

**WORKING WITH PATIENTS WITH AN ACQUIRED BRAIN INJURY:
STAFF EXPERIENCES OF INAPPROPRIATE SEXUALISED
BEHAVIOUR**

**Thesis submitted in partial fulfilment for the requirements of the Doctorate
in Clinical Psychology**

by

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Statement of originality

I confirm that this is an original piece of work. The literature review and research report contained within this thesis have not been submitted for any other degree, or to any other institution.

Target Journal

Literature Review: Qualitative Research in Psychology

(See Part One: Appendix C for author guidelines)

N.B. Following discussion with my supervisor, it was considered appropriate to follow APA guidelines for referencing rather than those specified in the guidelines to authors listed above.

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THESIS ABSTRACT

Title: Working with Patients with an Acquired Brain Injury: Staff Experiences of Inappropriate Sexualised Behaviour

Kerry Foley, Trainee Clinical Psychologist

Part One: Literature Review

Purpose: To explore the qualitative literature regarding staff experiences of challenging behaviour and to provide an overview of the quality of this research.

Method: A literature search was conducted using six databases to highlight relevant papers. Specific key terms and inclusion and exclusion criteria were applied.

Results: Several themes emerged from the reviewed studies, including understanding the behaviour, losing control, emotional reactions, managing a response, coping strategies, the relationship with clients and professionalism. However, many studies lacked methodological rigour.

Conclusions: Further research investigating coping strategies for care staff and effective support mechanisms is indicated. Staff experiences should be acknowledged in order to promote better psychological and emotional wellbeing.

Part Two: Research Report

Objectives: To explore staff experiences of sexualised behaviour from patients with an acquired brain injury.

Method: The data from ten semi-structured interviews and a diary from one participant was analysed using Interpretative Phenomenological Analysis (Smith, 1996).

Results: Three key themes emerged: Psychological Responses, The Continuing Ability To Cope and Evolving Relationships.

Conclusions: The results suggest that sexualised behaviour directed towards staff affects their emotional and psychological wellbeing. Participants identified multiple coping strategies to help them but specifically highlighted the importance of shared experience and shared understanding within the work support system. The clinical implications, such as enabling appropriate support systems within the work environment, include prioritising the psychological wellbeing of staff in clinical settings.

Part Three: Critical Appraisal

Reflections regarding the overall research process are provided. Barriers and facilitating factors as well as practical issues of interest are discussed, including the journey taken, reflexivity, the analysis process, the write up and limitations of IPA as the chosen methodology.

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Ultimately, however, this thesis is for my Mum

Ar dheis Dé go raibh a h-ánam dílis

WORD COUNT

Part One: Literature Review	5764 words
References / Tables	1326 words
Part Two: Research Report	16119 words
References / Tables	2364 words
Part Three: Critical Appraisal	3436 words
References	99 words
TOTAL (excluding references/tables)	25319 words
(with references/tables)	3789 words

CONTENTS

List of Tables	8
Part One: Literature Review	9
Abstract	10
1. Introduction	11
1.1 Background	11
1.2 Aims and Outline	13
2. Method	13
2.1 Search Strategy	13
2.2 Design of Review	15
3. Results	17
3.1 Summary of Themes	17
3.2 Quality Review of Studies	23
4. Discussion	31
5. Clinical Implications and Recommendations for Future Research	35
References	36
Appendices	
Appendix A Summary grid of papers reviewed: Process issues	45
Appendix B Summary grid of papers reviewed: Content issues	50
Appendix C Author guidelines for target journal	56
Part Two: The Research Report	60
Abstract	61
1. Introduction	62
1.1 Background Information	62
1.2 Research Aim	64
2. Methodology	65
2.1 Research Design	65
2.2 Epistemological Stance	67
2.3 Use of Interviews and Diaries	68
2.4 Researcher's Statement of Perspective	71
2.5 Participants	72
2.6 Measures	74
2.7 Procedure	75

3. Analysis	84
3.1 Results	84
4. Discussion	119
4.1 Themes	119
4.2 General Discussion	130
4.3 Limitations of the Study	133
4.4 Clinical Implications	135
4.5 Future Research	137
5. Conclusion	138
References	139
Appendices	
Appendix A Research Poster	151
Appendix B Information Sheet	153
Appendix C Headings for Diary Entries	159
Appendix D Ethics Approval	161
Appendix E Participant Consent Form	165
Appendix F Interview Schedule	168
Appendix G Examples of Memo Writing Reflections	171
Addenda	
Addendum 1 Interview transcripts (participants <i>pA – pE</i>) bound separately	
Addendum 2 Interview transcripts (participants <i>pF – pJ</i>) and diary transcript (participant <i>pK</i>) bound separately	
Part Three: Critical Reflection	174
1. The Journey	175
2. Why this route?	175
3. A question of numbers	176
4. Not just a matter of interviewing	177
5. Reflection on analysis	181
6. The write up	184
7. Shortcomings of IPA	185
8. Other aspects of reflexivity	187
9. The future	187
References	188
Appendices	
Appendix A Chronology of Research Process	189

LIST OF TABLES

Part One: Literature Review

Table 1:	Search terms	6
Table 2:	Summary of search results	7

Part Two: Research Report

Table 1:	Demographics of participants	66
Table 2:	Example of initial coding	70
Table 3:	Audit trail	72
Table 4:	Summary of superordinate and subordinate themes	77

Part One: Literature Review

Staff experiences of client challenging behaviour: review of qualitative studies

Abstract

Research investigating challenging behaviour is expansive across different client groups, the majority of which adopts a quantitative approach. Consequently, research regarding the subjective experiences of staff working with these behaviours, in particular the emotional impact, appears limited. To address this, experiences of staff who are exposed to client challenging behaviour were explored in a qualitative literature review. A transparent and systematic approach was used to identify and analyse key themes and quality issues. Themes identified from the reviewed studies included: understanding the behaviour, losing control, emotional reactions, managing a response, coping strategies, relationship with client and professionalism. However, many studies lacked methodological rigour. Understanding staff experiences may help promote psychological and emotional wellbeing. The clinical implications of the findings are discussed and possible areas for future research identified, including investigating coping strategies for care staff and effective support mechanisms.

Key words: Challenging behaviour, qualitative, staff, carer, care worker, care giver

1. Introduction

1.1 Background

It has only been in relatively recent years that the UK Department of Health (DoH) has focussed on aggression towards health care staff outside of the learning disability arena. As part of the “Working Together” initiative (DoH, 1999), the DoH undertook two surveys identifying nearly 85000 incidents of violence or aggression across all different types of healthcare trusts (including mental health and learning disabilities), an increase of 30% from the previous year. This figure increased by an additional 13% in the following year. A report by the National Audit Office (2003) stated that violence and aggression accounted for 40% of reported health and safety incidents amongst healthcare workers, with evidence to suggest a link between aggression and staff sickness absence.

Staff working in healthcare, particularly nurses, are at a higher risk of violence and aggression than most other professions (National Audit Office, 2003).

Winstanley and Whittington (2003) reported that aggression is widespread within hospital settings. From their survey, 23% of respondents experienced threatening behaviour from patients and over 68% reported verbal aggression.

The National Institute for Clinical and Health Excellence (NICE, 2005) produced a guide for staff to develop positive practice for the safe management of aggression and violence in mental health in-patient settings. In addition, the Department of Health National Taskforce to tackle ‘Violence Against Social Care Staff’ (Oser, 2000), highlighted the seriousness of violence and verbal

abuse towards those involved in social care. Staff experience of assaults and challenges to safety and well being was evident across client groups.

What has resulted in the UK is a focus on training and educating healthcare staff, to enable them to deal with aggressive acts. Whilst support and counselling services for staff are considered, there seems to be with a caveat that, before staff receive counselling, an assessment takes place first to assess the potential benefits. The net result is that only a small proportion of nurses who have been assaulted are offered counselling. What has not been considered is how this behaviour affects the targeted healthcare staff psychologically and emotionally; what are the actual personal consequences to their wellbeing?

There is a vast amount of research literature relating to challenging behaviour, the majority of which is generally quantitative in nature. This corpus of literature has incorporated studies including but not limited to: staff attitudes to behaviour (e.g., Jansen, Middel, Dassen & Reijneveld, 2006); behavioural management (e.g., Wheeler, Carter, Mayton & Chitiyo, 2006); psychotropic drug use (e.g., Matson & Neal, 2009); investigating characteristics of the behaviour (e.g., Tenneij & Koot, 2008); staff training (e.g., Tierney, Quinlan & Hastings, 2007); and tools for recording behaviour (e.g., Knight *et al.*, 2008).

There is research, albeit relatively limited, reporting the emotional and psychological effects of violence on staff (e.g., Rippon, 2000), and other research incorporating staff perceptions of challenging behaviour. In the main, the studies have been quantitative in approach, using, for example, questionnaires (e.g., Hastings, 2007).

Although questionnaire approaches to exploring challenging behaviour can be useful for specific questions, the use of qualitative methodologies to explore the experiences of staff who have been subject to challenging behaviour can be more suitable. Qualitative methodologies emphasise the socially constructed nature of reality and are better suited to exploring what it means to staff to experience these challenging phenomena. The current literature review addresses the question of: how staff experience challenging behaviour from clients by examining only those qualitative studies specifically addressing this question.

1.2 Aims and Outline of the Current Review

The aims of the current research were to provide a review of the qualitative literature focusing on staff experiences of client challenging behaviour *and* to provide an overview of the quality of this research. It aimed to be systematic in approach by detailing the search methodology used, what inclusion or exclusion criteria were considered and what papers were retrieved and selected for discussion.

2. Method

2.1 Search Strategy

To identify relevant articles, the following electronic databases and search engines were explored in March 2009: Medline (1950 - week 1, March, 2009), Embase (1980 – week 1, March 2009), PsychInfo (1980- March 2009), PsychArticles (1980 – March 2009), Scopus (1980 – March 2009) and Web of Science (1990 – March 2009).

2.1.1 Key Words/Terms:

Table 1: Search terms

Search term cluster	Search terms
1. Staff <i>and</i>	Staff <i>or</i> nurse <i>or</i> carer <i>or</i> caregiver <i>or</i> professional
2. Staff experiences <i>and</i>	Beliefs <i>or</i> perceptions <i>or</i> views <i>or</i> values <i>or</i> attitudes <i>or</i> experiences <i>or</i> feelings
3. Client behaviour <i>and</i>	Behaviour <i>or</i> behavior
4. Qualitative studies	Qualitative

2.1.2 Exclusion/Inclusion criteria:

All papers were required to be in the English language and from peer reviewed journals. Books and dissertations were excluded. All duplicates were removed through the use of Refworks. Titles and abstracts of articles were read and checked for potential relevance. The articles that were selected for full paper retrieval and further analysis needed to have a combination of all search term clusters listed above and related to studies with adult populations. Papers were excluded if: they used quantitative methodology; the experience of staff receiving challenging behaviour was not the sole focus of the research but were part of a wider research question or if both staff and client experiences were jointly discussed; and/or the studies were with non-adults.

2.1.3 Search Outcome

Table 2 provides a summary of the conducted database searches; the results highlight several difficulties. Firstly, there was an issue with identifying and

extracting purely qualitative studies. In addition, for the phenomenon in question, the search retrieval suggested a paucity of studies. Although a high number of initial papers were retrieved, after applying the exclusion/inclusion criteria, only a small proportion was subsequently reviewed.

Table 2: Summary of Search Results

Stage 1	Number of papers initially retrieved	780
	Number of duplicates removed using RefWorks	260
Stage 2	Total number of possible papers - abstracts examined	520
	Total number of papers excluded using criteria	475
	Potentially relevant abstracts - full papers retrieved	45
Stage 3	Papers excluded due to not meeting inclusion criteria	25
	Studies selected as relevant papers for review	20

2.2 Design of Review

To critically appraise the papers, a preliminary synthesis was developed; the main features were organised and initial descriptions of patterns across the selected studies were identified (Popay *et al.*, 2006). For the purposes of the current review, the preliminary synthesis was split into two stages: (1) to organise and synthesise the data, visually representing a summary of the studies in a tabulated format (Appendix A); (2) to summarise the most important and contrasting themes and concepts used within the studies (Appendix B). A summary of each theme was then provided. The summary incorporated the studies that supported each aspect of a theme.

Subsequent to this, by using a model defined by Meyrick (2006), the current review incorporated a systematic approach to interrogate the rigour of the studies, examining them in terms of theoretical perspectives used to support the studies; epistemological positions offered by and reflexivity of the researchers; methodological overview and methods of analysis employed; how sampling was achieved and how the data was used to answer the research question; to comment on transparency of approach and whether or not the process described by the researchers was systematic; credibility of conclusions drawn in light of the discussed results and whether or not the potential for transferability of findings was discussed. Checks of rigour were achieved using guidelines outlined by Popay *et al.* (2006).

The themes and general findings from the studies were then discussed within broader theoretical perspectives. The literature was critiqued to identify and discuss how staff perceived and experienced the behaviours in question, including any associated positive or negative factors, e.g. how staff managed their responses to this behaviour; what, if any, coping strategies they employed; and what support they received and needed.

The review concludes with comments on limitations with the review, clinical implications and future recommendations.

3. Results

The papers reviewed highlighted interchangeable terminology, to indicate both qualified and unqualified staff. Qualified staff consisted of terms such as assistant nurses, enrolled nurses and registered nurses. Unqualified staff included nurse aides, nursing assistants, support workers and auxiliary staff. For the papers retrieved, several categories of clients groups were identified: learning disabilities within residential care; mental health with in-patient settings; older adults (with/without dementia) within residential care; others.

3.1 Summary of Themes

In terms of what the papers found about staff experience of challenging behaviour, several themes appeared to emerge more often than others.

Understanding behaviour

In the context of the reviewed papers, staff experienced different kinds of client challenging behaviours (Raczka, 2005) and had individual descriptors for these (Finemma, Dassen & Halfens, 1994), including ‘disturbing’ and ‘provoking’ behaviour, ‘aggressive’ and ‘violent’ acts, ‘assault’ and ‘sexualised’ behaviour. What was evident was a hierarchy of physical, verbal and gestural behaviour (Beaulieu, 2007) that could either be intentional, deliberate, excusable despite the severity (Isaksson, Åström & Graneheim, 2008) or, needing to be controlled (Hantikainen, 2001).

Some studies suggested that understanding the behaviour was sometimes difficult for staff and might never be achievable, with misunderstandings

between staff and client occurring (Sandvide, Åström, Norberg & Saveman, 2004; Whittington & Burns, 2005). Although some staff retained their views regarding the behaviour, there was also credible evidence that temporal changes occurred, with some staff being more sympathetic over time (Whittington & Burns, 2005).

Staff had personal constructs of violence (Cutcliffe, 1999) and their perception of what constituted a challenging behaviour was contextual and relative to their individual experience and attitudes (Isaksson *et al.*, 2008). It seemed that differing opinions regarding what constitutes behaviour of concern resulted in the behaviour being 'in the eye of the beholder' (Isaksson *et al.*, 2008; O'Sullivan & Weerakoon, 1999). Additionally, individual client factors were not seen by staff as the sole causal reason for the behaviours. Rather, their behaviour was seen in the context of a combination of client related, situational and interactional factors.

Losing control

There was general agreement that staff experienced a sense of losing control when the patient behaviour was directed towards them, resulting in feelings of powerlessness and helplessness and of being a 'victim' (e.g., Chambers, 1998; Hellzen, Asplund, Sandman, & Norberg, 1999; Lundström, Åström & Graneheim, 2007; Miller, 1997). This was encapsulated in Lundström *et al.*'s (2007) theme of 'falling apart'. There was a sense that the power balance shifted uncomfortably away from the staff member towards the patient; with staff experiencing an 'inverted position of power', resulting in feelings of

oppression, disappointment and failure (e.g., Chambers, 1998; Hellzen *et al.*, 1999; Isaksson, Graneheim, & Åström, 2009). The need to feel in control and successful within a role might therefore depend on an individual worker's ability to retain a feeling of 'power' relative to their clients.

There were some quality issues with the above studies, with Miller (1997) appearing less robust than most due to lack of transparency and not appearing systematic in the analysis of the data. These studies did support their themes with direct quotes, but were not transparent in associating quotes to specific participants. Although not identifying participant quotes, the study by Hellzen *et al.* (1999) appeared more robust than the others.

Emotional reactions

Staff experienced a gamut of psychological effects and strong emotional and physical reactions when on the receiving end of behaviour, regardless of the client group they worked with. These included but were not limited to anxiety, fear, worry, anger, sadness, disgust, embarrassment and frustration (e.g., Chambers, 1998; Hellzen *et al.*, 1999; Jahoda & Wanless, 2005; O'Sullivan & Weerakoon, 1999; Raczka, 2005). These reactions were summarised in Hellzen, Asplund, Sandman, and Norberg's (2004) theme of 'being tormented'. However, some credibility issues with this paper were apparent.

Staff appeared to deal with these unpleasant feelings in a variety of ways, as discussed below. Whilst staff experienced immediate heightened emotional arousal at the time of the incidents, longer term consequences on emotional

wellbeing, perceived as being stress related, were also evident (e.g., Raczka, 2005). Additionally, feeling emotionally compromised appeared to affect both work and personal life (Kindy, Petersen, & Parkhurst, 2005). This latter study was particularly transparent and systematic in approach and hence the findings appear more credible than some of the other studies.

Managing a response

Whilst personal safety was a priority, a variation in responses was identified from ignoring or dismissing the behaviour to physically moving away from the individual (e.g., Miller, 1997; O'Sullivan & Weerakoon, 1999). Preconceived ideas and/or previous exposure to challenging behaviour had the potential for increasing arousal in staff, affecting their ability to manage their fear and the possibility of being hurt (Isaksson *et al.*, 2009). The ability of staff to trust the power of their own experience might have resulted in containing their fear and promoting a more positive encounter with the client (Carlsson, Dahlberg, Lützen & Nystrom, 2004).

A sense of just having to deal with it regardless of the aftermath appeared to prevail, despite possible negative implications, such as poor morale, fear and distrust (Kindy *et al.*, 2005). Sandvide *et al.*, (2004) found a level of acceptance by staff of violence in the workplace; viewed as part of their work. However, this particular study had issues with transparency and also appeared to exclude certain data, making the credibility of the findings questionable.

In some instances, habituation to these behaviours resulted in staff no longer interpreting certain behaviour as 'violent' (Lundström *et al.*, 2007). Staff had a need to 'just get on with the job' (e.g., Chambers, 1998; Isaksson *et al.*, 2008; Miller, 1997), perceiving this type of behaviour as something one had to learn to live with (Hantikainen, 2001). How staff responded to challenging behaviour depended in part on their own personal resources and coping strategies.

Coping strategies

Several different coping strategies were reported to be employed by staff to varying degrees. Staff described the importance of trying to not take the behaviour personally and either attributed the behaviour to a person's illness or diagnosis, 'have to remember she has a learning disability' or reminding themselves that this is part of their professional role, e.g. 'this is what I do for a living' (e.g., Jahoda & Wanless, 2005).

There was a sense that staff experienced an increase in vigilance when working with challenging behaviour (e.g. Kindy *et al.*, 2005), resulting in adopting some protective but avoidant coping strategies, such as physically avoiding clients by not 'being around' them or in some cases, saying to clients 'maybe it would be better if we had a different nurse looking after you' and hence transferring their care to others (Higgins, Barker & Begley, 2009). It was evident that this disengagement might ultimately affect the relationship between staff and client. There was a general need to feel supported, with staff receiving social support from other members of the team (e.g., Cutcliffe, 1999; Skovdahl, Kihlgren, & Kihlgren, 2003). Feelings of a team spirit and of solidarity resulted in increased

personal resilience (Chambers, 1998). An element of this social support included the use of humour as a way to express feelings, with staff ‘joking’ about situations. Whilst this type of informal support appeared to be readily available, it appeared to suggest evidence of a lack of formal support, in terms of debriefing or supervision. Staff also highlighted the importance of self reflection and holding in mind the ‘pleasure’ of working in these environments, rather than allowing their thoughts to be dominated by negative incidents (Lundström *et al.*, 2007). Some staff said that they ‘sit and have a chat about what it would be like if behaviours went away’. This type of wishful thinking strategy to overcome the stress of the situation was not uncommon (e.g., Raczka, 2005).

Relationship with client

After a challenging behaviour occurred, there was reported a discernable effect on the relationship between staff and the client, with clients sometimes being perceived negatively (Jahoda & Wanless, 2005). For some staff, this shift in attitude towards the client resulted in reduced empathy, ‘doing to’ rather than ‘being with’ them (Isaksson *et al.*, 2009). However, some staff were of the opinion that relationships had not been affected by incidents, citing professionalism as the key explanation.

