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A counselling psychology perspective on the experiences of therapists working with clients convicted of crime

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Thesis submitted in fulfilment of the requirements for the award of Doctorate in Counselling Psychology

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DECLARATION

I grant powers of discretion to the University Librarian to allow this Doctorate Portfolio to be copied in whole or in part without further reference to me. This permission covers only single copies made for study purposes, subject to normal conditions of acknowledgement.

TABLE OF ABBREVIATIONS

ACCT	Assessment, Care in Custody and Teamwork
ASPD	Anti-Social Personality Disorder
BPS	British Psychological Society
CBI	Copenhagen Burnout Inventory
CBT	Cognitive Behavioural Therapy
CFT	Compassion Focused Therapy
CMHT	Community Mental Health Team
CoPiFS	Counselling Psychologists in Forensic Settings
DH	Department of Health
HMCIP	Her Majesty's Chief Inspector of Prisons
IAPT	Improving Access to Psychological Therapies
IPA	Interpretative Phenomenological Analysis
MBI	Maslach Burnout Inventory
MHIRTs	Mental Health In-Reach Teams
MoJ	Ministry of Justice
NICE	National Institute for Health and Clinical Excellence
OBPs	Offending Behaviour Programmes
OCD	Obsessive Compulsive Disorder
PBI	Psychologists Burnout Inventory
PTSD	Post Traumatic Stress Disorder
RS	Restricted Status prisoner
SEU	Social Exclusion Unit
SOTP	Sex Offender Treatment Programme

PART A: PREFACE

1.0 INTRODUCTION

This doctoral portfolio consists of three pieces of work written at different stages of my training to become a counselling psychologist. There are two distinct but overlapping themes within the portfolio; the experiences of psychologists during therapy and therapeutic work with people who have a forensic history. These pieces of work reflect my evolving identity as a counselling psychologist practitioner and researcher and my longer-standing interest in working with people who commit crime.

Part B of this portfolio is an original piece of qualitative research investigating the experiences of therapists working with prisoners, Part C is a critical review of the literature pertaining to counselling psychologists' experiences of burnout and the portfolio concludes with Part D, a combined client study and process report detailing my therapeutic work with a client who had a criminal history. In the remainder of this preface, I will summarise each piece of work and explain how it relates to the themes of this portfolio.

2.0 PART B: RESEARCH PROJECT

Part B of this portfolio presents a piece of qualitative research entitled 'An interpretative phenomenological analysis of therapists' experiences of working with prisoners'. Eight therapists with experience of working with prisoners were interviewed and their accounts were analysed using Smith's Interpretative Phenomenological Analysis (see Smith, Flowers & Larkin, 2009). The focus of the study was on therapists' experiencing of themselves in relationship with their prisoner-clients, their experiencing of their clients and of the crime for which they were imprisoned. In-depth analysis of their accounts revealed four dominant themes which encapsulated the shared aspects of the participants' experiences. These themes and the research findings are discussed with reference to the extant literature and I identify their relevance to professional practice and the field of counselling psychology.

Working with people who have committed crime has been a dominant feature of my professional life, a feature which has continued throughout my training as a counselling

psychologist. It arises from my interest in the welfare, rehabilitation and management of offenders, a much deprived and socially excluded group (Social Exclusion Unit, 2002). The influence of my interest and experience upon the research is explored in more depth within that piece of work. The discipline of forensic psychology dominates the field with regard to psychological work with offending populations and interventions from that discipline typically focus upon factors that contribute to offending behaviour (Crighton & Towl, 2008). Counselling psychology is perhaps in a position to offer an alternative, broader approach to the same client group. It is hoped that this research contributes a counselling psychology perspective to this field of work.

3.0 PART C: CRITICAL LITERATURE REVIEW

The impact on psychologists of working with clients whose behaviour and history might be experienced as distressing or challenging is explored in literature with reference to the terms 'vicarious trauma', 'secondary trauma' and 'burnout'. The aforementioned research in Part B of this portfolio explores the potential for therapists working with prisoners to experience vicarious and secondary trauma from exposure to the details of clients' offences and their often traumatic personal histories. The critical literature review in Part C continues the theme of this portfolio concerned with therapists' experience of therapy by examining the potential for counselling psychologists in any setting to experience burnout. Job burnout is primarily associated with individuals who work with people in some capacity and is characterised by three domains of experiencing: emotional exhaustion; depersonalisation of the client and a reduced sense of personal accomplishment (Schaufeli, Leiter & Maslach, 2009). Whilst the literature review is not limited to psychologists working in prisons, the concept of burnout does appear to be particularly relevant to those practitioners; for example a recent study by Senter, Morgan, Serna-McDonald and Bewley (2010) found that psychologists in prison settings experienced significantly more job burnout than those working in hospital and university settings.

This review was written in my first year, and as such reflects an early interest in the process of therapy and the notion that the practice of counselling psychology is not done 'to' another but rather in a relationship with another, thus conveying the possibility that both people are affected by the experience.

4.0 PART D: COMBINED CASE STUDY AND PROCESS REPORT

The work presented in part D outlines my theoretical approach and conceptualisation of a client with severe and enduring mental health problems and a forensic history. The therapeutic approach of cognitive behaviour therapy (CBT) and specifically, a model for low self-esteem was combined with theoretical insights and techniques of compassion focused therapy (CFT). An outline of the client's difficulties is provided and followed by a psychological formulation and a description of the therapeutic work. Within this, a short excerpt of a transcript from a therapy session is presented and I reflect on my interventions and the process of the therapy.

