Exploring Boundary Violations between Staff and Clients in Healthcare and Forensic Settings.

By

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Declaration

I am a student of the Forensic Psychology Doctorate and I have prepared this project. This project is my original work completed under the supervision of Dr Kate Whitfield and Dr Simon Duff. This project contains no material that has been accepted for the award of any other degree in any University. To the best of my knowledge and belief, this project contains no material previously published or written by any other person, except where due reference is given in the text.

Thesis Abstract

Thesis Aim: Boundary violations are committed when a professional crosses the emotional, physical, spiritual or sexual limits of another, thus disrupting the relationship between staff and clients. This thesis explores this issue in the context of healthcare and forensic settings. It identifies boundary violation risk and protective factors for staff working with forensic healthcare patients. The thesis also investigates reasons why staff under-report and may not whistleblow their concerns in these areas.

Methods: A mixed method approach was used to explore multiple elements of this topic. A systematic review was used to identify risk factors associated with staff committing boundary violations in healthcare and forensic settings. This was then expanded, through a regression, to specifically look at risk and protective factors in the forensic healthcare settings. A thematic analysis was carried out to explore staff's perceptions of whistleblowing and boundary violating behaviours. A case study and several psychometrics (including the Exploitation Index) were also used to investigate this topic in more depth and assess the impact that boundary violating can have on the patients involved.

Findings: The setting and environment were shown, through the systematic review, to be key when exploring this topic, as they not only impact on the definition of boundary violating along with what factors protect or put staff at risk of boundary violating. The regression identified risk factors, including staff feeling they had no one to turn to and working alone with patients. There were also factors which protected staff from committing boundary violations, such as having good social support and receiving training about boundaries. The thematic analysis found that people did not raise concerns of colleagues' boundary violating due to concerns about anonymity, feeling that nothing would be done, and feeling that personally intervening (not management) would be a more effective method.

Conclusions: It is of great importance to explore this topic and develop a greater understanding of boundary violations, as the impact of and harm caused by this behaviour are wide ranging. This thesis can aid the identification of professionals at risk, and create strategies to prevent or manage this destructive behaviour. These findings can also help

create a more open and honest arena for concerns about boundaries to be raised and managed.

Preface: Overview of the thesis

This thesis aims to explore the issue of boundary violating behaviours between staff and patients in both healthcare and forensic settings. There are numerous definitions of boundary violations. For the purposes of this thesis the following definitions were used; a boundary violation occurs "when the transgression is clearly harmful to or exploitative of the patient" (Gutheil & Gabbard, 1998, p. 410) and a boundary violation is committed when "someone knowingly or unknowingly crosses the emotional, physical, spiritual or sexual limits of another for their personal gain" (Katherine, 1993). It is hoped that this research will highlight the detrimental impact that boundary violating behaviours have, as well as the importance of addressing this issue. Although there has been some research into specific areas of boundary violating behaviour, there are major features that are under-researched and poorly understood.

Chapter 1 provides an overview of this area and associated definitions. Chapter 2, in the form of a systematic review, explores and evaluates previous research into boundary violating risk factors for staff in both healthcare and forensic settings. The review concluded that the environment plays a major role in determining the relevance of associated factors and that further research is required. The aim of Chapter 3 was to address this issue of further research required into risk factors and expanding it to also look at protective factors. In addition, Chapter 3 investigated staff's views of boundary violating and whistleblowing in order to inform effective boundary violation management. In order to highlight the importance of addressing this issue, the impact of boundary violating on patients was explored in the case study in Chapter 4. This case study worked through the assessment, formulation and treatment of Mr U, a patient who had engaged in several illicit relationships with staff members.

Chapter 3 identified several management strategies to address the issue of boundary violating. This was continued in Chapter 5 by exploring an additional method; the Exploitation Index. This psychometric was created as a warning and deterrent system, and it aims to increase physicians' awareness of risk related behaviours associated with boundary violating to deter them from engaging in such behaviour. Chapter 5 outlines and critiques

this psychometric. Chapter 6 draws together the entire thesis, discussing the conclusions and implications of the research.

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Chapter 1:

Introduction

Chapter 1: Introduction

This chapter gives a broad introduction to this thesis and the topic of boundary violation. It begins by exploring the expansive topic of corruption and then, focuses on the more specific topic of boundary violating as a form of corruption. There are still major issues with boundary violating in forensic and healthcare settings. The impact of these causes harm to both patients and staff alike. This chapter recognises this and acknowledges that current methods of managing this issue need improvement. The thesis aims to increase people's understanding of the topic, as well as develop practical and effective strategies to manage this issue within these settings.

Corruption and environment

Corruption is defined as the dishonest or fraudulent conduct through the abuse of authority for material gain (Pearsall & Hanks, 1998; Frimpong & Jacques, 1999). Nye (2002) describes the effect of corruption as diverting people from their normal duties for personal gain. There are numerous forms of corruption including bribery, kleptocracy, misappropriation, manipulation, influence peddling, malpractice and abuse of power (Johnson, 2004). Corruption is a worldwide issue that has been described as being "one of the greatest challenges that society faces" (Johnson, 2004 p. 1). It exists in many forms including financial, political, systemic or for individual enrichment (Mauro, 1998). Corruption is a broad topic that concerns and impacts upon every profession working in every environment and field of work (Kurpad, Machado, Galgali, & Daniel, 2012; Robbins, 2000; Heyneman, 2004).

The type of corruption seen in these environments varies and is often influenced by the environment itself, due to the acceptability to certain powers or different potentials to influence. One form of corruption is boundary violating, which is prevalent in forensic, healthcare and forensic healthcare environments due to the type of work engaged in within these settings (Kurpad, et al, 2012).

Boundaries

A boundary violation is committed when someone knowingly or unknowingly crosses the emotional, physical, spiritual or sexual limits of another for their personal gain (Katherine, 1993). Gutheil and Gabbard (1998) stated that a boundary violation occurs "when the transgression is clearly harmful to or exploitative of the patient" (p. 410). These differ from boundary crossings which are defined as deviation in behaviour from accepted normal clinical practice, but in some instances may be seen as supporting the therapeutic process e.g. being responsive to clients' needs by moving the time of an appointment (Simon & Williams, 1999; Gutheil & Gabbard, 1993). The resulting boundary crossing can be seen as supporting the therapeutic process, such as empathy and transference (Gutheil & Gabbard, 1998). The result of a boundary violation is a blurring or disruption of the professional distance between staff and clients (Marquart, Barnill & Balshaw-Biddle, 2001). In healthcare therapeutic settings, a boundary violation has been described as any behaviour that infringes upon the primary goals of providing care for the client, developing their well-being and maintaining their safety and security (Epstein, 1994; Gutheil & Gabbard, 1998).

All major professional bodies have similar rules prohibiting the abuse of the staff/client relationship to gratify a staff member's own emotional, financial and sexual needs (British Psychological Society, 2009; General Medical Council, 2013; Canadian Psychiatric Association, 2002; American Nurses Association, 2001; Miles, 2005). Boundary violations present in a number of ways with motivators including greed, enabling, power seeking and sexual gratification (Epstein & Simon, 1990). There are numerous boundary violating behaviours, including overshare of staff members' personal information, sexual activity, trafficking and breaking confidentiality (Allen & Bosta, 1981). Studies exploring this topic consistently report that between 1.6% and 10% of staff populations engage in boundary violating behaviour (Swiggart & Starr, 2002; Pope, Tabachnick, & Keith-Spiegel, 1987; Pope, Levenson, & Schover, 1979). However, two of these studies are 29 years old or more and there have been numerous changes that have occurred in training, approaches and procedures during this time which may impact on the relevance of these studies to today's working environment. In addition all of these studies are based in the USA which has a

different healthcare system and processes so questions have to be raised again about its relevance to British organisations.

Relationships and Boundaries

A possible reason why boundary violating behaviour is so prevalent in these environments may be due to the important role that the staff/client relationship plays in this type of work (Sarkar, 2004). Extensive research has shown the importance of this relationship in maintaining security, compliance and the positive outcome of therapeutic treatment (Kurpad, et. al, 2012; Horvath, 2000; Thompson, 2003). Due to the large ratio of staff to prisoners, effective relationships and personal security are pivotal in the effective running of prisons. Marziali and Alexander (1991) found that clients' rating of the therapeutic-relationship was a reliable predictor of therapy outcome. This study only explored the therapeutic relationships within psychotherapy and thus, generalising these findings to other occupations and environments has to be questioned. Also, the study is 25 years old and reviewed research from as far back as 1980, so the findings may not be relevant to today's therapeutic settings and alliances.

Research has shown that good therapeutic alliances based on trust, openness and common goals are effective in improving outcomes in a wide range of different settings and treatment needs (Horvath, 2000; Krupnick, et. al, 1996; Horvath & Luborsky, 1993; Shapiro, 1995; Gelso & Carter, 1985, 1994). It is possible that the emphasis on having good therapeutic alliances is potentially why, in some instances, boundaries are crossed and that, in exceptional cases, professionals working in these environments violate boundaries. This thesis will explore research into therapeutic alliances and boundary violating to examine the balance between the two, and consider why individuals might cross the therapeutic line into boundary violation.

Initiators and impacts of boundary violating

Although forensic and healthcare settings have similarly negative connotations regarding boundary violating behaviour, there are some differences in their interpretation of this topic and its management. Research in the healthcare setting primarily identifies the staff member as the initiator of the boundary violation, whereas in the forensic setting this role is more commonly attributed to the offender (Sarkar, 2004; Marquart et. al, 2001; Worley, Marquart & Mullings, 2003). Boundary violations in forensic settings are more frequently attributed to prisoners 'conditioning' staff to break rules and boundaries (Arnold, 2008; Liebling & Price, 2003; Liebling, Price, & Shefer, 2010). However, whoever is attributed with trying to initiate the boundary violating behaviour, irrespective of setting, there is unanimous agreement that it is the responsibility of the staff member to maintain their boundaries and manage the situation appropriately (Kurpad, et. al, 2012).

It is well documented that engaging in boundary violating behaviour can have a significant impact on both the client and staff member regardless of whom initiates the behaviour (Sarkar, 2004; Luepker, 1999; Howells & Day, 2003). Pope and Vetter's (1991) findings suggest that 90% of patients who had engaged in a sexual relationship with their therapist had been harmed by the experience, with 14% subsequently attempting suicide. This study also found that only 17% of the affected clients reported full recovery from the trauma (Pope & Vetter, 1991). The harm caused by the experience varied, and included experiencing emotion regulation difficulties, increased sexual problems, lower self-esteem and also affected their inability to trust and engage in future treatment (Solursh, Solursh, & Williams, 1993; Pope & Tabachnick, 1994). However this study only looked at the impact on clients that sexual relationships with their psychologists had and did not explore the impact of other forms of boundary violating or the impact of relationships with other types of professionals. Pope and Tabachnick's (1994) study findings were based on responses to a questionnaire. There was a reasonable low return rate (59%) which may have led to a response bias, particularly when exploring a sensitive topic as this may have deterred some participants from responding. This may have impacted on the reliability of the findings being a true reflection of the target population.

The case history in Chapter 3 explores in more depth the impact that engaging in an illicit relationship has on the client. Professionals caught committing boundary violations often experience significant emotional distress, criminal prosecution and loss of job and registration (Sarkar, 2004; Miller & Maier, 2002). This type of behaviour persists despite professionals and employers being motivated to avoid these situations and their negative consequences.

The taboo of boundary violating

Boundary violating behaviour, particularly in forensic, healthcare and forensic healthcare environments, where maintaining safety and protecting clients is paramount, is often a very taboo subject (Folman, 1991; Bohm, Curtis & Willock, 2009). As a result of the associated punishment, shame and guilt, this topic is often not openly discussed amongst staff with many taking the attitude that it only happens to very deviant staff members (i.e. not them) (Celenza & Gabbard, 2007; Fronek, Kendall, Ungerer, Malt, Eugarde, & Geraghty, 2009; Pope, et. al, 2006; Sarkar, 2004). This stigma may also impact on an establishment being able to conduct research in this area (Kurpad, et. al, 2012). This results in limited research being undertaken or published in this field, particularly addressing risk and protective factors or the resistance to reporting boundary violations (Pope, et. al, 2006). The stigma also impacts on how boundary violating behaviour is managed at a grass roots level. Many organisations maintain a zero tolerance approach to this behaviour (Collins, 2011). These attitudes of non-discussion and zero tolerance have a significant impact on an establishment's management and training policy regarding boundary violation. One study found that 55% of staff had received 'no education' and 24% 'very little education' on maintaining boundaries (Pope, et. al, 2006). Another study found that the majority of people who committed boundary violations did not disclose this information to their supervisors, even at the early stages of concern about changes in feelings for clients (Pope, Keith-Spiegel, & Tabachnick, 2006).

Whilst it is understandable that organisations have a zero tolerance approach to boundary violating behaviour, as they cannot be seen to condone such harmful and potentially

criminal activities, research has shown that sexual attraction towards clients is far from uncommon with 87% of psychotherapists being attracted to a client at some point in their career (Pope, et. al, 2006). However, if left unchecked, this can progress into problematic behaviour. Research has shown that boundary violations often take place in the context of the 'slippery slope' with staff initially committing minor boundary crossings or violations, then progressing onto more serious transgressions (Galletly, 2004; Strasburger, Jorgenson, & Sutherland, 1992). Consequently, this approach of punishment and stigma appears to deter individuals from coming forward at an earlier stage due to fear of retribution.

The 'slippery slope' theory stated that people cannot engaged in some behaviours without it inevitably leading to other more serious behaviours and that those who have engaged in boundary violating did so after previously engaging in a range of smaller less serious behaviours . Whilst this potentially is the case it is important when using this argument to be mindful of the methodological limitations that are often present in the supporting studies. These limitations are mainly due to the fact that the studies which explored this effect tend to be retrospective. They select individuals who have committed boundary violations and then look back at the process and factors associated with this behaviour (Lode, 1999). They also tend not to have control groups and thus it is possible that numerous individuals engage in these 'slippery slope'/boundary crossing behaviours without ever progressing to boundary violating behaviours (Enoch, 2001). Although these studies do add valuable information about boundary violations, they are also biased as they do not assess these individuals who may have engaged in the same behaviours and share the same risk factors but do not engage in the end behaviour of boundary violating or at least do not get caught. Also this theory relies on interpretations of social reality and participants may have recall bias or hold different views on social reality when reflecting back on how they engaged in boundary violating. They may incorrectly attribute causality (Van der Burg, 1991) so incorrect conclusions may be drawn.

Strong punishment is not working

This approach of strongly condemning and punishing members of staff for committing boundary violations, although understandable, appears not to be working with studies reporting a consistent prevalence of boundary violating across environments (Swiggart &

Starr, 2002; Miller & Maier, 2002). The American Psychiatric Association expels on average 10 psychiatrists for sexual misconduct every year (Sarkar, 2004; Dehlendorf & Wolfe, 1998). Dehlendorf and Wolfe (1998) found that disciplinary orders against American psychiatric staff committing sex-related offences towards clients had increased from 42 in 1989 to 147 in 1996. There appears to be a similar picture in the UK, with the General Social Care Council revealing that 40% of their conduct cases involved allegations of 'inappropriate relations' (Doel, et. al, 2010). Due to the associated stigma it is not unreasonable to believe that these numbers may be very conservative, as all these studies either rely on self-reporting or data from cases that have been prosecuted; neither method is likely to provide a true reflection of what is actually happening. Although it is unrealistic to believe that boundary violating behaviour can be totally eradicated, it is evident that more information is needed and different approaches required to address this issue and decrease its impact on both staff and patients.

Thesis Objectives

It is evident that corruption takes place in a wide range of environments and is committed by numerous professionals (Frimpong & Jacques, 1999; Pearsall & Hanks, 1998). Whilst all professionals need to be aware of corruption and professional boundaries, healthcare and forensic staff have an additional duty of care to protect their clients from the harmful impact that this behaviour can cause. This highlights the importance of exploring this issue in these under researched environments to identify current barriers and investigate ways in which it can be addressed. The systematic review of this thesis will explore current research in this area and the impact that setting has on the risk factors for boundary violation. The empirical research chapter of this thesis will also explore what factors specifically protect and put people, who work in the forensic healthcare settings, at risk of committing boundary violations. The study will also look at what deters individuals from seeking support or from whistleblowing boundary violating behaviour. This information will subsequently be used to identify different approaches that can be used to manage boundaries in a more effective and open manner, to avoid the detrimental impact (explored in case study, see Chapter 4) they have on the therapeutic relationship.

Previous research has shown that boundary violations are prevalent and mostly harmful for those involved. It also indicates that current methods of management are not working and the large amount of fear and guilt associated with this behaviour interferes with an individual's ability to raise concerns or whistle-blow. It is therefore critical that more research is conducted in the healthcare and forensic settings. One of the objectives of this thesis is to open the discussion of boundary violation in a non-confrontational manner, so the topic can be fully understood within these environments. It also aims to explore the balancing act that professionals undertake to develop an effective therapeutic alliance without putting themselves or others at risk of committing boundary violations. This thesis will explore new ways in which to manage this issue and develop this discussion further. A primary aim of professionals working in these settings is to care for and support colleagues and clients in their charge. This thesis aims to help professionals develop ways in which to avoid harm and manage boundaries in a practical and effective manner.

Summary of Chapter 1: Introduction

Before any issue is addressed the problem has to be clearly defined. This was challenging in the case of boundary violating as it varied greatly, thus Chapter 1 set about defining what a boundary violation is and what behaviours this included.

The definition of boundary violations varies across professional environments, which makes researching this topic challenging.

This is a under researched area, potently due to the stigma attached to the behaviour.

Previous research focused on the prevalence of boundary violating behaviours and the impact these behaviours can have on the people involved.

Boundary violating risk and protective factors is an under researched area which chapter 2 explores further.

Forward to Chapter Two

In order for this thesis to effectively contribute to this area, it is necessary to explore and evaluate what research has previously been conducted. As highlighted above, some areas of research have attracted a large amount of interest and exploration but others have gone under-researched, such as the risk factors associated with staff committing boundary violations. The systematic review in Chapter 1 explored previous research in this area and evaluated its quality. It also highlighted the risk factors that have been identified, as well as highlighting avenues for further research.

Chapter 2: A Systematic Review of risk factors which impact on staff vulnerability to boundary violations

Chapter 2: A Systematic Review of risk factors which impact on staff vulnerability to boundary violations

Introduction

The importance of professional boundaries

Clinical literature states that maintaining professional boundaries is the most important responsibility and competency required of professionals in forensic and health service settings (Schafer & Peternelj-Taylor, 2003; Williams, 1997). Maintaining professional boundaries benefits clients by creating a safe and secure environment within which they can share information, take potentially harmful medicines and work effectively towards achieving their goals (Gutheil & Gabbard, 1993; Subotsky, Bewley, & Crowe, 2010). Research has also shown that modelling social interactions with appropriate boundaries can be key in decreasing re-offending rates by aiding offenders' social skills development (McGuire, 1995). The benefit to staff of maintaining professional boundaries is that they protect themselves from potentially harmful situations, maintaining the integrity of their profession (Smith & Fitzpatrick, 1995; Schafer & Peternelj-Taylor, 2003; Gutheil, & Gabbard, 1998).

Definitions

Studies into the maintenance of professional boundaries are relevant in a wide variety of fields. As a result, the definition of a professional boundary is extremely varied. There are general definitions, such as Miller and Maier's (2002) which states a professional boundary is "the limits that circumscribe professional relationships" (p. 310). Boundaries are also seen as the limit of appropriate behaviour within the working environment (Gutheil & Gabbard, 1993). There are more specific boundary purposes and definitions that relate to individual fields. In the counselling and therapeutic profession, boundaries define the "helping pathway, for both patients and professionals" (Schafer, 1997, p. 203) and aid in creating a

secure and trusting working alliance (Simon, 1999). Healthcare staff define a boundary as "the point at which the relationship changes from professional and therapeutic to unprofessional and personal" (Canadian Psychiatric Association, 2002, p. 22). A professional boundary is defined as "establishing appropriate limits to relationships" and "separating what is therapeutic from what is not" (American Nurses Association, 2010 p. 151). This is very different from the forensic setting definition, which states that boundaries maintain the professional distance between the correctional staff and prisoners (Marquart, Barnill, & Balshaw-Biddle, 2001).

A definition of a professional relationship as "an association between two or more people, whether short or long term, that is based on the provision of services by the professional. Boundaries in professional relationships are based on providing service to the client/resident in a safe and appropriate manner, and are often defined by professional ethics codes" (Canadian Nurses' Association, 2008 p. 1). Healthcare professionals emphasise the importance of "maintaining of appropriate professional boundary and ensuring their relationships are always for the benefits of the persons they serve. They recognise the potential vulnerability of persons and do not exploit their trust and dependency in a way that might compromise the therapeutic relationship. They do not abuse their relationship for personal or financial gain, and do not enter into personal relationships (romantic, sexual or other) with persons in their care" (Canadian Nurses' Association, 2008, p. 13).

Boundaries are not always maintained: Boundary violations, their prevalence and implications

Despite the importance of maintaining professional boundaries, boundary violations are still common in many caring professions. Research has indicated the percentage of particular staff populations, in forensic and healthcare settings, committing boundary violations varies from 1.6% to 10% (Swiggart & Starr, 2002; Pope, Tabachnick, & Keith-Spiegel, 1987; Pope, Levenson, & Schover, 1979). The impact of boundary violating is extensive. It interferes with the primary purpose of treatment plus clients involved can suffer multiple emotional and psychological effects. The staff involved often lose their jobs and subsequently suffer

financial and relationship difficulties. Due to these impacts it is an area of great concern which is why conducting a review on this topic is so critical.

Research into boundary violations

Some aspects of boundary violations have been thoroughly researched with generally accepted conclusions drawn. These tend to be areas such as the impact boundary violations have on clients (Solursh, Solursh, & Williams, 1993; Disch & Avery, 2001), dual relationships (Kagle & Giebelhausen, 1994; Clipson, 2008), prevalence (Swiggart & Starr, 2002; Pope, Tabachnick, & Keith-Spiegel, 1987) and transference and counter-transference (Bonosky, 1995; Racker, 2012). Research into transference and countertransference is primarily conducted within counselling settings and acknowledges it can be a normal part of the therapeutic process which if managed appropriately can support the therapeutic aim (Racker, 2012). For more detail about the impact boundary violating can have on clients see Chapter 4. However, there are other areas where findings are less conclusive. For example, some studies have identified gender as a risk factor. However, others state that this is merely a reflection of the proportion of female clients who engaged in therapy with male professionals (Miller & Maier, 2002; Pope, Keith-Spiegel, & Tabachnick, 2006). Also, many of the studies focus only on risk factors associated with certain professions, such as counselling or psychotherapy, with other professions being very under-researched (Sarkar, 2004; Garfinkel, Bagby, Waring, & Dorian, 1997; Garfinkel, Dorian, Sadavoy, & Bagby, 1997). This raises concerns, due to research bias, of the generalisability of these findings. This has the potential of resulting in erroneous conclusions being drawn about risk factors for violating boundaries in different professions.

Current risk factor findings

Several studies highlight that boundary breakdowns tend to happen over a length of time due to a series of smaller boundary crossings and violations. This term “the slippery slope” has been coined for this process (Maule, 2007; Strom-Gottfried, 1999). There have been few

conclusive findings about why boundary violations happen, and why they happen to certain individuals when others can cross smaller boundaries but not continue down the "slippery slope" (Gutheil & Gabbard, 1993; Gutheil & Simon, 2002). However, there are critiques of the "slippery slope" theory which are laid out in chapter 1. Most of the research addressing risk factors either examined them as a minor aspect of a bigger topic, or only looked at the risk factors that impact niche sectors e.g. forensic workers (Faulkner & Regehr, 2011) or counsellors (Moleski & Kiselica, 2005). There is also a growing amount of research into factors that protect staff against committing boundary violations (see chapter 3 for more details).

A reason for the shortage of conclusive research on this topic, particularly in the forensic setting, is thought to be because the subject of boundary violations in the workplace is "painful", "taboo" and politically embarrassing for establishments (Celenza & Gabbard, 2003; Folman, 1991). This is partially due to the amount of press coverage and sensationalising these incidences can trigger. This ethos has potentially resulted in bias of data collection, analysis and presentation. Consequently, literature reviews and systematic reviews tend to only focus on less taboo topics, such as training and boundary crossing, and only investigate risk factors as a side issue. In recent years there has been a rise in research due to increased public concern over boundary violations and the implication for public protection. This has been in response to a number of high profile cases being reported in the newspapers and major safety breaches at secure establishments being attributed, in part, to boundary violating behaviours (Brooks, Gendel, Early, Gunderson, & Shore, 2012; Hundert & Appelbaum, 1995).

Despite the importance of identifying boundary violations, there are mixed research findings in the area of risk factors associated with such violations. Some studies cite personal characteristics as the main risk factor (Marquart, Barnhill, & Balshaw-Biddle, 2001; Daniels, 2008; Worley & Cheeseman, 2006; Garfinkel, Bagby, Waring, & Dorian, 1997) whilst others blame more environmental or organisational factors as the main cause of boundary violations (Epstein & Simon, 1992). Many of these studies focus on a few particular risk factors and do not explore all the possible risk factors that previous research studies had identified. This means that the findings do not provide an expansive view of this topic and

this could have led to research bias in the exported factors. There is much variation in research quality and its conclusions, with the majority of research being conducted in the healthcare setting, counselling setting or American prisons. This may be due to the application of different methods, the research setting or a wide range of risk factors that have not been systematically looked at together.

Objectives: Why it is important to perform this review?

It is evident that problems with boundary violations are commonplace despite the obvious importance of maintaining professional boundaries. There are no randomised control trials (RCT) that look specifically at risk factors that put professionals at risk of committing a boundary violation; primarily due to this not being a feasible study because of the ethical considerations of encouraging boundary violations to take place for research purposes. There are no other systematic reviews and the literature reviews explore the general topic of boundary violations and not risk factors across working environments. A systematic review in this area is critical, as it will evaluate the research and consolidate the findings across sectors and studies. From this consolidation it is hoped that reliable conclusions can be drawn regarding the risk factors involved in boundary violations. The review will also assess whether these risk factors vary between forensic and other healthcare professional settings. The identification of such factors would aid recruitment strategies, identifying professionals who would benefit from training or other types of intervention, in order to avoid initial or repeat boundary violations.

Method

Systematic Review: The criteria for considering studies for this review

Types of studies

Due to the limited research in this area the review was open to all designs; no study was excluded on the basis of research design. The factors being extracted are all qualitative (e.g. risk factors such as gender or profession type) however, these data will be collected from studies using both qualitative (e.g. thematic analysis) and quantitative methods (e.g. psychometrics).

Types of participants

The participants are individuals employed to work with offenders or patients in various roles. Staff worked in healthcare, counselling or forensic settings. Staff who have either committed boundary violations or who have had their maintenance of professional boundaries evaluated in a study were included.

Types of Exposure

Exposure will be those factors that put staff at risk of committing a boundary violation. Staff members who commit boundary violations will be compared with staff members who have not. The differences between the two groups (i.e. age, job role, length of time in the service etc.) will be evaluated in order that boundary violation risk factors may be identified. If there is no control group of individuals who have not committed boundary violations, then only the factors which studies highlight as putting individuals at risk of boundary violation will be collated.

Types of outcome measures

The primary outcome measure is the presence or absence of a boundary violation. It should be noted that the definition of a boundary violation varies from study to study. However, for the purposes of this review, the definition of a boundary violation is committed when a professional knowingly crosses the emotional, physical, spiritual or sexual limits of another for their personal gain (Katherine, 1993). This includes any behaviour that the staff member uses to gratify their own emotional, financial and sexual needs (Canadian Nurses' Association, 2008). This definition was selected as it is a commonly used definition and incorporates behaviours that are most harmful for clients. Also, this definition includes incidences of manipulation where staff have committed a boundary violation but potentially with the client's consent e.g. a staff member bringing in a substance for a client.

Search methods for identification of studies

Electronic Searches

The following databases were searched without language restrictions.

- Cochrane Central Register
- MEDLINE (OVID)
- PubMed
- PSYCHinfo

These databases were selected as they enabled access to a large volume of research papers and specialised in research within related environments, such as healthcare.

The search terms used covered each section of the objective questions being asked. Each section of the question was broken down and then similar words for that term were explored e.g. prison, jail, correctional and forensic. A more detailed search strategy can be found in Appendix A and an example is shown below.

(Prison* or Jail* or Correctional or Forensic) OR (NHS or 'National Health Service' or Healthcare) OR (Therapist* or Psychotherap*) OR (counselling or counseling) OR (counsellor or counselor) OR (Nurse* or Doctor* or Officer*)

AND

(Boundary Violation* or professional misconduct or sexual relation* or Inappropriate relation*) OR "Maintaining professional boundaries".

These terms were then combined and searched enabling all the various combinations to be examined.

These search terms were searched for in abstracts, keywords and titles of papers.

Searching other resources

The reference list of key included studies was also screened. The search was not restricted to published research; unpublished works in the form of student research theses were not excluded.

Searches were also conducted through the Journal of Counselling and Development from 2003 to October 2013 and the British Medical Journal from 2006 to the 6th of July 2013 to find related articles. These are two key journals in their respective fields and cover a wide range of topics, including professional conduct. These dates were chosen as the complete records of the BMJ articles were able to be obtained from this date, thus, there would be no concerns around missing relevant articles in this time period. Searches were also conducted on three thesis databases in order to explore some unpublished work including Dissertations Space library, Saskatchewan Electronic Theses and British Library EThOS. These databases were selected as they possess access to a large number of theses. Also, they were not all Europe based facilitating a wider and more comprehensive exploration of this topic.

Data collection and analysis

Selection of studies

Three thousand and eighty one articles were identified using these search methods. The study titles and abstracts were screened to exclude irrelevant or duplicated studies (see Appendix B and Figure 1). For the 97 remaining studies, the author read the full paper to ensure that they met all the inclusion criteria. 15% of the total searched (title and abstract) and the full texts were also read by a second assessor working independently to check reliability in the inclusion process. This method was chosen because several studies have shown that using it and a second scorer increased the reliability of data extraction (Buscemi, Hartling, Vandermeer, Tjosvold, Klassen, 2006; Edwards, Clarke, DiGuiseppi, Pratap, Roberts, & Wentz, 2002). The second assessor was a Psychological Assistant who had good research experience and skills. They had undergone prison service training on boundaries and boundary violating. All disagreements were resolved by consensus. Good inter-rater reliability with substantial agreement between the two assessors was found using Cohan's Kappa in both paper sifts. Cohan's Kappa is a measure of agreement between two scorers and takes into account the amount of agreement which would be expected by chance (Field, 2009). The first co-scored sift (title and abstract) obtained a Cohan's Kappa score of $\kappa = 0.686$.

Research papers were excluded due to the fact that they did not meet the criteria outlined in appendix B. The main reasons for papers being excluded were due to the them exploring other elements beyond risk or protective factors; they were examining healthcare area boundaries (geographical) not boundary violations, looking at risk or protective factors for patients committing boundary violations or looking at other forms of corruption in organisations. Thus 10 studies were included in the systematic review as they met the 'inclusion and exclusion' criteria (see Figure 1).

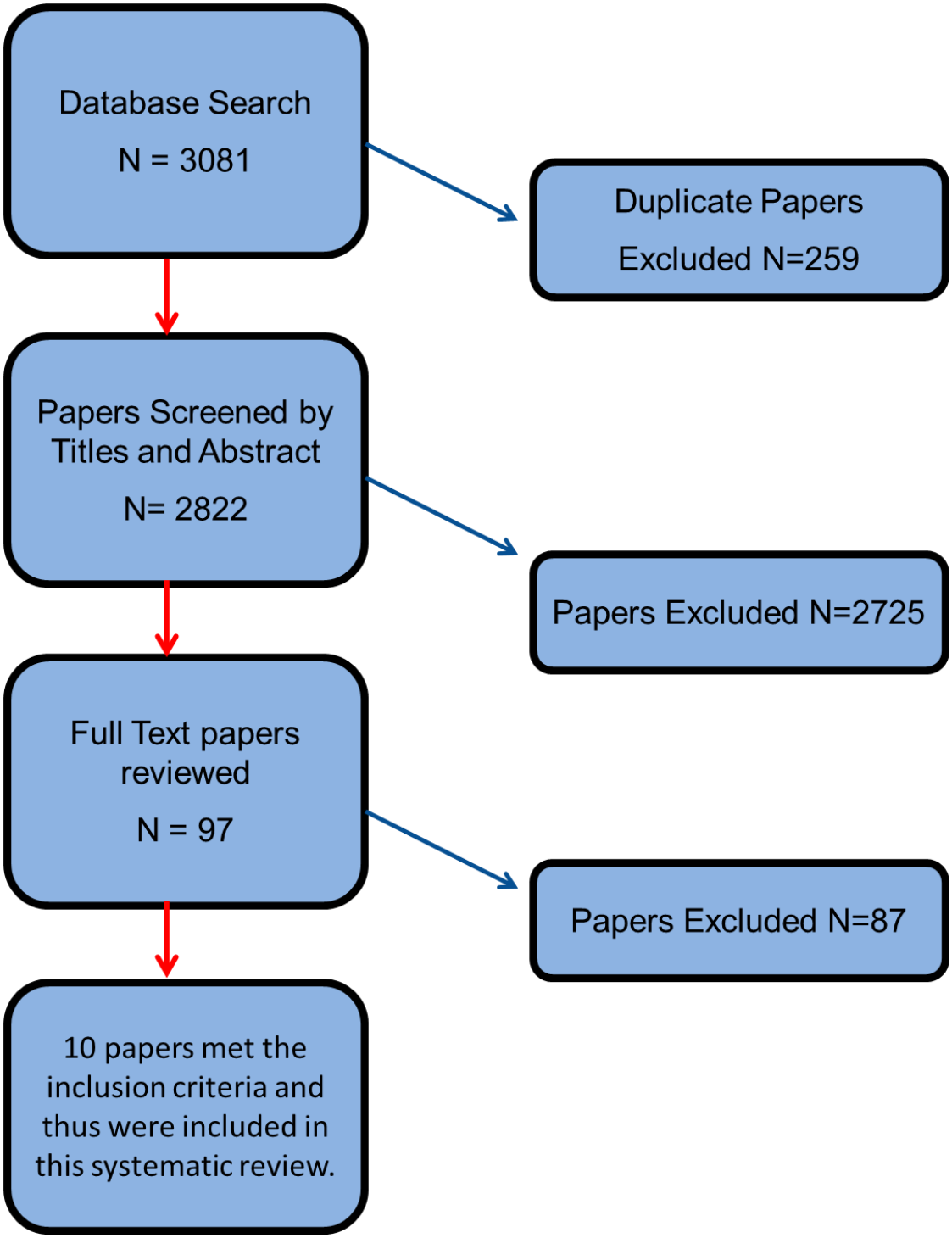


Figure 1: Study selection process.

Assessment of risk of bias in included studies

The quality of the included studies was assessed using a checklist (see Appendix C). This list consisted of common components from existing benchmarks for qualitative and quantitative study quality and bias assessments (Munro, Lewin, Smith, Engel, Fretheim, & Volmink, 2007). Each section, design, population and sampling, method and data analysis and conclusions, were individually assessed and scored for their quality.

The factors taken into account when assessing the quality of the paper where gathered from a wide range of previous systematic review quality control assessments (Downs & Black, 1998; Gardner, Machin & Campbell 1986). This study highlighted factors in the form of checklists to assess quality, these factors included; 'Were the studies hypothesis/aim/objective clearly described?' and 'Were subjects who were asked to participate representative of the entire population from which they were recruited?' Questions and factors to consider were collected and collated to form the Quality assessment sheet (see Appendix C).

The sections were scored in accordance with the checklist criteria ranging from 1 – 3 (1: Poor - major faults/bias and gaps, 2: Average - Good appropriate elements however either a number of small problems/areas of bias or gaps or up to 2 larger problems and 3: Good - a thorough and logical approach used, minimal faults/bias). These scores were then totalled to give each paper an overall score. These quality scores and their potential implications will be discussed in the results section.

The exclusion criteria are shown in Appendix B. It was decided that the quality of a study was not to be an exclusion criteria. The reason for this was that previous reviews have found that low quality studies contribute less information and fewer findings to the review overall. A poor quality paper will therefore have less impact on overall findings but including it will reduce the potential for bias (Juni, Altman & Egger, 2001). Thus there was no need for a quality cut-off as all papers that met the inclusion criteria outlined in Appendix B, irrespective of their quality, were included. However, all the quality scores from the different sections were totalled to determine the overall quality of each study. All sections were weighted equally in order to give fair representation across a wide range of different

studies. The score ranged from 4 to 12. One study each scored five, six, eight and twelve, with two studies scoring eleven and four studies scoring ten.

The main reviewer evaluated the quality of the included studies and the second independent reviewer evaluated 50% of these; their findings were jointly discussed (Buscemi, Hartling, Vandermeer, Tjosvold, Klassen, 2006). There was a moderate consensus between the two scorers. A moderate agreement level of inter-rater reliability between the two assessors was calculated, with Cohan's Kappa score of $\kappa = 0.474$ (Field, 2009). When there was a discrepancy between the two reviewers regarding the quality of a paper, the papers were re-read, the rationale for the scores discussed and a mutual score agreed.

Data extraction and management

Although the included studies used both qualitative and quantitative methods (i.e. thematic analysis and questionnaires), all the data collected were qualitative (e.g. gender, job role) as the relevant extracted data were risk factors. Any factors that a study analysed as being a risk factor for a person committing a boundary violation were extracted. The author extracted the relevant data (risk factors) onto standard data extraction forms (see Appendix D); 60% of these were independently extracted by the second reviewer to check for reliability. A good level of agreement was seen between the two assessors using the Cohan's Kappa, $\kappa = 0.613$. There were minimal discrepancies between the two reviewers regarding data extraction.

Data synthesis

The data that was extracted from the systematic review were the risk factors that are associated with boundary violations. Thus the data extracted included factors such as job role, age and gender. See Table 2 for more details.

Identification of themes and concepts among factors

Thematic analysis is regularly used to analyse qualitative data and add depth to research findings. Thomas and Harden (2008) recommend using this method in systematic reviews "to bring together and integrate the findings of multiple qualitative studies" (p. 44). This approach has been used with systematic reviews in order to gain a greater understanding of the research findings (Thomas, Harden, Oakley, Oliver, Sutcliffe, Rees, Brunton, & Kavanagh, 2004). This study identified several risk factors and further analysed them using thematic analysis to identify risk factor themes. This thematic analysis was performed by reading and re-reading the numerous risk factors to identify themes and patterns. The factors that put staff members at risk of committing boundary violations were then collated into subgroups (e.g. demographic and social). The factors identified in these sub-groups were separated depending on which setting they were collected in (i.e. either forensic or non-forensic/healthcare). See Table 1, 2 and 3 below.

Findings

From the 3081 studies which were initially found, 10 studies met the inclusion/exclusion criteria and constituted this systematic review. No randomised controlled trials were identified. Out of the included papers there were three which had conducted research in a forensic setting and seven from a non-forensic setting. For further information about these papers see Appendix E.

Forensic Studies
1) Fatal attraction: an analysis of employee boundary violations in a southern prison system - 1995-1998. - Marquart, Barnhill, & Balshaw-Biddle, 2001
2) Boundary violation in forensic inpatients facilities: survey tool development and survey results. - Daniels, 2008
3) Guards as embezzlers: the consequences of ''non-shareable problems'' in prison settings. - Worley & Cheeseman, 2006

Non Forensic Studies
4) Assessing boundary violations in psychotherapy: survey results with the exploitation index. - Epstein, Simon & Kay, 1992
5) The associations between psychologists' attachment patterns and their experiences with clients including sexual attraction and sexual contact: A National Survey. - Nigro, 2004
6) Boundary violations and personality traits among psychiatrists. - Garfinkel, Bagby, Waring, & Dorian, 1997
7) Boundary violations, gender and the nature of nursing work. - Chiarella & Adrian, 2013
8) A comparison of psychologists who engage in nonsexual and sexual dual relationships with psychologists who do not. - Ehlert, Cormier, Celenza, Danley, Marinelli, Messing, & Walls, 2002
9) Precursors to therapist sexual misconduct. - Celenza, 1998
10) Psychotherapists who transgress sexual boundaries with patients. - Gabbard, 1994

Table 1: The research papers included in this systematic review divided into forensic and non-forensic (healthcare) settings.

General findings

A summary of the 10 included studies and their findings are found in Table 2 below.

Aims of the studies

All ten studies included in this systematic review aimed to explore and investigate factors associated with staff boundary violations. However within this, the aims of the individual studies did differ. They ranged from “to examine boundary violations among 508 Texas state prison security staff” with specific emphasis on “What kinds of employees had sexual

contact with inmates?" and "Where did this behaviour occur?" (Marquart, Barnhill & Balshaw-Biddle, 2001) to exploring the contributing factors which lead psychiatrists to sexually abuse their patients (Garfinkel, Bagby, Waring & Dorian, 1997), to examining the psychodynamic characteristics of offending psychologists (Ehlert et al., 2002; Gabbard, 1994). Although the majority of the studies focus on sexual boundary violations, three of the studies also investigated more subtle, nonsexual boundary violations (Ehlert et al., 2002; Epstein, Simon & Kay, 1992; Daniels, 2008). Nine of the studies recruited staff members as participants in order to identify what factors put them at risk of boundary violations. However, one study by Worley and Cheeseman (2006) investigated what characteristics prisoners look for in staff when trying to initiate illicit relationships with them.

Definition of boundary violations

In addition to having differing aims the studies also had a variety of boundary violation definitions. The all met the definition laid out by Katherine (1993), which was an inclusion criterion. However, they did vary in more specific details from one paper to another. Most of the studies used broad definitions of boundary violation, roughly stating they involved any behaviour which interfered with the professional relationship between the staff member and the client which is not directly related to the treatment or job role. Under this umbrella definition over half the studies only looked at sexual boundary violations (Garfinkel, Bagby, Waring & Dorian, 1997; Gabbard, 1994; Nigro, 2004; Celenza, 1998). Although sexual boundary violations are clearly important, this suggests that non-sexual boundary violations have been under-researched. This may be due to people believing that these are less harmful or obvious to detect compared to sexual boundary violations or that they are less harmful and thus need less attention.

However other studies, such as Daniels (2008) investigated how nonsexual, under-involvement and over-involvement "constitutes fractures in the therapeutic process and negatively impacts on treatment" (p. 6). Two of the studies identified any behaviour which breached prison "rule of conduct 42" as a boundary violation, which included sexual activity. Rule 42, employee-inmate/client relationships (association or correspondence) states that

"employees are prohibited from continuing or establishing any personal relationships with inmates/clients or with family members of inmates/clients which jeopardises, or has the potential to jeopardise the security of the Agency or which compromises the effectiveness of the employee" (p. 204, Marquart, Barnhill, & Balshaw-Biddle, 2001; Worley & Cheeseman, 2006).

Sample demographics

The overall sample size was 2574 participants which included studies ranging from 17 (Celenza, 1998) to 1093 (Marquart, Barnhill, & Balshaw-Biddle, 2001). Not all the studies included details of their participants, from the studies that did the gender split of their participants were 948 female and 598 male. The participant age ranged from 18 – 71+ years old with an average of 43.2 years old. Only one American study broke down their participant's ethnicity, with 44% Anglo, 30% African-American, 16% Hispanic and 10% other (Marquart, Barnhill, & Balshaw-Biddle, 2001). The total sample size in the forensic setting (largely prison officers) was 1279 and the average sample size was 320 participants. The total sample size in non-forensic settings (largely doctors and councillors) was 1295 and the average sample size was 216 participants. However, Gabbard's (1994) case study did not have a specific participant group as he drew his conclusions from his years of experience working with this client group, thus, these total sample sizes did not include information this paper.

Recruitment and population of studies

There were two main recruitment strategies used by the majority of the selected studies. The majority (seven) examined individuals who had been formally identified, and in most cases, disciplined for their boundary violating behaviour (Ehlert et al., 2002; Gabbard, 1994; Marquart, Barnhill, & Balshaw-Biddle, 2001; Worley & Cheeseman, 2006; Celenza, 1998; Garfinkel, Bagby, Waring, Dorian, 1997; Chiarella & Adrian, 2013). Whereas two studies

used professional organisation mailing lists and asked for them to self-disclose any boundary violating behaviours.

Two studies employed the use of mailing lists (Epstein, Simon & Kay, 1992; Nigro, 2004) to distribute questionnaires to obtain a potentially large population sample. However, the return rates were relatively low, (21.3% and 40% respectively), which may have been due to the nature of the questions being asked, resulting in the samples being at risk of bias.

In some cases, control groups (i.e. people who had not been identified as boundary violators or whom had self-reported to not have committed any boundary violations) were also used to compare factors (Ehlert et al., 2002; Marquart, Barnhill, & Balshaw-Biddle, 2001; Garfinkel, Bagby, Waring & Dorian, 1997). The benefit of this approach guaranteed that all experimental participants had conducted boundary violations, as they would not disclose boundary violating behaviours if they had not engaged in them. However, it did not ensure that the control group had not committed boundary violations, they just reported that they had not. Thus, when comparing the two groups the difference could be between people who admit to boundary violating and people who keep it a secret.

Also, as these were outcome studies (cross-sectional) it is very difficult to draw definitive conclusions about whether the factors that were found to be different between the two groups were actually risk factors. This is due to the fact that cause and effect cannot be determined from this method. The studies that only used staff members who had been prosecuted would have meant that the experimental group had always only committed the more extreme boundary violating behaviours, most commonly sexual contact with clients, rather than smaller violations which may not have warranted formal disciplinary hearings. This again creates a sample bias.

However, Daniels (2008) did not use either of these strategies; their sample was an opportunistic voluntary staff sample from three forensic in-patient facilities. This has similar disadvantages as a study relying on surveys completed by voluntary participants, which means the sample may not be representative of the target population. Six studies relied on participants' self-reporting and thus concerns have to be raised about the reliability of the data collected, particularly when exploring a topic associated with shame. Although the

questionnaires were anonymous, there may have been response bias present in the data collected with participants under reporting incidents of boundary violating.

Marquart, Barnhill and Balshaw-Biddle's (2001) study recognised that if the staff member who had been challenged for committing a boundary violation resigned then no further disciplinary process took place. They would not have been disciplined, prosecuted or referred for help and therefore would not have been part of the experimental sample. Thus many of the studies did not include information about members of staff whose incidences of boundary violating had had insufficient evidence for a formal disciplinary hearing, or they resigned before such a hearing took place. This may lead to staff boundary violations being under reported and thus weakening the studies' results and conclusions.