Professionalism

There was general consensus that underpinning staff ability to return to work after an incident and to continue to perform their role was the concept of professionalism. A sense that staff persevered despite the uncomfortable and

challenging situations they experienced was not uncommon. Staff highlighted the importance of maintaining professional boundaries with clients, which although may suggest a degree of ‘control’ or ‘distancing’, still maintained the need to be ‘kind and respectful’ (Jahoda & Wanless, 2005; Whittington & Burns, 2005). ‘Knowing the client’ and ‘working through’ the behaviour were also important factors in both maintaining a professional approach and building confidence to be better able to cope when dealing sensitively with an incident and viewing the client empathetically rather than judgementally (e.g., Beaulieu, 2007; Hantikainen, 2001; Miller, 1997). However, this arguably admirable approach was balanced with the demands of the job role and a challenging and somewhat unpredictable environment exceeding the abilities and competence of the staff (Miller, 1997; Skovdahl *et al.*, 2003) and occasions when support from others was deemed lacking and feelings of abandonment occurred (e.g., Isaksson *et al.*, 2009; Kindy *et al.*, 2005). There was a sense that some staff experienced conflict in role identity, with their nurturing abilities being somewhat compromised as a result of having to cope with challenging behaviour (Chambers, 1998).

3.2 Quality Review of Studies

An overview of the quality of the reviewed papers was completed.

Use of theoretical perspectives as a foundation for studies

Two studies (Jahoda & Wanless, 2005; Whittington & Burns, 2005) incorporated staff attributions and beliefs as factors to compare differences in perception of the behaviour. How caregivers are exposed to risk, threat and the

phenomenon of fear as well as aspects of safety were discussed in other studies (e.g., Carlsson *et al.*, 2004; Hellzen *et al.*, 1999; Kindy *et al.*, 2005). The most common perspective within the reviewed papers related to the negative effects of these types of challenging behaviour on staff, incorporating physical, emotional and psychological aspects, construing the outcome as ‘affliction’, ‘blame’, ‘stress’, ‘burnout’ and ‘acceptance’ (e.g., Hellzen *et al.*, 2004; Raczka, 2005; Whittington & Burns, 2005). How aggression and violence are defined and perceived by the caregivers was also used (Lundström *et al.*, 2007).

Epistemological positions and reflexivity

Approximately half of the papers reviewed were vague on their epistemological position (Finnema, Dassen & Halfens, 1994; Higgins *et al.*, 2009; Jahoda & Wanless, 2005; Isaksson *et al.*, 2009; Lundström *et al.*, 2007; Miller, 1997; O’Sullivan & Weerakoon, 1999; Sandvide *et al.*, 2004), with very limited information provided regarding reflexivity within these studies. A phenomenological framework was the key coherent epistemological position used for the remaining papers, with sufficient detail for the reader to gain an appreciation of the philosophical underpinnings of this framework. To increase the integrity and trustworthiness of qualitative studies, researchers ought to declare how subjectivity and intersubjectivity have affected the research process as this can contribute to a broader understanding of the research process (Finlay, 2002). Qualitative research requires reflexivity by the researcher, so it was concerning that reflexivity was not a key foundation within all of the studies. Reflexivity was established by the researchers’ own position being considered to varying degrees (Cutcliffe, 1999; Skovdahl *et al.*, 2003), with reference being

made explicitly to the importance of 'bracketing' in some studies (e.g., Chambers, 1998; Kindy *et al.*, 2005) and also to the research as a 'process' (Hellzen *et al.*, 1999). Carlsson *et al.* (2004) emphasised the importance of the researchers' own 'life world', which became a focus of reflection within their study. One study (Miller, 1997) made reference to the researcher's role as a 'research instrument' but did not provide further explanation on what this meant either to the overall research process or to the findings.

Methodological overview

All but one study used interviews as their main data collection method, the remaining one solely using a focus group to collect data. Descriptors of interviews varied, including 'open-ended', 'unstructured', 'semi structured' and 'in depth'. Five studies specifically used 'narrative interviews', with a separate study using a cognitive behavioural interview based on Rational Emotive Behavioural Therapy as the format for their interviews. Carlsson *et al.* (2004) combined written participant narratives with re-enactment interviews, giving the caregivers the opportunity to relive and describe their experience in a significant way, resulting in the interviewees 'getting closer' to them. It was difficult to assess the usefulness of the structure or quality of the interviews as the vast majority of studies did not provide detail pertaining to questions asked, prompts used or the nature of the interviewer/interviewee interaction and how this may have impacted on both the responses received and the subsequent analysis. Cutcliffe (1999) used 'semi structured conversations', emphasising the exploratory nature of the process, attempting to ensure that it was not a one-sided process.

Raczka (2005) used focus groups as the primary method of data collection. Although focus groups are a useful and probably time reducing method by which to obtain data, limited information is available as to how the researchers accounted for inter-personal interactions and group dynamics when discussing the outcomes. The dynamics of the focus group were not recognised or discussed.

The vast majority of studies tape recorded participants' responses, with recording of responses by hand occurring in one interview study (Miller, 1997). No method of data collection can fully capture the nuances or idiosyncrasies of interactions between an interviewer and interviewee, but recording by hand possibly has limitations that might be overcome by audio recording. This perhaps is even more relevant when considering a focus group, where conversation can overlap between participants and the quality of what is captured might depend on the shorthand ability of the interviewer.

Whilst acknowledging the possible limitation of failing to capture the complexity of an experience, the use of a vignette instead of actual experiences to capture respondents' perceptions of behaviour was used by Isaksson *et al.* (2008). This approach seems to be at one end of a continuum of approaches, with re-enactment interviews at the other end.

All studies were conducted by the researcher or co-researcher, with only one study (Chambers, 1998) declaring a 'work relationship' with the participants but unfortunately not reflecting what impact, if any, this might have had on either

the data collected or subsequent analysis. The outcome of the analysis of the remaining studies should be viewed in light of the ambiguity of relationships between researchers and participants as these relational details are scant.

Methods of analysis

There was no one common framework for analysis adopted by either all or the majority of studies and descriptions of the analytic framework were wide ranging. Seven studies adopted either a phenomenological-hermeneutic approach inspired by Ricoeur (1976), a phenomenological approach based on the work of Colaizzi (1978) or a reflective lifeworld approach within a phenomenological framework. Six studies specifically stated use of qualitative content analysis inspired by various people (e.g., Graneheim & Lundman, 2004; Miles & Huberman, 1994; Spradley, 1979), with Whittington and Burns (2005) specifying the use of template analysis. A grounded theory approach was adopted by several studies (Beaulieu, 2007; Higgins *et al.*, 2009; Jahoda & Wanless, 2005), with the remaining studies having scant information regarding their approach, despite the importance of defining the relationship between research questions and methodology (Giorgi, 2000). This vagueness of approach appeared to be related to not having a coherent epistemological position.

Transparency/systematicity

Most studies used their methods of analysis to focus in on theme generation, which was achieved to various degrees. The journey in some studies from data analysis to theme generation varied from explicit and transparent (e.g.,

Hantikainen, 2001) to somewhat nebulous (e.g. Isaksson *et al.*, 2008). Some studies did provide transparent examples of analysis from participant text through to theme generation (e.g. Whittington & Burns, 2005). Issues with transparency clearly affect how systematic a study is. Due to different depths of detail provided, it was therefore difficult to judge how systematic some of the studies were. Although some studies provided details on data collection, analysis and theme generation, no study commented on deviations to and management of the analytic process.

Credibility

As part of theme generation, several studies opted to use a validation process. Several different methods were adopted. Whittington and Burns (2005) and Chambers (1998) used respondent validation, a process adopted as an attempt to maximise the authenticity of the participants' accounts (Henwood & Pidgeon, 1995) and to gain a sense of how coherent the researcher's analysis is. It might have been useful to have known how participants responded to this and what specific changes, if any were made, whilst bearing in mind the inherent difficulties within a power relationship (between researcher and participant), which might result in respondents just agreeing (Willig, 2001).

Independent scrutiny is an alternative quality check used in several studies. One approach adopted involved individually generating themes and then reflecting on similarities and differences within the research team. Another involved the researchers defending their analysis to an expert panel (Finnema, *et al.*, 1994). Lack of detail in other studies makes it difficult to gain a clear

picture as to how the researchers have reflected on their processes and if they gave proper consideration to alternative explanations that they might have initially dismissed. Very few studies provided reasonable descriptions of procedures and processes of analysis to enable the reader to follow a clear audit trail. It was difficult to clearly ascertain how credible some of the studies were in terms of the reliability and validity of their findings due to lack of detail with the papers, with very few overtly commenting on reliability or validity issues.

Sampling

Most studies provided limited information in their reasoning behind their sampling strategy, whether this was for individual interviews or for focus groups. Purposeful sampling was used in several studies. For those studies using grounded theory, mention was made of 'reaching saturation'. No study commented on either the process or issues with recruitment and only two studies commented explicitly on why participants were excluded. The level of detail pertaining to demographic information varied considerably and descriptors of job roles were at times, difficult to understand. Two studies (Hantikainen, 2001; Miller, 1997) provided partial data on ethnicity with only one study (Kindy *et al.*, 2005) clearly stating ethnicity for all participants.

Use of data

It seemed peculiar that within qualitative research, using participants' words as data, that some studies did not use participants quotes to support their arguments and for those that did use participant quotes, very few studies identified the participant (e.g., Heyman, Swain, & Gillman, 1998). There is a

sense within most studies that a huge amount of data was generated from the participant interviews, yet the proportion of quotes used is minimal, and for those quotes that were used, explicit reference is not made as to whether the quotes are illustrative or representative.

Some studies apparently removed data not relevant to the study aim; for example, Isaksson *et al.* (2009) commented that for their participants, data regarding earlier experiences of working in elderly care were not relevant.

Other studies were less specific about their reasons for excluding data. It is also unclear whether other studies excluded data but did not overtly mention this. It is difficult to assess if, within specific studies, some cases contradicted emerging themes, as no study mentioned deviant case analysis.

Transferability

Over half of the studies discussed general issues of transferability, although with limited detail. In these studies most concluded limited transferability due to the specific research context, but several commented on the possibilities for future research. Insufficient context details make it difficult to draw conclusions regarding transferability of the other studies.

4. Discussion

The aim of the current research was to provide a review of the qualitative literature on staff experiences of client challenging behaviour and to provide an overview of the quality of this qualitative research. It aimed to be systematic in approach by detailing the search methodology used, what inclusion or exclusion criteria were considered and what papers were retrieved and selected for discussion.

Within the different settings and client groups mentioned in the reviewed papers, staff have to contend with a multitude of demands, either directly from clients or indirectly, despite insufficient support being available. There was limited evidence for supportive mechanisms being in place, particularly relating to debriefing or supervision of staff. This appeared concerning to the researcher and highlighted that staff appeared to be solely reliant on themselves or informal support practices, rather than a systemic structure to enable them to manage the personal effect of these challenging situations.

Challenging behaviour was perceived to test role identity and professionalism to an extreme degree. The impact on staff of receiving challenging behaviour was at an emotional, psychological and physical level and appeared to have both immediate and possible long term consequences. The emotions reported (e.g. anger, anxiety, disgust) are stress related emotions, and having these emotions will affect how the staff responds. Perceived as well as actual vulnerability may increase emotional arousal in staff, but by reappraising the situation, the threat might be eliminated (Lazarus, 1993). Perhaps knowing this might help staff to

manage future situations. Losing control and feeling powerless was a key theme within the studies reviewed and the ability to regain a sense of control was in part due to coping styles. What process of coping adopted by staff to a psychological threat would depend on its significance to the individual and would have either a problem focused function or an emotion focused function (Lazarus, 1993). The evidence from some of the reviewed studies was that staff employed a variety of adaptive and possibly non adaptive cognitive and behavioural approaches to managing this psychological threat. Many staff sought social support from peers as a means of practical coping, which might suggest an internal locus of control. By receiving support, the emotional impact was lessened, which could result in a more positive outcome (Hastings & Brown, 2002), ultimately benefiting both staff and client.

In an attempt to possibly mitigate stress, reappraising the situation by distancing themselves from the clients or avoiding them were other reported means of coping with challenging behaviour. These strategies appeared to serve an emotion focused function whereby the relational meaning of what is happening is changed, whilst the actual conditions of the relationship remain the same (Folkman & Lazarus, 1988). Avoidant coping strategies also included 'wishful thinking'.

Weiner's (1986) model of helping behaviour suggests that if staff think that the client is unable to control his/her behaviour, staff are more likely to feel sympathetic and hence help the client. However, if staff believe that the client is able to control his/her behaviour, any challenging behaviour will be viewed as

intentional. This will result in staff having negative feelings (such as anger), resulting in not wanting to help the clients. There was certainly evidence of both types of staff attribution. Helping staff to increase their knowledge of a client's diagnosis or illness may change their attributions, which could reduce their emotional arousal.

Why some staff adopt certain strategies whilst others do not, may lie in differences in individual characteristics including considering how such things as their values and how they were raised influences their perception of aggression (Beaulieu, 2007). It may also relate to coping skills training or education. Being able to access a variety of coping skills could have the effect of increasing staff optimism, confidence and willingness to continue to engage with their clients.

Methodological limitations

Several methodological limitations within this report were found.

The identification of suitable studies to include in the current research was problematic. Evidence suggests that there are difficulties in searching for and identifying qualitative research studies as the process is inherently flawed (Dixon-Woods, Fitzpatrick & Roberts, 2001), and this was certainly experienced by the current researcher.

Assessing the robustness of the synthesis of data was also difficult. While a structured model for evaluating and critically appraising the studies was used by the researcher, this was subjective as it inevitably relied on the value

judgements of the researcher (Meyrick, 2006). It could be argued that this was perhaps further compounded by no independent validation occurring.

There are advantages to tabulating data, particular for ease of comparison. However, there are also disadvantages, particularly with the potential for loss of data context and detail and the implication that how the table was laid out might influence the reader's thought processes about possible associations between studies (Popay *et al.*, 2006). Despite successfully attempting to synthesise the data in this tabulated format, the studies were unavoidably reduced to their key characteristics, which might prove problematic for the reader when trying to draw their own conclusion about the data.

In terms of the robustness of the synthesis of data, it was difficult to draw an overall conclusion regarding the strength of each individual study and transferability potential in comparison to the others due to the limitations brought about by the methodological issues already discussed.

The current researcher also reflected that the critique related to the papers rather than necessarily the actual studies. Inevitably, the papers will be subject to limitations of the journal word counts. This might affect what has been reported in the actual paper, particularly if it is something lengthy like a detailed audit trail and hence could be the reason why some papers are missing useful or key pieces of information.

5. Clinical Implications and Recommendation for Future Research

Given that methodological flaws have been highlighted within the body of reviewed research, it is difficult to assess what the implications are in terms of transferability. However, the discussion has drawn attention to several important issues regarding coping strategies for care staff and effective support mechanisms. Rather than purely measuring the frequency of behaviours, ongoing research is needed to further explore staff actual experiences in these very challenging situations, which might prove useful for promoting better psychological and emotional wellbeing. Staff would benefit from further exploration of coping strategies, to enable them to better prepare for working in particular environments and to provide additional skills when actively working a role. Investigating how, if at all, staff experience different challenging behaviours might also enable support for them to be individually targeted. Further research into the importance of debriefing and supervision as support mechanisms for staff faced with challenging behaviour could be considered.

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APPENDIX A

Summary grid of papers reviewed: Process issues

APPENDIX A: Summary of reviewed papers: Process issues

Author (Year) & Country	Client group	Sample	Method of Data Collection	Method of Data Analysis	Coherent Epistemo - logical Position	Theoretical Perspective	Reflexivity (re: self as researcher & research as process)	Quality Issues	Transfer -ability
Hellzen <i>et al.</i> (2004) Sweden	LD	8 nurses U	I(N)	P&H approach (Ricoeur)	P&H	Affliction	Partial	C Q	B X
Jahoda <i>et al.</i> (2005) UK	LD	37 staff U	I	Grounded approach (Miles & Huberman); QCA	None	Staff beliefs, attributions, helping behaviour	None	T Q	A I
Lundström <i>et al.</i> (2007) Sweden	LD	44 care givers U	I(N)	QCA Nvivo software	None	Violence. Impact on staff.	None	C Q	B I
Raczka (2005) UK	LD	19 care staff U	Semi-structured focus group interviews	QCA	P	Stress	Yes	Q	B I
Whittington & Burns (2005) UK	LD	18 care staff U	I	Template analysis and respondent validation procedure	P	Stress and burnout.	Yes	Q	B X

APPENDIX A: Summary of reviewed papers: Process issues (cont...)

Author (Year) & Country	Client group	Sample	Method of Data Collection	Method of Data Analysis	Coherent Epistemo - logical Position	Theoretical Perspective	Reflexivity (re: self as researcher & research as process)	Quality Issues	Transfer -ability
Carlsson <i>et al.</i> (2004) Sweden	MH	12 nurses U	Written narratives and I	P Reflective lifeworld approach	P	Aggression. Fear.	Partial	C Q	A I
Cutcliffe (1999) UK	MH	6 nurses U	Semi- structured conversation	P&H	P	Violence. Aggression.	Yes	C Q	B X
Finnema <i>et al.</i> (1994) Netherlands	MH	24 nurses U	I	Constant comp. method. Some participant validation; expert panel	None	Aggression	None	C D E T Q	I
Hellzen <i>et al.</i> (1999) Sweden	MH	15 nurses U	I(N)	P&H approach (Ricoeur)	P&H	Risk and threat.	Yes	Q	B X
Higgins <i>et al.</i> (2009) R.O.I.	MH	27 nurses U	I(U)	Grounded theory	None	Sexual harassment. Coping.	None	C T	B X

APPENDIX A: Summary of reviewed papers: Process issues (cont...)

Author (Year) & Country	Client group	Sample	Method of Data Collection	Method of Data Analysis	Coherent Epistemo - logical Position	Theoretical Perspective	Reflexivity (re: self as researcher & research as process)	Quality Issues	Transfer -ability
Kindy <i>et al.</i> (2005) USA	MH	10 nurses R	I	P (Colaizzi)	P	Staff safety	'Bracketing'	Q	B X
Chambers (1998) UK	OA	5 nurses U	I	P (Colaizzi); respondent validation	P	Violence. Blame and acceptance.	Yes	E Q	B X
Miller (1997) USA	OA	27 nursing staff	I	Qualitatively analyzed (Miles & Huberman). QCA	None	Stress and burnout.	None	C Q S T	A I
Hantikainen (2001) Switzerland	OA	20 staff U	I(U)	P (Colaizzi)	P	Control and decision making.	Partial	None	B X
Isaksson <i>et al.</i> (2008) Sweden	OA	41 care givers U	I with vignette	QCA	None	Aggression	None	C T Q	B I

APPENDIX A: Summary of reviewed papers: Process issues (cont...)

Author (Year) & Country	Client group	Sample	Method of Data Collection	Method of Data Analysis	Coherent Epistemo - logical Position	Theoretical Perspective	Reflexivity (self as researcher & research as process)	Quality Issues	Transfer - ability
Isaksson <i>et al.</i> (2009) Sweden	OA	20 care givers U	I	QCA	None	Stress and burnout. Focus on females.	None	C T Q	A I
Sandvide <i>et al.</i> (2004) Sweden	OA	39 care providers U	I(N)	Qual. descriptive analysis; some respondent validation	None	Violence. Aggression. Abuse.	None	C E T Q	B X
Skovdahl <i>et al.</i> (2003) Sweden	OA	15 care givers U	I(N)	P&H approach (Ricoeur)	P&H	Aggression. Dementia.	Yes	Q	A
O'Sullivan <i>et al.</i> (1999) Australia	OTHR	9 physios U	I(SS)	A domain content analysis (Spradley)	None	Sexual harassment. Transference and counter- transference.	None	C T Q	A
Beaulieu (2007) UK	TBI	15 OTs U	I(SS)	Grounded theory	Multiple interpretation & meanings	Aggression. Brain injury.	Partial	E T	A

APPENDIX A: Summary of reviewed papers: Process issues

Key

<i>Client Group</i>	<i>Sample</i>	<i>Quality Issues</i>	<i>Transferability</i>
<p><i>MH - mental health</i></p> <p><i>LD – learning disabilities</i></p> <p><i>OA – older adults (with/without dementia) in residential care</i></p> <p><i>TBI – traumatic brain injury</i></p> <p><i>OTHR – non-specified client group</i></p>	<p><i>U = Ethnicity unreported</i></p>	<p><i>T = Lack of Transparency in presentation of analysis</i></p> <p><i>S= Does not appear to be systematic analysis of data (insufficient detail)</i></p> <p><i>D = Does not appear to be grounded in data</i></p> <p><i>E = Some data appears to have been excluded</i></p> <p><i>Q = Quotes not identified</i></p> <p><i>C = Credibility issues not addressed</i></p>	<p><i>X = Does not seem transferable to other settings</i></p> <p><i>I = Insufficient contextual detail to estimate transferability to another setting</i></p> <p><i>A = Transferability issues not explicitly addressed</i></p> <p><i>B = Transferability issues discussed</i></p>
<p><i>Epistemological Position & Methods of Data Analysis</i></p>	<p><i>P: Phenomenological H: Hermeneutic P&H: Phenomenological & Hermeneutic</i> <i>QCA: Qualitative Content Analysis</i></p>		
<p><i>Method of Data Collection</i></p>	<p><i>I: Interviews I(N): Narrative interviews I(SS) Semi-structured interviews I(U): Unstructured interviews</i></p>		

APPENDIX B

Summary grid of papers reviewed: Content issues

APPENDIX B: Reviewed papers: Summation of content

Author (Year)	Focus	Themes	Conclusions
Hellzen <i>et al.</i> (2004)	Nurse experiences of a provoking patient	<ol style="list-style-type: none"> 1. Being tormented 2. Being disrupted 3. Being helpless 	<ol style="list-style-type: none"> 1. More response to being spat on and to sexual invective 2. Frequent humiliations: deep symbolic meaning 3. Affliction perspective important: meaning of caring
Jahoda <i>et al.</i> (2005)	Staff perceptions of client aggression	<ol style="list-style-type: none"> 1. Emotional reactions 2. (Not) taking it personally 3. Negative perceptions of client 4. Professionalism, knowing client 	<ol style="list-style-type: none"> 1. Emotional arousal experienced. 2. Responses tempered in line with professionalism. 3. Interpersonal perceptions important
Lundström <i>et al.</i> (2007)	Caregivers experiences of client violence	<ol style="list-style-type: none"> 1. Multiple feelings 2. Need to keep it together 	<ol style="list-style-type: none"> 1. Feeling ground down, staff strive to maintain own and residents' dignity 2. Violence: strain on everyone
Raczka (2005)	Care staff – emotional responses to challenging behaviours	<ol style="list-style-type: none"> 1. Different behaviours experienced 2. Emotional responses 3. Future emotional well-being & stress 4. Wishful thinking 	<ol style="list-style-type: none"> 1. Stressors and emotional responses – stress? 2. Coping affects stress related outcomes 3. Wishful thinking - attempt to alter emotions. 4. Sources of stress – strategies needed
Whittington & Burns (2005)	Staff feelings about challenging behaviour	<ol style="list-style-type: none"> 1. Control vs. being respectful 2. Dealing with unpleasant feelings? 3. Difficulties understanding problem. 4. Understanding behaviour over time? 	<ol style="list-style-type: none"> 1. Integrative models of support helpful to staff 2. Coping strategies: getting to know client, protecting self, avoidance
Carlsson <i>et al.</i> (2004)	Caregivers fear: managing violence	<ol style="list-style-type: none"> 1. Inner dialogue vs. uncontrolled fear 2. True will vs. volatility 3. Adaptation vs. a forcing attitude 	<ol style="list-style-type: none"> 1. Violence: tension between presence and distance 2. Caregivers' ability and capacity to manager fear affects how encounter is viewed 3. Creatively managing threat of violence

APPENDIX B: Reviewed papers: Summation of content (cont...)