Within this report, I consider the use of CFT within a CBT approach. Gilbert's CFT (see 2010), with its theoretical consideration of early attachment experiences and the physiological and behavioural responses to perceived threats, appears to be particularly suited to the needs and presentations of clients who have committed violent crimes as this client group typically has less secure attachment styles (Ross & Pfafflin, 2004). Within the client piece, I reflect upon my own emotional and cognitive processes and how I was impacted by the therapeutic work. In particular, I identify the challenge to respond therapeutically and with compassion without colluding with thoughts and behaviours which have the potential to harm others.

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PART B: RESEARCH PROJECT

An Interpretative Phenomenological Analysis of therapists' experiences of working with prisoners.

ABSTRACT

Whilst there are published personal accounts of therapists' experiences working with prisoners, little research has been conducted on the subject. Interpretative Phenomenological Analysis was used to explore the experiences of eight therapists working in male and female adult prisons. Four dominant and shared themes emerged from the research interviews. Therapists conceptualised their role as providers of empowering, protective and non-judgemental relationships to clients who are otherwise deprived of their liberty, control and empathic relationships. Whilst emphasising an allegiance to the prisoners, therapists were aware of the danger their clients posed and adopted psychological and physical strategies to protect themselves. Participants sought to distance themselves from the criminal parts of their prisoner-clients, instead identifying and working with the victim within them. Participants reported clear benefits from working with prisoners; these appeared to counterbalance the potential for significant losses to their personal and professional selves.

CHAPTER ONE - INTRODUCTION AND LITERATURE REVIEW

1.1 INTRODUCTION

On the front of a five pound note is the face of a woman who changed the way Europe treated its prisoners. In the 19th Century, Elizabeth Fry, a Quaker and a gentlewoman, faced much criticism from her social counterparts and the Government for trying to draw the country's unwilling attention to the inhumane treatment of prisoners in jails. Whilst society condemned the 'wild and wanton' behaviour of the women of Newgate prison, Fry saw their human need and as a result of her compassion and active interventions, demonstrated that women-prisoners could behave respectably if they were treated with respect (Rose, 1994). Two hundred years later, criminality and imprisonment remain topics of political and social concern and the differing attitudes towards those in prison prevail (Wood & Tendayi Viki, 2004). Despite the lack of consensus, Fry's work induced a paradigmatic shift in the way society treated its prisoners (Rose, 2004) and the principle of humane prisons now exists separately from religious convictions and is incorporated into HM Prison Service objectives (Ministry of Justice [MoJ], 2012a).

In this, the 21st century, various organisations work both voluntarily or contractually within prisons providing services that address prisoners' drug and alcohol problems, their religious and spiritual needs, their education needs, and particularly relevant to the field of psychology and this study, their psychological and mental health needs. The provision of psychological services in prison is a relatively recent addition. When introduced into prisons in the late 1940s, psychologists' principle tasks were to assist governors and medical officers in reports to the courts; there was little treatment of prisoners involved (Farrington, 1980). The roles of these psychologists were later associated with the discipline of Criminological and Legal Psychology, formed in 1977 and renamed Forensic Psychology in 1999 (British Psychological Society [BPS], 2012). Forensic psychology was and continues to be the dominant psychological discipline within UK prisons (Crighton & Towl, 2008), the role typically involving the provision of individual and group-based interventions aimed at prisoners' criminogenic needs, that is the factors relating to criminal behaviour with the purpose of reducing reoffending (BPS, 2011).

Crighton and Towl (2008) remark on the "single-paradigmatic approach" (2008, p. 9) of psychology that has existed in prisons, referring to the specialism of forensic psychology. In the last decade and particularly in the last few years, there have been significant changes in the provision of psychological services (Crighton & Towl, 2008). Whilst some counselling, clinical or health psychologists have been working in prisons directly employed by individual institutions, the changes have resulted in greater opportunities for these psychologists to work within a structured and nationally consistent NHS mental health service (Towl, 2010). These services are aimed at providing mental health care equivalent to that which is available in the community (Crighton & Towl, 2008), rather than offence-focused interventions which are typically the domain of forensic psychology. Similarly, Harvey and Smedley (2010) also observe there to be increased opportunities for therapists from other specialisms, including psychotherapists and CBT therapists. Harvey and Smedley suggest this has created the possibility that the longstanding association in prison between psychological treatment and the aim of reducing criminality may be adjusted so that 'treatment' might have broader connotations.

Psychological interventions in prison which are not offence-focused have been little documented up to now and this study sets out to contribute to our understanding of this important area. The research explores the experiences of practitioners providing one-to-one 'talking' therapies that are focused on the mental health needs of their prisoner-clients.

1.1.1 Clarification of terms

In this study, therapeutic practitioners will be referred to as 'therapists', the term being used in its broadest sense to refer to those providing psychological therapy. This is an all-encompassing term to include different professional disciplines, such as counselling psychologists, psychotherapists, and CBT therapists.

The terms 'prisoner' and 'offender' are used throughout, these being the dominant current terms to refer to a person who is imprisoned and a person who has been convicted of a criminal offence. It is acknowledged, however that some people are convicted and imprisoned under a miscarriage of justice. The term 'inmates' is not used as it can also denote a person contained within a secure mental health unit. The use of the word 'prisoner' requires further clarification. It is acknowledged that the term can also refer to someone contained in a prison on remand (untried or unconvicted). In the present study

however, it is used to refer to someone who is contained in an adult prison having been convicted of a criminal offence, this group making up the majority of those held in prisons (MoJ, 2012b). The offences prisoners have been convicted of are likely to be serious, as the Sentencing Council (2012) outlines: "Custodial sentences are reserved for the most serious offences and are imposed when the offence committed is so serious that neither a fine alone nor a community sentence can be justified for the offence" (para 1).