Study cross-cultural variance

Six of the studies were conducted in America (Celenza, 1998; Marquart, Barnhill, & Balshaw-Biddle, 2001; Worley & Cheeseman, 2006; Ehlert et al., 2002; Epstein, Simon & Kay, 1992; Gabbard, 1994), three conducted in Canada (Daniels, 2008; Nigro, 2004; Garfinkel, Bagby, Waring, & Dorian, 1997) and one in Australia (Chiarella & Adrian, 2013). All of the studies had English as their first language. This lack of diversity in study location and language may result in their findings not being cross-culturally reliable, particularly as they are all developed English speaking countries.

						Risk Factors									
Title	**Nationality**	**Quality score**	**Method**	**Sample size**	**Gender**	**AGE**	**Education /Job**	**Contact with patients**	**Job type**	**Emotion difficulties**	**Social skills**	**Relationship difficulties**	**Breaking Rules**	**Self esteem**	**Personality**
1: Marquart et al,	USA	10	Case Control Between Group comparison	Control: 585 Experimental: 508	F	F	F	NF	-	-	-	-	F		F
2 Daniels	Canada	10	Cross sectional study	154	NF	NF	F	NF	F	F	-	-	-		
3 Worley et al,	USA	10	Case Control	Ex:32						F	F	F	F		
4 Epstei, et al,	USA	11	Cross sectional study	532	F	F	F		F						
5 Nigro	Canada	11	Cross sectional study	611	F	F	F			S					
6 Garfinkel, et al,	Canada	10	Co-hort study Between group study	Con:68 Ex: 2										F	F
7 Chiarella, et al,	Australia	8	Cross sectional study	Ex:29	F										
8 Ehlert et al,	USA	12	Between group comparison Cross sectional study	Con:20 Ex:39	F	F			F	F	F	F		F	
9 Celenza, et al,	USA	6	Case report	Ex: 17						F		F	F	F	
10 Gabbard, et al	USA	5	Case study	Unclear	F	F						F			F

Table 2: Factors that the 10 included papers highlighted (F= Factors reliant to staff risk of committing boundary violations, NF= Non-significant factors reliant to staff risk of committing boundary violations)

Design and analysis

Eight studies used a qualitative approach, one used a quantitative approach and one used mixed methods.

The design and analysis methods used in the ten included studies are described in Appendix E. All of the papers which used a quantitative approach and Worley and Cheeseman (2006), which used thematic analysis, described the data analysis approaches they used in detail. Three of the studies used a cross-sectional approach and so causality cannot be determined from the data (Nigro, 2004; Epstein, Simon & Kay, 1992; Daniels, 2008). Two studies used case-control methods which selected participants by outcomes, i.e. either those who committed and were disciplined, for severe boundary violations or not. The conclusions drawn from these studies may therefore not apply to individuals who commit less severe, or who are not disciplined for boundary violations (Marquart, Barnhill, & Balshaw-Biddle, 2001; Ehlert et al., 2002). Both these types of design can lead to problems with data generalising and result bias.

Gabbard (1994) used case series and Celenza (1998), who used a mixed methodology, did explain the rationale behind their choice of design and recognised that although their methods may lack reliability, the qualitative approach enabled a rich amount of data to be collected and analysed. However, despite them justifying the method used, the explanations of their data analysis and design was very scarce and poorly described. Nevertheless, it was felt that their findings still added understanding to this topic which is why study quality was not an exclusion criteria.

Methodological assessment

Various methods were used in the selected studies; six of the studies relied on psychometrics and questionnaire information to identify factors associated with boundary violations (Nigro, 2004; Epstein, Simon & Kay, 1992; Ehlert et al., 2002; Garfinkel, Bagby, Waring, Dorian, 1997; Daniels, 2008; Celenza, 1998). This allowed for large population sample sizes (the largest being 532 participants), however, the results relied on self-report.

Nigro (2004) and Epstein, Simon and Kay (1992) used anonymous questionnaires which might be expected to have elicited a more honest response from participants. It is possible that this approach would have resulted in identifying the more subtle forms of boundary violations, such as gift giving. These more subtle forms would not have been detected in the studies examining staff members who had been disciplined for boundary violations as these had primarily focused on sexual contact between staff and patients (Celenza, 1998; Gabbard, 1994; Marquart, Barnhill, & Balshaw-Biddle, 2001; Nigro, 2004; Worley & Cheeseman, 2006).

The tools used in the Nigro (2004), Ehlert et al. (2002) and Garfinkel, Bagby, Waring and Dorian (1997) studies were found to have good levels of reliability and validity. The exploitation index (EI) tool used by Epstein, Simon and Kay (1992) has subsequently been positively validated by Swiggart, Feurer, Samenow, Delmonico and Spickard (2008). However, Epstein, Simon and Kay, (1992) did remove items associated with sexual contact thus potentially affecting the validity of the EI, as they were concerned that it would affect response rates due to the unethical nature of the question topic. Both Epstein, Simon and Kay, (1992) and Daniels (2008) acknowledged that further research was required to verify the reliability and validity of the tools being used. Hence, the results from these studies need to be interpreted with caution.

Two of the studies included in this systematic review were case reports. The study by Gabbard (1994) was "based on psychodynamic themes I (the author) have observed" (p. 125) in the patients seen at "the Menninger Clinic, where therapists who have transgressed sexual boundaries with patients have been evaluated for many years" (p. 125). Celenza (1998) reported on seventeen therapists, all of whom had engaged in sexual intimacies with patients. There was no method outlined in the articles and it was very difficult to identify any systematic approach in analysing the themes identified. Gabbard's study (1994) draws on his experience of working with this client group as a way of identifying boundary violating risk factors. As a result, the approach used may have been biased and there was no way of checking either validity or reliability of the methods used therefore the data collected has to be assessed with caution. The other qualitative study (Worley &

Cheeseman, 2006) used a standardised and well researched method to conduct thematic analysis of interview transcripts.

A case control study method was commonly used in the studies included in this systematic review. This may be due to boundary violations or at least reported boundary violations being rare, with Nigro (2004) reporting that 4.3% of their sample had disclosed boundary violations, Pope, Tabachnick, and Keith-Spiegel (1987) reported 1.9%, Pope, Keith-Spiegel, and Tabachnick (1986) 6.5% and Pope, Levenson and Schover (1979) reported 7%. This approach is a reliable way of obtaining a large experimental group, which can result in studies with higher statistical power with more reliable and applicable findings. However, conclusions regarding risk factors may be skewed as the studies only examined severe boundary violations and not staff that went undetected or committed more subtle boundary violations. Also, it may fail to identify risk factors for the start of the 'slippery slope' that may precede a major boundary violation (Strom-Gottfried, 1999; Marquart, Barnill, & Balshaw-Biddle, 2001).

Published works

Two of the papers included in this study, Nigro (2004) and Daniels (2008), are doctoral theses which have not been published. Although they will have been supervised and reviewed through a viva, it is possible that they may not have been subjected to as intensive peer review as a published article. This is particularly relevant as Daniels (2008) designed a tool to measure and monitor boundary violations which has not been validated by other research. Thus, the 'Client-Staff Interactions survey' findings cannot be given as much credence as some of the other tools used in this review. However, this systematic review was mindful of this and tried to counteract it by critically evaluating this research study.

Quality of included studies

As can be seen from the general findings and critique above, the quality of the studies varied greatly.

Overall Study Quality scores are (see Appendix E for more detail):-

5 - Gabbard, (1994)

6 - Celenza, (1998)

8 - Chiarella & Adrian, (2013)

10 - Marquart, Barnhill, & Balshaw-Biddle, (2001)

10 – Daniels, (2008)

10 - Worley & Cheeseman, (2006)

10 - Garfinkel, Bagby, Waring & Dorian, (1997)

11 - Epstein & Simon, (1992)

11 – Nigro, (2004)

12 - Ehlert, Cormier, Celenza, Danley, Marinelli, Messing, & Walls, (2002)

Generally, the quality of the studies was good as can be seen from the reasonably high quality assessment scores; however there were some general criticisms of the included papers. Overall, the main areas of bias were sample selection, with few having control groups, and not using clearly defined definitions of boundary violating behaviours. Although they all fitted the boarder inclusion definition of a boundary violation, some were not very specific in their definitions. Both of these factors subsequently impacted on the quality of the conclusions that could be drawn from their findings.

Celenza (1998) and Gabbard (1994) were both qualitative case reports and scored the lowest on the quality assessment (six and five respectively). This was mainly due to a lack of logical method for sample selection, data collection or analysis. They both solely drew on their previous knowledge of working with staff who had committed boundary violations.

Neither had a control group for comparison and consequently it was hard to validate their findings and conclusions. Chiarella and Adrian's (2013) study also scored poorly on quality (eight) mainly due to a poorly outlined methodology, with no clear definition of what constituted a boundary violation, which impacted on the quality of the conclusions that could be drawn from the data.

Four studies (Marquart, Barnhill, & Balshaw-Biddle, 2001; Worley & Cheeseman, 2006; Garfinkel, Bagby, Waring, & Dorian, 1997; Daniels, 2008) all scored 10 in the quality assessment. Marquart, Barnhill, and Balshaw-Biddle (2001), and Worley and Cheeseman (2006), used similar methods. However, Marquart et al. (2001) had a stronger sampling method as their experimental group included all staff who had been disciplined for boundary violating in five prisons over a three year period. Furthermore, the Worley and Cheeseman (2006) sample was only a small proportion of the potential population of inmates who committed boundary violations with staff, as they were selected by availability and ease of location access. The results section for Marquart et al. (2001) was poor as they only looked at proportions and did not undertake statistical analysis comparing the experimental and control groups. In contrast, the method for Worley and Cheeseman (2006) was effective and conducted with a clear rationale. Thus, although the studies all had the same overall score, they exhibited different strengths and weaknesses.

Both Daniels (2008), and Garfinkel, Bagby, Waring, and Dorian's papers (1997) had a good overall design and the methods used were effective in addressing their research objectives. Daniels (2008) could have been improved by giving more detail on how the questionnaires were administered and the sampling methods used. Garfinkel et al. (1997) would have benefited from not just focusing on the extreme cases of boundary violations, where psychiatrists lost their licences, but exploring the risk factors of a larger sample of psychiatrists who committed subtle boundary violations.

Nigro (2004) and Epstein, Simon and Kay (1992) scored 11 on their quality assessment. They both only scored 2 in their method section due to low response rates which could result in a sample bias. They also relied on self-reporting which potentially may result in under reporting of boundary violating behaviours. This is evidenced by their findings of people who admitted to boundary violating being comparative lower than other studies that used

other methods (Pope, Keith-Spiegel, & Tabachnick, 2006; Pope, Levenson & Schover, 1979). Apart from this, they were good quality pieces of research with clear aims and conclusions drawn from the findings. The paper which scored the best overall quality score of 12 was Ehlert et al. (2002). Despite a reasonably small sample size of 59 participants, the methods used to analyse the data were appropriate and their conclusions logical. They also had a randomly selected control group which added validity to their findings.

Risk factors for staff committing boundary violations

The risk factors collated from the ten included studies were divided into those in a forensic and those in a non-forensic setting. This approach of using thematic analysis within a systematic review is helpful in ordering large amounts of data (see Appendix E) and aiding in obtaining a greater understanding of the research findings (Thomas, Harden, Oakley, Oliver, Sutcliffe, Rees, Brunton, & Kavanagh, 2004; Thomas & Harden 2008). It should be noted however that this method excluded some of the findings in table 3. When exploring the risk factors, six different types appeared to emerge; these can be seen in table 3 below.

	Forensic boundary violators were found to be:	**Non-forensic** boundary violators were found to be:
Demographic	Female Average age 36 years old Age ranged between 30-39 years old Worked in job for less than 36 months. Anglo ethnicity	Male Average age 45.6 years old. Age ranged between 42-52 years old Worked as a psychiatrist Increasing age was associated with higher incidences of boundary violating Married
Social	Having limited opportunities for relationships outside of work.	To report being socially incompetent Uncertainty about how to act with the

	Experiencing social isolation Experiencing relationship failures Experiencing an abusive relationship Reported being sexually promiscuous Recently separated or divorced Being outgoing Their social lives being described as 'Wild'	opposite sex, and social isolation
Personality / emotional management	Having negative emotions in response to patients:- • abusive/belligerent behaviour • resistance to treatment Having low self-esteem Being shy Being generally gregarious	Having lower self-esteem Shyness or nervousness Feel entitled (i.e. egocentric) Expressing anger toward authority figures Having a psychotic disorder Described as 'predatory psychopathy' and 'paraphilias' Expressing that they experience lovesickness Masochistic surrender Higher levels of: - • Anxiety • Antisocial attitudes and behaviours • Defensive cognitive–perceptual style • Psychopathic deviancy traits • Hypomania traits

Life events	History of rule violations. Financial problems Job-related problems Have been disciplined for related boundary violating transgressions before	Family history of boundary transgressions Experiencing a loss of a significant other Experienced physical, emotional and sexual abuse as a child Insecure attachment
Education and Employment	**Education:** Higher levels of BV among:- Individuals with higher levels of educational qualification (e.g. individuals with degree instead of a high school diploma)	**Education:** Master's degrees more likely to boundary violate compared with people who have a higher level of education
	Employment: Higher levels of BV among:- Clinical staff - other than nurses No military experience. Lower pre-employment evaluation scores	**Employment:** Located in suburban practice Working in private practice on their own (solo-working)
Psychodynamic factors		Intolerance of negative transference Expressing: • Parentification • Sexualized pregenital needs • Restricted awareness of fantasy • Narcissistic injury

		• Defensive transformation of countertransference hate to countertransference "love"
Non-significant factors found by some of the papers	No significant differences with:- • gender • age • between individual compared with group contact time	

Table 3: Breakdown and grouping of boundary violation risk factors.

Appendix E displays all the risk factors collated from the ten studies. Some of the risk factors were found to be similar between the two settings, such as social isolation. In the forensic setting, this risk factor was described as including not having a social life outside of the prison, shy or feeling socially isolated (Worley & Cheeseman, 2006). The non-forensic setting described social difficulties and socially incompetent as being risk factors. They stated that this was potentially due to insecure attachment which impacted on the staff member's ability to form secure, well-functioning relationships in adult life (Ehlert et al., 2002). Worley and Cheeseman (2006) did not hypothesise the reason behind forensic staff members feeling socially isolated. Two similar risk factors were having experiences of and exposure to boundary violations previously. This was either forensic staff having committed boundary violations in the past (Marquart, Barnhill, & Balshaw-Biddle, 2001; Worley & Cheeseman, 2006), or in the non-forensic setting, having a family member who had committed a boundary violation (Celenza, 1998). The final similar factor was staff member's reporting of higher levels of anger. In the non-forensic setting this was directed at authority figures (Celenza, 1998), whereas in the forensic setting this emotion was expressed towards patients' abusive or belligerent behaviour and when patients were resistant to treatment (Daniels, 2008). Although these behaviour triggers are different, both of these factors appear to show that staff members who committed boundary violations seem to have a higher than normal anger response when challenged or experiencing resistance.

From analysing the boundary violation risk factors there are also some distinct differences between forensic settings and non-forensic settings. One was the risk factor of gender. The forensic setting found that females were more at risk of committing boundary violations (Marquart, Barnhill, & Balshaw-Biddle, 2001) compared with males, whereas the opposite was true in the non-forensic settings (Epstein & Simon, 1992; Nigro, 2004; Garfinkel, Bagby, & Dorian, 1997; Chiarella & Adrian, 2013; Ehlert et al., 2002). Another difference was the impact that age had on the staff member's boundary violation risk. In the forensic setting the age appeared to be slightly younger with Marquart, Barnhill, and Balshaw-Biddle (2001) reporting the average age of boundary violators being 36 years old and Daniels' (2008) study found that members of staff who boundary violated by being 'under involved' and neglecting patients ranged from 30 to 39 years old. In contrast, in the non-forensic setting two studies found that it was the slightly older age group of either 45.6 years old in Ehlert et al's (2002) study or 42 to 52 years old in Epstein and Simon's (1992) study. Nigro's (2004) study reported that increasing age was associated with higher incidence of boundary violations in non-forensic settings. Interestingly, in contrast to these findings the other forensic setting papers (Daniels, 2008) found that factors such as gender, age and whether a staff member worked alone or in a group setting with clients, had no significant impact on their rate of boundary violation.

While some studies have found gender and age to be risk factors, which vary depending on the setting, such as forensic or healthcare, this is not a universal finding as Daniels (2008) found that age and gender were not significant risk factors. Further research is required for to confirm these results.

The impact of education levels also appears to differ depending on the setting. Marquart, Barnhill and Balshaw-Biddle (2001) and Daniels (2008) found that in the forensic setting having a higher level of education placed staff at a higher risk of committing boundary violations, whereas in the non-forensic setting this was the opposite (Nigro, 2004). There were other education linked protective factors identified in these studies, such as having a military background and scoring high on the entrance recruitment examinations in forensic settings (Marquart, Barnhill, & Balshaw-Biddle, 2001).

In the forensic setting, it appeared to be staff members who were currently experiencing problems, such as work troubles or current financial difficulties, who were at risk of boundary violations (Worley & Cheeseman, 2006). However, in the non-forensic group it appeared to be past difficulties, such as experiencing sexual abuse or the loss of a significant other that increased an individual's chances of committing a boundary violation (Ehlert et al., 2002; Gabbard, 1994). None of research conducted in forensic settings explored psychodynamic differences, thus they did not identify any psychodynamic risk factors, whereas two of the non-forensic setting studies (Celenza, 1998; Gabbard, 1994) had this as one of their aims, and both found psychodynamic related risk factors. This may be due to a genuine difference between the two settings or it may be a result of publishing or research bias between the two areas. Further research is required with the explicit aim of exploring psychodynamic factors in both settings for decisive conclusions to be drawn on this topic.

When comparing factors within the same environments, different articles recorded a number of similar findings that would suggest higher levels of reliability and applicability of these factors. One such risk factor was staff members in non-forensic settings having issues with social anxiety, which can be seen by their high levels of shyness and low self-esteem (Ehlert et al., 2002; Celenza, 1998). A number of studies also identified the presence of certain personality traits, such as psychopathic and narcissistic, in staff members who committed boundary violations (Gabbard, 1994; Garfinkel, Bagby, Waring & Dorian, 1997). These individuals if challenged often became aggressive, defensive or displayed signs of narcissistic injury. These personality traits may also explain the high levels of antisocial attitudes found in a number of the boundary violating members of staff (Garfinkel, Bagby, Waring & Dorian, 1997). A number of studies showed that the working environment also presented a risk, with individuals working in rural areas and on their own in a practice being at higher risk. In the studies that looked at psychodynamic factors, staff's inability to manage transference and counter transference also appeared to be a key risk factor.

Overall, there seems to be good internal consistency between the risk factors found within each setting, as several papers found similar factors, such as gender and age related risk factors. Although it is important to be mindful that this may be due to a particular focus on these factors as a result of publishing or research bias. Alongside this there were some

factors which were present in both settings and others that appeared to be setting specific. Among the papers there were also contradictory findings, such as whether gender and age was a risk factor or not, implying further research is required to gain stronger conclusive evidence.

Discussion

Boundary violations, in which staff cross professional boundaries with clients, is a taboo topic in most working environments (Folman, 1991; Bohm, Curtis & Willock, 2009). This combined with it being sensationalised by the media means that research on this topic is often limited to specific settings or themes of research. However, the impact of committing a boundary violation is wide ranging, not only affecting the individuals directly involved but also the integrity and safety of the working environment as well as the general public's safety and trust (Smith & Fitzpatrick, 1995; Schafer & Peternelj-Taylor. 2003; Gutheil & Gabbard, 1998; Gutheil & Gabbard, 1993; Subotsky, Bewley & Crowe, 2010).

Current research has mainly explored the impact of boundary violations on clients (Solursh, Solursh & Williams, 1993; Disch & Avery, 2001). As far as the author is aware this is the first systematic review to attempt to evaluate current research and examine the factors that put individuals at risk of committing boundary violations. Due to the prevalence across settings and the negative impact of boundary violations, it is important to analyse current research with the aim of developing a greater understanding of the risk factors involved. It is hoped that this will help develop strategies to reduce the risk of boundary violations, as well as highlighting areas for further research.

General findings

Maintaining professional boundaries is a key responsibility of staff in both the forensic and healthcare settings (Schafer & Peternelj-Taylor, 2003; Williams, 1997; Simon, 1999). However, as this review has shown, there are numerous factors that can impact on staff's

ability to maintain their boundaries. This review has found evidence of specific personal and environmental factors which put staff at risk of committing boundary violations. Some of these risk factors were consistent irrespective of the working environment (forensic or non-forensic) in which they were committed, such as social interaction difficulties, shyness and low self-esteem (Worley & Cheeseman, 2006; Ehler et al., 2002). Personality characteristics, interpersonal skills and social support have all been raised as factors connected to staff member's resilience to stress and burnout. McManus, Keeling, and Paice (2004) found similar factors to those highlighted in this systematic review, staff with poor social support, who were introverted and with high neuroticism scores possessed low resilience to stress. This implies that personal characteristics play a major role in ability of staff to work effectively and be resistant to boundary violating and burnout across settings (Jensen, Trollope-Kumar, Waters, & Everson, 2008; Jackson, Firtko, & Edenborough, 2007). Not all of the studies explored the same factors so there is potential for more cross context risk factors to be identified through future research.

Other studies found risk factors specific to only one environment type, e.g. working individually was only highlighted as a risk factor in the non-forensic setting (Ehlert et al., 2002; Epstein and Simon, 1992) and not found in the forensic setting (Daniels, 2008). This may be explained by the fact that when staff and patients work individually in a hospital environment they are often engaged in more therapeutic tasks, such as treatment or therapeutic interventions. When working in more therapeutic environments staff are often encouraged to show empathy, warmth and be non-judgmental to aid the formation of an effective therapeutic alliance (Marshall, 2005; Marshall & Serran, 2004). In some cases these factors may result in the creation of a more relaxed, open interaction with less boundaries which may result in an environment where staff are more vulnerable to boundary crossing and ultimately boundary violating (Galletly, 2004; Gutheil & Simon, 2002). This therapeutic and more relaxed environment is less encouraged and less likely to be created in forensic prison settings, even when staff work individually with prisoners as the emphasis tends to be more focused on security and concerns around conditioning (Cheeseman-Dial & Worley, 2008). This may account for why working individually is not a risk factor in this setting. Many of these context specific risk factors were identified in a number of the different studies

indicating good validity of these factors. However, it is worth being mindful that this outcome may also be explained by research bias.

One interesting finding was that some of the context specific risk factors were reversed depending upon the environment. The forensic studies highlighted being a female as a risk factor for committing boundary violation, whereas the non-forensic healthcare setting indicated that significantly more males boundary violated (Marquart, Barnhill & Balshaw-Biddle, 2001; Epstein & Simon, 1992; Garfinkel, Bagby, Waring & Dorian, 1997). This finding may potentially be more of a representation of the staff gender ratios in these environments, as comparatively, there is a very small number of female prisoners and there are more women working in male prisons. While there is a greater gender split in healthcare, there are potentially more female clients accessing therapy compared to males, statistically putting male staff at a higher risk of engaging in inappropriate relationships (Miller & Maier, 2002; Pope, Keith-Spiegel, & Tabachnick, 2006).

The same was found with age; in forensic settings being younger was a risk factor in contrast with being older in healthcare settings (Epstein & Simon, 1992; Daniels, 2008; Nigro, 2004). Some papers explained this by stating that individuals who were younger tended to be more naive and less knowledgeable about policies and procedures (Marquart, Barnhill, & Balshaw-Biddle, 2001; Worley & Cheeseman, 2006; Garfinkel, Bagby, Waring & Dorian, 1997). These factors made them targets of prisoners who wanted to exploit this weakness (Worley & Cheeseman, 2006). In hospital settings the patients are seen more as the victims and less as the instigators (Daniels, 2008). The research in non-forensic settings hypothesised that the older members of staff committed more boundary violations due to the older staff being overly self-confident, entitled and having a disregard for rules and policies (Ehlert, 2002). It is also possible that clients play a role in this environment, as they potentially looking up to them, admiring older and more senior members of staff, thus trying to initiate relationships with them. This indicates that risk factors differ between environments not only because of the staff or initially difference but also because of client difference. Some of the included papers highlighted factors which other papers reported as being insignificant (Daniels, 2008). These variations in findings may be explained by potential environmental differences even within similar environments, such as differences

in forensic settings, which may impact on the risk factor relevance. Crewe, Liebling and Hulley (2011) found a large variation between prisons, these included staff culture, prisoner behaviour, staff attitudes, prisoner quality of life, prison organisation and facilities. This indicates that even within forensic settings there is variation which may impact on the relevance of protective or risk factors associated with boundary violating. This is in part supported by this systematic review as it indicates that different environmental factors produce different risk factors. Moreover, research in this specific area is sparse and the lack of standardised outcome measures and numerous operational definitions of boundary violations make it difficult to interpret results and synthesise robust conclusions.

A number of factors which put people at risk of committing boundary violations were identified (see Appendix E and Table 2 and 3). This review highlights that these findings are not only specifically individual's risk factors, such as age, but also related to working conditions, such as lone working (Ehlert et al., 2002). This highlights the need to not only review individual staff's risk factors but also the associated environmental risks. A multifaceted and systemic approach to this topic is required. It is hoped that an awareness of these factors could help staff avoid the "slippery slope" toward boundary violations and thus protect themselves and their clients from harm (Maule, 2007; Gutheil & Simon, 2002). However, for this to be practical, further research of these discrepancies is required in order for a conclusive list of risk factors to be created. This is particularly relevant as there was variation in the quality of the included research studies.

Quality of included papers

Overall, the standard of the included research papers varied, with the majority (70%) of them scoring 10 or above out of a possible 12. Sample sizes were generally large and this systematic review incorporated the findings from over 2574 participants. The majority used reasonable designs and appropriate and logical data analysis of their findings. The average quality score for the design section was 2.7 and for the method and data analysis was 2.3, both scores are out of 3. This was not higher mainly due to factors such as no comparative analysis being conducted between boundary violators and non-boundary violators along

with poor definitions of boundary violations. All of the studies identified individuals who had committed boundary violations which, considering many past papers have talked about under reporting of this behaviour was encouraging (Simon, 1999; Nigro, 2004). This would imply that the methods used to detect boundary violations were fitting for this type of study however, it may also indicate the occurrence of publishing bias. The majority of the psychometrics used to measure the presence of particular risk factors had good levels of validity and reliability, which reinforces the validity of the findings. However, a criticism of using psychometrics is that participants are not always honest in their responses. This, combined with a low return rate in some studies, potentially may have led to response bias.

Criticism of included papers

There were some general criticisms of the papers included in this systematic review; namely that they generally scored the lowest on their sampling methodology (on average 2.1). This is mainly due to factors such as no comparative control group and a lack of detail and clarity about their sampling methods. They also did not have a control sample group which is why this section scored the lowest. This subsequently impacted on the quality of the conclusions that could be drawn from the findings, the conclusion section scored 2.2 on average.

The majority of the studies only evaluated risk factors associated with the more severe boundary violations, such as sexual contact, and tended to overlook the more subtle forms. This may have resulted in the risk factors highlighted in this systematic review only being relevant for severe boundary violations and not smaller ones. There may be additional risk factors that put individuals at risk of committing more minor violations. As minor may progress to major violations via the “slippery slope” it would be valuable to conduct further research in this area.

It is also important to consider how the sensitivity and controversy that surround this topic may have impacted on the accuracy of the data collected (Celenza, & Gabbard, 2003), particularly, as the majority of the studies relied on participant self-disclosure. However, when researching this topic it is very difficult to use any alternative and more reliable

methods. Consequently, there is the possibility that the studies did not identify all the related risk factors due to a lack of participant openness.

Strengths of current systematic review

One of the strengths of this systematic review is its wide searching approach which consisted of searching four databases, subsequent searching of paper journals and follow-up searches of references from relevant papers. This search was not exclusive to published papers and 2 of the 10 included works were currently unpublished theses. In order to avoid bias, a second scorer re-rated a percentage of the papers which showed moderate consistency between the two scorers.

Links to practice

Findings from this review can be used practically in several ways. Firstly, to increase staff awareness about boundary violating and the prevalence across sectors. Secondly, to increase staff members' self-awareness of what life events and personal characteristics can place them at higher risk of committing boundary violations. This awareness can aid them in being more mindful of potential risk factors in their practice and encourage them to develop resilience at times of high risk. Managers could also use this review to help them to highlight which groups of staff may require further training or supervision in order to support them and development their understanding of boundaries and security. Staff members can use the finding that the environment plays a key role in determining the relevance of risk factors to aid them in planning future studies. This review highlights the importance of not generalising findings across settings as the risk factors may not be relevant. It is hoped that all of these approaches could be used to improve patient and staff safety, and decrease the prevalence of boundary violations in numerous settings.

Limitation of current systematic review

Papers were not excluded from this systematic review on the basis of quality; whilst this did ensure more papers were reviewed and maximised risk factors identified, it did mean that lower quality papers were included. This can be seen by the fact that Nigro's (2004) paper scored 12 on quality while Gabbard (1994) scored 5 on quality. This variance in quality does need to be taken into consideration when analysing the findings from the different papers. Although there was a benefit of including unpublished papers in that it highlighted more risk factors, the fact that these papers have not been critiqued in detail by other professionals in this field must be taken into consideration. The papers were divided into two categories, forensic and non-forensic settings, for analysis. Whilst this was effective in comparing differences, there is still a wide range of professions and environments included in the non-forensic setting, such as psychologists, councillors and doctors. As this systematic review has shown environment plays a significant role in determining which risk factors are relevant, it may have been interesting to have subdivided the non-forensic group into specific settings. This would have enabled risk factors to be compared within the non-forensic setting and may have led to more insightful findings. Unfortunately there were not enough available studies to make this possible. A lack of studies from a wide range of cultures also limited the potential generalisability of the findings. This must be considered when making comparisons and recommendations to cultures that were not included in the studies. This systematic review also has only examined risk factors however, it would have been potentially useful and interesting to have looked for factors protective against boundary violations. This information could have been used in conjunction with the risk factors to provide a greater insight into the prevention of boundary violation.

Future research

This systematic review has highlighted the relative lack of research in this field. Clearly a number of gaps exist in the current research, along with variance in the quality of methods used. It is evident from this systematic review that environment plays a key role in what factors increase an individual's risk of committing a boundary violation. Thus subsequent

research into boundary violations needs to be mindful of this context when planning research and analysing the results. For example, research should not combine findings across a wide range of settings as this may result in key results, which are only relevant to one setting, being lost due to data noise from other settings. It potentially would not be appropriate to conduct studies across environments as the findings may be inconclusive or be cross context relevant. None of the research papers used in this review has been undertaken in Europe. More cross-cultural research is also required for the same reasons. Currently, the majority of research has been undertaken in the non-forensic healthcare sector which has very different demands on professionals from those working in the forensic setting. Further research is required in under analysed areas, such as forensics, for the same reason, that conclusions drawn in one setting cannot be automatically applied to another. This context specific research would also aid in the development of robust definitions of boundary crossing and violation specific to each setting, which is definitely required.

The definition of boundary violation did vary between papers and particularly between settings. The papers from forensics settings tended to have stricter definitions and lower tolerance for more subtle forms of boundary violations, such as sharing personal information or buying gifts, than the non-forensic papers. Traditionally, boundaries in forensic settings were very strict and rigid however, more recently there has been a shift towards exploring the beneficial impact of developing effective therapeutic relationships when working with offenders. This in turn encourages more flexible boundaries using more holistic and non-judgemental methods (Leach, 2005). This may mean that definitions of boundary violating may start to vary within the forensic setting dependent upon job roles. For instance, a forensic psychologist who shares personal information may only be considered as boundary crossing rather than boundary violating as it has potential therapeutic benefits and hence permitted within their job role. Thus it would be interesting for further research to explore how these changes in ethos impact on rates of boundary violating and also the associated risk factors.

None of these research papers used in this review has been undertaken in Europe. As context and environment appears to be key in determining risk factors it potentially would

not be appropriate to generalise these findings across cultures as they may not be cross context relevant. More cross-cultural research is also required for the same reasons.

As was found within this systematic review, there were non-conclusive and contradictory findings so further research is required to enable the creation of a conclusive list of factors that put staff members at risk of boundary violation. A national database/register collating anonymous information from both minor and major boundary violations would produce a rich vein of research, and could aid in producing conclusive findings about risk factors. Combined with this, research containing large, appropriately matched control groups would help comparison as well as potentially identifying protective factors against boundary violating. This information could be used to introduce staff education programmes to raise awareness and create risk reducing strategies.

Conclusion

This review shows that there are several factors that increase the likelihood of a boundary violation being committed. Thus it is important that staff are aware of their limits and how to manage this issue. It is evident that boundary violations and their consequences are wide ranging and significant. Great efforts are therefore required to reduce the likelihood of such behaviour. Developing awareness of factors that put individuals at risk is the first step in developing strategies to manage this behaviour. This, combined with further research into protective factors, should aid organisations to create training, relevant policies and strategies to effectively address this issue. The information gained in this systematic review aids this process and underlines that future research needs to be environment specific. It also highlights the widespread gaps in current knowledge which need to be addressed through good quality research. It is likely that only by a large scale multifaceted programme of research and education that significant reduction in the level of boundary violation and its consequences will be made. Overall, the current literature signposts risk factors for boundary violations, and given the serious and continuing problems they cause, there is a critical need for more research in this area.

Summary of Chapter 2: Systematic review

This was the first systematic review to examine which factors are associated with increasing staff members' risk of committing boundary violations, in both prison and health care settings. It also established whether these risk factors varied between forensic and non-forensic settings.

Ten studies met the inclusion/exclusion criteria; three from forensic and seven from non-forensic settings. These studies varied greatly in their quality and methodology.

Risk factors fell into six distinct categories (demographic, social, personality/emotional management, life events, education/employment and psychodynamic factors).

Some risk factors were the same for both forensic and non-forensic, such as social interaction difficulties, shyness and low self-esteem. Other risk factors, such as financial problems were only found to be a risk factor in one setting. Thus, indicating that the environment plays a pivotal role in the relevance of certain risk factors.

This has connotations for future research and questions the relevance of generalising study findings across settings; this is explored further in chapter 3.

Forward to Chapter 3

The empirical research study detailed in Chapter 3 aims to address in part the need for more research. In particular, targeting the need for further research into risk and protective factors associated with staff committing boundary violations. One of the conclusions from the systematic review in Chapter 2 was that environment plays a critical role in determining the relevance of certain risk factors. Thus the empirical research study focuses its analysis on one environment, a forensic secure hospital. It has the aim to increase the reliability of this study's findings and enable the conclusions drawn to be generalised to other secure forensic healthcare settings. The empirical research study also explores staff members' views on boundary violations and whistleblowing. It is hoped that by combining findings from Chapter 2 and 3 practical strategies to manage boundary violations can be developed.

Chapter 3:

Empirical Research Study

Exploring the Protective and Risk Factors Associated with Staff committing Boundary Violating Behaviour in a Secure Forensic Hospital

Chapter 3: Empirical Research Study: Exploring the Protective and Risk Factors Associated with Staff committing Boundary Violating Behaviour in a Secure Forensic Hospital

Introduction

This thesis so far has looked at what boundary violating behaviour is and what research there has been into the factors that put staff from different sectors at risk of engaging in such behaviours.

As is highlighted and mapped out in the section below, job roles and working environments within healthcare and secure services are changing. These changes are potentially quite critical to the topic of boundary violating within these environments. In particular, as the systematic review in chapter 2 has indicated, environment plays a major role in determining what factors (protective or risk) are associated with staff committing boundary violations. The review also highlighted that there is very limited research into boundary violating in general, but particularly in the UK, within forensic healthcare settings. The lack of research is made even more critical by the potential harm and risks that could occur if boundary violating behaviours were engaged in within the setting which cares for both potentially dangerous and vulnerable individuals. The purpose of this chapter is to address this issue of a lack of research in the environment of UK secure forensic settings. It does this by presenting an up-to-date look at what factors protect and put UK forensic staff at risk of committing boundary violations.

Traditionally staff boundary violating has been a controversial and at times taboo topic which has resulted in not only researchers not exploring this topic, but also organisations and management wanting to avoid it too (Folman, 1991; Bohm, Curtis & Willock, 2009). There are great concerns that the prevalence of boundary violating behaviour is underreported primarily due to a reluctance within staff to self-report or whistleblow related concerns. The topic of whistleblowing will also be discussed and suggestions made

on how the issue of boundary violating can be safely and effectively addressed. The overall purpose of this chapter is to gain a greater understanding of these two complex issues and to identify practical methods that can be implemented in order to maintain the safety of staff and patients within secure forensic health settings.

Environments and the related staff roles

Traditionally the main purpose of forensic institutions, such as prisons, was security, punishment and social justice. More recently there has been more emphasis on rehabilitation (Cullen, Latessa, Burton & Lombardo, 1993; Gendreau, Goggin & Law, 1997; Steiner & Wooldredge, 2008).

Hospitals on the other hand focus more on caring, treatment and safety of the patients. (Conti, 2005). Included within healthcare there are approximately 6,000 inpatient beds in secure mental health services (National Health Service Standard Contract, 2013). These forensic hospitals are tasked with the complex roles of providing care, treatment, protection and security for both their patients and the general public.

Staff have to balance quite different roles such as security and therapy, custody and care, all within a restricted environment (Mason, 2002; Schafer & Peternelj-Taylor, 2003). Staff are often trained to manage violence with de-escalation and restraint training as well as provide effective therapeutic relationships and treatment (Mason, 2002; Zwirn & Owens, 2011). All these factors make it a very challenging environment to work in and staff are often called upon to take on multiple roles when working with patients.

Changing Environments and Job Roles

Over recent years, there have been many changes to all three environments (Healthcare, Forensic and Forensic Healthcare). Nurses are being given more training and responsibility in treatment care and medication. Prison officers are playing a larger role in offender

rehabilitation. Mental health workers now practice in a wider range of environments including secure hospitals, outpatient clinics and schools (Watson, Stimpson, & Hostick, 2004; Miller, Bener, Ghuloum, Commons & Burgut, 2012; Thornicroft & Tansella, 2004). The type of treatment provided has also changed, with a shift away from the more traditional high-intensity psychoanalytical treatment, towards the shorter and thus less expensive treatments, such as Cognitive Behavioural Therapy (Jones, Fitzpatrick & Drake, 2008).

In parallel with these changes there has also been the impact of the economy on the organisations and the services that are provided. The government has reported a shortfall in NHS funding in 2014 approaching £20 billion (Mulley, 2010). In addition, the cost of the criminal justice system has risen from 2% of gross domestic product (GDP) to 2.5% over the past 10 years (Marsh & Fox, 2008). This drive to safe money has resulted in many areas seeing cuts in staffing levels, training and treatment budgets (Miller, Bener, Ghuloum, Commons & Burgut, 2012). Jones, Fitzpatrick and Drake (2008) identified that due to budgetary constraints and an increased need for technical skills, nursing training courses were cutting certain content topics, including interpersonal skills training.

Interpersonal relationships have always been at the heart of the medical profession, and co-dependent working relationships between clients and staff are pivotal in maintaining safety and order in both forensic and healthcare settings (Schafer & Peternelj-Taylor, 2003). The development of these relationships is a complex process, involving the development of trust and understanding in environments that may not, due to patients' illnesses, security constraints and safety concerns, naturally facilitate this (Schafer & Peternelj-Taylor, 2003). It is widely recognised that the development and maintenance of boundaries between clients and staff in all these environments are key (Peternelj-Taylor, 2010). Although broadly speaking boundaries are recognised as important, there is still a lot of debate around how best to describe and explain what these boundaries are. There are numerous different definitions. One which is commonly used and covers staff boundaries is Sarkar's (2004) definition. Sarkar (2004) describes boundaries as "delineating the personal and professional roles and the differences that should characterise the interpersonal encounters between the client and the professional" (p. 314). These boundaries are essential in ensuring the delivery of effective treatment, as well as the maintenance of a safe environment and clarity

of the difference in staff and patients' roles (Sarkar, 2004). There are also changes in the way professionals are advised to interact with patients. Staff are being encouraged to move away from the more traditional, formal client-expert staff relationship towards a more reciprocal and balanced relationship (Jones, Fitzpatrick & Drake, 2008).

Thus, in summary, there are on-going changes in environments, job roles and interpersonal styles within forensic healthcare settings (Jones, Fitzpatrick & Drake, 2008). There are concerns that policies and guidelines are not being updated to reflect these more subtle role changes (Miller, Bener, Ghuloum, Commons & Burgut, 2012). This, combined with cuts to establishments' budgets, means that staff are overstretched and not receiving the appropriate level of training, supervision or support to adhere to effective and appropriate interpersonal relationships. This may increase the likelihood of boundary difficulties (Miller, Bener, Ghuloum, Commons & Burgut, 2012; Jones, Fitzpatrick & Drake, 2008).

There are a number of different behaviours that can cause someone to commit a boundary violation. Some of these are context specific, such as a prison officer posting a stamped letter for a prisoner, however in a hospital setting this is more acceptable. Some of these different forms of boundary violations are outlined in Epstein and Simon's (1990) Exploitation Index, which is critiqued in chapter 5. This is a psychometric tool used to assist therapists' ability to monitor their boundaries with patients in seven areas, including, eroticism, dependency, power seeking, and greediness.

Boundary violation occurs in all environments.

Despite boundary violating being widely condemned, this behaviour is present and persistent in many different areas including nursing practice (Jones, Fitzpatrick & Drake, 2008), social work (Stromm-Gottfried, 1999), prison settings (Cheeseman-Dial & Worley, 2008), counselling (Hermansson, 1997), mental health settings (Miller & Maier, 2002; Quadrio, 1996), psychology (Ehlert, Cormier, Celenza, Danley, Marinelli, Messing & Walls, 2002; Garrett & Davis, 1998) and general hospitals (Miller & Maier, 2002). Although the types of behaviours seen in these settings vary, it is commonly accepted that they are

harmful for the individuals involved, the profession's reputation, and on occasion the general public. These types of behaviours blur the professional distance between clients and staff and disrupt the primary aim of the professionals and their related organisation's work (Marquart, Barnill & Balshaw-Biddle, 2001; Epstein, 1994; Gutheil & Gabbard, 1998).

There are concerns that there may be an increase in staff vulnerability to boundary violating activities due to changes in job roles, cuts in staffing levels, lack of support and a decrease in training resources. Therefore research must turn to identifying the best way to manage boundary violating activity in the workplace. Whilst there is literature examining the prevalence of boundary violating behaviour (Birch & Miller, 2000; Epstein, Simon & Kay, 1992) and its impact (Pope & Tabachnick, 1993), there is significantly less research into the factors that put people at risk of these behaviours and how to protect them. This is particularly true when exploring factors that put all members of staff at risk of committing boundary violations, as the majority of previous research in this field (e.g., Worley & Cheeseman, 2006; Epstein, Simon & Kay, 1992; Nigro, 2004) explores risk factors associated with therapists, and not other professions such as nursing.

Previous research into risk factors

The available research has found that North American prison staff who commit boundary violations with prisoners are significantly more likely to be of Anglo ethnicity, female, have no military experience, score lower on pre-employment evaluation, have a history of rule violation, and have worked less than 36 months in the prison service (Marquart, Barnill & Balshaw-Biddle, 2001). Worley and Cheeseman (2006) collated a list of risk factors that North American prisoners look for when identifying members of staff who are "easier" to corrupt. This includes appearing socially isolated, having a ''wild'' social life, financial problems or job-related issues. It is important to be mindful that the experimental participant groups in these two studies consisted of staff members who had been caught, and prosecuted, for committing serious boundary violations. This may mean that the experimental group missed data from individuals who committed less severe boundary violations, or did not get caught, or rescinded before disciplinary action took place. This may

lead to selection bias and indicate factors only associated with people who get caught committing more severe violations. Consequently, the studies do not provide a full picture of relevant risk factors for all people who commit boundary violations. Also prisons in the United States of America (USA) are different from United Kingdom (UK) establishments in a number of ways, including having lower staff to prisoner ratios, population size, rules, regulation and ethos (Camp & Gaes, 2002; Mitchell, Mackenzie, Styve & Gover, 2000; Ross, Diamond, Liebling & Saylor, 2008). It is therefore unclear if these findings can be extrapolated to the UK prison system, let alone a secure hospital.

Epstein, Simon and Kay (1992) identified risk factors that put psychotherapists at risk, such as being male, working in a suburban setting and working alone in a practice. However, this study relied on participant self-disclosure which may have impacted on the reliability of the findings, particularly when discussing taboo topics. Other studies set in healthcare settings identified low self-esteem, having a personality disorder, experiencing childhood abuse and high levels of anxiety as risk factors (Celenza, 1998; Ehlert et al., 2002; Nigro, 2004; Somer & Saadon, 1999). See Chapter 2 for more information about the previously identified factors that place staff at risk of committing boundary violations. However, it is not clear from these studies whether these factors are applicable in different cultures, job roles or professional settings.

Other research (e.g., Twemlow & Gabbard, 1989; Luepker, 1999) has highlighted client characteristics that increase the chances of a member of staff committing boundary violations. These include the clients being young, suffering from psychosis, having unhelpful personal relationships or a diagnosis of personality disorder, such as narcissism or psychopathy. See Chapter 4 for more related information with regard to what factors place patients at higher risk of entering into boundary violating behaviours with staff. Many of the studies are quite old and in cultures outside of the UK, primarily the USA. It is therefore difficult to identify whether these factors are generalisable to the UK population and across environments, particularly in light of recent changes in these areas.

Current research regarding protective factors relating to boundary violation

Some protective factors that relate to maintaining professional boundaries have been identified. However, again the majority of this research has been conducted on counsellors and therapists, rather than other staff groups. One protective factor is experience. Research indicates that people who have more experience of working with forensic clients, and who are more familiar with their job role, find it easier to maintain personal boundaries (Love & Heber, 2002). Another protective factor which is thought to be effective is staff training, both before starting employment and on-going during employment (Glass, 2003). Such training relates to maintaining professional boundaries, the impact of not maintaining them and the ethics involved (Arnold, 2008; Grady, Danis, Soeken, O'Donnell, Taylor, Farrar & Ulrich, 2008; Jones, Fitzpatrick & Drake, 2008; Goldie, Schwartz, McConnachie & Morrison, 2003; Nisselle, 2000). An individual's knowledge of rules and regulations has also been shown to decrease the likelihood of committing a boundary violation (Gutheil & Simon, 2002). However, research in this area is not consistent, as other studies have concluded that training relating to boundary violation has little impact on decreasing its level in an establishment (Olarte, 1991). There is limited research into the effectiveness of theoretical training in interpersonal relationships and boundaries and their impact on adapting clinicians' practice and behaviour (Jones, Fitzpatrick & Drake, 2008). More research regarding the effectiveness of training and whether it protects staff from committing a boundary violation is therefore required.