Author (Year)	Stated Aims	Themes	Conclusions
Cutcliffe (1999)	Nurses experiences of client violence	<ol style="list-style-type: none"> 1. Personal construct of violence 2. Feeling equipped 3. Feeling supported 	<ol style="list-style-type: none"> 1. Relationship between exposure to violence and ability to deal with incidents therapeutically. 2. Formal support systems for nurses influence this relationship.
Finnema <i>et al.</i> (1994)	Nursing perspective on client aggression	<ol style="list-style-type: none"> 1. Aggression - individual descriptors; positive & negative aspects 2. Intervention depends on nurse's perception, the rules, ward type. 3. Same interventions to prevent/stop aggression 	<ol style="list-style-type: none"> 1. Aggression: nurses used own descriptors 2. Majority of measures for aggression were non-restrictive.
Hellzen <i>et al.</i> (1999)	Carers' experiences of patient disturbing behaviour.	<ol style="list-style-type: none"> 1. Losing control 2. Inverted position of power 3. Being a victim 4. Carers own dark side (e.g. disgust) 	<ol style="list-style-type: none"> 1. Ethical perspective important when searching for meaning of caring for patients
Higgins <i>et al.</i> (2009)	Nurses' responses to clients sexualizing the nurse-client encounter	<ol style="list-style-type: none"> 1. Sexualizing the nurse-client encounter 2. Suppressive and protective strategies 	<ol style="list-style-type: none"> 1. Clients sometimes engaged in behaviour labelled 'sexualizing the nurse-client encounter'. 2. Nurses discourses: 'bad/mad' and 'inappropriate' 3. Discourses: limited alternative 'understanding'?
Kindy <i>et al.</i> (2005)	Nurses working in 'high risk of assault' environments	<ol style="list-style-type: none"> 1. Staff defences: personal, tangible 2. Violence: identifiable catalysts 3. Perplexing aftermath 4. Pervasive/invasive sequelae 	<ol style="list-style-type: none"> 1. Serious work-related hazards exist 2. Nurses and clients: Intervention/improvement of conditions needed

APPENDIX B: Reviewed papers: Summation of content (cont...)

Author (Year)	Stated Aims	Themes	Conclusions
Chambers (1998)	Patient violence: nurses knowledge	<ol style="list-style-type: none"> 1. Professional competence 2. Identity – reflection and nurturing 3. Strategies for survival 4. Loss 5. Powerlessness and oppression 	<ol style="list-style-type: none"> 1. Violence: a profound effect on nurses 2. Some tensions persist in nursing, resulting in negative feelings
Miller (1997)	Nursing staff experiences of patient aggression	<ol style="list-style-type: none"> 1. Need to work through aggression 2. Demands exceed abilities of staff 3. Dealing with it 4. Priority: personal safety 5. Losing it 	<ol style="list-style-type: none"> 1. Most aggression during personal care. 2. Staff unprepared to manage patient complex needs: few alternatives to manage aggression.
Hantikainen (2001)	Restraint use: staff perceptions	<ol style="list-style-type: none"> 1. Behaviour - needing to be controlled 2. Behaviour - learn to live with: adequacy of behaviour, coping ability of patient, avoiding judgemental attitudes 	<ol style="list-style-type: none"> 1. Perceptions of behaviour crucially important in decision to use restraint 2. Importance of staff understanding their perceptions and the effects of these on thinking and actions. 3. Primary source of change: staff themselves.
Isaksson <i>et al.</i> (2008)	Client violence: female caregivers perceptions	<ol style="list-style-type: none"> 1. Violence: in the eye of the beholder 2. Challenging: staff way of relating to being physically hurt 3. Intentional: deliberate 4. Excusable: in spite of being serious 5. Part of their work 6. Relative to own experience and attitudes 	<ol style="list-style-type: none"> 1. Being subjective - risk that violent incidents will be under/over reported 2. Importance of well-defined definition of violence 3. Caregivers: individual structured/adjusted support needed

APPENDIX B: Reviewed papers: Summation of content (cont...)

Author (Year)	Stated Aims	Themes	Conclusions
Isaksson <i>et al.</i> (2009)	Client violence: female caregivers' experiences	1. Being on guard, being disgusted 2. Losing control 3. Striving for control: searching for excuses and for support	1. Caregivers may distance themselves from residents 2. Quality of care: 'doing to' rather than 'being with' 3. Violence normalised as part of the job, persists. 4. Importance of support for caregivers to gain control.
Sandvide <i>et al.</i> (2004)	Care providers accounts of violent events	1. Misunderstanding each other 2. Invasion of personal space 3. Work: acceptance of violence	1. Process of violence in narratives 2. Mutual misunderstanding: antecedent to violent events? 3. Invasion of personal space reveals is key 4. Staff acceptance of violence: a natural consequence
Skovdahl <i>et al.</i> (2003)	Aggressive behaviour: caregivers' reflections and attitudes	1. Balance between demands and competence needed 2. Support needed	1) Development of positive relationships: balance needed 2) Coping: different types of support crucial 3) Understanding 'meaning' with implementing necessary care skills - curb distressing behaviour?
O'Sullivan <i>et al.</i> (1999)	Client inappropriate sexualised behaviour: physiotherapists' perceptions	1. Unexpected nature/effects on staff deemed worst 2. Differing opinions of behaviour as sexual harassment; differing staff responses 3. Psychological effects	1. Inappropriate sexual behaviour towards physios widespread (low rate). 2. Behaviours ignored due to own feelings of discomfort. 3. Role of transference/counter-transference in understanding behaviour.
Beaulieu (2007)	OTs perception of aggression with adults post brain injury	1. Hierarchy of physical, verbal, gestural 2. Personal influences on perception 3. Managing aggression: knowing client, coping strategies	1. Increased awareness needed of problems associated with aggression. 2. Some triggers to aggression identified. 3. Important to establish strategies to reduce perceived threat

APPENDIX C

Author guidelines for target journal

Qualitative Research in Psychology

Instructions for Authors

Qualitative Research in Psychology aims to become the primary forum for qualitative researchers in all areas of psychology—cognitive, social, developmental, educational, clinical, health, and forensic—as well as for those conducting psychologically relevant qualitative research in other disciplines.

Qualitative Research in Psychology will publish empirical papers that report psychological research using qualitative methods and techniques, those that illustrate qualitative methodology in an exemplary manner, or that use a qualitative approach in unusual or innovative ways

All papers are refereed by, and must be to the satisfaction of, at least two authorities in the topic. All material submitted for publication is assumed to be exclusively for *Qualitative Research in Psychology*, and not to have been submitted for publication elsewhere. Priority and time of publication are decided by the editors, who maintain the customary right to edit material accepted for publication if necessary.

Submission of Manuscripts

Manuscripts should be submitted via the web at <http://mc.manuscriptcentral.com/ugrp>. All components of your paper (including tables and figures) should be contained within a single document (preferably in Word but files can be accepted from any of the common Macintosh, Windows, or MS-DOS word processing programs). Please send two versions of your paper, blinding one version for peer review purposes (i.e., author names and affiliations removed). The editorial office accepts papers in either UK or U.S. page size formats.

Manuscripts should be double-spaced throughout, especially the references. Pages should be numbered in order. The following items must be provided in the order given:

1) Title Page. Authors and affiliations: Authors should include their full name and the establishment where the work was carried out (if the author has left this establishment his/her present address should be given as a footnote). For papers with several contributors, the order of authorship should be made clear and the corresponding author (to whom proofs and offprints will be sent) named with their telephone/fax/e-mail contact information listed.

Abstract: Please provide an abstract of approximately 150 words. This should be readable without reference to the article and should indicate the scope of the contribution, including the main conclusions and essential original content.

Keywords: Please provide at least 5-10 key words.

About the author: Please provide a brief biography to appear at the end of your paper.

2) Text. Subheadings should appear on separate lines. The use of more than three levels of heading should be avoided. Format as follows:

1 Heading

1.1 Subheading

1.1.1 Subsubheading

3) References. The Harvard style of references should be used. The reference is referred to in the text by the author and date (Smith, 1997) and then listed in alphabetical order at the end of the article applying the following style:

For a book: Hollway, W. and Jefferson, T. 2000: *Doing qualitative research differently: free association, narrative and the interview method*. London: Sage.

For an edited book: Brown, L.M. 2001: Adolescent girls, class, and the cultures of femininity. In Packer, M.J. and Tappan, M.B., editors, *Cultural and critical perspectives on human development*. Albany, NY: SUNY Press.

For a journal article: Madill, A., Jordan, A. and Shirley, C. 2000: Objectivity and reliability in qualitative analysis: realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology* 91, 1–20.

4) Acknowledgements. Authors should acknowledge any financial or practical assistance.

5) Tables. These should be provided on a separate page at the end of the paper and be numbered in sequence. Each table should have a title stating concisely the nature of information given. Units should be in brackets at the head of columns. The same information should not be included in both tables and figures.

6) Figure captions. These should be provided together on a page following the tables.

7) Figures. Figures should ideally be sized to reproduce at the same size. All figures should be numbered consecutively in the order in which they are referred to in the text. Qualifications (A), (B), etc. can only be used when the separate illustrations can be grouped together with one caption. Please provide figures at the end of your paper on a separate page for each figure. Once accepted you will be required to provide a best quality electronic file for each figure, preferably in either TIFF or EPS format.

Illustrations

Illustrations submitted (line drawings, halftones, photos, photomicrographs, etc.) should be clean originals or digital files. Digital files are recommended for highest quality reproduction and should follow these guidelines:

- 300 dpi or higher
- sized to fit on journal page
- EPS, TIFF, or PSD format only
- submitted as separate files, not embedded in text files

Colour illustrations will be considered for publication; however, the author will be required to bear the full cost involved in their

printing and publication. The charge for the first page with colour is \$900.00. The next three pages with colour are \$450.00 each. A custom quote will be provided for colour art totalling more than 4 journal pages. Good-quality colour prints or files should be provided in their final size. The publisher has the right to refuse publication of colour prints deemed unacceptable.

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Part Two: The Research Report

Working with Patients with an Acquired Brain Injury: Staff Experiences of
Inappropriate Sexualised Behaviour

Abstract

Objectives: To explore staff experiences of sexualised behaviour from patients with an acquired brain injury.

Method: The data from ten semi-structured interviews and a diary from one participant was analysed using Interpretative Phenomenological Analysis (Smith, 1996).

Results: Three key themes, with ten subordinate themes, emerged: Psychological Responses (emotional responses to unpleasant feelings, powerlessness, making sure you're safe, self blaming); The Continuing Ability To Cope (importance of talk, psychological defences, acclimatisation and acceptance); Evolving Relationships (knowing versus not knowing the client, importance of supportive relationships, the difficulty with outsiders).

Conclusions: The results suggest that sexualised behaviour directed towards staff affects their emotional and psychological wellbeing. Participants identified multiple coping strategies to help them but specifically highlighted the importance of shared experience and shared understanding within the work support system. The clinical implications, such as enabling appropriate support systems within the work environment, include prioritising the psychological wellbeing of staff in clinical settings.

1. Introduction

1.1 Background Information

Head injury is a serious problem not only for those physically affected by it but also on supporting services, with NHS providers in England reporting (for the year 2007/08) 171,754 'injuries to the head', of which 91% gained admission to NHS hospitals (NHS, 2008). Individuals with an acquired brain injury (ABI) may experience a plethora of issues: problems with communication, cognition, sensory processing, mental health issues and challenging behaviour, sexually inappropriate behaviour being just one example. There appears to be a paucity of research specific to sexualised behaviour within an ABI client group, with its impact on staff receiving relatively minimal attention.

Care staff experience different kinds of patient challenging behaviour but perhaps the more emotive to cope with are 'sexually' related behaviours. Some research suggests that sexual invective behaviour rather than other challenging behaviour, results in more psychological and emotional responses and feelings of helplessness in staff (Hellzen, Asplund, Sandman & Norberg, 2004).

Additionally, when patients engage in 'sexualised' behaviour, staff might label these behaviours as 'inappropriate' and by doing so, alternative understandings of the behaviour are limited and not necessarily explored (Higgins, Barker & Begley, 2009).

Addressing sexuality issues with patients in whatever form (be it discussing sexual matters with patients or having to manage a sexually inappropriate

behaviour) can have a disabling effect on staff, possibly resulting in staff disgust, embarrassment and low morale, leading to a less than conducive environment. Consequently, they may act either passively or aggressively: neither of which may be in the best interest of the patient. For some, the discussion of sexuality issues is a cultural taboo (Ducharme, 1994). Staff might experience embarrassment and anxiety when managing patient sexualised behaviour, with their reactions being influenced, amongst other factors, by their social and cultural background. The importance of knowing how staff socially construe 'sexuality' has been highlighted (Nagaratnam & Gayagay, 2002). As staff values and beliefs might represent potential barriers and affect the support offered (Christian, Stinson & Dotson, 2001), gaining a better insight into them could be beneficial.

Inconsistencies in definitions of inappropriate sexualised behaviour and both under and over reporting may affect our understanding of the prevalence of inappropriate sexualised behaviour (Johnson, Knight & Alderman, 2006).

Bezeau, Bogod and Mateer (2004) claim that seventy percent of staff working within rehabilitation services report that 'sexual touching was a common problem' and that twenty percent of these professionals reported commonality of 'sexual force' by patients.

Of concern in brain injury rehabilitation is how staff can be supported in managing their own wellbeing whilst ensuring the patients' needs are met. Some evidence suggests that reluctance from staff to deal with issues surrounding sexuality (e.g. dealing with a patient sexualised behaviour or

talking about sexual issues with patients) might hamper a patient's rehabilitation process (Ponsford, 2003). Although Ponsford (2003) suggests that an 'openness' is required between patients and staff, a difficulty in achieving this is the probable inability to alter or affect a staff member's value system.

The psychological health and emotional wellbeing of staff involved with acquired brain injured patients who display sexually inappropriate behaviour is deserving of greater attention. Inappropriate sexualised behaviour amongst this client group is a relatively neglected area within the literature (Johnson *et al.*, 2006). The rehabilitation of individual patients can be vastly compromised by the patient's behaviour but this, in turn, may be compromised by the attitudes of the staff (Benson Yody *et al.*, 2000). Whilst Malec (1996) pointed out that it is natural that people will have differing views based on their own values, research exploring how staff make sense of the meanings of these events and experiences is virtually non-existent. Being better informed about the individual experiences of staff might serve to not only provide us with clearer descriptions of these phenomena and aid in future service provision but consequently indirectly impact the speed at which patients with a brain injury recover.

1.2 Research Aim

The key research aim of the current study was to explore qualitatively staff subjective accounts of how they experience sexualised behaviour from patients with an acquired brain injury.

2. Methodology

2.1 Research Design

A qualitative methodology is more suited to research when the focus is concerned with the exploration of personal experiences of individuals and the way in which meaning arises in these experiences (Willig, 2008). Whilst Grounded Theory (Glaser & Strauss, 1967) was considered it was viewed as being more directed towards social processes and practices, with the systematic generation of a theory rather than individual meaning and experiences. The paucity of research in the area of staff experiences of inappropriate sexualised behaviour indicated that a method concerned with novelty, complexity and process would be advantageous, therefore allowing for a full exploration of experiences of patient sexualised behaviour from a staff perspective.

With a focus on subjective experiences and descriptions of events, Interpretative Phenomenological Analysis - IPA (Smith, Jarman & Osborn, 1999), with roots in phenomenology and symbolic interactionism, was selected as the most appropriate qualitative methodology to explore staff experiences. IPA was viewed as a highly accessible qualitative methodology (Brocki & Wearden, 2006) and this appealed to the researcher.

Not only has IPA been used in clinical and social psychology, it has been used widely by researchers in health psychology (e.g., Ablett & Jones, 2007; Hunt & Smith, 2004; Thompson, Powis & Carradice, 2008; Whittington & Burns, 2005). It is also viewed as a qualitative methodology of choice in healthcare

research (Biggerstaff & Thompson, 2008), is apt for researching in unexplored territory (Reid, Flowers & Larkin, 2005) and is seen as particularly well suited to making sense of individual experiences of phenomena (Brocki & Wearden, 2006).

With its focus on exploring in detail how individuals actively engage and make sense of their world (Smith and Dunworth, 2003), IPA is particularly suited to the current research aim of exploring what individual experiences of patient sexualised behaviour mean to the participants. It is flexible and inductive in approach, grounded in the expressed words of the participants, allowing them to tell their own story about their experiences, in their own words. It encourages a self-conscious approach to research, by both the participant and the researcher and through joint exploration, can uncover concealed meanings embedded in the participants' narrative (Smith, 2003), moving beyond the text to a more interpretative and psychological level (Smith, 2004).

It is exploratory and views the researcher as the data collection instrument (Sorrell & Redmond, 1995); recognising the researcher as one who, whilst maintaining a focus on the participant's subjective account, interprets the participants' views or understanding of experience and therefore co-constructs the subject. A dual interpretation process or double hermeneutic underpins this process: "the participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world" (Smith & Osborn, 2003, p51).

The researcher believed that IPA was the most suitable method with which to address the aim of the current research of exploring, in detail, staff subjective accounts of how they experience and make sense and meaning of inappropriate sexualised behaviour from patients with an acquired brain injury.

2.2 Epistemological Stance

Qualitative research is accordant with a number of epistemological positions on a realist/constructionist continuum (Madill, Jordan & Shirley, 2000). In determining her epistemological stance, the researcher considered the three questions posed by Willig (2008): what kinds of knowledge does the methodology aim to produce; what kinds of assumptions does the methodology make about the world; how does the methodology conceptualise the role of the researcher in the research process?

The researcher was most closely aligned to a social constructivist position, giving consideration to relativist ontology, a subjective and transactional epistemology and a hermeneutical methodology (Willig, 2001). The inquiry aim of constructivism is understanding and reconstruction of individual constructions. It aims to give voice to the participant as a facilitator of reconstruction.

Additionally, the researcher believed that the research interviews were a dynamic process, transactional in nature, in which she took an active role in constructing meaning with the participant, with knowledge being created within the interaction of the interview. By adopting a reflexive and hermeneutic position, she accepted an inherent subjectivity to interpretation. By having

awareness of her own past (e.g., as a manager, as an assistant psychologist) and integrating this awareness within her own present (e.g., as a trainee clinical psychologist, as a researcher, as a visitor/stranger), the researcher recognised the importance of acknowledging rather than hiding interpretation biases (Finlay, 2006). Her beliefs were necessary for making sense of the experiences of the participants' stories and that the data produced by the interviews would have been socially co-constructed between the researcher and the participant. The researcher believed that the participants would be able to recall and reconstruct their experiences of patient directed sexualised behaviour within the interview. The researcher appreciated that how these experiences were perceived and then shared by the participant would depend partly upon the participants' own views, feelings, opinions and expectations. How they chose to represent this knowledge during the interview was their own choice.

2.3 Use of Interviews and Diaries

Interviewing is viewed as 'one of the most common and powerful ways in which we try to understand our fellow humans' (Fontana & Frey, 2000, p645) and it is asserted that they give voice to individuals, enabling them to express themselves in their own words (Kvale & Brinkmann, 2009). As a method of collecting qualitative data, interviews are viewed as 'highly attractive' (Lewis-Beck, Bryman & Liao, 2003).