The terms 'offender' and 'prisoner' are all-encompassing labels when in fact there is much more to a person than their offending behaviour. The reader is urged to bear these observations in mind, despite the terms being used for clarity and brevity.

1.1.2 Outline of the rest of the chapter

In order to fully understand the distinction between the work of therapists conducting non-offence focused work and their offence-focused colleagues, I will summarise the main characteristics of both; this will necessarily involve a degree of reflection upon the recent developments in psychological-service provision in prisons. I will also briefly describe the work of forensic psychotherapists who are positioned between these two poles in that their work is concerned with both the mental-health needs and the criminal behaviour of their clients. Forensic psychotherapists however, mainly work within NHS psychiatric and forensic services, including secure hospitals such as Broadmoor and Rampton. I will briefly describe their perspective and approach to providing therapy to people convicted of a crime. This summary of different types of psychological intervention with prisoners sets the context for the present study.

An understanding of the needs of prisoners contributes both to the understanding of the experiences of their therapists and to an understanding of the importance of therapy to this client group. I will therefore summarise relevant literature.

The second half of the introduction is dedicated to a review of the literature that pertains directly to the work of therapists in prisons. Following this, the rationale for the current study and the research aims are identified.

1.1.3 Offence-focused psychological interventions

Offender Behaviour Programmes (OBPs) were developed within the discipline of forensic psychology and introduced in the late 1990's. They continue to be the main source of

psychologically-informed interventions to address offending behaviour (Clark, 2010). OBPs are typically based on the theory of Cognitive Behavioural Therapy (CBT) and are delivered to groups of prisoners with the aim of teaching offenders how to manage those aspects of their lives that increase the risk for re-offending (Sainsbury Centre for Mental Health, 2008b), typically thinking styles, attitudes and emotion management (Robinson & Crow, 2009). There are also OBPs aimed at challenging offenders' sexual offending, these are known as sex-offender treatment programmes (SOTPs). Completion of OBPs is often recommended by the courts at time of sentencing or by prison and probation staff and whilst prisoners have to consent to participate, they do so with awareness that completion will increase their chances of early release (Sainsbury Centre for Mental Health, 2008c).

The content of OBPs is carefully manualised and the 'delivery' by 'facilitators' is monitored through video recording to ensure treatment is consistent (Robinson & Crow, 2009). All aspects of these programmes have been debated (see Clark, 2010, and Crighton & Towl, 2008 for a review), not least over whether they serve their aim in reducing reoffending. Additionally, commentators have questioned whether such programmes can be referred to as 'therapy' or are even therapeutic. Clark reviews these criticisms, acknowledging that facilitators are typically not trained therapists but prison officers trained for the role with little understanding of therapeutic theory. Additionally, the use of prison officers as facilitators was seen to reflect the fact that these interventions are more psycho-educational, as opposed to psycho-therapeutic (Clark, 2010). Crighton and Towl (2008) also acknowledge that the manualised content and restrictive delivery guidelines limits opportunity for response to individual needs and Clarke further links the structure to limited potential for the consideration and development of a therapeutic alliance. He goes on to describe however, the recent move towards a more psychotherapeutic approach within OBPs, including an increased focus on the collaborative engagement of participants with additional one-to-one sessions, an empathic and supportive facilitation style and consideration of a therapeutic alliance. Separately, Robinson and Crow (2009) discuss concerns over the 'treatment model' of OBPs which places the causes of crime firmly with the individual with little consideration for contributory environmental factors. Whilst debate may continue as to whether OBPs can be termed therapy or therapeutic, it is clear that their main focus is on reducing reoffending, as opposed to addressing wider needs of the prisoner (Crighton & Towl, 2008).

1.1.4 NON-OFFENCE FOCUSED INTERVENTIONS

The provision of healthcare within prisons has changed dramatically since the 1990's as a result of a damning prison inspection which reported a lack of adequate health assessment and provision (Her Majesty's Chief Inspector of Prisons [HMCIP], 1996). Where previously prisoner health was managed by HM Prison Service and provided by prison staff, between 2003 - 2006 responsibility for the provision of health services to prisoners transferred to the NHS and the notion of equivalence was introduced, meaning that the provision of services to prisoners should be equivalent to services available in the community (Cinamon & Bradshaw, 2005). Home Office advice recommended the broadening of disciplines involved in psychological services to improve the quality of psychological work within prisons (Towl, 2012). These radical changes brought about some improvements to prisoner mental health care. Following the introduction to prisons of Mental Health In-Reach Teams (MHIRTs) in 2001 (Mills & Kendall, 2010), more standardised services were available to prisoners where previously provision had been sparse and inconsistent (Department of Health [DH], 2009) and of varying quality (Reed & Lyne, 1997). Psychological therapy was provided to address prisoners' mental health needs exclusively, where previously psychological therapy focused on the link between mental health and offending behaviour (Harvey, 2011). Provision has recently been further extended by the introduction of Improving Access to Psychological Therapies (IAPT) for Offenders, a Department of Health (DH) initiative intended to improve mental health treatment within prisons and bring the provision of mental healthcare for prisoners in line with services available to the rest of the population (DH, 2009). IAPT services are diagnosis-orientated and offer evidence-based psychological therapies, primarily cognitive behavioural therapy, to reduce symptoms as measured by outcome measures (IAPT, 2012). IAPT services typically employ clinical or counselling psychologists at senior grades with therapists from various professional backgrounds who have been trained in Cognitive Behavioural Therapy (CBT).

