Mikulincer, Shaver, Izsak and Popper (2007) adapted the ECR instructions to measure leadership-follower patterns in the workplace. Evidence of further adaptations includes the development of the Adult Attachment at Work (AAW; Collins & Read, 1990) and the Short Workplace Attachment Measure (SWAM; Leiter et al., 2013), which has subsequently been used in practice (Leiter et al., 2015).

Conclusion

The ECR-R is based on the ECR and assesses two dimensions of attachment; anxiety and avoidance. This critique has summarised relevant evidence to demonstrate that the ECR-R has good levels of reliability and validity, however, the evidence base for the psychometric properties is relatively small. Furthermore, a general criticism of the ECR-R is that much of the validity and reliability research has been conducted with undergraduate students. This may limit its applicability to broader populations, particularly since relationship status, including marriage, has a large impact on attachment dimensions. However, Fraley et al. (2000) have subsequently provided norms of over 17,000 people, increasing the measures representativeness to a wider population. Additionally, much of the validity research stems from researchers successfully attempting to measure attachment tendencies across different cultures, therefore increasing the external validity.

Multiple authors have compared the ECR-R to the RC. However, it is important to note that the RC is not without its own limitations. For example, Cronbach alphas for the scales have ranged from .32 to .79 (Bäackström & Holmes, 2001; Fortuna & Roisman, 2008), leading critics to suggest its use may be best suited to research whereby attachment is not the focal point (Ravitz et al., 2010). Conversely, the ECR-R is likely to be a more reliable and precise measure (Sibley et al., 2005).

The emergence of research into attachment tendencies within the workplace has discovered some interesting and practical themes for organizations. This is a growing area of research and researchers have successfully demonstrated the ability to adapt the ECR for broader contexts.

Given the similarities between this measure and the ECR-R it is reasonable to suggest that the ECR-R could also be adapted in future research.

Chapter Four: How do Professionals in Forensic Mental Health Settings Perceive Physical and Verbal Boundary Crossings and Violations?

Chapter Rationale

Chapter one discussed how forensic mental health settings are unique environments to work. However, it is recognised that many health care professionals within these environments have engaged in both boundary crossings and violations, which are forms of interpersonal workplace behaviour. Since not all individuals engage in these forms or workplace behaviour, it is of interest to explore employee characteristics which may be associated with perceptions of boundary crossings and violations.

Abstract

There is a significant lack of research into boundaries within forensic hospitals. Research into these settings is relevant because of the complex dynamic between care and security which staff are expected to offer to patients. Boundary crossings create an imbalance in this dynamic and ultimately jeopardise aspects of security within forensic hospitals, putting other patients, staff and potentially members of the public at risk. Therefore, this research sought to explore the employee perceptions about the seriousness and acceptability of boundary crossing behaviour, using vignettes, to understand this topic in greater detail.

Using a cross sectional, correlational design, 151 participants were recruited from two secure hospitals and a social media platform. All participants had experience of working in a secure hospital. Participants were required to

complete a demographic questionnaire, as well as rate their perceived acceptability and seriousness of 8 vignettes which depicted various boundary crossings and violations.

There was a significant difference between participant's perceived acceptability and seriousness of the boundary vignettes presented, with boundary crossing behaviours being deemed less acceptable than they were serious. This difference was not significantly different across male and female participants. Individuals who had less experience (<5 years) were more likely to perceive the boundary vignettes as more acceptable than those who had more experience. Additionally, individuals with a therapy-based role (psychologists and occupational therapists) considered the boundary vignettes as more serious than other professionals (M=20.0). In practice, such perceptions may lead professionals to justify crossing and violating boundaries in practice.

Keywords: Professional boundaries, forensic mental health, prevalence, individual risk factors

Introduction

Boundaries within forensic mental health are complex, since they rely on a delicate balance between providing care for patients whilst simultaneously retaining the security principles of the hospital. Chapter one outlined the theoretical basis behind boundaries; however, it is relevant to review the individual factors which mean some individuals never breach boundaries, whilst others go on to commit the most serious of boundary violations.

Individual Risk Factors

Some researchers argue that there are no individual differences which lead to boundary problems with patients (Norris et al., 2003). Indeed, this is supported further by the fact that individuals who violate boundaries are usually more similar to us than they are different and usually have no previous history of ethical misconduct (Gabbard, 1996). Furthermore, type of profession does not seem to affect the likelihood of violating boundaries (Gutheil & Brodsky, 2011; Wachtel, 2007). It is therefore argued that professionals should be aware of their own shortcomings in their practice and work responsibly to avoid boundary violations (Norris et al., 2003).

Conversely, others have alluded that individual characteristics do make boundary crossings and violations more likely. One individual characteristic is experience; a common assumption being that new staff are most likely to violate boundaries due to inexperience (Ashton, 2016), with likely candidates having less than 5 years of experience working within a profession (Bachmann et al., 2000). However, it is suggested that professionals at all stages of their career are just as likely to violate boundaries, and others have suggested that it is actually those whom are further into their professional careers who are more likely to be perpetrators (Baca, 2009; Coe, 2012). Other risk factors which have

been considered include life crises, job changes, illness, loneliness, pride (resulting in not seeking supervision), lack of training, substance use, being a victim of childhood sexual abuse and counter transference (Baca, 2009; Bachmann et al., 2000; Norris et al., 2003).

Factors specifically involving the context of a forensic environment have also been established as relevant. For example, some believe that workplaces involving weekend work, access to private spaces and skews in staff sex ratios, such as those found in health care organizations may be more vulnerable to boundary problems (O'Donohue, Downs, & Yeater, 1998). Furthermore, it is suggested that, in line with a social learning perspective, professionals can become "corrupted" by being in close proximity to others who also involve themselves in "wrongdoing" within the workplace (Welsh, Ordóñez, Snyder, & Christian, 2015).

Gender

Previous research in Australia has indicated a higher prevalence of boundary violations involving male professionals (two-thirds), given the relatively small proportion (9%) of nursing professionals whom are male (Chiarella & Adrian, 2014). This is a pattern which has generally been replicated elsewhere (e.g. Andreopoulos, 2017; Campbell, Yonge, & Austin, 2016; Delgado, 2002; O'Donohue et al., 1998; Pope 2001).

However, it is not uncommon for female employees to also be involved in boundary violations, particularly, when the place of employment is a forensic setting (Celenza & Gabbard, 2003; Marquart, Barnhill, & Balshaw-Biddle, 2001; Peternelj-Taylor, 1998). For example, 61% of all boundary violations in prisons between 2007 and 2008 involved female staff (Guerino & Beck, 2011). Whilst the aforementioned prevalence rates illustrate the role of gender in boundary

violations, it is likely that gender stereotypes also play a role in the perceptions of both the acceptability and seriousness of such unethical acts. For example, some have suggested that female gender stereotypes may explain the increased boundary violations occurring by females within prison settings (Marquart et al., 2001).

Gender stereotypes often portray males as sexual predators and females as victims (Marquart et al., 2001; Siegal, 1999); for example, on reviewing accusations of boundary violations, it was discovered that one of the patient's complaints regarded a male nurse who have given them a gift. Authors note that female staff members had also engaged in the same or similar behaviour and not received complaints (Chiarella & Adrian, 2014). This evidence suggests that some male workplace behaviour is more likely to be interpreted as predatory or their actions assumed to have ulterior motives (Huston, 2013). Furthermore, such stereotypes may make male nurses more hesitant with regards to some intimate touching which is necessary for their role, due to concerns their behaviour may be misconstrued (Harding, North, & Perkins, 2008). Thus, indicating the importance which such views may have upon the perceptions of boundary crossings and violations, dependent upon gender.

Within the literature, females have been perceived to be more susceptible to flattery (Marquart et al., 2001; Worley, Marquart, & Mullings, 2003; Worley & Cheeseman, 2006), and be more likely to make attempts at "rescuing" a difficult patient (Evershed, 2010), all of which it is argued could influence their propensity to engage in boundary violations. Furthermore, the fact that young, attractive, females are particularly likely to be accused of boundary violations (Evershed, 2010) is indicative of further gender stereotypes in the role of acceptableness of boundaries.

Additionally, it is noted that correctional institutions have traditionally been dominated by males; the institutions having their own cultural norms and values (Stevens, 1993). Consequently, female staff are more likely to experience hostile working environments whereby they may experience discrimination or harassment (Marquart et al., 2001; Pogrebin & Poole 1997; Zupan, 1992). Additionally, a sexualised working environment is likely to be created by male staff (Pogrebin & Poole, 1997) and patients alike (Chiarella & Adrian, 2014; Higgins, Barker, & Begley, 2009).

In sum, whilst several authors have expressed the significance of forensic environments providing a unique working relationship between professionals and clients, which may impact on the likelihood of boundary violations; to our knowledge, no empirical research has examined professionals' views regarding the seriousness and acceptableness of boundaries which occur within secure hospitals. As reviewed in the literature, gender stereotypes are likely to impact upon the perceived seriousness and acceptableness of boundary violations which is why it is important to investigate the role of gender. Furthermore, several employee characteristics, such as length of time working for an organization can affect perceptions of boundaries. It is beneficial to gain a greater understanding of these characteristics, since boundary violations in forensic environments put the safety of other patients, employees and potentially members of the public at risk (Schafer, 1997; Worley, Tewksbury & Frantzen, 2010). A series of research questions were proposed, as opposed to hypothesis's, due to a lack of relevant literature in the area.

Research Questions

1. Do participant's perceptions of seriousness significantly differ from ratings of acceptableness in terms of boundary crossings and violations?
2. Is there a significant difference between the mean seriousness and acceptableness scores of boundary crossings and violations for male and female employees?
3. Is there a significant difference between the mean perceived seriousness and acceptableness scores of boundary crossings and violations between employees working in low or medium security hospitals?
4. Is there a significant difference between the perceived seriousness and acceptableness between individuals who have different years of work experience working with forensic patients?
5. Is there a significant difference between the perceived seriousness and acceptableness of boundary crossings and violations between individuals who have different job roles?
6. Do male and female employees differ in their perceptions of boundary crossings and violations depending upon the gender of the perpetrator?

Method

Participants

The required sample size for this study varied due to several different statistical techniques which were used. The largest necessary sample size was calculated to be 66, based on G Power for an A priori between factors MANOVA, for two groups, with two variables. This was based on a medium effect size (f = .25), alpha = 0.05, power = .80. The total number of participants recruited was 153. The decision to remove two participants was made since a significant

proportion of data was missing in their responses (51.4% and 42.9%) which meant including them may bias the results. A total of 151 participants, aged between 21 and 64 years of age (*M*=34.31, *SD*=10.21), 72.2% of whom were female, took part on a voluntary basis between April and July 2017.

Participants were recruited either via their employers or by social media. Those participants who were recruited from their place of employment (*n*=64) took part by following an electronic link to the online research. This was distributed to participants through their work e-mail addresses by the lead researchers in each of the two recruitment sites; two NHS run medium secure hospitals in the UK. Participants who were recruited via social media (*n*=89) followed an electronic link to the research which was advertised by the main author. Participants from either of the recruitment groups were not compensated for their time.

Recruited participants worked in a number of different roles including mental health nurses (RMN's), health care assistants (HCA's), managers, consultants, psychologists, social workers and occupational therapists. Participants were all aged 18 and over and there were no limits placed on the amount of time they had been employed in a secure hospital. For the purpose of analysis, professional groups were collapsed so that the "therapies" group consisted of psychologists and occupational therapists, the "nursing" group of health care assistants, mental health nurses and learning disability nurses. Finally, the "other professionals" group consisted of social workers, managers, consultant psychiatrists and reception staff. This was due to very small numbers of participants representing each of these professional groups (particularly those in the "other professionals" group), and desire to retain their confidentiality.

Procedure

All participants completed the same aspects of the study. After following the research link, participants were asked to provide informed consent. Subsequently, participants were required to provide basic demographic information and were then asked to read 8 vignettes and answer three questions for each vignette (Appendix H). Finally, participants were fully debriefed and thanked for their time.

Materials

Participants completed two separate questionnaires.

Demographics. Participants were asked to complete a brief questionnaire regarding demographic information which would help inform the authors about the population who took part in the study. These included, years of experience working in a forensic environment, age, gender, job role, security of hospital and their employment status.

Boundary vignettes. Participants were asked to read 8 vignettes of boundary behaviour which varied in terms of the gender of the perpetrator and whether the boundary behaviour was physical or not. Vignettes also varied in the seriousness of the behaviour, with half of the vignettes representing boundary crossings and half representing boundary violations. The vignettes were developed by the author under supervision to represent various boundary phenomena which may occur within forensic mental health contexts (table 6). These were based on relevant themes which have been suggested by researchers in the field, which included disclosing personal information, accepting gifts, disclosing confidential information and physical contact with patients (e.g. Gabbard & Myers 2008).

Table 6

Example of Vignette Conditions

Condition	Gender	Seriousness	Physical/non-physical
1	Male	Serious (violation)	Physical
2	Male	Serious (violation)	Non-physical
3	Male	Less serious (crossing)	Physical
4	Male	Less serious (crossing)	Non-physical
5	Female	Serious (violation)	Physical
6	Female	Serious (violation)	Non-physical
7	Female	Less serious (crossing)	Physical
8	Female	Less serious (crossing)	Non-physical

Extreme boundary violations (e.g. sexual boundary violations) were purposely not chosen for this research. This decision was based on research which suggests boundary violations are usually the product of a "slippery slope" of smaller boundary crossings or violations. Additionally, the focus of violations, both in academic research and within the media has been heavily focussed on sexual boundary breaches. It was therefore of more value to the authors to try and explore perceptions of smaller boundary crossings/violations which may be addressed before a major boundary violation occurs.

To establish if the vignettes assessed what the authors intended, a small pilot group of participants was created. The pilot group consisted of 8 females and 2 males (5 assistant psychologists, 2 clinical psychologists, 2 RMNs and a nursing assistant). Two independent t-tests were run to assess that there was a) a significant difference between the intended varying levels of seriousness regarding boundary crossings/violations and b) *no* significant differences

between vignettes which involved male or female employees. Results demonstrated that the desired effects had been achieved; *t(*3.47)=6, *p*= 0.01 and *t*(.41)=6, *p*= 0.69 respectively.

Participants were required to answer three questions following each vignette. The first two responses were given on a 5 point likert scale and asked, how *acceptable* (1= completely unacceptable, 2= somewhat acceptable, 3= neutral, 4= somewhat acceptable and 5= completely acceptable) and how *serious* (1= extremely serious, 2= very serious, 3= neutral, 4= somewhat serious, 5= not serious as all) they perceived each of the scenarios to be. The third question asked participants if the scenario had occurred within their workplace.

Ethics

Ethical approval was sought from the following bodies; Health Research Authority (HRA; IRAS project ID, 218133), the University of Nottingham's ethics board; Faculty of Medicine & Health Sciences Research Ethics Committee (ID, A14102016) and a University of Nottingham sponsorship review (Ref, 17002). Participants were not made aware of the full aims of the research until they were debriefed; this was deemed necessary to limit any response bias. Additionally, participants may have been concerned with confidentiality since the topic was regarding perceptions of unethical work based behaviour. Participants were assured that their responses would remain anonymous. They were also asked to provide a unique code rather than identifiable information in case they wanted to withdraw from the study. They would be able to do this by contacting the researchers and stating their unique code.

Results

The following tables provide an overview of the research data covering relevant variables for analysis.