Consideration was given to alternative methods of capturing participants' experiences in depth, such as the use of focus groups, reviewing clinical case notes or incident forms, and naturalistic observations. Focus groups can be dominated by a few participants. Additionally, other participants might feel a

degree of peer pressure to respond in similar ways, feel uneasy disagreeing with the dominant view or have difficulties expressing their opinions (Madriz, 2003). In addition to consent and confidentiality issues, reviewing clinical case notes or incident forms are limited to the space available to write details of an incident, might be constrained by the time pressures of the job and would unlikely incorporate the meaning the experience holds for the individual. Ethical issues of consent and confidentiality are also an issue with naturalistic observations, which might not be appropriate with the given client group. Furthermore, although one might spend a lot of time on a ward, inappropriate sexualised behaviour might not necessarily be observed, for example, in instances when it occurs during personal care.

Semi-structured interviews were the main data collection route as these are not only the chosen method for much qualitative data collection (Reid, Flowers and Larkin, 2005; Willig, 2008) but are arguably considered the exemplar data collection method in IPA (Smith & Osborn, 2003). IPA studies predominantly employ semi-structured interviews to collect data and remain the method of choice for IPA researchers (Langridge, 2007).

The semi-structured interview is relatively non-directive, permits a greater flexibility of coverage and the opportunity to explore novel areas and they provide a space for the generation of meanings (Smith, 2003). One-to-one interviews allow participants to think, speak and be heard (Reid, Flowers & Larkin, 2005). A goal in interviewing is 'understanding' (Fontana & Frey, 2000). With the researcher and participant being face-to-face in the interview, it

is not only essential but possible for this understanding to be facilitated by the development of both rapport and empathy. It also provides an opportunity for the researcher to follow up, in situ, interesting and important issues (Smith, 2004).

Additionally, an important factor in face-to-face interviewing is the opportunity for both the researcher's and the participants' reading of each others' nonverbal behaviour of cueing from, for example, personal characteristics such as gender (Fontana & Frey, 2000). Interviewing provides the opportunity for the researcher to check the participants' interpretations of questions and allowed for the monitoring of the participants' wellbeing when possible sensitive issues were discussed. It is argued that semi-structured interviews tend to produce richer data (Smith, 1995).

The interview process aims to develop a conversational relationship between the participant and the researcher and to reach a negotiated understanding of the essence – the experience itself, resulting in rich descriptions of participants' experiences being generated (Van Manen, 1990). The current researcher acknowledged certain limitations with interviewing as an approach for capturing these types of experiences. For instance, when responding to questions within the interview, participants might be adjusting to the particular demands of the situation and respond accordingly, for example, by justifying their position (Smith *et al.*, 1999). In addition, it is inevitable that a balance of power exists within the relationship between researcher and participant. To some degree, the participant might feel threatened by the researcher's role, and

this might impact on how they respond to the questions posed (Hale, Treharne & Kitas, 2007). Additionally, it is argued that contextual features of the interview are not always attended to (Potter & Hepburn, 2005). For example, what understanding does the participant have of what the interview will be used for and what is their understanding of their role in the interview.

However, IPA is committed to the detailed exploration of personal experience and face-to-face interviewing with a participant is clearly compatible with this commitment (Smith, 2004; Willig, 2008). Interviewing was therefore viewed as an appropriate and acceptable method for addressing the research question.

Diaries were also utilised as a supplementary data collection method, allowing for the 'immediacy of the experience to be captured' (Cassell & Symon, 2004), providing an alternative rich source of data (Alaszewski, 2006).

2.4 Researcher's Statement of Perspective

A researcher's statement of perspective is deemed useful to help the reader interpret and understand the analysis (Elliott, Fischer & Rennie, 1999).

At the start of the research process, the researcher had not worked clinically with individuals with acquired brain injury or with individuals who displayed sexualised behaviour within the clinical setting. However, having acquaintances who experienced this behaviour from patients with ABI and listening to how they spoke about these experiences ignited her interest in this area.

Additionally, in the data analysis phase, the researcher started working in an in-patient setting with older adults with dementia, some of whom displayed

inappropriate sexualised behaviour. The researcher provided support to members of the staff team and was herself on the receiving end of some 'low level' inappropriate sexualised behaviour during this time (e.g., patients saying 'I love you' and 'give us a kiss').

At the start of the current research, the current researcher held the view that being on the receiving end of unexpected sexualised behaviour would be distressing for those involved, requiring systemic support. She held the view that the participants in the research would be able to construct and share accounts of their experiences, that these accounts would have some meaning for them and represent a manifestation of their psychological world. Construction of accounts inevitably relies on the individuals' ability to articulate a meaningful interpretation of their experiences, as well as identify and label emotions and feelings and on the researcher's ability to interpret the participants' interpretations. The researcher believed that the interview process provided a conduit to enable participants to express themselves.

2.5 Participants

2.5.1 Recruitment of Participants

Employees working within the multi-disciplinary team of a National Brain Injury Centre were invited to take part in the current study. As the research was exploring a specific experience (i.e. client sexualised behaviour directed towards staff), a homogeneous sample of clinical staff working within this Centre was targeted and recruited. The stages of recruitment were as follows:

- a. Participants were initially alerted to the research via posters and information leaflets (Appendices A and B) displayed in common staff areas.
- b. An email detailing the research was sent out by the field supervisor to all staff within the Centre asking for consent to be approached.
- c. An overview of the research was given by the field supervisor at team meetings within the Centre.
- d. The field supervisor was contacted either verbally or via email by staff expressing an interest. These details were then passed to the researcher via email.
- e. On receipt of this consent to be approached, participants were contacted by the researcher via email to discuss the research in more detail. At this point, if consent via email was given, a date and time was set for the interview.

Although Smith and Osborn (2003) comment that studies using IPA should be conducted using small sample sizes of between 5 and 6 for student research, the preferred number as outlined by the University of Leicester (DClin Coursework Guidelines and Assessment Regulations Handbook, 2007) was between ten and twelve participants for a thesis.

2.5.2 Inclusion and Exclusion Criteria

Only those ward staff members who had experience of and were in regular and direct contact with patients who exhibited sexualised behaviour were recruited.

Due to timescale and cost restraints, only the first eleven volunteers were

invited to take part. However, only eleven participants volunteered, resulting in no participants being excluded.

2.5.3 Participant Information

Eleven participants were recruited for the current study; all but two being female (see Table 1 below). The majority of participants were unqualified members of the team (e.g. rehabilitation assistants and health care assistants), with four qualified non-nursing professionals also taking part. Specific professional details pertaining to qualified staff have been omitted to minimise potential for identification. All participants were white British, most of whom were below 30 years of age.

Table 1: Demographics of Participants

Gender	Number of participants
Female	9
Male	2

Age Range	Number of participants
20 – 29	7
30 - 39	2
40+	2

2.6 Measures

2.6.1 Development of the Interview Schedule

In reviewing the literature on both staff experiences of challenging behaviour and interviewing as a method, as well as in discussion with peers with experience of working within ABI, broad themes were incorporated into a draft

interview schedule by the researcher. An initial pilot interview was conducted with a fellow trainee to help further construct the interview schedule. The pilot interview aimed to ensure that the structure of the schedule was sufficiently flexible to ensure scope for the interviewee to make sense of their experience of sexualised behaviour and the meaning that this experience held for them, without being constrained by the schedule.

2.6.2 Development of the Diary

The outcome of the pilot interview helped to provide direction for the diary entries, as some limited structure to the diary has been viewed as helpful (Corti, 1993). This guidance was in the form of open-ended questions (Appendix C). The intention was not for these questions to dictate what should be recorded, but to enable the participants to focus and reflect on incidents that had occurred and allow them to provide, where possible, insight into their individual experience.

2.7 Procedure

2.7.1 Ethical Approval and Considerations

Ethical approval was granted by the University of Leicester Research and Development board and by Leicestershire, Rutland and Northamptonshire NHS Ethics Committee 2 (Appendix D).

Participant anonymity was maintained by allocating each participant a code (*pA*, *pB*, *pC* etc.), subsequently used to refer to them throughout the Research Report. Confidentiality was maintained by ensuring that only the current

researcher was aware of participants' names and that all interviews were held in private. All participants signed a consent form (Appendix E) and were debriefed after the interview.

No patient names were voiced by participants in any of the interviews. All participants used pronouns when referring to patients. If specific wards or units were named, these were replaced by 'x' when the interview was transcribed by the researcher.

2.7.2 The Interviews

Scheduled dates and times of interviews were at the participants' convenience and all took place in a private but not isolated quiet office, away from the main wards. The researcher conducted all interviews. Duration of interviews ranged from 32 minutes to 58 minutes. Before the interview commenced, the researcher reminded the interviewee about the purpose of the research and gained signed consent. The interview schedule incorporated a series of questions and prompts and was used as a guide to enable joint exploration of the subject and encourage participants to describe their experiences (Appendix F). The researcher held in mind the importance of establishing and maintaining rapport during the interview, with the first few questions of the interview schedule designed to enable participants to feel comfortable in talking. The schedule was used with consistency but flexibly, maintaining a conversational style with the participants' talk and for meaning to emerge inter-subjectively between participant and researcher (Kvale & Brinkmann, 2009).

2.7.3 Data Analysis

All interviews were audio tape recorded and subsequently transcribed verbatim by the researcher using a transcribing software package, incorporating questions asked, interruptions, slight pauses and laughter.

2.7.4 Coding

Qualitative research involves an interpretive, naturalistic approach to the world and stresses the socially constructed nature of reality. It attempts to make sense of or interpret phenomena in terms of the meanings people bring to their experiences (Denzin & Lincoln, 2003). Combining IPA with semi-structured interviews allowed for detailed in-depth exploration of these phenomena and the opportunity to illuminate and enrich understanding of individual experience.

The researcher personally transcribed verbatim each of the interviews in order to engage in an interpretative relationship with and hence become closer to the data. Following IPA guidelines outlined by Smith & Osborn, (2003), analysis was split into several stages as described below.

The analysis was idiographic in approach, starting with the reading and detailed examination of the first transcript to familiarise the researcher with the participant and the interview. Once read, the researcher re-examined the transcript for a second time looking for anything of interest or significance.

Working through the transcript, the researcher noted any similarities or differences with earlier parts of the transcript, as well as strengthening or repetition of previous comments or contradictions. What was commented upon

was not prescriptive and the aim was not to look at frequency of comments but on the content and complexity of meanings. In addition, when struck by the language used by the participant or if a specific sense of the participant emerged, this was also noted. The researcher annotated these initial thoughts in the left hand column of the transcript as shown below in Table 2.

On completion, the transcript was read again, and whilst taking into account previously noted points, the researcher attempted to capture and document the essence of the text into emerging theme titles. The researcher annotated these in the right hand column of the transcript, as illustrated in Table 2 below.

Table 2: Example of Initial Coding

Initial comments/thoughts	Interview Extract: A: 31, 762-769	Initial themes
Problem is real for the clients A lot of them lack insight Different reasons for behaviour – impulsive or immediate attention? Real problem for them Understanding risk – at a team level?	“For these guys cos it’s a very real problem, which a lot of them don’t have any insight into, a lot of them who knows how some of them, we don’t know it if it’s impulsive or if it is just, you know for that immediate attention on the ward, erm it doesn’t again, it doesn’t sort of interact because it’s a very real problem with these guys and that’s part of the reason why they are here and we understand that risk”	Defending client Multiple explanations for behaviour Acceptable risk

Using the information from the right hand column, emergent themes were then listed chronologically in a table. The researcher looked for relationships between the themes, clustering into groups where appropriate. Clustered themes were then checked and validated against actual text from the transcript. In addition, all themes were transferred into a separate document, incorporating supporting participant quotes. Each cluster of themes represented a superordinate theme and was subsequently named by the researcher.

The list of clustered themes was used as a template to guide the analysis of the second and subsequent transcripts. Holding in mind the initial themes during analysis of subsequent transcripts, the researcher remained vigilant to variation or discrepancies that occurred. The analysis was iterative, with the researcher revisiting previous transcripts in light of new themes and only moving on to subsequent transcripts once a level of closure had been achieved.

During this process, an element of renaming superordinate themes occurred as new data affected the theme. However, once all transcripts were analysed, a final set of superordinate themes was established. An example of the audit trail and how a selection of transcript text and initial emerging themes contributed to a superordinate theme is summarised and illustrated in Table 3 below.

Table 3: Audit Trail: Examples of transcript text, initial comments, initial theme, subordinate and superordinate theme assigned to them*

Text	Margin code	Initial Emergent Theme	Subordinate Theme	Superordinate Theme
“even though I know, even though it’s not nice...I sort of think...it’s about-it’s not pleasant, it’s definitely not pleasant”	Incident not nice, unsure of how to respond – laugh it off	Uncertainty of response	Emotional response to unpleasant feelings	Psychological Responses
“I was very upset, like I felt very distressed about that and, you know, quite disgusted about it and, and not happy”	Mixture of emotions – distress, shock, disgust, upset, not happy	Strong emotional feelings		
“I don’t want it to happen again, what if he does it again, I-you know I don’t <u>feel</u> , <u>safe</u> , you know...that’s what he does, I remember just kind of repeatedly saying that”	Not wanting it to happen again - not feeling in control	Not being in control	Powerlessness	
“he came up behind, and put his hands round onto the chair and touched my breasts and sort of got hold of them, had hold of me and I couldn’t really get out”	Not being able to get out – feeling trapped	Feeling trapped		

* N.B. This table is not a comprehensive summary of the data contributing to the theme, but shows some examples of data at each level of analysis

Table 3 (cont...): Audit Trail: Examples of transcript text, initial comments, initial theme, subordinate and superordinate theme assigned to them*

Text	Margin code	Initial Emergent Theme	Subordinate Theme	Superordinate Theme
"...trying to just make sure you're in a safe, you know, you can move away and make sure you're in a safe sort of environment"	Needing to be safe – need to move away – safe environment	Needing to be in a safe environment	Making sure you're safe	Psychological Responses
"...make sure I was protected as much as I could...as in staying the right distance away so I wasn't automatically grabbed or sworn at..."	Need to be protected – need to move away – protecting self	Protecting self - need to move away		
"you do start to do things without thinking and you do put yourself in vulnerable positions because you just don't , you just think oh that's fine...it becomes too much of a habit, you don't stop and think...you automatically assume that you know"	Do things without thinking – becomes a habit	Putting yourself into a vulnerable position	Self blaming	
"it sort of made me realise that it's silly to let it become lax anyway cos you're putting yourself and others at risk, it's not even just yourself, you put other people at risk as well"	Silly to be lax – putting yourself and others at risk	Becoming a bit lax		

* N.B. This table is not a comprehensive summary of the data contributing to the theme, but shows some examples of data at each level of analysis

Diary

One additional participant, who was not interviewed, held a diary for a period of four weeks resulting in eight entries, the contents of which were typed into a transcript format. The analysis process for the diary was identical to the interviews.

2.7.5 Memo Writing

The outcome of interviewing should encapsulate more than just what is spoken and should take into account the dynamics of the situation (Kvale & Brinkman, 2009). For the interview process, Finlay (2006) highlighted the need to attend to matters relating to embodiment: bodily empathy, embodied self awareness and embodied inter-subjectivity. On completion of each interview, the researcher noted in her research diary her immediate thoughts using these three aspects of embodiment as pointers for reflection.

2.7.6 Methodological Rigour

Although a common standard of excellence for qualitative methods might not be attainable (Reicher, 2000), guidelines produced by Elliott *et al.* (1999) were used as a framework for establishing methodological rigour for the current research. Several aspects were considered: owning one's perspective, situating the sample, grounding in examples, providing credibility checks and coherence, accomplishing general vs. specific research tasks and resonating with readers.

Throughout the research process, the researcher annotated in a research diary reflections, issues, questions and solutions, enabling her opportunity to

continually evolve with the process. Viewed as a useful strategy to highlight potential contra explanations, the researcher was part of a qualitative peer support group, enabling discussion of coding and checking of and validating process issues (Barbour, 2001). Credibility of coding was also checked by discussion of two coded transcripts between the researcher and her academic supervisor.

After each interview, memos were written to capture immediate thoughts and reflect on the essence of the relationship between the researcher and the participant. These memos were used as an additional reference during data analysis (see Appendix G for examples of memo reflections).

3. Analysis

3.1 Results

The researcher identified three major themes and ten subordinate themes within the participants' narratives on their experiences of sexualised behaviour of their patient group. The identified themes were not necessarily the most prevalent or mutually exclusive but were considered to be the most striking within the transcripts (see Table 4 below). Each major theme is illuminated upon and illustrated through the use of direct participant quotes¹, with the researcher's interpretation interspersed throughout. The descriptive accounts are subsequently followed by a discussion of the overall findings, where the shared narrative is pieced together to form a coherent and meaningful account of the participants' experiences of patient sexualised behaviour.

¹ Participants' quotes are in the format of participant identifier, page number and line numbers. For example, pA: 22, 202-210 relate to participant A, page 22, lines 202-210. Each quote begins with either the researcher's question or last statement that the response stemmed from. The researcher's questions, prompts or interjections are in capital letters. Any interjection by either the researcher or the interviewee, whilst the other person is talking that does not interrupt their flow of talk, is captured within brackets, e.g., [yeah]. Text omitted from a quote is denoted by ... and any word particularly emphasised by the participant has been underlined. All quotes are *italicised* for easier recognition.

Table 4: Summary of Superordinate and Subordinate Themes

<p>1. Psychological responses</p> <ul style="list-style-type: none">➤ Emotional responses to unpleasant feelings➤ Powerlessness➤ Making sure you're safe➤ Self blaming
<p>2. The continuing ability to cope</p> <ul style="list-style-type: none">➤ Importance of 'talk'➤ Psychological defences➤ Acclimatisation and Acceptance
<p>3. Evolving relationships</p> <ul style="list-style-type: none">➤ The patient: Knowing versus not knowing the patient➤ The colleague: Importance of supportive relationships➤ Family and friends: The difficulty with outsiders

In their accounts, participants used a selection of terms to describe the people with whom they worked. These terms were used interchangeably and included client, patient and service user. As these were individuals who were in a hospital environment and being treated for various disorders associated with brain injury, with the exception of the actual quotes provided below and for purposes of continuity, the researcher refers to the person as 'patient'.

3.1.1 Theme 1: Psychological responses

A theme that consistently emerged throughout the data was that of participants' internal and external psychological responses to the behaviour. When participants were on the receiving end of sexualised behaviour, they immediately experienced a plethora of emotions and unpleasant feelings. It was not uncommon for them to be in a state of shock:

*FOR THAT SPECIFIC EXAMPLE [yeah] OF BEING
INAPPROPRIATELY TOUCHED, WHAT WAS YOUR
INITIAL REACTION TO THAT?*

*I think your initial reaction is shock even though you
work in that environment where...you know that may
happen or you know, that individual well enough to
know that may happen you're quite shocked at the time
(pA: 5, 114-120)*

As further expressed by pA, the initial response by all other participants evoked many other emotions that 'spilled out' in their talk, perhaps reflecting how un-containing the incident of the sexualised behaviour was for them at the time:

*DO YOU WANT TO TELL ME ABOUT THAT THEN?
...I was very upset, like, I felt very distressed about that
and, you know, quite disgusted about it and not happy
and that's probably the only, one of the only occasions
I think where the sexual behaviour, where I've gone
home and I've been quite upset about it
(pA: 12, 254-274)*

This deluge of strong emotional feelings was evident throughout, which at times seemed difficult to personally contain, resulting in a few participants openly expressing their emotions at the time of the incident:

WERE YOU VISIBLY UPSET?

...I was hysterical I was just crying [OK]...I was upset

(pH: 8, 196-198)

There was a sense that reflecting back on the incident enabled participants to have an element of closure and whilst there was a feeling that what was being talked about was very much 'in the past', for some, there were hints that by allowing the memory to re-emerge and talking about it in the here and now, resurfaced the emotions felt at the time, as indicated by pF:

YOU FELT SICK, YOU KNOW

*...just the initial feeling of oh God someone's just said
that to me...*

SO THE FEELING, A PHYSICAL SENSATION?

*...it was so shocking and unexpected but even that
makes me feel a bit sick by even saying it...it's horrible*

[YEAH]

(pF: 14, 334-346)

It seemed that for some, the sexual nature of the behaviour was a struggle for them and this was something that was touched on by several participants, encapsulated by pH:

*WHAT IMPACT IF ANY DOES BEING FEMALE HAVE
ON HOW YOU COPE?*

*...I'd rather have someone hit me in the face than do
something like that to me, [YEAH] I think I'd be able to
cope with that better, and not feel, so
violated...[RIGHT]... it's a horrible experience for
someone to touch you in that way [UHM]*

(pH: 28, 669-687)

The initial emotional reactions gave rise to a sense of fear and powerlessness; both feeling overwhelmed by 'being trapped' and not being able to control the situation. It appeared that not being able to predict what was about to happen caused extreme anxiety and increased the feelings of powerlessness:

DID YOU HAVE A PHYSICAL SENSATION?