This is not intended to be an exhaustive review of therapeutic and psychological interventions employed in prisons, particularly as such a review is rendered near-impossible by a lack of documentation or recording of therapeutic activities. Whilst provision of psychological therapy has increased in recent years, it has not been possible to find data for the number of therapists at work in prisons, their dominant theoretical orientations or for their employing organisations. There appears to be a wide range of therapeutic providers; from the NHS to third sector organisations, volunteer counsellors or

therapists located in chaplaincy departments or employed by charities. Similarly, I am anecdotally aware of a variety of therapists-in-training working voluntarily in prisons to gain experience.

Notably absent from this summary is reference to the work conducted in forensic therapeutic communities such as HMP Grendon. This is a specialist institution; a democratic community in which rehabilitation is sought through prisoners' communal living, participation in therapy groups and attention to the individual's criminogenic needs (Shuker & Shine, 2010). Such institutions are deserving of far more exploration than is possible here and are therefore considered to be beyond the scope of this study.

1.1.5 Forensic psychotherapy

The discipline of Forensic Psychotherapy is associated with the provision of therapy to offenders. Whilst they may work in prisons, particularly therapeutic community prisons, their main territory remains NHS forensic institutions such as secure mental health units and outpatient clinics (McGauley & Humphrey, 2003). Their work largely adheres to psychoanalytic and psychodynamic theory, although they also give weight to some cognitive behavioural and systemic theory (Cordess, 2000). Cordess and Cox (1996), in their seminal textbook for the discipline cite the main focus of a forensic psychotherapist's work as being the treatment of mental illness and emotional distress, however importance is also placed on how the offending behaviour may be re-enacted in the therapy and the therapeutic relationship. The understanding of these factors combined is considered to help the patient contain himself better, including the containment of offending behaviours (Cordess, 2000). Attending to transference and counter-transference are key techniques. Related to this, through being engaged in a relationship with another person, patients develop their ability to understand others' minds (mentalization) and their impact upon others, thereby increasing their capacity for empathy (McGauley & Humphrey, 2003). A distinctive task for many forensic psychotherapists is the provision of psychodynamically informed consultation to teams or managers within organisations or services, with the aim of understanding how patients' psychopathologies can become incorporated into the institutional functioning and affect the staff (McGauley & Humphrey, 2003). The discipline has contributed a huge amount to our understanding of the psychological and relational factors of offending behaviour and the relational dynamics within institutions that work with offenders (see for example Cordess & Cox, 1996).

1.1.6 The mental health needs of prisoners, their experience of therapy and the impact of the prison environment

The majority of prisoners have mental health problems which are frequently undiagnosed because as a socially excluded group (Social Exclusion Unit [SEU], 2002), they have difficulty accessing health care services (DH, 2009). We therefore do not know the full extent of prisoners' mental health difficulties. Research indicates that prisoners have lower levels of mental wellbeing compared with other groups in society (DH, 2009). Over 40% of male and 60% of female prisoners have a neurotic mental disorder; 62% of male and 57% female prisoners are thought to have personality disorders (Stewart, 2008). Individuals with Antisocial Personality Disorder (ASPD) are over-represented within the criminal justice system (McGauley, Yakeley, Williams & Bateman, 2011), with a prevalence of slightly less than half (National Institute of Clinical Excellence, 2009). This disorder is characterised by failure to conform to social norms and laws, repeated deceitfulness, impulsivity, irritability and aggression, irresponsibility and lack of remorse (American Psychiatric Association, 2000). McGauley et al. (2011) point to the difficulty in establishing a therapeutic alliance with people with this disorder as they are often aggressive and deceitful. Further common problems observed amongst the prison population are high rates of self-harm and suicide in prisons, and high rates of substance misuse and learning disabilities (HMCIP, 2007). Comorbidity is high, dual diagnosis with drug and alcohol misuse likewise (Bradley, 2009).

Because of the reduced likelihood that a prisoner will have accessed mental health treatment or therapy in the community (DH, 2009; Howerton et al., 2007; SEU, 2002), a prisoner's first experience of therapy may be in a prison environment (Harvey, 2011). There is very little literature documenting prisoners' experience of therapy; this is possibly reflective of the paucity of literature regarding therapy in prison more generally. Meek's (2011) study into the benefits prisoners perceived from receiving relationship counselling identified that the most highly prized gain was that of increased hope for the future. Other important findings included that some participants were motivated to address difficulties whilst they had the opportunity in prison and that participants valued the independent position of the therapist, viewing them as trustworthy in comparison with prison officers (Meek, 2011). The finding regarding prisoners' perceptions of prison officers is one that has been reported elsewhere, for example Harvey and Smedley describe prisons as "low trust environments" (2010, p. 19) in which prisoners' distrust is particularly heightened towards prison staff. In contrast with Meek's findings, Crewe (as cited in Harvey & Smedley, 2010)

found that psychologists were seen by prisoners as agents of the state, there to protect the public rather than to help them. It is not clear however, what specialism of psychology these psychologists belonged to, and whether for example, therapists attending to mental health problems might be perceived differently from forensic psychologists focused on crime reduction.