Table 7

Prevalence of Boundary Crossings & Violations in Secure Forensic Hospitals

Boundary Type	"Yes" (%)	"No" (%)	"Maybe" (%)
Male			
Verbal – Serious (Violation)	25.8	33.1	41.1
Verbal – Less Serious (Crossing)	55.6	14.6	29.8
Physical – Serious (Violation)	25.2	43.7	31.1
Physical – Less Serious (Crossing)	62.9	13.9	23.2
Female			
Verbal – Serious (Violation)	31.1	21.9	47.0
Verbal – Less Serious (Crossing)	66.2	6.6	27.2
Physical – Serious (Violation)	26.5	39.1	34.4
Physical – Less Serious (Crossing)	45.7	18.5	35.8

Table 8

Acceptability and Seriousness Perceptions across Participant Groups

Variable	Acceptability – Mean(SD)	Seriousness – Mean (SD)
Overall sample	14.16 (3.61)	18.25 (4.39)
Gender		
Males	13.41 (3.28)	18.36 (3.88)
Females	14.45 (3.70)	18.21 (4.59)
Experience (years)		
<2 years	2.18 (.78)	1.88 (.76)
2-5 years	2.10 (.88)	1.97 (.71)
5-10 years	1.63 (.71)	1.94 (.84)
10 years+	1.84 (.81)	1.80 (.76)
Security type		
Low Security	14.13 (3.42)	17.83 (4.52)
Med Security	14.19 (3.85)	18.78 (4.20)
Job role		
Therapies	13.72 (3.64)	17.40 (.44)
Nursing	14.29 (3.18)	18.25 (3.74)
Other	14.84 (4.10)	20.0 (4.90)

Data Analysis

The data was analyzed using quantitative methods; a series of T-tests and ANOVA's were conducted to assess the effects of the independent variables on the dependent variables. The dependent variables (perceived acceptableness and seriousness) were assessed for normality. The Kolmogorov-Smirnov test (KS- test) was significant (P = <0.001), indicating a violation of the assumption of normality. Skewness and kurtosis values did not deviate significantly from zero (acceptability; 1.15 and 2.79, seriousness; .625 and 1.09 respectively). Additionally, 5% trimmed mean values did not differ significantly (acceptableness; 5% *trimmed mean*=13.94, *M*=14.16, seriousness; 5% *trimmed mean*=18.10, *M*=18.25) suggesting no concerns in this area.

Finally, histograms and plots were inspected for normality. The normal probability plots formed reasonably straight line; suggesting normal distribution. Furthermore, the detrended normal Q-Q plots depicted residuals which were mainly clustered around the zero line, indicating no major concerns with normality. The acceptableness histogram was demonstrated a slight positive skew distribution, suggesting the mean was to the right of the median. Given that the sample size of this study was large, which has been shown to counteract the violation of normality (Field, 2009), a logarithm transformation was not deemed necessary. However, where appropriate, additional tests of assumptions were conducted for specific analyses e.g. MANOVA's. An Alpha level of .05 was used in IBM SPSS 23 for all statistical analyses.

Difference between ratings of seriousness and acceptableness. A paired samples t-test was conducted to investigate differences between participant's perceptions of acceptableness and seriousness of the boundary crossings and violations. A Levene's test for equality was insignificant; indicating equal variances could be assumed. The analysis demonstrated a statistically significant difference between the acceptableness (M=14.16, SD=3.61) and the seriousness of the presented scenarios (M=18.25, SD=4.39, t(150)= -15.91, p<.0005). The eta squared indicated a large effect size (.30; Cohen, 1988).

Gender differences in overall seriousness and acceptableness. A one-way between-groups multi analysis of variance (MANOVA) was performed. Two dependent variables were used: acceptableness and seriousness, the independent variable was employee gender. Preliminary assumption testing was conducted to check the assumptions of the MANOVA were met.

Preliminary assumption testing and results. Mahalanobis distances were used to assess for multivariate normality, the value (21.97) was found to

be greater than the critical value for the number of dependent variables in this analysis (16.27); thus suggesting that the data had multivariate outliers. Since further exploration revealed that only one value exceeded the critical value of 16.27, the decision was made to keep this case within the data set.

Scatter plots were produced for the dependent variables and the assumption of linearity was satisfied. Analysis demonstrated that the multicollinearity assumption had not been violated; all dependent variables had a tolerance value of >.10 (.51) and a VIF value of <10 (1.99; Tabachnick & Fidell, 2001). The Levene's test of equality of error variances was >.05, suggesting that this assumption had not been violated. Finally, the assumption of homogeneity of variance-covariance's matrices was met (.615).

There was no statistically significant difference between males and females on the combined dependent variables, although the results suggest the analysis was approaching significance: F (2, 148) = 3.05, p=0.51; Wilks' Lambda =.96; partial eta squared=.04. Males were observed to view boundary crossings and violations as slightly less acceptable (M =13.41, SD = 3.28) than females (M =14.45, SD = 3.70) however there were no differences in perceived seriousness (males: M = 18.36, SD = 3.88, females: M = 18.21, SD = 4.59).

Security type and perceptions of seriousness and acceptableness. Two independent t-tests were conducted in order to explore differences between perceptions and hospital security type. No significant difference was found between the perceived seriousness of the vignettes and the security level of the hospital; low security: M=17.83, SD=4.52; medium security: M=18.78, SD=4.20, t(149)=-1.31, p=.19. Nor was there a significant difference between perceived acceptability and security level of hospital; low security: M=14.13, SD=3.42; medium security: M=14.19, SD=3.85, t(149) = -.11, p=.91.

Experience and perceptions of seriousness and acceptableness. This question was addressed by using two one-way between-groups ANOVA's. Subjects were divided into four groups depending upon their experience (Group 1: 2 years of less; Group 2: 2 to 5 years; Group 3: 5-10 years; Group 4: 10 years and above). Levene's tests revealed that the assumption of homogeneity of variance had not been violated.

There was no statistical difference between the four groups and perceived seriousness, $F(3, 147)=.39$, $p=.76$. However, there was a statistically significant difference between the four groups and perceived acceptableness of the boundary scenarios, $F(3, 147)=3.96$, $p=.01$. The differences in mean scores were considered to demonstrate a medium effect size, as calculated using eta squared (0.7). Post-hoc comparisons were completed using the Tukey HSD test since data met the assumption of homogeneity of variances. Results indicated that the mean score for Group 1 ($M=2.18$, $SD=.78$) and Group 2 ($M=2.10$, $SD=.88$) were significantly different from Group 4 ($M=1.63$, $SD=.71$). Group 3 ($M=1.84$, $SD=.81$) did not differ significantly from either Group 1, 2 or 4.

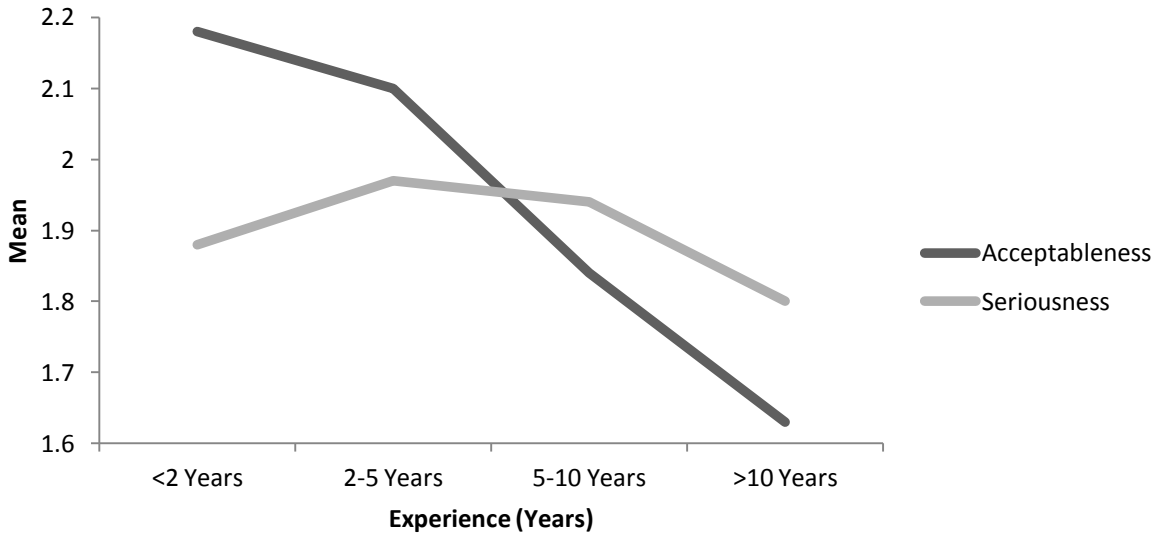


Figure 2. The relationship between experience (years) and perceptions of boundary crossings/violations.

Job Role and perceptions of seriousness and acceptableness.

This relationship was assessed using two one-way between-groups ANOVA's. Subjects were divided into three groups, Group 1: Therapies (psychologists and occupational therapists); Group 2: Nursing (RMN, HCA and learning disability nurses; Group 3: Other (social workers, managers, consultant psychiatrists and reception staff). Levene's tests revealed that the assumption of homogeneity of variance had not been violated.

There was no statistical difference between the three groups and perceived acceptableness, $F(2, 148)=1.15$, $p=.32$. However, there was a statistically significant difference between the three groups and perceived seriousness of the boundary scenarios, $F(2, 148)=4.07$, $p=.02$. Despite this significance, the differences in mean scores were considered to demonstrate only a small to medium effect size, as calculated using eta squared (0.5). Post-hoc comparisons using the Tukey HSD test indicated that the mean score for Group 1 ($M=17.40$ $SD=4.4$) was significantly different from Group 3 ($M=20.0$, $SD=4.90$). Group 2 ($M=18.25$, $SD=3.74$) did not differ significantly from Group 1 or 3.

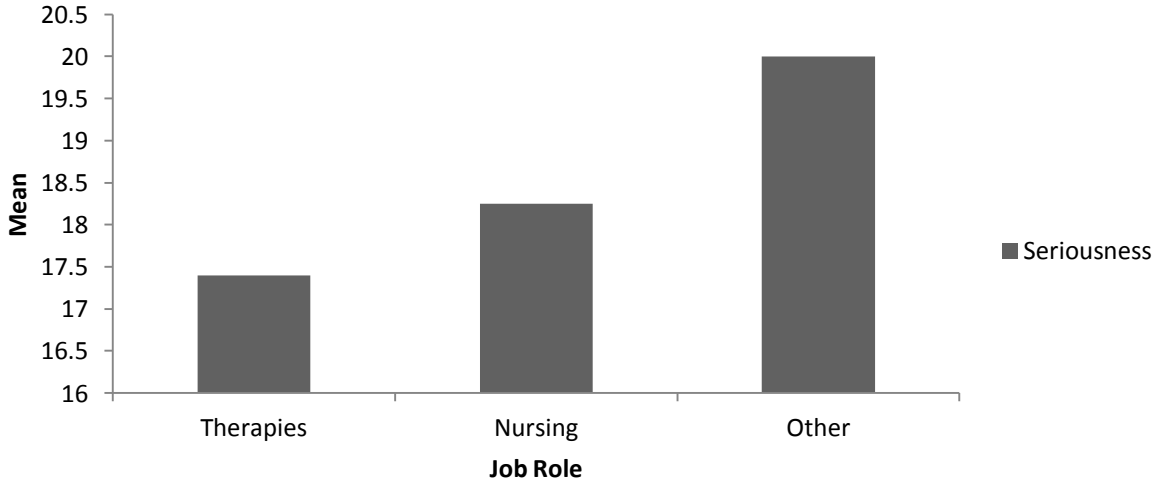


Figure 3. The relationship between Job Role and perceptions of boundary crossings/violations.

Interaction between employee gender and vignette gender. A one-way between-groups multi analysis of variance (MANOVA) was performed to assess this relationship. Four dependent variables were used: the perceived seriousness and acceptableness for the male and female vignettes, the independent variable was employee gender. Preliminary assumption testing was conducted to check the assumptions of the MANOVA were met.

Preliminary assumption testing and results. Mahalanobis distances were used to assess for multivariate normality, the value (28.20) was found to be greater than the critical value for the number of dependent variables in this analysis (18.47); thus, suggesting that the data had multivariate outliers. Further exploration revealed that only two values exceeded the critical value of 18.47. Since there were only two cases (28.20 and 18.74) and the values were not too extreme, the decision was made to keep these cases within the data set. Histograms were produced for all possible pairs of dependent variables and the assumption of linearity was satisfied. Analysis demonstrated that the multicollinearity assumption had not been violated; all dependent variables have a tolerance value of >.10 and a VIF value of <10 (Tabachnick & Fidell, 2001). The Levene's test of equality of error variances was >.05, suggesting that this assumption had not been violated. Finally, the assumption of homogeneity of variance-covariance's matrices was met (.628).

Inferential statistics demonstrated minor differences between the dependent variables, but not across genders. Generally, vignettes were rated as being equally as serious across male (male participants, *M* = 9.07, SD = 2.10, female participants, *M* = 9.22, *SD* = 2.28) and female perpetrators of boundary crossings or violations (male participants *M* = 9.14, *SD* = 2.60, female participants *M* = 9.04, *SD* = 2.90). Vignettes that involved female staff members

were observed to be slightly less acceptable (male participants *M* = 6.38, *SD* = 1.51, female participants *M* = 6.59, *SD* = 2.02) than those with male staff as perpetrators; (male participants *M* = 7.10, *SD* = 1.90, female participants *M* = 7.71, *SD* = 2.19). However, no statistically significant difference was discovered between these variables *F*(4,146)=.351, p =1.01; Wilks' Lambda =.402; partial eta squared=.027.

Summary of findings

In sum, statistical analysis revealed a significant difference between participant's perceived acceptability and seriousness of the boundary crossings and violations presented, *t*(150)= -15.91, *p*<.0005); boundary crossings were deemed to be less acceptable (*M*=14.16) than they were serious (*M*=18.25). Further analysis revealed that this distinction was not significantly different across male or female participants, *F* (2, 148) = 3.05, *p*=0.51; Wilks' Lambda =.96; partial eta squared=.04, or the security level of hospital participants worked in; *t*(149)=-1.31, *p*=.19, *t*(149) = -.11, p=.91.

However, differences were observed in the perceived acceptableness and the amount of experience one had in forensic psychiatric hospitals, *F*(3, 147)=3.96, *p*=.01; with individuals who had less experience being more likely to perceive boundary crossings and violations as more acceptable than those who had more experience. A further significant difference was observed between job type and perceived seriousness of boundary crossings and violations, *F*(2, 148)=4.07, *p*=.02; whereby post hoc analysis revealed participants who had a therapy based job role were more likely to consider the crossings and violations as more serious (*M*=17.40) than nurses (*M*=18.25) and other professionals (*M*=20.0). Finally, no statistical difference was observed between the gender of the participants and their perceptions of the gender of the individual who was

portrayed as crossing/violating boundaries within each of the scenarios; $F(4,146)=.351$, p =1.01.

Discussion

The aim of this research was to explore how serious and acceptable employees who work in secure hospitals perceived various boundary crossings and violations to be. To our knowledge this type of research has not taken place previously, so the aim was exploratory in nature; with the hope that general associations between variables may be discovered. The research explored the prevalence of boundary crossings and violations across secure hospitals, the relationship between the gender of the employee, which level of security hospital they worked in and the length of experience in this type of work they had.