...I purely felt fear [OK]

AND FEAR WAS THE INITIAL

The initial of the hands around my neck

*HANDS AROUND NECK [yeah] WHEN YOU
THOUGHT, ONCE HIS HANDS MOVED, [uhm] THAT
YOUR LIFE WASN'T IN DANGER?*

*danger...that was my first thought [YEAH] but then my
second thought was you know,...it makes me shudder...
when I realised what he was then doing [UHM], I
thought*

SO DID FEAR CHANGE TO SOMETHING ELSE?

*violator...I was still scared but I just felt really
powerless...I just didn't know what to do [UHM]...to
get him to stop [YEAH]
(pH: 18, 442-461)*

The need to regain control was consistent throughout the interviews and appeared to be on several levels. The initial control of the immediate situation being faced, that is taking back control from the patient was needed to help participants manage their emotional response, giving them back a sense of self and coherence. This was not always achieved by them alone, but more so, by their team, coming to 'rescue' them.

Despite knowing that it could happen, the unpredictable nature of the behaviour gave rise to possibly being defenceless. Participants highlighted the importance of not feeling so vulnerable but trying to be more in control of where they work, perhaps in order to maintain their sense of self.

As acknowledged by pH, like many other participants, maintaining a sense of control all the time is unrealistic, but feeling that you have some control enables you continue in your work:

*DOES THAT MEAN THAT YOU FEEL MORE IN
CONTROL?*

*...I'm not always gonna be in control, I kind of feel a
little bit more like I've got a, bigger possibility of*

being in control rather than feeling so vulnerable like I

did [UHM]

(pH: 22, 522-528)

The importance of making sure that they were safe was evident throughout all of the participants' talk. This was in the context of working in an environment that, by all accounts, despite inherent risks, was extremely safety conscious, focused on identifying and minimising risk whilst holding in mind the unpredictable nature of patients' actions. It seemed that many participants took personal responsibility and ownership for their own safety. This personal responsibility was echoed by pB, who talked about being responsible for protecting oneself as a matter of course:

*SO WHEN YOU CAME BACK ON YOUR SHIFT THE
NEXT DAY OR WHENEVER THE NEXT SHIFT WAS,
ERM, AND YOU CAME INTO CONTACT WITH THAT
SAME CLIENT*

... make sure I was protected as much as I could

[RIGHT]... as in staying the right distance away so I

wasn't automatically grabbed or sworn at

[RIGHT]...that was something I did...with everyone

[RIGHT, OK]

(pB: 14, 332-339)

A minority of participants expressed that they did not feel unsafe as a result of being on the receiving end of a sexualised behaviour, as pointed out by pF:

OK SO THE RAPPORT OUTWEIGHS THE RISK?

...I didn't feel at risk for my safety, [OK] no, and I don't know if that's because of the ward environment...there's a lot of precautions in place for staff to be safe [YEAH]
(pF: 42, 1025-1032)

The ward environment was acknowledged by all participants for ensuring that staff are safe and protected. However, for some it appeared that this feeling of not being at risk was, in part, related to these participants being on the receiving end of a verbalised sexual comment rather than a physical behaviour. This is not to minimise the impact that a verbal comment certainly has on an individual, but serves to further highlight the 'violation' felt by a physical act.

There was a sense that many participants wanted to account for their role in the behaviour and take some responsibility for the action of the patient. In essence, this appeared to a degree to be self-blaming, taking partial ownership for putting themselves into a vulnerable position, as though that responsibility was theirs.

As pH said:

*JUST GOING BACK TO WHEN THE INCIDENT
HAPPENED AND ERM YOU SPENT THE
REMAINDER OF YOUR SHIFT ON ANOTHER WARD,
[uhm] WHAT WAS THAT LIKE?*

...I was kind of like, not blaming myself for what happened, but I was kind of thinking I should have been more alert...

*HOW COULD YOU HAVE BEEN MORE ALERT DO
YOU THINK?*

... maybe been a bit more aware of my surroundings and may be situated a little bit better

(pH: 11, 258-270)

Accepting that they might have put themselves into a vulnerable position was echoed by many participants. It appeared that participants struggled and fluctuated in their belief between knowing and wanting to be alert all the time, which was expected, and realising that it is unrealistic to be alert all the time:

IT SOUNDS LIKE RISK AWARENESS [yeah] WAS HEIGHTENED

...when you just work on that environment for forty hours a week, sometimes things do become lax...[UHM] people should be on the ball [YEAH] all the time but it's just human nature...you get to know someone [YEAH] and you start to sort of, you know forget about other things

(pA: 17, 439-451)

The environment in which individuals worked and the job roles that they performed located them in the epicentre of being targeted. It was as though pA and others experienced a level of turmoil, 'knowing' that they should be constantly alert and aware of risk but possibly accepting that it is not always achievable and that this can have consequences. However, the choice of pronouns used by pA might suggest not wanting to admit to forgetting things, preferring to say that it is 'others' who become 'lax'.

3.1.2 Theme 2: The continuing ability to cope

Much of what emerged from the data related to the ability of participants to cope. Coping occurred during or in the immediate aftermath of the experience. It also appeared to be part of an ongoing inner dialogue participants have with themselves to enable them to cope daily. Coping came in a variety of guises. One essential mechanism was the importance of having a good team around to enable 'talking', which increased a sense of safety and this was central to many participants' narratives:

CAN YOU REMEMBER THE CONVERSATION?

...[my manager] gave me loads of reassurance...just gave me the opportunity to say anything that I wanted to [YEAH]...sometimes you just need to say something to someone [YEAH]... I can remember saying now I don't want it to happen again...

AND WHAT RESPONSE DID YOU GET?

...she gave me reassurance and she, gave me the opportunity and understood...obviously working with him as well

(pH: 8, 172-191)

It seemed that pH sought comfort from another, needing to share the experience with someone who would understand and by talking it through, a sense of reassurance was achieved. This was further resonated by pC below, who, like several others, wanted the option of talking if they decided that the incident

warranted it. Shared experience seemed to be integral to ‘talking’ as a support mechanism:

WHAT DO YOU THINK WOULD HELP YOU COPE BETTER?

...what I've found helped me to cope is having a good team around you [OK]...if you do have an incident that you're unsure about and you're a bit confused about and you want to talk to somebody about it then, having a good team around you is good, because, they all share the same experience

(pC: 16, 385-395)

As for the majority of the others, talking appeared to be an essential component in maintaining a sense of self-esteem in the wake of such an experience.

However, ‘talking’ was not necessarily the quintessential protective factor in coping, as others alluded to the possibility that one can still be affected.

There was an element expressed by some participants of using the experience and the resultant ‘talk with others’ as a means of being proactive in both minimising participants exposure to such behaviour and helping to understand why the patient exhibited the behaviour.

As a possible method of offloading some emotions or seeking containment, talking appeared to be a sensible strategy. However, a few participants acknowledged that having the opportunity to talk was not always readily

available, either immediately after an incident or as a proactive measure. In addition, talking was not necessarily viewed as a comfortable means by which to find a source of anxiety relief:

ARE THERE ANY OTHER COMMENTS THAT YOU WANT TO MAKE ABOUT YOUR EXPERIENCES OF RECEIVING SEXUALISED BEHAVIOUR FROM THIS CLIENT GROUP?

...[staff] do need ...an opportunity to have a better understanding of it...the opportunity to learn a lot more about it...people deserve a lot more...training...

...WORKING WITH THIS CLIENT GROUP, IS THERE ANY OTHER WAY THAT INDIVIDUALS COULD BE SUPPORTED?

...just constantly providing people the opportunity to talk [UHM]...people run themselves down...bottle stuff up...don't express what they're thinking or feeling [UHM]...it just gets too much

(pH: 31, 751-785)

Different psychological defences were employed and appeared to be a protective factor for all participants, enabling them to cope or perhaps survive in the face of fear invoking situations. Psychological defences were also used as an ongoing strategy in helping participants to perform their role and maintain their confidence.

It appeared important for the majority of participants to keep the sexualised behaviour in perspective. This seemed to be achieved by either intellectualising or rationalising the behaviour. This was by no means an easy task and was rarely, if at all, achieved at the moment of the participants being on the receiving end of the sexualised behaviour. More so, participants reflected on why the patient behaved in a particular way.

The main ‘understanding’ expressed by participants related to the patient’s brain injury and the implications of this on the patient’s ability to control themselves, as indicated by pA:

*WHAT ARE YOUR THOUGHTS ON WHY THE
CLIENT BEHAVED IN THIS WAY?*

*...they’re extremely sexually disinhibited as a result of
their brain injury and because of their exceptionally
poor memory...it’s virtually impossible for them to learn
new information since their brain injury*

(pA: 9, 197-203)

As participants recounted these explanations, it seemed to become clear that these reflections were not necessarily shared with other colleagues at the time of an incident but tended to be ‘held’ by the participant in their own mind, almost as a prepared statement. Consequently, it seemed possible that these were statements learnt from training that participants were holding on to as a form of self-defence to protect themselves from alternative explanations, where wanting to ‘believe’ was sometimes overshadowed by a degree of reservation.

Although brain injury was the underlying reason considered by participants to be the ‘cause’ of the behaviour, there were elements of doubt indirectly or directly expressed by some participants about the degree to which other factors might have played a part:

*HOW DO YOU COPE WITH SEXUALISED
BEHAVIOUR THEN?*

*...they're here due to their head injury...you have got to
have...a bit of an empathy, because of that [YEAH]
...this is probably something that they wouldn't have
done prior to their head injury, [YEAH] so I
think...there's reasons behind why they're responding
and acting this way, and you know, we're here to help
them [YEAH]*

(pI: 12, 284-296)

As indicated by pI, there was almost a ‘suspension’ of thinking in terms of what the patient might or might not have been capable of prior to their brain injury. To contain themselves and to keep the situation in perspective, it seems preferable to keep the causal link between the behaviour and brain injury rather than to necessarily seek alternative explanations.

Knowing and keeping in mind that by working with these patients an element of risk would be present, was essential, as was the importance of keeping the behaviour in context. As indicated later by pA and the majority of the participants, keeping the behaviour in context was second to the initial emotional reaction:

DO YOU WANT TO TELL ME ABOUT THAT THEN?

...these are the guys that I work with, [UHM] this is part of the risk...when you put it into context, sometimes, sometimes these guys can help it and choose to do it, but sometimes, they can't [YEAH] or it's difficult for them, or...it's related to impulsiveness and things

(pA: 12, 254-297)

Although participants tried very hard to attribute patient behaviour to their brain injury, it was also apparent that underlying this attempt to intellectualise the behaviour, many participants still struggled with that as the sole explanation. This difficulty was not uncommon and seemed to be related, to a degree, to the psychological and emotional impact of the sexualised behaviour toward the participant, as expressed by pH:

DID HE REMEMBER THE INCIDENT WITH YOU?

no [NO] he said he didn't when then he was spoken to

OK, DID YOU BELIEVE HIM?

...there was incidents after mine... [RIGHT]... he'd remembered some of them but then not mine and I kind of thought well why... why don't you remember... you know, [he] did hurt me [YEAH] and did scare me...you've made me feel like this, why don't you... know that you actually did it

DID YOU COME TO A CONCLUSION?

no I still don't ...understand it

(pH: 16, 376-394)

The need to be sure about the reason behind the behaviour was sometimes an unanswered question. However, when achieved, the ability to put the behaviour in perspective appeared to enable a form of psychological 'distancing' for some participants, indirectly preserving a sense of self:

*HOW DO YOU COPE WITH SEXUALISED
BEHAVIOUR?*

...by distancing myself from it I think

OK, PHYSICALLY?

Erm, no mentally I think, [RIGHT] yeah, just erm

HOW DO YOU DO THAT THEN?

...by putting it into perspective... looking at it in terms

of their brain injury, [RIGHT] and not in terms

of...behaviour particularly that's directed at you

[RIGHT]...I can distance myself from it by looking at it

in that way

(pJ: 17, 409-421)

The data consistently showed that patient sexualised behaviour was commonplace and that a hierarchy of displayed behaviour was apparent, ranging from 'low level' to a more 'serious level'. Because of the commonality of some behaviour, to be better able to cope daily, it appeared important for

some participants to be able to dismiss, brush off or even pretend that the 'low level' behaviour did not happen:

*WHAT DO YOU THINK WOULD HELP YOU COPE
BETTER THOUGH, IS THERE ANYTHING [uhm]
THAT COULD BE DONE, TO HELP YOU COPE?*

...in the most part I'm able to sort of brush it off

[OK]...when you know you've got the support of a team

[UHM]... that they understand...are aware...that's a

pretty effective way to make you feel better about things

(pF: 31, 740-757)

Although some participants suggested that shrugging off or ignoring the behaviour enabled them to continue, there was an element of 'wanting' this to be the case rather than necessarily it actually being the case. Many participants commented that they were just 'in the wrong place at the wrong time' when the behaviour occurred. This attempt by them not to take the behaviour personally was another important coping strategy emphasised by participants:

*CAN YOU REMEMBER WHAT YOU WERE
THINKING AT THE TIME THAT HE WAS (CAN'T
HEAR)?*

*...I didn't personalise it [NO]...it could have happened to somebody
else*

(pD: 11, 238-258)

For some, however, ‘knowing’ why a patient exhibits a certain behaviour is not necessarily the same as actually ‘believing’ this to be the case. This disparity might be associated with the participants’ inability to think rationally without reminding themselves of the actual emotional experience:

GOT ON WITH YOUR WORK?

...I know in my head that’s why he’s doing that

and...that it’s likely to happen to anyone on the ward,

[RIGHT] if you’re a target you just sort of,[YEAH]

carry on I suppose

(pA: 10, 232-241)

Not taking the behaviour personally seemed to be essential in protecting the participants against possible feelings of being a ‘victim’, as pF points out:

*HOW DO YOU GENERALLY COPE WITH
SEXUALISED BEHAVIOUR?*

...it wasn’t person directed, it was female directed [RIGHT]...there

was another member of staff...she got it just as much as me so I

didn’t feel particularly victimised...that was just how it was

(pF: 29, 696-716)

In addition, attempting to keep emotions separate was talked about by participants. For example, pH said:

*AND WHEN YOU SEE, THIS BEHAVIOUR TOWARDS
ANOTHER CLIENT OR TO STAFF, HOW DO YOU
RESPOND EMOTIONALLY?*

...I tend to try and keep my emotions separate [OK]...I

just do my job, you know, I kind of switch off

(pH: 4, 93-98)

Understandably, not all participants were able to separate themselves emotionally from the behaviour, experiencing it personally. For some and as expressed by pF, the degree to which behaviour is taken personally appeared to depend on the participants' perception of the patient's actual ability relating to their brain injury:

THE LAST TO KNOW?

...he should have been able to control himself and he

would have thought and planned the action of thinking

about me, going to buy [it], thinking about me, writing it

thinking about me...so it was more, upsetting because it

was [UHM]...it was deliberate, sort of personally

orientated

(pF: 21, 484-504)

As with other participants, a degree of inconsistency surfaced between pF talking about the actual experience of being on the receiving end of a sexualised behaviour and reflecting about that experience. For pF, it would appear that being able to 'brush off' the behaviour and not to feel 'victimised' was difficult 'in the moment' of the behaviour but was more likely when looking at the incident rationally.

Several participants spoke about the importance of releasing tension with colleagues, possibly by using humour as way of distancing themselves from the behaviour. It was important that, although this was ‘understandably’ used as a coping strategy, participants pointed out that this method was not at the expense of the patient:

I'M JUST GOING TO MOVE ONTO COPING STRATEGIES, [yeah] YOUR COPING STRATEGIES, HOW DO YOU COPE WITH SEXUALISED BEHAVIOUR?

...sometimes you cope with it by making it into a bit of a, a joke and a laugh and things and you obviously shouldn't do that...[YEAH] but that's human nature...it is a little bit like, making light of it [YEAH]

(pA: 22, 525-548)

It was evident from the data that the continuing capacity of participants to cope was reliant on their ability to acclimatise themselves to the environment. Although the environment was seen initially as quite frightening and un-containing, the majority of participants very quickly acclimatised, becoming ‘used to it’:

YOU JUST TELL ME A LITTLE BIT ABOUT YOUR JOB, YOUR WORKING HERE, ABOUT YOUR EXPERIENCES

...the very first time I walked onto the ward...I was like, what am I doing here and some of the staff were just

walking around like it was normal...then after a few months, I kind of became that way...it's second nature, I was able to ignore it and just carry on with other tasks
(pC: 1, 2-30)

As a coping strategy, becoming accustomed was common amongst participants and enabled them to continue in their role. This was not always seen as a completely positive approach but perhaps a necessary one, as further articulated by pF:

IS THERE ANYTHING ELSE THAT YOU WOULD LIKE TO TELL ME ABOUT, SEXUALISED BEHAVIOUR THAT OCCURS HERE AND YOUR INVOLVEMENT

...it's very easy to very quickly become...accustomed to it... and not react...in a good way you can't let it affect you if it's happening to you daily...in a bad way...it could lead to complacency, if you've got patients that are attempting to grab you on a near daily basis and you're just jumping out of the way,[YEAH] and getting on with what you were doing...very quickly you could just get used to it...just part of the job, not even worth...giving a second thought to it
(pF: 39, 954-970)

The interview transcripts suggested that no participant expressed total immunity to sexualised behaviour but that over time, this continued acclimatisation enabled them to physically and possibly psychologically prepare themselves for the next instance. A consistent narrative expressed by all participants was an acceptance that being on the receiving end of unwanted sexualised behaviour was just ‘part of the job’, something to be expected and needing to be dealt with, as with any other behaviour:

*IS THERE A SENSE OF HAVING TO DEAL WITH IT
AT WORK AND NOT TAKE IT HOME?*

Yeah, yeah, yeah

WHY DO YOU THINK THAT WOULD BE?

*...in terms of the sexualised behaviour, I do just see that
as part of my job, [RIGHT] I don't kind of look at it in
another way than that... like I say it is kind of, I do know
they're disinhibited [RIGHT]*

(pJ: 10, 218-227)

A few participants talked about the usefulness of being ‘prepared’ beforehand to expect sexualised behaviour as a ‘norm’ within this environment, as pB commented:

*HOW PREPARED WERE YOU FOR DEALING WITH
SEXUALISED BEHAVIOUR?*

*...before I started here I'd been warned that there will
be service users that are sexually disinhibited [RIGHT]*

*and inappropriate[RIGHT]...so don't be surprised if it
is directed at you [RIGHT] ...[I was] quite prepared
(pB: 16, 363-377)*

Although pB's preparation was partly due to knowing somebody already in the job, a few participants commented that being told to expect sexualised behaviour was, in some way, an attempt at preparing them. It appeared that being told to expect the behaviour as part of the job did not necessarily translate into actually attaining the skills to effectively be able to cope with sexualised behaviour and as such, not all staff were necessarily psychologically or emotionally equipped. For some, there appeared to be a divide in knowing that the behaviour would happen and actually being able to effectively deal with it:

*FOR EITHER OF THOSE TWO INSTANCES, DO YOU
WANT TO TALK ABOUT ONE OF THOSE
INSTANCES?*

*...coming into work in this environment, [UHM] you
know they've had a brain injury you know they're going
to be disinhibited, [YEAH], erm so you know that, those
sort of things are going to happen [YEAH]*

(pJ: 5, 145-155)

3.1.3 Theme 3: Evolving relationships

The third theme that consistently emerged throughout all participants' narratives was that of continuously evolving relationships, be it with the patients, colleagues or with family and friends.

All participants spoke about the importance of building rapport with patients as this enabled a better working relationship and allowed staff to effectively support the patient in terms of learning new skills and promoting a better quality of life. Although having rapport was deemed essential, for the majority of participants, the building of rapport resulted in some negative, and in hindsight, not unexpected consequences. Reflecting back on this closer working relationship with the patient, participants concluded that their interactions with patients sometimes became a 'bit of a habit'. As a result, there was an increased likelihood that their 'defences' dropped and they could become complacent with regard to risk. This appeared to be only 'realised' after staff were on the receiving end of sexualised behaviour. As pA said:

IN THAT INSTANCE [yeah] YOU'RE, YOU'RE, IT SOUNDS LIKE YOU'RE A BIT MORE WARY OF [yeah] THAT CLIENT. WHAT ABOUT OTHER CLIENTS?

...when you get into the habit of working on a ward like that, then you build...rapport...[YEAH] you do start to do things without thinking...it becomes too much of a habit, you don't stop and think...you just automatically assume that you know...[YEAH] it did make me stop, and take stock...the levels of risk you're putting yourself at...

IT SOUNDS LIKE RISK AWARENESS [yeah] WAS HEIGHTENED

...it sort of made me realise that it's silly to let it to become lax anyway cos you're putting yourself and others at risk

(pA: 17, 406-443)

For some participants, it was inevitable and understandable that as rapport increased, a level of trust between staff and patient occurred:

DID THAT CONCERN YOU?

...I'd sort of trusted the patient not to do me any harm [YEAH] which is probably, you know in retrospect, a stupid thing to do...you shouldn't really...become, complacent

(pF: 6, 138-143)

As relationships developed between participants and patients, awareness of risk did reduce for many participants, who perhaps then became complacent. There was an apparent dichotomy between knowing the patient and not knowing the patient. However, risk awareness appeared to be a rather fluid concept, lowering as rapport gained momentum but becoming heightened after an incident of sexualised behaviour. Consequently, this affected how participants interacted with the patient:

HOW DID IT MAKE YOU FEEL WHEN YOU NEXT WORKED WITH HIM?