The existence of low levels of trust in relationships with prison staff may be a result of what Harvey (2011) describes as the imported vulnerability of prisoners entering prison, arising from the huge complexity of presenting problems due to backgrounds that stem from multiple chronic traumatic life events and insecure attachments. Snow (2002) suggests that early relational difficulties and trauma may partly explain why prisoners frequently report difficulties in their interpersonal relationships. The potential for prisoners to develop mental health problems does not appear to stop once they enter prison. Whilst there is limited research about the impact of imprisonment on prisoners, what exists has led to a common acceptance that the impact of imprisonment on mental health is far from positive (Appelbaum, Hickey & Packer, 2001; Bradley, 2009; HMCIP, 1996). In 2008, The Sainsbury Centre for Mental Health conducted research across five prisons in the Midlands with ninety-eight prisoners suffering from a variety of mental health problems (2008a). They identified several factors within prison thought to affect negatively prisoners' mental health, including having no one they trusted to talk to, unresolved past traumas and difficulty accessing consistent healthcare, especially therapy. The organisation of prisons has also been found to have a negative effect, for example there are often delays with transferring prisoners to secure NHS mental health facilities (HMCIP, 2007). Similar findings were reported by Nurse, Woodcock and Ormsby (2003), who additionally found that negative relationships between prisoners and officers had significant adverse impact on prisoners' mental state. It is evident then, that not only do the physical aspects of incarceration and loss of liberty affect prisoners' mental health, so too do their relationships with prison staff.

This brief summary of the main types of psychologically-based interventions within prisons and what is known of the prisoner-clients' perspectives was intended to provide the reader with a context for the further exploration of the role of therapists working with prisoners. The review will now present literature directly concerned with therapists' experiences of working with prisoners, in addition to important works from related disciplines that may aid our understanding.

1.2 Literature review

1.2.1 Overview

The research literature pertaining to psychological therapists' experiences of working with prisoners in the UK is sparse and what exists is predominantly qualitative in nature. In contrast, the experiences of nurses delivering health care to people in prison have been more thoroughly documented and given that nurses and therapists share what could be described as a caring rather than crime-reduction orientation, the nursing literature will be summarised for what may be inferred about the therapist's experience.

Subsequently, there is a review of research that has investigated particular aspects of providing therapy or healthcare in prisons and a review of research which investigated the related topics of working with offenders in the community or in mental health settings. One of the most researched aspects of providing therapy to offenders is the potential impact upon the therapist; this body of literature will be explored. Finally, a summary of the published personal accounts and theoretically framed literature regarding therapists' experiences is presented.

1.2.2 Research investigating the experiences of therapists working with prisoners

Harvey (2011) conducted interviews with several clinical psychologists working within MHIRTs in prisons as part of his preparation for co-authoring a book about psychological therapies in prison (Harvey & Smedley, 2010). The article explores the results of those interviews and draws from Harvey's experience in the field. Although the work is anecdotal rather than based on a rigorous, replicable research methodology, it does provide useful insight into some aspects of therapists' work in prisons, particularly the complexity they encounter.

Harvey's interviewees reported that it was difficult to be purist in approach because prisoner-clients presented with multiple difficulties and their work included helping prisoners to cope in the environment. Additionally, therapists reported an awareness that they practised within a punishment-orientated culture and reported that prison staff taught therapists to distrust the prisoners. The environment and prison staff were experienced by the clinical psychologists as being unreflective, with little value given to thinking about things. These factors were felt to impact upon the therapeutic relationship. Harvey observed that the various deprivations inherent in the environment, for example

the loss of liberty, impacted on the prisoner and therapist in turn. As a result, Harvey stressed the need for the therapist to hold the environment in mind when working with prisoners. Harvey made recommendations for professional practice, supporting them with quotes from interviews rather than providing an in-depth analysis of the therapists' experiences. In addition, the article is particularly concerned with the therapists' interaction with the prison environment and there is little exploration of how therapists experienced being in relationship with their prisoner-clients or how they experienced their client's criminality.

These factors were addressed however, in research by Bertrand-Godfrey and Loewenthal (2011), published at the time the present study was being completed. This appears to be the only published research to take a broad scope in investigating the experiences of therapists working with prisoners. Using Interpretative Phenomenological Analysis (IPA) methodology, Bertrand-Godfrey and Loewenthal investigated what it is like for therapists to work in a prison, the impact of the setting upon therapy, the therapeutic relationship and the therapists themselves. The authors found that therapists experienced the environment as putting them in a position of power over their prisoner-clients; additionally it provided them with opportunities to protect their clients from prison officers. The authors suggested the main source of power attributed to therapists in the environment was in their ability to release overwhelming levels of emotions in prisoners, which prison officers feared could not be contained within the prison. Participants described prison officers telling them they did not want therapists to "open a can of worms" (2011, p. 11) in therapy. A further finding was that participants did not see their work as being related to crime reduction or being linked to the OBPs that also existed in prison. Bertrand-Godfrey and Loewenthal (2011) observed that participants were prisoner-centred in their approach and were able to be empathic towards prisoner-clients as a result of their awareness of prisoners' experiences of victimisation. They found that the work was not without risks however; participants were aware of manipulation, had felt unsupported by the prison institution and experienced a sense of danger when on the wings. Despite this, all participants felt that the positives of the work outweighed the risks. The authors found that participants appeared to feel a sense of "specialness" (p.12) in managing to work in the challenging environment and held the belief that not everyone was able to work in prisons. Bertrand-Godfrey and Loewenthal's findings support some previous research and accounts, as outlined below. Perhaps as a consequence of the study's broad scope, there is little in-depth exploration of the dynamic between prisoner and therapist. Furthermore, the

authors reflected that they did not encounter therapists' experience of vulnerability when working with prisoners, which they appeared to have anticipated in light of their clients' offending histories. Additionally, it would have been interesting to have understood how the authors conceptualised the findings to relate to one-another.