Firstly, in considering prevalence it is clear to see that all the boundary crossings and violations illustrated in the vignettes have occurred within secure forensic hospitals (e.g. Table 6.). Descriptive analysis demonstrated that the prevalence of verbal boundary crossings/violations was slightly more common than non-verbal crossings/violations (frequencies being observed as 67.5 and 60.5 respectively). Additionally, less serious boundary breaches (boundary crossings) were more likely to occur than the more serious (boundary violations), a frequency of 87 compared to 41, which is generally fitting with other research literature (Gutheil & Brodsky, 2011). However, many participants responded with "unsure" to this question and their responses are limited by their awareness, indicating that their responses may not reflect the true extent of boundary crossings and violations within forensic mental health hospitals.

Additional analysis aimed to explore some individual factors which may be relevant for the differences in perceptions of boundary crossings and violations.

The findings suggested that there was a statistically significant difference in individual's ratings of acceptableness and seriousness; individuals viewed boundary scenarios as less acceptable than they were serious. It may therefore be inferred that although individuals know that boundary crossings and violations are not acceptable, and thus perhaps not ethical, they are less likely to rate the seriousness of crossings as high. This could have implications since perceiving boundary breaches as less serious may act as a justification for an individual to engage in such behaviour, even if they know this may be wrong, unethical and usually against their professional contracts.

Despite this, subsequent analyses discovered no significant differences between the genders of participants and their perceptions of boundary crossings and violations committed by male and female perpetrators; as indicated by similar means (male perpetrator *M*= 6.38, female perpetrator *M*=6.59). However, when the means of respondents who said a specific boundary scenario had occurred within the workplace were controlled for gender, no differences were found (male *M*=64, female *M*=64). This result may also be a result of the type of respondents who took part, as the majority were female which may have altered the results.

These results were not consistent with the general assumptions made within the boundary literature, which broadly suggest male staff are more likely to cross or violate boundaries in general psychiatric care, and females within forensic services (Adshead, 2012b; Thomas-Peter & Garrett, 2000). However, this is likely because the research enquired about participant's views and perceptions, rather than their actual engagement in boundary crossings or violations. Previous research has indicated that gender stereotypes and sexualised working environments may be factors which contribute to both the

views and execution of boundary violations; however gender stereotypes do not appear to have impacted the results of this study.

There were no significant differences in participant's views about boundary crossings or violations across hospital security levels. Previous research suggests that individuals working in high secure hospitals may perceive boundaries to be less important (Dale & Storey, 2004). Although participants in the current research were not asked about the relevance of boundaries, it is possible that if one does not consider boundaries to be relevant, then their views regarding the seriousness or acceptability may also vary, however this was not the case. One of the reasons for this could be that the largest difference found was between high security hospitals, with those employed within low and medium hospitals revealed to have similar scores on relevance. It is therefore likely that more significant differences would be discovered between individuals working in high secure hospitals, a population group which did not form part of the current research.

A final set of analysis considered if there were differences in participants views of boundary crossings and or violations depending upon how many years experience they had or their job role. Individuals who had less experience were more likely to perceive boundary crossings and violations as more acceptable than those who had more experience. However, scores on seriousness did not significantly differ. These findings partially support previous research (Ashton, 2016; Bachmann et al., 2000)

A further significant difference was observed between job type and perceived seriousness of boundary crossings or violations whereby participants who have a therapy-based job role were more likely to consider the breaches as more serious (M=17.40) than nurses (M=18.25) and other professionals

(*M*=20.0). It is likely that the specific job roles within this group are likely to be more cautious of boundary breaches because of the higher likelihood that they would be accountable for boundary violations, particularly those within a management role.

Additionally, it is recognised that nursing staff spend the most time with patients and due to the nature of forensic inpatient wards, patients are likely to spend years within such institutions. These factors are likely to alter the views that nurses have towards boundaries. It is likely that they have the most experience in facing boundary dilemmas and are likely to have adapted a different approach to dealing with and subsequently perceiving them.

Implications for practice

This chapter was intended to be exploratory in nature and the findings do not necessarily lend themselves to clear learning objectives for the workplace. However, what is clear is that several boundary crossings and violations do, and have occurred within secure forensic hospitals. It seems reasonable to assume that many of these instances have not been reported, and indeed perhaps this procedure is not necessary for the smaller boundary crossings, such as personal disclosure. However, it also appears to indicate that individuals are aware of either themselves or others committing these acts and perhaps not knowing how or wanting to act on this knowledge. Once again, this would not be necessary for all cases, however, it may support the theoretical argument that staff may in some cases pay a blind eye to such situations (Adshead, 2012b).

Whilst not all the boundary scenarios in this research were depicted to be extremely serious, literature suggests that smaller crossings and violations can lead to major boundary breaches (Simon, 1995). Serious boundary breaches

have the potential to bring a hospital, and indeed an NHS trust into disrepute. Additionally, due to the nature of the clients within secure hospitals, it is possible that some boundary breaches put other patients, staff and possibly members of the public at risk of harm, making future research into this area beneficial. Furthermore, it is acknowledged that there is need for boundaries to be flexible, since rigid boundaries can impair the therapeutic relationship (Lazurus, 1994), however achieving this balance can be extremely challenging (Gutheil & Brodsky, 2008; Gutheil & Brodsky, 2011).

Previous research has acknowledged that training into boundaries is not something which is offered as mandatory training within most forensic hospitals (Evershed, 2010). Whilst training is unlikely to eliminate the risk of serious boundary violations from occurring, it would beneficial for the topic of boundaries to be discussed regularly. This would help to reduce the shame and taboo that often surrounds the topic, which may ultimately prevent staff from seeking support (Gilbert & Andrews, 1999).

Limitations

One of the limitations of this research is the population group. Whilst the sample size was adequate, 72% of individuals were female. Should there have been a larger number of male participants, then differences may have been observed within results, particularly the analysis which focussed on gender differences.

Furthermore, this research assessed individual's perceptions of boundary crossings and violations rather than asking about lived experience of committing boundary crossings or violations. By using vignettes, it was hoped that participants would feel more able to provide honest responses, rather than if asked to disclose boundary crossings or violations which they had personally

been involved in. Additionally, the vignettes could only portray several situations. They are therefore not fully representative of the full range of boundary dilemmas which are likely to occur on a day to day basis within forensic mental health settings.

Moreover, whilst it is reasonable to assume that ratings of acceptableness and seriousness are connected to an individual's propensity to engage in such acts, just because someone indicates they think something is a serious boundary breach, does not confirm that they would not go on to engage in the behaviour.

Finally, on some of the analyses the independent variable was manipulated to complete the analysis. For example, job role was condensed into three groups. This was deemed appropriate as some job role categories only had a small number of participants. Issues of confidentially could be raised if groups were not created, since it would be more likely to identify participants based on the other demographic information which was collected. Subsequently, this makes it difficult to distinguish exactly which job role had different views about the different boundaries.

Summary and future research

The prevalence of boundary crossings and violations illustrated in this research is not necessarily surprising, especially given the dynamic nature of boundaries and the uniqueness that forensic environments present as a work place. Despite the existence of policies, boundaries have their roots in interpersonal interaction, for which there are no black and white rules, but rather many grey areas in terms of what professionals should and shouldn't do. Whilst major boundary violations, such as having a relationship with a patient are generally regarded as being "wrong", there is much less clarity regarding smaller boundary crossings, as outlined in the less serious vignettes within this

research. Since these smaller crossings can eventually lead to a more serious boundary violations, further research into this area would be beneficial.

This research identified some interesting relationships between employee characteristics and perceptions of boundaries; particularly indicating the difference that years experience and job role can have on these perceptions. However, it would be especially beneficial to involve a wider number of hospitals and a larger participant sample to investigate some of these principles further. Differences in high security hospitals may be particularly likely to differ in their perceptions.

Chapter Five: Exploring the Role of Attachment Tendency and Employee's Perceptions of Boundary Crossings and Violations

Chapter Rationale

Chapter four explored some individual employee characteristics which predicted perceptions of various boundary crossings and violations. However, since chapter two identified important relationships between attachment tendencies and interpersonal workplace behaviour, it was relevant to extend this exploration into the area of boundary crossings and violations. This chapter therefore explores if employee's attachment tendencies are a predictor of perceptions of the seriousness and acceptability of boundary crossings and violations within secure forensic hospitals. Following the psychometric review in chapter three, the ECR-R was chosen to measure attachment tendencies.

Abstract

Previous theoretical justification and limited empirical research has suggested that individual's attachment styles may impact on their likelihood to engage in boundary violations, with individuals whom have insecure tendencies being at greatest risk. However, there has been no empirical research to test out these assumptions in staff who are employed within secure forensic hospitals.

Using a cross sectional, correlational design, 151 participants were recruited from two secure hospitals and from a social media platform. All participants had experience of working in a secure hospital. Participants were required to complete a demographic questionnaire, an attachment measure (ECR-R; Fraley et al., 2000) as well as rate their perceived acceptableness and seriousness of 8 vignettes which depicted various boundary crossings and violations.

Research questions sought to establish how well job role, experience and attachment tendencies predicted the perceived acceptableness and seriousness of boundary crossings and violations, and how much of the variance could be explained by these four predictors. Using the enter method, a significant model emerged for each of the analyses; seriousness: F (4,146) = 3.299, p = .02, R^2 = 8.3% and acceptableness: F (4,146) = 4.79, p = .001, R^2 = 11.6%. Job role was found to be a significant predictor of the two dependent variables on both analyses, however, all the predictor variables were found to be significant predictors of acceptableness of boundary crossings and violations.

Keywords: Attachment, boundary violations, professional boundaries, forensic mental health, secure hospital

Introduction

Previous chapters have outlined the role of boundaries within secure hospitals. However, this chapter aims to incorporate attachment tendencies as a potential predictor of perceptions of boundaries due to the interpersonal nature of both attachment tendencies and boundary crossings and violations.

The role of Attachment

Early research into attachment styles suggests that babies innately try to form attachments with others (primarily caregivers) to survive (Bowlby, 1980). This attachment then provides a "secure base" from which a child can explore the world. Individuals also develop an internal working model; a mental representation of how we understand the world, ourselves and others (Bretherton & Munholland, 1999).

Over the last few decades, there has been a focus on attachment in adults, which is relevant since the attachment style we form as a child is said to provide a "prototype" for future relationships (McLeod, 2007); with our internal working model therefore providing a "blueprint" of how we socially relate to others (Bretherton & Munholland, 1999). Adults are broadly thought to fall into two major categories of attachment tendency; secure and insecure (Hazan & Shaver, 1990). It is considered that those with insecure tendencies are less likely to be able to process anxiety or arousal during times of stress (Bowlby, 1980). Furthermore, our internal model is said to directly affect how we seek care and how we give it (Bowlby, 1980) making it relevant to the therapeutic relationship.

Attachment and Boundaries

Previous chapters have illustrated that the application of attachment theory to the work place is a relatively new concept (Leiter et al., 2015). It is therefore unsurprising that limited research has investigated the attachment styles of staff who work with forensic clients. The limited body of research which has explored employee attachment and boundary breaches has been conducted within general health care professions, whereby the subjects of boundary crossings have usually been physicians. Generally, it is suggested that unresolved trauma, which may stem from insecure attachments, can have an influence on sexual misconduct behaviours with patients; whereby insecure attachments "resurface" into risky behaviour (Giugliano, 2006). Such professionals are more likely to come from dysfunctional families and have symptoms of trauma (Spickard, Swiggart, Manley, Samenow, & Dodd, 2008).

A further study of healthcare professionals attending a conference demonstrated that the prevalence of attachment anxiety and avoidance were low; with more than half considered to have secure attachment styles (MacDonald et al., 2015). The authors formulated a hypothetical risk factor model for boundary violations; whereby insecure attachment, stemming from childhood adversities, was more likely to lead to boundary difficulties in professionals (MacDonald et al., 2015).

Attachment in Forensic Patients

Forensic mental health patients can also be considered as a specific patient group, especially where issues of attachment are considered. The connection between a patient's adverse early experiences and subsequent unstable attachment styles, along with their increased likelihood to be involved with the criminal justice or mental health systems has been well demonstrated (Farrington, 2003; Rutter, 1995; Van IJzendoor & Bakermans-Kranenburg, 1996). Furthermore, it is thought that 80% of forensic populations have experienced significant maltreatment within their childhoods; meaning they are more likely to experience unresolved trauma and disorganised attachment styles (Adshead, 2002). Psychiatric illness is particularly likely to initiate attachment behaviour since the patient is presented with threat to both internal and external safety (Adshead, 2012a).

Insecure attachment styles have also been particularly associated with personality disorders (Crawford et al., 2007; Cohen et al., 2017; Fonagy, 2000) which hinder an individual's ability to form and maintain interpersonal relationships. Additionally, the over-representation of personality disorders within the criminal justice system (Evershed, 2010) demonstrates the

connection between early poor attachment styles and subsequent offending behaviour; whereby some individuals often resort to violence to solve psychological conflict (Fonagy, Target, Steele, & Steele, 1997; Mikulincer & Shaver, 2007a). Attachment theory suggests this is because these individuals have learnt to manage unpleasant feelings physically, potentially due to deficits in their ability to mentalize and empathise with others (Bateman, Bolton, & Fonagy, 2013). Importantly, this also impacts upon their ability to relate to professional staff and interactions may be dysfunctional, consisting of aggression or enmeshment (Adshead, 2012); factors which may make boundary crossings and/or violations more likely to occur.

Attachment styles of staff

Indeed, it appears apparent that attachment theory has provided a valuable practical framework for understanding complex service users (Adshead, 2012a). However, the connection between health care professional's attachment styles and work behaviours is less clear. The relevance of attachment in healthcare professionals and boundary crossings and violations may be best understood by the continuum of boundary behaviours; with under and over involvement being the two extreme forms of this behaviour (Darnley et al., 2012; Peternelj-Taylor, 2002). It would appear that being under-involved may lead to neglect and being over-involved may lead to boundary crossings and violations of an interpersonal nature. Over involvement may result from "compulsive care givers" (Bowlby 1979) who form a sub group of professionals whom enter the care giving profession because of their own childhood trauma and insecure attachment styles (Adshead 1998; Valliant et al., 1972).

It is suggested that these individuals are more likely to experience "lapses" in professional care and subsequently demonstrate dysfunctional care behaviours, including transgressing professional boundaries (Adshead, 2012b). Minor examples of such behaviour may include inconsistencies in behaviour; however, this can also include major boundary breaches (Adshead, 2012b). Individuals may also enact their anxiety by rule breaking since they may have experienced a history of rule breaking during their childhoods, making it more likely that they would collude with other rule breaking behaviour, such as boundary crossings and violations, within a professional context (Adshead, 2012b). Furthermore, it is suggested that individual risk factors, such as job changes, illness, birth of a child, bereavement etc. (Baca, 2009) may result in an "attachment crisis" in the employees' life which, if not dealt with, may result in the employee "acting out" their attachment anxieties within the work place (Adshead, 2012b). It is further suggested that this is particularly likely in forensic environments where patients with their own attachment insecurities can become predatory towards the employee's vulnerability.

In sum, the role of attachment within forensic mental health is complex. Patients within a forensic ward are said to act as a "toxic family group" in which "multiple toxic attachments" to professionals and peers exist (Adshead, 2012a). Thus, staff may play an important role in providing a secure base (Ma, 2006), and potentially be viewed as attachment figures for patients (Adshead, 1998; Goodwin, 2003; Wilkinson, 2003). Furthermore, whilst healthcare professionals can't help having feelings about patients (Adshead, 2012b), professionals with their own attachment difficulties may be more likely to act upon such feelings by providing "atypical" care giving behaviours (Goldberg, Benoit, Blokland, & Madigan, 2003).