...I would still talk to him and just keep it, you know, in a fairly sort of matter of fact way [RIGHT]...but it was

just...a feeling that we've all got to be very careful of

this man really [YEAH]

(pD: 23, 562-573)

It seemed important for participants within this environment to maintain the appearance of 'normality', as though nothing has happened. This might be related to the programmes in place on the ward, where it is important not to give a reaction to a patient's behaviour. However, for some participants, it seemed as though they needed to tell themselves that they could cope, that they could do their job. However, as expressed by pH, in the immediate aftermath of the incident, participants were challenged to keep the same level of interaction with the patient as they had had with them before the incident:

OK AND WHEN YOU NEXT CAME INTO CONTACT

WITH HIM, WHAT HAPPENED?

...I wanted to act normal but I knew I came across as quite tense I felt myself being tense and I was like a little bit, reluctant, to do too much [YEAH] for him, but not...because I didn't think he deserved it...[YEAH]... I didn't know if he remembered doing it to me, how he felt about doing it or, you know how he felt about me, did he...want to do anything to hurt me [YEAH] or anything like that so I just kind of, withdrew myself...[YEAH]... I just kind of had minimal, interaction with him

(pH: 13, 321-337)

As already noted, most participants appeared, at least to some degree, to acclimatise to the behaviour, so it seemed understandable that after an incident, and given time, some participants said that their focus on risk settled. The nature of the relationship between these particular participants and 'risk' appeared circular:

HOW WERE YOU IN SUBSEQUENT DAYS AND WEEKS WORKING WITH HIM?

...the professional relationship we had, pretty much got back to where it was

(pC: 13, 304-309)

A key narrative that emerged in the data was that of participants 'defending the patient'. All participants' narratives highlighted that the type of sexualised behaviour shown to them by patients was not something that they would tolerate or accept in the 'outside world' and not behaviour they would defend. Compared with the 'outside world', on the ward, it seemed to be different. Despite the psychological and emotional impact that sexualised behaviour had on participants, in most accounts, there was a consistent underlying 'defence' of the patient. Within this environment, it was as though instinctively, their 'caring role' persona superseded concerns they might have had. This was not just in terms of the behaviour itself, but rather, concerned with defending the person:

WHAT ARE YOUR THOUGHTS ON WHY THIS CLIENT BEHAVED IN THIS WAY?

...I think he's just...a normal guy...he's a young man [UHM] in his early twenties... he's got the normal...the same wants...as everybody else [YEAH]...the kind of

*sexual relationships and obviously, you know he's had
a... horrific accident and he's now in hospital and... he
doesn't get that...he hasn't got that chance at the
moment for a normal [RIGHT] kind of relationship...
RIGHT, OK [uhm] SO IT'S BECAUSE HE'S HAD THIS
ACCIDENT
...no...he's just a normal male...at that age I think he's
got those normal [RIGHT] kind of wants [OK] and
needs [OK] and...probably a lot of men that age think
the same thoughts [RIGHT] but obviously they don't say
them and I think, the difference is he's just saying
them...[BECAUSE]... because of his brain injury
(pJ: 13, 302-326)*

Participants seemed to suggest that by looking through a lens of what the person was or could have been before their head injury and 'normalising', helped their understanding and ultimately their ongoing relationship with the patient:

*YOU HAVE TOUCHED ON HIS DISINHIBITION,
[yeah] IMPULSIVENESS [yeah] THE WORD THAT
YOU USED, [yeah, yeah] IS THAT HOW YOU, ERM
UNDERSTAND WHY HE BEHAVED IN THAT WAY?
...a ...misunderstanding [OK] about social
relationships, and, impulsivity...he wouldn't have been
like that but-if he hadn't had a head injury, you know
what I mean [RIGHT], his history which showed that*

he'd had, better, you know, respectful kind of relationships, he wasn't somebody [OK] who would do that until he'd had a head injury and then it changed [RIGHT, OK]
(pD: 13, 315-328)

Taking into account possible alternative explanations was apparent in some participants' narratives and appeared to be further evidence of a need to 'defend' the patient. Deterioration in mental health as an explanation was not an uncommon description as expressed by pH:

OK DISAPPOINTED IN?
...you know most of them only portray their behaviours when, you know maybe their mental health's deteriorated [YEAH] and things like that so then you know... when they start showing behaviours like that it's kind of a bit of a downturn for them [YEAH]...in a way I do sympathise with them as well [RIGHT] because obviously you know it can... be behaviour you can't control [YEAH]
(pH: 4, 82-92)

A consistent message throughout all participants' narratives was that having and being part of supportive relationships with work colleagues was essential to being able to work in this particular, potentially unpredictable, environment. By all accounts, the emphasis was definitely on 'shared experience':

*ARE THERE ANY OTHER FACTORS THAT YOU
THINK MAY HAVE INFLUENCED HOW YOU
RESPONDED TO BOTH BEHAVIOURS, [uhm]
YOU'VE TALKED ABOUT*

*...working in a close team makes quite a difference
because we do share then a lot of the same experiences
that makes a difference*

(pD: 39, 957-965)

This shared experience and understanding was echoed throughout all participants' accounts. Participants knew that whatever sexualised behaviour was directed at them and whatever psychological or emotional impact it had on them, they were not alone: other staff had similar experiences. This empathy for one another appeared to facilitate a general sense of safety and security. It was evident that despite the risk of sexualised behaviour, being part of a team with the knowledge that they could rely on their colleagues, counterbalanced the 'fear':

*I'M JUST WONDERING WHAT WOULD HELP YOU
COPE BETTER*

*...a definite feeling of security in here [UHM]...you can
just pull your alarm [YEAH]...people are always there
to help me...having a general sense that you're part of
the team that get on well together*

(pG: 21, 486-502)

Amidst this unity of ‘sameness’, there was also an element of disparity in several participants’ accounts, where the importance of not being different from their colleagues was expressed. For some participants, it appeared important not to give colleagues any indication of possible vulnerability or any impression of an inability to do their job. Ensuring that their own personal response matched that of other colleagues who did not react to a sexualised behaviour, was important, as *pB* said:

WHAT ABOUT THE GRABBING INCIDENT, HOW DID THAT AFFECT THE REMAINDER OF YOUR SHIFT?

...[other] staff were getting it a lot more regular [YEAH] and seeing their reaction of how they would carry on with it, to the service user and not show [YEAH] that it’s affecting them as much is something I took on board and, I use that myself [RIGHT]
(*pB*: 14, 318-329)

For some, to enable them not to appear different from their colleagues, putting on a ‘brave face’ was a way of achieving this. It was plausible that for their self esteem, it seemed really important that these participants were not perceived as a ‘victim’ and treated differently from their peers, as *pH* said:

SO HOW WERE YOU WITH THE OTHER CLIENTS ON THAT OTHER WARD FOR THE REMAINDER OF THE SHIFT?

*...keeping myself busy I just kind of carried on as normal
really [OK] but still with thoughts in my head about
what had happened but without really expressing it or
really showing that it had affected me when I was
[UHM] working there
(pH: 12, 284-295)*

There was also evidence in several accounts of ‘being looked after as a female’ and the importance of risk awareness and having males in attendance in situations where risk was deemed high. As described by pG and with other participants accounts, the implicit expectation is that being ‘looked after’ is related to being female:

*YOU MENTIONED ABOUT YOUR UPBRINGING
AND BEING ABLE TO STAND UP FOR YOURSELF,
ERM, HAS THAT THEREFORE IMPACTED ON HOW
YOU VIEWED THAT TYPE OF BEHAVIOUR IN THIS
CONTEXT?*

*...I feel quite protected in here, because there are a lot
of men on the ward [OK]...there is an expectation that
you’re looked after...you know that if there’s a risk, you
don’t go in there... so I feel... very safe, really
(pG: 24, 579-591)*

A few participants described their relationship with their line managers and of the positive outcome for them, in terms of continued support and gaining

affirmation of their responses in an incident of sexualised behaviour. It seemed that for these particular participants, this was containing for them.

The positive connotation of sharing with colleagues was distinctly absent with family and friends. The majority of participants disclosed that it was preferable for them to withhold sharing with outsiders, as expressed by pI:

DID YOU TELL ANYBODY ELSE?

*...I don't tend to talk greatly about work to anybody else
out of work*

WHY WOULD THAT BE?

*...I find that if you're not dealing with this sort of
situation people think you're mad and ask why do you
want to do that job, and I suppose...having friends that
work in offices...[YEAH] ...people don't tend to
understand as well as those being you know familiar
[NO] in the environment [OK]*

(pI: 8, 180-190)

The emphasis appeared to be, as pI said, on shared understanding and 'knowing', which was difficult and possibly not achievable with other 'outsiders':

*IN THAT PARTICULAR INCIDENT WHO DID YOU
TELL THEN WHEN YOU WENT HOME?*

*...if you've never worked in this sort of environment, it's
just totally abstract to your friends who work in offices*

[YEAH]...to them it's the most shocking...you have to try to rationalise it [YEAH]...it's hard really to talk about...I tend not really to talk about work to my parents... because it absolutely terrifies my mum [YEAH]...it's quite hard to talk to people outside of work about this sort of work [YEAH] because if they've never experienced...working with these people...[UHM] especially in this sort of setting, I don't think they can...really understand, everything sounds [UHM] really [UHM] scary or dangerous...they say what are you putting yourself through that for...that's sometimes why you make such good friends working in these sorts of environments because it's someone who understands [YEP] and who you can share your experiences

(pA: 13, 301-324)

There perhaps was a suggestion in participants' accounts that they found it difficult enough to manage their own emotions when being involved in an incident, without then having to manage the emotions of outsiders. Many, who found it easier and perhaps more containing not to share, expressed this difficulty:

CAN YOU THINK ABOUT WHAT TYPE OF REACTIONS YOU GOT FROM THAT?

...their shock was a lot more than my shock was...because they don't understand maybe why [NO]

that behaviour would happen whereas I can rationalise

it a lot easier

(pF: 18, 423-431)

3.1.4 Summary

Three themes emerged throughout participants' narratives. Powerful emotional and psychological responses were experienced during an incident of patient directed sexualised behaviour, resulting in a sense of powerlessness and a need to be safe. Whilst the relationship between participant and patient was initially affected, this appeared to be short-lived. Participants' continuous ability to cope was enabled by the opportunity to talk with colleagues who had a shared understanding, adopting different psychological defences and to some degree, by acclimatising and accepting the behaviour. The strength and essential nature of work relationships, as well as an underlying sense of professionalism appeared to motivate individuals to continue to work in this environment.

4. Discussion

The aim of the current study was to explore how staff perceived and experienced patient sexualised behaviour within an acquired brain injured population. It was clear from the analysis that patient sexualised behaviour directed towards staff was common. However, as the extant literature on staff subjective experiences of patient sexualised behaviour appears limited, where applicable, reference has been made to the broader challenging behaviour literature. Where appropriate, the researcher has also drawn upon broader psychological theories to support the thematic analysis.

4.1 Themes

Psychological responses

Powerful psychological emotional responses to sexualised behaviour were evident in all accounts, with participants experiencing varying degrees of shock, disgust, distress and anger. Although not always explicitly articulated, underlying some accounts was 'fear' and a sense of being overwhelmed by the situation in response to threat of personal safety. This tied in with the findings of Raczka (2005) and Whittington and Burns (2005) who suggested that challenging behaviour can engender unpleasant feelings including fear and anger. The increased emotional arousal experienced by participants also ties in with the findings of Jahoda and Wanless (2005). The sexual nature of the behaviour was particularly frightening and difficult to manage for some and this particularly related to the finding of Hellzen *et al.* (2004) who suggested that

staff respond more to sexual invective behaviour than other challenging behaviour.

Not being in control, of either the situation or of their own emotional state gave rise to feelings of powerlessness in some participants, and this was noticeably evident in the literature (e.g., Chambers, 1998; Isaksson, Graneheim & Åström, 2009; Lundström, Åström & Graneheim, 2007). The inability to predict the occurrence of the sexualised behaviour compounded feelings of powerlessness, which was echoed in other research (e.g., O'Sullivan & Weerakoon, 1999). It was clearly important for participants to be safe and feel safe and regain control: this narrative might be understood in terms of Maslow's (1943) hierarchy of needs, where, at an instinctual level, a person's need to be safe and survive can dominate their behaviour. This supported the findings of Miller (1997) who also found that personal safety was a priority for staff.

Some participants spoke of their own responsibility for potentially putting themselves in a vulnerable position that resulted in them becoming a target for sexualised behaviour. To some extent, participants held in mind the possible role they played in the patient behaviour rather than, for example, causally linking the behaviour solely to the brain injury of the patient. Although there is some evidence for the role that staff 'misunderstanding' acting as a possible antecedent to challenging behaviour (Sandvide, Åström, Norberg & Saveman, 2004), the perception of self-blaming is negligible in the broader literature, with the findings from Heyman, Swain and Gillman (1998) explicitly noting that staff avoided explanations of behaviour that referenced their own actions. In

terms of the psychological responses narrative, the overall findings of the current study appeared consistent with previous research.

The continuing ability to cope

In terms of the overall narrative that emerged from the analysis, the most compelling theme related to the continuing ability to cope; the ongoing cognitive and behavioural efforts by participants to manage their psychological stress (Lazarus, 1993). Coping and stress was reported widely in the challenging behaviour literature (e.g., Jahoda & Wanless, 2005; Lundström *et al.*, 2007; Raczka, 2005; Whittington & Burns, 2005). Coping as an adaptive and contextual process was invoked immediately, on a moment to moment basis in response to a sexualised behaviour; dynamic in the sense that as the situation unfolds, the participants' thoughts and actions change, with no two situations being the same. It was also a continuous process for participants to maintain their emotional and physiological equilibrium to effectively function in their role. This tied in with other research, which described the on-going need to have coping and survival strategies (e.g., Chambers, 1988) to alleviate the tension experienced by staff and to help them come to terms with the outcomes of these experiences. However, what was evident was a distinct lack of discussion within the current literature of the value in 'talking' to others. At times of stress, affiliation with other colleagues for support, facilitated by 'talking' was apparent throughout the narrative from the current study.

Evidence has shown that psychological defences in individuals form over time in the context of a group (in this case the staff group), which could be described

as an implicit social defence system against anxiety (Menzies-Lyth, 1960). Whilst not necessarily explicitly stated, viewed as a whole, the undercurrent in the participants' narratives did have an underlying sense of a social defence system, in place to diminish the anxiety provoking aspects of the environment. Participants adopted many different psychological defences as coping strategies, some of which could be viewed within a psychodynamic framework. For example, a few participants cited the use of humour to counterbalance increased emotional arousal whereas others used suppression to alleviate stress by intentionally not thinking about the sexual behaviour or pretending that the behaviour did not happen to them; both useful in certain circumstances, serving to protect them. These were similar to the finding of Higgins *et al.* (2009), who suggested that staff use humour as a 'suppressive' strategy albeit within a negative staff discourse.

An alternative but possibly complementary way of viewing the use of coping strategies could be in terms of Lazarus and Folkman's (1984) stress and coping model. This incorporates how staff appraised the sexualised behaviour in terms of its personal significance to them and how staff evaluated what options were available to them for coping. The stress and coping model makes a distinction between emotion focused and problem focused coping. Both are used to manage, reduce, tolerate or minimise the demands created by the behaviour in order to control one's stress level. Emotion focussed coping seeks to regulate or eliminate emotional distress. This is achieved by changing how the relationship with the stressful environment is attended to (e.g., using vigilance or avoidance) or by changing the relational meaning of the sexualised behaviour (e.g., denial,

wishful thinking or distancing). The majority of the coping strategies employed by participants were intrapsychic defensive processes, such as denial, repression and intellectualisation. There is evidence to suggest that emotion focused coping is negatively correlated with overall good health (e.g., Penley, Tomaka & Wiebe, 2002).

Problem focused coping is concerned with management of the behaviour, weighing up the pros and cons of actions by being active in problem solving and seeking information. This approach to coping is not only focused on altering the stressful situation but also directed at the self, for example, by intentionally altering one's cognitions or positively reappraising the situation (Brannen & Petite, 2008). These strategies were used to varying degrees with the majority of participants using intellectualisation in an attempt to 'really' understand why the patient behaved sexually towards them. Individuals do not necessarily consciously decide on which type of strategy to adopt. Some evidence would suggest that if staff feel extremely threatened by the sexualised behaviour, to be able to effectively deal with it, they must first use emotion focused coping before being able to adopt a problem focused strategy (Rukholm & Viverais, 1993).

Participants appeared to adopt a mixture of coping styles and therefore understanding and explaining what and why staff choose different strategies perhaps should not be explained in a unitary fashion. Consequently, consideration should also be given to other factors, for example, what attributions staff have of patient sexualised behaviour. Weiner's (1980)

attribution model, would suggest that if staff attribute sexualised behaviour as purely under the control of the patient, then they might be less willing to engage with the patient, decreasing the likelihood of helping. This may be borne out in some participants' stories that tell of an initial, though short lived, change in how they engaged with the patient after an incident of sexualised behaviour, which might be related, amongst other things, to their attributions. This temporary change in engagement, although not evidently affecting the patient, appeared transient. It might be argued that staff attributions are altered over time through the specific use of coping strategies, enabling them to make sense of the behaviour and continue in their helping behaviour.

Where there is less perceived control of the situation, it might be considered a useful short term strategy to help staff reduce their immediate emotional arousal and allowing them to then engage in problem focused coping (Brannen & Petite, 2008). Problem focused coping changes the nature of the staff-patient relationship, requiring staff to change their behaviour by taking some action to counter the threat of the situation. If staff believe they can take control and change the situation, then a problem focused strategy is possibly considered a more effective coping strategy.

The participants did use intellectualisation to avoid or possibly minimise the emotional arousal and unpleasant feelings experienced. It was not uncommon for them to put the sexualised behaviour into context by using abstract thinking or generalisation. For some, having empathy for the patient appeared to enable

the relational meaning of the behaviour to change, considered as a powerful regulator of staff stress and emotion (Lazarus, 1993).

It seemed that intra-psychic defences helped participants to effectively cope with anxiety provoking situations. These perhaps were used as a transparent shield to protect them from their patients. Transparency was important to maintaining their professional identity, so as not to jeopardise their relationships with patients. The importance of coping at times of emotional distress is axiomatic. It enables the individual to increase their 'tolerance for negative realities in order to hold on to a positive self-image' (Oxington, 2005, p106). The process of coping during adverse situations indicated high staff resilience, having personal qualities to 'bounce back', whether individually or as a team. This resilience to risk enables individuals to maintain positive self regard (Seligman, 2002). Additionally, it appeared that some consolidation of coping occurred over time, with staff achieving stable strategies.

Antonovsky's (1993) 'sense of coherence' theoretical formulation might suggest that as staff work within a sometimes unpredictable workplace, this will affect their ability to cope with stress. However, the narrative expressed by the current participants identified an underlying belief that they do have the skills, ability and systemic support to enable them to manage and have a level of control in their environment and that the role they perform does have meaningfulness. This would suggest that participants in the current study did have a good sense of coherence, which positively worked towards maintaining their own health.

Staff experiences and perceptions of sexualised behaviour suggest a hierarchy to the behaviour (Beaulieu, 2007), possibly affecting how quickly they habituate to it. Acclimatising and accepting the behaviour would appear to be an inevitable outcome as shown within the majority of participants' accounts. This appears to be similar to the findings of Sandvide *et al.* (2004) who found that acceptance of challenging behaviour was a natural consequence for staff who view events as unavoidable and part of daily work. However, unlike Sandvide *et al.* (2004), the narrative from the current study suggests a more positive perception of participants' ability to resolve problems. Although there was an attempt by participants to not take the behaviour personally, there was some evidence that this was not always achievable, tying in with the findings of Jahoda and Wanless (2005), who suggested that professional role and knowing the patient tempered any initial doubt or negative perceptions that staff might have had of the patient.

It appeared that the participants in the current study strove to hold on to intellectualisation, almost as a need to 'really' understand why the patients were behaving as they did. This might be seen in terms of 'containment'; guarding themselves against a possible 'attack' of their own sense of self.

Evolving relationships

The changing and possibly cyclical nature of the relationship between participants and patients was apparent throughout the current study narrative. Existing research into the evolving nature of the relationship between staff and patient is limited. Within the current study, participants naturally built rapport

with patients to help them with programmes, quality of life and improving social relationship skills. What appeared to occur was that as rapport increased, the prospect of risk awareness reduced. It seemed that when this happened, participants' defences dropped, increasing the risk of the participants being on the receiving end of sexualised behaviour, resulting in a challenge to their previously held perception of 'knowing the patient'. Whittington and Burns (2005) suggested that getting to know the patient is a means to manage unpleasant feelings experienced by staff but, in essence, this can result in a dilemma for staff. The current study highlighted that when an incident of sexualised behaviour occurred, the initial relationship with patients was affected. Participants increased their vigilance, heightened their alertness and were more aware of their own safety, resulting in distancing themselves, both physically and psychologically from the patient and needing others to be around. However, this 'state' seemed to be short lived. Over time, as participants re-established rapport with the patient, they became more comfortable in the environment.