The British Psychological Society's (BPS) code of conduct recommends supervision as a way of maintaining accountability and professional boundaries (British Psychological Society, 2009). Good supervision can aid awareness of the signals being conveyed through appearance, body language and level of personal disclosure, all of which aid the maintenance of professional boundaries (Gutheil & Gabbard, 1993). A range of literature supports the argument that supervision is important in professional boundary maintenance (Miller, Bener, Ghuloum, Commons & Burgut, 2012). Marquart et al. (2001) observed that people who are reluctant to attend supervision and peer consultation have an increased risk of committing boundary violations. However, this may also be due to staff who are boundary violating or contemplating it avoiding supervision. Supervision assists with

problem solving, as it enables staff to process and express difficult emotions, which helps maintain personal boundaries (Jones, 2003; Spence, Wilson, Kavanagh, Strong & Worrall, 2001; Strong, Kavanagh, Wilson, Spence, Worrall & Crow, 2004)

Although there is literature that examines factors that protect staff from committing boundary violations (Marquart, Barnhill & Balshaw- Biddle, 2001; Glass, 2003; Love & Heber, 2002), the majority are in the form of guidelines or recommendations without any supporting evidence. It is still unclear whether these protective practices, although theoretically sensible, have any real practical impact in avoiding boundary violations. The research in this area is limited and more is required to examine, in a measurable way, the specific factors that either protect or place staff at risk of committing boundary violating behaviour (Ehlert, Cormier, Celenza, Danley, Marinelli, Messing & Walls, 2002).

The environment is a key factor determinate

Previous research and the systematic review in Chapter 2 confirm that environment is key in determining the associated risk and protective factors in boundary violation. Studies that have explored cross-cultural differences have found that boundaries vary between cultures along with the perception of how harmful are certain boundary violating behaviours (Rubin & Dror, 1996; Miller, Commons & Gutheil, 2006; Miller, Bener, Ghuloum, Commons & Burgut, 2012). There is also variation in the comfort levels between professionals in different lines of work in discussing this issue, which has implications for the effectiveness of supervision, training and self-disclosure (Jones, Fitzpatrick & Drake, 2008). Consequently, conclusions regarding boundary violations in one environment cannot necessarily be extrapolated to another.

Workplace culture and environmental factors play a major role in influencing the behaviour and experiences of the work force (Baldwin, 2006). Organisational justice is part of the work place culture and has the potential to play a major role in boundary violating and whistleblowing behaviours. Organisational justice is “the extent to which employees perceive that workplace procedures, interactions and outcomes to be fair in nature” (pg. 1

Baldwin, 2006). There are different components to this including, the perception regarding fairness of outcomes, perceptions of the process that lead to these outcomes and the fairness of interpersonal interactions and treatment. Another element is how these perceptions are communicated and information about them is provided (Brockner, 2011). These elements impact on the satisfaction of staff, the willingness of them to work together, report wrongdoing and maintain rules. Thus, being aware of organisational justice and work environment is pivotal when exploring boundary violating in a particular environment.

The responsibility for adhering to interpersonal boundaries always lies with the professional (Miller & Maier, 2002). However, the effect that working with different client groups has on an individual's ability to maintain boundaries has to be taken into consideration when exploring this area, particularly when working with challenging clients who may be using conditioning techniques. Conditioning refers to a patient manipulating a staff member's behaviour with the aid of subverting security or decreasing security vigilance (Crawley, 2013). The techniques or behaviours they may use to achieve this aim range from using intimidation to flattery. Additionally, the type of behaviour that is deemed appropriate varies depending on the client group and the professional's role. For example, staff who work with children may have a different approach and boundaries than staff working with adults (Thomas & Pastusek, 2012; Zwirn & Owens, 2011). Consequently, when the findings of research conducted in a certain environment or with a specific client group are applied to a different population, questions have to be raised about the generalisability of these findings, particularly when environments such as hospitals, prisons and secure hospitals vary so widely. When research is conducted into boundaries and boundary violations, the findings should only be applied to the specific areas where the research was conducted.

This highlights the fact that further research is required in general, but especially in under-researched areas such as UK establishments and in forensic healthcare settings (Sarkar, 2004). As the systematic review highlights, it would not be appropriate to apply findings drawn in other settings to these environments. It is also likely that the challenging environment and client group encountered in forensic hospitals are particularly susceptible to boundary difficulties due to the patients often possessing several of the factors that make them vulnerable to illicit relationships, such as a having a history of relationship difficulties,

previously experiencing abuse, and possessing personality disorders with anti-social traits (Peternelj-Taylor, 2010). See chapter 4 for more details on this topic. In response to this need for further research, the current research study is conducted in a UK low secure forensic hospital.

Increase the Knowledge Base.

Increasing the knowledge base regarding boundary violating risk and protective factors would be greatly beneficial for both individual staff, by increasing their self-awareness, and management, by aiding them in protecting and supporting their staff members (Ehlert et al., 2002). However, this knowledge of related factors is only beneficial to staff and patients if it results in changes in behaviours at a grassroots level, and consequently leads to a decrease in the amount of boundary violating behaviours being committed.

Supporting Staff to desist from Boundary Violating

Research has shown that thoughts about inappropriate relationships or boundary violation are extremely common. From a national survey study of American therapists, Pope and Tabachnick (1993) reported that most psychologists self-reported feels of sexually attracted to at least one of their clients during their career. Although most professionals will not act upon these thoughts, they still need support and help with how to manage the situation and how to decrease the likelihood of this impacting on their work (Ehlert et al., 2002). Managers and supervisors also need support in how to identify warning signs, deal with suspicions and protect staff and clients in their care. Staff perception on organisational justice within a hospital will play a role in determining how this issue is addressed by them.

Previous research has explored the different behaviours that clients utilise, including bribing and intimidation, to encourage staff members to commit boundary violations (Allen & Bosta, 1981; Liebling, Price & Shefer, 2010). There is also research that shows that clients will target particular staff members in whom they have identified vulnerability risk factors,

such as poor social networks or experiencing personal difficulties (Cheeseman-Dial & Worley, 2008). It is potentially of great benefit for both staff and managers to be trained and aware of the techniques used by clients and the signs of vulnerability in order to protect themselves. The current research will explore both the protective and risk factors that staff members associate with boundary violation. This study will also explore the different approaches that patients residing in a secure forensic hospital use to try and encourage staff to commit boundary violations.

Whistleblowing

While increasing staff understanding of this subject is key, it is even more critical that they utilise this understanding in a practical way by adapting their behaviour, supporting others and identifying areas of malpractice or boundary violating. Eby (1994) defines whistleblowing as the "ancient art of bringing to light wrongdoings in any area of life" (p. 56). McDonald and Ahern (2002) define a whistleblower as one "who identifies an incompetent, unethical, or illegal situation in the workplace and reports it to someone who may have the power to stop the wrong" (p. 16). In the context of healthcare, whistleblowing has been described as "speaking out about unsafe or questionable practises affecting people receiving care or working conditions" (Burkhardt & Nathaniel, 2002, p. 506).

Research shows that staff members are aware that boundary violating behaviours are harmful and at times illegal, however there is a disconnect between this and them taking action to deter or stop such behaviour (Goldie, Schwartz, McConnachie & Morrison, 2003). A survey of medical students found that 61% of them had witnessed unethical behaviour at work, however only 27% of them had reported it to another professional (Feudtner, Christakis, & Christakis, 1994). A similar study, of Scottish medical students, found that only 40% of medical students felt they "should whistleblow" if they had concerns about another students misconduct, and only 13% said they "actually would" do so (Rennie & Crosby, 2002).

Stevens (2000) states that professionals need to support people who have the courage to highlight unethical practices. However, reports often show this is not the case and whistleblowers are frequently 'ostracised', harassed and mistreated (Peternelj-Taylor, 2010; Mesmer-Magnus & Viswesvaran, 2005; Rost, 2006; McDonald & Ahern, 2000; Burrows, 2001). It is also possible that, just like with boundary violating risk factors, there are environmental factors that impact on staff members' willingness and ability to whistleblow. Further, it is potentially a company's policies and procedures that may impact on reporting concerns or other factors (e.g., high levels of lone working limit the ability of staff to peer monitor each other) (Nigro, 2004; Chiarella & Adrian, 2013; Epstein, Simon & Kay, 1992). Whistleblowing on a colleague is often fraught with difficulties and dilemmas involving loyalty, and this is even more challenging in the healthcare profession where patients are potentially put at risk if this behaviour is ignored (Ahern & McDonald, 2002; Beckstead, 2005; King, 2001). However, research has shown that whistleblowing can be a key factor in improving patient safety and care (Myers, 2008), and it is the ethically correct thing to do when patients may be at risk (Peternelj-Taylor, 2010). Not only is there hesitancy regarding whistleblowing, but there also appears to be a lack of understanding of the appropriate processes and methods to do so (Peternelj-Taylor, 2010). Thus meaning that concerns go unrecorded and are not addressed, which places both staff and patients potentially at risk. Concerns have been raised about the lack of professional training addressing this issue and the training's effectiveness in encouraging staff to whistleblow (Grady, Danis, Soeken, O'Donnell, Taylor, Farrar & Ulrich, 2008).

Rationale and Aims of this Research

The interpersonal relationship between clients and staff is crucial in all caring professions (Schafer & Peternelj-Taylor, 2003). Boundaries are complex and involve a balancing act between developing a beneficial therapeutic relationship and boundary crossing and boundary violating behaviours (Smith & Fitzpatrick, 1995). With changes to funding, time, resources and job roles, there is potential that this balancing act is becoming even more challenging. This study is an up-to-date look at the topic of boundary violations in this changing climate, and explores what can be done to manage this issue and minimise the

effect boundary violating has on all involved. This research, unlike previous studies (e.g., Sarkar, 2004).), is not solely looking at therapists and boundary violating behaviour, but explores risk and protective factors associated with a wide range of professionals who work with clients.

Research has shown that boundary violations occur in all environments. Although there is a reasonable amount of literature on boundary violation prevalence and impact, there is limited research into risk and protective factors in a UK setting (Sarkar, 2004). Much of the literature and guidelines (British Psychological Society, 2009) in this area are very clear about what not to do, but give little specific guidance on preventing the slippery slope of boundary violations. The guidelines (British Psychological Society, 2009) encourage "maintaining good professional relationships" (p. 4) and avoid "personal relationships – where the psychologist infringes or violates the trust of a client or clients" (p. 6). However, it does not outline warning signs or exactly what would be classed as a "bad professional relationship". There are no examples given around what would be considered appropriate and what is not. This puts professionals and supervisors as risk of going down the slippery slope of boundary violation. More conclusive evidence on what leads to boundary violation could result in clearer guidance for policies and codes of conduct. This may in turn help to protect staff members and clients from the problems that arise from boundary violation.

It is also concerning that there is such limited research in forensic health care settings, which is particularly vulnerable due to the complexity of the clients and job roles within the setting that affect the client and professional interface (Peternelj-Taylor, 2010). The systematic review in Chapter 2 has shown that context is key. As such, the current research study will explore the topic within a specific environment. It is hoped that increased knowledge in this area will aid professionals' awareness and increase their resilience. Once these risk factors have been identified, they may assist in identifying professionals who would benefit from training or other types of intervention to reduce the risk of repeat or initial boundary violation. These findings could also contribute to creating effective training packages which are grounded in empirical research (Ehlert et al., 2002).

Whilst it is commonly recognised that boundary violations are harmful, and that reporting and managing them is critical, there appears to be a disconnect between what people know

they “should do” and what they actually do (Peternelj-Taylor, 2010). This is particularly true in forensic settings where the boundary violating behaviour is not just an ethical issue, but also a legal and criminal issue. Most forensic settings have a zero tolerance approach to corruption and boundary violation. Many of the corruption prevention posters highlight the risk of a prison sentence for offences relating to boundary violations. Example of this are posters saying “don’t cross the line”, showing staff being in prison, or their children being taken into care due to their parents committing trafficking offences. This approach, although understandable, potentially may account for the low reporting rates of concerns about boundary violations. As a result, the current research will explore staff members’ views on boundary violations, their experience of being conditioned, and their apprehensions of reporting boundary violating concerns. It is hoped that these findings could encourage a more transparent and effective way of addressing this issue.

Research questions

This research aims to address the following research questions:

1. What factors put staff members at risk of committing boundary violations in a forensic hospital setting?

2. What factors protect staff members from committing boundary violations in a forensic hospital setting?

3. What are staff members' experiences of boundary violating?

4. What are staff members' views on whistleblowing?

5. What deters staff from reporting concerns about boundary violations that are committed?

Method

Participants

The participants all work at a low secure forensic hospital which specialises in care for mental health and learning disabled patients with forensic needs. All the patients in the hospital were sectioned under the Mental Health Act (1983). Compared to other forensic hospitals, it is a small hospital consisting of five wards. The hospital is run by a private company which mainly cares for NHS referred patients. Private healthcare companies make up a large section of care providers for this client group, and this hospital is owned by one of the largest private healthcare providers in the UK. All of these elements need to be taken into consideration when comparing or applying the findings from this study with other settings, as they may impact the ability to extrapolate results to other care settings.

There are 87 participants in the study which represents 73% of the total number of staff in the hospital. The participants come from a wide range of disciplines and experiences. Fifty-six per cent are support workers, 15% are nurses, 8% are a member of the care team (e.g., Psychology, Occupational Therapy), 7% are senior support workers, 7% are administration staff, and 6% are members of the senior management team. The participants' age ranged from 20 to 66 years (M=38.71, SD=11.93). The participants comprised of 51% female members of staff and 49% male members of staff. The ethnicity of the participants consisted of 67% 'White British', 16% 'Black other', 7% 'White other', 5% 'Mixed race', 2% 'Asian British', 2% 'Black British' and 1% 'Asian other'. Out of the 87 participants, 11 admitted to being disciplined or spoken to about committing boundary violations of various forms, either at the current hospital or in a previous post. The average number of years a member of staff had worked in care was 10.8 years with the average time working in this specific hospital being seven years.

Design

A cross-sectional design was used to explore the relationship between different staff members' characteristics and their history of boundary violating. The dependent variable

was whether or not the staff member had been disciplined for boundary violating (either in the current hospital or at a previous hospital) and the independent variables were the staff members' personal characteristics that may be risk or protective factors associated with boundary violations.

Materials

The data were collated from a questionnaire pack (Appendices F-H) that was disseminated throughout the hospital's workforce. The first questionnaire (Appendix F) had 48 items which participants answered through check boxes, for example 'Yes', 'No' answers. This questionnaire was derived from reading numerous articles about boundary violating. The questions were based on factors that previous research had highlighted as being risk or protective factors associated with boundary violating behaviour and corruption. The questionnaire mainly asked about staff members' personal lives and demographic information, such as 'what is your age?', 'what is your marital status?', 'Do you receive supervision?' and 'Have you separated from your partner in the last year?' (Strom-Gottfried, 1999; Sarkar, 2004; Marquart, Barnhill & Balshaw-Biddle, 2001; Worley, Tewksbury & Frantzen, 2010; Love & Heber, 2002).

The second questionnaire was the Exploitation Index (EI), which was developed by Epstein and Simon (1990), with the purpose of aiding therapists in their ability to self-evaluate their potential risk of violating boundaries with patients (Appendix G). This is a 32 item questionnaire which explores a wide range of boundary violating behaviours. Members of staff who score highly on this questionnaire, by reporting how frequently on a four point Likert scale they engage in certain behaviours (never through to often), are at a high risk of committing boundary violations and potentially already have. Although the reliability and validity of the EI is under researched, initial studies are encouraging. The internal reliability of the EI is scored at Cronbach's $\alpha = .81$, which indicates a moderately high coherence between the items. However, there are some concerns about the EI's predictive validity and whether being alerted to potential risk does actually change an individual's practice.

The third and final questionnaire (Appendix H) had 28 items and asked about the participants' views and experience of boundary violations and whistleblowing, such as 'Have you ever suspected a member of staff of boundary violating behaviour?' and 'did you report it?' These questions could be answered in various forms including check boxes, open-ended answers and on Likert scale options. The questions were based on other studies that explored whistleblowing in different environments (Ahern & McDonald, 2002; Goldie, Schwartz, McConnachie & Morrison, 2003; McDonald & Ahern, 2002). The questions asked about staff members' beliefs regarding risk and protective factors, such as 'Please circle the four main factors you think put people at risk of boundary violating?' The questionnaire also explored what behaviours staff members believe are used by clients to condition or corrupt them. Further, the participants were asked what methods they have seen patients use to make staff commit boundary violations. They could tick as many behaviours as they wished and could also add their own suggestions to answer this question. These questions were informed by the findings of other studies that explored similar topics (Cheeseman-Dial & Worley, 2008; Hoglend, Amlo, Marble, Bogwald, Sorbye, Sjaastad & Heyerdahl, 2006; Allen & Bosta, 1981).

Before the questionnaire and information sheets were distributed to participants, they were piloted with members of the psychology department and some members of the Senior Management Team who had experience of research. They critiqued the questionnaires and added in a few questions about factors that they felt (due to their experience) may be relevant to the study. This focus group helped in checking the face validity of the questionnaire and made sure that more idiosyncratic factors, that may be reliant on forensic secure hospitals, were thought about.

Procedure

Permission to use the data and ethical approval for the study was obtained from the University of Nottingham and Hospital Manager the Senior Management Team of the hospital (see appendix I). All the data were collated and stored on a secure database.

Seventy-three percent of the total staff population was recruited for the study. This was a very good recruitment percentage. It is believed this was due to the hospital being quite small and thus it being easy for everyone to be aware of the study. The researcher also spent time going round every ward (during night and day shifts) to explain the study and the process involved. The participants were given an information sheet (Appendix J) along with the questionnaire pack (Appendices F-H). Every ward had a quantity of questionnaires and information sheet stored in a visible place which was regularly kept supplied. Their consent to engage in this research was shown by them completing and returning the questionnaires to a sealed box in the hospital reception. The process was anonymous and the participants could take their time in completing the study. It was felt that this approach was the most ethical as it enabled participants to be fully aware of the research and its purpose, without feeling pressured by management or the researcher to engage in the study.

The questionnaire pack took approximately 30 minutes to complete. After completing the questionnaires they were given a debrief sheet which explained where to go for more information or support (Appendix K). It was felt that this was key to maintain a transparent and ethical approach to the research study where staff could give information concern and access further information if they required.

The qualitative data, collated through the third questionnaire (Appendix H), was transcribed for analysis. The qualitative data was all transcribed by one individual to aid with consistency. When there were difficulties in deciphering handwriting the option of another independent person was asked to support and clarify. This was rarely required due to the quality and clarity of the participant's answers. The thematic review was also reviewed by the researcher supervisor to enhance methodical accuracy.

To maintain anonymity, no names or directly identifying information were provided by the participants and all the questionnaires were assigned codes. Due to time limitations the data was not double entered however, the researcher's supervisor reviewed the data and the statistics to check accuracy.

The data from the 32 item Exploitation Index was totalled to form the EI total score. This was done in accordance with Epstein and Simon's (1990) guidance, with no question responses being weighted more than another.

The responses to the questions, 'Have you ever been disciplined or talked to about committing a boundary violation while working at this hospital?' and 'Have you ever been disciplined or talked to about committing a boundary violation while working for another employer?' were added together. This created a score for staff members' history of boundary violating behaviour, which was used as the dependant variable in the study.

Data analysis

The quantitative data were analysed using SPSS version 18 for Windows, while the qualitative data were analysed using thematic analysis. All scale measures were tested for normality to see if the data significantly differed from a normally distributed set of scores. The Shapiro-Wilk test was used to test for normality as it has good power and is effective on small sample sizes (Shapiro & Wilk, 1965). This test showed that out of the five continuous variables, four were not normally distributed. As a result, on these four variables non-parametric tests were used.

In order to address the first two research questions of the study (i.e., What factors put staff members at risk of committing boundary violations in a forensic hospital setting? (Question 1); What factors protect staff members from committing boundary violations in a forensic hospital setting? (Question 2)), a binary logistic regression was conducted. This particular type of regression was used because the outcome variable is categorical and the predictor variables are both continuous and categorical. However, prior to the regression analysis, a series of tests were run to assist in determining which variables should be included as predictors in the regression analysis. This was so as to ensure no arbitrary variables would be incorporated in the regression model. The series of tests used consisted of point-biserial correlations, Pearson's chi-square test, and Fisher's exact test.

Point-biserial correlations were completed with continuous variables and the dichotomous variable of whether or not staff had committed a boundary violation. Pearson's correlation coefficient was used where the continuous data were normally distributed. Where the continuous data were not normally distributed, Spearman's correlation coefficient was used instead. Pearson's chi-square test was run on the categorical data to assess for any significant relationships with whether or not staff had committed a boundary violation. In the cases where at least one of the expected counts were five or less, Fisher's exact test was used instead.

The aim of the binary logistic regression was to create a model to predict the variation in the outcome variable of staff history of boundary violating. The 'enter' method was used so that all the predictors were placed into the regression simultaneously. This was deemed most appropriate as previous research and statistical exploration (e.g., Gutheil & Simon, 2002; Arnold, 2008; Jones, Fitzpatrick & Drake, 2008; Worley & Cheeseman, 2006; Celenza, 1998) has demonstrated that all of these factors have a significant relationship with 'history of boundary violating'. However, there is not enough information to determine which order these variables should be included in the model, thus hierarchical entry would have been inappropriate. Additionally, the stepwise method was not chosen as it discriminates between variables which can affect variability if the model was retested; this issue is reduced with the enter method (Field, 2009).

Thematic analysis was conducted to identify patterns, themes and sub-themes in participants' responses to questions about boundary violating and whistleblowing. Braun and Clarke (2006) describe thematic analysis as "a method for identifying, analysing, and reporting patterns (themes) within data. It minimally organises and describes your data set in (rich) detail. However, it also often goes further than this, and interprets various aspects of the research topic" (p. 82).

Initially, the entire qualitative dataset was read in order to gain familiarity with the data and an overall picture of the participants' responses. While reading through all the responses to each question, initial thoughts of potential themes were recorded.

The next stage was to code the data. In order to do this, the question responses were re-read and initial features and areas of interest from the answers were highlighted. The aim of this process is to organise the data into meaningful groups (i.e., identifying any similar responses and collating them together). At this stage the highlighted features were quite specific and no efforts were made to draw together or identify larger common themes (Braun & Clarke, 2006). In order to increase accuracy, this process of coding was repeated to make sure all potential areas of interest were identified. During this stage, key quotes from participants were also highlighted, as these add context and richness to illustrating the participants' responses.

The interpretive analysis of the data then took place and themes started being drawn together (Boyatzis, 1998). A mind map was used for the purpose of drawing together common features to create potential broader themes. The names of these themes had to be clear to give an accurate interpretation of the included common features.

Once the overarching themes were identified, the original dataset was then analysed to check that key features had not been missed and that the identified themes were able to capture the overall message of the participants' responses (Braun & Clarke, 2006).

Results

Correlations with staff history of committing a boundary violation

As a result of 'EI scores' being normally distributed, a Pearson's point-biserial correlation was run to assess its relationship with 'staff history of boundary violation'. A positive significant relationship was found, indicating that as EI scores increased, so too did the commission of boundary violations (r= 0.302, n = 87, p=.002). This was a two tailed hypothesis.

Point-biserial correlations using Spearman's correlation coefficient were conducted where the variables were not normally distributed. There were no significant relationships between having a history of boundary violation and the participants' age (*rs* = 0.023, n=84,

p=.835), years spent working in care (*rs* = 0.137, n=86, p=.208), and salary (*rs* = 0.023, n=84, p=.833). There was however a significant positive relationship between participants' history of boundary violation and the number of years spent at the current hospital (*rs* = 0.350, *n*=84, *p*=.001).

Exploring possible boundary violating risk factors

Pearson's chi-Square test was run to assess the relationship between 'history of boundary violating' and the categorical variables. Two variables were found to have a significant relationship. These included 'Working on own with patients' (χ^2 (1) = 7.22, *p* =.007, ϕ = .288) and 'working 1:1 with patients' (χ^2 (1) = 4.309, *p* = .033, ϕ = .223).

Fisher's exact test results showed that eight variables had a significant relationship with history of boundary violating. These variables were 'Having family or any close friends disciplined for committing a boundary violation' (ϕ = .260, *p* = .037), 'feeling they have people to turn to' (ϕ = -.294, *p* = .021), 'having a good social life' (ϕ = -.234, *p* = .045), 'having supervision' (ϕ = -.278, *p* = .022), 'Telling patients how many children you have' (ϕ = .287, *p* = .035), 'telling patients your children's name' (ϕ = .512, *p* = .001), 'telling patients your partner's name' (ϕ = .389, *p* = .006), and 'having received training on boundary violations' (ϕ = -.290, *p* = .011). These results indicate that there were six risk factors (due to having a positive ϕ value) and four protective factors (due to having a negative ϕ value). The risk factors were 'Working on own with patients', 'working 1:1 with patients', 'Having family or any close friends disciplined for committing a boundary violation', 'Telling patients how many children you have', 'telling patients your children's name', and 'telling patients your partner's name'. The protective factors were staff 'feeling they have people to turn to', 'having a good social life', 'having supervision', and 'having received training on boundary violations'.

As can be seen from the above findings, a number of tests were completed on the data set. It is acknowledged that this increased the risk of Type I error. However, due to the limited research in this area, this approach was necessary to determine which predictors to use in

the regression analysis. To decrease the risk of Type I error, the p-value for these tests could have been adjusted. However, this would increase the risk of Type II error. As this is an under-researched area, it was considered more important not to leave out any *potentially* significant predictor variables from the regression analysis.

Binary Logistic Regression results

A binary logistic regression was performed to address Research Questions 1 and 2. All the variables from the previous analyses that had been found to have a significant relationship with staff having a history of boundary violation were used as predictor variables. However, the 'EI scores' were not deemed suitable to be included in the logistic regression, as it is a psychometric measure of risk of boundary violating and not a personal risk or protective factor. 'Working 1:1 with patients' was also not included in the analysis due to it creating a quasi-complete separation. In this study, it meant that all the participants who had admitted to boundary violating also worked 1:1 with patients, thus "there was no case that had an alternative value" (Webb, Wilson & Chong, 2004 p. 275).Quasi-complete separation is when the predictors almost produce a perfect prediction of the response variable, there is a slight overlap in the middle range. This almost perfect predictor prevents the convergence of the maximum likelihood estimates for the coefficients. In real terms this does not mean that it is a perfect predictor, but more likely that the data set is too small to observe events with low probabilities (McCarthy & Guo, 2009).

The regression model was statistically significant ($x^2(12) = 29.31$, *p<.005).* It explained 58% (Nagelkerke $R^2 = 0.58$) of the variance in history of boundary violating and correctly classified 89.6% of cases. The model indicated that two variables significantly predict boundary violating, namely, 'Having family or any close friends disciplined for committing a boundary violation' and 'Years spent at the hospital'. The results of the logistic regression for the individual predictor variables are presented in Table 4. It shows the factors that were included in the regression model and the relevance of each risk factor.

	B	*SE*	Wald	Exp(B)
Family member or close friend having a history of boundary violating	3.639*	1.796	4.105	38.045
Working on your own with patients	1.161	1.172	0.981	3.194
Having people to turn to	-1.906	2.487	0.587	0.149
Having a good social life	-0.426	1.307	0.106	0.653
Having supervision	1.971	2.051	0.923	7.175
Not telling patients how many children you have			1.171	
Telling patients how many children you have	3.375	3.372	1.002	29.218
Answering not applicable to the questions 'do you tell patients how many children you have?'	1.068	2.141	0.249	2.911
Not telling patients the names of your children			1.375	
Telling patients the names of your children	-2.851	2.431	1.375	0.058
Answering not applicable to the questions 'do you tell patients the name of your partner?'			4.054	
Not telling patients the name of your partner	-4.244	2.766	2.354	0.014
Telling patients the name of your partner	0.353	2.145	0.027	1.424
Having received training in boundary violating	-0.575	1.07	0.289	0.563
Number of years worked at this hospital.	0.318*	0.147	4.658	1.374
Constant	-1.456	1.944	0.56	0.233

*p<.05

Table 4: Logistic Regression predicting History of Boundary Violating

Other Quantitative Findings

On average, participants were aware of 4 different methods for reporting boundary violations. The most common methods were talking to their supervisor and reporting incidents to the nurse in charge. Interestingly, a high number of participants would also consider talking to the perpetrator about it.

When asked for their preferred method to report relational security concerns, the most popular method was speaking to their line manager. The majority of participants reported feeling very comfortable at reporting suspected relational security issues.

Figure 2 shows the most common reasons why, according to the participants, staff commit boundary violations.

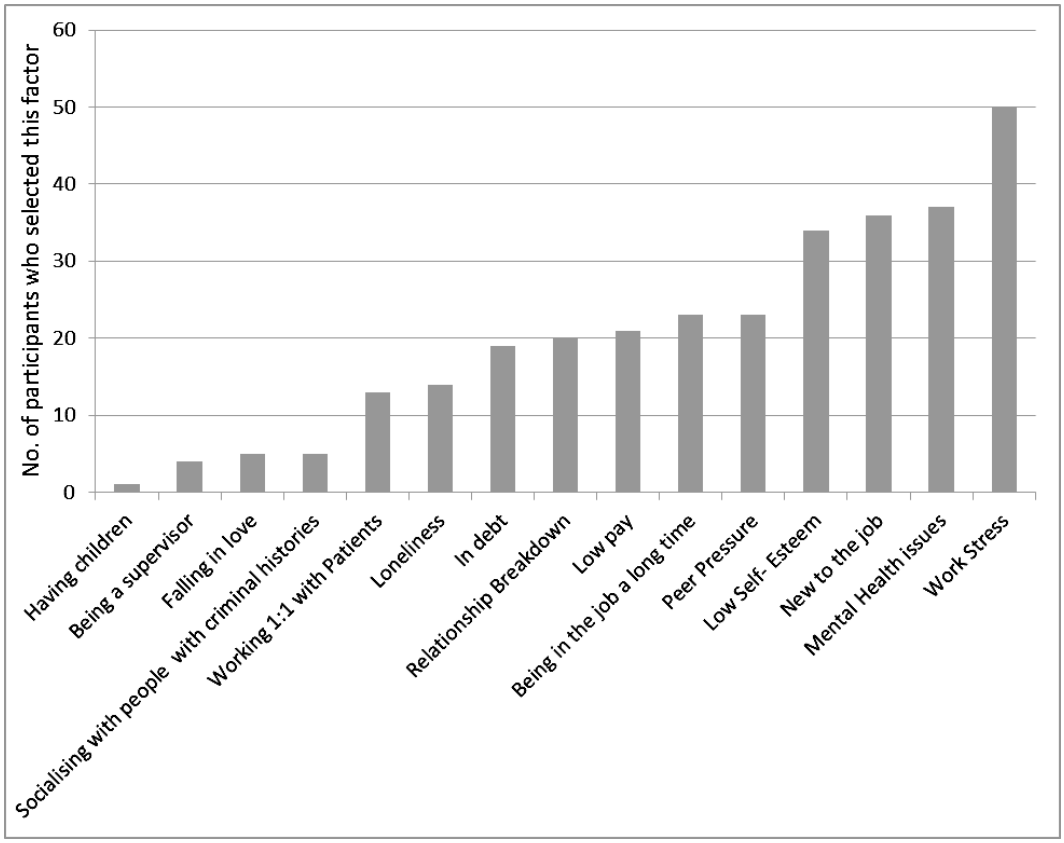


Figure 2: Participants' views on what features are risk factors related to boundary violating.

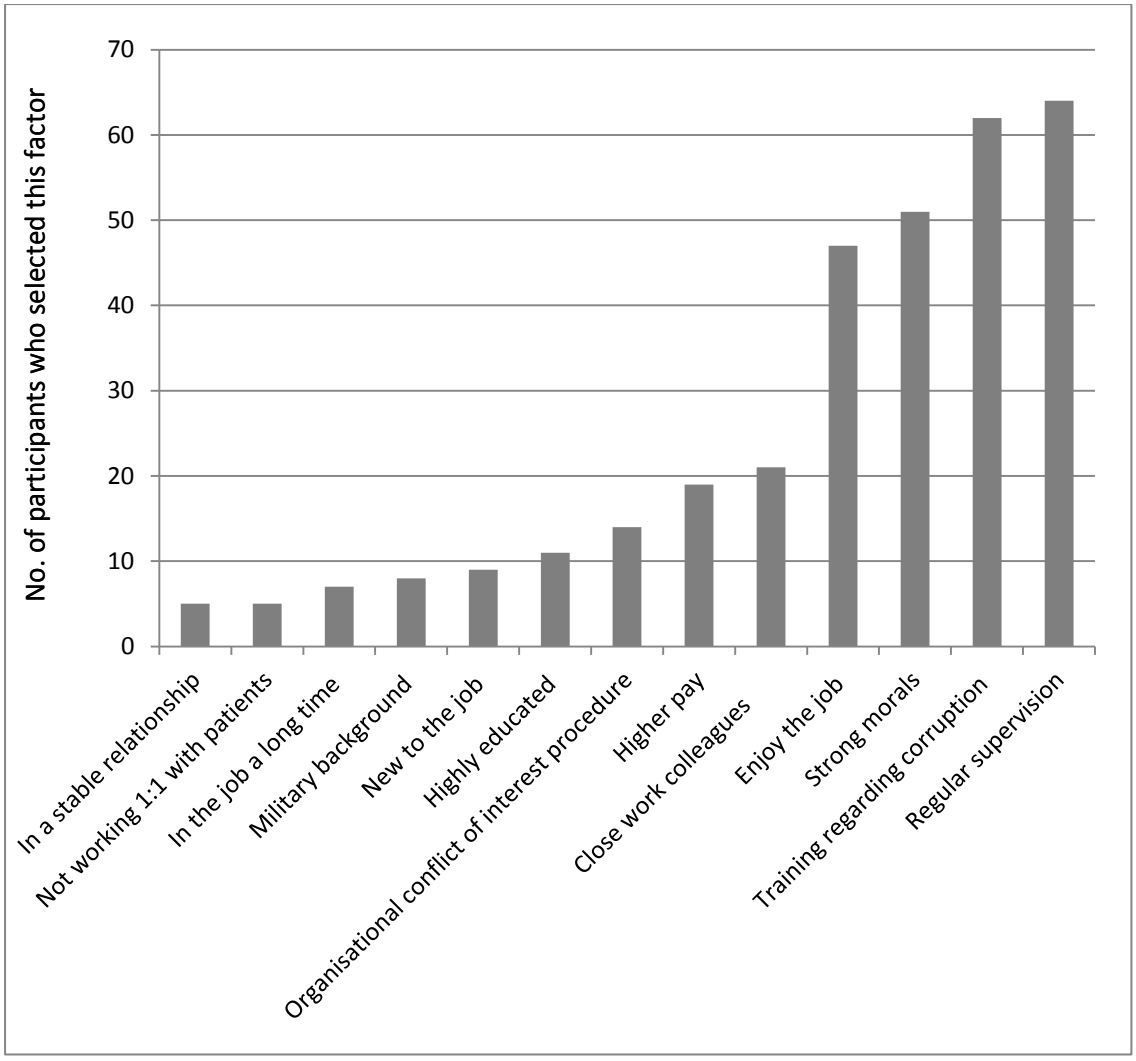


Figure 3: Participants' views on what features are protective factors related to boundary violating.

Figure 3 shows that the four most common protective factors that staff identified were having regular supervision (64 participants highlighted this as a factor, which made up 19.8% of responses), obtaining training regarding corruption (62 participant responses, 19.2%), having strong morals (51 participant responses, 15.8%), and enjoying the job (47 participant responses, 14.6%).

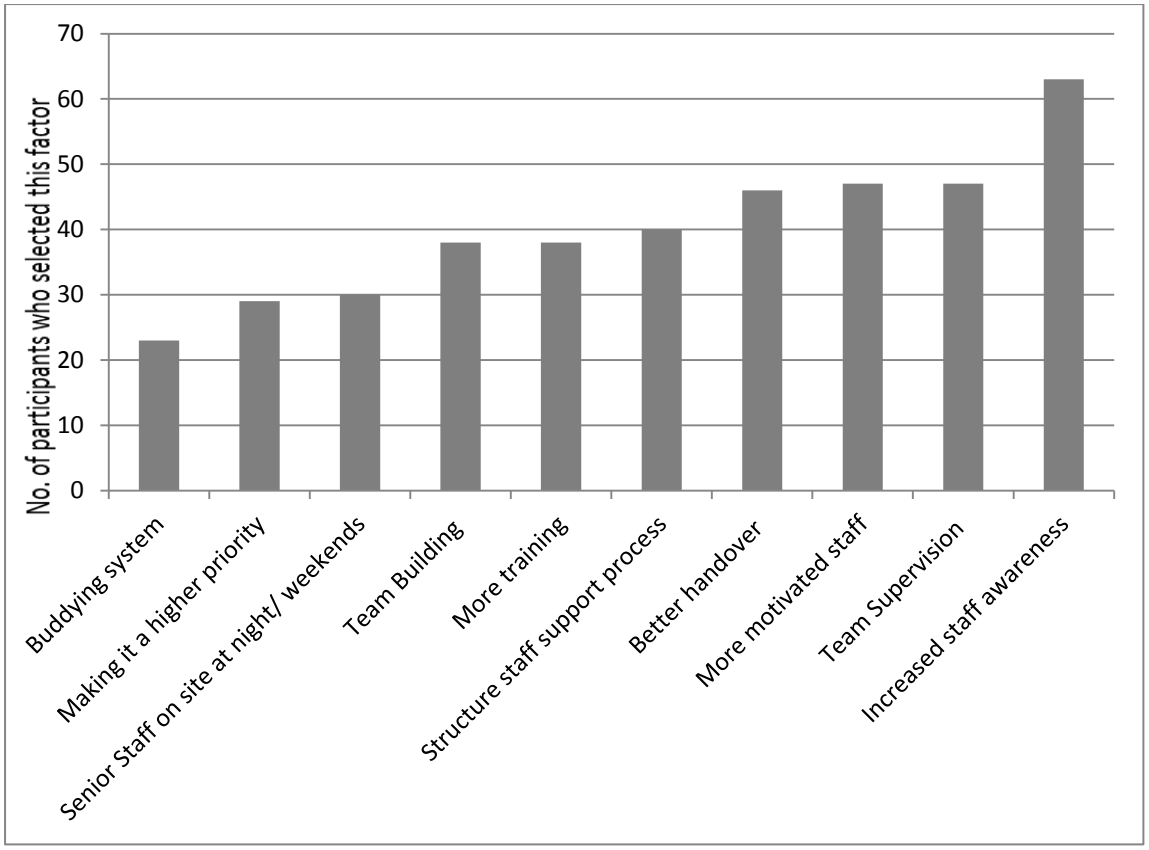


Figure 4: Methods identified by staff to decrease relational security issues and unprofessional/inappropriate behaviour.

Figure 4 shows that the four most popular ideas staff identified to decrease relational security issues or unprofessional/inappropriate behaviour in the work place were promoting staff awareness (63 participant responses, 15.7%), having team supervision (47 participant responses, 11.7%), developing more motivated staff (47 participant responses, 11.7%), and creating better handover (46 participant responses, 11.5%).

When asked if they felt that the hospital had a relational security issue, 29.9% of the participants responded with 'Yes', 29.9% responded with 'No', and 40.3% responded with 'In places'. Participants reported that 48% of them had suspected a member of staff of corruption or unprofessional/inappropriate behaviour and that 77.8% of that group had reported these concerns.

When asked why they had reported their concerns, staff members gave numerous responses, the most common being their "fears of putting others at risk", "people acting

unprofessionally or inappropriately towards patients" and "patients being allowed to cross boundaries/ rules". When staff had not reported their concerns about boundary violating, the most common reasons given for this were that the boundary violating staff member was friends with the potential whistleblower's line manager and thus feeling like their "concern would not be listened to", "worries that their life would be made difficult", and "feeling that it was a common behaviour" and "everyone else was ok with it". The four most common ideas for making the process easier were: having a structured staff support process (20.8%), having better handover (16.8%), more supervision (15.8%), and team supervision (15.8%). When asked about how often participants felt patients tried to encourage staff to commit boundary violations, 44% of the participants stated that this happened "sometimes" and 38% reported that it happened "often". When asked if they had ever experienced a patient trying to make them commit a boundary violation, 59% stated that they had.

The four most common methods that participants felt patients used to encourage them to commit boundary violations were: targeting new staff (57 participant responses, 7.4%), splitting the team (telling one staff member one thing and another staff member something else) (56 participant responses, 7.2%), asking staff not to report issues/ conversations (53 participant responses, 7.1%), and refusing to work with some staff (50 participant responses, 6.9%).

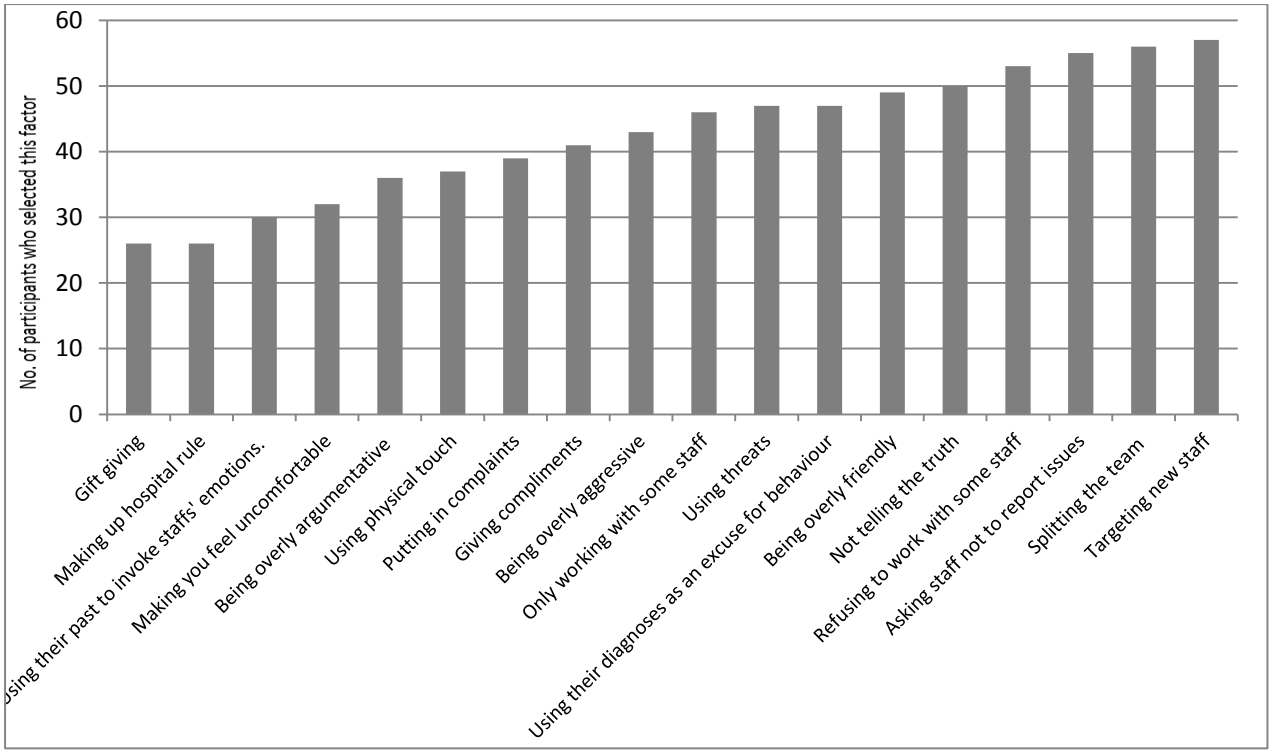


Figure 5: Behaviours staff perceived were displayed by patients to encourage them to commit boundary violations.

In response to seeing these behaviours, 60% of the participants stated that they had reported this behaviour to their managers, while 33.3% only reported their concerns in the ward notes. The ward notes are regularly read by the nurse in charge, who writes a summary of the day's activities for other members of staff, including the senior management team, to read. Thus, other ward staff may often not be aware of these incidences and depending on the quality of the summary neither may management. The final questions asked participants about training on relational security. Seventy-two per cent of the participants reported that they had received such training and 59% of them stated that this was good quality training. However, 57% stated that it was not enough training and 71% reported that they would like more training in this area.

Comparative data from participants

To draw together all of the quantitative findings, comparisons were made of data from the non-boundary violating staff with the staff that had engaged in boundary violating behaviours.

Table 5: Comparative table of findings

	Boundary violators	Non- boundary violators
Male	45%	71%
Age	38 years old	40 years old
Average Exploitation Index Score	9	13.5
Had been in the Armed Forced	7%	0%
Separated from their partner in the last year	11%	14%
Working on their own	49%	79%
Felt Lonely	18%	36%
Have people to turn to	93%	71%
Has finances trouble	13%	7%
Impulsive	10%	0%
Feeling anxious	22%	21%
Has low self-esteem	18%	21%
Shy	24%	14%
Has had training on boundary violations.	76%	50%
Qualifications:		
NVQ	14%	29%
GCSE	26%	14%
A level	10%	21%
Degree	39%	29%
Higher Degree	10%	7%
Marital Status:		
Single	29%	50%
Cohabiting	14%	7%
Married	19%	29%
Divorced	6%	14%
Separated	7%	14%
Widowed	3%	0%
Years working in care	9.5 years	11.2 years
Years working at the hospital	4.1 years	8.7 years
Average Salary	£20,537	£19,479
When asked how they felt that about their own boundaries:		
Not strong enough	1%	0%
Could be stronger	40%	43%
Very strong	57%	57%

Thematic analysis results

See tables 6 to 15 below for more details and the frequency tables.

Participants' understanding of managements' views on whistleblowing

When staff were asked for their perceptions on management's views on whistleblowing, the participants' responses presented with two main themes. The first, and most common theme, was they '*take it seriously'*. Staff felt that the hospital's managers understood the importance of whistleblowing in this forensic setting, and that if staff did whistleblow to managers, then their complaint would be taken seriously. Widespread staff views were that "management see whistleblowing as very important" (Participant #18), "serious" (#47), "a key area in ensuring standards are maintained and concerns investigated at earliest opportunity" (#2), and "very important that these concerns are reported, as breaches security" (#7). Some participants also talked about their personal experience of how management had reacted when they raised concerns with them on the issue of relational security. They stated that their concerns were viewed as "a critical matter that needed to be addressed, they thanked me for the info" (#16).