As previously indicated, there is a substantial amount of research investigating the psychological interventions in prisons which are aimed at reducing reoffending (see Crighton & Towl, 2008). Of particular relevance to this study is research investigating the experiences of the treatment programme facilitators. For example, Collins and Nee (2010) used Foucaultian discourse analysis within a qualitative research design to investigate facilitators' experiences as mediators of change, working with sex offenders on a treatment programme. Their participants were prison officers or trainee forensic psychologists so it is unclear the extent to which the findings can be generalised to therapists providing one-to-one therapy. Collins and Nee found that prison officers display overtly negative attitudes towards sex offenders and the treatment programme which resulted in a 'them and us' narrative between staff; those who were 'enlightened' as to the value of therapy and those who felt prisoners should not be given rehabilitation because they were considered undeserving or un-reformable. Positive and negative outcomes of the work were reported for the programme facilitators; including some emotional hardening, increased personal vulnerability and difficult counter-transference experiences. A positive outcome was increased self-knowledge; the authors suggest this conveyed a sense of reciprocity in the therapy. The facilitators reported that the therapeutic relationship was threatened as a result of facilitators' duty to report risk issues. The authors describe the challenge as inherent in their position as a 'double agent' serving both therapeutic (for the prisoner) and control (for the state) functions. Collins and Nee suggest that the facilitators struggled to "disconnect the offender from the offence" (2010, p. 324) saying that this could negatively affect their ability to form an effective therapeutic relationship. The authors unfortunately do not fully describe the experiences of their participants that led to this conclusion, but in line with their methodology discuss the societal discourses relating to the 'otherness' of sexual offenders which may have contributed. Greater transparency may have been enabled by the inclusion of more extracts from the participants' accounts. This study provides a useful overview of OBP facilitators' experiences which will enable some comparison with the experiences of therapists providing non-offence focused therapy.

1.2.3 Research investigating nurses' experiences working with prisoners

The concept of conflicting cultures and values between different professionals working in prisons has also been widely documented within the nursing discipline. In one of the earliest pieces of research investigating nurses' experiences, Maeve (1997), applied a critical hermeneutic analysis to her journal of personal experiences and reflections on other nurses' experiences working in a prison in the United States, and compared the findings with data gathered from another nurse in the prison. Maeve describes nursing practice as being significantly restricted both by the dominant punitive culture within the prison and overt actions by prison officers. Physical acts of caring and expressions of empathy were forbidden by the more powerful officers and nurses were warned by prison officers to treat prisoners with suspicion to protect themselves from manipulation. Maeve further reports that nurses found it difficult to advocate for the prisoner-patient or to defend their caring actions because the nurses could not afford to lose their jobs.

Whilst the small sample and highly reflexive methodology utilised by Maeve (1997) might raise doubts about the potential for generalisation to other nurses, her findings regarding the culture clash between punitive and security-orientated prison staff and the caring orientation of nurses have been consistently reported in subsequent research (Doyle, 1999; Flanagan & Flanagan, 2001; Weiskopf, 2005). Hardesty, Champion and Champion (2007) also found this to be a dominant feature of nurses' work in the environment and subsequently constructed a typology of nurses' working styles within prisons. This positioned nurses on a continuum of culture orientation; those nurses who were predominantly orientated to the prison culture and identified with the officers' security values were at one end, and those who remained orientated to nursing culture were placed at the other end. Generally however, nurses have been found to submit to the dominant security culture within prison resulting in a restriction to their nursing practice; in the extreme, some nurses have been found to collude with prison officers' abusive behaviour towards prisoners (Weiskopf, 2005). It is notable that the majority of this research was conducted in the USA or Australia so it is unclear the extent to which the findings are relevant to UK prison culture.

Another consistent research finding is that nurses experience prisoners as having complex difficulties and challenging behaviour (Doyle, 1999; Maeve, 1997). Indeed, Flanagan and Flanagan (2001) who surveyed 287 nurses working in prisons across a State in USA, found that nurses had adopted strategies to manage prisoners' attempts to manipulate them and

stressed the importance of rigorous assessments to ensure their professional judgements had not been adversely influenced. Weiskopf (2005) interviewed nine nurses in the USA and subsequently analysed the interviews using descriptive phenomenology to identify their lived experience of working with prisoner-patients. She reported that nurses found it challenging to put aside the knowledge of their patients' offences and they attempted to overcome this by focusing on the person of their patient and being committed to offering a non-judgemental relationship. She additionally found that nurses experienced themselves as often at risk, resulting in an awareness of their own safety and of the protective presence of the prison officers. More recently, Weiskopf's findings have been supported by Walsh (2009) who conducted what appears to be one of the few pieces of research regarding nurses' experiences in UK prisons. Utilising a qualitative reflexive approach, Walsh conducted nine interviews with nurses and concluded that managing prisoners' manipulative and aggressive behaviour was emotionally demanding and that nurses found it difficult to deal with knowledge of their patient's offence. A strength of the research is the exploration of nurses' coping strategies to manage these challenges; nurses spoke of the need to be 'strong' and detach themselves emotionally. Walsh links this to the adoption of a 'professional' self that suppresses their emotional side. The author discusses the extent to which nurses' emotional detachment could impact upon their ability to offer an empathic caring relationship and interprets it as a protective function to prevent them appearing weak and liable to manipulation.