Despite the theoretical justification for insecurely attached professionals being more likely to cross professional boundaries, there is very limited empirical research which has explored this area. Perhaps in part due to the somewhat controversial nature of the topic. Research which does exist focuses mainly on physicians, however, the review of theoretical work within a forensic context suggests that attachment styles of staff are likely to have an impact upon their involvement with rule breaking at work, namely transgressing professional boundaries.

To the author's knowledge, this is the first empirical piece of research that aims to assess the role of attachment tendency and the perceptions of boundary scenarios (crossings and violations) with individuals who are employed within forensic mental health.

Research Questions

1. How well do job role, experience and attachment tendencies predict perceived seriousness and acceptableness of boundary crossings and violations in forensic hospitals?
2. How much variance in perceived seriousness and acceptableness can be explained by these four variables?

Method

Participants

Participants for this study were the same as those in chapter four, where participant characteristics are examined in more detail. A total of 151 participants, aged between 21 and 64 years of age (*M*=34.31, *SD*=10.21), 72.2% of which were female, took part on a voluntary basis between April and July 2017.

Materials

The procedure and materials used for this study were largely the same as those outlined in chapter four. However, these will be reviewed briefly. Additionally, the ECR-R was used to assess participant's attachment tendencies.

Demographics. Participants were asked to complete a brief questionnaire regarding demographic information which would help inform the authors about the population who took part in the study. Questions included, years of experience working in a forensic environment, age, gender, job role, level of security of hospital and their employment status. Please refer to chapter four for more information.

Attachment Tendency. Attachment tendency was measured by the ECR-R (Fraley, et al., 2000). The ECR-R contains 36 items and asks participants to rate their attachment with romantic partners on a 7-point likert scale where 1= strongly disagree and 7 = strongly agree. Several items on the scale are reversed. The ECR-R is one of the most widely used self-report tools to measure adult attachment (Mikulincer & Shaver, 2007a) and the scale has been found to be reliable (α = > .90), a full review of this measure can be found in chapter two of this thesis.

Criticisms of the measure are based on the belief that the romantic references in the ECR-R limit its applicability to other contexts (e.g. Wei et al., 2007). However, others argue that the fundamental content of the measure

would be applicable to other environments (Wei et al., 2007). The original version of this measure, the ECR (Brennan et al., 1998) has previously been adapted to create a "context independent" version of the measure. Authors discovered that the factor structure and psychometric properties of this adapted measure retained its validity (Richards & Schat, 2011). For this study it was decided that the method used by Richards and Schat (2011) would be employed to allow the attachment measure to be more appropriate for use in a workplace context. This adapted measure appears to have retained high levels of internal consistency; the overall Cronbach alpha coefficient was 0.93 (anxiety subscale; α = 0.94, avoidant subscale; α = 0.83).

Boundary vignettes. As detailed in chapter four, participants were asked to rate the perceived seriousness and acceptableness of boundary crossings and violations, the 8 variations can be observed in chapter four, table six.

Procedure

As in chapter four, participants accessed the study via a website link which was either sent to their workplace e-mail or advertised on social media. Participants were required to read a consent form and agree to their part in the study. Participants then completed the questionnaires in the order presented in the materials section. Finally, they were required to read through debrief forms.

Ethics

Ethical approval was obtained as outlined in chapter four.

Results

Data Analysis

The data was analyzed using quantitative methods, using IBM SPSS version 23. Two standard multiple regression analysis were performed, where the overall estimate of seriousness and acceptability perception were used as outcome variables in each of the regression analyses. Independent variables were attachment tendency (attachment anxiety or avoidance), job role and years of experience.

Evaluation of Assumptions

Preliminary screening was conducted through IBM SPSS, assumptions are addressed below in turn.

Ratio of cases to IV's. Firstly, sample size was considered by consulting the formula provided by Tabachnick and Fidell (2001; N >50 + 8*m*, where *m* = the number of IV's). In this study the total population exceeded the predicted number (*n* =151) and so this assumption was met.

Multicollinearity. The bivariate correlation between variables was found to be .35 which is less than the recommended .7 (Tabachnick & Fidell, 2001), therefore all variables could be retained. Collinearity diagnostics were performed for further exploration of multicollinearity, as evidenced by tolerance and VIF values. Tolerance values for the independent variables were all >.10 (.93, .86, .76 and .86 respectively), therefore the multicollinearity assumption was not violated. This is supported by the VIF values which were all below the cut off value of 10 (1.07, 1.17, 1.32, 1.16 respectively).

Outliers, Normality, linearity, homoscedasticity and independence of residuals. Outliers were assessed firstly from a scatter plot. There were no obvious systematic patterns to the residuals. Outliers were further examined

from assessing Mahalanobis distances. None of the highest five values (13.78, 13.13, 11.77, 11.48 and 9.30) exceeded the critical value for four variables (18.47; Tabachnick & Fidell, 2001). Two cases were found to be poorly predicted by the model; with their actual scores of perceived seriousness being much higher than the predicted values (34 & 33 compared to the predicted values of 18.41 & 19.40 for perceived seriousness and 31 & 26 compared to the predicted values of 15.67 & 14.04 for perceived acceptableness). Cook's distances were assessed to examine if these cases were having a significant impact upon the overall model. The maximum Cook's Distance for perceived seriousness and acceptableness was .12 and .18 respectively, which were both less than the maximum recommended value of 1 (Tabachnick & Fidell, 2001), suggesting that these two cases were causing no major problems and thus no further action was needed.

Descriptive statistics

Table 9 displays the means and standard deviations for the main independent and dependent variables in this study.

Table 9

Average Scores for Perceptions of Boundary Crossings/Violations and Attachment Tendency

	Perceived Seriousness Mean (SD)	Perceived Acceptableness Mean (SD)	Anxiety Mean (SD)	Avoidance Mean (SD)
Overall Sample	18.25 (4.39)	14.16 (3.61)	2.83 (1.20)	3.49 (1.10)
Males	18.36 (3.88)	13.40 (3.28)	2.60 (1.14)	3.62 (1.04)
Females	18.21 (4.59)	14.15 (3.70)	2.93 (1.22)	3.44 (1.20)

Regression Analysis

Analysis 1 – Seriousness. Using the enter method, a significant model emerged: F (4,146) = 3.299, p = .02. The model explained 8.3% of the variance (R^2 = .083). Table 10 provides information regarding the predictor variables which were entered into the model. Job role was significant; however, attachment tendencies and experience were not. Thus, job role was considered to make a significant unique contribution to the prediction of perceived seriousness of boundary crossings and violations.

Table 10.

Statistical Output for Predictor Variables for Regression Analysis 1

Variable	B	SE B	β
Job Role	1.50	.46	.27*
Experience (years)	-.42	.33	-.11
Attachment Anxiety	.32	.33	.09
Attachment Avoidance	.56	.35	-.13

* p = 0.001

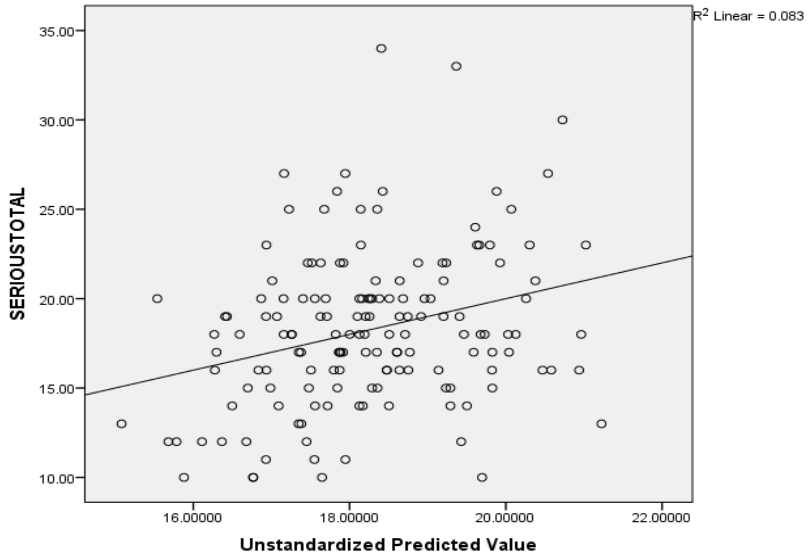


Figure 4. Predictor variables for regression analysis one, illustrating the 8.3% variance.

Analysis 2 – Acceptableness. Using the enter method, a significant model emerged: F (4,146) = 4.79, p = .001. The model explained 11.6% of the variance (R^2 = .116). Table 11 provides information regarding the predictor variables which were entered into the model. All the variables were significant, leading to a significant unique contribution to the prediction of perceived acceptableness of boundary crossings and violations.

Table 11.

Statistical Output for Predictor Variables for Regression Analysis 2

Variable	B	SE B	β
Job Role	.96	.37	.21 **
Experience (years)	-.62	.26	-.20*
Attachment Anxiety	.58	.27	.19*
Attachment Avoidance	-.61	.29	-.18*

* p = <0.05. ** p = 0.01

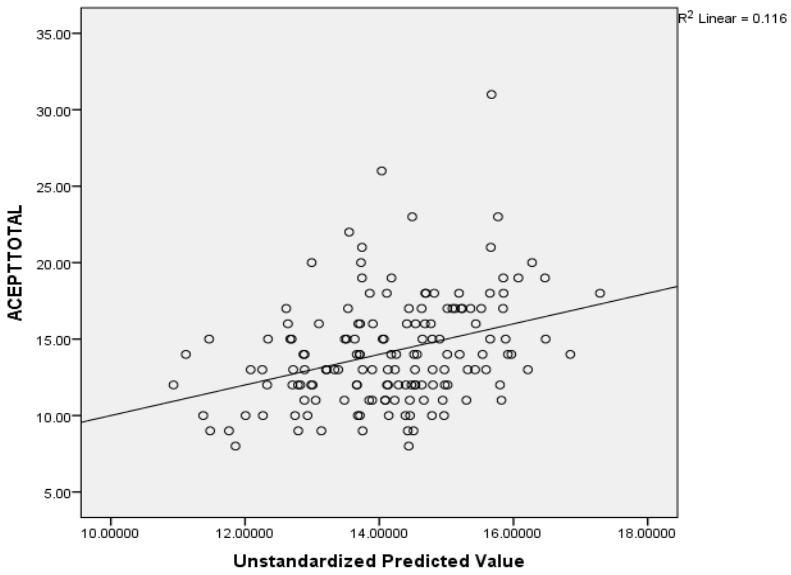


Figure 5. Predictor variables for regression analysis two, illustrating the 11.6% variance.

Summary of Findings

Two multiple regression analyses were conducted to establish if there was a relationship between job roles, years of experience and attachment tendency with perceptions of the seriousness and acceptability of boundary crossings and violations within forensic mental health services. Using the enter method, a significant model emerged for each of the analyses; seriousness: F (4,146) = 3.299, p = .02 and acceptableness: F (4,146) = 4.79, p = .001. Job role was found to be a significant predictor of the two dependent variables on both analyses; however all the predictor variables were found to be significant predictors of acceptableness of the boundary scenarios. The model which includes job role, experience (measured in years) and attachment tendency explained 8.3% and 11.6% of the variance in perceived seriousness and acceptableness respectively. Of these four variables, job role made the largest unique contribution for seriousness; β =.27, followed by attachment avoidance; β = .14, experience (years); β = .11 and attachment anxiety; β = .10. In terms of acceptableness, job role also made the largest unique contribution; β = .21, following by attachment anxiety; β = .19, attachment avoidance; β = .18 and experience (years); β = .11.

Discussion

The aim of this research was to investigate the role that employee attachment tendency has on an individual's perception of boundary crossings and violations with patients in secure forensic hospitals. More specifically, this was assessed by measuring individual perceptions of seriousness and acceptability for a range of different boundary crossings and violations which were conveyed as vignettes. The research questions were "how well do job role,

experience and attachment tendencies predicted the perceived seriousness and acceptableness of boundary crossings and violations"? and "how much variance can be explained by these variables"? Findings suggested that all four independent variables significantly contributed to the prediction of perceived *acceptability* of boundary crossings and violations, however only job role significantly predicted the *seriousness* of boundary crossings and violations.

The overall models only accounted for a small percentage of the variance as indicated by R^2 scores; .083 and .116 for perceived seriousness and acceptability respectively. Whilst additional predictors may have increased the explanatory power of the model by some amount, it is likely that in this study, there was an intrinsically higher amount of unexplained variability due to the interpersonal nature of the variables and the unpredictable nature of these.

The results suggest that four different variables predict perceptions on the perceived acceptability of boundary crossings and violations. It was decided that for this study, participants would not be asked to disclose if they have breached boundaries themselves since this may limit their likelihood to participate. Therefore, the results can only be interpreted in terms of employee's perceptions of boundary crossings and violations rather than considering if they have actually engaged in such acts. However, it is considered that perceptions and potential likelihood of engaging in boundary crossings and violations are likely to be connected; since one may convince themselves that their participation in an unethical act was not so serious and, on some level, acceptable.

Of the included variables, job role was the strongest predictor. Results demonstrated a positive relationship with this predictor variable. Whilst research suggests that any professional, regardless of job role is at risk of engaging in

boundary crossings or violations, the results suggest that perceived acceptableness and seriousness vary by job role. Specifically, the positive correlation suggests that "group 1", formed of occupational therapists and psychologists, were more likely to rate boundary scenarios as less acceptable than other colleagues. "Group 2", formed of nursing staff, were more likely to rate a scenario within the median range. Finally, "group 3", formed of a mixture of social work staff, consultants, managers and reception staff were the most likely to rate a scenario as more acceptable.

Whilst all boundary crossings and violations run the risk of developing into more serious violations and thus causing serious harm to patients, all professionals engaging in such behaviour run the risk of losing their registration with their professional bodies. This is one factor which could help interpret the results. For example, it could be speculated that some individuals may be more inclined to view boundary crossings or violations as less serious and more acceptable if they are not at risk of losing their professional registration. There are several professionals working in forensic mental health for whom this is relevant. For example, healthcare assistants, administration, domestic and reception staff. Although this wasn't specifically examined within this research, it is a factor which may explain differences and could be an avenue for future research. Furthermore, some staff with potentially greater responsibilities (managers and consultant psychiatrists) were less likely to perceive the boundary crossing and violations as unacceptable. However, this is likely the result of unqualified professionals also forming this group. Alternatively, it is possible that these professional groups are not exposed to as many boundary dilemma scenarios and thus have a different perception of them.

For example, it is recognised that different members of staff spend varying amounts of time in the company of forensic patients; a further factor which may explain the difference in results. For instance, it has been recognised that nursing staff are the individuals who are usually "on the front floor" with patients and thus have the most interactions with patients (Kelly & Wadey, 2012). In particular, weekend and evening shifts, where there is usually less supervision, are suspected to be a particularly high-risk time for boundary crossings such as "small talk" and self-disclosure to take place (Love & Heber, 2002). Thus, nursing staff within forensic mental health hospitals are likely to have the most exposure to boundary crossings in particular. In some ways, this may alter their perceptions, since they are likely to have the most experience dealing with the situations outlined within the vignettes.