The other theme that arose was '*unwanted work'.* Participants described this in terms of believing that management feel that whistleblowing increased their level of paperwork and disrupted their daily workloads. Participants described management's views on whistleblowing as a "nuisance that needed to be addressed" (#54), "address if it suits them" (#40), whistleblowing is "creating more work" (#46), and "try and avoid the extra work until it is essential to act" (#80).

Participants' understanding of other staff members' views on whistleblowing

When discussing their perceptions of other staff members' views on this issue, three themes were identified; '*importantly necessary',* '*trouble makers'* and '*reluctant, try to avoid*'. The most common theme was '*importantly necessary',* with people emphasising that "It [whistleblowing] is part of our job" (#81), "they [other staff] view it very seriously" (#18),

"these behaviours can compromise others so individuals should be reported" (#7), and "essential" (#47). Other staff also talked about how hospital rules, policies and regulations directly stated that they should whistleblow if they had concerns around security and inappropriate behaviours. Thus, they deem this an important part of their job role.

The '*reluctant, try to avoid'* theme described more about how participants believe other staff are aware that they should whistleblow concerns, however felt that it would be easier to avoid trouble (both from colleagues and managers) through not reporting it. Participants stated that they "probably do not want to whistleblow when a friend and colleague may be in trouble" (#52), "unlikely to report issues due to lack of confidence, support in/from management" (#3), and concerns that "I am getting my friends into trouble and lose my job" (#8). Participants emphasised the difference in opinion amongst staff regarding whistleblowing, stating "some will be supportive, others won't" (#9) and that "some will embrace the process due to professional integrity some staff are fearful of process and will stay silent and watch situations unfold" (#2).

The final theme was '*trouble makers'.* Although this was the least common theme, the participants used the most emotive and descriptive language when discussing it. Some participants used unprofessional and unflattering terms when labelling these people. They talked about whistleblowers as being "grasses" (#77 and '#46) (informers), "trouble makers" (#45), "doing it for tit for tat" (#39) and "telling on their mates" (#28). While other participants passed judgments on the reasons for whistleblowing, some talked about how staff who whistleblow do so for malicious reasons. For example, "some people make up stuff to get others in trouble" (#48). They also viewed whistle-blowers as being overly vigilant and critical.

Participants' own views on whistleblowing

When discussing their own views on whistleblowing, two themes were identified; '*difficult but important'* and report with *'no concerns'*. Although both of these themes incorporate the response of reacting to concerns around relational security by whistleblowing, there

was a difference between the two themes. The '*difficult but important'* theme identified that it would be challenging to whistleblow, particularly if a colleague was also a friend. However, they also stress that they knew it was necessary to whistleblow concerns and thus would act. One participant stated, "I would prefer to avoid whistleblowing but if I saw inappropriate or dangerous practise I would report it" (#68). Another wrote, "whistleblowing has negative connotations but it is important to do" (#3), while another participant reported "it's good to whistleblow but a difficult situation" (#58). Many participants reported feeling torn between the "right thing to do" and the easy, more comfortable action of ignoring concerns. However they talked about always acting on their concerns despite this uncertain feeling.

The participants whose responses fit within the *'no concerns'* theme, stated that whistleblowing in all situations would be essential and thus they would be willing to do it with no hesitation or concern. One participant described their feelings as "unprofessional behaviour needs to be stopped so whistleblowing is necessary" (#50). Others responded with "whistleblowing is necessary if people are at risk" (#22), "essential" (#46), "no hesitation in reporting unlawful/ immoral activities" (#2), and another (#67) talked about how "it was essential for all staff to raise any concerns they have". The most common responses fell into the '*difficult but important*' theme with participants recognising that although it was challenging whistleblowing concerns was critical.

Overall, a response that appears to sum up the feeling among staff on the issue of whistleblowing, irrespective of whose views they are talking about, is that "if it (the relational security issue) is bad then whistleblowing is fine, if not don't get management involved" (#48). This quote encapsulates staff views that whistleblowing is an important act that needs to happen to maintain safety and security. However, it also recognises that it is difficult, which can deter people from acting on concerns.

Reasons staff whistleblow

There were three themes for the rationale behind reporting relational security concerns. The most common theme, '*maintain safety*', included participants' desire to keep both patients and staff safe through whistleblowing concerns. Participants wrote that they would report concerns "if I felt there was risk of harm to individuals involved" (#74), "if there are risks that are likely to cause harm if not rectified" (#15), "anything considered dangerous or unsafe for staff and patients" (#55), "if I saw a patient being abused" (#85), and maintain "wellbeing for all" (#77).

The second most common theme was '*desisting rule breaking*'. Many participants shared how they would whistleblow if they knew a hospital rule or policy was not being adhered to and thus this needed to be addressed through whistleblowing. This view was raised by one stating, "anything that goes against policy makes it a negative place of work and people may be inappropriate and cause issues." (#78). Additionally, another said, "I would report those that compromise patients or that don't follow regulations" (#47).

The final theme was '*persistent concerning behaviour*'. Some staff reported that they would whistleblow if the boundary violating member of staff continues with this behaviour, particularly if this happens after other staff member has tried to intervene. A participant stated, "I would report if a staff member failed to listen to advice and continues to breech relational security" (#45). Another said "I would talk to them and if they did not stop doing what they were doing then I would be forced to whistleblow, people need a chance as they may not know that what they are doing is wrong" (#64).

Despite a wide range of reasons for reporting the behaviour, many participants felt that it was part of their job to whistleblow concerns they had, and that they would take this action if they had concerns. A participant stated "it is part of my job to be aware of other staff behaviours and I would not hesitate to report this to management" (#7). While another summarised many participants' views on motivations to report: "I would report relational security concerns if it compromised safety or quality of care, if it put others at risk or if it could not be addressed informally" (#5).

Reasons that discourage staff from whistleblowing

Seven different themes were identified, with six of them explaining why staff feel discouraged from whistleblowing. The most common themes were '*personal relationships'*, '*lack of confidentiality'* and '*fear of victimisation'*.

The first theme of '*personal relationships'* referred to staff members feeling discouraged to whistleblow if the colleague who was committing the relational security concerning behaviour was a friend. A participant stated "I would be discouraged due to friendships" (#64), while another wrote "If I had a personal relationship with that staff member or their friends" (#48). This is particularly concerning, as the fact that the staff member is not doing their job correctly and whistleblowing concerns due to a duel relationship with their colleague, implies that more boundaries are being violated, not just the ones that they are witnessing.

Within the *'lack of confidentiality'* theme, participants raised concerns around their complaint not being addressed professionally or appropriately. One participant raised concerns that "everyone would know, nothing is a secret for long" (#69), while another stated "I would be discouraged if the person that I am reporting finds out that I have reported them" (#22).

This concern may also be linked with the theme of '*fear of victimisation',* with staff raising concerns around being bullied or judged by other staff for whistleblowing. One participant stated that they would be discouraged by the thought that "if nothing comes of it then they are likely to target me. I would be seen as a grass" (#48), while another stated "if you are targeted for doing it" and "I'd be put off by the worry of personal comebacks" (#67).

The other less common themes about what would discourage them from whistleblowing were '*new staff member'*, '*paperwork involved', 'no action'* and finally '*nothing' would discourage*. The first of these themes relates to participants' views that they would not whistleblow if the member of staff whom the concerns were about was new to the job. They shared views around them needing time to learn and everyone makes mistakes. A

participant wrote that they would be discouraged "if a new member of staff made a mistake. Instead I would offer guidance" (#57).

The participants who expressed views around '*no action'* stated that they would be discouraged from whistleblowing relational security concerns due to worries around not being believed, and thus no significant preventative action being taken by management. Thus they were concerned that they would risk their reputation for little change or gain. A participant talked about "I have a fear of not being believed and nothing happening" (#11), which was echoed by another, "if I felt I would not be believed I would be hesitant initially, but I would still go ahead with reporting and make sure I had evidence of doing so (#21). Thus they would have taken action for no benefit. Others talked about purely believing "that nothing would be done" (#18) and thus this belief deterred them from even reporting concerns in the first place.

Another less common theme was the amount of '*paperwork involved'* in the process, which participants shared would discourage them from whistleblowing. One participant wrote that "the amount of paperwork and complicated processes puts me off, it's just too difficult" (#75), while another wrote "I am discouraged by the procedures and forms, there are too many hoops" (#40). While this may be true about the amount of paperwork, it also raises concerns around member of staff's views on how important raising concerns about boundary violating is, and their level of understanding of how damaging and dangerous it can be for both staff and patients. As if they did then you would like to think that paperwork would not be a deterrent. This also highlights the need for staff to have support through the whistleblowing process.

The final theme '*nothing would discourage*' is illustrated by a participant who wrote "nothing, if I thought something was wrong I would say" (#50). Additionally, a participant wrote "Nothing, it is inappropriate behaviour and required action" (#7) and another participant stated "I would report every time" (#30). The quotes highlight this group of participants' understanding of the importance of whistleblowing and its role in maintaining standards and safety.

Staff suggestions for making reporting concerns easier.

Many of the responses in this section try to combat several of the concerns raised in the previous section. There were seven themes identified, the two most common being; '*anonymous reporting'* and *more 'approachable management'*. The other themes were '*more support',* '*effective change'*, '*simplifying reporting'*, '*training'* and the final theme '*nothing'* need change.

The most common theme was staff feeling that '*anonymous reporting*' would make reporting concerns easier. They talked about wanting "secure sealed boxed or envelopes to report concerns through, so no one needs to know who said what" (#66). While others talked about "more confidentiality would lead to less gossip and this is the main thing that daunts people" (#57), and "information being kept confidential and not divulged to other parties" (#46).

Within the theme of *approachable management,* participants also expressed a desire for "people to be approachable and take you seriously… deal with the issue and not ignore it" (#54), and "more helpful and caring management with a less judgmental culture might make it easier" (#21).

Another theme highlighted staff feeling that whistleblowers needed to obtain *more support* with the process and that this would encourage them to report their concerns. An awareness and an effective supportive procedure would be key in encouraging staff to act on their concerns. One participant talked about "more support for the person once they have reported would be good, otherwise people just feel used for information and then dropped" (#78).

Staff also stated that they wanted confidence that *effective change* and actions would be taken to rectify their concerns about another member of staff. Whistleblowing should be the start of the process for managing boundary violating behaviour. Staff reported that they need to feel that this is the case, as this would motivate them to raise their concerns. A participant reported that "you want to see your complaint being taken seriously and something happening, not just 'thanks', 'that's interesting' but actually something

happening. Management changing things, people being moved on who aren't right for this job" (#80).

Within the themes, '*simplifying reporting'* and *'training'*, several participants shared views that the process of reporting needed to be changed, and more guidance and training given on how to engage with it. Participants talked about drawn out and complicated approaches being taken to report and process staff concerns, and that this was discouraging staff from engaging in the process. Participants raised concerns about "getting lost in the [whistleblowing] process because it's way too complicated" (#79) and not knowing "what or how to report" (#57). Other participants disclosed that they wanted more training to help them with the process of whistleblowing. A participant stated "training on the process and improved knowledge about possible outcomes. Training that clearly highlights adverse outcomes of NOT reporting" (#5), while another participant suggested "on-going training in this area to increase staff awareness". These two themes are summarised by a participant's (#67) view that "more and clearly available info on written reporting (anonymous if possible) of security breaches".

The final theme was feeling that '*nothing'* more was required. Participants talked about it being simple enough to report and that the policy and procedures that were in place were adequate and did not discourage the reporting of concerns. A participant wrote "It is easy enough to express your concerns" (#7) and another wrote "fine as it is" (#65).

Staff perceptions on how they feel patients encourage them to commit boundary violations.

Participants reported 10 different groups of behaviours that they had personally experienced and felt that patients were intentionally doing to encourage them to commit boundary violations. The most commonly experienced behaviours were: '*Rule changes'*, '*Eliciting personal information'* and '*Inappropriate touching'*. The other behaviours encountered were: '*Threats', 'incentives', 'Passing messages', 'Overhearing', 'Trafficking', 'Team Splitting'* and *'encouraging omitting'.* It is unclear from these responses if the

patients were actually intentionally using these behaviours in order to encourage staff to violate boundaries. However, it is clear that all of these behaviours, if staff members had been compliant with them, would have led to boundaries being violated.

'*Rule changes'* involved staff feeling that patients were reporting that the hospital/ house rules had been changed, when they had not. The intention being that the patient wanted to obtain some form of benefit through stating that policies or procedures had been altered. One example of this was when patients "inform staff members they were allowed to do something they weren't" (#52).

'*Eliciting personal information'* was when a patient asked personal questions of staff, which the staff perceived as a method to obtain information that they could use for various gains. Staff talked about patients attempting to elicit private information from staff through "wanting to know where I lived, what car I drive" (#45) or "asking my wife's name, where I live etc. or even asking me about another patient's behaviour" (#9). Another participant shared that they felt a patient tried to encourage them to commit a boundary violation "by asking me directly for personal information, then trying to get other staff to ask when I would not discuss the information requested" (#21). Staff reported that they felt the patients tried to obtain this information to "use it against me" (#75) or "find out more about me to get closer to me" (#80). These are hypotheses from the staff, however they highlight the staff feeling alternative, more sinister, connotations for asking staff about themselves. This raises questions about how these views of patients' interest in staff and potentially innocent questions may impact on staff members' ability to form effective therapeutic relationships based on trust.

'*Inappropriate touching'* refers to staff feeling that patients were touching them inappropriately and using this as a method to encourage boundary violating. An interesting issue that arose from this was that some staff felt that the touching had the intention of trying to develop a closer relationship with the relevant staff member or to reassure them. A participant stated "they may be overtly sexual or try and chat you up and stroke you" (#3), and another shared that "they tried to hug me" (#29). However other staff reported that they felt this method was used to threaten and intimate them. "They make you very aware of how strong or tall they are, by grabbing your arm or pushing past you. It makes you

uneasy" (#77). Context is key to fully evaluate this, however it is interesting to see that the same behavioural theme incorporated different inferred intentions.

'*Threats'* covered behaviour such as verbal and physical gestures which staff felt were used to desist them from doing their job correctly and increasing the chances that they would commit a boundary violation. One participant reported that "it's the patients who talk about getting their lawyers on you if you do something wrong when all you are doing is your job, say checking post or asking them to come away from the windows. With some patients this is a constant conversation" (#50). While another participant stated that "one patient always raises their voice, complains and is verbally intimidating whenever anyone tries to conduct a rub down search, this makes some people not want to do it on him or at least do it quick. I'm not like that but at times I want to not bother" (#18). A participant stated "they threaten you, if you don't do ….." (#48) as a way of encouraging you to commit a boundary violation.

'Incentives' included staff being offered money to "bend rules, that they know you cannot do but they will try it" (#81) or "patients will try anything to push their luck. I have had some offer to make my day easier if I just do X or don't do Y, it's crazy" (#77). A participant talked about feeling incentivised and "bribed by giving me a gift for taking him on a home visit" (#8) and while another stated that they had been "offered presents or bits and pieces" from patients (#5).

'Passing messages' was not a very common theme, however some participants stated that staff had been given personal messages to pass on to other patients, family members or staff. One staff member stated that "a patient once asked me to pass on a crude sexual comment to another member of staff, it made me uncomfortable which I think was the point. I'm not sure what they thought I was going to do but I told him that it was inappropriate and wrote it in his patient notes. I never told the other staff member" (#74).

'Overhearing' was when staff felt that patients listened into private conversations and then would inform the staff member that they had heard. Staff were less clear about what they felt the specific function or purpose was of this, however they felt that it was a method used to encourage boundary violating. A participant wrote that "I found that a patient had

eavesdropped on a private conversation. He repeated what I had said. I think he did this to see how I would react and use the info to bond or confuse issues."(#5).

Another theme was patients asking for items to be trafficked, including cards, food and magazines. A participant stated that staff are "manipulated into bringing items into the hospital for patients" (#46), while another participant stated "asking staff to purchase them an item that's not allowed in house" (#54).

Another theme which was raised as a boundary violating method was "team splitting". This theme was explained less by staff, with most of them just stating that they felt that patients were trying to "split members of staff" (#69) or "trying to divide teams" (#77). Several participants also used the phrase "team splitting" (#8, 17, 42, 78 and 80). They were less clear on the methods patients used to achieve this aim. One potential reason for why this phrase was used, but with limited details, may be that 'team splitting' is a topic which is regularly brought up as a risk of working with this particular client group, and that staff have had training on this during their induction process. It is possible that either staff were more aware of this type of behaviour or that they felt this was a method that they had learnt about and thus included it more as an academic answer. Further exportation of this would be required for a more detailed answer.

The last theme was "encouraging omitting". This included staff being asked to not report information. A participant shared "It is fairly regular e.g. asking not to document things in the clinical notes" (#41), and another reported 'I've been asked by several patients not to document incidences or events in their obs [observation] forms. I always do but it makes you think that others [staff] may not. They [patients] can be quiet persistent' (#65).

Overall, it is unclear from these responses if the patients involved were intentionally using these behaviours in order to encourage staff to boundary violate. However, it is clear that all of these behaviours, if staff members had been compliant with them, would have led to boundaries being violated.

How staff realised they may be about to commit a boundary violation.

Four themes were identified with these responses tending to be less detailed and less specific than previous answers given by participants. The most common themes of factors that aided them in realising that they were potentially being encouraged to commit a boundary violation were participants' own '*personal boundaries'* and '*feeling uncomfortable'*. Other themes identified were '*patient awareness'* and '*knowledge'*.

Staff reported that being aware of their own '*personal boundaries'* helped them identify when they felt like they were being pushed or compromised. A participant stated "I know what I'm happy to do and not do. It both helps me and the guys [patients] know where to stand. When I feel I'm not being so clear or I do things in a way I don't normally this is a warning" (#55). Other participants talked about a more emotional or physiological reaction of '*feeling uncomfortable'* being a protective factor. These were covered by a participant's quote "my own defensive response and feeling of unease showed me what was happening" (#66).

Within the theme of '*patient awareness'* staff reported that knowing a patient's history and care plan, which highlight previous problematic behaviours, helped them maintain resistance. A participant stated "the patient had a history of doing this and I was very aware of how he did this" (#21), while another participant talked about "a clear knowledge of residents' history and care plans" (#48) made them realise that they may be being encouraged to commit a boundary violation.

Others reported that a different type of '*knowledge'* protected them. This knowledge included factual information about procedure, hospital rules, having training on boundary violating and how to maintain boundaries. A participant wrote "just knowing that this was against policy helped" (#42), and "after training in this area it was obvious what he was doing" (#53).

One participant highlighted how their knowledge about the hospital policy and the patient's background were protective factors against boundary violating. A participant stated "I just

know that what he was asking was against policy… he has a reputation for doing these kinds of things" (#81).

Feelings and responses reported after these incidences

There were six themes of how the participants had felt after feeling like patients were encouraging them to commit boundary violations. The most common themes were feeling '*fine*' or '*uncomfortable'*. The other themes were '*irritated'*, '*manipulation is easy'* and '*increase vigilance'*.

The '*fine'* theme included staff who reported that they were not concerned by the incident and that it did not affect them. Some participants felt that this experience was common and a normal part of their job, and thus they felt unperturbed by the experience. They used phrases to describe this such as "fine" (#8, 14 and 78), "it was ok" (#45) and "I felt no different afterwards".

Other participants, however, within the 'uncomfortable' theme, reported that this experience of believing that they were trying to be manipulated by a patient was unnerving. A participant stated "I felt anxious and edgy, it was just a bit creepy, but reassured when my thoughts and concerns were right… I told the resident I need to check policies and then asked the nurse" (#8). Another participant stated "I was left feeling slightly uncomfortable after this experience" (#14), and another said "I felt uneasy during the conversation, just not relaxed. Just kept thinking about what was right and why they were doing this?" (#79).

The '*irritated'* theme illustrated participants who were either annoyed at the patients for pushing boundaries or themselves for letting them try. "I was annoyed that they tried to do that to me, I thought that we worked well together and then he tried that, was not impressed" (#77). While another participant talked about "I felt that it was a close shave and I did not like the fact I nearly fell for it. I was pissed" (#67).

Other participants talked about being surprised at how easy it was for boundary violations to occur and that they could be involved. The '*manipulation is easy'* theme included quotes

such as “this experience made me realise how easy it is to get sucked into situations” (#18) and ‘I came close and I was amazed how simple it was for me to be manipulated” (#66).

Within the ‘*increase vigilance’* theme, one participant stated “It highlighted the need to be aware and on my guard” (#17) while another participant talked about “care and attention is what you always need to keep in mind with this client group, lots of people think because they are patients that they are not capable of some things but they are and we have to know that” (#49). The ‘increase vigilance’ theme highlighted staff using their experience and this making them change their practise, and learning from this to increased watchfulness and vigilance against boundary violating behaviour. While it is important for staff to be aware of boundary violating and increase their resilience to resist it, it is also important not to lose sight of other aspects of their job such as caring for and supporting the patients. For this to occur, a therapeutic relationship, built on trust, has to be developed with staff balancing not going too far one way and being overly close and ‘friendly’ or moving the other way and becoming cold and untrusting. There were several participants' contributions that did appear to verge on the more distant end of the spectrum. Participants report “beware of regulation and the patients….. be politely assertive in all interactions” (#9), “avoid having any violating, by keeping a professional approach at all times” (#33) and “if residents make a request, staff member should always find out if he has already been refused” (#1). A participant spoke about needing “personal distance at all times” (#35). While it is not possible to explore how strictly participants adhere to these personal rules around working or what they practically mean by terms such as “professional” or “check everything” we have to recognise that over vigilant, emotional distance and always being hyper aware member of staff who may see every request as a boundary pushing opportunity will interfere with the development of an effective therapeutic relationship.

Staff views on the best way to manage boundary violating behaviours

When the participants discussed what they believed were the best methods to manage relational security and boundary violating behaviour, they identified methods that fell into six different themes. The most common themes were ‘*Informing others’*, ‘*training*’ and

'*clear rules'*. The other identified themes were '*supervision'*, '*consistency'* and '*directly addressing behaviour'*.

The '*Informing others'* theme described the importance of staff passing on key information about potentially risk-related situations or boundary violating situations. There was talk about having effective 'hand overs' between staff on different shifts in order to avoid boundary violating and boundary pushing. One participant wrote that one effective way to decrease boundary violating was "to know the patient's history and to share information amongst the team. Detailed entry in clinical notes, referenced in CPA/MHRT reports." (#2). Within this theme participants also talked about particular methods that can help this process of informing others, such as "making reporting anonymous", "make the reporter aware that their concerns will not be ignored and that they are made aware of the outcomes of their reporting" (#22), staff "feeling listened to" when they share information (#17), and "if staff report – listen, we are the ones working day in day out with them" (#39). Participants talked not only about passing on information to other staff working with the patients, but also informing management of the situations. A participant wrote "share concerns with line management to ensure transparent communication channels" (#2).

Within the '*training'* theme, some participants reported wanting specific training, such as "all staff need training in having some stock phrase to use to address them [patients] in a non-inflammatory way at the time e.g. "you know the rules- I'm not going to discuss that with you". While others spoke of wanting more general training on the topics of boundaries, managing problematic behaviours and learning about patients' histories.

Participants talked about wanting '*clear guidance'* on how they, as staff, should interact and how patients should behave. They felt that this would help decrease ambiguity. Participant 4 talked about how "clear guidelines would be helpful, particularly for new staff, to give us help on how to manage patients, answer their requests and maintain boundaries". A participant wrote "maintain house rules" (#54) and another participant said "keeping to house rules" is the best way to manage this issue (#6). Another stated "clear rules and consequences of violations is what is needed [to manage boundary violation]" (#48) and stop them from becoming a problem. Others talked about clear guidance based on policy and procedures around boundary violating, stating "be aware of regulations and hospital

policies on this stuff" (#15), "setting up strong organisation policies so we know what to do' (#4) and "ensure that all are aware of the "See, Think Act" and what to do with concerns" (#8).

'*Supervision'* was discussed as an effective method of raising concerns and sharing information. A participant stated supervision was a way of "keeping all staff aware, as well as management [of any concerns]" (#56), while others talked about it being an effective method of monitoring staff on a regular basis. One participant stated "regular supervision is the best ways to manage boundaries" (#55) which was echoed by another who said "lots of supervision on a regular basis" (#22) is supportive in decreasing the prevalence of boundary violating. A participant also wrote that staff and managers should "openly acknowledge them [boundary violations] with all concerned and address issues in supervision." (#21).

'*Consistency'* between staff in the way they interact with patients and maintain the same boundaries was raised by numerous participants as an effective way to manage boundary violations. They talked about staff being "uniform" (#6) in the way they interact with patients, "maintaining consistency in care provision" (#11), and another recognised that "a consistent approach is so important with this patient group" (#28). They also talked about being constant in their use of procedures and avoiding certain behaviours, for example: "for all staff to work as trained and not disclose information about other staff members" (#50), and "consistency between staff where we document issues, concerns/handover all help to maintain rules and boundaries" (#54).

Several staff felt that the most effective methods of managing boundary violating were not procedures or documenting concerns, but that '*directly addressing behaviour'* with the patients involved when it arises. They talked about "being firm, telling patient if they make inappropriate comments. Remain professional" (#7), "address directly and quickly" (#75), and "directly addressing these issues with the patients, and then make sure everyone in the team is aware of the strategies used by the patient" (#41).

Frequency table of themes collated from the thematic review.

The frequencies that themes were recorded are shown below. The total frequencies vary du to some participants not answering all the questions, not all answers formed themes and some participants identified several themes within their one answer. See Tables 6-15 below.

Table 6: Frequency of themes regarding participants' understanding of Management's views on whistleblowing

Themes	*F*	%
Take it seriously'	48	84
Unwanted work'	9	16

Table 7: Frequency of themes regarding participants' understanding of other staff members' views on whistleblowing

Themes	*F*	%
Importantly necessary	42	71
Reluctant, try to avoid	11	19
Trouble makers	6	10

Table 8: Frequency of themes regarding participants' own views on whistleblowing

Themes	*F*	%
Difficult but important'	38	53
No concerns'	34	47

Table 9: Frequency of themes regarding reasons staff Whistleblow

Themes	*F*	%
Maintain safety	25	45
Desisting rule breaking	19	35
Persistent concerning behaviour	11	20

Table 10: Frequency of themes regarding the reasons that discourage staff from whistleblowing

Themes	*F*	%
Personal relationships'	16	24
Lack of confidentiality'	15	23
Fear of victimisation'	12	18
New staff member'	7	11
Paperwork involved'	7	11
No action	5	8
Nothing' would discourage	4	6

Table 11: Frequency of themes regarding staff suggestions for making reporting concerns easier.

Themes	*F*	%
Anonymous reporting	15	27
More approachable management	13	23
More support	7	13
Nothing' need change	6	11
Effective change	6	11
Simplifying reporting	5	9
Training	4	7

Table 12: Frequency of themes regarding staff perceptions on how they feel patients encourage them to commit boundary violations

Themes	*F*	%
Rule changes'	10	18
Eliciting personal information'	7	12
Inappropriate touching'	7	12
Threats'	6	11
Incentives'	5	9
Passing messages'	5	9
Overhearing'	5	9
Trafficking'	4	7
Team Splitting'	4	7
Encouraging omitting'	4	7

Table 13: Frequency of themes regarding how staff realised they may be about to commit a boundary violation

Themes	*F*	%
Personal boundaries'	24	39
Feeling uncomfortable'	19	31
Patient awareness'	10	16
Knowledge'	8	13

Table 14: Frequency of themes regarding feelings and responses reported after these incidences

Themes	*F*	%
Fine	26	42
Uncomfortable	14	23
Irritated	8	13
Manipulation is easy	6	10
Increase vigilance	4	6
	4	6

Table 15: Frequency of themes regarding how to manage boundary violating behaviours

Themes	*F*	%
Informing others	25	34
Training	15	20
Clear rules	14	19
Supervision	9	12
Consistency	6	8
Directly addressing behaviour	5	7

Discussion

This study was motivated by an awareness of the critical importance of developing effective working relationships between staff and patients, and the devastating effects boundary violating behaviour can have on all involved. Unlike previous research (e.g. Ehlert, Cormier, Celenza, Danley, Marinelli, Messing, & Walls, 2002; Celenza, 1998; Gabbard, 1994), this study is not restricted to looking at only boundary violations among therapists, but explores a wide range of professions. This study aimed to increase the knowledge base regarding boundary violating risk and protective factors, with a view to (a) benefiting patients by minimising potential harm caused to them, (b) staff by increasing their resilience, and (c) management by helping them to protect and support their staff members. This study also addresses the current complicated topic of whistleblowing, along with exploring what can be done to effectively manage and encourage this behaviour. The results from this study illustrate the factors and issues relating to boundary violating and whistleblowing within a low secure forensic hospital. The results indicate that this hospital, has some issues with boundary violating behaviours. Different ways to manage these issues have been identified through quantitative and qualitative methods.

Factors placing staff at risk of committing boundary violations

Previous research has indicated several risk factors including life events, personal characteristics and environmental factors that all impact on staff resilience to engaging in boundary violating behaviours (Daniels, 2008; Epstein & Simon, 1992; Garfinkel, Bagby,

Waring & Dorian, 1997; Marquart, Barnhill & Balshaw-Biddle, 2001; Worley & Cheeseman, 2006). The systematic review in Chapter 2 also highlights how the environment plays a key role in determining the relevance of factors. Findings from previous studies, primarily based in either the USA or non-forensic settings, were not necessarily applicable to this forensic healthcare setting, highlighting that further environmentally specific research is required.

Initial analyses, in the form of correlations, Fisher's exact tests and chi-square tests, indicated that several risk factors have a significant relationship with staff having a history of engaging in boundary violating behaviours. These included some risk factors that support previous research findings, such as working alone with patients and disclosing personal information (Epstein & Simon, 1992). The potential rationale behind this is twofold. One being that staff members who want to engage in boundary violating behaviours will seek to work alone with patients and share personal information in order to have the opportunity to commit boundary violations undetected. However, the other possibility is that spending time alone with patients as part of their normal job role may create a more intimate environment for a more personal interaction and thus boundaries become blurred.

Previous research also supports the finding that staff self-disclosing personal information, such as the number of children they have or their partner's name, is a risk factor (Epstein, Simon & Kay, 1992). It was interesting that the current study found that staff sharing with patients if they had children or a partner was not a risk factor; however, sharing more personal details, such as the name of your children was. This supports research regarding the 'slippery slope' theory, which indicates that some personal disclosure and boundary crossing is supportive of the development of the therapeutic alliance and not harmful. However, some more personal self-disclosure is harmful, as it increases the chance of individuals committing boundary violations (Galletly, 2004; Strasburger, Jorgenson & Sutherland, 1992). Therefore, awareness of this oversharing behaviour may be an early warning sign for staff, supervisors and management that the professional boundaries are shifting and the relationship dynamics are changing.

Although these variables were highlighted as potential risk factors due to their significant relationship with the dependent variable of having a history of committing boundary violations, they were not significant predictors in the regression model. Thus, further

research and a larger sample size is required to develop a better understanding of the influence of these factors on staff members' ability to desist from engaging in boundary violating behaviours.

The regression model indicated that the longer a member of staff worked at the hospital, the more at risk they were of committing a boundary violation. Although a limitation is that it is unclear from the data when the boundary violation took place and thus, further research would be needed to explore this in more depth.

This risk factor was also explored by Marquart, Barnhill and Balshaw-Biddle (2001), who found that on average prison staff who commit boundary violations have been in the job for three years. The average length of time working in this hospital for staff who had committed a boundary violation was 8.7 years, implying that in forensic healthcare settings, the risk related time period differed from a prison setting. As the length of time working in care was not a significant risk factor, it indicates that being settled and with a set client group for a long time, rather than in the job, was the risk factor. One explanation for this may be that, in this specific hospital, generally patients stay for a long time with some residing in the facility for over 15 years, with patients and staff becoming very familiar with each other over time. This familiarity may result in a shift away from the more formal and professional interactions, towards more boundary blurring and violating behaviour. Social psychology research into friendship development has shown that simply spending time with one another is one of several significant factors in a friendship development (Keane, 1991; Athanasiou & Yoshioka, 1973; Kahn & McGaughey, 1977). Also, research has shown that boundary violations often happen after a period of time within which boundaries have broken down due to a series of smaller boundary crossings, that is, it takes time for staff members' boundaries to be eroded and for them to go down the "slippery slope" (Maule, 2007; Gutheil & Simon, 2002). Staff who have worked longer in the hospital are more at risk of committing boundary violations, though it is also possible that they are more likely to be caught due to being there longer.

While time is required to develop effective therapeutic and trusting relationships, these findings highlight the importance of staff being mindful of the potential pitfalls of working long term with individual patients (Berger, 1993; Horvath, 2000). This study recommends

that if long term work is necessary, then it is important that systems are put in place to monitor the impact of being exposed to this particular risk factor.

Having a family member or close friend disciplined for committing a boundary violation also increases staff members' likelihood of engaging in boundary violating behaviours. Although there is no other boundary violating research with similar findings, there is research which indicates that an individual's ethics and morals are strongly influenced by their social experiences (Haan, Smith & Block, 1968; Straughan, 1988). Forensic studies also indicate that having a criminogenic family or peer group increases an individual's chance of engaging in criminal activities (Webster, MacDonald & Simpson, 2006; Andrews, Bonta & Wormith, 2006). Social learning theory describes how individuals develop their understanding of appropriate and inappropriate behaviours through observing their family, and this can subsequently be similarly reinforced by their peer group (Bandura, 1977; Akers, Krohn, Lanza-Kaduce & Radosevich, 1979; Bandura, Ross & Ross, 1961). Staff who are exposed to social networks, such as close friends or family members, who possess less strict boundaries or potentially support boundary violating behaviour, are more likely to engage in similar behaviours. It would be interesting to explore whether it was just the exposure to this, or if other factors, such as how influenced people are by others or the type of relationship, played a role in the influence of this risk factor on staff.

The Exploitation Index (EI)

The correlations indicated that individuals who scored highly on the EI were more likely to have previously engaged in boundary violating behaviours. It was hoped that there would have been some reduction in their level of risk, since there are no restrictions on how regularly EI measures can be repeated and staff are asked about their behaviour over the last year.

The finding that staff who had previously engaged in boundary violating behaviours scored high on the EI adds support for the validity of the EI tool. This may also indicate that staff are aware of their boundary violating behaviour and that the disciplinary action is not a

protective factor to lower their risk of boundary violating as they are still scoring high on the EI. This is of concern, as disciplining is the most prevalent method currently used to address this issue. This finding indicates that high EI scores are a risk factor, but that disciplining staff and drawing their attention to potentially risk related behaviour does not lead to a substantial shift in their boundary violating risk related behaviour as the EI scores remain high. A limitation is that if the boundary violation took place in the last year, then you would expect the score to remain high, as the EI would have detected this behaviour.

This study highlighted four potential risk factors that increase the chances of people committing boundary violating behaviour. Interestingly, none of these were selected by staff as being the main factors they believed increased people's risk of boundary violations. It is particularly concerning that one of the factors "being a new member of staff" is actually the opposite of what was found through the regression. However, a potential explanation for this is explored later in more detail in regard to whistleblowing. It appears that staff have a poor understanding of what factors put them at risk of boundary violating. This is worrying, as research indicates that both self-awareness and awareness of these issues are protective factors (Epstein & Simon, 1990). This study recommends further training in these areas to increase insight and resilience.

Overall, there appears to be several personal and environmental factors that put staff members at risk of engaging in boundary violating behaviours. Further research is required to add validity to these findings, however, it is hoped that raising awareness of these factors will help highlight ways to increase staff awareness of risk and implement effective protective measures

Factors protecting staff members from committing boundary violations

The regression did not identify any protective factors that explained the variance in the dependent variable of staff members' having a history of boundary violating. However, the correlations and Fisher's exact tests indicated that four protective factors had a significant relationship with staff members' having a history of boundary violating. Although the

regression results are more reliable, it is worth considering the significant relationships identified by the preliminary tests, as they suggest further research with a larger dataset may identify more protective factors. It is possible that these variables were not significant in the regression analysis due to interactions between the variables in the model. Alternatively, these significant relationships in the preliminary tests could be due to coincidence (i.e., Type I error). Again, further research would help to establish whether or not this is true. However, at this stage, the results of these early tests run prior to the regression should not be ignored. Two of these protective factors were related to social support, 'feeling they have people to turn to' and 'having a good social life'. Studies have indicated that some staff commit boundary violations to fulfil needs that they are missing in their life outside of work from patients, such as social contact, closeness, friendship and sexual relationships (Gabbard, 1994; Hamilton & Spruill, 1999). Thus, having emotional support and a good social life outside of work protects staff from seeking these needs inappropriately. This supports the previous finding that social groups influence individuals' boundary violating behaviours (Straughan, 1988; Webster, MacDonald & Simpson, 2006; Andrews, Bonta & Wormith, 2006). Worley and Cheeseman, (2006) found that a risk factor for boundary violating was having 'non-shareable problems'; offenders who discovered this would use this to develop a relationship with the staff member. Having a 'good' supportive friend who you can disclose problems to is a protective factor against this and is exactly what this study has found.

Several articles have considered training and supervision as potential protective factors to maintain boundaries (Strom-Gottfried, 1999; Sarkar, 2004; Fronek, Kendall, Ungerer, Malt, Eugarde & Geraghty, 2009). However, no specific quantitative research has previously been conducted to specifically explore this relationship. This study found that both factors potentially had significant relationships with boundary violating. Staff also stated that they felt these two factors were the most effective protective factors against boundary violating, implying they have a more accurate and well informed understanding of protective factors against boundary violating than risk factors.

The potential explanation for this is that supervision and training are ideal methods to develop an individual's self-awareness and monitor potentially risk related behaviours.

Epstein and Simon (1990) identified that self-awareness of changing behaviours, thoughts and feelings towards patients, was key in decreasing boundary violating risk. Participants' qualitative answers also raised the importance of self-awareness and stated that knowing their own personal boundaries and recognising that they were feeling uncomfortable, alerted themselves to the potential that patients were trying to encourage boundary violations.

Training on the practical areas of avoiding boundary violating and staff members' role in maintaining relational security is also key. Participants reported that knowing factual information about boundaries, policies and patient history aided them from desisting from boundary violating behaviours. The importance of staff possessing this knowledge was demonstrated by the fact that staff felt that patients would report that a rule had been changed, potentially to elicit boundary violating behaviour from staff. This indicates that supervision and training needs to focus on policies and increasing knowledge of the patients, as well as increasing an individual's self-awareness and insight. Having time for supervision and training is important. In this study 85% of staff stated that they were supervised and 72% reported that they had attended boundary violating training. The staff who did not engage were more likely to have committed a boundary violation. More effort and support from management is recommended for establishments to fully utilise and benefit from these two protective factors.

Overall, the findings indicated that there are several factors which potentially protect staff from engaging in boundary violating behaviours. Activities such as training and supervision appear to develop staff knowledge, insight and skill base. While social factors, such as having individuals to turn to, appear to strengthen staff resilience to engaging in these behaviours. As the regression did not find that these factors significantly predicted variation in boundary violating, further research is required to verify the reliability of these findings.

The majority of participants had some form of experience of boundary violating behaviours, 70.2% stating that the hospital had issues in at least some places with boundary violating behaviours. Along with this, 48% reported that they suspected a staff member had engaged in corrupt or inappropriate behaviour, highlighting that boundary violating is an area of concern and that it does need to be addressed.

Staff recognised that there were personal factors that increased their risk of committing boundary violations, such as having mental health issues. However, they also cited patient behaviour as one of the contributing factors. Although the responsibility of maintaining a professional boundary always resides with the professional, previous research has also indicated that client's behaviour can influence a staff member's decision to engage in boundary violating behaviour (Allen & Bosta, 1981). When asked about how often participants felt patients tried to encourage staff to commit a boundary violation, 44% stated that this happened 'sometimes' and 38% reported that it happened 'often', with 59% stating they had personal experiences of this. While there is no evidence to support the real intentions of the patients when engaging in these behaviours, it is worrying that staff believed this behaviour. Participants felt patients used a wide range of different behaviours to encourage staff to commit boundary violations including targeting new staff, splitting the team, asking staff not to report issues or conversations and refusing to work with some staff. Previous US prison based research has identified similar methods, particularly around obtaining personal information, targeting new and vulnerable staff, intimidating and 'rule bending' as a way of conditioning and manipulating staff (Allen & Bosta, 1981; Cheeseman-Dial & Worley, 2008). It was interesting to see that the participants were reporting patients using similar behaviours in a secure mental health and learning disabled environment.

It was also noteworthy that staff felt that patients targeted new staff members, however, the regression indicated that it was staff who had been in the hospital longer who actually engaged in more boundary violating behaviours. One potential reason for this may be that although patients target new staff, they have recently received induction training on boundary violation, which acts as a protective factor discouraging them from engaging in such behaviour. Another factor may be the way new staff members are treated by other colleagues, which is explored in more detail below.

There were two themes that appear to summarise staff experiences of boundary violating at work; 'realising how easy it is to be manipulated' and 'feeling the need to increase their vigilance.' These highlight the challenges that staff encounter on a reasonably regular basis, their genuine concerns about how these behaviours can happen and also their understanding that vigilance along with other factors are key in addressing this issue.

However, the systematic review also raised concerns that staff may become overly vigilant and hyper aware to the risk of boundary violating. This in turn may impact on their ability to be caring, responsive and develop an effective therapeutic relationship if they are constantly interpreting patients' behaviour in the context of boundary pushing and violating.

There is always a concern that when discussing boundary violating staff think of it as something that 'other' people do, that it is a fault with that person and thus they would never engage in that behaviour. When looking at the factors participants believed put staff at risk, there was evidence of this way of thinking i.e. people having mental health illness and 'poor morals'. However, the thematic analysis indicated that staff did not believe they were at risk when asked about them. By exploring staff experiences of boundary violating, it is clear that boundary violating behaviour is a concern to them. Not only because they see other staff members engaging in boundary violating behaviours but also, because they feel that patients play a contributing role in encouraging staff to do so.

Staff views on whistleblowing and factors that deter people from reporting concerns

The overall theme from staff on whistleblowing concerns about boundary violating behaviour is that it is important, but potentially challenging to do. Participants recognised that it is necessary and 'the right thing to do'. This fits with the findings of McCabe, Trevino, and Butterfield (2001) and De Graaf, (2010) that institutions and individual staff understand the importance of peer monitoring and value the role of whistleblowing. However, some participants felt torn between this and their concerns around creating more work, encountering judgement and feelings that their actions may be ineffective. These findings support Firtko and Jackson's (2005) paper which found very similar beliefs; they felt that it is right to whistleblow but staff still have reservations. They described this as 'the ethical and moral dilemmas' of whistleblowing (p. 56). Similarly, Rennie and Crosby (2002) found that although students understood that corruption had occurred and that they 'should' whistleblow, they resisted acting on this.

The participants also raised views that whistleblowers were 'grasses', being overly vigilant or critical and only using this method in order to get other people into trouble. This theme of 'trouble maker' had not been encountered in previous research (Ahern & McDonald, 2002; Decker & Calo, 2007). However, studies have found that whistleblowers had concerns that they would be seen in a negative light by their colleagues and many have faced discrimination (Jackson, Peters, Hutchinson, Edenborough, Luck & Wilkes, 2011; Lewis, 2007). This fear of judgment has been raised as one of the main deterrents and reasons why boundary violating and other forms of corruption are under reported (Mesmer-Magnus & Viswesvaran, 2005; Mansbach, Ziedenberg & Bachner, 2013).

Whatever their feelings about whistleblowing, the participants demonstrated a good knowledge of how to engage in this process with an average of 3.7 different methods for raising concerns being identified. The majority of the methods recognised were formal routes laid out in the hospital's policy, such as reporting concerns to supervisors or the nurse in charge. However, interestingly there was an additional unofficial approach, 'speaking to the perpetrator', which was frequently mentioned. This approach is not formally supported by management or outlined in policy, nonetheless, the frequency by which it was mentioned by staff members implies that it is a recognised method used by staff as a way of self-policing and addressing this issue. This response indicates that staff are taking on the task of maintaining boundaries and enforcing workplace fairness. This maybe an indicator that they do not feel that there is organisational justice, due to management not addressing boundary violating issues effectively. Thus, they are tasking themselves with the role of challenging this behaviour to maintain organisational justice because they do not feel that the traditional process of managing boundaries is effective. This may account for the suspected high levels of under reporting of boundary violating behaviour; people use this approach rather than going through official pathways. Hence, boundary violating incidences are not going unnoticed or unchallenged, just not officially reported. This view was also supported by responses to the follow-up question 'what would make people whistleblow?' Participants stated that they would only involve management if their personal interventions were ineffective at curbing this behaviour amongst peers. This again raises the potential for under reporting of both concerning behaviours and effective interventions. Peer regulation may be a very effective desisting method which goes under researched due

to a lack of official data on this approach. This was a particularly interesting as no previous research has highlighted the potential that staff may try to address relational security issues with their peers without involving management.

Reasons for whistleblowing

Aherns and McDonald (2002) previously reported that patient advocacy was a common motivator in whistleblowing acts. Mansbach and Bachner (2010) also identified that nurses would whistleblow if they witnessed “harmful misconduct of a colleague” due to a “desire to correct the wrongdoing” (p. 483). Near, Rehg, Van Scotter and Miceli (2004) also found that people would whistleblow if they felt that a significant “wrongdoing” had taken place and to minimise harm to others. These findings were supported by this study which also highlights that the main motivation for staff to whistleblow is the maintenance of staff and patient safety and their awareness that rules were being broken. This indicates that staff member's understanding of the harmful effects of boundary violations motivates them to intervene.

Reasons for not whistleblowing concerns

Previous research papers have found that people under report or do not whistleblow their concerns, despite having a good knowledge about the importance of whistleblowing (Near, Rehg, Van Scotter & Miceli, 2004; Soeken & Soeken, 1987; Peternelj-Taylor, 2003; Bernard & Jara, 1986). Staff in this study were also open about which factors inhibited them from whistleblowing, including concerns that the boundary violating staff member was friends with management, the whistleblower being friends with the potentially boundary violating colleague, feeling like their concern would not be listened to, “worried that their life would be made difficult” and “feeling that it was a common behaviour - everyone else was ok with it”. The first two responses also raise concerns that participants feel that boundaries between some staff members and management are blurred, which in turn impacts on their ability to do their job. This highlights that boundary violating does not only occur between

patients and staff, but also within the staff population. The impact of this can be equally harmful and can subsequently impact on the effectiveness of addressing boundary issues in general.