1.2.4 Differing perspectives and cultures in prison

The culture clash between healthcare professionals and prison staff has also been explored in professional practice articles and research within the literature of psychology. Adams and Ferrandino (2008) remark that despite the tension first being written about in the 1940's by Clemmer there has been no simple resolution, and practitioners continue to note the incompatibility of the controlling, security and punishment orientated environment with mental health treatment. From the USA, Weinberger and Sreenivasan (1994) describe differences in perspectives on prisoner's behaviour. They suggest prison officers interpret disruptive behaviour as criminal and therefore requiring punishment, whereas mental health workers might interpret it as a symptom of an underlying disorder which requires treatment. Weinberger and Sreenivasan observe that there is little automatic understanding between the two professions, although where efforts have been made to increase prison staffs' understanding of mental illness amongst prisoners, benefits to all

have been observed (see Bowers et al., 2005). Further to the contrasting perspectives towards prisoners, also in the USA, Appelbaum et al. (2001) describe the conflict that can arise between mental health and prison officer staff as a result of their differing missions. They cite the widely held view amongst prison staff that mental health staff are "soft, gullible and coddling" towards prisoners (2001, p. 1344); in return mental health workers often view prison officers as being unnecessarily harsh and punitive. The researchers also report that conflict is not always present and many staff groups work well together when workers from both groups are effective and enlightened as to one-another's roles (Appelbaum et al., 2001).

In the UK, similar differences in perspective have been reported. Kenning et al. (2010) conducted interviews with both female prisoners and members of prison staff about self-harm. A thematic analysis of the resultant data found that prison officers viewed self-harming behaviour as 'manipulation' and 'attention-seeking', whereas prisoners themselves, healthcare staff and prison governors saw it as a difficulty in managing distress or self-punishment. It is interesting to note that prison governors, more senior than prison officers, adopted a view more in line with healthcare staff despite being from the same profession as the officers; the authors suggest that differences in training might account for this.

Differences in outlook towards those who commit crime have also been reported beyond the prison culture. Lea, Auburn and Kibblewhite (1999) conducted qualitative research into the perceptions and experiences of professionals whose work involved contact with sex offenders. Participants included therapists on prison-based SOTPs, prison officers, probation staff and police officers. The researchers found that those with extensive training and experience of working closely with sex offenders, such as the SOTP facilitators, held more positive views of offenders than those with less direct training and experience, police officers for example. Even those participants with more knowledge of sex-offending and individual sex offenders and who had more positive and less stereotypical attitudes, still reported tension between creating a professional, therapeutic relationship and personal feelings of abhorrence for the offences. Some participants tried to overcome personal feelings by attempting to separate them from their professional tasks, though were aware that this could result in emotional hardening in their interaction with offenders. More experienced professionals adopted a strategy of separating the offender from their sexual offence. The researchers referred to this as a 'personal-professional dialectic' and this

appears to add to our understanding of how professionals with close contact with sex-offenders cope psychologically with their clients' offences. The impact on therapists of working with clients who have committed crime is returned to later in this review.

1.2.5 Further ethical dilemmas for therapists working in prisons

A further dimension to therapists' experiences of working within a non-treatment orientated environment is explored within literature regarding ethical practice. This is dominated by professional practice articles within the discipline of psychology, although there has been some research conducted as a result of concerns raised (Haag, 2006; Weinberger & Sreenivasan, 1994). Authors discuss the ethically challenging position psychologists are considered to be placed in when working within a control and punishment orientated environment. Monahan (1980) and Brodsky (1980) document a variety of concerns regarding the power prisoners have to decline treatment when it is offered within a period of punishment and often on the recommendation of criminal justice staff. This concern over a prisoner's consent to treatment continues to be raised (Haag, 2006; Pont, Stover & Wolff, 2012) and has been found to concern facilitators on OBPs where completion of the programme is often directly linked to early release (Collins & Nee, 2010). There is little research however as to how therapists working with a mental well-being orientation might experience this ethical concern, if at all.

Another ethical concern is the dual role that practitioners necessarily adopt within prison; they are required to contribute to the security and punishment agenda of the prison authority by upholding prison rules whilst fulfilling their responsibility to the prisoner by delivering therapeutic services (Pont et al., 2012). As already indicated, these can be conflicting agendas with the potential to challenge the practitioner (Maeve, 1997; Weiskopf, 2005) but additionally there is the potential to erode the trust of prisoners (Pont et al., 2012; Scott, 1985; Weinberger & Sreenivasan, 1994) and prisoners might feel that their treatment is compromised by the therapist's association with the criminal justice authorities. This dual role is highlighted in the issue of confidentiality and practitioners have reported the challenge of fulfilling their responsibilities to prison authorities by reporting incidents and information relevant to risk assessments, whilst maintaining the trust and confidentiality of the prisoner-client (Brodsky, 1980; Haag, 2006; Scott, 1985). As this literature mainly takes the form of discursive articles, there is little research documenting the extent to which these issues affect therapists in their practice in prisons.

1.2.6 Research concerned with working with offenders in the community or in mental health services

Bertrand-Godfrey and Loewenthal (2011) remark on the similarities between prisons and acute healthcare settings and given the limited amount of research concerning therapists' experiences in prisons, it is helpful to consider literature dealing with the experience of healthcare staff working in forensic psychiatric units. This section also presents selected literature that pertains to practitioners working with offenders in the community.