What was evident within the narratives was a real sense of need by participants to defend the patient. This had vague similarities to the findings of Isaksson, Åström and Graneheim (2008), who suggested that in spite of the seriousness of the behaviour, staff sought excuses to account for it. It might be debatable whether this is a good or a bad thing for the individual staff member but it is difficult to draw a conclusion on this within the current study. Despite the traumatic experiences shared within the interview, the researcher was left with an empathetic essence; participants just could not help but try and understand

the patient. This might be related to attempting to maintain a high self efficacy by making a greater effort with patients and be underpinned by their underlying sense of professionalism.

Previous research has featured the interrelationship between staff and patient within the realms of challenging behaviour but there appears to be less focus on the relationships between staff, particularly as a much needed source of support and in terms of group identity. The supportive role of colleagues and staff group identity were emphasised clearly throughout participants' narratives, particularly in terms of 'shared experience'. This resulted in feelings of security and containment. Colleagues were often described as 'good friends', a particular source of support needed within this environment that was not necessarily available elsewhere. Their identification with this social 'in-group' could be understood in terms of social identity theory (Tajfel & Turner, 1986) and seems to be particularly evident when considering staff relationships with the 'outsiders'; that is, the possible 'out-group'. In this sense, the fundamental shared 'characteristic' is the 'shared experience'. Throughout, the current narrative described strong identification and cohesion with colleagues; that is, participants seeing themselves very much in terms of the staff team, also serving to bolster the individual's self-esteem. The more the staff member identifies with the staff group, the more likely they are to act in accordance with the social identity alluded to by that group. This is borne out in some of the stories expressed by the current participants, where *not* wanting to be different was expressed. The need to not respond emotionally to a sexualised behaviour, to put on a 'brave face' or to keep the response 'casual' was important for some. There is limited research that incorporates the relationship between support

structures and the psychological wellbeing of staff (e.g., Cole, Scott, & Skelton-Robinson, 2000). Though not evident in the extant literature, an underlying, implicit and possibly natural consequence of the supportive relationships apparent in this environment was that of being looked after as a female. Considering gender as a social construct, this perhaps may just be reflective of social learning.

In contrast to relationships with colleagues, a very different story emerged regarding relationships with people from outside the team. What was expressed was a distinct difficulty by participants in talking about and sharing their work with close friends and family. It seemed that those experiences shared were restricted and appeared to be dependent on the experience having limited impact on the participant (e.g., a low level behaviour, easily 'brushed off'). It appeared that sharing experiences with 'outsiders' was tempered with a possible need by participants not to reignite their own emotions about an experience at work, but, perhaps more distinctly, to contain the emotions of the listener; whom, by all accounts, expressed similar shock and outrage. The narrative highlighted the difficulty by participants in managing the receiver's response. Consequently, the participants might have held this in mind when sharing their experiences with the researcher, possibly viewed as another 'outsider'. The majority of participants commented that their job role is just 'too abstract' for others to understand. Withholding information was not uncommon. One perhaps could consider if there are any patient safety or staff safety issues in instances when staff do not share information. Participants do need to share their stories, particularly when it has been an incident that has affected them emotionally (e.g., affected their sense of self, invaded their personal space, disempowered

them) and it was clearly better to share with those who have had the same experience and who understand. Knowing the difficulties in managing outsiders' responses, participants were dependent on colleagues as their main support system. Discussion of the impact when working in these types of environment on staff relationships with outsiders is virtually nonexistent within previous research.

4.2 General Discussion

The overall sentiment of the current narrative was of shared experiences of patient directed sexualised behaviour that were shocking to staff, affecting them emotionally and psychologically. Consequently, participants experienced feelings of powerlessness resulting in a need to be and feel safe. Participants adopted a variety of psychological defences (problem focused or emotion focused strategies) that enabled them to continue to cope and maintain their self-esteem. The importance of a support system was axiomatic. They gained enormously from the supportive relationships *within* the environment, underpinned by shared understanding, and in a sense, were to a considerable degree dependent on these. Participants were optimistic that they could protect themselves psychologically by means of this support and that over time, they became acclimatised, though not entirely psychologically immune, to most sexualised behaviour. Rapport building, vigilance and the need to consider risk were common factors underpinning ongoing relationships between staff and patients.

Similarities are clearly evident when comparing the findings of the current study to previous research. The current study has also highlighted areas that have not previously been touched on in depth. The nature of the relationship with outsiders is just one. What was not necessarily evident in the themes was how much participants' accounts were influenced by their current role or the career path they were taking. Although from a variety of professions, most of the accounts were from unqualified staff, some of whom had clearly mapped out a career route. Being focused on a career goal might have affected what strategies they employed to manage the behaviour, how quickly they became accustomed to the environment they were working in and why they remained working there.

It was interesting to note that most participant volunteers were unqualified staff. It is difficult to account for possible reasons for this. One might speculate that it is the unqualified staff who experience the majority of the behaviour; being on the 'shop floor' so to speak. This might suggest that more qualified staff did not volunteer as their experiences are fewer. However, an alternative explanation might be that more qualified staff either have greater skills in dealing with sexualised behaviour at a personal level, or perhaps, they might not want to expose their actual level of ability or their vulnerability to cope with this type of behaviour.

Most volunteers were young in age. It was difficult to ascertain clearly whether an individual's ability to cope necessarily related to their age. Some of the narratives suggested that as individuals became more experienced and probably,

more used to the behaviour and environment, they were better able to cope. However, within this current study, despite the fact that participants accepted the behaviour and expected the behaviour, it still had its 'shock' value, regardless of the participant's age or experience.

It was interesting to note how some participants appeared to need to talk about a 'less severe' incident of sexualised behaviour first before introducing an example that clearly had more of an effect on them. Not knowing the researcher, participants may have felt that they needed to feel safe, secure and possibly contained within the interview before disclosing their stories. The researcher may have been viewed as an 'outsider', and therefore not necessarily someone to share with. However, possible barriers to disclosing information may be inherent within an interview. It is not unexpected that some participants may have had difficulties in thinking about and articulating their experiences (Baillee, Smith, Hewison & Mason, 2000). Whilst they were aware of the nature of the interview, they may have had difficulties reflecting back or even remembering accurately the instances that they narrated. Having to identify what emotions were felt could have been difficult for some. In any interview, what is disclosed is affected by the nature of the dynamics between interviewer and interviewee and this could have resulted in things being excluded from the talk; although it is worth noting that interpretation of participants' narratives might also be limited to the researcher's ability to reflect and analyse (Brocki & Wearden, 2006).

Interestingly, only one participant volunteered to hold a diary. It occurred to the researcher that perhaps asking staff to complete a diary in addition to their already very busy working day might have been too much of a burden for them. On reflection, several other thoughts occurred to the researcher as to why only one person volunteered. Some individuals find it difficult to express or articulate their thoughts in writing, and this might have limited some. Writing something on paper might seem more 'real' to some, rather than verbally talking about something that is just 'out there'. Perhaps some did not want to have a detailed written record of what happened. Others might have wanted the opportunity to verbally share their experiences. As talking was shown to be a key facilitator of coping, this is perhaps unsurprising. The process of writing might have been deemed too un-containing for staff.

4.3 Limitations of the Study

The demographics of the volunteers, mainly young unqualified staff, might explain the emergent themes and general findings. More experienced, autonomous professionals might have reacted differently to sexualised behaviour and might have possibly narrated a different story.

Qualitative research might be viewed as restrictive, particularly in terms of agendas and questions being set by the interviewer and not being controlled by the interviewee. More useful ways to access subjective experiences were considered. The use of a diary was a conceivable option, viewed as a worthwhile alternative to providing a narrative account (Brocki & Wearden, 2006). Whilst the researcher was not expecting many volunteers to write a

diary, it is interesting that only one person volunteered and in terms of the collective, one could question its added value. Diaries are personal things and possibly the personal nature of these particular subjective experiences were not something, specifically in this format, to share.

Within IPA, homogenous samples are used and studies do not have the expectation that the findings will necessarily generalise to a broader population. In terms of being able to generalise the findings, this study is no different from other IPA studies. Whilst some qualitative studies have used the option of checking emergent themes with their participants, this current study has not done the same. The value of doing this is debatable and strategies to achieve this possibly controversial (Langridge, 2007). It might be argued that some form of respondent validation would have maximised the authenticity of the participants' accounts, whilst remaining sensitive to the negotiated understanding (Henwood & Pidgeon, 1995). Others believe that participant validation should be viewed as an elaboration rather than a validation of emerging themes (Sparkes, 1998). What happens if the researcher is only able to validate themes with a few participants? Would this be considered sufficient? The possibility of disagreement between participants might also arise (Barbour, 2001). Social desirability might also occur with participants agreeing with the meaningfulness of the researcher's interpretation. One perhaps should hold in mind the sensitive and personal nature of this debate, particularly if participants feel the need to 'put on a brave face' and feel obliged to agree with the findings. Within IPA specifically, the analysis is dependant on the researcher's

interpretation and it might be argued that soliciting participant validation of themes, to some degree, undermines this role.

At the point of interviewing, the researcher had not experienced patient sexualised behaviour directed towards her. Despite building an interview schedule with a staff member, the researcher's lack of this type of experience may have influenced or even discouraged her to incorporate certain questions. Additionally, although attempting to be aware of both her verbal and nonverbal reactions, these might have contributed to what was or was not disclosed. Furthermore, an essential component of the participants' narratives related to their perception of and ability to share with 'outsiders'. In essence, the researcher was not a colleague and therefore could be labelled an 'outsider'. This might have constrained the participants' talk.

4.4 Clinical Implications

Although IPA studies cannot necessarily be generalised, the findings from the current study could be transferred to staff exposed to sexualised behaviour in other brain injury centres and hence the sharing of the emergent themes might prove useful.

The psychological wellbeing of staff is essential and should be a focus within any care giving environment. The findings from the current study suggest that maintaining staff well being by helping them to cope effectively in stressful situations, can be narrowed down to the role played by colleagues. Staff need to be offered the opportunity of time and available space in which to share their

experiences with colleagues, either on an informal or formal basis. The lack of sharing with outsiders was particularly salient. This would further support the need to build on appropriate team and peer support mechanisms and systems within the work environment for staff to manage and alleviate stress whilst on-site.

It is difficult to assess whether the participants reached clinical levels of emotional distress when being subject to patient sexualised behaviour but it did appear evident that they used psychological defences to defend themselves against anxiety. Whilst talking and sharing was not required in all instances, this further highlights that the opportunity of some 'space' to talk was essential. It might be that more available supervision could or should be offered. This might facilitate a mechanism to check with staff about their ongoing stress levels, possibly enabling more appropriate support at a systemic level. However, it would be important to be cautious about any form of debriefing so as not to heighten distress.

Some of the narratives in the current study suggested that additional training relating to sexualised behaviour might be beneficial to increase staff knowledge base. To help address the emotional impact of sexualised behaviour, staff might benefit from being taught alternative coping skills, such as active problem solving skills and relaxation techniques, such as controlled breathing, deep muscle relaxation, mindfulness meditation or imagery.

4.5 Future Research

Various avenues could be explored resulting from the current study. Further research and specific training might be useful in identifying and providing staff with additional strategies to manage the emotional impact of sexualised behaviour. The effect of any new strategy could be measured in at least two ways: (1) by assessing change in staff ability to cope by using, for example, Folkman and Lazarus' (1988) 'Ways of Coping' questionnaire; (2) by measuring staff's ability to 'manage' their psychological response by using a stress or anxiety scale: for example, the Burnout Inventory (Maslach & Jackson, 1981) or the Occupational Stress Inventory (Cooper, Sloan & Williams, 1988). An understanding of the group dynamics might also prove useful in determining how staff acquire and build upon their skills. As the narrative was conclusive in expressing support through shared experience, this could be built upon, possibly through some form of group dialogue focused on problem solving.

The majority of those who volunteered within the current study were female. It might prove useful to further investigate what it is like to be: (1) a female or male member of the team who have experienced sexualised behaviour from a patient of the same gender or the opposite gender; (2) a junior or more senior member of the team; (3) younger or more mature member of the team, to establish if there are differences and if so, what their support needs are.

The current study specifically investigated staff experiences of sexualised behaviour. It would be interesting and certainly of benefit to look at how staff experience other challenging behaviour within this patient group, particularly if

the coping strategies and support needs are different. In addition, as this current study found that staff experienced a wealth of psychological and emotional responses, it might be beneficial to look at the impact of providing additional support on individual's self-esteem.

A variety of professions were represented in the current study, some more so than others; the majority being unqualified staff. Additionally, there were professions that were not represented. Perhaps future research could ask specific professions about their experiences, to see what differences unfold. Holding in mind the barriers stopping staff from discussing specific experiences with family and friends, it might also prove beneficial to better understand these relationships by incorporating these outsiders into this type of research.

5. Conclusion

The current study set out to explore how staff experience and make sense of patient sexualised behaviour. The findings suggest that staff experienced a tumult of psychological and emotional reactions. They identified multiple coping strategies to help them but specifically highlighted the importance of shared experience and shared understanding within the work support system that should be built on and developed within teams.

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APPENDIX A
Research Poster



**Staff Meaning and Interpretation of
Sexualised Behaviour in an Acquired Brain
Injury Population:
A Qualitative Study**

I am inviting you to take part in research that aims to develop a better understanding of how staff experience and make sense of client sexualised behaviour.

Please read the Information Sheet



If you would like to know more about this research, or would like to take part, please contact me.

Kerry Foley

Trainee Clinical Psychologist & Lead Researcher

Phone: 07989 263109

Email: kf50@le.ac.uk

Address: Clinical Psychology, University of Leicester,
104 Regent Road, Leicester, LE1 7RH

APPENDIX B
Research Information Sheet

Research Information Sheet

I am inviting you to take part in this research, which will form part of my doctorate in clinical psychology.

Title of Study

Staff Meaning and Interpretation of Sexualised Behaviour in an Acquired Brain Injury Population: A Qualitative Study

Lead Researcher

Kerry Foley
Trainee Clinical Psychologist

What is the purpose of the research?

This research aims to develop a better understanding of how staff experience and make sense of client sexualised behaviour. Although there has been research into sexualised behaviour, there have been limited studies within an Acquired Brain Injury population (ABI) and even less research exploring staff perspectives and experiences of this.

Who can take part?

Due to the specific nature of the research, only those staff members who are in regular and direct contact with patients who exhibit sexualised behaviour can take part. In addition, as this study is constrained by both timescales and cost, only the first 10 staff volunteers will be asked to take part.

Why have I been chosen?

You have been invited to take part as you currently work with ABI clients. If we gain a better understanding of staff professional and emotional needs, this may help inform and develop clinical practice both in terms of staff support and client work.

Do I have to take part?

No. It is entirely your choice to take part or not.

What will happen to me if I take part?

If you decide to take part after having read this information sheet, then you will need to give consent to be approached. This can be done by emailing me. I will then contact you to provide an opportunity for you to ask further questions or clarify any details of the research.

What will I have to do?

You will be asked to sign a consent form confirming your participation in this research. You can withdraw from the research at any stage.

There are two different parts to this research. You will be involved in one of these. Either:

- Interview – we will arrange to meet for you to tell me about your experiences of client sexualised behaviour. This will be one session only. This discussion may last up to one hour, but you can stop this session at any point if you so wish. I will have some questions to ask you. These are to help the discussion. There are no right or wrong answers. I will record this session using a voice recorder so that I can accurately capture everything you say. I will then transcribe this information onto my computer. This will help me to have a better understanding of your personal experience.
- Diary – I will provide you with a diary. In this diary, there will be some questions listed on the inside page that are aimed at helping you to record information. You will be asked to record all client sexualised behaviour that you experience within a month period and how this has affected you. You can either record the details immediately after they happen, or if you prefer, record the details at the end of each day. After

you have completed the diary for a month, I will collect this from you. I will then transcribe the details from your diary onto my computer.

Will my taking part in this study be kept confidential?

Yes. All information collected from you, either in the interview, or within the diary, will remain confidential. However, if instances of poor practice are revealed (e.g. if concerns are highlighted regarding either your practice or another member of staff's practice), then I would be obliged to breach confidentiality. In this instance, I would inform the Field Supervisor, Dr xxxx.

All transcripts and diaries will be held in locked cabinet in my office. All identifiable information, including names and places will be anonymised to protect your identity. You will be given a pseudonym and it will be this name that will be quoted in the written material. All information entered onto the computer will be password protected. On completion of successful transcription of interviews and diaries data, both audio tapes and diaries will be destroyed. On completion of my studies, the transcribed data will be held by the University in a secure location for a period of five years before being destroyed.

What are the possible disadvantages and risks I should know about before I take part?

You may find that talking or writing about client sexualised behaviour results in you becoming emotional and distressed. If you do not wish to continue with the interview or with writing in the diary, you can stop at any time. Should this happen, the Lead Researcher will offer to debrief you or you may wish to contact your Line Manager or Clinical Supervisor to talk this through.

What are the possible benefits of taking part?

There may be no benefits to your involvement, other than having an opportunity to either talk or write about these experiences. However, the information you provide may help inform and develop clinical practice in this area, benefiting both staff and clients.

What happens if I have a complaint?

If you wish to complain or if you have a concern about any aspect of the way you have been treated or approached during the study you may speak to the Academic Supervising Researcher, Dr Marilyn Christie who will do her best to answer your questions (0116 223 1639). If you remain unhappy and wish to complain formally, you can do this through the Leicester Partnership NHS Trust Complaints Office (0116 246 3461).

What will happen to the results of the study?

The results of this research will form part of my doctoral thesis that will be submitted to the University of Leicester. It may be presented to key stakeholders, namely Leicestershire Partnership Trust, xxxx and the University of Leicester. A brief written summary will be available to you if you request it and you will also be offered the opportunity of receiving verbal feedback. This research may be published within a peer-reviewed journal. In addition, I may provide a poster presentation of the research at appropriate conferences.

Who is organising and funding the research?

I am organising this research and will be supported by a Clinical Psychologist. The University of Leicester will provide costs associated with this research.

Who has reviewed the study?

This study has been formally peer-reviewed by the University of Leicester and has had ethical approval from xxxx Research Committee and the Leicestershire, Northamptonshire and Rutland Ethics Board.

Conclusion

Thank you for taking the time to read this information sheet. If you consent to be approached, then please email me. I will then contact you either to agree a date/time for an interview or to agree a date to meet with you to discuss the diary recording.

If you do not wish to be approached about this study, then I thank you for your time in considering this.

Contact Details

Kerry Foley

Clinical Psychology, University of Leicester, 104 Regent Road, Leicester, LE1

7RH

kf50@le.ac.uk

APPENDIX C
Headings for Diary Entries

Headings for Diary Entries

Please do not put names of people in your diary. Please use 'staff' to describe any member of staff and 'client' to describe the person displaying the behaviour.

Describe the behaviour

What was your initial reaction (what did you do/say, whom did you discuss it with)?

What did you think at the time?

Why do you think the client behaved in this way and why did they direct it towards you?

How did the incident make you feel at the time, for the rest of your shift, when you got home?

How did you cope with this incidence?

Are there any other factors that you think may have influenced how you responded to this behaviour?

APPENDIX D
Ethics Approval

Leicestershire, Northamptonshire & Rutland Research Ethics Committee 2

1 Standard Court
Park Row
Nottingham
NG1 6GN

Telephone: 0115 9123344 ext. 39428
Facsimile: 0115 9123300

14 July 2008

Miss Kerry Foley
Trainee Clinical Psychologist
University of Leicester
104 Regent Road
Leicester
LE1 7LT

Dear Miss Foley,

Full title of study: **Staff Meaning and Interpretation of Sexualised Behaviour
in an Acquired Brain Injury Population: A Qualitative
Study**

REC reference number: **08/H0402/57**

Thank you for your letter of 11 July 2008, responding to the Committee's request for further information on the above research and submitting revised documentation, subject to the conditions specified below.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for [other] Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission at NHS sites (“R&D approval”) should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Application	AB/137823/1	29 May 2008
Investigator CV		27 May 2008
Protocol	5	01 May 2008
Peer Review		21 April 2008
Interview Schedules/Topic Guides	6	11 July 2008
Sample Diary/Patient Card	5	01 May 2008
Advertisement	5	01 May 2008
Letter of invitation to participant	5	01 May 2008
Participant Information Sheet	6	11 July 2008
Participant Consent Form	6	11 July 2008
Response to Request for Further Information		11 July 2008
CV - xxxx		
CV - Marilyn Christie		01 May 2008

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

08/H0402/57

**Please quote this number on all
correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely,

**Dr Carl Edwards/Miss Jeannie McKie
Chair/Committee Coordinator**

Email: jeannie.mckie@nottspct.nhs.uk

APPENDIX E
Participant Consent Form

Research Briefing and Consent Form

Title of Study: Staff Meaning and Interpretation of Sexualised
Behaviour in an Acquired Brain Injury Population –
A Qualitative Study

Researcher: Kerry Foley

*Signing this form does not commit you to complete the study.
At any time, you remain free to leave the study without having any reason for
doing so.*

I have read the information sheet	yes/no
I have had the opportunity to ask questions and discuss this study	yes/no
I have had all my questions answered to my satisfaction	yes/no
I have received enough information about the study	yes/no
I understand that I am free to withdraw consent	
- at any time	yes/no
- without having to give a reason	yes/no
- without my employment or legal rights being affected	yes/no
I would like to receive a copy of my transcript	yes/no
I would like to receive a summary of the results of this study	yes/no
I understand that the results of this study may be presented to others, including my colleagues	yes/no
I understand that the results of this study may be submitted for publication in a journal	yes/no
I give consent for my interview to be audio taped	yes/no

APPENDIX F
Interview Schedule

Interview Schedule

It is not intended that all of these questions will be asked during the interview.