If staff do not think that management may take action, value protocols or act in a "fair way" relating to an environments feeling of organisational justice (Brockner, 2010), then these comments imply that some staff members feel that the procedural justice (i.e. the process that leads to fair outcomes) is not being upheld. If staff do not have faith that management will act in an appropriate and fair manor, then this has consequences on reporting concerns to management. Some of these findings support Lewis' (2007) and Martin's (2003) papers which state that people do not whistleblow due to the perception that the relevant authorities would not take necessary action. This highlights that this is a common and real concern for staff members and a major contributing factor for desisting staff from whistleblowing. Management strategies such as feeding back actions or acknowledging that action will be taken may combat these concerns. However, this would have to be balanced with maintaining confidentiality.

Through thematic analysis the study found that participants are less likely to whistleblow or get management involved when a boundary violating staff member is new. They were more likely to ignore the potential boundary violating behaviour or self-intervene. This is particularly interesting as other studies have found that clients target new or naïve members of staff (Allen & Bosta, 1981; Cheeseman-Dial & Worley, 2008). Thus new members of staff are more vulnerable and need more support. This could be achieved by informing their managers via whistleblowing but it does not appear to be happening. The regression found that staff members who have been in the job for a longer period of time are at an increased risk of committing boundary violations. Although there may be numerous reasons for this, one potential explanation is the potential under reporting of boundary violating in new staff members, thus only staff members who had been in post for a longer time are addressed by management. As numerous studies indicate that boundary violating behaviour is under reported, it was interesting to see that there were so many different reasons why people are discouraged from whistleblowing (Lewis, 2007). This highlights the need for a multimodal approach to address this issue of under reporting,

mirrored in the wide and varied approaches recommended to staff as a way of encouraging and supporting whistleblowing, including simpler reporting methods and appropriate training.

Concerns of being identified, subsequent judgements and negative consequences have been identified in the literature in relation to whistleblowing (e.g., Firtko & Jackson, 2005; Miceli & Near, 1994; McDonald & Ahern, 2000; Jackson, Peters, Hutchinson, Edenborough, Luck & Wilkes, 2011). The participants' responses in this study demonstrate that there is still a stigma attached to this behaviour, which consequently impacts on the effectiveness of any intervention to either encourage whistleblowing or motivate staff to have an honest and open discussion involving the issue of boundary violating with the aim of effectively managing it.

Implications

Overall, there appears to be several factors that put staff at risk and protect them from engaging in boundary violating behaviours. These factors are both individual and environmental, therefore, both staff and hospitals have to take a proactive approach in using this new information to address boundary violating behaviour. Hospitals should inform staff of these factors, organising training and supervision in order to best support them. Staff have a responsibility to be aware of their potential vulnerabilities and work hard at reflecting on their patient relationships and managing them effectively. Staff could potentially use the EI tool to support them with this (Epstein & Simon, 1990). They should also increase their resilience through attending supervision, training and monitoring the impact that their social interactions are having on themselves and their work. Some risk factors can be avoided, while others may require awareness and extra support in order to manage. The current judgemental, blaming and dismissive attitudes that surrounds boundary violating behaviours do not encourage staff to be open about them, whistleblow their concerns or seek support if needed. Social influences have been found to be key in mitigating boundary violating behaviours and thus, one of the main implications of this study is to encourage a more open and transparent working environment. It is hoped that

these findings will be the first step in creating this ethos and effectively addressing this common behaviour.

Study limitations

This study does have some limitations which have potentially reduced reliability and the ability to accurately determine protective and risk factors associated with staff violating boundaries. As previously mentioned, the sample size of 87 was small and consisted of staff from only one hospital, a factor which may have restricted the robustness of the results and their generalisability. Efforts were made to recruit as many participants as possible, however, due to the sensitive nature of the topic and the study only being conducted in one hospital, recruitment was restricted and therefore, the study lacked power. Although there were some encouraging findings, the ratio of participants to the number of factors placed into the regression did not meet the recommended minimum (Field, 2009). Therefore, it would be advisable to replicate this study using a larger sample size and across additional hospitals. This would increase the reliability of the regression, helping to meet the participants to factor ratio and potentially, stopping the quasi-complete separation from occurring with the factor of working 1:1 with patients. Researchers would have to be mindful of the systematic review findings (that the environment impacts on the relevance of factors), replicating the study within a similar forensic secure hospital setting in order to produce more reliable and generalizable results.

Another limitation of the study is that information was dependent on participants' self-disclosure. Inaccurate or socially desirable answers are always going to exist in any form of questionnaire based research. However, this issue is more prevalent when the topic is sensitive and controversial. This had the potential to impact on responses to several questions including detecting boundary violations. The dependent variable was having a history of being disciplined or spoken to about committing a boundary violation. It was hoped that using this criteria would mean that only true cases of boundary violating were included; those that raised a level of concern, had a reasonable level of evidence and those that both management and staff believed were boundary violating. This, along with having a

definition of boundary violating at the start of the questionnaire were used to screen cases of real boundary violating in the dependent variable. However, due to inaccurate reporting and socially desirable answers, there is a possibility that other staff members who have engaged in boundary violating activities, but have not been caught, will not be included. This in turn impacts on the accuracy of the conclusions drawn. To address this and encourage openness, the questionnaires were anonymous and returned in a sealed box. This appeared to have encouraged honesty as there was a reasonably high rate of participants disclosing boundary violating behaviours, while previous questionnaire-based studies had encountered high under reporting of this behaviour. This may imply that participants also answered additional questions with the same level of openness. Nevertheless, this issue will never be truly mitigated in questionnaire collected data and thus readers must be mindful of this when interpreting the results of this study.

There were also limitations in the thematic analysis of the study. Overall, the variety and richness of the data collected through the thematic approach was detailed, useful and insightful. However, some of the answers from the analysed questions were missing, short and lacked detail, thus potentially resulting in some themes or participants' true motivations not being identified. Further research could explore the issues of whistleblowing by using interviews and focus groups, as this may result in richer data.

Recommendations for further research

Further research is required into how to effectively develop protective factors against boundary violating. There is a growing body of research into resilience against stress and staff burnout, however, there is limited research in resilience to boundary violating (Ablett, & Jones, 2007; Clarke, 2008; Taormina & Law, 2000). Some studies suggest that staff members commit boundary violations in order to obtain personal needs that are missing in their lives (Gabbard, 1994; Hamilton, & Spruill, 1999). Future research could examine the possible links between this theory, the research into increased resilience to stress and the findings from this thesis on protective factors with the aim of strengthening staff resilience to committing boundary violations. In addition, it would be interesting to explore whether

this approach could also be used to support the desistance of previous boundary violators from re-offending.

Using a similar method, further research could identify risk and protective factors related to boundary violating in different settings such as UK prisons, high or medium secure forensic hospitals. These results could be compared to identify if factors vary between settings and explore the possible reasons for this. This is particularly important as these are also under researched settings and, as this and previous research has shown, conclusions from other cultures and settings are not necessary transferable (Ghuloum, Bener, Commons, Miller, Burgut & Bhugra, 2012).

There are numerous types of boundary violations and during this study the type of violating that people committed was not explored. Further research could investigate the prevalence of particular types of boundary violations and whether the risk and protective factors vary depending on the type of boundary violating behaviours being committed, additional questions could be asked about what type of behaviour participants have engaged in. Furthermore, focus groups or participant interviews could be conducted to explore these incidents further, as this would provide more detailed and richer data. However, this approach would still be vulnerable to participants giving socially desirable answers and may impact on participant recruitment.

Conclusions

Boundary violating behaviour is a complicated and controversial topic. However, as this research has shown, it is a prevalent behaviour which both staff and management are motivated to address. This study was able to identify significant findings about factors which increase the risk of staff committing a boundary violation and other factors which show encouraging signs of potentially being related to risk. Although no protective factors were significant in the regression, again there were several which did have a significant relationship with boundary violating. It is hoped that with further research and a larger sample size, these factors will be significant and help staff increase resistance to boundary

violating. Through these findings and the research into whistleblowing, this study made several recommendations on how to address boundary violating in order to minimise its harmful impact. Due to there not being one overarching cause of boundary violating, a multi model approach must be developed to address this issue and minimise harm to all involved.

Summary of Chapter 3: Empirical study

The empirical study explored the potentially related protective and risk factors associated with staff's risk of committing boundary violations. Along with exploring staff views on boundary violating behaviours and concerns related to whistleblowing.

The regression analysis identified several significant risk factors associated with boundary violating, including working for numerous years at the hospital, and having a family or any close friends disciplined for committing a boundary violation.

The regression did not find any significant protective factors however, the correlation identified having good social support, receiving supervision and training about boundaries as potentially protecting staff from committing boundary violations.

The Exploitation Index psychometric, which is critiqued in chapter 5, was also supported through this research finding (Epstein & Simon, 1990).

Whistleblowing Findings

The thematic analysis identified reasons why people did not whistleblow boundary violations, such as concerns around anonymity, feelings that nothing would be done and feelings that peer interventions were more effective than involving management.

The ethos and setting of a work environment also appeared to impact on staff's willingness to raise concerns about boundary violating.

This was a small participant population from only one hospital which relied on self-disclosure, all limitations of this study, thus further research is encourage.

Forward to Chapter Four

The empirical research study in Chapter 3 highlights several key findings. Firstly, there are several protective and risk factors associated with staff committing boundary violations. Secondly, there are difficulties in managing this issue due to staff's concerns around being disciplined and the associated shame. Along with this, the research drew attention to the reluctance other staff members have with whistleblowing concerns about boundary violating. Chapter 4 is a case study about a patient who has engaged in several illicit relationships with staff. It explored the impact that these relationships had on this patient, his associated risk factors and attempted treatment. This case study also emphasised why it is so important that research is conducted in this area and that staff build their resilience against engaging in boundary violating behaviours. It also emphasised the need for staff members to whistleblow their concerns and that efforts must be made to implement effective strategies and address the areas of need highlighted in Chapter 3 as the impacts of boundary violating behaviours are significant and wide ranging, as the case study below will highlight.

Chapter 4:

Case Study

Assessment and treatment of an adult IPP offender who has previously engaged in an inappropriate relationship with a staff member: Exploring the effects.

Chapter 4: Case Study: Assessment and treatment of an adult IPP offender who has previously engaged in an inappropriate relationship with a staff member: Exploring the effects

Abstract

This research case study explores the impact that staff committing boundary violations and engaging in an illicit relationship can have on the patient involved. It also investigates factors that are associated with increasing a patient's vulnerability to engage in an illicit relationship and the potential associations with offending. Mr U is serving an indeterminate sentence for public protection (IPP) for robbery; he initially resided in the prison system. However, after experiencing difficulties coping with social situations and presenting with problematic aggressive behaviour, Mr U was assessed by a multi-disciplinary team and the decision was made to section him due to the above behaviour and his associated learning disability. He was then moved to a low secure hospital. Throughout Mr U's life he has encountered numerous difficulties with offending, relationships and social skills. While at a low secure hospital he engaged in an illicit relationship with a member of staff. The termination of this relationship triggered Mr U to become extremely volatile and seriously assault four members of staff.

Mr U's treatment needs were assessed and a formulation completed. Due to Mr U's poor understanding of relationships and maladaptive social skills it was recommended that he initially engage in a relationship program. Mr U was de-selected after attending eight of the fourteen sessions. This was due to his treatment interfering and problematic behaviour. This case study explores the risk factors associated with Mr U offending, his previous relationship difficulties and how these two factors are interlinked. It also explores the impact of his engagement in an illicit relationship on him, his abilities to form effective therapeutic relationships and participation in successful treatment.

Introduction

Mr U, a patient who has engaged in illicit relationships with several members of staff

Mr U is a 25 year old male who has been diagnosed with a mild learning disability, antisocial personality disorder, with traits of narcissism and psychopathy. He currently resides in a low secure hospital under section 47/49 of the Mental Health Act (1983 amended 2007). He had been transferred from prison where he had been serving an indeterminate sentence for public protection (IPP) for robbery.

Mr U has long struggled with managing relationships and appropriate boundaries. This behaviour has continued since his incarceration. His difficulties with relationships have led him to become a victim of bullying in prison. This was one of the main prompts for moving him to the hospital for more appropriate treatment and support. While he was in the prison, concerns were raised about the appropriateness of his relationship with a staff member. Contact with this staff member continued after the transfer however, this ceased after a few months. No formal investigation was ever carried out. He subsequently formed an illicit relationship with a member of staff in the hospital, who was later dismissed. This relationship became sexual and when it was eventually discovered Mr U became violent and was later convicted of assault on three staff members (one of the assaults was not taken to court).

Background information on topics raised in Mr U's case

Therapeutic alliance and how it is formed

The therapeutic alliance has been defined as "the collaborative and effective bond between therapist and patient" (Martin, Garske, & Davis, 2000, p. 438). Horvath, Del Re, Flückiger and Symonds (2011) stated that a good therapeutic relationship should consist of an effective bond with the two parties agreeing on treatment goals and addressing this in a collaborative nature. This alliance can be developed through techniques such as reflection, praise, exploration, accurate interpretation and developing an understanding of the patient.

A professional's personal attributes such as respectfulness, warmth, confidence, trustworthiness and flexibility have all been found to positively enhance the therapeutic alliance (Ackerman & Hilsenroth, 2003).

The benefits of an effective therapeutic alliance

Creating a therapeutic relationship grounded in appropriate boundaries benefits clients by creating a safe and secure environment within which they can share information and effectively work towards achieving treatment goals (Gutheil & Gabbard, 1993; Horvath, 2001). A good therapeutic relationship has been shown to improve treatment effectiveness (Howells & Day 2003, Meier, Barrowclough & Donmall, 2005), social behaviour (Woody & Adessky, 2003), relationship difficulty (Karver, Handelsman, Fields & Bickman, 2006) and violence levels (Howells & Day, 2003). Research has shown that modelling appropriate social interactions can also be key in decreasing re-offending rates by aiding offenders' social skill development (McGuire, 1995).

These findings have led some individuals to understanding that the quality of the therapeutic relationship is more important than the treatment type in achieving an effective outcome (Martin, Garske & Davis, 2000). This meta-analysis indicated that the overall relationship between therapeutic alliance and outcome is moderate, and very consistent across settings and studies. The rationale being that either the therapeutic relationship itself makes the change, or that it enables the patient to accept the process and follow a treatment more faithfully. Whatever the reason, the evidence is clear that a strong and effective therapeutic alliance is a key part of effective treatment (Bordin, 1994).

The opposite of an effective therapeutic relationship is a boundary violating relationship

Literature on maintaining a therapeutic alliance frequently covers boundary violations (BV), and the effect that this can have on the therapeutic relationship. The harm this can cause is frequently far reaching.

Impact of boundary violating on staff

A staff member's boundary violating behaviour can damage the integrity and reputation of their profession. It has the potential to increase the risk to other staff by placing them in harmful situations (Smith & Fitzpatrick, 1995; Moleski & Kiselica, 2005; Schafer & Peternelj-Taylor, 2003; Gutheil, & Gabbard, 1998; Lamb & Catanzaro, 1998). The impact on the boundary violating staff member can be devastating, including loss of their job, the trauma of the investigation and legal hearing, loss of registration, financial hardship, relationship breakdown and media publicity. There is also considerable impact on the professional's family and friends (Cruess, Johnston & Cruess, 2004).

Impact of boundary violations on patients and future treatment

Patients who are caught up in illicit relations with professionals have reported experiencing intense shame, guilt, depression, loss of employment, post-traumatic stress, suicidal thoughts and increased drug and alcohol use (Sarkar, 2004; Quadrio, 1996; Luepker, 1999). Also, due to the stress and negative impact caused by the situation, many patients experience a breakdown of other relationships (Luepker, 1999). This, in turn, is associated with increased levels of mistrust, understanding of boundaries and difficulties developing and maintaining future relationships.

Research indicates that clients who have difficulty maintaining social or family relationships, have unresolved relationships or have experienced stressful life events find it harder to develop strong therapeutic alliances (Ackerman & Hilsenroth, 2003; Kokotovic & Tracey, 1990; Horvath, & Luborsky, 1993). Previous engagement in illicit relationships with staff impacts on a patient's ability to form helpful relationships with staff in the future. Difficulty in forming a therapeutic alliance is associated with poor therapeutic effectiveness, poor treatment adherence and premature treatment termination (King & Bambling, 2001; Horvath & Symonds, 1991; Howells & Day, 2003; Kokotovic & Tracey, 1990).

Thus engaging in illicit relationships can have a major impact on a patient's emotional and social life, as well as affecting their ability to effectively engage in subsequent treatment.

Although a patient's previous relationship experiences do influence their ability to develop a strong therapeutic alliance, it does not determine it (Horvath & Luborsky, 1993). The quality of the current interpersonal therapeutic interaction and the client's motivation are seen as pivotal in their working collaboratively towards the treatment goal (Ackerman & Hilsenroth, 2003).

Principles of care and iatrogenic harm

Caring for patients is at the heart of all healthcare setting principles and has been for centuries, as can be seen by the Hippocratic oath. This talks about "make a habit of two things — to help, or at least, to do no harm" (Miles, 2005). However, this principle of care is not always upheld and iatrogenic harm can take place. Iatrogenic harm is any adverse condition in a patient resulting from treatment by a healthcare professional (Illich, 1975). In the case of boundary violating the iatrogenic harm usually takes the form of emotional and psychological damage. For example stress, depression, guilt and the other factors listed above. This harm can have far reaching consequences even after the patient leaves the hospital environment (Simon, 1991).

Relationship difficulties and offending

Although unhelpful staff relationships can lead to later relationship difficulties, individuals who are over dependant on their therapist or who have previously experienced abusive therapy relationships have an increased risk of engaging in later illicit relationships with staff. Potential reasons for this include the individuals involved having poor social skills, a dysfunctional defence mechanism, experiencing transference or poor coping mechanisms (Norris, Gutheil & Strasburger, 2007).

Having relationship difficulties is also a risk factor for various types of offending. Factors such as rejection from peers as a child, difficulties managing peer pressure, family conflict, lack of parent-child closeness, poor relationship maintenance and alienation have all been

associated with substance misuse, sexual and violent offending (Fergusson, Horwood, & Lynskey, 1992; Hawkins, Catalano, & Miller, 1992; Beech, Fisher & Thornton, 2003; Douglas, Hart, Webster, & Belfrage, 2013).

Client current presentation and referral process

Mr U has resided in this low secure hospital for three years. Throughout this period Mr U continued to present with problematic behaviour with peers, mainly verbal aggression and threats. Mr U's relationship with staff is strained at times, with him making false allegations, refusing treatment, only talking with his "favourite" individual and refusing to engage with others.

Mr U was transferred to this hospital to receive risk related treatment that was responsive to his learning disability. Mr U was referred by his lead psychologist for the following psychological assessment to explore his difficulties surrounding relationships and his treatment interfering behaviours. The outstanding treatment needs would then be addressed through the recommended form of treatment.

Assessment and formulation

Summary of the assessment process

A wide range of different assessment methods were used to gather information for Mr U's formulation. They included a historical file search, clinical interview and psychometrics. The 'What Works' literature (McGuire, 1995) highlighted that an effective rehabilitation programme takes into account three key factors of 'Risk, Need and Responsivity', when assessing if a client requires a specific intervention.

Risk

Risk of reoffending

The research indicated that the most effective programmes match the intensity of the treatment to the offender's risk of reconviction (Bonta & Andrews, 2007). Mr U holds eight previous convictions.

Mr U has a very high probability of violent-type reoffending according to the OVP (OASys Violence Predictor) and a medium risk of reoffending according to his OGRS3 (Offender Group Reconviction Scale) and OGP (Offending General Predictor) score. He has also been highlighted as a high risk of harm to the public and medium risk to children and staff. His HCR-20v3 score of future violence is high. These scores combined with his IPP sentence indicate that Mr U requires long term high intensity treatment for his offence related risk factors.

Risk of becoming a victim

Previously Mr U has been a victim of bullying and violence, and has engaged in an illicit and potentially exploitative relationship with a staff member. Due to Mr U's low IQ, poor understanding of relationships and limited social skills, he is at high risk of entering into inappropriate and unhelpful relationships, as well as suffering violence from others.

Needs assessment

'What Works' literature (McGuire, 1995) stated that effective treatments are clear in addressing specific criminogenic 'needs'. His assessment of needs was based around his formulation and the HCR-20v3 risk factors (Douglas, Hart, Webster & Belfrage, 2013).

All of the historical risk factors were scored as 'present' in Mr U's HCR-20v3. He also scored highly on the clinical and risk factors, therefore, addressing Mr U's violent associated risk

factors was the main treatment need. Below is a summary of the most relevant information combined with his background information gathered through interviews and file documentation.

Relationships

Mr U was born into unstable and regularly changing environment. His parents divorced when he was 12 years old. He experienced physical abuse from both his biological father and later his stepfather (his paternal grandfather). He was placed in care and moved through numerous foster homes and schools.

Mr U reports not having friends whilst growing up. He has a very volatile and fluctuating relationship with his family. Mr U speaks very fondly of his godparents who he feels mainly brought him up, despite them only seeing him for a few weeks over the summer. Mr U changed his surname to his godparents' name, as he felt more a part of his godparents' family than his own. Mr U appears to have formed a strong association with his godparents, however, this may be more of a mythical attachment (according to his godmother) than a reflection of their actual relationship. Mr U currently has limited support from his family as his contact fluctuates. Mr U's family relationships are directly associated with his offending; when he feels rejected by a significant family member he often resorts to alcohol consumption and violence to solve problems and increase his feeling of self-worth. There is no record of Mr U having any previous intimate relationships, prior to the one he formed with the member of staff.

Mr U has limited support and his response to rejection and relationship difficulties is often to offend. On occasions, when he experiences these feelings and does not offend, it is often when he has several protective factors present. These protective factors can be seen in his formulation in Appendix L. On these occasions he often expresses his emotions through shouting rather than being physically aggressive. Also, Mr U's poor interpersonal skills and trust difficulties impact on his ability to engage with and benefit from treatment and hence are a key treatment need.

Violent attitudes

Mr U has violent attitudes as illustrated by his persistent use of violence and threats, which he frequently self-publicises. When describing his previous offences Mr U has expressed the views that violence is the only way and "what else could he have done?" He appears to use violence as a way of gaining respect from others. Addressing Mr U's pro-violence cognitions with a CBT based intervention is an important treatment need.

Stress or coping

Mr U appears to act out violent and aggressive behaviour, both physical and verbal, when he is under stress. At the time of his index offence he had recently been made homeless and was concerned about his family relationships. This resulted in his using alcohol and violence for financial gain and to manage his stress levels. Consequently, emotional management and coping skills will be a key treatment need.

Mr U's Index Offence (see Appendix L)

Mr U stated that he took drugs on the morning of his offence, however, the police have questioned this. In the morning he arranged to see his former care worker to ask for help, he asked him for money and became angry when he refused. The former care worker then gave him a lift to the station, which broke his company policy. As Mr U was an ex-client of this individual and there were no professional reasons to stay in contact or drive him it would appear that professional boundaries had been crossed. Several guidelines and boundary violating researchers discourage the professional from engaging in personal relationships even after the termination of working together (British Psychological Society, 2009; Epstein & Simon, 1990; Appelbaum & Jorgenson, 1991). For example, the BPS code of conduct states that "Recognise that conflicts of interests and inequity of power may still reside after professional relationships are formally terminated, such that professional responsibilities may still apply" (p. 22) and "Refrain from engaging in any form of sexual or

romantic relationship with persons to whom they are providing professional services, or to whom they owe a continuing duty of care, or with whom they have a relationship of trust. This might include a former patient, a student or trainee, or a junior staff member" (p. 23). Thus although Mr U may not have been harmed through this boundary crossing, it does imply that he has experiences boundary crossing with staff in the past. This intern may have impacted on his understanding of boundaries and how interactions with staff are different than interactions with friends or family.

Mr U jumped the barriers after his former care worker dropped him off at the station and caught a train. Once aboard Mr U selected his victim, a young teenager whom he perceived as weak, threatened him and robbed him of his mobile phone.

Inappropriate relationships and most recent violent offending (see Appendix M)

This incident occurred when Mr U was engaged in a treatment session with a member of staff with whom, it is now known after a professional investigation, he was having an illicit relationship with. The session had overrun and Mr U reported that the member of staff was talking about ending their relationship. A member of nursing staff interrupted the session and Mr U attacked the nursing staff and punched her unconscious. He then assaulted three other members of staff including the staff member with whom he was in a relationship. After the incident Mr U stated that the triggers had been his "not liking being bossed around" and that "people needed to be taught a lesson". Mr U has demonstrated very limited insight throughout his offending and there consequences which is a further key treatment need. The professional investigation discovered that the illicit relationship had occurred over many months. Mr U was engaging in individual sessions with this member of staff. During this time there were several boundary crossings, such as sessions over running and the member of staff over disclosing personal information about her lifestyle and children. This had progressed to physical touching and her confiding in him about her relationship difficulties with her husband. The relationship also became sexual and Mr U talked to the member of staff about having children together.

Psychometric Assessment

Several psychometrics were used to assess potential treatment needs as well as monitor pre and post treatment change. These psychometrics were selected as they were deemed as measuring factors that the programme would address. Although both the Relationship Questionnaire and the Manchester Attachment Scale-Third Party Observational Measure (MAST) explore the topic of attachment it was felt that it would be useful to have Mr U's own views on his relationship style as well as staff's. The MAST also brought a more behavioural measure of Mr U's attachment style and how it was currently presenting. All the psychometrics below have been previously used by research with a learning disabled population, more specific details are below.

The Relationships Questionnaire (RQ)

The RQ is made up of four different vignettes which are designed to measure adult attachment styles (Bartholomew & Horowitz, 1991). The four different attachment styles are: secure, dismissing-avoidant, fearful-avoidant and preoccupied. It was felt that the brevity and clarity of this attachment questionnaire made it most appropriate for use with clients with learning difficulties. The participants self-report, on a seven point Likert scale, how much they agree or disagree that this statement describes them. This psychometric has very strong face reliability and test-retest reliability (Bartholomew & Horowitz, 1991). Although its internal reliability cannot be determined due to it consisting of only one item, several researchers have broken down the vignettes into several item questionnaires. These have indicated a good level of internal reliability and validity (Collins & Read 1990; Simpson, 1990). Keeling, Rose and Beech (2007) also found that the RQ had a fair reliability and validity when used on a learning disabled population. Mr U strongly disagreed with secure (1) and mildly disagreed (2) with dismissing, however, he strongly agreed with preoccupied (7) and agreed with (6) for fearful.

Manchester Attachment Scale-Third Party Observational Measure (MAST)

Mr U's named nurse completed the MAST. This is a third-party measure that carers complete on their patient's behaviour and interaction styles (Penketh, Hare, Flood & Walker, 2013). This tool was specifically designed for use on learning disabled patients (Schuengel, Schipper, Sterkenburg, & Kef, 2013). There are 16 questions with responses being scored on a four point Likert scale. These scores are totalled, with the negative worded items being reversed. A lower total score equates to more adaptive attachment behaviours (Penketh, 2011). The MAST was chosen as it has been designed to be used by caregivers about clients with learning disabilities. The MASTs internal consistency was tested and the Cronbach's α ($\alpha = 0.750$) indicated good reliability, with no evidence of multi-collinearity (Penketh, Hare, Flood, & Walker, 2014). It has good face validity, reliability and highly correlates with other assessments designed to assess the same factors (Penketh, 2011). A limitation of the MAST is that it does not have a 'cut-off' score for a secure attachment (Penketh, Hare, Flood, & Walker, 2014). Also, there is concern that it may be measuring the relationship style between the staff member and the patient, rather than the patient's overall relationship style (Schuengel, Schipper, Sterkenburg & Kef, 2013). However, these limitations are less critical as it is used in conjunction with the RQ.

The Inventory of Interpersonal Problems questionnaire (IIP-32)

The IIP-32 consists of 32 items, which measure interpersonal relationship difficulties (Horowitz, Alden, Wiggins & Pincus, 2000). The first 19 items include the statement "it's hard for me to…" which participants respond to on a five-point Likert scale ranging from 'Not at all' to ' Extremely'. In the final 13 items the participants have to score behaviours which they "may do too much" on the same Likert scale. An individual is scored on eight subscales including Domineering/controlling, Vindictive/self-Centred, Cold/Distant, Socially inhibited, Non-assertive, Overly accommodating, Self-sacrificing and Intrusive/needy.

This tool has good reliability and correlates strongly with other similar measures (Soldz, Budman, Demby & Merry, 1995; Horowitz, Alden, Wiggins & Pincus, 2000). The IIP-32 has

good internal consistency with a high cronbach's alpha of 0.93. The IIP-32 had moderate test-retest reliability over a median retest interval of 7 days. It also had a very high correlation, ranging from 0.88 to 0.98, with the IIP-62 (Horowitz, Alden, Wiggins & Pincus, 2000). Kellett, Beail, and Newman (2005) found that this tool maintained good reliability and validity when used with a learning disabled population.

The IIP normative information was based on a national standardization sample of 800 cases, which aimed to be representative of the US population of adults aged 18-89 year old. The Total T score indicated the persons self-report of overall interpersonal difficulties across all problem areas. If the Total T score is more than 2 standard deviations above the mean (T= 70), the person's distress is very high relative to the general population and thus indicated specific areas of interpersonal difficulties. Mr U had high scores in cold and distant and self-centred prior to treatment. He was also just below the cut-off point for domineering and controlling. He had particularly low scores on self-sacrificing and needy.

Revised UCLA Loneliness Scale (R-UCLA).

Although there are many facets to healthy social relationships, one way of measuring whether an individual's social needs are being met is by measuring their levels of loneliness (Baumeister & Leary, 1995). The need for social intimacy can be achieved in a prosocial or antisocial manner according to the good lives model. Loneliness is also associated with self-esteem, poor social skills, shyness, emotion regulation of anxiety and anger (Berscheid & Reis 1998; Hughes, Waite, Hawkley & Cacioppo, 2004). The R-UCLA consists of 20 statements which patients respond to on a four point Likert scale. Ten of the questions were worded positively and ten worded negatively to avoid response bias. This tool has demonstrated good levels of reliability and validity across a wide range of populations (Russell, 1996). The R-UCLA has shown internal consistency (coefficient α ranging from .72 to .94) (Russell 1996; Hughs, Waite, Hawkley, & Cacioppo, 2004). Its test-retest scores over a year showed strong reliability (r = 0.73) which was not found to be a significant change (Russell, 1996). It has been used with moderate reliability among learning disabled patients in previous research. Although the "Modified Worker Loneliness Questionnaire" (MWLQ)

has been found to be more reliable with this client group, unfortunately this tool was not available. Also, there is very limited general research into its reliability and validity (Stancliffe, Wilson, Bigby, Balandin, & Craig, 2014), therefore the R-UCLA was used. However, these factors were considered when evaluating the findings. Higher scores indicate greater degrees of loneliness and Mr U's pre-treatment assessment score of 55 is significantly higher than the recognised average score of 40.

URICA - The Stages of Change Questionnaire

The URICA measures an individual's readiness and motivation to engage in treatment and change problematic behaviour (McConnaughy, Prochaska, & Velicer, 1983; Norcross, Krebs, & Prochaska, 2011). It is made up of 32 self-reported items which correlate with four subscales that measure whether an individual is at the pre-contemplation (PC), contemplation (C), action (A) or maintenance (M) stage. The responses are given on a 5 point Likert scale. The subscales are combined arithmetically (C+A+M – PC) to produce an overall score, which can be used for pre and post treatment measures of motivation. The URICA has been found to possess excellent reliability and validity. It has also been shown to significantly predict treatment retention and dropout rates, and is a good predictor of treatment effectiveness (Dozois, Westra, Collins, Fung & Garry, 2004).

The limitation of this tool is that it was originally designed to test motivation to change in substance abusers and its application has subsequently been extended, to be used with learning disabled patients (McConnaughy, DiClemente, Prochaska & Velicer, 1989; Dozois, Westra, Collins, Fung & Garry, 2004; Patterson & Thomas, 2014; McNair, Woodward, & Mount, 2010). There are also no cut-off norms for this tool as the stages are deemed to be continuous, therefore variation within the individual's scores are used to measure change. Mr U's pre-treatment score demonstrated that he was in the pre-contemplation stage of change with a score of 6.9. (see URICA: the stages of change questionnaire ranges Table 20, for further details). This means that Mr U has not identified any specific problems with his relationship style or any relationship difficulties and thus his motivation to address this is low. However, his score of 6.9 is near the contemplation score of eight, which suggests that

he may have some motivation to explore this issue. Research has shown that therapists have to adapt their methods and relationship style in order to nurture an increase in motivation and not 'scare patients off' (Norcross & Beutler, 1997; Prochaska, Norcross & DiClemente, 1995; Norcross, Krebs & Prochaska, 2011). This was identified as an initial treatment need.

Summary of psychometric profile

The pre-course RQ indicated that Mr U has a preoccupied, anxious, ambivalent attachment style with some elements of a fearful avoidant style. This insecure attachment and relationship difficulty was verified by his key nurse through the MAST psychometric. This indicated that he had significantly lower than average adaptive attachment behaviour (Penketh, 2011.) The IIP-32 highlighted that some of these interpersonal problems were associated with high levels of cold, distant and self-centred behaviour. Mr U also had reasonably high levels of domineering and controlling behaviours. These behaviours fit with his attachment style of avoidant and having difficulties trusting others. This may explain his high loneliness levels measured by the R-UCLA (Russell, Peplau & Cutrona, 1980). It is hypothesised that although Mr U presents as cold and distant, he also desires interpersonal connections and closeness despite his difficulties with trust, thus his high loneliness scores. This would be expected from an individual who has a preoccupied attachment style. His desire for relationships, surrounded by his difficulties around trusting, may explain in part why he engages in inappropriate behaviour with staff members. It also explains his hypersensitivity to rejection and mistrust. These psychometrics highlight areas of treatment. The URICA gauged his awareness of this problem along with his motivation to change. During the interview Mr U was open about his struggling with trust and that he had formed an illicit relationship with a member of staff. However, the psychometric indicates that he has low levels of motivation to address this difficulty, which will be something to explore and address during his treatment.

Interview assessment summary

During the assessment interview when discussing the most recent illicit relationship, Mr U became very angry, verbally abusive to the member of staff, insulting and questioning her reliability. He also stated that he had trusted her, and liked how she had listened to and loved him. He felt that the problem was that other people had interfered. During this assessment Mr U's presentation fluctuated between minimal and guarded answers to flowing open responses. This later shift often occurred when he was feeling a strong emotion attached to the topic, such as anger which overcame his inhibition and mistrust. During this interview it was also evident that Mr U had a poor understanding of relationships and the appropriateness of different behaviour within them. This is a particularly key initial treatment need and thus relationship psycho education is recommended. Mr U was open about having difficulties trusting others, which corroborates with the psychometric findings (see above). Consequently, developing a good therapeutic alliance will be important, whilst also being mindful of his difficulties in relation to boundaries and his ability to split teams.

Formulation and functional analysis

Formulations and functional analysis were used to help describe and explain Mr U's behaviours. They also identified treatment needs and highlighted appropriate interventions to support changes in these problem behaviours.

Stimulus, Organism, Response, and Consequence (SORC):

The functional analysis tool used to formulate Mr U's two most recent offences was the SORC functional analysis model (Goldfried & Sprafkin, 1976). This was used as it draws together historical factors with incidences and triggers for events. It uses all of this information to draw conclusions about the function of specific behaviours and what is reinforcing this pattern. The stimulus variables are the events preceding an offence;

organism variables are the patient's background and dispositional characteristics; response variables are the offending behaviours themselves; and the consequence variables are the events that follow which either positively or negatively reinforce the behaviour. The consequences highlight the function of the behaviour demonstrated by Mr U. See Appendix L, M and N for the SORC diagram and formulation.

The five aspect conceptualisation model

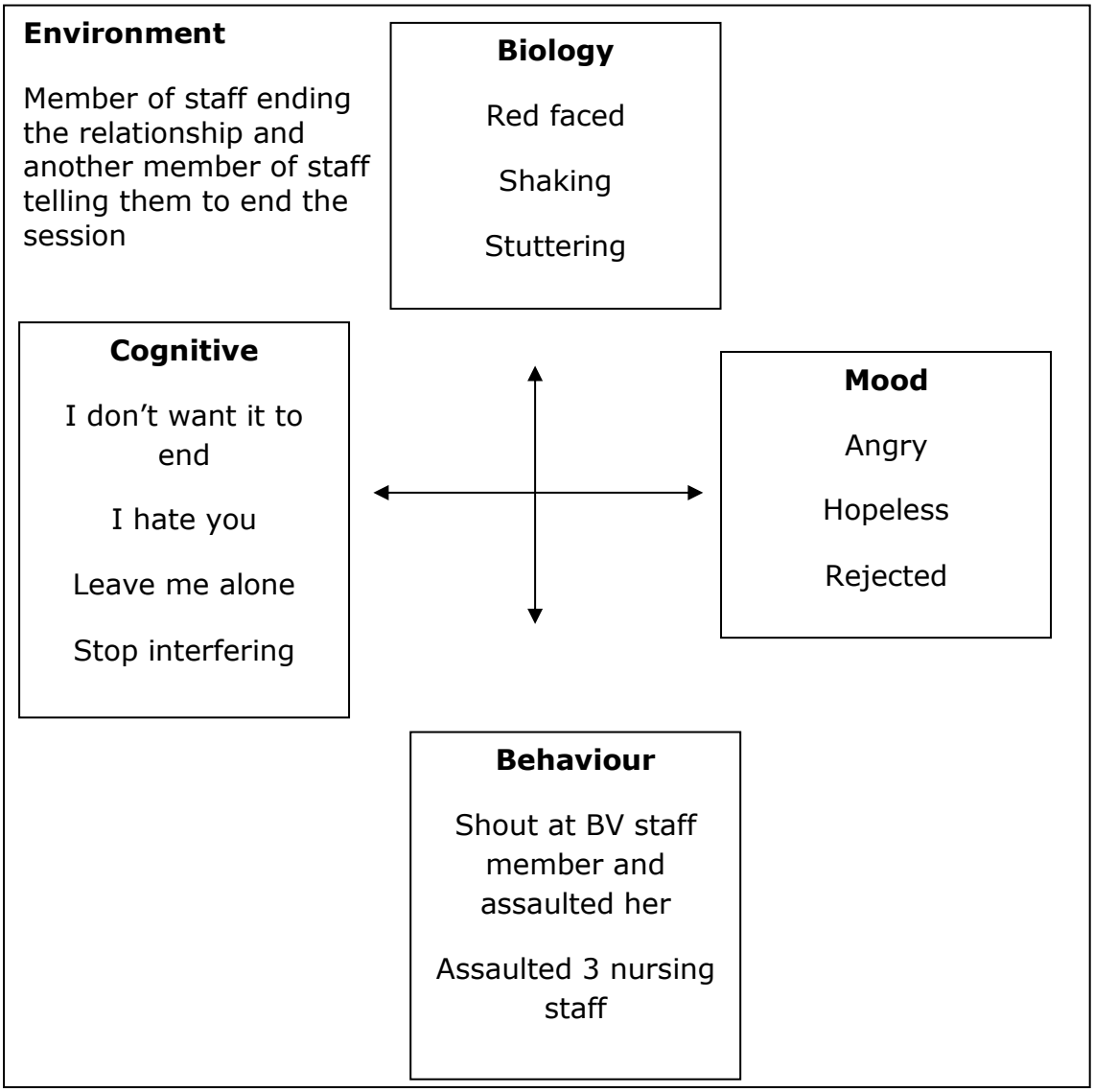


Figure 6: Padesky & Mooney's (1990) five aspect conceptualisation model of the incident in which Mr U was charged with three counts of assault by beating.

The five-factor model of formulation (Padesky & Mooney, 1990) was used to highlight to Mr U the several elements that were present during this incident (see Figure 6). This model highlights the antecedent stimulus to Mr U's most recent violent offence that occurred in the context of an illicit relationship in which a member of staff committed a boundary violation (Hart, Gresswell & Braham, 2011). It also highlights in a simplistic and pictorial manor aspects of the cognitive behavioural theory, such as some of his contributing distortions and emotion regulation responses. It helps by breaking down and separating out the different factors involved in this situation. Each of these factors can then be addressed through treatment. As all the factors are interlinked, it can be motivational to see that if Mr U addresses one issue he will be able to see benefits in several areas. It hopefully makes the treatment process less overwhelming.

Responsivity considerations and action plans to manage them

Research has indicated that effective programmes were responsive to different clients diversity needs, such as different learning styles and readiness for treatment (McGuire, 2006). This flexible approach has been found to be more effective than taking the "one fits all" approach (Howells & Day, 2003). Mr U presented with several potential treatment barriers, all of which need to be addressed.

Readiness, motivation and responsiveness

Day, Bryan, Davey and Casey (2006) found that readiness for treatment was a key factor in treatment effectiveness. Previously, Mr U has frequently offered justification for his behaviour and has said that he is engaging in treatment just to "get you [staff] off my back". In a previous establishment, his persistent refusal to engage with or be open to treatment led to the conclusion that he was "untreatable, at this point".

It had been raised with Mr U that if he did not engage in treatment then he would be breaching the terms of his section and be returned to prison. Mr U stated that he was happy

to attend a treatment group and wanted to complete it in order to prove that he could stay in the hospital rather than be returned to prison due to poor treatment compliance. Mr U was open and had some insight regarding his difficulties with relationships, however, he was more reserved and expressed doubts regarding the potential benefit of this course. This was supported by the URICA psychometrics. While his motivation to engage was not ideal, it was felt that this could be addressed during the course by exploring the consequences of mismanaged relationships and the benefits of helpful relationships. Exercises to increase his motivation were therefore highlighted to support him in this specific area.

Learning Disability

Mr U has a mild learning disability. The material would be pitched at an appropriate level as all of the group members have learning disabilities. There would also be the opportunity for extra support in individual sessions if a particular difficulty arose. The programme facilitators are experienced in working with learning disabled patients and are aware of the different techniques that can be used to enhance their ability to benefit from treatment. These include the use of repetition, adapting techniques to address differing learning styles, appropriate session links and skills to check comprehension. All of these techniques have been highlighted through research as being effective when working with this client group (Swanson, 1999; Glover, McLaughlin, Derby, & Gower, 2010; Dumas, Bedell, & Hamill, 2003).

Boundaries and therapeutic alliance

Mr U has previously made false accusations about staff members and used team splitting techniques whilst engaging in treatment. This has, unfortunately, usually resulted in the cessation of treatment whilst investigations are undertaken. It is felt that much of this behaviour reflects his treatment needs and highlights the importance of engaging in specific treatment in this area, while implementing strategies to prevent this behaviour interfering with treatment. Consequently, there were always two facilitators in the room and regular

Multi-Disciplinary Team (MDT) meetings were held about Mr U's presentation and treatment plan, of which Mr U was aware. Both facilitators were aware of Mr U's history and had engaged in boundary violating behaviour training prior to this group.

Developing a strong and helpful therapeutic relationship is critical for treatment, particularly when working with patients who have difficulties with relationships and trust. Additional time and effort was spent in training the facilitators and focusing on creating a safe working environment, effective modelling and a therapeutic alliance. Group and facilitation skills were implemented to develop therapeutic alliances, such as having group agreement, making links between specific therapy tasks and the overall goal treatment. The personal benefits of engaging in therapy were reinforced with facilitators being helpful, supportive and non-judgemental (Bedi & Vassiliadis, 2010; Gilbert, 2009).

Formulation and functional analysis outcome

Mr U's formulation and functional analysis indicates that he has difficulties in forming and maintaining relationships. He appears to have very limited experience and understanding of relationships and boundaries which results in him, either forming inappropriate and unhelpful relationships, or creating mythical connexions (as with his godparents) to achieve his goal of feeling accepted and belonging. Subsequently, when he encounters rejection within these relationships, he experiences high levels of anger and has antisocial and violent endorsing cognitive distortions, which in turn, result in him becoming angry and aggressive.

It is not uncommon for violent offenders to have a wide range of complex treatment needs, such as Mr U's (Polaschek, Collie & Walkey, 2004). The functional analysis (Appendix L and M) highlighted eight main treatment targets. Due to Mr U's high risk of reoffending, his multiple areas of treatment need to be coupled with his learning difficulties and it was thought best to initially address one area of need (relationship difficulties and social skills). It was hoped that this would positively impact on the other areas (his violent offending). This would hopefully be a more achievable goal in a short period of time and avoid Mr U becoming overwhelmed and confused by the process.

Taking all the above factors into consideration, it was deemed that Mr U was behaviourally stable enough and the time was right in his treatment plan to cope with the programme. Mr U was invited to the course, which he accepted and consented to the process. He was also read and given a copy of the relationships leaflet (see Appendix O).

Theory to practice: Treatment of relationship difficulties and aggression

Attachment theory of violence

Bowlby (1973) believed that a bond develops between a child and their caregiver, from which the child is able to develop self-concept, schemas of the social world and mindfulness. All of these factors will shape future relationships. However, if a person developed an insecure attachment this may lead to dysfunctional schemas and behaviour, particularly in interpersonal situations. Mr U has had attachment difficulties and subsequent relationship troubles from an early age. He presents with an ambivalent relationship with his father, frequently expressing anger or dismissal towards him but at other times citing his father's views in support of his own. Individuals with insecure attachment style are associated with difficulties relating to others, forming dysfunctional patterns of attachment, expressive aggression, fear of abandonment and an unstable view of themselves (Bowlby, 2005; Kesner & McKenry, 1998; Fonagy, 2000). This insecure attachment can lead to violent offending, previously after an argument with his sister he smashed a window of a nearby car. He reported that he was jealous of her spending "too much time with her kids". This violence has also been observed within intimate relationships or when their relationships break down (Johnson, Gilchrist, Beech, Weston, Takriti & Freeman, 2006). This was evident when Mr U's assaulted four staff members when his illicit relationship ended. It is also linked to his index offence when his family refused to house him, then an ex-care worker, whom he trusted, declined to help resulting in his feeling rejected and stating that he wanted to prove that he could cope without them. This culminated in him committing a robbery and GBH offence, with the function of problem solving, obtaining financial gain, increasing his self-esteem and releasing unpleasant emotions. A limitation of this theory is that the method of measuring attachment styles is mainly undertaken using self-reporting

and is thus subject to response bias. As the research above outlines, the patient's ability to form a good and strong therapeutic alliance and working relationship with their therapist is key to effective therapy outcomes. Through this therapeutic alliance, the patient develops a greater understanding of appropriate relationships, boundaries and communication styles in a safe environment. These skills can then be applied to their wider social group (McGuire, 1995).