Years of experience was also discovered to be a predictor in the perceived acceptableness of boundary crossings. However, this was a negative relationship, as indicated by the negative correlation. Results thus indicate that those with less experience are more likely to view a boundary crossing or violation scenario as more acceptable, than their counterparts with more experience. This is supported by previous research that suggests newly qualified individuals or those with less than 5 years experience (Ashton, 2016; Bachmann at al., 2000) are particularly high risk. Controversially, others have discovered that those with more experience may be just as likely to breach boundaries (Baca, 2009; Coe, 2012). However, comparison to the previous research literature can only be speculated as this empirical research assessed individual's perceptions regarding boundary crossings and violations rather than their actual engagement in such behaviour.

Finally, insecure attachment styles (avoidance and anxiety) were predictors of perceived acceptableness of boundary crossings and violations. More specifically, attachment anxiety demonstrated a positive correlation, whilst attachment avoidance indicated a negative correlation. Thus, individuals with anxious attachment tendencies were more likely to perceive boundary crossings and violations as acceptable, whereas the reverse relationship was true of those with avoidance tendencies.

These results add to the literature regarding the relationship between attachment tendencies and workplace behaviour. It supports the view that an individual's internal working model affects how individuals relate to others on a social level (Bretherton & Munholland, 1999), including how individuals seek and offer care (Bowlby, 1980). It is possible that individuals with anxious attachment tendencies viewed the scenarios as less serious due to their desires to be close to another individual emotionally. This may result in them paying less attention to ethical decision making or being able to effectively problem solve an interpersonal dilemma (Chugh et al., 2014; (Mikulincer, Shaver, & Rom, 2011), leading them to view boundary crossings and violations as acceptable. Conversely, those with avoidant attachment tendencies are likely to avoid close interpersonal relationships with others. It is therefore possible that this view influenced their perceptions of boundary crossings and violations since they usually involve a degree of social relationship with another (Harms, 2011). Furthermore, although individuals with avoidant tendencies were more likely to view boundary crossings and violations as unacceptable, their strong desire to be self-reliant may make them a particularly risky group should they actively engage in boundary crossings or violations, simply because they are much more unlikely to seek support.

Additionally, it is possible that individuals with insecure tendencies are more likely to have difficulty managing anxiety which can stem from working in forensic settings (Adshead, 1998) which only adds to this relationship and future research would benefit from measuring work related stress as an additional variable in this relationship.

Implications for practice

In terms of the broader context, this research is important because it has demonstrated several independent variables to be predictors of perceptions of boundary crossings and violations. To our knowledge it was the first to empirically assess employee attachment style and perceptions of boundaries. The model only accounted for relatively small percentage of variance; however, the model was significant, suggesting that important conclusions can still be drawn from the data. Whilst it is not practical, nor ethical to suggest that staff should be employed based upon their attachment style, this research does imply that attachment style is a further individual factor which contributes to the perceived acceptableness and seriousness of boundary crossings and violations and may further contribute to boundary crossings and potentially violations in practice within secure hospitals. Rather, it is suggested that the importance of managers being able to identify certain interpersonal relations in individuals and how these may be connected to attachment tendencies. Once a manager has some idea about what type of attachment tendency an individual presents with, then they may be able to better support them through supervision in order to address any vulnerabilities an individual may have, which makes it more likely that they will engage in boundary violations.

The importance of honest supervision has been highlighted by others (Gutheil & Gabbard, 2003; Halter, Brown, & Stone, 2007). However, it is recognised that interpersonal topics, especially those which involve potential wrongdoing, are not easy to discuss. Furthermore, individuals who have been involved in boundary crossings or violations are likely to experience shame and guilt, leading to avoidance rather than disclosure (Gilbert & Andrews, 1999). Thus, supervisors are required to be skilled and non-judgemental in order to allow such matters to be discussed (Adshead, 2012b).

It is suggested that nursing managers should encourage discussions and education regarding boundaries (Valente, 2017). This education is particularly important for nursing students, or any new staff members due to their inexperience of managing professional relationships (Ashton, 2016). Indeed, ongoing education is necessary (Benbow, 2013), since professionals who understand the risk factors are more likely to proactively maintain boundaries (Ashton, 2016). However, whilst training is usually provided at the start of employment, criticisms have been made suggesting boundary training does not adequately discuss grey areas and is not offered as continued mandatory training across some high and medium secure hospitals (Evershed, 2010).

Despite training and supervision being a suggested mediator to boundary crossings and violations, it is proposed the key performance statistics for supervision in forensic services is 80% with the further 20% possibly being avoidant of supervision (Evershed, 2010), or at least not making it a priority. Within the compliant 80%, it has been estimated that only 10% of staff discuss boundary issues; leading others to doubt the value of supervision and its role at preventing boundary problems (Gardner, 1993). However, it is hoped that the

implementation of the See Think Act guide (Allen, 2016; Department of Health, 2010) where the issues of boundaries are highlighted as an aspect of relational security, may lead to discussions on this topic on a more regular basis. Whilst this guide does provide some useful guidance on the topic of boundaries, the difficulty of distinguishing what constitutes as a boundary remains (Gutheil & Brodsky, 2011; Gutheil & Gabbard, 1993).

Limitations

A limitation with this study is that job role was manipulated into a dichotomous independent variable. The result of this manipulation was three distinct groups. Group 1 consisted of "therapy" staff (occupational therapists, psychologists and assistant psychologists). Group 2 formed the "nursing" group (consisting of staff who disclosed their role to be a registered metal health nurse, a healthcare assistant or a learning disability nurse). The third and final group was entitled "other" and included individuals with the following job roles, consultant psychiatrist, manager, social worker, reception staff and 'other'. Due to the low numbers of staff forming each of the sub groups it was decided that they should form the "other" group.

An aspect of this decision making was based on confidentiality and the fact that where there are significantly less numbers of certain job roles, specifically management and consultants, that their responses would be unfairly identifiable, as well as the small number raising issues of bias. This is therefore an area which could be further researched.

A further limitation is the way that boundary crossings and violations were presented and scored by participants. Boundary crossings and violations were depicted in 8 different vignettes which varied by conditions of employee gender

and whether the boundary crossing or violation was physical or verbal. Vignettes were also designed in a manner so that 4 of the 8 were significantly more serious (violations) than the others (crossings). Although these variables were controlled for analysis in study 1, for the regression analysis, totals of acceptableness and seriousness were calculated. Combining the vignettes may have limited the degree of perceived acceptableness and seriousness.

Additionally, the way participants rated their perceived acceptability and seriousness was on a 5-point likert scale (completely unacceptable to completely acceptable and extremely serious to not serious at all). This may have proven to be a design limitation since it did not allow for much variation in the responses, which may have limited the analysis. Although this study was quantitative in nature, there is scope for future studies to incorporate a qualitative element into research on boundaries. This would allow for a further and more in-depth analysis behind individuals reasoning in their perceptions regarding boundary crossings and violations. Finally, it was impossible to incorporate all possible boundary crossings into the vignettes for this study, and they are by no means completely representative of all possible scenarios. However, they were based on real life examples of boundary crossings or violations which have occurred within forensic units, for them to be valid for the chosen environment.

Finally, as with all self-report questionnaires, there is a possibility that individuals provided socially desirable responses on the scales. This may have also been the case for ECR-R. Although some have argued that interview style assessments of adult attachment style are the gold standard, this was not practical for the scale of this study. Additionally, it was felt that participants may provide more valid responses if they complete an anonymous online

questionnaire instead; since they may be less likely to provide socially desirable responses. Whilst the form of assessment may therefore be viewed as a limitation, the ECR-R remains one of the most widely used self-report tools to measure adult attachment (Mikulincer & Shaver, 2007a).

Summary and Future research

This research has demonstrated that attachment tendency, along with job role and amount of experience contribute to provide a significant model which predicts perception scores on the acceptability of boundary crossings and violations. Although the model only accounted for a small percentage of prediction (R^2 = 11.6%), a significant model was found suggesting the importance of these predictors. As mentioned previously, this is also likely due to the nature of the variables assessed, and the fact that other individual differences are likely to be predictors.

There has been previous theoretical justification for the importance of attachment tendency and the relationship this may have on boundary violations. However, to the author's knowledge, this is the first empirical research to explore the role of attachment style in the perceptions of professional boundary crossings and violations. As suggested by Adshead (1998), it is hoped that a deeper understanding of the role of attachment theory within forensic services may offer a new perspective on clinical practice.

It would be beneficial for future research to explore this association in further detail. It would be interesting to draw specific correlation patterns between individual attachment tendencies and whether they have committed any boundary crossings or violations, rather than just their opinions on cases. However, this kind of a study raises additional ethical concerns. It would also be

beneficial for the nature of smaller boundary crossings to be continually explored within forensic settings. Research has confirmed that forensic mental health is a dynamic and unique place to work. Whilst major boundary violations receive media attention, less is known about why certain staff members are likely to engage in the apparently less significant transitions of boundaries. However, it is likely that these smaller crossings are indicative of future major boundary violations and thus they warrant further research.

Chapter Six: Discussion

This thesis has focussed on exploring the perceptions of boundary crossings in forensic mental health hospitals. The thesis also examined if employee attachment tendencies could account for differences in this relationship. The first aim of the thesis was to review the current evidence base between attachment tendencies and workplace behaviour, including boundary maintenance.

The review in this area focussed on two types of workplace behaviours (OCBs and CWBs), due to the similarities between these constructs and boundary behaviours. Additionally, these types of workplace behaviours are interpersonal in nature and thus further relate to the two key concepts of this thesis; boundary behaviour and attachment tendencies. The results of this review illustrated that individuals with secure attachment tendencies were more likely to engage in OCBs (Falvo et al., 2015; Little et al., 2011; Syna Desivilya et al., 2006). Conversely, those with anxious attachment tendencies were less likely to demonstrate OCBs (Geller & Bamberger, 2009; Leiter et al., 2015; Richards & Schat, 2011) and more likely to engage in CWBs (Leiter et al., 2015). A final association between these variables considered avoidant attachment tendencies, which were discovered to be associated with less OCB *and* CWB behaviours (Leiter et al., 2015; Richards & Schat, 2011).

These results were in line with research discussed within the introductory chapter which propose attachment tendencies are related to different types of interpersonal relationships and behaviours at work. For example, it appears plausible that those with secure attachment tendencies have successfully developed pro social values and a positive working model which they can apply to an organizational setting (Mikulincer & Shaver, 2007a). The application of

these values subsequently leads them to engage in more OCBs whilst simultaneously having a reduced likelihood of engaging in CWBs (Syna Desivilya et al., 2006).

Alternatively, individuals with anxious attachment tendencies are likely to possess a negative working model of others (Mikulincer & Shaver, 2007a) leading them to be preoccupied with rejection and with seeking the approval of others (Hazan & Shaver, 1990). Logistically, these tendencies may cause individuals to engage in OCBs in an attempt to seek approval; however results did not confirm this association. Rather, it is likely that their preoccupation with securing the acceptance of their romantic partner which may leave them with little energy to put into OCBs (Rom & Mikulincer, 2003; Gillath et al., 2005). However, an additional perspective in terms of boundary crossings (Chapter five), is that anxiously attached individuals may cross boundaries in order to seek the approval of a patient due to fear of rejection should they not comply with a request the patient makes of them, despite knowing that this is against his or her professional conduct.

On the other hand, those with avoidant attachment tendencies are thought to have a working model based on threat (Bartholomew, 1990). Such that they are likely to believe that any interpersonal closeness may increase their likelihood of rejection and abandonment, so they would rather avoid such situations altogether (Geller & Bamberger, 2009). This has led to the view that such individuals may take a somewhat "distant" approach; leading them to engage in less OCBs *and* CWBs (Leiter et al., 2015; Richards & Schat, 2011). This distant approach is a result which is comparative to the empirical research in this thesis, which discovered a negative relationship between perceptions of boundary crossings and violations and avoidant attachment tendencies.

As discussed in the introductory chapter, aspects of forensic environments have been shown to make for stressful working conditions due to the degree of risk and violence which is involved in these roles. In turn, such environments are likely to increase the likelihood of CWBs; such as boundary crossings or violations. For example, Searle at al. (2017) used the stressor-emotional model (Spector & Fox, 2005) to illustrate that stress within the workplace can lead to CWBs which are otherwise "uncharacteristic" to that individual, especially those within a healthcare context (Searle et al., 2017).

Whilst research in this area is still in its infancy, the results appear to demonstrate a key role for attachment tendencies in the propensity for employees to engage in various workplace behaviours, including boundary crossings and violations. However, this review also discussed the various strengths and weaknesses of the studies which may limit the extent to which they results can be applied to broader contexts. One consideration of strengths and weaknesses was the variability in the way constructs were measured. Since it is important that a tool is reliable at measuring a given construct in order for the results of the research to be reliably interpreted, the second aim of the thesis was to evaluate an adult attachment tool, the ECR-R, and explore the feasibility of accurately measuring attachment tendencies of employees.

The psychometric evaluation demonstrated that the ECR-R has good levels of reliability and validity, which has led it to be the widest used tool in this area (Mikulincer & Shaver, 2007a). This provided good evidence for its use in a subsequent chapter of this thesis, whilst simultaneously indicating that research which uses this measure is likely to have accurately measured the construct of attachment tendencies in adults. However, as with all measures, there were some observed weaknesses. For example, the authors themselves suggest that,

despite the improvements made on the ECR, the ECR-R still possesses a relative weakness at accurately capturing secure attachment tendencies (Fraley et al., 2000). Additionally, academics that prefer to assess attachment via interview style assessment methods have criticised the ECR-R based on the potential limits of self-reporting attachment tendencies (Bateman & Fonagy, 2010). However, within an organizational setting it is not likely to be practical to use other methods due to time and confidentiality constraints.

Furthermore, much of the research into assessing the psychometric properties, as well as the original normative data was based on participants who were students. Additionally, many of these individuals had not been involved in long term romantic relationships, an aspect which the ECR-R focuses on. This could limit the ability for the tool to be used in wider populations. However, large quantities of normative data have subsequently been provided by the authors which may counteract this problem.

Critics have also suggested that the romantic connotations of many adult attachment measures, including the ECR-R, places limits on is applicability to other contexts, including organizational settings (Wei et al., 2007). Specific workplace attachment measures, such as the AAW (Collins & Read, 1990) and the SWAM (Leiter et al., 2013) have been developed to measure attachment tendencies within the workplace. Alternatively, the developers of the ECR-R have readily promoted the modification of their scale based on contextual needs (Fraley et al., 2000). This is something which has been successfully achieved by other authors in the field, using the ECR (Richards & Schat, 2011). Thus, in sum, given the high levels of reliability and validity it is plausible to adapt the ECR-R for an organizational context, rather than use a specific work place measure

which is less reliable or valid, and thus this was utilised in chapter five. The adapted ECR-R retained its internal consistency; α 0.93.

The third aim of the thesis was to explore individual staff factors associated with perceptions of boundary crossings and violations within forensic mental health settings. Due to the limited research in the area, this chapter was designed to be exploratory in nature. Results indicated that all the boundary crossings and violations, as depicted within vignettes, had occurred within forensic mental health hospitals. Furthermore, verbal crossings/violations were slightly more prevalent than nonverbal, and the more serious crossings (boundary violations) were less common than the less serious (boundary crossings); a finding which generally corresponds to the wider research literature (Gutheil & Brodsky, 2011).