These are merely prompts, to enable participants to engage with the Lead

Researcher in the interview.

Introduction/Background

1. How would you describe your current experience with this (ABI) client group?
2. What, if any, previous work experiences have you had that included sexualised behaviour?

How would you describe sexualised behaviour?

Identity/Sense of Self

1. How would you describe yourself?
Most important characteristic
2. How would others describe you?

Description of sexualised behaviour

1. How often have you witnessed sexualised behaviour towards others?
2. How often has sexualised behaviour been directed at you?
3. Please describe an example of sexualised behaviour by a client directed at you.

What was your initial reaction?

What did you do?

What did you say?

Whom did you tell?

Did you discuss it with friends/family outside of work?

What do you remember thinking at the time?

What are your thoughts on why the client behaved in this way?

Why do you think they directed their behaviour towards you?

How did this sexualised behaviour make you feel when it occurred?

How did you feel for the remainder of your shift?

How did it affect you when you went home?

How did it make you feel coming on your next shift?

How does this type of behaviour affect how you interact with this particular client/other clients?

How did it affect your everyday life?

4. Why did you choose this particular example?

Coping Strategies

1. How do you cope with sexualised behaviour?

How prepared were you for dealing with sexualised behaviour?

What would best describe your coping behaviour?

What could help you cope better?

2. What impact, if any, did your age have on how you coped?

3. What impact, if any, does being female/male have on how you coped?

4. What impact, if any, do you think your:

- Culture
- Background
- Upbringing
- Models of Sexuality
- Values
- World view

have on how you viewed this behaviour?

5. Are there any other factors that you think may have influenced how you responded to this behaviour

APPENDIX G

Examples of Memo Writing Reflections

Example of Memo Writing Reflections

During the analysis phase of the research, the current researcher reflected on the memos that she had written after each individual interview. The following excerpts (shown in *italics*) are two examples from these memos and illustrate how they might have influenced the analysis.

Example 1

... What was it about the situation and sitting talking to me that meant this participant appeared hesitant in sharing her experiences with me? Was this my imagination, it being the first interview? Possibly. Although perhaps it was to do with trust. Did she trust me? She didn't know me... what did she see me as? Come to think of it - trust me with what? A supportive response perhaps or trust that she would be listened to? That her experiences would be believed? I had a sense of 'willing' her to share and without actually saying it to her, I wanted to get across to her that it was okay to share with me. She selected two examples to talk about - it is interesting, or at least worth making a mental note of, that the more serious one was talked about after some time. Perhaps she needed to feel safe and secure in talking to me - needing to size me up before exposing herself and talk about such an emotive subject. I think that something must have changed between us to enable her to talk about the second example...

In considering this particular excerpt whilst analysing the interview data, I wondered about relationships in general and the specific relationship between the participant and me and what, if any, impact did this have on the degree to which information was disclosed. In a research interview, the expectations are made explicit through both the participant information sheet and the preamble at the start of the interview. However, it seemed important that the sharing of information was not straight forward but probably quite complex and dependent upon the relationship between two individuals. Thinking about this might have provoked me into thinking about staff relationships and possibly giving the theme of relationships more salience. Within this interview, my ability to contain my responses (when compared to the 'shocked' nature of the responses received from friends and family) might have resulted in me being viewed by the participant as 'one of us', a colleague rather than an outsider. What was the value of talking to me? Apart from a possible altruistic act of wanting to help out with research, it seemed possible that the value in meeting with me was possibly the space to talk, feel heard and feel supported. This is not dissimilar to

the participants' needs of being supported within their workplace when incidents occur and feeling safe – both physically but also having space to feel safe to talk about incidents.

Example 2

...I found it interesting that outside of talking about the actual experience and the resultant shock and reaction of feeling 'sick', she seemed very keen to express that she wasn't really affected by the behaviour. She was certainly flushed when talking about it – what was this about? I'm thinking that perhaps it's as simple as that she doesn't know me and it's not something you would normally share with a stranger. I wonder whether her upbeat manner is reflective of her general personality or as a means to tell me that she wasn't affected and wouldn't be affected by this behaviour - does she feel she needs me to see her as a capable person? I felt that she certainly seemed very capable – did I give her this impression? That said, I do wonder if to get through the day, she finds it easier just to dismiss the behaviour and get on with her job...

It seemed that this extract highlighted once again, the potential difficulty with sharing this type of experience with others, particularly someone who perhaps might not understand. This seemed to give further credence to attending to the idea of relationships and different types of relationships meant to the individual. Additionally, in considering this particular extract during analysis, I wondered about the notion of coping and the strategies adopted by staff to deal with the sexualised behaviour. It helped me to reflect on the nature of how an individual defends against forms of physical or verbal threat. What might have it been like for this particular participant within the work environment to show others that she was coping and needing her colleagues to perceive that she was coping? In thinking about how I perceived her to be possibly just 'dismissing the behaviour' as a way of coping, this perhaps added salience to the 'acclimatisation and acceptance' sub-theme. It felt as though when she was recounting the story with me, she needed or perhaps wanted to respond in the same way that she had responded when the incident happened; that of someone who can dismiss the behaviour and can show another person that she can cope; a useful coping strategy.

Part Three: Critical Reflection

Working with Patients with an Acquired Brain Injury: Staff Experiences of
Inappropriate Sexualised Behaviour

Critical Reflection

1. The Journey

This has been an exciting, but at times, tumultuous journey for me. The route initially mapped appeared at first glance to be fairly straightforward, with achievable deadlines (Appendix A). Many lessons were learnt throughout my journey, some more obvious and quickly remedied than others. I reflect on the importance of preparation, holding in mind and considering the possibility of continuous change and recognising the availability of guidance.

2. Why this route?

My initial interest was sparked by a research fair, organised in the first year of my clinical training. In attendance, were several local clinicians promoting research; one focus of which was sexualised behaviour. Existing research was evident across client groups and very much focused on recording, measuring and managing sexualised behaviour; in the main, quantitative in nature. An initial review of literature suggested that a key focus was on the sexuality of patients and how staff managed this rather than necessarily how staff experienced being on the receiving end of patient sexualised behaviour. In addition, I had listened to colleagues discussing their experiences of these types of behaviour from patients with an acquired brain injury. Further exploration of what to focus on was discussed with my supervisors (MC and LBS). Due to the paucity of studies and to complement existing research, it seemed appropriate and worthy to qualitatively gain an understanding of staff experiences of sexualised behaviour. This was achieved using IPA.

3. A question of numbers

I struggled in gaining agreement as to how many participants were suitable for an IPA study. On attending an external workshop, intended to enhance my understanding of IPA, the suggestion was that 'small' numbers were preferable. The university's guidelines of preferring 10-12 participants seemed particularly constraining; having a broad statement about sample size requirements of qualitative research was possibly misguided and certainly confusing. Establishing how many participants would be suitable for my research was a source of frustration.

The site in which the study was undertaken had many other research projects underway at the time and had a history of producing quality research. The site also actively encouraged staff to support and take part in research. However, what was it about this particular research that interested staff to volunteer?

Perhaps it was an opportunity not normally available for them to talk about their experiences; perhaps it was perceived to be some form of therapeutic space.

Alternatively, perhaps it was just a general interest or an altruistic act to support research. What about those staff who did not volunteer? Most volunteers were younger, unqualified staff with less representation from qualified or older staff.

Why was this? The evocative nature of the research may indeed have restrained staff from volunteering, as perhaps is borne out by the gender mix and ethnic make-up of those that did volunteer. The majority of volunteers were female and all were white British. This might have been a missed opportunity but perhaps a focus for future research. For example, identifying barriers to volunteering could prove useful. On reflection, the findings of the study could

be explained by the demographics of the sample. However, I am unsure if older, more autonomous professionals would have reacted differently and this is an area of future research.

4. Not just a matter of interviewing

At the outset, I was aware that my aim in interviewing was to enable and facilitate the sharing of stories; viewing the accounts as co-constructions (between the participant and the researcher) of the participants' experiences. I accepted that recording interviews would not necessarily translate to fully capturing the participants' experiences but expected that in part, they would help me capture the essence of those experiences. The narrative constructed and produced was a product of the relationship between the participant and myself; highlighting the importance of understanding my influence on this.

Throughout, I was conscious of the role I played in each interview. Would the participants perceive me as the 'researcher' or the 'trainee clinical psychologist' and how would participants' connotations of these two roles affect the interview-interviewee relationship? In hindsight, I believe that participants saw me in the main as a researcher but also as a clinician, able to 'contain' them within the research 'space'. Additionally, I tried to hold in mind aspects of embodiment that I could attend to: bodily empathy, embodied self-awareness and embodied inter-subjectivity (Finlay, 2006). Although perhaps not always successful in attending to these features, memo writing post-interview aided this and encouraged my reflexivity.

Self written descriptive accounts, e.g. diaries, are evident in qualitative research and in subsequent IPA analysis. I originally thought that participants might prefer to use this method, as an alternative to being interviewed, assuming that it would possibly be less intrusive and more empowering for participants. No definitive conclusions were drawn about why participants did not opt to diarise events, with the only completed diary being 'expressively' limited, including edited detail. I wondered if I was asking too much commitment of the participants or if they were wary of writing a 'concrete' account of their experiences. These could have been factors limiting the use of diaries. However, on reflection, I might not have sufficiently attended to the approach of incorporating and explaining the use of the diary as a means of data collection; this might have been the reason for minimal uptake. For future research, I would certainly consider better promotion of the use of diaries, perhaps by explaining these in more detail both as part of the initial briefing of teams and by incorporating more detail into the research information sheets. It was interesting to note the power of recording interviews and how participants visibly relaxed once the recorder was switched off.

I was thankful that a fellow clinical trainee, who was working on placement at the time of starting my research, agreed to talk to me about her experiences of patient sexualised behaviour. This enabled the formation of an interview schedule. The trust needed to share emotive information is implicit. It was curious to note that several participants initially chose a fairly 'low level' behaviour to talk about. I think in these instances, there was an element of 'testing', not only a need to feel that I could be trusted with this information, but

that they could trust themselves to divulge the experience without becoming uncontained. I had structured the interview schedule to incorporate, what I thought to be initial 'easy' questions, allowing participants to 'ease' into the interview without feeling overwhelmed. What I had not fully appreciated when forming the interview schedule was that this schedule was based on a discussion with somebody that I knew and who therefore felt comfortable in talking to me. Reflecting on this, the use of a *naïve* participant might have proved more beneficial as this would have challenged my assumptions and tested out the appropriateness of the initial questions. Additionally, a naïve participant might have resulted in alternative initial questions to establish trust and rapport. Using this naïve participant within a pilot interview, I would specifically address the issue of these initial questions and ask the volunteer not only what they think of the questions but also at what point they feel comfortable or at ease in answering questions.

I was aware of my own contradictory thoughts; the importance of recording the interview so that 'nothing was missed' was forefront in my mind. I was conscious of knowing that the recording would not fully encapsulate the exchanges between interviewer and interviewee and that the process of transcribing had the potential to alter the data to some degree. Power differentials within an interview are expected and this might have constrained responses. In preparing for the interviews, I believed that I was relaxed in my questioning and seemingly expecting to be relaxed, to listen to the answers and share the experiences with the participants. Initially, I sometimes found myself holding back additional questions that perhaps would have explored other

avenues, reasoning that by not asking, I was 'containing' the participant. After finishing the interviews and when transcribing, I realised that there was possibly more opportunity to explore the narrative being presented by the participants and that 'containment' might not have been just of them and their experiences but perhaps of me as well. I accepted that interviewing was a skill that although I have not mastered it, I am now certainly more competent.

The emotive content of the interviews was understandable considering the focus of the research. In one interview, the participant was clearly affected when recalling the impact of the behaviour and at one point in the interview, I felt as though I needed to help contain the participant's emotions. I was very conscious that, although my role was as a 'researcher', it was equally important for me to utilise my clinical skills in these situations and to alleviate any distress felt. At the time, and in retrospect, I believed this was the right thing to do.

For some participants I wondered if they perhaps regretted to a certain extent to volunteering. A couple of the participants seemed almost keen to keep answers brief, wanting to move on to answering the next question and be on their way as soon as the recorder was switched off. What factored into this I am not totally sure of but might have been a combination of personal and situational characteristics. The pressures of the workplace might have resulted in some participants feeling the need to return to the ward quickly and perhaps giving them the opportunity to rearrange the interview might have been worthwhile. Although informed of the purposes of the study, others might have had a distrust of what the study was really looking at. This particular issue perhaps

could be mitigated in future by providing potential participants with more information regarding previous research in the area so as to better contextualise the current research.

5. Reflections on analysis

Memo writing enabled me to pause for thought about my relationship with the participants. What did it mean to them to volunteer to take part in my research and disclose information that was both quite emotional and personal? I wondered whether in some sense it was cathartic for them, as through their talk it appeared that they had not spoken in such detail about any incident, particularly to an outsider. The act of narrating itself can result in relief for the participant (Gaydos, 2005), and this was spoken about specifically by two participants. What must this have felt like for the other participants? Any hesitation they had might have been related to a concern that I would not know what they were talking about, or I would not understand how it felt: whilst perhaps not a conscious thought, there might have been a need to feel contained when sharing such information. Narrating the accounts generally appeared unproblematic for the participants but I wondered if this truly were the case. At times, I felt a slight tension between my role of researcher (the dominant role in this study) and my role as clinician and having a duty of care for my participants. Debriefing was undertaken but I did wonder if this was sufficient. However, I reflect that as future presentation of the findings is forthcoming, this might provide an additional opportunity to assess the impact of the research and its findings on individuals.

Whilst transcribing and analysing the data, I started working within the same hospital on an in-patient dementia ward, with staff being on the receiving end of some fairly regular patient sexualised behaviour. I was party to listening to this type of behaviour being discussed regularly at ward rounds. There were also personal incidents of receiving sexualised behaviour. It surprised me how my initial reactions mirrored that of the participants in this study. I questioned myself as to why I was not particularly open about these incidents to colleagues, and felt some of the emotions expressed by the participants. What was striking was that I did not mention these incidents to family and friends. Reflecting on this, my reasoning appeared to match that of most participants, believing that outsiders perhaps wouldn't understand and I did not want to be in a position of having to 'contain' their emotional response in addition to my own.

This exposure to sexualised behaviour and personally experiencing some low level sexualised behaviour did not militate against how I interpreted the data but instead helped put the narratives into perspective. It also enabled me to reflect back on the dynamics of the interviewer/interviewee relationship, particularly when discussing such intimate and personal detail; their stories entwined with my story.

When analysing the results and writing up the Discussion, I was extremely conscious not to assume that my findings were anything other than one interpretation of possibly many. Believing that what was shared by participants in the interviews was a meaningful interpretation and construction of that experience as consciously available and recalled in the participants' minds, at

times, capturing this seemed extremely difficult. I tried not to be naïve in my understanding of what I had captured. However, I do believe that, in essence, the shared experience, although transformed by recording and by transcribing, shares a likeness with the lived experience.

The emergent themes discussed were pivotal to the participants' narratives. However, with such a high volume of data, I question whether reducing the data to manageable themes was inevitably a means to an end. I also wondered, given more time, would the interpretation be more elaborate. Did I deliberately escape the hermeneutical cycle? As a means to ensure quality of my analysis and interpretation, I was part of a qualitative support group, with other members of my trainee cohort. This enabled me to develop my skills and helped me to reflect on my research. In addition, it encouraged me to keep in mind the importance of ensuring that themes were grounded in the words of the participants. This process was helped by me sharing and discussing my initial interpretations of the data with my research supervisor.

I wondered whether given time, if I would have considered validating the themes with the participants. It is difficult to answer this but I feel that, whilst not wanting to dis-empower the participants, I was aware of not disempowering myself. It was important for me to hold in mind the importance of the fundamental principle of interpretation and that my interpretation was just one of possibly multiple interpretations. Nevertheless, I would still be interested in knowing how the themes fit with each participant's experiences of sexualised

behaviour. This might still be forthcoming if participants are willing to share their thoughts on the themes with me when I feedback my findings.

6. The write up

Whilst transcribing did take a lot of time, it allowed me to re-familiarise myself with the interviews and become closer to the data. Although by the end of analysing, I felt as though I was almost drowning in data, I did wonder whether I had the capacity to understand what I had in front of me. At times, I did not want to share my progress, particularly when little progress was being made. Fortunately, my supervisors were able to contain these feelings of almost being overwhelmed; providing encouragement and guidance throughout.

The number of participants within this study generated much data and I wondered if the breadth of exploration compromised the depth of exploration. I reflected that for future research, I would need to be more confident in determining the appropriateness of sample size if using IPA again. Participants shared their stories with me, which was not necessarily an easy thing to do. I held in mind that I needed to do full justice to the experiences shared with me, and at a minimum, I firmly believed that I could do a 'good enough' job. Whilst the findings from a study using IPA are not necessarily generalisable, this does not mean that the emergent themes would not be of interest or of use to other similar services.

7. Shortcomings of IPA

I acknowledge that to be transparent in choosing a particular method of analysis, I needed to accept that inevitably, any choice would have shortcomings. In this respect, IPA is no different. Within IPA, the exemplar method of data collection is the interview and because the use of interviews within IPA is almost taken for granted and readily accepted, what perhaps are not discussed in any depth are the restrictions and limitations to this method. Potter and Hepburn (2005) suggested that by not including questions, intonations and prompts in the quotes, that not only will this take the participant's responses out of context, it also results in the 'removal' of the interviewer and by doing so, the interactional nature of the interview is lost. Potter and Wetherell (1995) suggested that more weight be given to the interactional nature of the interview so as not to lose the jointly constructed nature of the interview or features of the conversation, such as, the close dependence and consequential nature of what the interviewer says and how the participant responds. Potter and Hepburn (2005) further suggested that within an interview, how questions are constructed by the interviewer will introduce an element of 'coaching' of the participant and that this needs to be acknowledged.

Despite interviews being the main method of data collection within IPA, no standard convention or specific guidelines are suggested for transcribing interviews, and as such, I reflect that this possibly increased the likelihood that some nuances of the conversation were missed. Indeed, one common criticism of interview transcripts is that the context is lost when coding occurs (Bryman, 2001).

Willig (2008) highlighted practical and conceptual limitations with IPA, which perhaps should be acknowledged and could have been given more consideration when selecting the methodology and also during the analysis phase. These limitations are the role of language, the suitability of accounts and explanation versus description. I accepted that the account of the experience would be constructed by both the participant and me as the researcher. However, in considering the role of language, Willig (2008) argued that an interview transcript can only reflect how the participant *talks* about their experience rather than necessarily the experience itself. In addition, what is talked about is constrained by the ability of the participant to articulate their experiences and use language in such a way that the subtleties and richness of their emotional experiences are expressed. For those participants that might not have been used to expressing their thoughts so openly, this might have resulted in only a partial story being shared with me. I wonder if some staff might not have volunteered to participate because of a concern regarding their ability to articulate their thoughts and that perhaps, in contrast, those participants who did volunteer, were confident in their ability to express themselves.

Willig (2008) further suggested that although fundamentally interpretative, because of a focus on description rather than explanation, IPA is unable to expand the researcher's understanding of why such participant experiences occur. By reducing the participants' stories to description and because of the potential for a researcher's lack of awareness of the context and conditions of

these experiences, a full appreciation and explanation of the phenomena is restricted.

8. Other aspects of reflexivity

I have occasionally 'bumped in to' some of the participants who took part in this study. Now no longer the 'researcher' but 'colleague', it is a somewhat precarious situation for both parties. I find myself waiting to see if I am acknowledged before acknowledging them as if in some way, by not waiting, I might jeopardise their trust in me keeping their confidence. When 'talking' amongst staff was viewed as a positive coping strategy, it surprises me to a degree that some participants appear to 'deny' having talked to me. Do they regret taking part in the study or is it because I am still perceived as the researcher, with the stories told needing to remain within that sphere? This might fit better with their overall construction of a researcher and hence, perhaps now construe me as a trainee clinical psychologist, very distinct from the person that interviewed them.

9. The future

Now that I have completed the study, whilst I feel exhausted by the process and sheer volume of work, I feel that I have developed my knowledge and skills and built upon my existing skills. I believe that I have developed my ability to conduct research and I am inspired to pursue further research, especially of a qualitative nature, in the hope that I will better capture the amazing experiences shared.

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APPENDIX A
Chronology of Research Process

Chronology of Research Process

On-going Review of Literature	March 2007 – April 2009
Submit draft research proposal	May 2007
Review Panel for Research Proposal	June 2007
Agree and confirm field and academic supervisors	August 2007
Submit proposal for peer review	April 2008
Submit brief statement of intent – LREC	May 2008
Research Ethics Committee Application Form	May 2008
Ethics Approval	July 2008
Preparation / pilot of interview schedule	August 2008
Data collection – interviews / diary	September – November 2008
Transcribing	November – December 2008
Analysis	January – March 2009
Final Analysis	April 2009
Writing up of Thesis	February – May 2009
Submit to University of Leicester	May 2009
Dissemination	2009/2010