Cognitive Behaviour Theory

Cognitive behaviour theory explains that relationship difficulties and violent offending are caused by distorted beliefs about others and situations (Pretzer & Beck, 1996; Ward, 2000). Research indicates that children who experienced insecure attachment whilst growing up were less likely to form strong, well-adapted, trusting and caring relationships as adults (Davis, Ace & Andra, 2002; Magdol, Moffitt, Caspi & Silva, 1998) They were also far more likely to behave in a violent manner within their relationships (Miga, Hare, Allen & Manning, 2010). The theory states that every person has their own distinct schemas which impact on their interpretation and behaviour (Beck & Freeman, 1990). These schemas are formed through life experiences and can be learnt from others, such as family members.

Despite this tension, Mr U will often use his family as part of his threats against staff, as he threatens to get them involved. They have on occasions supported and encouraged Mr U's way of thinking in this area. Mr U reports a number of rules that he has learnt about life and violence and relates some of these to his family, "saying we have a code to look out for each other" and "if you piss me off my brothers will hurt you, bad". These schemas can result in dysfunctional responses, such as excessive anger and subsequent violence if an individual has distorted cognitions about particular situations (Clarkin & Lenzenweger, 1996). Mr U has a number of distortions and core beliefs round people "needing to help" and "respecting" him and his family. He has previously used violence when he felt that these have not been adhered to. In Mr U's index offence he exhibited several cognitive distortions regarding how relationships should be and the use of violence. Novaco's model of anger determinants (1994) suggests that anger is not an automatic response to a situation but that it is a

product of an individual's cognitive processes. Both attachment theory and cognitive behavioural theory recognise that social interactions impact on cognitions and vice versa. Cognitive behavioural therapy (CBT) believes that cognitive distortions are learnt and not inherited (Lipsey, Landenberger & Wilson, 2007), thus through treatment people can relearn and restructure these cognitions to avoid problematic behaviour and relationship patterns (Lösel, 1995; Pearson, Lipton, Cleland & Yee, 2002; Wilson, Bouffard & MacKenzie, 2005).

CBT based treatment aims to re-structure these processes to produce pro-social outcomes and therefore reduce risk levels. During the group sessions patients will look at their views on relationships and highlight the differences between helpful and unhelpful.

Social learning theory

Social learning theory is a behavioural theory which states that people learn set behaviours by observation and reinforcement through consequences (either positively or negatively) (Bandura, 1977). This theory explains that people engage in set relationship patterns or antisocial behaviour because they observe others gaining or gain themselves something through crime or avoiding punishment, both of which reinforces that behaviour (Akers, Krohn, Lanza-Kaduce & Radosevich, 1979). An example of this is a child witnessing an adult acting aggressively and benefiting. Subsequently, the child will imitate this aggressive behaviour in order to seek the same benefits (Bandura, Ross & Ross, 1961; Mihalic, & Elliott, 1997). Mr U reported witnessing violence and abuse at home whilst growing up. He reported that his parents would fight regularly prior to their divorce. Mr U stated that both his stepfather and father physically abused him as a child. Mr U talks about looking up to his older brothers who also engaged in criminal activities, thus Mr U's violent offending may be due to a learnt script from his family about how to behave in certain situations.

Social learning theory also helps to explain relationship difficulties. If a child experiences unhelpful or dysfunctional relationships whilst growing up they are more likely to repeat these patterns through learnt behaviour. Experience of inappropriate social modelling in childhood may impede the development of basic social skills affecting the formation of

positive relationships in adulthood (Bandura, Ross & Ross, 1963). Mr U often reported feeling distant and unloved by his mother. He also experienced a 'chaotic' childhood, with his primary carer changing regularly along with abuse. After divorcing his father Mr U's mother married his paternal grandfather. This blurring of boundaries and family roles may have taught Mr U unhelpful scripts around relationships and boundaries, which he subsequently played out in later life. All of these experiences potentially resulted in him learning antisocial scripts about how to behave within a relationship. An example of this is his prior exposure to relationships with staff, where boundaries were broken. It appears that Mr U, understandably, has trust difficulties, particularly with staff.

A criticism of social learning theory is the fact that it can be quite deterministic implying that children purely act on observation, driven by desired consequences, with no logical or moral thought about the action itself (Bandura, 1977). This is something to be mindful of, particularly when working on complicated and multifaceted topics such as relationships. Skills practised are incorporated into the course along with pro-social modelling from facilitators to encourage the learning of different behaviours within relationships.

Conclusion for interventions

The 'Good Lives Model' and numerous research indicate that developing an individual's social skills and ability to build pro-social relationships is a good protective factor against reoffending (de Vries Robbé, de Vogel & de Spa, 2011; Ward, Mann, & Gannon, 2007; Ward, 2002; Mulvey, Steinberg, Fagan, Cauffman, Piquero, et al, 2004).

Thus it was felt that Mr U would benefit from a programme that developed his relationship skills. This relationship programme aims to develop patients' understanding and skill base insight into their relationship styles, boundaries and social interactions. This has been shown to improve relationship quality and decrease associated problems, such as psychological distress and engaging in unhelpful or illicit relationships (Estroff & Zimmer, 1994).

Overall outcome

In the case of Mr U it was hoped that developing his abilities to form strong, appropriate and supportive relationships, along with his insight into his relationship patterns would aid him in avoiding problematic social situations in the future. It was also hoped that by developing Mr U's social skills and ability to form a strong therapeutic alliance he would desist from therapeutic interfering behaviours, such as making false accusations. This in turn would enable him to engage in and benefit from future treatment, for example, emotional management.

Intervention: the relationship programme

Aims

Using all the referred patients' formulations and treatment plans, the programme was designed to address the following treatment targets:

1. To increase the patients' understanding of the different types of relationship and how appropriate behaviour varies between them (including exploring the topic of therapeutic relationships and boundary violating).
2. To gain insight into their different personal relationship and interaction styles.
3. To learn and practice interpersonal skills, such as asking for help.
4. To learn and practice skills to aid in managing unhelpful relationships (risk factors).
5. To learn and practice skills to help strengthen helpful relationships (protective factors).

Research has shown that a combination of group and individual work is an effective way in running reoffending reducing programmes, thus this relationship programme used this approach (Landenberger & Lipsey, 2005). Conclusions about relationships difficulties from the three theories listed above were used to help plan the sessions and identify effective methods to help address the above treatment needs. For example, social learning theory and research studies all highlight the importance of learning skills and observing skills in others (McGuire, 2006) therefore, appropriate social modelling and number of role plays

were used to support the patients in their development of new skills. Cognitive behaviour theory explains that offending and unhelpful behaviours are caused by distorted beliefs about others and situations (Pretzer & Beck, 1996). These thoughts impact on people's interpretations and behaviours which result in dysfunctional responses (Beck & Freeman, 1990; Clarkin & Lenzenweger, 1996). Several meta-analyses have shown that cognitive-behavioural programs are effective in reducing recidivism rates compared to control groups by 20 – 30% (Pearson et al. 2002; Wilson et al. 2005). Hence, work was conducted to explore their thoughts around different types of relationships, their different purposes and the impact they can have on their behaviour. Initially, psycho-educational exercise explored differed types of relationships and the patients spent time looking at how they behaved with different people in their life. Then, a more CBT approach was used to identify patients' core beliefs about different relationships, such as just because some relationships are not fun or easy does not mean that that they are 'bad' or 'unhelpful' relationship, like working relationships with staff. Equally 'fun' relationships with some friends may be unhelpful. Exploring the consequences and decisional balance exercises were used to explore if certain behaviours or relationships were helpful or unhelpful for them. Then social skill exercises were used to aid patients in managing unhelpful or strengthening helpful relationships (Landenberger, & Lipsey, 2005)

Summary of Intervention

Session Plan

Session	Content
Individual Session 1	Individual assessment session: The initial assessment interview - Exploring the topic of relationships in reference to his family, friends, romantic and with professionals.
Individual Session 2	Individual assessment session: The administration of psychometrics. Explaining the purpose of the group and what would be addressed through it. Invite and consent to attend.
Individual Session 3	Individual goal setting for the programme and motivational work.
Group Sessions	
4	Group introduction and collaborative formulation of group contract. Introducing the topic of relationships; define relationships and look at different types. Motivational work.
5	Look at life/recovery star and see how helpful relationships fit and the negative impact unhelpful relationships can have on us. – (Good lives model)
6	Looking at helpful and unhelpful people who increase risk factors. – how do we know if they are 'helpful' or 'unhelpful' – can you have a mixture? Create a personal social circle drawing.
7	Identify helpful relationships in a personal social circle. How to strengthen helpful relationships – why important? – role plays of how to ask for help/ share information etc.
8. An individual session	Mid-course psychometrics (URICA and IIP)
9 Group sessions which	Identify unhelpful relationships in a personal social circle. How to weaken unhelpful relationships influence on us – why that is important? – relate to

Mr U did not attend	personal social circle.
10	Learn and role play practise of how to manage peer pressure / not to get persuaded.
11	Learn and role play practise dealing with criticism or feedback
12	Learn and role play practise 'Asking for help' or sharing personal information.
13	Summary and recap session
14 Final individual session	Review and assess individual progress. Set further work on outstanding treatment needs. Re-administering of the psychometrics.

Table 16: Session plan for the Relationship course (Mr U attended the sessions in bold)

Intervention methods

The group was facilitated by a trainee forensic psychologist and an assistant psychologist. The course was comprised of five individual sessions interspersed throughout nine, one hour long group sessions. There were four other group members, along with Mr U, all of whom have treatment needs involving relationship and boundary difficulties. The programme aimed to develop the patients' understanding of different types of relationships, their social skills and social management skills. This was primarily achieved through group discussions, role plays, subgroup and individual work. Facilitators were aware that it was not just the material taught that impacts on course effectiveness and re-offending rates, but other factors, including facilitators' responsiveness to participants, programmes focussing on an individual's risk factors, maintaining programme design integrity and engendering a collaborative approach (Farrall, 2002; Gendreau, Little & Goggin, 1996). This is why having trained and experienced facilitators delivering best practice was key in addressing treatment needs. The facilitators kept these factors in mind when they delivered sessions, ran individual work and conducted staff supervision sessions.

Collaborative approach, boundaries and therapeutic alliance

Numerous studies have demonstrated the benefits of developing an effective therapeutic alliance in order to obtain optimal treatment effectiveness (Meier, Barrowclough & Donmall, 2005; Woody & Adessky, 2003; Karver, Handelsman, Fields & Bickman, 2006). Due to Mr U's previous history with boundaries difficulties, facilitators were very aware that developing an effective therapeutic alliance was important for the progression of his treatment. Facilitators were also aware of research that emphasises the importance of patients understanding their risk factors and involvement in addressing them (Mair, 2004). Thus, in order to encourage Mr U to take ownership of his risk factors and their management, he worked through his functional analysis with a facilitator. A simplified and pictorial version of the SORCs (Appendixes L and M) was used to aid this process. The elements were explained to Mr U and he added additional information that he felt was important. His functional analysis was an open document which was worked on and added to up until his de-selection. As Mr U's openness and insight developed into his previous relationship history and difficulties more information was added. It was also used to monitor his treatment needs progress, by staff and himself.

Not only did this collaborative approach appear to develop, in part, Mr U's openness and insight into his own history and empowered him in addressing his treatment needs, it also enabled the development of a transparent and trusting working relationship between him and the facilitators. These factors, self-belief in his ability to change and a good working relationship, have been associated with effective treatment (Mair, 2004).

The facilitators used all group members', including Mr U's, functional analysis to direct specific questions and select specific skills for them to practise with the aim of focusing them on their treatment needs. The skills practise process was performed with Mr U prior to conducting the skills practices with him. It was ensured that Mr U had a situation to use for the practices of skills such as asking for help, and coached him through the process in order to create a safe and productive learning environment. Mr U was given constructive feedback on a number of occasions to highlight concerns regarding his progression and behaviour, both inside and outside the group room. It was hoped that this open and transparent approach would help Mr U in identifying and addressing his areas of need.

Learning disability and learning styles

Mr U was prone to impulsiveness and a short attention span. Research has indicated that lifestyle instability and general impulsivity are reliable predictors of treatment attrition (Wierzbicki & Pekarik, 1993). Thus, in order to maintain his interest in the course, facilitators monitored his interest levels, kept exercises to time and delivered at an effective pace of treatment. Facilitators also looked at how to best work with and be responsive to the patient's different learning styles and levels of learning disability.

Research indicates that learning is most effective when facilitators are aware of clients' different learning styles and adapt their delivery methods appropriately (Arthur, Bennett, Edens & Bell, 2003; Morgan, Vickers & Moore, 2010). Studies by Kolb (1981) and Honey and Mumford (1986), found that clients learn best when a varied and wide range of methods were used. A wide range of different exercises and delivery methods were utilised in order to optimise their potential learning outcomes (Morgan, Vickers & Moore, 2010; Ford & Chen, 2001). As many of the group members, due to their learning difficulties, found it difficult to read and write, numerous diagrams and pictures were used along with verbal discussions to aid their understanding. Also, different types of tasks were alternated throughout the sessions to maintain the patients' interest and focus. This was supported by the findings of Goettl, Yadrick, Connolly-Gomez, Regian, and Shebilske (1996) that varying tasks aided learning and retention of information.

Cohesive group

Previous research has shown that group cohesion is important in delivering effective treatment (Tuckman, & Jensen, 1977; Corey, 2011), therefore, the group was monitored by the facilitators in order to assess whether it was following the predicted norms of group development. To support this patients worked collaboratively both within group, subgroup and in pairs in order to complete different tasks. Facilitators also used different techniques, such as having a group behavioural contract, emphasising confidentiality and encouraging openness among patients to support the group development.

Readiness, motivation and responsiveness

Efforts are made to increase participant's motivation to change and treatment readiness within the individual sessions and the first few group sessions. Day et al. (2006) found that readiness for treatment was an important factor in treatment effectiveness. Hence, facilitators continually monitored Mr U's motivation to complete the programme. Although Mr U stated that he was motivated to engage in the programme, he did present with numerous treatment interfering behaviours which are discussed in more detail further on in the case study.

Facilitators aimed to increase patient's motivation to engage through highlighting the costs and benefits of engaging in helpful and unhelpful relationships, making links to risk and patients' own goals, developing discrepancy between what they value and how they act (Serin, Mailloux & Kennedy, 2007). The 'Good Lives Model' was also used to emphasise the importance of relationships and how developing social skills can aid the patients in developing their "goods" (Ward, & Brown, 2004). Mr U did engage in most of these activities, however, he still presented with a high external locus of control when it came to addressing his relationship difficulties, as he often blamed others for his problems in this area.

Developing understanding and insight

Boundary violating behaviours have been linked with relationship difficulties and problems with maintaining appropriate relationship norms (Sarkar, 2004; Luepker, 1999). Sessions 5 to 9 looked at increasing patients' awareness of different types of relationships, with a particular emphasis on what behaviours would be appropriate within these different types of interactions. One exercise that was conducted explored whether it would be appropriate to ask a friend, a staff member or a romantic partner for one of their cigarettes. It was against hospital rules to trade with patients or request to share tobacco, thus it enabled discussions on when behaviours were suitable and how context can affect behaviour appropriateness. There were group discussions on the rationale behind why social interactions vary depending on your relationship with the person. Mr U demonstrated a good understanding of the

different types of behaviours that were appropriate within friendships with peers and romantic partners. For example, kissing, borrowing computer games from or asking out on a date. However, Mr U did find it difficult to determine what was appropriate when exploring the more subtle types of behaviour, such as asking for a cigarette or asking about their family, particularly in relation to staff. Mr U appeared to struggle with the concept of how it was acceptable for staff to ask him about his family but not the other way around. There were also discussions about how to develop good working relationships and the impact that this can have on patients addressing their treatment needs and supporting progression.

Skill development and risk management

Social skills training and relapse prevention exercises aimed at developing recognising and coping with high risk situation have been shown to be effective in reducing reoffending (Landenberger & Lipsey, 2005). Thus, the end sections 10 to 14 focused more on these elements. Social skill development was performed using a wide range of different approaches including role plays, group practises, observations and feedback. The sessions also aimed to increase patients' self-esteem and confidence in using these different methods. They were encouraged to practice the skills, not just within the group room, but also out on the wards to develop skill continuity and transferability. Relationships have been seen to either positively or negatively impact on a patients' chances of reoffending (Cobbina, Huebner & Berg, 2012; Niven & Stewart, 2005). This group looked at increasing patients' insight into this risk factor and develop their skills in managing the influence other people had on them. Research has shown that having positive pro-social relationships plays a role in reducing reoffending (Bales & Mears, 2008). Patients were encouraged to identify who in their social circles was a positive influence on them and they then looked at different ways in which they could strengthen this relationship and were encouraged to apply these methods, such as engaging in contact through phone calls or letter. They also conducted role plays to practise related skills such as asking for help. Equally research has shown that anti-social peers can increase a patient's chances of reoffending (Hucklesby, 2008; Deuchar, 2012). Patients were encouraged to reflect on relationship factors and specific individuals that impacted on their offending. They then drew up relapse prevention plans on how to limit the negative impact these types of

relationships have on them. They also practised skills such as saying no to peer pressure and dealing with criticism to aid them in managing these influences. However, Mr U did not progress to these sessions as he was de-selected after session 8.

Overall, numerous methods were used to support Mr U and help in creating an effective working environment within which it was hoped that his treatment needs could be addressed. Due to numerous factors listed below, this was not possible. On reflection, it may have been beneficial for him to have engaged in more motivation building work prior to the relationship group and for extra individual sessions outside of the group to support him more.

Patient's engagement, presentation and therapeutic alliance

Mr U attended three initial individual sessions and four of the group treatment sessions. Research has indicated that there are two pivotal parts to developing an effective therapeutic alliance. The first takes place in the first five sessions during which collaboration and trust have to be established (Horvath, & Greenberg, 1989; Horvath & Luborsky, 1993). The client and the staff member should jointly agree on the purpose of the work and their goals. The client should also develop the belief that this procedure will provide the desired outcomes. It was felt that Mr U was aware of his difficulties regarding trusting individuals, developing relationships and the associated problems, however, he did place a lot of blame for this on other people. Mr U was reasonably open in his individual sessions prior to the group commencing. He attended every session on time, answered all the questions asked of him and engaged in all the different exercises. He often presented as calm and happy to be there, particularly if he was voicing negative views about others. It was felt that this might be a test to see how the facilitator would react in these situations.

There was definitely a shift in Mr U's presentation during the group sessions with him becoming more withdrawn. When this was explored with him, it appeared to be related to Mr U feeling that he had to maintain his image in front of other patients, along with feelings that the methods being used and the group would not be effective in achieving his goal of developing more successful relationships. It was felt that this was potentially due to him feeling that the "fault" was with other people rather than himself and thus his attending a

group would have no effect. Mr U would also on occasion use very provocative language and statements, particularly on blaming others including his victim and staff. This may be, as the formulation hypothesises, Mr U's method for testing members of staff's view, their loyalty to him and boundaries, with the aim of checking that facilitators are not going to reject or abandon him and that staff will meet his needs.

The second phase of the development of the therapeutic alliance is when the staff members begin to use challenging as a therapeutic tool. This shift in the relationship may result in the client seeing a decrease in sympathy and support, as well as an increase in challenge strength. This may lead to a weakening of the therapeutic alliance which must be reinforced at this pivotal point in order to achieve the effective goal (Crits-Christoph, Barber & Kurcias, 1993; Muran, Safran, Gorman, Samstag, Eubanks-Carter & Winston, 2009; Safran, Muran, Samstag & Stevens, 2001). Although this is the aim, it is felt that this stage was not reached during the group due to the first part of the group being more exploratory and educational. Mr U had been de-selected before the second part of the course in which skill development and challenges are more prevalent. This stage would have been beneficial for Mr U as it would have aided him in developing an effective therapeutic alliance and overcoming difficulties together.

Reason for de-selection

Prior to engaging in group treatment, Mr U had been attending individual psychology sessions with a senior psychologist. Due to a complaint about the psychologist, his sessions had been postponed for an investigation to be completed. The investigation concluded that there was no wrongdoing on the part of the staff member, and recommended for the treatment to restart providing an additional member of staff was present. This work with Mr U was pivotal for his treatment and recovery, and was the main reason for his transfer and detainment to the secure hospital. Despite the investigation outcome and changes to the individual treatment work plan, Mr U refused to engage with this process. He continued to present with challenging, aggressive behaviour, making accusations both in these sessions

and on the ward. He was also not attending any of his occupational therapy or education sessions.

Although he was attending the relationship group, he was still voicing very pro-violent views, blame and exhibiting low motivation to change. There were mixed views among the staff about the best path of action. However, due to his long-term resistance, lack of engagement and unwillingness to take an open approach to treatment, the senior management team deemed that Mr U was currently "unready for treatment". Although the fact that he was attending the relationship group was taken into consideration, the decision was made that Mr U was not adhering to the terms of his section and thus would be returned to prison. Consequently, he was de-selected from the relationships programme after session 7.

Follow-up session

At the end of the programme, Mr U engaged in follow-up and ending sessions in which he discussed how he had found the programme, how he felt about his de-selection and move back to prison. He also discussed what he could take away from the programme and what areas he felt he needed to work on. He also completed the post-course psychometrics.

Overall, he presented as angry about the de-selection decision, blaming one particular staff member, stating that he had never trusted them and that they had "had it in for me" from the beginning. He also kept repeating the fact that he had told a facilitator previously that people always let you down, particularly therapists who say they want to help and that this just proves his point. Mr U found it difficult to reflect on his behaviour and continually blamed others. He appeared to find it difficult to comprehend the difference between attending therapy and engaging in an open and constructive manner. With facilitators he talked about his behaviour, how this had interfered with his treatment, and how people felt he was not ready for treatment at the time. He also discussed how this fitted with his section and how he could not stay in hospital without therapy. He discussed the future potential difficulties he may encounter in being open to people and change. He set goals for

working on these areas. Overall, Mr U presented as angry and blamed staff. It was felt that these emotions were shown in his post-course psychometric answers and that although he may have answered in an emotive manner, which may have biased them, it did show the impact de-selection had on Mr U and his beliefs.

Results

Psychometric results

The psychometrics were administered during the initial individual assessment sessions prior to the start of the group, repeated at the midway point after session (8) and finally, at the end of the course. Despite Mr U being de-selected from the group after 8 sessions, he still agreed to complete the post-course psychometrics. The results can be seen below. The RQ was not retested due to the function of the tool being to gauge an individual's attachment style, which is not expected to change over an individual's lifetime. Mr U indicated that he had a preoccupied, anxious ambivalent attachment style with some elements of a fearful avoidant attachment style.

Table 17: Manchester Attachment Scale- Third Party Observational Measure (MAST)

	Pre-treatment	**Post-treatment**
Score	35	32

The MAST was only administered twice at the beginning and end of the programme. This showed a small shift in Mr U's scores, towards less adaptive attachment behaviours (Penketh, 2011). On examination, most of the responses had remained the same with no shift, however, Mr U did score slightly less adaptively on "solicits comforting when distressed" and "the individual is direct and active in seeking help" and "seeks cooperation from their carer".

Table 18: The IIP-32 – Mr U's Total T Scores.

Factor	Pre-treatment	Mid-treatment	Post de-selection
Domineering/controlling	59	59	59
Vindictive/self-Centred	70 *	70 *	70 *
Cold/Distant	69	67	72 *
Socially inhibited	48	42	48
Non-assertive	55	52	52
Overly accommodating	36	36	36
Self-sacrificing	36	36	38
Intrusive/needy	33	33	33

* Total T scores more than 2 standard deviations above the mean (T= 70), indicates the person's distress is very high relative to the general population and thus highlights a specific area of interpersonal difficulties.

The IIP-32 scores demonstrated no significant shift in the scores between the pre, mid and post assessment. There were small differences in Mr U's level of socially inhibited and cold and distant scores. Pre-group he had scored highly, however during the group this shifted marginally to a lower level and after de-selection this increased higher than the pre-group level. There was a shift in his response to questions such as "I get along with people" and "Join in on groups". This may demonstrate Mr U feeling that he does not fit in and needing to self-regulate and distant himself rather than rely on others. Mr U demonstrated a marginal shift in his non-assertive scores between the pre-and mid questionnaire. This change was maintained after the course. Mr U's social inhibited scores shifted to being more socially inhibited from the midcourse and the post de-selection questionnaires. Mr U changed his responses to questions such as "confront people with problems that come up", which may be in response to him feeling that he has been more open and expressed his feelings towards the management team about his de-selection.

The IIP-32 scores all showed only small differences and thus these changes may have been merely a natural variation in Mr U's responses over time and may not be related to his treatment or being de-selected.

Table 19: Revised UCLA loneliness scale (R-UCLA)

	Pre-treatment	**Mid-treatment**	**Post de-selection**
Score	47	43	52

Average score for similar group is 40

Mr U's R-UCLA pre-group score indicated that he did experience higher than average scores of loneliness. During the group this score decreased, potentially in response to him forming relationships with other group members and feeling that he was not alone in struggling with different issues. When he was de-selected his loneliness scores increased dramatically there was a particular shift in his response to questions such as "there is no one I can turn too". This may be his way of informing staff that he is unhappy with the decision and that he now feels separated from them and that he can no longer trust them or turn to them for help. It may also be in response to him being de-selected and his no longer being in contact with other group members.

Table 20: URICA: The stages of change questionnaire ranges

Stage	**Scores**
Pre-contemplation	8 or lower
Contemplation	8 – 11
Preparation (action)	11 – 14
Maintenance	14 and above

Table 21: Mr U's URICA scores

	Pre-treatment	**Mid-treatment**	**Post de-selection**
Score	6.9	8.8	3.5
Stage	Pre-contemplation	Contemplation	Pre-contemplation

The URICA, which measures an individual's motivation to change, demonstrated a notable shift in Mr U's score. Halfway through the programme he appeared to have increased his motivation to change and moved from the pre-contemplation stage to the contemplation stage. This may have been due to work highlighting relationship difficulties and education around appropriate and inappropriate behaviours within relationships. The post de-selection assessment appears to show that Mr U had reverted back to the pre-contemplation stage, being less motivated to change than at the beginning of the course. On review, it was felt that Mr U was responding in a way that indicated he felt the problem was with other people and not his to address. This can be seen in a large shift in his response to questions, such as "Trying to change is pretty much a waste of time for me because the problem doesn't have to do with me" and "All this talk about 'psychology' is boring. Why can't people just forget about their problems?" between mid and post-course psychometrics.

Self-reported change

During treatment Mr U had stated that he felt he had a greater understanding of his family and the difference between helpful and unhelpful relationships. He reported that he used to believe that these were down to how individuals made you feel or if they did things that you wanted. However, he now felt that there were other factors to be taken into consideration when assessing an individual's helpfulness. He stated that "someone may help you by giving you drugs or money and this might make you feel good however in the long run this is not

helpful as it is helping you go back to prison or hospital which I don't want to do." He also seemed to develop a less "black-and-white" opinion of some of his family members, particularly his sister, who is a very good source of support and structure in his life. However, he often presented his sister in a very negative light and on occasion had argued with her. Mr U was able to see how their relationship was a mixture of helpful and unhelpful behaviour patterns. Mr U was also more open about his relationship difficulties in the past stating that he struggled with trusting people and how he still thought about the member of staff in a sexual way.

After treatment was terminated he stated that he had not learned anything from the course apart from "you should not trust anyone", in particularly staff and that even when you work hard it still does not "pay off". It was evident that Mr U was very hurt by the decision to transfer him back to prison and struggled to understand the difference between attending sessions and actively addressing his treatment needs.

Discussion

Summary of assessment, intervention and outcome

Overall, it appears that there were some changes in Mr U during the course, primarily in his awareness of specific relationship difficulties, and his motivation and self-efficacy in his ability to address them. There was also an increase in his knowledge base of relationships, particularly around helpful and unhelpful relationship behaviours. It does appear that Mr U also benefited from developing relationships with other group members and this may explain the decreased loneliness scores at the course midway point. Mr U was seen talking and associating with his group members during the breaks. Mr U was de-selected from the programme before he was taught any new social skills, thus it is unsurprising that his skill development with regard to relationships remained the same.

It does appear that the decision to de-select Mr U from the group did affect his motivation to change and he appeared to revert back to his standpoint of blaming others for relationship difficulties. This response to de-selection could be seen in his URICA scores.

There also appeared to be a shift in Mr U becoming more withdrawn from staff members in general and in turn, his feeling more isolated with less support. This is a very unfortunate outcome of de-selection and highlights the detrimental impact of not finishing and being de-selected from programmes can have. It also highlights the extent of Mr U's outstanding treatment needs and relationship difficulties, as well as their effect on inhibiting his treatment. This appears particularly problematic with the more intensive individual treatment that he was being offered by the lead psychologist. It seems that he demonstrated less treatment disruptive behaviour in groups which may be a sign of being contained more by others, or him finding it less demanding as this course was only ever designed to be of low intensity and primarily psycho-educational.

Therapeutic relationship

In terms of the therapeutic alliance between Mr U and the lead facilitator, it was felt that the relationship, although spending eight sessions together, was still in its formative stages. A number of different approaches to develop this relationship had been used, such as reflection, interpretation, active listening and collaborative goal setting (Ackerman & Hilsenroth, 2003). This appeared to have worked in part, as Mr U had presented as reasonably relaxed within sessions and had shared more about past relationships and difficulties than previously. However, it was still evident that Mr U struggled with trust and there would be an obvious shift in his presentation if he did not agree with a particular exercise or question asked of him. This would result in him either talking about something that was unrelated, giving very short answers or reverting to an angry, anti-social response. It is felt that although a tentative therapeutic relationship was developed during this course overall, it was very superficial. It was hypothesised that this was due to a range of factors, including time constraints to develop the relationship, being in a group environment and Mr U having very entrenched cognitions around mistrust and authority. It was very evident from the post course interview that this therapeutic alliance had been damaged by the decision to de-select him.

He had been aware of the possibility of his returning to prison if he did not engage in treatment and apply what he was learning. Staff had been transparent and clear regarding this from the start. However, despite this after his de-selection he was far less willing to be open, apart from placing blame on others for his de-selection. Similarly, Schafer and Peternelj-Taylor (2003) and Horvath and Luborsky (1993) found that although prisoners were aware that establishment rule enforcement was part of their treatment team's role, they still felt that trust had been violated when rules were enforced. This highlights the frequent discrepancy between staff's and patient's perception of relationship boundaries and acceptable behaviour, despite this apparently being clear from the start. Mr U appeared to struggle after de-selection with a feeling that facilitators were not adhering to his personal rules around trust and had betrayed him. Despite his obvious anger and feelings of rejection, Mr U did engage in the last session and completed the post course psychometrics which potentially implies that he was still willing to have contact with staff and engage with them. As his attachment style suggests he wants that connection but does not know how to achieve it or deal with the anxiety of being abandoned.

Practical and theoretical issues and other factors which affect course effectiveness

Engaging in illicit relationships can have a major impact on a patient's life, not only emotionally and socially, but also affecting their ability to effectively engage in subsequent treatment. However, although a patient's previous relationship experiences do influence their ability to develop strong therapeutic alliances, they do not determine it (Horvath, & Luborsky, 1993). The quality of the current interpersonal therapeutic interaction and the client's motivation are seen to be most pivotal in their working collaboratively towards treatment goals (Polaschek, & Ross, 2010; Horvath & Luborsky, 1993).

Although an individual's past relationship difficulties and the impact of engaging in the unhelpful therapeutic relationship has evidently impacted on Mr U, there were other factors that have to be taken into consideration when assessing the effectiveness of this intervention. Low motivation, poor relationships and stressful life events have all been shown to impact on treatment effectiveness and Mr U was experiencing all of these at the

time of the group treatment (Roth and Fonagy, 1996), especially Mr U's initial level of motivation and insight. Research shows that interventions initiated when a patient is in the pre-contemplation stage have to be very mindful not to be counterproductive and intimidate clients away from treatment. It is possible that Mr U should have undertaken specific motivational work prior to engaging in risk related treatment.

Furthermore, this was a short, low intensity intervention and it is important not to have overly high expectations of what could be achieved in a short space of time. Intervention should always be sequenced appropriately which is why this low intensity relationship was deemed to be an appropriate initial introduction to group work for Mr U.

Challenging decisions and their impact

The decision to return Mr U to prison and de-select him from the relationship programme and all psychological treatment appears on one level to have damaged his development of the therapeutic relationship with staff members. This decision was not taken lightly or with a naivety of the potential consequences. However, it was felt that Mr U, although engaging in the group by attending, was not adhering to any other aspect of his treatment and was still not open to change. It was believed that boundaries needed to be maintained and there had to be consequences if he did not adhere to the treatment contract, which he was transferred to hospital to complete. Although this decision did impact on Mr U's trust levels and willingness to engage, it was a hard balance between this and allowing him to not make changes, push boundaries and continue to offend without consequences. It was hoped that through re-establishing these boundaries and highlighting consequences, that this may in the long-term motivate Mr U to increase his level of reflection, develop his insight into his problematic behaviour and be more motivated to engage in therapy in the future.

Impact of boundary violating behaviour

Overall, this case study demonstrates that boundary violating behaviour damages the individuals involved in the short term by disrupting relationships, creating emotional stress and distraction from the purpose of therapy. This could be seen in the way that Mr U reacted after the relationship ended and how he reported this had an impact on him personally. In addition, it also has longer term and far reaching consequences. Patients who have previously experienced boundary blurring relationships continue to experience relationship difficulties, trust difficulties, problems forming therapeutic alliances, poor understanding of relationships and treatment. It is believed that Mr U has experienced all of these consequences through the different boundary crossing and boundary violating behaviour of previous staff members with whom he had worked. These unhelpful relationships have resulted in Mr U having distorted cognitions and limited social skills, which in turn impacted on his ability to cope and reinforced his anti-social and pro-criminal behaviours and attitudes.

The negative effects highlighted above have in turn impacted on Mr U's ability to engage productively and successfully with his treatment plan. Mr U was moved to a hospital setting as a result of him finding it difficult to cope in prison and for him to access specialist help. Due to the damage caused by boundary violating staff, Mr U was not able to access this appropriate care and treatment, and thus he breached the terms of his section. Therefore, he was deemed not ready at this time for treatment and returned to an environment which potentially would not be as supportive and would not provide specialist care.

This highlights the long term impact that boundary violating can have on patients and their treatment pathway. Not only does it affect the individual emotionally and psychologically, it also impacts on their ability to gain support and treatment. It is possible that without the appropriate intervention Mr U may continue to engage in offending and encounter further relationship difficulties.

Implications for future work

There is a large volume of literature on the prevalence of boundary violating relationships in a variety of settings, the impact that this has on both staff and clients, and the benefits of forming strong therapeutic alliances. However, there is still very limited research and guidance out there around how to truly develop strong therapeutic alliances. It appears to be something that is simply expected of therapists. Evidently something that is so pivotal to therapeutic interactions and treatment outcome deserves far more emphasis and training.

Conclusion

It is hoped that with time Mr U will be able to develop the coping strategies and skills that will enable him to manage future relationships more productively. No professional starts out thinking they will cause harm through their work and even the individuals who form illicit relationships probably believe that they are "helping" or at least not harming their patient. Some research even shows that some minor boundary crossing supports the development of a therapeutic relationship (Henretty, & Levitt, 2010; Knox, Hess, Petersen, & Hill, 1997; Gutheil & Gabbard, 1993; 1998). However, in the same way that the good strong therapeutic alliance can be pivotal in treatment effectiveness and outcomes, so unhelpful and misguided relationships can be destructive and harmful to the patient and course of treatment. Gutheil and Gabbard (1993) stated that creating a therapeutic relationship, grounded in appropriate boundaries, benefits clients by creating a safe and secure environment within which they can share information and effectively work towards achieving their goals. Interpersonal relationships are complex and powerful, and staff need to be continually mindful how best to use and manage them to achieve our goals in a safe and secure environment for both clients and staff.

Summary of Chapter 4: Case study

Mr U was a patient residing in a secure forensic hospital who had a history of engaging in illicit relationships with staff.

The case study examined the patient factors that may contribute to them forming illicit relationships such as insecure attachment style, previous relationship difficulties, poor impulse control, poor insight, and poor understanding of relationships and boundaries.

It also found that boundary violating behaviour not only has short term effects on patients like Mr U such as anger, loss of trust, violence and aggression. However, it also impacts on their ability to engage in treatment, lengthens their treatment pathway and affects their views on further relationships.

Mr U was offered to engage in the 'Relationship group' however, several treatment interfering behaviours ultimately resulted in him being de-selected from the program.

This case study highlights the human element of boundary violations and the wide spanning impact these behaviour can have on people's lives.

Forward to Chapter Five

Chapter 4 highlights the long and short term implications that boundary violating behaviours can have on a patient. These include difficulties with understanding relationships, developing trust and the displaying therapeutic interfering behaviours. This case study demonstrates that different theories can be drawn upon, such a social learning theory and CBT, to detect treatment needs and methods to address these. These theories identified several strategies which can be implemented by staff, potentially through a 'relationship programme', to assist recovery and progression. However, for this to be possible, staff need to develop effective therapeutic relationships, be consistent with patients and maintain appropriate boundaries. In Chapter 3 several strategies are highlighted to aid with this, such as supervision and training. Previous research developed a method to help staff maintain appropriate boundaries with patients, the Exploitation Index (EI) (Epstein & Simon, 1990). Chapter 5 describes and evaluates this psychometric tool and assesses its effectiveness.

Chapter 5:

Critique of Psychometric Assessment:

The Exploitation Index

Chapter 5: Critique of Psychometric Assessment: The Exploitation Index

Introduction

The harm that boundary violating can cause clients is outlined in the case study in chapter 4. Research indicates that more serious boundary violations tend to occur after a period of less serious boundary violations and crossings (Simon, 1989). This process has been coined the 'slippery slope' and is the reason why Gutheil (1989) stresses the importance of recognising minor boundary violations before they progress.

Many see professional behaviour and conduct as being on a continuum with cold and distant patient-staff relationships being on one side and over-involved relationships being on the other (Epstein, Simon & Kay, 1992). The extremes of both ends of the continuum can subsequently lead to boundary violations. This continuum obviously makes monitoring and making judgements on professional relationships challenging, as it is hard to define "how close is too close?" and "how far is too far?" This combined with the fact that boundary violations are hard to detect and often professionals are unaware, or in denial, about their potentially harmful actions, highlights the need for a tool to help monitor professional behaviour (Gartrell, Herman, Olarte, Feldstein & Localio, 1986).

For this reason, psychometric tools have been developed to monitor boundary violation, the Exploitation Index (EI; Epstein & Simon, 1990) and the Boundary Violation Index (BVI; Swiggart, Feurer, Samenow, Delmonico & Spickard, 2008). BVI was derived from the EI. This critique will evaluate the EI in terms of its scientific properties, research uses and use as an effective psychometric in the field of boundary violations. The EI was selected over the BVI as the BVI is more specifically focused on assessing a respondent's risk of engaging in sexual boundary violations and this study wants to explore a wider range of boundary violating activities. Also, BVI validity and reliability has only been investigated in one published paper (Swiggart, et. al, 2008). Thus the EI was deemed a more appropriate tool for this thesis.

Overview

The Exploitation Index (EI)

Epstein and Simon (1990) used actual examples of exploitive behaviour found in published case reports, forensic records from cases involving litigation against mental health professionals, and personal clinical observation, to identify factors which they believed were related to boundary violating and patient exploitation. They identified 32 items based on the following seven factors: generalized boundary violations, eroticism, exhibitionism, dependency, power-seeking, greediness and enabling. Boundary violating behaviours come in many forms including, exploiting clients for material gains, breaking the clients' confidentiality for personal gain or engaging in sexual activities (see Appendix P for more examples). The aim of EI was to support therapists in self-assessing and highlighting potentially small boundary violations that they may be making. This in turn would aid their reflective practice and prompt them to alter this problematic behaviour before it escalates into more damaging violations (Epstein & Simon, 1990).

Therapists answer these questions on a four-point Likert-type scale, indicating the frequency with which they acted in particular ways. For example, "Do you accept gifts or bequests from patients?" Never (scores 0), Rarely = about once a year or less (scores 1), Sometimes = about once every 3 months (scores 2) or Often = once a month or more (scores 3). These scores are then added up to make a total final score, the higher the score the higher the risk of a staff member committing a boundary violation. Epstein, Simon and Kay (1992) chose scores of <27 on the EI to represent the boundary violating 'high-risk' category, as it represents 10% of the participants. This is comparable to the estimated percentage of boundary violating physicians in general.

Use of the Exploitation Index

The primary use of the EI was for therapists to assess their own behaviour and attitudes in order to increase their insight into potential warning signs of boundary violation and prompt them to make changes to their practise. This tool has also been used to guide group

discussions among professionals, guide supervisors in their monitoring of therapists and as a teaching aid (Epstein & Simon, 1990). The EI has the potential to be used for identifying professionals who lack education and awareness of boundary issues, monitor change after an intervention and training to assess its effectiveness. The aim of the EI, if used effectively, is to potentially increase a therapist's integrity and ability to deliver effective treatment in a safe environment.

Where the EI fits with the current body of work: possible alternatives

Despite the volume of literature regarding the problems caused by boundary violations, there are only two major validated and reliably tested psychometrics that assess the risk of staff-client boundary violation; EI and BVI (Swiggart, et. al, 2008). The BVI was an adaptation of the EI. Previously, Menninger and Holzman (1973) and Langs (1973) compiled lists of thoughts and behaviours to help therapists identify transference and counter transference impulses towards clients. These lists were not widely available and thus not used by therapists. However, Epstein and Simon (1990) integrated some of these factors into the EI. More recently, two doctoral theses, Nigro, (2004) and Daniels, (2008), designed surveys exploring this area. Nigro (2004) explored the association between psychologists' attachment patterns and their interactions with patients, including sexual contact. Daniels (2008) explored the risk factors associated with staff committing boundary violations with forensic inpatients. Although these are very detailed and preliminary tests indicate good levels of reliability and validity, the findings have not been widely tested or verified. Indeed, these research findings were not published and their methods have not been peer reviewed. Since the EI is the most researched and used tool in this area, it is most fitting to evaluate it, thus it will be the focus of this critique.

Published research conducted in relation to the EI

There are three main EI associated papers. The first paper, 'The Exploitation Index: an early warning indicator of boundary violations in psychotherapy' by Epstein and Simon (1990),

outlined the research and rationale behind each exploitation and their inclusion in the EI. A follow-up paper titled 'Assessing boundary violations in psychotherapy: survey results with the Exploitation Index' by Epstein, Simon and Kay (1992) distributed EI to 2500 psychiatrists, 532 were returned completed and from this data they evaluated the validity and reliability of the psychometrics. However, a major criticism of this paper, and the testing of the EI, was that it left out questions regarding overt sexual conduct with patients. These questions were considered detrimental to the response rate as participants may fear legal ramifications of answering them. Despite focusing on more responsive questions, the return rate was only 21.3%, which may mean that people were concerned about being associated with this taboo topic, that the tool was not easy or practical to use or that the therapists who were ashamed of their boundary violating actions did not participate. This is something to consider when evaluating the paper's results.

The third paper, 'Sexual Boundary Violation Index: A validation study' by Swiggart, et. al, (2008) detailed the adaption of the EI into the Sexual Boundary Violation Index (BVI) and the subsequent validation of this tool. The BVI comprises all of the EI's subscales, except the sixth subscale "greediness", which was replaced by 12 items relating to "professional and ethical behaviours" (Swiggart et al., 2008, p 179). This resulted in the BVI being a 44 item questionnaire compared to 32 items for the EI. The adapted EI (BVI) was distributed to a group of physicians engaged in treatment for boundary violating behaviours, and compared the results with a group of physicians who had never reported committing any boundary violating behaviours. Although participation in the control group did rely on self-disclosure, there were some significant differences between the two groups that helped to validate the psychometric. All of these papers will be explored in more depth and used to analyse the EI throughout this critique. This paper was included even though it explored the BVI and not the EI as it included very similar items and used the same method to explore this topic, thus it was felt that this research did add to the evaluation of the EI. It was particularly valuable as there is very limited research into the EI and thus gathering as much related information as possible is key. However, as they are different psychometrics, caution has to be used when comparing and drawing conclusions from the BVI.

Critiquing the Exploitation Index (EI)

The characteristics of a good psychometric

Rogers (2003) states that psychometrics 'clarify ambiguous information, elicit previously unattainable data and add objectivity, validity and reliability to peoples' interactions and behaviours' (p5). However, not all psychometrics live up to these objectives and cannot be classed as useful or effective in the role they aim to achieve. According to Kline (1986), a good test is required to have at least an interval scale, consistent reliability, strong validity, discriminating and appropriate norms. This critique will analyse the EI with regard to all of these factors in order to determine its effectiveness.

Reliability

This tool was primarily designed and tested on psychotherapists, thus it may not be applicable to a wider population of staff and further research is required.

Internal reliability

Internal reliability is the extent that the EI measures are consistent within it. Epstein, Simon and Kay (1992) measured the EI's internal reliability using Cronbach's Alpha. Encouragingly, it scored .81, indicating a moderately high coherence between the items and that the test is consistent, with all the included items measuring the same feature, boundary violation.

Inter-method reliability of the EI cannot be assessed as no research has been conducted on this area. However, the most commonly used method of administrating the EI is for it to be sent to or given to participants to complete and return in their own time, which raises some concerns. Some participants may be more honest and open when answering in private, whereas others may be more truthful if the questions are being read to them and their answers recorded by an experimenter or supervisor. This is particularly relevant when the

psychometric topic is very sensitive. Although all the papers highlighted confidentiality, the fear of legal retribution or judgement must surely affect the participants' responses (Celenza & Gabbard, 2003; Folman, 1991). The effect on the participant and their level of openness will vary depending on the method used to administer the EI, which would potentially impact on its inter-method reliability. Further research is required in this area.

Test-retest reliability

The test-retest method assesses the EI's external consistency by evaluating if the scores are stable over time. This is achieved by retesting the same group of people twice and comparing their scores.

The lack of research regarding the EI's test-retest reliability means that no conclusions can be drawn about this element of the EI's reliability. The test-retest reliability of EI is particularly important as one of the EI's advertised uses is its ability to monitor change in an individual therapist. Clinicians are advised to regularly use this tool in order to monitor change in their behaviour and thus variance in their levels of risk of boundary violation. Therefore, it is key that the EI's test-retest reliability is high otherwise the variance the clinicians' record may be due to the inconsistencies of the tool rather than changes in their behaviour and risk level.