Analysis also indicated several differences across individual perceptions of boundary crossings and violations. Individuals who had less experience working in forensic settings, perceived boundary crossings and violations to be more acceptable than those who had more experience. However, there were no observed differences in perceived seriousness. Thus, suggesting that although all employees perceived the scenarios to be equally as serious, those with less experience thought they were acceptable. It is possible that employees with less experience working within forensic settings could be more prone to experiencing moral disengagement, in which they believe certain ethical standards are not applicable to them. Furthermore, there were differences in perceptions of acceptableness which were dependent upon job role; staff in a therapeutic job role were more likely to view scenarios of boundary crossings and violations as more serious than those in other roles. It is likely that this is due to the broad differences across professional job roles within forensic hospitals.

No differences in perceptions were discovered between the security levels of forensic hospitals, despite previous research indicating that those working in high security hospitals were less likely to view boundaries as necessary (Dale & Storey, 2004). However, this difference is likely due to participants working in medium and low security hospitals only. It could be argued that the transitions in working practice are more similar between these two levels of security and thus broader differences may have been observed if participants have experience of working in a high security hospital. Finally, no differences were observed in perceptions between genders of participants. Previous research indicates that females may be more likely to cross or violate boundaries with patients in forensic settings (Adshead 2012b; Thomas-Peter & Garrett, 2000). However, this research did not examine traits of those who have crossed or violated boundaries, but rather professional perceptions. A further reason no difference was observed between genders may have been due to the high proportion of female participants (72%) which could have reduced the role of any potential gender stereotyping.

The results of chapter four provided useful information regarding certain individual factors and the relationship to perceptions of boundaries. However, many of the variables in this chapter, except for gender, were based on employee, rather than interpersonal characteristics. Chapter two demonstrated the significant relationship between workplace behaviour and attachment tendencies. Similarities between boundary crossings or violations and CWBs were also highlighted, such as theft, misuse of time, harm towards individuals, including bullying and sexual harassment and generally endangering others (Gruys & Sackett, 2003; Sackett & Devore, 2001). Therefore, the penultimate chapter aimed to connect all of the chapters together.

The aim of chapter five was therefore to assess the association between attachment styles and individuals perceptions of boundary crossings and violations among staff in forensic mental health settings. Attachment tendencies were measured using an adapted version of the ECR-R to make it independent of context, as discussed in chapter three. Attachment tendencies were chosen as a variable due to the significant associations found between attachment tendencies and workplace behaviours (chapter two). Additionally, the regression analysis was informed by the significant association between two employee based variables, experience and job role, as outlined in chapter four. These additional variables were therefore added into the regression analysis.

Findings indicated that a significant model existed for each of the analyses. The first analysis, exploring seriousness, indicated that the predictors explained 8.3% of the variance. The second analysis, which explored acceptableness, explained 11.6% of the total variance. The relationship between job role and experience as predictors was, unsurprisingly the same as in chapter four; a significant positive relationship was found between job role and perceived acceptableness and seriousness of boundary crossings and violations. Conversely, a significant negative relationship was found between experience and acceptableness but not seriousness.

Attachment tendencies were not found to be a significant predictor of perceived seriousness. However, interesting relationships between attachment tendencies and perceived acceptableness were discovered. A significant positive relationship was observed between individuals who had anxious attachment tendencies and their perceived acceptability of boundary crossings and violations. Alternatively, a significant negative relationship was observed between individuals with an avoidance attachment tendency and their perceived

acceptableness. It can be argued that these results potentially reflect the complexity between attachment tendencies within forensic mental health hospitals, when considering the tendencies of both professionals and patients alike.

These results may be interpreted in a number of ways. Firstly, as highlighted in the introductory chapter, there is extensive research which indicates most of the forensic population has experienced significant maltreatment and subsequently they are more likely to present with insecure attachment tendencies. A prevalence which is likely to increase in those who have a psychiatric illness, due to their experience of threat to both internal and external security (Adshead, 2012a). Forensic patients, who spend lengthy periods of time within secure hospitals, in comparison to the general psychiatric populations are subsequently more likely to view health care professionals as attachment figures (Adshead, 1998; Goodwin 2003; Wilkinson, 2003). This relationship dynamic between professional and patient is likely to be complex, however, one central dimension which further adds to this complexity is the interaction of an employee's attachment tendency.

Although not true of all mental healthcare professionals whom work within forensic mental health, some researchers have poised a relationship between an employee's insecure attachment tendency and their likelihood to enter into an occupation within the health care profession. Furthermore, it is believed that healthcare professionals who have experienced a degree of childhood adversity, may also experience boundary difficulties (Giugliano, 2006; MacDonald et al., 2015), such as expressing "dysfunctional care behaviours" as a means to re-create attachment anxiety by rule breaking (Adshead, 2012b).

Specifically, it has been theorised that attachment difficulties within the healthcare profession are illustrated by either under or over involvement with patients. Under involvement is usually demonstrated by neglect and over involvement as compulsive care giving (Darnley et al., 2012; Peternelj-Taylor, 2002). Given their definitions, it appears logical to view under involvement as representing those with avoidant attachment tendencies and those who are over involved as having anxious attachment tendencies (Hamilton, 2009).

Whilst these theories cannot be directly linked to the findings of chapter five, due to the research investigating boundary perceptions rather than boundary crossings and violations in practice, it is plausible that perceptions are connected to one's behaviour. Whilst this is an area which warrants further exploration, the significant correlations between attachment tendencies and perceptions of the acceptableness of boundary crossings/ violations certainly fits the hypothesis that those with anxious tendencies may become over involved in their patients care, whilst those with avoidant tendencies may be under involved. Both of which may be considered a form of boundary crossing or violation. As mentioned previously in this discussion, these results also largely replicate those found in chapter two, whereby individuals with anxious attachment tendencies were discovered to be more likely to engage in workplace behaviours which had negative connotations, compared to those with secure and avoidant attachment tendencies.

Limitations and Future Research

There are several limitations regarding the research conducted within this thesis. Firstly, should the systematic review have been completed on a larger scale, additional data bases may have been searched and thus additional research in the selected area may have been discovered. Additionally, whilst

completing the search process, there were several articles discovered which focussed on attachment *to* the work place. Whilst this was not a focus of this thesis, and therefore not part of the inclusion criteria used for the systematic review, these articles may provide an additional insight into the role of attachment behaviours at work and it would be beneficial to incorporate these into additional reviews.

Whilst the tool used to assess attachment tendencies within this thesis has demonstrated good reliability and validity, research has suggested that various methods of attachment assessment can produce substantially different results (Roisman et al., 2007). This is therefore an implication for the findings in the systematic review; as a number of different tools were used, suggesting the results should be interpreted with caution. Additionally, whilst the dimensional models of attachment have been deemed the most accurate (Fraley & Waller, 1998), it has been noted that much research is still conducted using a typological model (Harms, 2011). These inconsistencies can make comparing results of studies challenging. It may therefore be beneficial to complete further research in this area with additional or in fact multiple measures. However, this is likely to be more time consuming, especially if using an interview style measure which may not always be feasible within the workplace.

In terms of the empirical research, one of the main limitations is the way in which boundary crossings and violations were assessed. The decision to use vignettes in this research was made to allow participants to give the most honest response as possible. If participants were asked directly about their involvement, it was felt they would be less likely to provide valid responses. Furthermore, this would have likely raised several ethical dilemmas in terms of disclosing

behaviour which is likely unethical in nature. Nevertheless, future research which explores attachment tendencies and their relationship with disclosure of boundary crossings and violations would likely provide richer research data.

The vignettes themselves aimed to represent a wide range of various crossings and violations which have occurred within forensic mental health settings. However, due to the grey area of boundaries themselves, it is impossible to gather the perceptions on all possible boundary crossings and violations which exist in practice. Furthermore, in chapter five, all the vignettes were classified as one group as opposed to serious and less serious scenarios, which was the case in chapter four. There may therefore be further useful exploration which could be conducted around examining more or less serious boundary crossings and violations in relation to attachment tendencies.

Participants were asked about the perceived acceptableness and seriousness of several boundary scenarios. This was completed on a 5-point likert scale, which may have limited the full potential of analysis. Qualitative research in this area would therefore be useful within future research. Additionally, since the research asked about perceptions and not actual engagement in boundary crossings or violations in practice, only inferences can be made at this stage regarding the potential relationship between attachment tendencies and the propensity to act on these views. However, previous research does seem to support the relationships found in the empirical research within this thesis; with anxious attachment tendencies being directly related to ethical decision making (Chugh et al., 2014) and a negative relationship identified between avoidant tendencies and ethical decision making (Cophik, 2015). Additionally, boundary crossings and violations may depend upon the perceived

effect upon a patient rather than what is ethically or morally correct (Ghuloum et al., 2013). Thus, measuring for this variable in future would be beneficial.

To conduct statistical analysis, some of the variables had to be manipulated. The variable which may have been particularly affected by this is and individuals job role which was condensed into three categories to form a dichotomous variable. It is therefore impossible to know how much variance a specific job role may add to the relationship between attachment tendencies and boundary crossings and violations.

Furthermore, there are several other variables which may be important in considering further research. For example, most of the participant sample was female. This could mean that the results found within the two empirical pieces of research are not valid for males. Additionally, had more male participants taken part, there may have been variances in the scoring of gender specific boundary crossings and violations. In a similar manner, differences may be observed between those who work in high security hospitals and thus future research into this population sample will be beneficial.

Finally, researchers have indicated the role of stress and burn out as potential factors which may both trigger an individual's attachment behavioural system (Albert, Allen, Biggane, & Ma, 2015; Mikulincer & Shaver, 2008) and subsequently increase the likelihood of boundary crossings and violations. Furthermore, some have indicated the possibility that attachment tendencies may be most importantly viewed as a moderator with work place behaviour (Harms, 2011). This would appear to be the case with the results of chapter five and the fact that attachment variables only account for a small proportion of model variance. Therefore, other variables, such as stress or burn out would be

relevant to measure alongside attachment tendencies within future research in this area.

Implications for Managers/Supervisors

The results of this thesis can hopefully provide an insight for employers of staff within forensic mental health hospitals. Whilst it has been argued that attachment styles should be considered in the selection process within organizations (Manning, 2003), this approach is generally unethical. However, it may be beneficial for managers and supervisors to have awareness about individual attachment styles of existing employees and for them to understand why individuals may behave in a particular manner within certain interpersonal situations at work. Having this knowledge, as well as being able to support employees with any difficulties, may help to avoid individuals engaging in unprofessional work behaviours, namely boundary crossings and violations.

Some have suggested that attachment styles remain stable across our lives (Fraley & Brumbaugh, 2004); however, others have demonstrated that attachment tendencies can change in response to experiences (Gillath, Selcuk, & Shaver, 2008) and across contexts (Brumbaugh & Fraley, 2007; Klohnen et al., 2005). Of relevance for this thesis is evidence that priming a secure attachment may reduce an individual's likelihood of engaging in unethical behaviour (Gillath, Sesko, Shaver & Chun, 2010). This is most likely to be achieved with employees in secure hospitals by supportive supervision as well as on-going training and awareness of boundary issues. Whilst regular supervision, where the topic of boundaries can be openly discussed is imperative, individuals with avoidant tendencies have a reduced ability to seek support due to having a strong sense of self-reliance (Mikulincer & Shaver, 2005), thus limiting the effectiveness of

supervision. Other employees should also be encouraged to speak up about behaviours they witness in colleagues which they feel may be on the verge of, or indeed actually crossing or violating boundaries. Further training in the area of boundaries appears to be an aspect which some hospitals are employing, with the help of the implementation of the See Think Act guide, which highlights the importance of boundaries within relational security, a form of security which specifically focuses on interpersonal factors which can impact upon the security within forensic mental health hospitals.

The implications of breaking boundaries within forensic mental health settings includes putting the safety of other employees, patients and members of the public at risk, and thus illustrates the importance of research in this area. Although attachment tendencies have been highlighted as an important interpersonal factor in the perceptions of boundary crossings and violations, research in this area is still very much in its infancy. Future research would benefit from exploring further the role which attachment tendencies play in the complex relationship between service user and professional. Participants recruited in the empirical pieces of research indicated that the prevalence of boundary crossings were more prevalent than boundary violations. Thus, this finding, as well as the theoretical perspective which suggests boundary crossings lead to more serious boundary violations, suggests more research is needed within this area. Furthermore, other means of assessing boundaries outside of using vignettes may be useful in future research, as well as qualitative research aimed at providing richer data connecting attachment tendencies to the views of or involvement in boundary crossings or violations.

Practical implications related to Policies and Procedure

The previous section considered the importance of managers being able to create an environment in which staff feel comfortable to discuss boundary issues, as well as potentially being able to identify individual risk factors which may be connected to an individual's perceptions about boundaries. However, boundaries within forensic mental health settings are far from a perfect science. Rather, boundary crossings are and will continue to be an aspect of the work in this area, due to the interpersonal nature of this employment (Kelly & Wadey, 2012). A core area of the practical implications must therefore consider how to deal with boundary crossings and how best to support the employer. Historical research has implied that boundary crossings eventually lead to a more serious boundary violation (Simon, 1995). Whilst it is likely that a series of crossings are the likely antecedents of for example, a romantic relationship with a patient, it is not true to say that all boundary crossings lead to a more serious violation in every instance; with smaller boundary crossings continuing to be much more prevalent than boundary violations.

Despite the fact that boundary slips will continue to occur within forensic mental health services, the existence of broad expectations of professional behaviour (including boundaries) should be established within each secure hospital. Whilst hospitals are likely to develop their own policies, broader guidance is available, such as the See, Think, Act guide (Department of Health, 2010) which was developed to highlight the importance of relational security aspects within secure hospitals, and aspect of which is boundaries. The See Think Act literature suggests that any boundaries which are developed should reflect the "clinical philosophy" of the service. Furthermore, it is suggested that

individual wards should have open discussions about what the negotiable and non-negotiable boundaries are within a given ward environment. This principle supports the fact that boundaries within forensic mental health settings are expected to be flexible and decision making can vary from day to day, especially regarding negotiable boundaries.

It is further suggested that the ward boundaries should be transparent to patients (Gabbard & Crisp-Han, 2010) and it is suggested that the best way to communicate this information is when a new patient first arrives to a ward, perhaps additionally contained within a welcome pack. In a similar manner, the same information should be divulged to new staff as they join the ward, with them being informed about inappropriate interaction between staff and patients (Gabbard & Nadelson, 1995; Gabbard, 1996). Furthermore, it would be useful for various patient pathologies, such as personality disorders, which may affect boundary setting and maintenance, to be highlighted to staff on a regular basis (Kelly & Wadey, 2012).

Staff should also receive yearly refresher training on the general topic of boundaries as a minimum, with additional workshops facilitating continuous learning to be offered where possible (Kelly & Wadey, 2012). This training would ideally include the relevance of recognising signs of transference and countertransference (Aiyegbusi, 2004; Celenza & Gabbard, 2003; Gabbard, 1996). Furthermore, ongoing mentoring should consider the use of a tool which may help individuals to reflect on their practice. A number of such tools exist including The Exploitation Index (Simon, 1990), The Nursing Boundary Index (Pilette, Berck, & Achber, 1995) and The Sexual Boundary Violation Index (Swiggart, Feurer, Samenow, Delmonico, & Spickard, 2008). Additionally, it is

suggested that the use of hypothetical vignettes may be used to role play boundary crossing/violation scenarios which would be a less threatening than asking an employee to talk about their own experiences (Peternelj-Taylor, 2012).