Overall, the tests that have been conducted on the EI have indicated good reliability. However, as this research is very limited and only conducted by the authors of the EI, further evaluation is necessary before accurate conclusions can be drawn.

Validity

Face validity

Face validity assesses to what extent the EI looks like at face value, that it is measuring what it aims to measure. From looking at the EI questions (see Appendix P), good face validity

appears to exist as the questions focus on behaviours associated with both sexual and nonsexual boundary violating, thus implying that the psychometric is testing what it aims to. A potential criticism is that as the topic being tested is so evident to the user, and boundary violating is such a 'taboo' topic, the user may be less open and willing to admit to such behaviours, compared to answering more subtle questions about their aims (Folman, 1991; Bohm, Curtis & Willock, 2009).

Another element associated with the EI's face validity is that some of the behaviours the EI covers do not appear to necessarily link with boundary violating risk factors. This may be due to the EI now being over 20 years old and definitions of appropriate behaviour have changed. For example, question 12 asks 'Do you and your patients address each other on first name basis?' Recently, in medicine there has been a decrease in formality as the relationship between patient and doctor is encouraged to be more collaborative rather than authoritative (Galletly, 2004). Consequently, doctors are more likely to use first names in order to develop a relaxed relationship in which both sides are seen as equals. Thus, this question may be out-dated and unhelpful in identifying boundary violating risk factors. Particularly, as even in 1992 this statement was endorsed by 56.5% of respondents (Epstein, Simon & Kay, 1992). Epstein and Simon (1990) included this question as they felt that using first names may lead both the physician and the patient to feel that this was less of a professional relationship and more of friendship. It is potentially true that this shift to a more relaxed and collaborative relationship may be an indication of a lack of vigilance around boundary violating. However, it was felt that there were other questions in the EI that would be more sensitive and effective at highlighting boundary violating risk factors. This is particularly true as the EI's scores are not weighted dependant on the questions and the severity of the behaviour indicated.

Another frequently endorsed question (83.8%), which would imply that it is not related to risky boundary violating behaviours, was question 23, 'Have you accepted treatment for individuals known to be referred for treatment by a current or former patient?' (Epstein, Simon & Kay, 1992). This question was included as Langs (1973) felt that accepting referrals in this way "breach the boundary of limiting compensation to money alone" and thus, implied that the therapist is amenable to subtle forms of bribery. This rationale may be seen

as quite extreme, particularly in specific settings, such as rural environments, where it is unrealistic to assume that this behaviour does not occur due to limited facilities in the area.

Despite some concerns regarding face validity for some questions, data analysis does imply that even highly endorsed questions, such as 12 and 23, are highly correlated with other EI questions. Factor analysis also indicates these items have high positive rating scores related to violating behaviours and hence, are useful indicators of risk when employed in conjunction with other questions (Epstein, Simon & Kay, 1992).

Construct validity

Construct validity assesses the ability of the EI to measure what it actually aims to measure. The EI was initially constructed on the basis that seven factors are associated with committing boundary violations (Epstein & Simon, 1990). When Epstein, Simon and Kay (1992) examined this using factor analysis they found that the hypothesis of sub-categorization of exploitation was mainly supported, as eight factors were identified. These factors explained 49.7% of the variance and indicated that the EI has moderately good construct validity. Despite this, many of the items do not load onto any of the seven factors, implying that other factors may also be associated with boundary violating or that the other items are measuring some other factor. Further research would need to be conducted to evaluate this.

Subsequently, Swiggart, Feurer, Samenow, Delmonico and Spickard (2008) tested the occurrence of these seven factors in the BVI through exploratory principal component analysis. Although the BVI is an adapted version of the EI, it does include all items associated with six of the original factors. They found no evidence to support the presence of seven or six statistically distinct subscales which Epstein and Simon (1990) hypothesised. Instead, the analysis supported the presence of a more general wide ranging component of “boundary violation” that accounted for 31% of the total item covariance with a strong internal consistency (coefficient alpha = 0.92). Although this discredits that the EI measures Epstein and Simon’s (1990) seven hypothesised factors, in more general terms it validates the fact

that the BVI and subsequently, the EI, do indeed measure risk factors associated with boundary violating. The lack of validation for the seven factors may have arisen because the BVI test (Swiggart, Feurer, Samenow, Delmonico & Spickard, 2008) was administered to 'helping professionals' rather than just therapists; the EI and Epstein and Simon, (1990) hypotheses were originally based on therapists. Therefore, the EI and its seven associated factors may not be appropriate for use on certain professions. However, this may also be explained by the different interaction between items within the two psychometric tests.

Does it achieve its aim?

The main aim of the EI is to highlight to physicians counterproductive behaviours that may put them at a higher risk of committing boundary violations, encouraging reflective practice and change. Epstein, Simon and Kay's (1992) study found that 43% of respondents were "alerted" to at least one behaviour that was counterproductive to treatment. Additionally, 29% reported that they felt stimulated to make specific changes to their practice. They identified a significant relationship between professionals being alerted to potentially problematic behaviour by the EI and subsequently stating that they were "stimulated for future change" in the way they practised ($r = .60$, $p < .0005$, two-tailed) (Epstein, Simon & Kay, 1992). Although these percentages are small, this is still very encouraging and indicates that the EI is achieving its aim. However, just because physicians indicate that they will change, does not equate to them actually doing so. The impact of the EI in practical terms of changing therapists' interactions with patients has not been researched.

Due to the stigma attached to boundary violating, a number of papers report how physicians tend to minimise or deny this type of behaviour (Celenza, & Gabbard, 2003; Garfinkel, Bagby, Waring, & Dorian, 1997; Simon, 1999). Since the EI is a self-administered questionnaire which relies on honesty and an ability to be self-reflective, the tool would potentially be ineffective on therapists who are in denial. Consequently, the EI has low validity for this particular group of therapists.

Measuring risk of boundary violation or just boundary violations

The key criticism of the EI's construct validity is that the tool aims to highlight to physicians behaviours which are risk factors for committing boundary violations. However, many of the behaviours are in themselves boundary violations. For example, prescribing medication to family members or lowering fees because of sexual attraction, is not just a risk factor for boundary violations but is a boundary violation in itself. Therefore, to say that a high EI score is a good predictor of boundary violation is true but equally a false statement, as in order to get a high EI score you are technically committing boundary violations. An effective tool would indicate to staff that they were committing boundary violations and at a high risk of engaging in this behaviour. Consequently, there is concern that such behaviour would continue as staff are unaware that they are engaging in potentially harmful behaviour.

The BVI demonstrated good construct validity as it produced a significant difference between the non-boundary violating group of physicians and the boundary violating groups scores ($p < 0.001$).

Concurrent Validity

The concurrent validity assesses how accurate the psychometric score compares to similar tools that assess similar behaviours. As the EI and the BVI are the only tools designed to assess risk of practitioners committing boundary violations, the comparison psychometrics are not ideal matches and hence, the findings have to be interpreted with caution. There has been no direct research into the EI's concurrent validity however encouragingly, research into BVI found that it had strong concurrent validity with the Sexual Addiction Screening Test (SAST, $r = 0.68$, $p < 0.001$) (Swiggart et al., 2008). The SAST was originally designed to assess patients' sexually compulsive behaviour, primarily in heterosexual men, so it is not the ideal comparison tool. Consequently, a good correlation may indicate that the EI does not have good validity for measuring boundary violating risk but another factor more related to sexual compulsion.

An additional study indicated that it was not significantly correlated with the Sexual Symptoms Assessment Survey (S-SAS), a psychometric designed to assess the severity of compulsive sexual behaviour (Raymond, Lloyd, Miner, & Kim, 2007). Despite non-significant results, there were encouraging indicators which implied that the result may have been due to a very low participant population size rather than an accurate measurement of how the two scales measure boundary violating behaviours (Menassa, 2011). Although these two tests assess similar behaviour they were designed for very different purposes from the EI and thus, there are concerns around their suitability for assessing the EI's concurrent validity.

Predictive Validity

Predictive validity is the degree by which the EI accurately predicts which therapist commits boundary violations. It is very challenging to not only create a psychometric that predicts which physicians will go on to commit boundary violations but also test that tool's predictive validity.

Pope's (1990) review of papers spanning the last quarter century suggest that therapist-patient sexual involvements may be significantly decreased. This is potentially due to an increased awareness of the associated harm caused and thus, therapists desisting from this behaviour. Although this may have been true, it is possibly more realistic to believe that professionals may have become less open to the topic and equally more motivated to hide such behaviour because of an increased awareness of the consequences of committing boundary violations. Alternatively, due to the associated stigma companies are not motivated to detect such behaviour, devoting fewer resources to investigate and thus, fewer cases are being identified. As a result, potential risk factors may be under reported in questionnaires, combined with boundary violating offending not being identified. As a consequence of physicians' own denial and self-deception resulting in an under reporting of boundary violations, the EI questionnaire's ability to predict future behaviour will be impacted.

Pope (1989) and Twemlow and Gabbard (1989) both talked about professionals with "malignant forms of denial" surrounding their behaviour. If this is the case, then the EI will not only be ineffective in highlighting relevant risk factors but will also not predict accurately their future behaviour, as often individuals with strong denial patterns subsequently go on to commit boundary violations (O'Connor, 2001).

As a result, there are no cohort follow-up studies that measure whether high EI scores do equate to boundary violating in the future. Thus, conclusions about the EI's predictive validity have to be drawn from other less direct sources.

The BVI's predictive validity was tested and found that if an individual scored a total ≥ 6, then they were 20 times more likely to be in the boundary violating group compared to the non-boundary violating group of physicians. A BVI score of ≥ 6 for interpreting substantive risk had a sensitivity of 83% when comparing groups (Swiggart et al., 2008).

Content Validity

Content validity is the measure of how accurate the EI is at assessing all aspects of boundary violating behaviours. Despite there being very little detail behind the methods Epstein and Simon (1990) used to collate information about the different types of boundary violating, the EI appears to have good content validity. The EI measures a wide range of aspects associated with boundary violating (the seven factors highlighted above) rather than just relying on one, such as sexual boundary violating. There is a slight concern that as the more extreme types of boundary violations are either unreported or minimised, combined with the fact that many boundary violators would not have participated in the voluntary studies, there may be some associated risk factors which have gone under reported and thus, are not included in the EI. However, when collating the associated factors, Epstein and Simon also used case studies of boundary violating physicians who have faced legal proceedings to mitigate against this.

EI response scale

The validity of the response recording method appears good because it uses an interval scale rather than binary responses, which was one of Kline's (1986) requirements for a good psychometric. The EI psychometrics indicates that the higher the final score, the higher the risk of a boundary violation occurring. However, the EI's construct and predictive validity has not been statically tested. From assessing the questions however, it does feel that a weighted system would improve EI validity. For example, questions relating to more severe boundary violating behaviours, such as boundary violating actions (question 29), would score higher than less severe ones, such as boundary violating thoughts (question 14). This would hopefully make the tool more accurate in highlighting individuals at real risk of committing future boundary violations or who were currently engaged in server boundary violating behaviours.

Supporting findings from the empirical research in chapter three

The empirical research in chapter three also supports the EI. The correlation indicated that individuals who scored highly on the EI were more likely to have previously engaged in boundary violating behaviours (Epstein & Simon, 1990). Thus, this finding adds support to the growing reliability and validity data for the EI tool.

Nevertheless, it also potentially indicates that individuals who have previously been disciplined or spoken to about their boundary violating behaviours are still at risk, in accordance with the EI, of committing further boundary violations. Despite being disciplined they are still engaging in risk related behaviours. Therefore, this method of increasing staffs' awareness of potential risk or disciplining does not considerably decrease their level of future boundary violating risk. The aim of the EI is to raise staff awareness of the risk of committing a boundary violation. However, this finding suggests that this approach of disciplining boundary violating staff and thus raising staff awareness of wrong doing is not a protective factor as it is ineffective in lowering an individual's risk of boundary violating (according to the EI tool). This raises doubts about the potential effectives of the EI in

achieving its aim of decreasing the changes of physicians engaging in boundary violating behaviour due to increasing their awareness of the issue.

Discriminating factors

Cross culturally relevant

All the research that has been conducted on both the EI and BVI has taken place in the USA. As cultural norms and professional boundaries vary between countries, this would imply that these tools potentially are not appropriate for use in different cultures, as their cross-cultural reliability has not been assessed. Equally, the EI was designed and tested on psychotherapists so this tool should be limited to use within this professional group, as its validity and reliability when applied to other professionals is untested. This in turn limits the practical use of the tool and further research should be conducted in this area.

EI findings that reflect other studies

Encouragingly, individuals who score highly on the EI share many of the characteristics of people that other studies have found to have committed boundary violations. For example, the EI found that females had lower mean scores (women's average score: 13.35; men's average score: 16.42, $p = .0002$) and were significantly less likely to be in the "at risk" high scoring group ($82 = 6.32$, $df = 1$, $p = .012$) (Epstein, Simon & Kay, 1992) in comparison to several studies which found that males are more likely to commit boundary violations than females (Garfinkel, Bagby, Waring & Dorian, 1997; Chiarella & Adrian, 2013; Ehlert et al., 2002; Gabbard, 1994). The EI also highlighted that two other demographic characteristics exhibited a higher likelihood of scoring in the top 10%, namely working in private solo practices and working in rural areas. Both of these factors have equally been supported by subsequent research (Nigro, 2004; Chiarella & Adrian, 2013). It should be noted that Nigro (2004) has not been published or peer reviewed as it is a doctoral thesis.

Other limitations

Although Epstein and Simon (1990) arbitrarily postulated that an EI cut-off score of 27 or higher would justify inclusion in a high-risk category, there has been no research into the appropriateness of this assumption. This may lead to increased false positives which could potentially concern physicians unnecessarily, or increase false negatives which would leave the public at risk of potentially risky therapists continuing to practise. This area requires further investigation.

Appropriate norms

The two main papers that have evaluated the EI (Epstein, & Simon, 1990; Epstein, Simon & Kay, 1992) did not use control groups. This, combined with the arbitrary cut-off point of 27, implies that no conclusive judgements can be passed on the appropriateness of EI's norms. However, Swiggart, Feurer, Samenow, Delmonico and Spickard (2008) did use a control group to compare findings of the BVI between physicians who were seeking treatment for boundary violating behaviours and those who were not. They found that people who scored over six on the BVI were 20 times more likely to be in the boundary violating group, indicating the BVI's good level of validity. However, the methods used in recruiting the control group relied upon self-reporting of previous boundary violating behaviour; this is evidently a major criticism particularly as denial is a feature of this type of behaviour. Nonetheless, as the BVI varies from the EI in terms of several items, these conclusions cannot necessary be accurately transferred with regard to the EI validity.

Furthermore, the control group also consisted of less "generalists (doctors) and psychiatrists" and more "medical specialists and surgeons". Considering that both the BVI and EI were designed to be used with therapists and surgeons spend less time with their patients than generalists, it would imply that the control group is naturally a lower risk group of doctors compared to the experiment. This indicates that the findings on the usefulness of the BVI may not be measuring risk factors to do with individuals but actually measuring differences between professional groups. This is a major criticism of the study by

Swiggart, Feurer, Samenow, Delmonico and Spickard (2008), particularly, as appropriate boundaries vary between professionals and the EI was designed for psychiatrist use. Therefore, it is strongly encouraged that further research is conducted using more appropriate control group norms.

Conclusion

The use of psychometrics to monitor and highlight boundary violating behaviour is largely under researched and utilised. This has resulted in only two tested psychometrics being developed, with the BVI being an adapted version of the EI. The reliability of the EI is under researched however, initial studies are encouraging. The same is true for the EI's validity; it currently appears to have moderately good validity, in that it measures the seven factors associated with exploitation, and it alerts physicians to potentially problematic behaviour which they subsequently report motivates a change in their practice. However, there are still a number of concerns related to the EI's predictive validity and whether being alerted to potential risk does actually change an individual's practice. More research is required into the related "slippery slope" theory and whether the risk factors highlighted by the EI are actually risk factors of future boundary violation or just boundary violations in themselves. There are huge benefits that can be gained from having a well-researched, reliable and valid tool which would reduce the reliance on clinical judgement. Further research is also required into expanding the use of this psychometric into other countries and other professions where boundary violating is also an issue. Overall, the EI should be used by professionals to aid them in monitoring their practice as it can highlight potential risk factors or actual unethical behaviours. However, this tool requires further research and should be used with caution around the cut offs and when utilised as a prediction tool.

Summary of Chapter 5: Psychometric critique

The Exploitation Index is a 32 item questionnaire that aims to support therapists in self-assessing and highlighting potential boundary violations.

The strengths of this tool are: it assesses a wide range of different boundary violating behaviours; it has sufficient test/retest reliability; good internal consistency; and, moderately good validity.

The main limitations are: limited research has been conducted into its use; it relies on self-disclosure; and, it requires staff to reflect on their own practice. Another limitation is that it appears to be measuring if someone is boundary violating rather than at risk of engaging in related behaviours.

The EI appears to present with encouraging reliability and validity. This was further supported through the empirical study, in chapter 3, which found that higher scores on the expectation index were a reliable predictor of individuals who had committed boundary violations.

Forward to Chapter Six

The exploitation index findings were encouraging and it has the potential to be used by staff to increase insight and awareness of behaviours associated with boundary violating. However, it also highlights, similar to the rest of this thesis, that addressing this issue of boundary violating behaviour among staff members can be challenging and demanding. A multifactorial approach is required for best results. This topic is explored and expanded in the discussion in Chapter 6. The chapter also provides an overview of the whole thesis and states the conclusions.

Chapter 6:

Discussion

Chapter 6: Discussion

Purpose, aims of the study and why it was important

The purpose of this study was to examine the factors associated with staff committing boundary violations against clients in their care. This is an important area to research due to the well evidenced benefits of developing good therapeutic alliances and the hugely detrimental impact that boundary violations can have on patients and staff. Historically this is an under investigated area, particular exploring boundary violations among all staff and not just therapists. This is potentially due to the embarrassment and controversy associated with this topic and a reluctance to conduct research (Celenza & Gabbard, 2003). However, due to the prevalence and persistence of such behaviour, and fears about the impact that economic cutbacks may have on factors such as staffing levels and training, it was felt that further research is critical at this time of change.

Chapter 1: Introduction

Before any issue is addressed the problem has to be clearly defined. This was challenging in the case of boundary violations as it varied greatly, thus Chapter 1 set about defining what a boundary violation is and how this definition varies across professional environments. This topic has been previously explored so knowledge gained from previous boundary violation research was outlined. Overall, it was clear from these findings that exploring the prevalence of boundary violating behaviours and the impact these behaviours can have were the two most researched areas. The areas that have been under researched were also highlighted, in particular, a lack of clear conclusions drawn around boundary violating risk and protective factors in certain environments. The limited research conducted in this area was primarily focused in the American healthcare setting and questions were raised concerning the cross-cultural differences. Associated stigma and fear of retribution were also raised as issues that not only impact on the amount of research conducted in this area, but also the openness by which this topic is discussed by staff members and their managers.

This is such an important topic to address due to the long term and far reaching detrimental impact boundary violating can have on those involved. Therefore, it was concluded that further exploration into the research that has been conducted in boundary violating risk factors and the quality of these previous studies is required.

Chapter 2: Systematic review

This further exploration took place in the form of a systematic review in Chapter 2. This was the first systematic review to examine which factors were associated with increasing staff members' risk of committing boundary violation in both prison and health care settings. It also established whether these risk factors varied between forensic and non-forensic settings.

Ten studies met the inclusion/exclusion criteria; three from forensic and seven from non-forensic settings. The systematic review incorporated the findings from over 2557 participants. Six distinct categories of risk factors were identified: demographic, social, personality/emotional management, life events, education/employment and psychodynamic factors. There are specific personal and environmental factors which put all staff (forensic and non-forensic) at risk of committing boundary violations, such as social interaction difficulties, shyness and low self-esteem (Worley & Cheeseman, 2006; Garfinkel, Bagby, Waring & Dorian, 1997; Celenza, 1998; Ehlert, Cormier, Celenza, Danley, Marinelli, Messing, & Walls, 2002). Other risk factors are specific to only one environment type; having financial problems was a risk factor in the forensic setting alone (Worley & Cheeseman, 2006). This was particularly interesting as it implied that the environment plays a pivotal role in the relevance of certain risk factors, indicating that findings collected from one setting should not be generalised across environments. This highlights the need for more environment-specific research to be conducted. The quality of the included studies varied greatly, though overall the standard was good. However, concerns were raised around the reliability of the smaller scale designs as they introduced the potential for bias within the investigation. There was also the possibility that not all variables were examined,

leading to the possibility that potential associated risk factors may have been missed. This in turn strengthens the argument for the need for future research.

The review assessed the methodological quality, strength of evidence and consistency of findings among the included papers and concluded that current literature provides only crude indicators of risk factors for boundary violations. There was particularly limited research in the forensic environment, with only three papers being identified and one coming from an unpublished source. There is a critical need for more research in this area given the associated serious consequences of boundary violating behaviours.

The systematic review highlighted some risk factors associated with boundary violating. However, it also highlighted the need for further research to be conducted. More specifically, further research in forensic settings as this was a particularly under researched area. Indeed, the setting plays a pivotal role in determining relevant risk factor findings and studies performed in other settings could not be generalised to this environment. For these reasons, it was decided to conduct the empirical study in a forensic healthcare setting.

Chapter 3: Empirical study

The empirical study sought to add to the current knowledge base of risk factors associated with boundary violating in forensic health care settings. It explored the potential related protective factors that decrease risk, staff views on boundary violating behaviours and concerns related to whistleblowing. The data was also used to validate a psychometric that aimed to highlight staff at risk of boundary violating; the Exploitation Index (Epstein & Simon, 1990). In order to address the fact that previous studies had primarily focused on sexual boundary violating behaviours, this study explored factors associated with a wide range of boundary violating behaviours including, exhibitionism, dependency, power-seeking, greediness and enabling (Epstein & Simon, 1990; Marquart, Barnhill, Balshaw-Biddle, 2001; Nigro, 2004). The use of both qualitative and quantitative methods to fully evaluate the data added a new depth of detail to this topic, as well as increasing the ability for the findings to be practically applied in the workplace.

The regression analysis identified several significant risk factors associated with boundary violating, including working for numerous years at the hospital, and having a family or any close friends disciplined for committing a boundary violation. The correlations found factors which protected staff from committing boundary violation, such as having good social support, receiving supervision and training about boundaries. However, these were not supported by the regression, which raises concerns about their reliability.

Risk and protective factors

Some of these findings, such as having people to turn to, were consistent with earlier studies (Worley & Cheeseman, 2006). This supported the conclusion that these were pivotal risk factors associated with staff boundary violating. Others, such as having a family or any close friends disciplined for committing a boundary violation, were new risk factors which may have been only relevant to this setting. Both of these findings demonstrate how an individual social environment plays a key role in their resilience or vulnerability to boundary violating. The thematic analysis did however raise another interesting finding about the difficulties and importance of creating an effective therapeutic relationship. The participants' responses showed this to be challenging, particularly when discussing a potentially taboo topic. Staff must balance being able to work closely with clients without becoming too overly friendly or empathic, losing their objective and blurring boundaries or shifting the other way, being cold and untrusting.

Whistleblowing findings

The thematic analysis identified reasons why people did not whistleblow boundary violations, such as concerns around anonymity, feelings that nothing would be done and feelings that peer interventions were more effective than involving management. The qualitative research findings supported conclusions from other studies that staff have concerns around anonymity and judgement which deterred them from whistleblowing (Mesmer-Magnus & Viswesvaran, 2005; Rost, 2006 cited in Mansbach, Ziedenberg, Yaacov,

Bachner, Fahy, & Fisher, 1992; McDonald & Ahern, 2000; Burrows, 2001). However, there were some other new findings that previous studies had not identified, including the feeling that they as a staff member could address the issues more effectively than involving management, through whistleblowing. This highlights some reasons why studies believe that there is a high level of under reporting and why whistleblowing is not more prevalent (Epstein, Simon & Kay, 1992; Martin, 2003). These feelings that nothing may be done and concerns around judgment for both parties (the boundary violating and the whistleblowing) have potentially led to a system of self-monitoring and peer interventions. This demonstrates how the ethos and setting of a work environment impacts on staff willingness to raise concerns about boundary violating. This would be an interesting area for further research.

Limitations of the empirical research; the study relied on self-disclosure of personal boundary violating behaviour, which may have potentially impacted on the validity of the data. The issue of participants not disclosing previous boundary violating behaviour may have resulted in some risk factors not being identified. Also, this study was only conducted in one hospital and consisted of a reasonably small population size, thus raising concerns around the generalisation of the conclusions drawn.

These limitations highlight a number of possible avenues for further research. Expanding the study across other forensic healthcare settings, thus increasing the population size, would allow for generalisation of findings and would also control for corporate or geographical differences. Further research could also explore the possibility of incorporating official information on boundary violating disciplinary cases, thus mitigating participant self-disclosure. Another opportunity could include investigating risk and protective factors associated with staff working in a prison environment, or exploring which factors make patients and prisoners more vulnerable to engaging in boundary violating activities. This may help in developing approaches to increase patient resilience against this type of abuse and aid in minimising the detrimental effects that these violations can cause.

Chapter 4: Case study

Due to the need highlighted above and the potential impact that boundary violating behaviour can have on patients, it was important to explore the issue of boundary violating relationships between patients and staff. The case study in chapter 4 aimed to examine the patient factors that may contribute to them forming illicit relationships and the impact that this can have on them. Mr U was a patient residing in a secure forensic hospital who had a history of engaging in illicit relationships with staff. In the case study, potential risk factors were identified such as insecure attachment style, previous relationship difficulties, poor impulse control, poor insight and understanding relationships and boundaries. These findings supported previous research in this area (Norris, Gutheil & Strasburger, 2007).

It was recommended that Mr U engaged in a 'relationship group' to increase his understanding of different relationship types, the associated appropriate behaviours and development of his social skills. Unfortunately, Mr U presented with several treatment interfering behaviours which ultimately resulted in him being de-selected from the program. It was felt that many of these behaviours were associated with relationship difficulties, his heightened sensitivity to rejection and testing boundaries. His previous experience of boundary violating with members of staff reinforced many of his early difficulties with relationships. This in turn had decreased his ability to develop an effective therapeutic relationship and engage effectively in treatment.

The case study highlighted the multifaceted elements that both staff and patients possess that, when brought together, can increase the chance of boundaries being broken. It also highlighted the short-term and long-term impact that these relationships can have on patients; increasing their vulnerability to future difficulties and decreasing the effectiveness of future treatment. The case study highlighted why it is important to increase our understanding of boundary violations as a way of trying to avoid, or at least minimise, the number of patients affected. It is particularly important that this is performed in forensic health care settings where patients are vulnerable due to past traumas, outstanding treatment needs and the impact these can have on their progression and ultimate freedom.

Chapter 5: Psychometric critique

Previous research has attempted to identify various ways in which harm to patients can be minimised by increasing the physician's awareness of their vulnerabilities and risky behaviours associated with boundary violating. The EI is a 32 item questionnaire that aims to support therapists in self-assessing and highlighting potential boundary violations. The theory being that this would aid their reflective practice and prompt them to alter problematic behaviour before it escalates into more damaging violations (Epstein & Simon, 1990).

Chapter 5 provided an overview of this tool, its uses and research into its reliability and validity. Despite there being very few similar tools, there has been reasonably limited research into its effectiveness. The strengths of this tool are: it assesses a wide range of different boundary violating behaviour, it has sufficient test/retest reliability, good internal consistency and moderately good validity (Epstein & Simon, 1990). However, overall the psychometric, despite the limited research conducted on it, appears to present with encouraging reliability and validity.

The tool is limited as it relies on self-disclosure and staff to reflect on their own practice. Also, the psychometric test lists a number of behaviours as warning signs that the physician is at risk of committing a boundary violation e.g. seeking social contact with patients outside of clinically scheduled visits or using information learned from patients, such as business tips or political information, for your own financial or career gain. However, these behaviours are actual boundary violations themselves, so if a physician scores highly on this psychometric they are not at high risk of committing a boundary violation in the future but they have already committed several.

When the psychometric was used in the empirical study it was found that higher scores on the expectation index were a reliable predictor of individuals who had committed boundary violations. This study therefore supports the validity of the EI psychometric and its association with boundary violating behaviour. It also implies that the tool could be effectively used in forensic healthcare settings to identify members of staff who are

potentially at a higher risk of committing boundary violations and need a preventative intervention.

Theoretical implications

From the information gathered throughout this thesis, it is evident that the causes of boundary violating behaviour are multifaceted. When Pope (1990) concluded "that therapist-patient sexual involvement may be systematically associated with a variety of factors" (p. 1) he only identified factors associated with the clinicians. As can be seen in Figure 7 below, this research indicates the presence of many more elements and interactions. Staff members have individual risk factors, such as having a friend or family member who are boundary violators. This aspect supports the research into social learning and how significant others impact a person's moral and cognitive development, which in turn affects how they behave in different situations (Haidt, 2001). These can be counteracted by protective factors including good social lives and having people to turn to. Patients presenting with factors, such as having a history of relationship difficulties or a personality disorder make them more vulnerable to engaging in relationships in which boundaries are violated (Marquart, Barnhill, & Balshaw-Biddle, 2001; Worley & Cheeseman, 2006; Garfinkel, Bagby, Waring & Dorian, 1997; Ehlert, 2002; Gabbard, 1994). However, patients also have protective factors which potentially include motivation to seek and engage in treatment and develop helpful therapeutic relationships, increasing their resilience. Patients and staff come into contact with each other in various working environments. These environmental factors can deter staff from entering into boundary violating behaviours, such as training and supervision. However, similarly they can present with risk factors, such as not offering training and an unwillingness to whistleblow. All of these factors will affect the chance of boundary violating behaviour occurring. Thus, when researching and discussing boundary violating behaviours, it is key to consider all of these multifaceted elements and how they interact to create the outcome (see Figure 7 and Table 22 below).

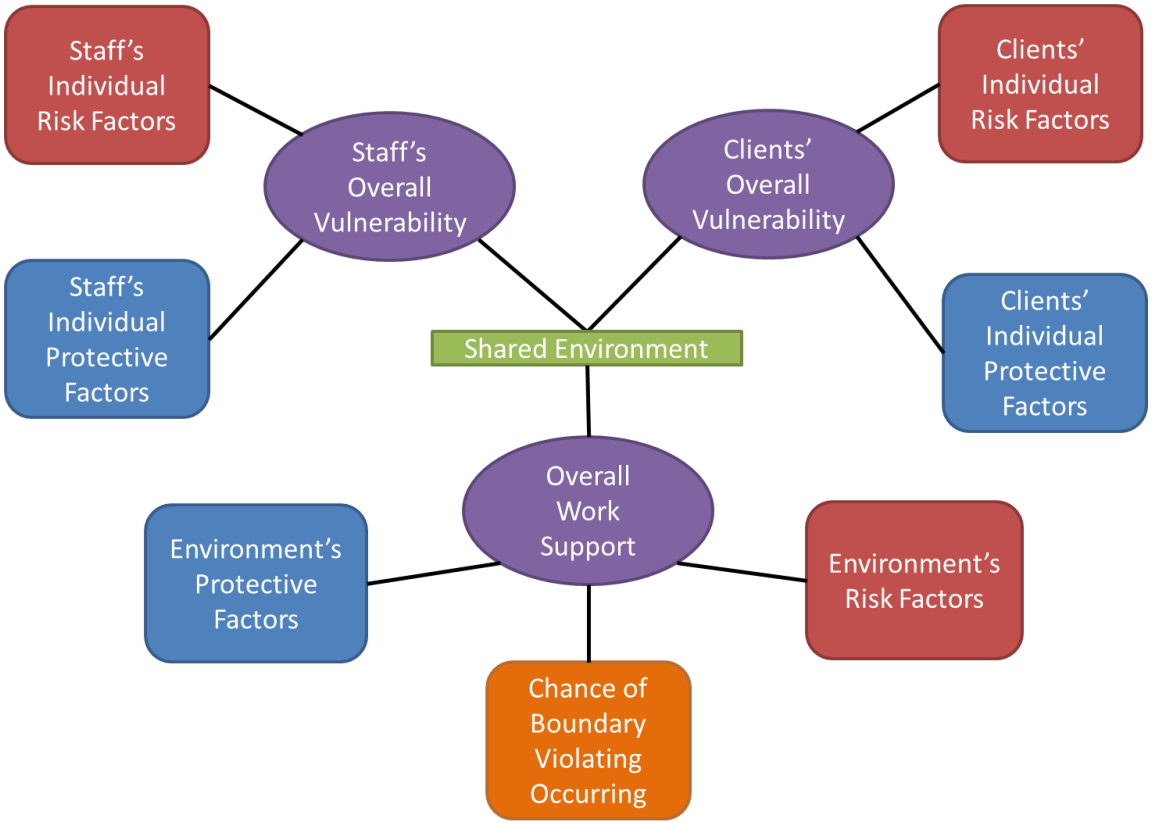


Figure 7: Multifaceted elements and the interaction model of boundary violating.

	Protective Factors	**Risk Factors**
Staff	Feeling they have people to turn to Having a good social life Having supervision Having received training on boundary violations	**Having a friend or family member whom is a boundary violator.** **Increased number of years spent at the same hospital.** Having received training on boundary violations Working on own with patients Having family or any close friends disciplined for committing a boundary violation Telling patients how many children you have Telling patients your children's name Telling patients your partner's name
Client	Motivation to seek and engage in treatment Develop of helpful	Having a history of relationship difficulties Young in age

	Therapeutic relationships Increased resilience	Suffering from psychosis Having unhelpful personal relationships Having a diagnosis of personality disorder, such as narcissism or psychopathy.
Environment	Training Supervision	Not offering training No supervision An unwillingness to whistleblow

Table 22: Outlines the key boundary violating factors for the model in figure 7.

Due to the high prevalence of BV risk factors in clients residing in low secure mental health hospitals, the model should be weighted towards the presence of staff risk factors. Thus, if a staff member working in this environment possesses undue risk factors listed above then the likelihood of them engaging in BV behaviour is high. This can be combatted with supervision and training. However, due to the "at-risk" staff member's views of social norms and learnt behaviours this risk will still be significant. It is hypothesised that if the negative risk factors for the staff member and their environment outweigh the corresponding positive risk factors by 2 or more, then the likelihood of BV becomes extremely high. Determining clients with the highest risk factors will identify those individual with whom the BV is most likely to occur. Further research is required to link the weighting and combination of these factors to create an overall risk score for BV.

(Staff BV risk factors - Staff BV protective factors) + (Environmental BV risk factors - Environmental protective factors) = 2 or more = High risk of BV

Practical implications

From this model it can be concluded that a multimodal approach is required to address boundary violations. Both researchers and professionals need to move away from the ethos where the individual staff member is solely to blame, and move towards a more holistic management approach. Staff have a responsibility to develop their awareness of risk and protective factors, the understanding that these can change and adapt over time, and

motivation to develop their resilience in this area. Professionals also need to be aware of patient vulnerabilities and aid patients in addressing their treatment needs to increase their ability to manage relationship difficulties. Staff also need to support patients in developing effective therapeutic alliances as these can improve patients' recovery. It is important for the professional when working with a victim of boundary violations to address the potential impact this incident has had and support them in minimising the negative consequences. Research is not currently at the point to support recruiters in identifying candidates who are at a higher risk of committing a boundary violation. It would be unethical, unproductive and against the aim of this thesis to use the research in such a way as the findings are insufficiently conclusive. Also, due to the multifaceted elements involved in boundary violating, it is unlikely that recruiters will be able to use this information. However, these findings can and should be used by companies and managers to identify potential employees at risk and adopt supportive measures. Companies should also focus on developing an environment where concerns around boundaries can be openly discussed, along with providing appropriate training and support on these issues. All staff members need to feel that their concerns would be appropriately considered, anonymity would be maintained and an effective response undertaken in order to minimise harm to both staff and patients. A multifaceted management approach to the many risk factors should be adopted to address this complex issue.

This model also raises implications for further research, highlighting the need for multi-factors to be explored, with consideration given to how factors (from the staff members, clients and the environment) interact to promote boundary violations. More research is also required into the factors highlighted by this thesis in order for their reliability and validity to be evaluated.

Thesis strengths and limitations

Overall, the strength of this thesis is that it addresses a currently under researched and important area of concern for many sectors. In particular, it addresses the lack of research in the UK and in a secure forensic mental health setting. As the systematic review highlighted,

due to the environment impacting on the relevance of boundary violating factors, findings cannot be generalised across settings. This emphasises the pivotal importance of conducting research in specific environments as it would be questionable to try and apply previous research findings across settings.

There are however limitations with all research, the main limitation of this study being the reliance on self-reporting and its associated apprehension. This increases the risk of under reporting, resulting in a lack of openness and a response bias which impacted on all the thesis chapters. It will always be present to some degree despite numerous approaches to minimise this impact. However, this adds further weight to the importance of developing a more open and transparent approach to discussing and managing boundary violations, which in turn would improve future research reliability, management's ability to address issues sooner and limit the impact on patients and staff. Other limitations included small sample sizes and a lack of research in this area to validate findings. This leads to questions being raised around the generalisability of the findings.

Areas of further research

More work is required at clinical practice, policy and academic research levels to limit harm to both staff and clients. One area for further research is an expansion of this study to incorporate more research sites within the same setting and a larger population size. This would enable the findings to be more reliable as they can be generalised within similar settings.

There is more research on the impact that boundary violations have on clients. However, there is very limited research into how to limit this trauma, how to address the issue and develop effective therapeutic relationships in order to progress treatment and recovery.

Overall, it is evident that boundary violating behaviours are persistent and prevalent. The current strategies are not effectively dealing with such behaviour and more work is required, both at the clinical level to implement findings from research and at a research level in order to further our understanding.

Individual approaches

This thesis has revealed factors that appear to increase or decrease an individual's risk of committing a boundary violation. However, currently there is no reliable test to detect if an individual will commit a boundary violation. This study highlights that the subject of boundary violating is a multifaceted topic and thus a multimodal approach is needed to manage this issue. Awareness and openness are key, both at an individual and systemic level, to enable issues to be effectively addressed. Staff and client relationships are pivotal in the effective working of all employment areas addressed in this thesis. The positive impact that the therapeutic relationship can have on a client is huge and this boundary violating research should not deter professionals from developing effective therapeutic relationships. On the contrary, this research should emphasise the importance of relationships and how every effort should be made by employers and clinicians to see that they are key to effective working. Relationships are complicated and many different elements impact on them. Staff members have a challenging job in managing these relationships and their related boundaries. However, as this thesis has shown, multiple elements play a role in the development of boundary violating, thus the responsibility for addressing this issue lies not only with the individual clinicians but also the greater community. Clinicians have a responsibility to maintain their skill base, awareness and resilience. Colleagues have responsibility to raise concerns, challenge and support others. Employers have a responsibility to train, support and create an environment with in which therapeutic alliances and boundaries are given the acknowledgement, awareness and resources that they deserve.

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Appendices

Appendix A: – Search Terms

These words were selected as they covered each section of the objective questions being asked. Each section of the question was broken down and then similar words for that term were explored e.g. prison, jail, correctional and forensic.

Population: Staff

1. Prison – Prison*
2. Jail –Jail*
3. Correctional
4. Forensic
5. NHS
6. 'National Health Service'
7. Psychotherapists/ Psychotherapy - Psychotherap*
8. Therapists - Therapist*
9. Counselling/ counseling
10. Counsellor/ Counselor
11. Healthcare
12. Nurse - Nurse*
13. Doctor - Doctor*
14. Officer - Officer*

Outcome: Boundary violations

15. Boundary Violations - Boundary Violation*
16. Professional conduct
17. Sexual relationships - sexual relation*
18. Inappropriate relations - Inappropriate relation*
19. 'Maintaining professional boundaries'

Search Combinations: these are the words combinations that were searched for.

Population: Staff

20. (Prison* or Jail* or Correctional or Forensic)
21. (NHS or 'National Health Service' or Healthcare)
22. (Therapist* or Psychotherap*)
23. (counselling or counseling)
24. (counsellor or counselor)
25. (Nurse* or Doctor* or Officer*)

Outcome: Boundary violations

26. (Boundary Violation* or professional misconduct or sexual relation* or Inappropriate relation*)
27. "Maintaining professional boundaries"

All of these combinations e.g. (Prison* or Jail* or Correctional or Forensic) OR (NHS or 'National Health Service' or Healthcare) OR (Therapist* or Psychotherap*) OR (counselling or counseling) OR (counsellor or counselor) OR (Nurse* or Doctor* or Officer*) AND (Boundary Violation* or professional misconduct or sexual relation* or Inappropriate relation*) OR "Maintaining professional boundaries". This will enable all the various combinations to be searched for.

Appendix B: – Inclusion and Exclusion criteria

	Inclusion	**Exclusion**
Type of Study	Qualitative, Qualitative or mixed design Studies conducted between 1993 and July, 2013	Studies that were conducted over 20 years ago.
Population Exploring factors related to staff who have committed boundary violations.	1. Adult men and women (>18 years) who have either been or who are employed in the health sector (e.g. doctors and nurses), counselling or forensic sector.	1. People who are not employed in the health sector, counselling or forensic sector. 2. Volunteers in these areas. 3. Boundary violator in other sectors. 4. Staff members who engage in other illegal activity (e.g. fraud) that are not linked to boundary violating with offenders, patients or clients. 5. Studies that use staff participants under <18 years old.
Exposure (Factors)	1. Any factor that has been looked at in association with boundary violation e.g. individual characteristic, environmental characteristic etc.	1. Papers that do not explore factors that put people at risk or protect them from boundary violating.
Comparison (no risk factors)	Staff who maintain professional boundaries.	

	Staff members who stays within the “zone of helpfulness” . Staff members who are not under suspicion of committing boundary violations.	
Outcome (Boundary Violations)	Members of staff who: Committed boundary violations against clients. Knowing or unknowing crosses the emotional, physical, spiritual or sexual limits of another (Katherine, 1993). Behavior infringes upon the primary goal of providing care to the client and developing their well-being (Epstein, 1994, Gutheil & Gabbard, 1998).	Individual who form relationships after the client has left the work environment/ been discharged or released. Staff who commit professional violations, which are unrelated to client boundary violations e.g. Fraud or corruption. When clients are the only group committing the boundary violations, not the staff member.

Appendix C: Quality Assessment form for included studies

The definition of boundary violation is clear: Comments:	Well covered/defined Not addressed Adequately addressed Not reported Poorly addressed Not applicable (Poor quality definitions of boundary violations will not affect inclusion – however may impacts on the articles quality as it may indicate a lack of clarity or guidance in the article's ability to comment on boundary violations.)		
Main strengths:			
Main weaknesses:			
Quality Criterion	**Yes**	**No**	**Unclear**
<u>Design</u>			
Are the research questions/ aims clearly stated?			
Clear and appropriate (for this systematic review) definition of BV?			
Is the qualitative/ quantitative approach clearly justified?			

Total score for the quality of design			
<u>Sample population and sampling method</u>	**Yes**	**No**	**Unclear**
Is the sampling method clearly described? For experimental Participants-			
For control Participants –			
Is the sampling strategy appropriate for the research question? Experimental Participants-			
Control Participants			
Were participants recruited to the study in an unbiased way? (e.g. did everyone who has committed boundary violation in a particular organisation have an equal chance of being included in the study or were participants selected on a particular basis?' Experimental Participants-			
Control Participants –			
Are participants representative of the target population?			
Was the sample biased in any particular way? e.g. include self-selection, pre-screening of trial participants, discounting trial subjects/tests that did not run to completion and migration			

bias by excluding subjects who have recently moved into or out of the study area. Experimental Participants-			
Control Participants –			
Total score for the quality of sampling methods			
<u>Method and data analysis</u>	**Yes**	**No**	**Unclear**
Was the method used to identify boundary violators appropriate/ valid? i.e. was it based on client's complaints, self-report, disciplinary procedures?			
Is the method of data collection clearly described?			
Is the data collection method appropriate to the research question?			
Is the data collection method controlled and consistently used?			
Quantitative studies only	**Yes**	**No**	**Unclear**
Was the method used to analyse data clearly explained?			
Has the data collection method's validity been tested? (i.e. if a paper is stating that boundary violating staff member are impulsive has the psychometric that they are using to measure			

impulsivity been validated.)			
Has the data collection method's reliability been tested?			
Was the data analysis tool appropriate? (was the sample size big enough for the method used?, was there a more appropriate tool which could have been used?)			
Total score for the quality of Method and data analysis used			
Conclusions	**Yes**	**No**	**Unclear**
Are the claims made supported by sufficient evidence?			
Were the studies objectives achieved/ research questions answered?			
Were the conclusions logical and realistic given the findings?			
Total score for the quality of conclusions drawn.			
Total Scores – Quality of study			

Overall score for appropriateness of conclusions drawn

3 – Good - a thorough and logical approach used – minimal faults

2- Average – Goods appropriate elements however either a number of small problems or gaps or a couple of larger problems

1 – Poor – major faults and gaps

Appendix D: Data Extraction form

Name of Assessor:	
Study Title:	
Authors:	
Publication type:	
Publication date:	
Publication language: Geographic origin:	
Study Objectives:	
Study design:	
Definition of Boundary Violation being used:	
Participants work location/setting:	Forensic - Forensic mental health - Forensic secure/prison Healthcare / Counselling Control group: same / different? - How
Recruitment strategy	
Experimental Participant	Participant sample size:

characteristics; Overall/ average / range of sample. Control Participants	Age: Gender: Job role: Employment status: Ethnicity: Any Other notable/ unique characteristics of study population? Participant sample size: Age: Gender: Job role: Employment status: Ethnicity: Any Other notable/ unique characteristics of study population?
In the case of Case Studies specific information of the case study individuals.	Type of Boundary Violation: Other
Data collection method:	Psychometrics: Interview: Control group comparisons: Observation: Other:

Identification of Boundary Violation:	Discovery: Other: Self disclosure:
Main statistical analysis method used?	
Key finding:	
Risk factors/ differences	1) 2) 3) 4) 5)
Associated factors in	1)

control group	2) 3) 4) 5)
Non-Significant findings	
Their Interpretation of the investigators. Were the conclusions drawn appropriate?	
Your conclusions	

Appendix E: Summary of papers and methods.

Title **Overall Quality score**	**Study design and method/ analysis**	**Sample Population and sample method**	**Outcomes – Risk factors – conclusions**
Forensic Studies			
Fatal attraction: An Analysis of employee boundary violation in a southern prison system, 1995-1998* Marquart, Barnhill, and Balshaw-Biddle USA 2001 Overall Quality score: 10	Quantitative Case Control Between Group comparison Collating factors from HR files (e.g. age, job role) comparing boundary violating staff with non-boundary violating staff.	Forensic secure/prison - focused on the prison staff members (security personnel, mail room clerks, secretaries) who had daily interactions with inmates. Control: 585 prison employees employed between 1995-8 Experimental 508 who had been disciplined from breaking "Rule 42" – (this states that "employees are prohibited from continuing or establishing any personal relationships with inmates/clients or with family members of inmates/clients which jeopardises, or has the potential to jeopardise the security of the Agency or which compromises the effectiveness of the employee" (p. 204).	When compared to controls boundary violators were more likely to be:- Anglo ethnicity Females Have a degree instead of a High-school diploma, Have no military experience. Most custodial boundary violations occurred within 36 months of employment. Average age of Boundary Violators was 36years old. Disciplined employees received significantly • Lower pre-employment evaluation scores; • Lower scores were risk markers for boundary violations. • To have had a history of rule violations.

Boundary Violation in forensic inpatient facilities survey tool development and survey results T.A. Daniels Canada 2008 Overall Quality score: 10	Quantitative Cross Sectional study Psychometrics were sent out to all clinical staff at 3 forensic hospital sites.	154 clinical staff (e.g. nurses, not correctional). – questionnaires were sent out to 347 staff. 154 returned them completed.	No gender differences between boundary violating staff and non-boundary violating staff No difference in age between boundary violators and non-boundary violating staff. No sig difference between individual or group contact time whether staff committed boundary violations or not. Staff identified as clinical (not nurses) reported significantly more behaviour of 'Slippery Slope' and boundary violating compared to staff members identified themselves as nurses. Diploma- level staff reported fewer boundary violations compared to degree- level staff. Degree level reported more boundary violations than post graduate. Staff who reported negative emotions in response to patients abusive/ belligerent behaviours had significantly more incidences of boundary violations. Staff who reported negative emotions in response to patients resistance to treatment reported had significantly more incidences of boundary violations.
Guards as embezzlers: the consequences of ''non-shareable problems'' in prison settings. R. Worley & K. A. Cheeseman 2006 USA	Qualitative Theme analysis	32 participants (prisoners who had committed boundary violations with staff) identified through disciplinary files. Contacted and those who consented to the face to face interviews included. Interview of offenders who had committed boundary violations with staff members who had been disciplined for	Boundary Violators were reported to be:- Feeling social isolated Having low-self esteem Being shy Being below average in physical appearance. Having limited opportunities for relationships outside of work. Experiencing relationship failures Experiencing an abusive relationship

Overall Quality score: 10		their behaviour. Theme analysis conducted on the interviews in order to identify risk factors they believed placed staff at risk of committing boundary violations.	Reported being sexually promiscuous Recently separated or divorced Have been disciplined at work before. Offenders described the boundary violating staff as:- Having ‘‘Wild’’ social lives and potentially coming in to work tired and/or ‘‘hung over’’ or may sleep on the job. Being described as generally gregarious and outgoing Financial problems and likely to be perceived as ‘‘greedy’’. May only want to make a ‘‘one-time, quick buck’’ Job-related problems and likely to be perceived as not getting along well with supervisors. Perceived as identifying more with inmates than other staff members.
Non Forensic	**Study design and method/ analysis**	**Sample Population and sample method-**	
Assessing boundary violations in psychotherapy: survey results with the Exploitation Index Epstein & Simon, 1992 Overall Quality score: 11	Quantitative Psychometric Cross sectional study The 32-question Exploitation Index (EI), Demographic information	Of 2,500 questionnaires mailed to psychotherapists, 532 were returned within the assigned days, for an overall response rate of 21.3 %.	Women reported significant less boundary violation then men. Women also reported significantly less server boundary violations compared to men. Middle-aged psychiatrists (45-56 years) were most likely to commit boundary violations. People with the highest Exploitation Index scores were more likely to commit boundary violations. With people aged 61-82 years old were the least likely to commit boundary violations

			BV were most likely to:- Work in a practice located in a suburban setting Work for a private solo practice
The Associations Between Psychologists ' Attachment Patterns and Their Experiences with Clients Including Sexual Attraction and Sexual Contact: A National Survey. T. L. B. Nigro 2004 Overall Quality score: 11	Quantitative Psychometrics . Cross sectional study Logistic regression analysis	Random sample of 1500 mailing labels was generated by Information systems personnel at Canadian Register of Health Service Providers in Psychology (CRHSPP). 611 were returned for a response rate of 42%. A total of 588 (40%) returned surveys were considered adequate for subsequent analysis.	Male respondents were two to three times more likely, than females, to report boundary violations. Increasing age of respondents was associated with higher incidences of "Accepting an invitation to a client's special occasion", "Becoming social friends with a former client", and "Holding a client's hand." Education - Respondents with Master's degrees were more likely than those with Doctorate degrees to endorse "Hugging a client", "Becoming social friends with a former client", "Giving a client theatre, sports, or other event tickets that you learned at the last minute you could not use." Graduate training. A significant relationship was found between graduate training regarding sexual attraction and the item engaging in Sexual Contact With a Client that included intercourse. Those who reported such training were less likely to endorse this item. Anxiety dimension- Increasing factor scores on the ECR-R Anxiety dimension were related to higher endorsement of three items: a) Feeling sexual attraction toward male clients (even when gender was accounted for) b) Flirting with a client c) Engaging in sexual contact with a client not including intercourse.
Boundary Violations and Personality Traits among Psychiatrists	Quantitative Co-hort study Psychometrics Between	The participants were physicians solicited from residency programs from several different universities who were entering	Both the boundary violating psychiatrists were male. The 2 psychiatrists who were disciplined scored approximately 10 points higher than did the remaining group on 3 scales: one validity scale—the K-scale—and 2 clinical scales—Psychopathic Deviancy and Hypomania.

Garfinkel, Bagby, Waring & Dorian, 1997 Overall Quality score: 10	group study	their first year of psychiatrists training. All were within the first 3 months of their first year of their psychiatric residency they were all given a number of psychometrics. Follow up was done 13-17 years later by which time 2 psychiatrists had lost their licences due to Boundary violations. 68 control 2 experimental (who lost their licence due to Boundary Violating)	The 2 psychiatrists had clinically significant scale elevations on the Psychopathic Deviancy and Hypomania scales. High scores on the Psychopathic Deviancy scale is associated with antisocial tendencies, have difficulty incorporating the values and standards of society and are likely to engage in lying, cheating, stealing, and sexual acting out. They also show poor judgement, take risks, and typically do not learn from past experiences. The two BV psychiatrists scored high on the Hypomania scale; due to presenting as being energetic, talkative, and preferring action to thought. The two Boundary violators also had:- Great difficulty in inhibiting expression of impulses. Exaggerated appraisal of their own self-worth and self-importance. Difficulties with authorities and are also described as having poorly developed consciences and fluctuating ethical values. Present as selfish and self-indulgent and are not very successful in delaying the gratification of their impulses. In summary, the profiles of the 2 psychiatrists who had their licences revoked because of boundary violations revealed evidence of: 1) antisocial attitudes and behaviours, 2) defensive cognitive–perceptual style, Both of these characteristics were generally absent in the study participants who did not have their licences revoked.

Boundary violations, gender and the nature of nursing work Chiarella and Adrian 2013 Australia Overall Quality score: 8	Quantitative Cross sectional study	The study undertook to review the findings of close to 200 disciplinary decisions relating to complaints about nursing staff. A total of 29 were boundary violation cases. They were identified by self-report, patient report or colleague report.	It is of note that two-thirds of the boundary violating respondents were male. This is in contrast to the percentage of men in the nursing profession, which was about 9% in Australia in 2006-7. Thus being male is a risk factor for committing boundary violations.
A comparison of Psychologist who engage in Nonsexual and sexual dual relationships with psychologists who do not. D.K Ehlert 2002 USA Overall Quality score: 12	Quantitative Between group comparison Cross sectional study Psychometrics and questionnaires	Three distinct groups of psychologists were recruited to participate in this investigation: Group A - 20 doctoral level psychologists who were sanctioned by their respective state psychology licensing board for engaging in a nonsexual dual relationship with a client(s), Group B - 19 doctoral level psychologists who were sanctioned by their respective state psychology licensing board for engaging in a sexual dual relationship with a client(s), Group C - 20 doctoral level licensed	More males than females engaged in nonsexual and sexual dual relationships and there were more female than male client victims. People who committed boundary violations were significantly more likely:- To be male To have had a mean age was 45.6 years old. Worked in solo private practice (77% of the sanctioned psychologists in this study worked exclusively in private practice at the time of the violations). To be married To be experiencing the loss of a significant other To have crossed boundaries with a much younger female client. To have experienced physical and sexual in their past To present with insecure attachment To be experiencing a life crisis To have a history of childhood abuse (particularly

		psychologists who were not sanctioned by their respective state psychology licensing board (control group). Names and addresses of sanctioned psychologists (Groups A and B) were requested from state licensing boards and also found on the world-wide-web. Names and addresses of 20 non-sanctioned psychologists (Group C) were provided from the American Psychological Society.	emotional or sexual abuse) To express parentification, and narcissistic injury To have 'damaged' self-esteem To experience:- • more shyness • nervousness • uncertainty about how to act with the opposite sex • social isolation • unsatisfactory sexual adjustment as a result of abuse Other findings were:- The sexual and nonsexual dual relationship groups did not differ from one another in terms of self-esteem levels. Nonsexual dual relationship group struggled in the object relations realm, especially reporting feelings of alienation and insecure attachment. The sexual dual relationship group appeared not to feel alienated like the nonsexual dual relationship group. Rather, they appeared to feel entitled (i.e., egocentric) and to use the therapy relationship improperly and thus they may have been more prone to act out with new clients.
Precursors to Therapist Sexual Misconduct - Preliminary Findings *Andrea Celenza,* 1998 Overall	Mixed method Case report The evaluations of the Boundary violating staff included extensive interviews, a full psychological	The data for these inferences came from therapies, evaluations, or supervisions of 17 offenders (14 male and 3 female). (This sample was of mental health professionals who had sexually involved with a patient).	Individuals who boundary violated had:- low self-esteem sexualized pregenital needs restricted awareness of fantasy family history of boundary transgressions anger toward authority figures intolerance of negative transference

Quality score: 6	test battery, and, whenever possible, consultation with the therapist's supervisors, colleagues, spouse, and therapist, as well as the patient–victim.	The therapists were referred to the treatment sessions in a variety of ways from self-referral to supervisors referring after the suspension of their license.	defensive transformation of countertransference hate to countertransference "love." All of these characteristics were reflected in 73% or more of the cases. More than half of the characteristics were present in 88% or more of the boundary violating staff.
Psychotherapists who transgress sexual boundaries with patients. Gabbard, 1994 Overall Quality score: 5	Qualitative Case study Theme analysis	The sample came from the Menninger Clinic, where therapists who have transgressed sexual boundaries with patients have been evaluated and treated for many years. The authors identified a diversity of psychodynamic themes that emerged through working with these individuals over a number of years.	Staff who boundary violated presented with:- Psychotic disorders Predatory psychopathy and paraphilias Masochistic surrender Narcissistic personality disorder Lack of empathy or concern for the victim, Shared that they were "lovesickness" – and had a hunger to be loved and idealized, Potentially had have borderline personality disorder Poor impulse control - act on their feelings of infatuation Insecurity regarding masculine identity Conflicts around sexual orientation Masochistic and self-destructive tendencies to allow themselves to be intimidated and controlled by a patient. Boundary Violators were generally middle-aged males Boundary violators were also more likely to be experiencing:-

			• Divorce or separation • Disillusionment with his own marriage • The loss of a significant person in his life.

Appendix F: Questionnaire 1

Thank you for taking the time to complete this questionnaire. It should only take about seven minutes to complete. Please read the questions carefully and tick the relevant box or enter the correct information. Some of the questions may be personal. They are not written to cause offence but purely to help us explore what life events are potentially associated with this topic.

A boundary violation is committed when someone knowingly or unknowingly crosses the emotional, physical, spiritual or sexual limits of another (Katherine, 1993). The result of a boundary violation is that it blurs or disrupts the professional distance between staff and clients (Marquart et al., 2001).

Have you ever been disciplined or talked to about committing a boundary violation at work?
1a. While working at this hospital?

Yes ☐ No ☐

1b. While working for another low secure forensic hospital with patients?

Yes ☐ No ☐

1. Has anyone in your family or any close friends been warned or disciplined for committing a boundary violation?

Yes ☐ No ☐

2. What gender are you? Male ☐ Female☐

3. What is your age? _____

4. How would you describe your ethnicity?

White British ☐	Asian other ☐	Mixed Race ☐
White other ☐	Black British ☐	Other ☐
Asian British ☐	Black Other ☐	Rather Not Say ☐

5. What level of qualification do you have?

NVQ ☐ O-levels/ GCSEs A-levels ☐
Specific work qualification (Higher than GCSEs) ☐ Diploma / Degree ☐
Higher than degree level☐

6. Have you ever worked for the armed forces?

Yes ☐ No ☐

6a. If yes, which one?

Air force ☐
Navy ☐
Army ☐

7. What is your marital status?

Single ☐ Co-habiting ☐ Married ☐ Divorced ☐ Separated ☐ Widowed☐

8. Have you separated from your partner in the last year?

Yes ☐ No ☐

9. How long have you worked in a caring profession?_____

10. How long have you been employed by this hospital? _____

11. What is your job role? _____

12. How much do you earn per year? _____

13. Do you work on your own (away from other staff) with patients for more than 30 minute periods?

Yes ☐ No ☐

14. Do any patients call you by your first name or a nickname?

Yes ☐ No ☐

15. Do you work in unstructured or structured employee-patient situations?

unstructured ☐ structured ☐

16. Do you feel lonely at times?

Yes ☐ No ☐

17. Do you feel you have people to turn to if you have a problem?

Yes ☐ No ☐

18. Have you ever been in an abusive relationship?

Yes ☐ No ☐

19. Do you have financial commitments that you have trouble meeting?

Yes ☐ No ☐

20. Would you describe yourself as impulsive or having poor self-control?

Yes ☐ No ☐

21. Would you describe yourself as being an anxious person?

Yes ☐ No ☐

22. Would you describe yourself as having low self-esteem?

Yes ☐ No ☐

23. Would you describe yourself as being shy?

Yes ☐ No ☐

24. Are you disillusioned with your job?

Yes ☐ No ☐

25. Would you say that you drink too much?

Yes ☐ No ☐

26. Do you have a very good social life?

Yes ☐ No ☐

27. Would you say that you go out a lot?

Yes ☐ No ☐

28. Are you in debt?

Yes ☐ No ☐

29. Would you say that you get on with your work colleagues?

Yes ☐ No ☐

30. Do you have any problematic job relationships?
Yes ☐ No ☐

30 b). Are you angry at management?
Yes ☐ No ☐ At times ☐

31. Do you get supervision?

Yes ☐ No ☐

32. Do you supervise others?
Yes ☐ No ☐

33. Have you ever experienced feelings of…

33a. Attraction to a patient Yes ☐ No ☐

33b. Pity for a patient Yes ☐ No ☐

33c. Being threatened by a patient Yes ☐ No ☐

33d. Identification with a patient Yes ☐ No ☐

33e. Anger to a patient if they are abusive or belligerent Yes ☐ No ☐

33f. Anger to a patient if they are resistant to you Yes ☐ No ☐

34. Do you work one on one with patients?

Yes ☐ No ☐

35. Have you ever been given a gift from a patient?

Yes ☐ No ☐

36. Have you ever self-disclosed more than you feel comfortable with?

Yes ☐ No ☐

37. Have you ever discussed your personal life with a patient?

Yes ☐ No ☐

38. Where were you recruited from?
Locally ☐ Nationally ☐

Thank you for taking the time to complete this questionnaire. Please now turn to Questionnaire 2.

Appendix G: Questionnaire 2

Please circle the response that best characterizes your behaviours over the last two years with any patient you have worked with:

Do you feel that you have strong professional boundaries when working with all patients?

Yes, very strong They could be stronger Not strong enough No not at all

Do you find yourself doing any of the following for your family members or social acquaintances: prescribing medication, making diagnoses, offering psychodynamic explanations for their behaviour?

Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Are you gratified by a sense of power when you are able to control a patient's activity through advice, medication, or behavioural restraint? (e.g., hospitalization, seclusion)

Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Do you find the chronic silence or tardiness of a patient a satisfying way of getting paid for doing nothing?

Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Do you accept gifts or bequests from patients?

Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Have you engaged in a personal relationship with patients after treatment was terminated?

Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Do you touch your patients? (exclude handshake, for medical purposes or restraint)

Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Do you ever use information learned from patients, such as tips or information, for your own financial or career gain?

Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Do you feel that you can obtain personal gratification by helping to develop your patient's great potential for fame or unusual achievement?

Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Do you feel a sense of excitement or longing when you think of a patient or anticipate her/his visit?

Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Do you make exceptions for your patients, such as providing special scheduling or reducing fees, because you find the patient likeable, appealing, or impressive?

Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Do you ask your patient to do personal favours for you? (e.g. get sweets or lunch for you, mail a letter)

Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Do you and your patients address each other on a first-name basis?

Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Do you undertake business deals with patients?

Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Do you take great pride in the fact that such an attractive, wealthy, powerful, or important patient is seeking your help?

Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Have you accepted for treatment persons with whom you have had social involvement or whom you knew to be in your social or family sphere?

Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

When a patient has been seductive with you, do you experience this as a gratifying sign of your own sex appeal?

Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Do you disclose sensational aspects of your patient's life to others? (even when you are protecting the patient's identity)

Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Do you accept a medium of exchange other than money for your services? (e.g., work on your office or home, trading of professional services)

Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Do you find yourself comparing the gratifying qualities you observe in a patient with the less gratifying qualities in your spouse or significant other? (e.g., thinking: "Where have you been all my life?")

Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Do you feel that your patient's problem would be immeasurably helped if only he/she had a positive romantic involvement with you?

Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Do you make exceptions in the conduct of treatment-because you feel sorry for your patient, or because you believe that he/she is in such distress or so disturbed that you have no other choice?

Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Do you recommend treatment procedures or referrals that you do not believe to be necessarily in your patient's best interests, but that may instead be to your direct or indirect financial benefit?

Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Have you accepted for treatment individuals known to be referred by a current or former patient?

Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Do you make exceptions for your patient because you are afraid she/he will otherwise become extremely angry or self-destructive?

Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Do you take pleasure in romantic daydreams about a patient?

Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Do you fail to deal with the following patient behaviour(s): paying the fee late, missing appointments on short notice and refusing to pay for the time (as agreed), seeking to extend the length of sessions?

Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Do you tell patients personal things about yourself in order to impress them?

Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Do you find yourself trying to influence your patients to support political causes or positions in which you have a personal interest?

Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Do you seek social contact with patients outside of clinically scheduled visits?

Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Do you find it painfully difficult to agree to a patient's desire to cut down on the frequency of therapy, or to work on termination?

Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Do you find yourself talking about your own personal problems with a patient and expecting her/him to be sympathetic to you?

Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Do you join in any activity with patients that may serve to deceive a third party? (e.g., insurance company)

Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Have you given a patient some of your food?
Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Have you given a patient a piece of your property (maybe because you no longer wanted/ needed it)?
Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Have you told a patient what village/ town etc you live in?
Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Have you told a patient about your family?
Never Rarely(yearly) Sometimes(quarterly) Often(monthly)

Have you ever told a patient:-

How many children you have?
Yes ☐ No ☐ Not applicable ☐

What your children's names are?
Yes ☐ No ☐ Not applicable ☐

If you have a partner?
Yes ☐ No ☐

What your partners name is?
Yes ☐ No ☐ Not applicable ☐

What your partner's profession is?

Yes ☐ No ☐ Not applicable ☐

What roads you travel to work on
Yes ☐ No ☐

Thank you for your help.

Appendix H: Questionnaire 3

Thank you for taking the time to complete this questionnaire. It should only take about seven minutes to complete. Please read the definitions below and then answer the questions that follow as fully as possible.
The study uses the following definitions:

- **Whistleblowing:** Informing on a person or organisation regarded as engaging in an unlawful or immoral activity.
- **Boundary violations:** A boundary violation is committed when someone knowingly or unknowingly crosses the emotional, physical, spiritual or sexual limits of another (Katherine, 1993). The result of a boundary violation is that it blurs or disrupts the professional distance between staff and clients (Marquart et al., 2001).
- **Corruption:** Dishonest conduct by those in power.

1. **How do you think the following people view whistleblowing with regard to boundary violating behaviour?**

a) Management

b) Staff

c) You

2. **What are the different routes you know of for reporting concerns about boundary violating or poor practice?** (please list as many as possible)

3. **Which method would you use to report suspected boundary violating behaviour?**

4. **How comfortable would you feel reporting suspected boundary violating issues?**

Very comfortable Very uncomfortable

10 9 8 7 6 5 4 3 2 1

5. **What would make you report boundary violating concerns?**

6. **What would discourage you from reporting boundary violating concerns?**

7. **What do you think should be done to make reporting boundary violating concerns easier?**

8. Please circle the <u>FOUR</u> main factors you think put people at risk of boundary violating professional boundaries.

Low pay	New to the job	Mental health issues
Low self-esteem	Debt	In the job a long time
Peer pressure	Falling in love	Relationship breakdown
Having children	Work stress	Working 1:1 with patients
Being a supervisor	Loneliness	Socialising with people with criminal records

Or others (please specify) _____

9. Please circle the factors you think would protect people from boundary violating.

Highly educated	Regular supervision	Training regarding corruption
Enjoy the job	Close work colleagues	In a stable relationship
Strong morals	Military background	Not working 1:1 with patients
New to the job	In the job a long time	Organisational conflict of interest procedures
Higher pay	Or others (please specify) _____	

10. Do you think this hospital has a boundary violating issues?

Yes ☐ No ☐ In places ☐

11. What do you think should be done to decrease relational security issues or boundary violating behaviour in the work place?(Tick as many as you need)

☐Better handover	☐Increased staff awareness	☐More motivated staff
☐Team Building	☐Budding system	☐Structure staff support process
☐Team Supervision	☐Senior Staff on site at night/ weekends	
☐More training	☐Making it a higher priority	Others_____

12. Have you ever suspected a member of staff of committing boundary violations?

Yes ☐ No ☐

a) Did you report it? Yes ☐ No ☐

b) What was your reasoning for this?

c) How did you feel about doing it?

Very comfortable Very uncomfortable
10 9 8 7 6 5 4 3 2 1

d) What would have made the process easier?

☐Better handover ☐Structure staff support process
☐Team Supervision ☐ Specific forms to report
☐SMT being more visible ☐ Direct questions about this issue in supervision
☐ More supervision ☐ Others_____

13. Do you feel that any patients have ever tried to make you commit a boundary violation?

Yes ☐ No ☐

If yes,
a) How did the patient do this?

b) What made you realise this was happening?

c) How did it make you feel?

d) How did you handle the situation?

e) Did you inform managers or senior staff?

14. How often do you feel patients try to make staff commit boundary violations? (please circle)

Never – Rarely – Sometimes – Often – All the time

a) What methods have you seen patients use? (e.g., give compliments, pick on new staff)

b) What do you feel is the best way to manage boundary violations and stop them from becoming a problem?

c) Have you had training on boundary violating?

No ☐ Yes ☐

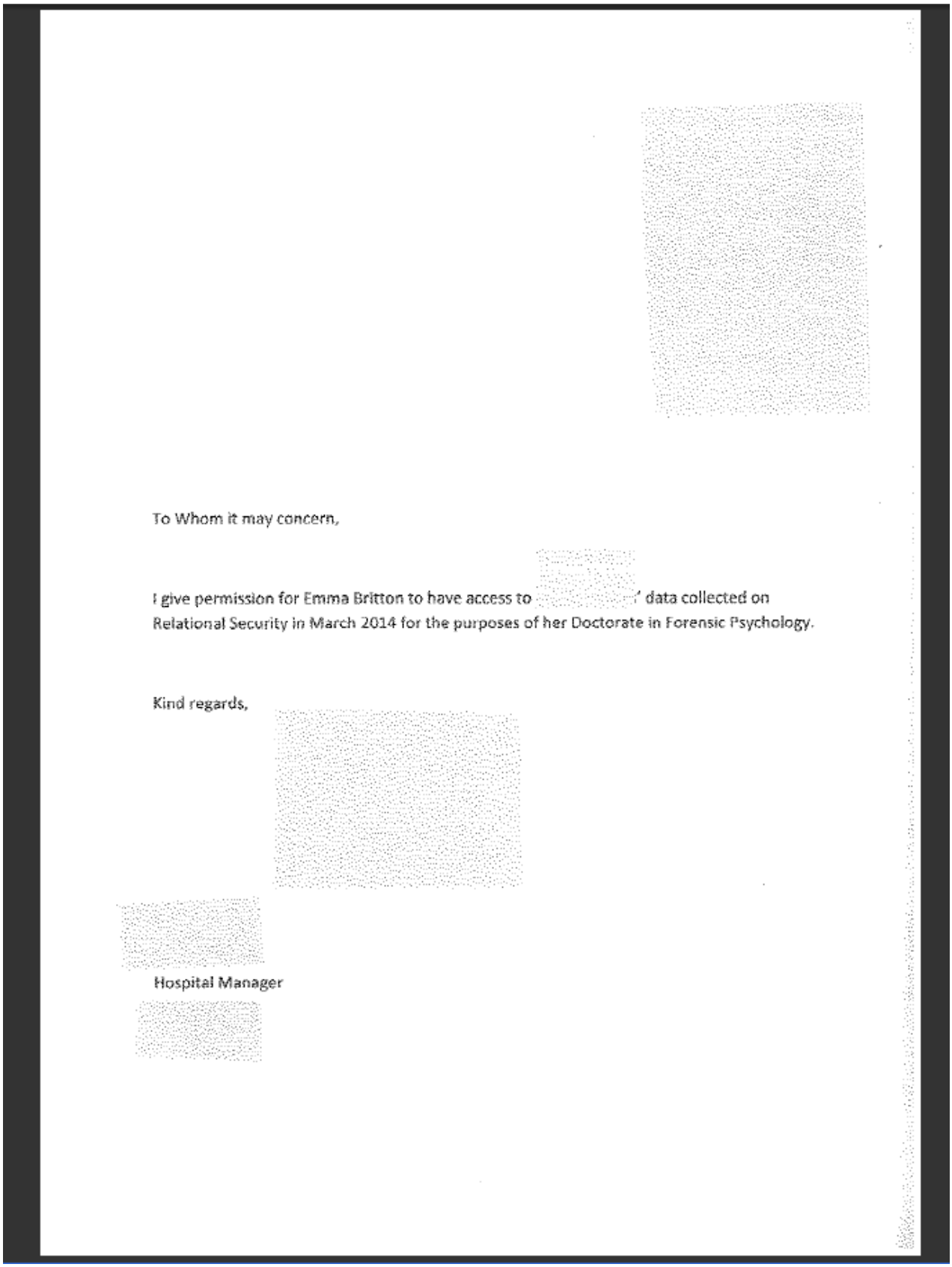
If yes: Was it enough? Yes ☐ No ☐

Was it good enough quality? Yes ☐ No ☐

Would you like more training in this area: Yes ☐ No ☐

Thank you for taking the time to complete this questionnaire. Your input is very much appreciated. Please return both completed questionnaires to Emma Britton. Thank you.

Appendix I: Participant Information Sheet



To Whom it may concern,

I give permission for Emma Britton to have access to [redacted]' data collected on Relational Security in March 2014 for the purposes of her Doctorate in Forensic Psychology.

Kind regards,

[redacted]

Hospital Manager

[redacted]

Email from University Sponsor

From: BB-sponsor
Sent: 21 May 2014 11:10
To: Britton Emma
Subject: RE: Research Project and Sponsorship

Hi Emma

I've just looked into this again and used the following tool http://www..hra-decisiontools.org.uk/ethics/, you don't need ethics or IRAS (IRAS seems to suggest that you do need to complete the form, but the toolkit suggests otherwise) - you'll just need permission from the hospital manager to give you the data anonymised. You don't need any other formal approvals

I hope this helps

Sam

Miss Sam Bateman Research Governance Officer

Sponsor enquiries should be sent to sponsor@nottingham.ac.uk

Please quote the Sponsor's reference number in the subject line of your emails
Please note that I do not work on Friday afternoons

Appendix J: Participant Information Sheet

Title of Study: Investigating the risk and protective factors regarding hospital staff committing boundary violations

Name of Researcher: Emma Britton, Trainee Forensic Psychologist.

I would like to invite you to take part in our research study. Before you decide, I would like you to understand why the research is being done and what it would involve for you. Emma Britton will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask Emma if there is anything that is not clear.

What is the purpose of the study?
The study aims to identify significant risk and protective factors in terms of hospital staff committing boundary violations. Specifically, the study will address the following research questions:

1. What factors put staff members at risk of committing boundary violations in a hospital setting?
2. What factors protect staff members from committing boundary violations?
3. What knowledge do hospital staff members have about boundary violations (e.g., what puts them at risk and how to report concerns)?
4. What deters staff from reporting concerns about boundary violations being committed?

As a result of this research, it is hoped that conclusions can be drawn about the risk and protective factors involved in maintaining relational security and boundaries. Once these factors have been identified, they can assist with training, support and intervention.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to complete a questionnaire. By completing and returning the questionnaire you are consenting to engage in the research. If you decide to take part you are still free to withdraw at any time up until submitting the questionnaire and without giving a reason. This would not affect your legal rights.

What happens when the research study stops?
All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Emma Britton will then analyse the data and describe the results in an academic report. Only Emma Britton and her

supervisors will have access to the spreadsheet and questionnaires. Emma will write a report of the study's findings to the senior management team and any members of staff at this hospital who request it. This study forms part of a Doctorate in Forensic Psychology at the University of Nottingham. The participants' anonymity will be maintained throughout the study and in any publications or conference presentations. If the participants wish to know more about the study, Emma Britton will provide a summary of the research and its findings.

How do I become involved and give my consent?

By returning the completed questionnaire you are consenting to your data being used in this research project. By doing this you are confirming that you have read and understood the information sheet for the above study and all it entails.

Further information and contact details:

Emma Britton: lwxesbr@nottingham.ac.uk

[redacted]

Appendix K: Debrief Sheet

Thank you for taking the time to participate in this study. Your input is very much appreciated. The study aims to identify significant risk and protective factors in terms of relational security and staff committing boundary violations. As a result of this research, it is hoped that conclusions can be drawn about the risk and protective factors involved in boundary violations. Once these factors have been identified, they can assist with identifying professionals who could benefit from training or other types of intervention work in order to avoid boundary violations.

The information you have provided will be kept strictly confidential and your anonymity will be maintained throughout the study and in any publications or conference presentations. If you feel distressed as a result of completing the questionnaires, please contact the [redacted]).

If you have any concerns regarding relational security, boundary violations or wish to report any issues, please contact [redacted]

If you wish to know more about the study or are interested in the final results of the research, please contact Emma Britton (contact details below).

Researcher contact details

Emma Britton: lwxesbr@nottingham.ac.uk

[redacted]

Appendix L: SORC Formulation of Mr U's Index Offence

<table>
<tr><th>Antecedents
Setting Conditions(Triggers)</th><th>Behaviour
Response Stimuli</th><th>Consequences
Positive Reinforcement</th></tr>
<tr><td>➢ Being made homeless
➢ Family refusing to house him.
➢ Asking for money from an ex care worker and him stating no.
➢ Becoming angry
➢ Drank alcohol
➢ Went to train station
➢ Saw the victim (a 15yr old male)</td><td>Asked for a the victim if he had a phone
the victim denied having a phone
Mr U then stated "I have been in prison for stabbing people".
He then re-demanded to have the phone
The victim gave him his phone
Mr U then treated him and told him not to tell anyone.
He then watched the victim leave.</td><td>➢ Gain his feeling of power and control (potentially why he chooses a vulnerable victim).
➢ Increase his self-esteem levels
➢ Gain financial benefits – potentially for alcohol to self-medicate and increase his self-esteem.
➢ To teach people who reject him a lesson.</td></tr>
<tr><td colspan="2">Organism Variables</td><td>Negative Reinforcement</td></tr>
<tr><td colspan="2">➢ Mr U has a history of developmental delay and had behavioural problems from an early age.
➢ Diagnosed with middle of the mild range of learning disability and ADHD.
➢ Family described as chaotic family– lots of social services involvement - due to children's disruptive behaviour and reports of physical abuse from both biological father and stepfather.
➢ Spent large amounts of time in care and moved through numerous foster homes.
➢ Moved around numerous special-needs schools, mainly due to expulsion following incidents of poor behaviour, e.g. setting fire to a school.
➢ Parents divorced – he states he was never been close to mother.
➢ Mother married paternal grandfather.
➢ Mr U lived with father due to him not getting along with his new stepfather –moved into the care of social services.
➢ Mr U reported that he was encouraged to drink by his father who he describes as an alcoholic.</td><td>➢ Release his anxiety and stress about being homeless.
➢ Release his anxiety about his limited money.
➢ Release his anger at being rejected.</td></tr>
</table>

➢ Mr U's contact with family fluctuates along with his feelings towards them. ➢ Good relationship with godparents, change his name to theirs, although they are fond of him it is clear that he places more significant on this relationship they do as they stated that they only saw him for a few weeks a year while growing up. ➢ No previous employment ➢ No records of previous intimate relationships - Mr U does on occasions make references to girlfriends however it is not clear if they existed. ➢ History since childhood of making superficial cuts to his arms when he is under pressure and verbalised suicidal thoughts. ➢ Some reports have suggested that Mr U has features of antisocial and emotional unstable personality disorder. ➢ Mr U reports excessively using alcohol and illicit substances including cannabis and heroin in the past and offended under the influence – not corroborated ➢ Offence History: offences against the person, offences against property, theft and kindred offences and miscellaneous offence.	
Function: It is hypothesised that the function of this offence was to increase his feeling of self-esteem, power and control. It also helped in decreasing his anxieties about uncertainty and rejection in his life.	
Hypothesis: If this functions are correct, the following interventions should reduce the risk of engaging in future offence related behaviour:	
Mr U would benefit from: Increasing his understanding of his family relationships and attachments Developing his coping mechanisms for rejection Developing his problem solving strategies when he feel rejected or when he has low self esteem Developing his ability to manage his anxiety and stress in a more productive manor Increasing his ability to manage anger Challenging his offence related distortions around using threats and violence. Developing his problem solving strategies. To explore and developing coping strategies for his alcohol use.	

Appendix M: SORC Formulation of Mr U's Boundary Violations and subsequent violence

<table>
<tr><th>Antecedents
Setting Conditions(Triggers)</th><th>Behaviour
Response Stimuli</th><th>Consequences
Positive Reinforcement</th></tr>
<tr><td>➢ Being in a relationship with a member of staff
➢ Having longer and more frequent sessions with this member of staff.
➢ The member of staff stating that the relationship was over.
➢ Another member of staff repeating trying to end the session as it had over run.</td><td>Assaulting the member of staff who was trying to terminate the session.
Hit the member of staff who he was having a relationship with.
Then punched the nursing staff who intervened and knocked them unconscious
Chased another member of staff down a corridor and assaulted them.</td><td>➢ Gain his feeling of power and control.
➢ Increase his self-esteem levels.
➢ Rejecting the member of staff who he preserved was rejecting him - Protecting himself from being hurt emotionally.
➢ Teaching the person who reject him a lesson.</td></tr>
<tr><td colspan="2">Organism Variables</td><td>Negative Reinforcement</td></tr>
<tr><td colspan="2">➢ Mr U has a history of developmental delay and had behavioural problems from an early age.
➢ Diagnosed with middle of the mild range of learning disability and ADHD.
➢ Family described as chaotic family (two brothers (criminal records) and one sister) – lots of social services involvement - due to children's disruptive behaviour and reports of physical abuse from both biological father and stepfather.
➢ Spent large amounts of time in care and moved through numerous foster homes.
➢ Moved around numerous special-needs schools, mainly due to expulsion following incidents of poor behaviour, e.g. setting fire to a school.
➢ Parents divorced – he states he was never been close to mother.
➢ Mother married paternal grandfather.
➢ Mr U lived with father due to him not getting along with his new stepfather – moved into the care of social services.
➢ Mr U reported that he was encouraged to drink by his father who he describes as an alcoholic.
➢ Mr U's contact with family fluctuates along with his feelings towards them.</td><td>➢ Release his anxiety and stress about the ending of the relationship.
➢ Release his anger at being rejected.</td></tr>
</table>

➢ Good relationship with godparents, change his name to theirs, although they are fond of him it is clear that he places more significant on this relationship they do as they stated that they only saw him for a few weeks a year while growing up. ➢ No previous employment ➢ No records of previous intimate relationships - Mr U does on occasions make references to girlfriends however it is not clear if they existed. ➢ History since childhood of making superficial cuts to his arms when he is under pressure and verbalised suicidal thoughts. ➢ Some reports have suggested that Mr U has features of antisocial and emotional unstable personality disorder. ➢ Mr U reports excessively using alcohol and illicit substances including cannabis and heroin in the past and offended under the influence – not corroborated ➢ Offence History: 5 offences against the person, 2 offences against property, 3 theft and kindred offences and 1 miscellaneous offence. ➢ Feels rejected by his ex-care worker when he refuses to give him money for drugs. ➢ Commits a robber – obtains an IPP sentence ➢ Engaged in a potential illicit relationship with a member of staff while in prison.	
Function: It is hypothesised that the function of this offence was to increase his feeling of self-esteem, power and control. It also helped in decreasing his anxieties and anger about the breakdown of his relationship with a staff member.	
Hypothesis: If this functions are correct, the following interventions should reduce the risk of engaging in future offence related behaviour:	
Mr U would benefit from: Increasing his understanding of his family relationships and attachments Increase his understanding of appropriated relationships and boundaries and how to not base his self-esteem on how others view him. Developing his coping mechanisms for rejection. Developing his problem solving strategies, particularly when he feel rejected or when he has low self esteem Developing his ability to manage his anger, frustration, anxiety and stress in a more productive manor Challenging his offence related distortions around using threats and violence to achieve a goal.	

Appendix N: Four P's Formulation

Formulation – Index offence	
Predisposing – distal factors	**Precipitating factors - trigger**
• Subjected to physical and potentially sexual abuse while growing up - Core beliefs about the use of violence. • Chaotic family life - Poor attachment • Hyper-sensitivity and response to rejection. • Pro-offending family. • Learning disability • ADHD • Conduct disorder	• Demands not being met immediate. • Experiencing stress, anxiety and anger • Experience rejection • Needing finical gains • Having low self esteem • The need to increase his self-esteem, control and feeling of power.
Perpetuating Factors –maintaining problematic behaviour	**Protective factors**
• Unstable self-esteem which is dependent on other's opinions of him. • Relationship difficulties • Employment and accommodation issues. • Fluctuations in emotions and moods. • Alcohol and possibly illicit drugs.	• Familiar staff and environment. • Stable family relationships • Engaging in activities with increase his self-esteem and identity • Good and stable relationships with peers. • Conducting work around attachment

Formulation – BV	
Predisposing – distal factors	**Precipitating factors - trigger**
• Subjected to physical and potentially sexual abuse while growing up – cognitive distortions about appropriate relationships and interactions. • No previous sexual/ romantic relationships • No previous experiences of friendships – particularly with women. • Chaotic family life - Poor attachment • Hyper-sensitivity and response to rejection. • Learning disability • Conduct disorder – pushing boundaries/ rules.	• Demands not being met immediate. • Experiencing stress, anxiety and anger at the risk of relationship ending. • Experience rejection • Having low self esteem – depending on others view of him • Feeling pressured by staff. • Feeling that his level of control and power was being taken away/ tested. • Cognitive distortion about "being a man" and "appropriate relationship".
Perpetuating Factors –maintaining problematic behaviour	**Protective factors**
• Unstable self-esteem which is dependant on other's opinions of him. • Family relationship difficulties • Fluctuations in emotions and moods. • Difficulties with understanding relationships and understanding others. • On the autistic spectrum - Misunderstanding information from others. • A desire for romantic relationship – feeling wanted, supported by someone • Desire for a stable attachment	• Familiar staff and environment. • Stable family relationships • Engaging in activities with increase his self-esteem and identity • Good and stable relationships with peers. • Consistent boundaried staff.

Appendix O: Relationship Group Leaflet

Appendix P: The Exploitation Index

The Exploitation Index: Rate yourself according to the frequency that the following statements reflect your behaviour, thoughts, or feelings with regard to any particular patients you have worked with within the past 2 years, by placing a check in the appropriate box. Approximate frequency as follows:

Rarely = about once a year or less Sometimes = about once every 3 months Often = once a month or more

Please give your immediate, “off the cuff” responses:

Text of the Exploitation Index (EI) questions (Epstein & Simon, 1990)

1. Do you find yourself doing any of the following for your family members or social acquaintances:

prescribing medication, making diagnoses, offering psychodynamic explanations for their behavior?

Never Rarely (Yearly) Sometimes (Quarterly) Often (Monthly)

2. Are you gratified by a sense of power when you are able to control a patient's activity through

advice, medication, or behavioral restraint? (e.g., hospitalization, seclusion)

Never Rarely (Yearly) Sometimes (Quarterly) Often (Monthly)

3. Do you find the chronic silence or tardiness of a patient a satisfying way of getting paid for doing

nothing?

Never Rarely (Yearly) Sometimes (Quarterly) Often (Monthly)

4. Do you accept gifts or bequests from patients?

Never Rarely (Yearly) Sometimes (Quarterly) Often (Monthly)

5. Have you engaged in a personal relationship with patients after treatment was terminated?

Never Rarely (Yearly) Sometimes (Quarterly) Often (Monthly)

6. Do you touch your patients? (exclude handshake)

Never Rarely (Yearly) Sometimes (Quarterly) Often (Monthly)

7. Do you ever use information learned from patients, such as business tips or political information, for your own financial or career gain?

Never Rarely (Yearly) Sometimes (Quarterly) Often (Monthly)

8. Do you feel that you can obtain personal gratification by helping to develop your patient's great potential for fame or unusual achievement?

Never Rarely (Yearly) Sometimes (Quarterly) Often (Monthly)

9. Do you feel a sense of excitement or longing when you think of a patient or anticipate her/his visit?

Never Rarely (Yearly) Sometimes (Quarterly) Often (Monthly)

10. Do you make exceptions for your patients, such as providing special scheduling or reducing fees, because you find the patient attractive, appealing, or impressive?

Never Rarely (Yearly) Sometimes (Quarterly) Often (Monthly)

11. Do you ask your patient to do personal favors for you? (e.g., get you lunch, mail a letter)

Never Rarely (Yearly) Sometimes (Quarterly) Often (Monthly)

12. Do you and your patients address each other on a first-name basis?

Never Rarely (Yearly) Sometimes (Quarterly) Often (Monthly)

13. Do you undertake business deals with patients?

Never Rarely (Yearly) Sometimes (Quarterly) Often (Monthly)

14. Do you take great pride in the fact that such an attractive, wealthy, powerful, or important patient is seeking your help?

Never Rarely (Yearly) Sometimes (Quarterly) Often (Monthly)

15. Have you accepted for treatment persons with whom you have had social involvement or whom you knew to be in your social or family sphere?

Never Rarely (Yearly) Sometimes (Quarterly) Often (Monthly)

16. When a patient has been seductive with you, do you experience this as a gratifying sign of your own sex appeal?

Never Rarely (Yearly) Sometimes (Quarterly) Often (Monthly)

17. Do you disclose sensational aspects of your patient's life to others? (even when you are protecting the patient's identity)

Never Rarely (Yearly) Sometimes (Quarterly) Often (Monthly)

18. Do you accept a medium of exchange other than money for your services? (e.g., work on your office or home, trading of professional services)

Never Rarely (Yearly) Sometimes (Quarterly) Often (Monthly)

19. Do you find yourself comparing the gratifying qualities you observe in a patient with the less gratifying qualities in your spouse or significant other? (e.g., thinking: "Where have you been all my life?")

Never Rarely (Yearly) Sometimes (Quarterly) Often (Monthly)

20. Do you feel that your patient's problem would be immeasurably helped if only he/she had a positive romantic involvement with you?

Never Rarely (Yearly) Sometimes (Quarterly) Often (Monthly)

21. Do you make exceptions in the conduct of treatment-because you feel sorry for your patient, or because you believe that he/she is in such distress or so disturbed that you have no other choice?

Never Rarely (Yearly) Sometimes (Quarterly) Often (Monthly)

22. Do you recommend treatment procedures or referrals that you do not believe to be necessarily in your patient's best interests, but that may instead be to your direct or indirect financial benefit?

Never Rarely (Yearly) Sometimes (Quarterly) Often (Monthly)

23. Have you accepted for treatment individuals known to be referred by a current or former patient?

Never Rarely (Yearly) Sometimes (Quarterly) Often (Monthly)

24. Do you make exceptions for your patient because you are afraid she/he will otherwise become extremely angry or self-destructive?

Never Rarely (Yearly) Sometimes (Quarterly) Often (Monthly)

25. Do you take pleasure in romantic daydreams about a patient?

Never Rarely (Yearly) Sometimes (Quarterly) Often (Monthly)

26. Do you fail to deal with the following patient behavior(s): paying the fee late, missing appointments on short notice and refusing to pay for the time (as agreed), seeking to extend the length of sessions?

Never Rarely (Yearly) Sometimes (Quarterly) Often (Monthly)

27. Do you tell patients personal things about yourself in order to impress them?

Never Rarely (Yearly) Sometimes (Quarterly) Often (Monthly)

28. Do you find yourself trying to influence your patients to support political causes or positions in which you have a personal interest?

Never Rarely (Yearly) Sometimes (Quarterly) Often (Monthly)

29. Do you seek social contact with patients outside of clinically scheduled visits?

Never Rarely (Yearly) Sometimes (Quarterly) Often (Monthly)

30. Do you find it painfully difficult to agree to a patient's desire to cut down on the frequency of therapy, or to work on termination?

Never Rarely (Yearly) Sometimes (Quarterly) Often (Monthly)

31. Do you find yourself talking about your own personal problems with a patient and expecting her/him to be sympathetic to you?

Never Rarely (Yearly) Sometimes (Quarterly) Often (Monthly)

32. Do you join in any activity with patients that may serve to deceive a third party? (e.g., insurance company)

Never Rarely (Yearly) Sometimes (Quarterly) Often (Monthly)

Scoring Key: Never = 0, Rarely = 1, Sometimes = 2, Often = 3.