Whilst it is always the responsibility of the individual staff member to uphold boundaries, they should be supported if a boundary slip or crossing occurs. This could ideally be addressed via an informal review of boundary incidents to avoid blame towards the professional and support them to develop strategies to manage future boundary slips (Kelly & Wadey, 2012). Although it would usually be a ward manger who outlines the expected boundaries on a ward, involving staff at all levels with regular discussions about what the negotiable and non-negotiable boundaries are will likely achieve the best results, since staff would feel actively involved in the process. It has been suggested that organizations being subjected to an "environmental audit" may also help with this process (Gabbard, 1996). It would perhaps be helpful for members of staff within the same organization but who work on a different ward to complete this; since such an individual would be aware of the broader organizational policies whilst being objective enough to notice areas in which boundary crossings may be occurring.

Although not always achievable, the culture of the working environment should be as open as possible so that individuals feel able to discuss the difficulties they are facing with boundary dilemmas (Kelly & Wadey, 2012). In a similar manner, all staff should be encouraged to address and support each other if they notice boundary crossings occurring, since a manager is unlikely to witness all of these instances. In order to avoid shame, if staff are found to have

engaged in a boundary crossing, this should be spoken about on a 1-1 basis. Staff may be more willing to disclose such issues amongst peers in the same area of work (Thomas & Garrett, 2000). In terms of practicing psychologists, it may also be beneficial for them to seek ongoing personal therapy which may help address unconscious motivations for entering their field of work and any defensive styles they may have (Thomas & Garrett, 2000). Overall, it is suggested that the responsibility should not lay with the individual themselves, but instead their organization, professional bodies and peers (Evershed 2011; Peternelj-Taylor & Schafer, 2008); in order to create a sense of collective responsibility for boundary issues (Kelly & Wadey, 2012).

In many hospitals, it is possible that one of more of the above mentioned systems or policies are in place. Although not supported by empirical evidence, due to the lack of research in this area, it is also possible that such systems may have impacted the results observed in this thesis. For example, it may therefore be hypothesised that if someone felt they had been penalised for boundary crossings by a supervisor who, for a number of reasons, may not have supported the employee in the best manner, then they may be less likely to seek support in the future (Kelly & Wadey, 2012). Individuals may be more likely to perceive boundary crossings and/or violations as less acceptable, although may potentially by more likely to engage in such behaviour but not feel able to seek support for boundary crossings which may later lead to boundary violations.

Conversely, a member of staff who felt they worked in a supportive climate may be more likely to perceive a boundary crossing as acceptable. This may be because within an environment where people share their experiences of their own boundary crossings, an individual is more aware that such behaviour

does exist and that they too can share their experiences without judgement. Finally, as mentioned earlier in this section, each individual ward may have a pre-agreed category of boundaries which should be adhered to. Participant's ratings of acceptableness and seriousness may therefore have been affected by ward specific policies which are likely to vary within hospitals as well as between different hospitals (Gabbard & Crisp-Han, 2010), depending on what these individual criteria consist of.

Conclusions

This thesis has identified the ability of attachment tendencies to influence professional behaviours within the workplace, with a specific focus on how these may affect professionals who work in secure forensic hospitals. Overall, anxious attachment tendencies have been associated with perceptions which may support the crossing of boundaries with patients. The opposite relationship was true of those who have avoidant attachment tendencies, a relationship which was supported in a review of workplace behaviours and attachment styles (Chapter two). In sum, those with anxious attachment styles are likely to have difficulties with interpersonal workplace behaviours. This is likely to have particular implications for those working within healthcare, where individuals with anxious attachment tendencies may be more likely to provide compulsive care giving (Kunce & Shaver, 1994); which may include crossing professional boundaries in order to feel better about themselves (Erez et al., 2008; Gillath et al., 2005). Due to the potential implications of boundary crossings upon the wider community, further investigation into an important interpersonal variable, attachment tendency upon this type of workplace behaviour is warranted.

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Appendix A – Reference lists searched

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Appendix B – Search Syntax

Database	Years Searched/Limits	Concept	Key Word Searching	MeSH Terms
Ovid: PsychINFO	**All**	Attachment	(attachment* or attachment theor* or attachment behavio* or attachment style*).	exp attachment behavior/ or exp attachment theory/
		OCB	(organizational citizenship behavio* or OCB* or extra role performance or employee motivation or work ethic or employee attitude* or work* performance).	exp organizational citizenship behavior/ or exp employee attitudes/ or exp employee characteristics/ or exp employee motivation/
		CWB	(counterproductive work behavio* or CWB* or dysfunctional work behavio* or employee devianc* or work* bully* or work* harrass* or work* aggress* or work* abus* or work* violence).	exp workplace violence/

Ovid: Medline	**All**	Attachment	(attachment* or attachment theor* or attachment behavio* or attachment style*).	
		OCB	(organizational citizenship behavio* or OCB* or extra role performance or employee motivation or work ethic or employee attitude* or work* performance).	
		CWB	(counterproductive work behavio* or CWB* or dysfunctional work behavio* or employee devianc* or work* bully* or work* harrass* or work* aggress* or work* abus* or work* violence).	exp work performance/ or exp workplace violence/
Business Source Premier	**All**	Attachment	attachment* or attachment theor* or attachment behavio* or attachment style*	

		OCB	Organi!ational citi!enship behavio* or OCB* or extra role performance or employee motivation or work ethic or employee attitude* or work* performance	(((((DE "JOB performance") OR (DE "EMPLOYEES -- Attitudes")) OR (DE "JOB involvement")) OR (DE "JOB satisfaction")) OR (DE "WORK ethic")) OR (DE "VIOLENCE in the workplace")
		CWB	counterproductive work behavio* or CWB* or dysfunctional work behavio* or employee devianc* or work* bully* or work* harrass* or work* aggress* or work* abus* or work* violence	
ABI/INFORM Global	**All/Limited to Abstract & title** [1]	Attachment	(attachment* or attachment theor* or attachment behavio* or attachment style*)	
		OCB	(organizational citizenship behavio* or OCB* or extra role performance or	SU.EXACT("Workplace

	employee motivation or work ethic or employee attitude* or work* performance)	violence") OR SU.EXACT("Work rules") OR SU.EXACT("Employee attitude") OR SU.EXACT("Work ethic")
CWB	(counterproductive work behavio* or CWB* or dysfunctional work behavio* or employee devianc* or work* bully* or work* harrass* or work* aggress* or work* abus* or work* violence)	

Database	Search order	Search Terms
PsychINFO	1	exp attachment behavior/ or exp attachment theory/
	2	(attachment* or attachment theor* or attachment behavio* or attachment style*).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]
	3	1 or 2
	4	exp organizational citizenship behavior/ or exp employee attitudes/ or exp employee characteristics/ or exp employee motivation/
	5	(organizational citizenship behavio* or OCB* or extra role performance or employee motivation or work ethic or employee attitude* or work* performance).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]
	6	4 or 5
	7	exp workplace violence/
	8	(counterproductive work behavio* or CWB* or dysfunctional work behavio* or employee devianc* or work* bully* or work* harrass* or work* aggress* or work* abus* or work* violence).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]
	9	7 or 8
	10	3 and 6
	11	3 and 9
	12	10 or 11

Database	Search order	Search Terms
Medline	1	(attachment* or attachment theor* or attachment behavio* or attachment style*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
	2	exp workplace violence/
	3	exp work performance/
	4	(counterproductive work behavio* or CWB* or dysfunctional work behavio* or employee devianc* or work* bully* or work* harrass* or work* aggress* or work* abus* or work* violence).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
	5	2 or 3 or 4

	6	(organizational citizenship behavio* or OCB* or extra role performance or employee motivation or work ethic or employee attitude* or work* performance).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
	7	1 and 5
	8	1 and 6
	9	7 or 8

Database	Search order	Search Terms
Business	1	attachment* or attachment theor* or attachment behavio* or attachment style*
Source	2	(((((DE "JOB performance") OR (DE "EMPLOYEES -- Attitudes")) OR (DE "JOB involvement")) OR (DE "JOB satisfaction")) OR (DE "WORK ethic")) OR (DE "VIOLENCE in the workplace")
Premier	3	organizational citizenship behavio* or OCB* or extra role performance or employee motivation or work ethic or employee attitude* or work* performance
	4	counterproductive work behavio* or CWB* or dysfunctional work behavio* or employee devianc* or work* bully* or work* harrass* or work* aggress* or work* abus* or work* violence
	5	S2 OR S3 OR S4
	6	S1 AND S5

Database	Search order	Search Terms
ABI/INFORM	1	ab(attachment* or attachment theor* or attachment behavio* or attachment style*)
Global	2	SU.EXACT("Workplace violence") OR SU.EXACT("Work rules") OR SU.EXACT("Employee attitude") OR SU.EXACT("Work ethic")

3	ab(organizational citizenship behavio* or OCB* or extra role performance or employee motivation or work ethic or employee attitude* or work* performance)
4	ab(counterproductive work behavio* or CWB* or dysfunctional work behavio* or employee devianc* or work* bully* or work* harrass* or work* aggress* or work* abus* or work* violence)
5	(SU.EXACT("Workplace violence") OR SU.EXACT("Work rules") OR SU.EXACT("Employee attitude") OR SU.EXACT("Work ethic")) OR ab(organizational citizenship behavio* OR OCB* OR extra role performance OR employee motivation OR work ethic OR employee attitude* OR work* performance) OR ab(counterproductive work behavio* OR CWB* OR dysfunctional work behavio* OR employee devianc* OR work* bully* OR work* harrass* OR work* aggress* OR work* abus* OR work* violence)
6	ab(attachment* OR attachment theor* OR attachment behavio* OR attachment style*) AND ((SU.EXACT("Workplace violence") OR SU.EXACT("Work rules") OR SU.EXACT("Employee attitude") OR SU.EXACT("Work ethic")) OR ab(organizational citizenship behavio* OR OCB* OR extra role performance OR employee motivation OR work ethic OR employee attitude* OR work* performance) OR ab(counterproductive work behavio* OR CWB* OR dysfunctional work behavio* OR employee devianc* OR work* bully* OR work* harrass* OR work* aggress* OR work* abus* OR work* violence))

The search strategies employed in each of the databases.

1 Please note that limits were placed on this database only due to the unmanageable hits which were retrieved without such a limit.

Appendix C - Inclusion/Exclusion Criteria

Inclusion/Exclusion Criteria	Yes	No	Comments
Participants aged 18+?			
Participants are employed in some manner (full/part time)			
Attachment Measure has been used			
OCB/CWB Measure has been used			
Research paper?			
Commentaries/opinion paper/editorial/letters			
Measures attachment *to* workplace			

Appendix D - Data Extraction Form

Data Extraction Form	
1. General information	
Author	
Title	
Year of publication	
Country of origin	
2. Study Characteristics	
Aims/objectives	
Number of participants	
3. Participant Characteristics	
Age	
Gender	
Employment type	
4. Method	
Was OCB or CWB or both measured?	
What measure of attachment was used?	
What measure of CWB/OCB was used?	
5. Results	
What are the results	
6. Study Characteristics	
Aims/objectives	

Appendix E **QUALITY ASSESSMENT CRITERIA**	**Syna Desivilya et al. (2006)[1]**	**Geller & Bamberger (2009)[2]**	**Little et al. (2011)[3]**	**Richards & Schat (2011)[4]**	**Falvo et al. (2012)[5]**	**Leiter et al. (2015)[6]**	**Harms et al. (2016)[7]**	**Schusterschitz et al. (2012)[8]**
1. SELECTION BIAS a. Individuals selected to participate are likely to be representative of a broader population?	Students who are employed **Low**	Newly hired employees **Low**	Employees within an organiza-tion who chose to take part **Medium**	Participant selected from "study response project" **Low**	Voluntary basis from given organiza-tion **Medium**	Voluntary basis from different hospital districts **Medium**	Voluntary basis from given organiza-tion **Medium**	Participant selected from those attending a course **Medium**
b. Was there a sufficient number of participants to provide confidence in findings?	212 **Medium**	320 **Medium**	406 **Medium**	146 **Low/Med**	161 **Low/Med**	1781 **High**	152 **Low/Med**	132 **Low/Med**
c. Was the response rate equal or greater to 52.7%?	"Nearly 100%" **High**	100% (96% due to missing data) **High**	67% **Medium**	Not listed **Low**	40.25% (postal) **Medium**	Not listed **Low**	86.4% **High**	Not listed **Low**
AVERAGE RATING	MEDIUM	MEDIUM	MEDIUM	LOW	MEDIUM	MEDIUM	MEDIUM	MEDIUM

2. STUDY DESIGN a. Was an appropriate method used to answer the research questions?	Yes **Medium**	Yes **Medium**	Yes **Medium**	Yes **Medium**	Yes **Medium**	Yes **Medium**	Yes **Medium**	Yes **Medium**
b. Were the study aims and objectives clearly stated?	Yes **High**	Yes **High**	Yes **High**	Yes **High**	Yes **High**	Yes **High**	Yes **Medium**	Yes **High**
c. Were participants aware of the research question?	Unclear **Low**	Unclear **Low**	Unclear **Low**	Unclear **Low**	Unclear **Low**	Unclear **Low**	Unclear **Low**	Unclear **Low**
AVERAGE RATING	MEDIUM	MEDIUM	MEDIUM	MEDIUM	MEDIUM	MEDIUM	MEDIUM	MEDIUM
3. MEASUREMENT BIAS a. Was the attachment measure valid?	Yes **High**	Yes **High**	Yes **High**	Yes **High**	Yes **High**	Yes **High**	Yes **Medium**	Yes **Medium**
a. Was the OCB/CWB measure valid?	Yes **High**	Yes **Medium**	Yes **Low**	Yes **Medium**	Yes **Low**	Yes **Low**	Yes **Low**	Yes **Medium**
b. Was the attachment	Yes (α =	Yes (α =	Yes (α =	Yes (α =	Yes (α =	Yes (α =	Yes (α =	Yes (α =

	measure reliable?	>0.7)	>0.7)	>0.7)	>0.7)	>0.7)	>0.7)	>0.7)	>0.7)
		High	**High**	**High**	**High**	**High**	**High**	**High**	**High**
c.	Was the OCB/CWB measure reliable?	Yes (α = >0.7)	Yes – Peer rating used	Yes (α = >0.7)	Yes (α = >0.7)	Yes (α = >0.7)	Yes (α = >0.7)	Yes (α = >0.7)	Yes (α = >0.7 for 3 of 5 subscales)
		High	**Medium**	**High**	**High**	**High**	**High**	**High**	**Medium**
d.	Were the measures completed in a standardised manner?	Yes – given at the start of class	Yes – different time points	No – location and time scales unknown	Unclear	No – received measures at home	No – online or paper versions	Unclear	No – could complete over three days
		High	**Medium**	**Low**	**Low**	**Low**	**Low**	**Low**	**Low**
e.	Was data collection from a single source?	Yes	No - peer assess and assess themselves	No self report and supervisor	No – supervisor	Yes	Yes	No – supervisor	Yes
		Medium	**High**	**High**	**Medium**	**Medium**	**Medium**	**Medium**	**Medium**
	AVERAGE RATING	HIGH	HIGH	MEDIUM	MEDIUM	MEDIUM	MEDIUM	MEDIUM	MEDIUM

4. ATTRITION BIAS	Unclear	List-wise	Unclear	Pair-wise	Unclear	Unclear	Unclear	Unclear
a. Were missing data dealt with appropriately?	**Low**	**Medium**	**Low**	**Medium**	**Low**	**Low**	**Low**	**Low**
b. Were participants who withdrew comparable to those who completed the study?	Unclear **Low**	Unclear **Low**	Unclear **Low**	Unclear **Low**	Unclear **Low**	Unclear **Low**	Unclear **Low**	Unclear **Low**
AVERAGE RATING	LOW	MEDIUM	LOW	MEDIUM	LOW	LOW	LOW	LOW
5. ANALYSIS a. Were the appropriate analysis conducted?	Yes – multiple regression **High**	Yes – regression **High**	Yes – regression **High**	Yes – regression **High**	Yes – regression **High**	Yes – correlation **High**	Yes – regression **High**	Yes – regression analysis **High**
b. Did authors control for age of participants?	Yes **High**	No **Low**	Yes **High**	Yes **High**	No **Low**	No **Low**	Yes **High**	No **Low**
c. Did authors control for length of time participants had	Partially – seniority	No	No	No	No	No	Partially – tenure	No

been in the organisation?	**Medium**	**Low**	**Low**	**Low**	**Low**	**Low**	**Medium**	**Low**
AVERAGE RATING	HIGH	MEDIUM	MEDIUM	MEDIUM	MEDIUM	MEDIUM	HIGH	MEDIUM
OVERALL RATING	**HIGH/MED**	**MEDIUM**	**MEDIUM**	**MEDIUM**	**MEDIUM**	**MEDIUM**	**MEDIUM**	**MEDIUM**

Appendix F – Reliability and Validity of the measures used in the studies

Study	OCB/CWB tool used	Reliability	Validity	Altered Y/N	Details of Alterations
Syna Desivilya et al. (2006) [1]	Stated the use of the Niehoff and Moorman (1993) tool, who in turn had used the Organizational Citizenship Behaviour Scale (Podsakoff et al., 1990). This is a 5 dimensional scale measuring altruism, courtesy, civic virtue, sportsmanship, conscientiousness.	The original tool was found to have good levels of reliability with Cronbach's alpha of >.7 for all of the dimensions (Podsakoff et al., 1990; Moorman, 1991).	Confirmatory factor analysis showed evidence for a five-factor model, with a Tucker-Lewis fit index of .94 (Podsakoff et al., 1990).	Y	Original measure was designed to measure supervisor ratings, adapted for self report. Although the overall reliability of this adapted measure was α = .78, the reliability of the other dimensions were somewhat lower (altruism α = .77, courtesy α = .43, sportsmanship α = .65, conscientiousness α = .51 and civic virtue α = .73)
Geller & Bamberger (2009) [2]	Bowler & Brass (2006) – measure of instrumental co-	The method of peer rating has been deemed a highly reliable method of measuring		Y	Asked only immediate co-workers rather than all employees in the

	worker helping (peer rating method).	interpersonal reactions (Geller & Bamberger, 2009).			organisation.
Little et al. (2011) [3]	Williams and Anderson's (1991) OCB-I and OCB-O measure.	Good levels of reliability α = .82	As outlined previously for the Harms et al (2016) study.	N	
	Hollinger and Clark (1982) production deviance measure	Good levels of reliability α = .79	Authors have highlighted that this scale was specifically designed to assess occupations in retail, hospitals and manufacturing environments (Bennett & Robinson, 2000). This suggests that the external validity outside of these occupations would be limited. However, the measure would appear appropriate for the occupation assessed in this study.	N	

			The measure has further been criticised for failing to address interpersonal deviant behaviours (Robinson & Bennett, 1995).		
Richards & Schat (2011) [4]	Organizational Citizenship Behaviour Scale (Podsakoff et al., 1990)	The original tool was found to have good levels of reliability with Cronbach's alpha of >.7 for all of the dimensions (Podsakoff et al., 1990; Moorman, 1991).	Researchers have suggested this scale has reasonable construct validity but limited discriminant validity (Mahembe et al., 2015).	Y	Used supervisor ratings, unlike Syna Desivilya et al. (2006) who altered this aspect of the measure. However, only used 15 of the 24 items. Selected these based on factors loadings as indicated by Podsakoff et al., (1990). The authors also divided the 5 dimensions to form OCB-I and OCB-O aspects.
	Bennet and Robinson's (2000) measure. This is a 12	The original tool was deemed to have high levels of validity, organizational deviance = α	Factor analysis has confirmed a two factor model has an acceptable	Y	As with the measure of OCB the authors only used 10 items to measure

	item measure for organizational deviance and a separate 7 item measure for interpersonal deviance.	.81 and α.78 for interpersonal deviance.	fit and that the measure has good construct and discriminate validity (Bennett & Robinson, 2000).		CWB-O and CWB-I out of the possible 19 in total. Again, the rational for choosing the items was based on the highest factor loadings.
Falvo et al. (2012) [5]	The two factor measure designed to measure Altruism and generalised compliance (Smith, 1983).	Altruism, α = .91, generalised compliance α = .81. These reliabilities have also been replicated by Organ and Konovsky (1989), α = .89 and α = .91 respectively.	A factor pattern correlation of 43 was evidenced; which suggests the two concepts may not be distinct (Smith et al., 1983).	Y	The original scale was designed to be answered by supervisors. Falvo et al. (2012) reworded the questions in order for the measure to be self report.
Leiter et al. (2015) [6]	The 8 item CREW civilty scale (Osatuke et al., 2009) was used to measure OCB	α = .89	There is some evidence for the validity of the CREW intervention (Leiter, Day, Oore, & Laschinger, 2012). However, there is a lack of evidence of the validity	N	

			for the scale itself.	
	Incivility was measured with the Straightforward Incivility Scale (Leiter & Day, 2013).	Supervisor incivility α = .82, co-worker incivility α = .94, individual instigated incivility α = .90.	Research has confirmed that the three factor structure has the best fit (Portoghese, Galletta, Leiter, & Campagna, 2015); suggesting construct validity.	N
Harms et al. (2016) [7]	Williams and Anderson (1991) OCB-I Scale	α = .81	Critics have suggested that this scale includes items which reflect workplace deviance, rather than OCB (Lee & Allen, 2002), suggesting lower levels of construct validity. This has led other researchers to suggest that a four factor model is more appropriate (Blaich et al., 2008).	N

Schustersc hitz et al. (2014) [8]	A German speaking OCB questionnaire (Staufenbiel & Hartz, 2000).	Cronbach's alpha's are provided below: civic virtue (α =.72), sportsmanship (α =.69), altruism (α =.70), conscientiousness (α =.54), loyalty (α =.61).	A five factor model has been confirmed within the current research.	N

Study	Attachment tool used	Reliability of the tool	Validity	Altered Y/N	Details of Alterations
Syna Desivilya et al. (2006) [1]	Experiences in Close Relationships (Brennan et al, 1998).	α = .81 for avoidance and α = .88 for anxiety.	Good levels of validity have been found; a two dimensional structure has been confirmed (Brenan et al, 1998; Mikulincer & Florian, 2000) as well as construct and discrimante validity (Shaver & Mikulincer, 2004).	Y	Hebrew version used (Mikulincer & Florian, 2000).
Geller & Bamberger (2009) [2]	Experiences in Close Relationships (ECR; Brennan et al, 1998).	α = .85 for avoidance and .86 for anxiety.	Construct (Mikulincer & Shaver, 2007a) and discriminate validity (Brennan et al., 1998, Bartholomew & Horowitz, 1991) have been demonstrated.	Y	Hebrew version used (Mikulincer & Florian, 2000).
Little et al. (2011) [3]	Self Reliance Inventory (SRI; Joplin et al., 1999)	Secure attachment, α = .82, counter-dependence, α = .79 and overdependence, α = .81.	The scale has been found to have acceptable validated; demonstrating three factors (secure, counter dependent and over dependent; Frazier et al., 2007).	Y	Modified to represent an individual's attachment style in the workplace (Frazier et al., 2007).
Richards & Schat	Experience in Relationships		Factor analysis has confirmed the two factor model. Research has	Y	Replaced the references to romantic partners in Brennan et al's (1998)

(2011) [4]	Scale (ERS)		also been provided for external validity (Jan Conradi et al., 2006).		original scale to say "other people" or "others".
Falvo et al. (2012) [5]	Mixture of tools used. 16 item scale based on what Mikuliner et al. 1990 used, this was originally adapted from Hazan and Shaver's (1987) scale. The Italian version (Fossati et al., 2003 of the Attachment Style Questionnaire (Feeney, Noller, & Hanraham,	α = .61 for anxious style, α = .72 for avoidant and α = .78 for secure. Test-retest reliabilities = 0.65 – 0.84, for the ASQ (Axfors, Sylven, Skalkidou, & Ramklint, 2017).	Validity of the Hazen and Shaver (1987) scale has been indicated by cluster analysis (Feeney, Noller, & Hanrahan, 1994).	Y	For the 16 item tool Falvo et al. (2012) excluded items referring to romantic relationships and replaced them with the work "others". Participants were also advised that researchers were interested in their social relationships in general. Selected items were also taken from the Attachment Style Questionnaire (Feeney, Noller, & Hanraham, 1994).

	1994) was also used to assess the "secure" styles.			
Leiter et al. (2015) [6]	Short Work Attachment Measure (SWAM; Leiter et al., 2013)	α = .78 Anxiety α = .78 Avoidance	Factor analysis has confirmed a two factor model (anxiety & avoidance) which were weakly correlated *r* = .02 (Leiter et al., 2015).	N
Harms et al. (2016) [7]	Bartholomew and Horowitz's (1991) self-report relationship questionnaire (RQ).		Construct validity has been demonstrated within Swedish research samples (Bäackström & Holmes, 2001).	N
Schustersc hitz et al., 2014 [8]	Scales to measure two dimensions of attachment insecurity	α = .86 for avoidance and α = .91 for anxiety.	Other authors have confirmed the two dimensional approach of measuring attachment (Brennan et al., 1998; Geller & Bamberger, 2009)	N

(Grau, 1999)

Appendix G – ECR-R items

1. I'm afraid that I will lose my partner's love.

2. I often worry that my partner will not want to stay with me.

3. I often worry that my partner doesn't really love me.

4. I worry that romantic partners won't care about me as much as I care about them.

5. I often wish that my partner's feelings for me were as strong as my feelings for him or her.

6. I worry a lot about my relationships.

7. When my partner is out of sight, I worry that he or she might become interested in someone else.

8. When I show my feelings for romantic partners, I'm afraid they will not feel the same about me.

9. I rarely worry about my partner leaving me.

10. My romantic partner makes me doubt myself.

11. I do not often worry about being abandoned.

12. I find that my partner(s) don't want to get as close as I would like.

13. Sometimes romantic partners change their feelings about me for no apparent reason.

14. My desire to be very close sometimes scares people away.

15. I'm afraid that once a romantic partner gets to know me, he or she won't like who I really am.

16. It makes me mad that I don't get the affection and support I need from my partner.

17. I worry that I won't measure up to other people.

18. My partner only seems to notice me when I'm angry.

19. I prefer not to show a partner how I feel deep down.

20. I feel comfortable sharing my private thoughts and feelings with my partner.

21. I find it difficult to allow myself to depend on romantic partners.

22. I am very comfortable being close to romantic partners.

23. I don't feel comfortable opening up to romantic partners.

24. I prefer not to be too close to romantic partners.

25. I get uncomfortable when a romantic partner wants to be very close.

26. I find it relatively easy to get close to my partner.

27. It's not difficult for me to get close to my partner.

28. I usually discuss my problems and concerns with my partner.

29. It helps to turn to my romantic partner in times of need.

30. I tell my partner just about everything.

31. I talk things over with my partner.

32. I am nervous when partners get too close to me.

33. I feel comfortable depending on romantic partners.

34. I find it easy to depend on romantic partners.

35. It's easy for me to be affectionate with my partner.

36. My partner really understands me and my needs.

Appendix H – Boundary vignettes used in Chapter 4 & 5

Male/Verbal/Serious

Mohammed is a 30 year old healthcare worker; he works in a secure psychiatric ward. He is working a night shift and a patient asks for a 1:1. During this 1:1 the patient asks about another patient's index offence. Mohammed tells this patient all about the other patient's offending history.

Female/Physical/less serious

Joanne is a 30 year old healthcare worker; she works in a secure psychiatric female ward. She develops a good therapeutic relationship with all of the patients on her ward. One day at work a patient returns from unescorted community leave and Joanne completed the pat down search. She does not wait for the second observatory member of staff to be present.

Female/Verbal/Serious

Vivian is a 30 year old healthcare worker; she works in a secure psychiatric ward. She has been experiencing problems within her marriage. During a 1:1 with a patient Vivian is asked if she is married. Vivian tells the patient that she is and proceeds to go into great detail about the problems she is experiencing within her marriage. She thanks the patient for their time and tells them that they listen to her more than her own friends.

Male/less Serious/Physical

John is a 30 year old healthcare worker; he works in a secure psychiatric ward. John is requested to go to another ward in order to pick up some medication. Whilst on this ward John sees Patient X who he used to work with and has not

seen in a long time. John embraces Patient X in a hug in front of other staff and patients.

Female/Verbal/less serious

Jessica is a 30 year old healthcare worker; she works in a secure psychiatric ward. Jessica is playing pool and chatting with several patients in the ward day area. One patient asks Jessica if she is going anywhere on holiday this year. Jessica proceeds to give this information in front of several patients in specific detail.

Female/Serious/Physical

Amy is a 30 year old healthcare worker; she works in a secure psychiatric ward. Recently Amy has started to hug patients on a regular basis. She has also been seen walking out of a patient's room on several occasions.

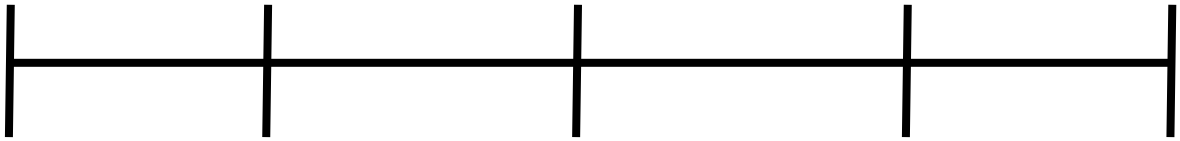
Male/Serious/Physical

Jake is a 30 year old healthcare worker; he works in a secure psychiatric ward. Jake has a built a good relationship with several patients on his ward. Recently he has been bringing in contraband items for the patient including tobacco and lighters.

Male/Verbal/less serious

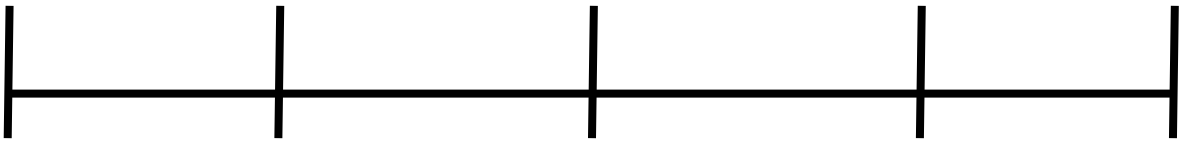
Henry is a 30 year old healthcare worker; he works in a secure psychiatric ward. He has known patient X for several years. When addressing patient X Henry uses a nickname. Patient X does the same to Henry, which he does not challenge.

Q1. How acceptable do you find this behaviour?



Completely Unacceptable | Somewhat Unacceptable | Neutral | Somewhat Acceptable | Completely Acceptable

Q2. How serious do you find this behaviour?



Extremely Serious | Very Serious | Neutral | Somewhat Serious | Not serious at all

Q3. Has this or similar behaviour happened in your work place?

- Yes
- No