In a literature review and thematic analysis of roles and experiences of forensic nurses, Mason (2002) observes that fear amongst staff is not often openly identified, speculating that this might be a result of the macho culture that prevails in forensic psychiatric units. This has been subsequently reported by other researchers, for example Kurtz and Turner (2007) who suggest this is a defence mechanism, enabling staff to work effectively. Jacob and Holmes (2011) also report that fear and vulnerability is hidden in order to present a valued identity of being in control; they describe this as a 'masculinisation' of staff. When fear was discussed by participants, it was often viewed positively, its presence indicative of a heightened state of awareness. Nurses' reports of being security-minded are a central aspect of this work; authors cite the influence of the organisation in which nursing staff are also responsible for the security of the unit. Strategies to increase physical safety are widely reported (Jacob & Holmes, 2011; Kindy, Petersen & Parkhurst, 2005). Less widely reported is the finding from Trenoweth's research (2003) that the development of a strong nurse-patient relationship is perceived by nurses as a protective factor against the risk of violence from patients.

Nurses' experiences of knowing about their patient's criminal behaviour are also recorded in the literature and findings typically suggest that nurses struggle to maintain an empathic and engaged relationship with their client whilst knowing of their criminal behaviour (Jacob & Holmes, 2011; Rose, Peter, Gallop, Angus & Liaschenko, 2011). It has been reported that nurses adopt various strategies to manage their experience of the patient's crime, including attempting to distance themselves from the information about the offending, attempting to disconnect themselves from their personal thoughts and feelings (Jacob & Holmes, 2011) or adopting a style of 'detached empathy' in which they remain wary and vigilant but less actively engaged in their patient's care (Rose et al., 2011).

Scheela (2001) investigated therapists working with sex-offenders in the community; she reported their approach as seeing the patient as a human rather than a criminal and this perspective was made possible by hearing about their client's own experience of victimisation. Similarly, Kurtz and Turner's (2007) research investigating mental health nurses on a medium secure psychiatric ward found that they struggled "to connect simultaneously with the victimised and victimising aspects of patients" (p. 428). The nurses described feeling fond and protective towards the familiar person they worked with and hard to link this to the violent offender they had read about.

1.2.7 Therapy with offenders - the impact on therapists

Slater and Lambie (2011) observe that there is significantly more research investigating the negative effects upon therapists of working with offenders than there is investigating the positives of the work. I will present the documented benefits reported by therapists' from their work followed by a review of literature that investigates the potential negative impact upon the therapist.

Scheela (2001) investigated the benefits experienced by therapists working with offenders in the community and found that they relished the challenge inherent in the work and the complexity of the presenting problems of clients. This finding has been replicated by Kurtz and Turner (2007) amongst forensic mental health staff and by Bertrand-Godfrey and Loewenthal (2011) amongst prison therapists. Furthermore, several studies within a prison context, including Bertrand-Godfrey and Loewenthal (2011) and Slater and Lambie (2011) reported that therapists enjoyed working with people who had been outcast by society and that they experienced a sense of 'specialness' believing that not many people could do the work. Whereas both Scheela (2001) and Bertrand-Godfrey and Loewenthal (2011) suggested that the positives identified by therapists outweighed the negative aspects of the work, Slater and Lambie (2011) suggested that therapists' experience was more accurately portrayed as a balancing act between the highs and lows of the work. Contributing to our understanding of what is important in creating a positive experience in working with prisoners, Garland and McCarty (2009) conducted a quantitative survey of job satisfaction amongst 430 prison healthcare staff in the USA. They found that the extent to which participants felt effective in their work with prisoner-clients and the nature of their interaction with patients was a significant predictor of job satisfaction.

Amongst the limited literature investigating therapists' experiences working with prisoners, some negative effects to the therapist are reported; these are distinct from general challenges they experience as a result of working in the environment, some of which have already been explored and further accounts are presented in the following section. Bertrand-Godfrey and Loewenthal report that for some therapists, working in a prison was "at times virtually damaging" (2011, p. 11). An example was given of a therapist who encountered a prison riot and potentially fatal violence, experience of which had a negative effect on her mental and physical health. Danger was felt by participants on the wings of the prison, where there was more violence and tension than in the therapy environment. Other painful emotional experiences included feeling isolated, depressed and trapped.

Literature from nursing research and from research with therapists working with offenders in the community also reports some downsides to the work. Research from both nurses and therapists has found that members of the public, media and fellow professionals have negative reactions towards their work and their client group, creating a stigma by association (Doyle, 1999; Kurtz & Turner, 2007; Scheela, 2001). This finding was contradicted by Hardesty et al.'s (2007) study which found that nurses did not experience such stigma from working with prisoners.

There is a significant amount of research investigating the negative effects on therapists working with sex offenders in the community, typically offence-focused work. One of the earliest pieces of research was conducted in America by Farrenkopf (1992), via surveys with 24 therapists working with sex offenders. Farrenkopf found that therapists reported a shift in their perspective following their work with the offenders, becoming discouraged about client change. Half of the therapists experienced emotional hardening, rising anger and increased aggression. Over one-third suffered frustration with the criminal justice system or society; one third, female therapists in particular, reported increased suspiciousness and vulnerability. Farrenkopf notes that the therapists went through several adjustment phases in which a variety of perspectives and emotions are held. She reports that as a result of the work, one quarter of the sample experienced burnout; those that did not burn-out adapted to protect themselves by lowering their expectations, becoming more detached and accepting of the human dark side.

Following Farrenkopf's work, researchers have gone on to investigate the levels of vicarious trauma, compassion fatigue and burnout amongst therapists who work with sex offenders.

Steed and Bicknell (2001) found secondary traumatic stress symptoms amongst the 67 therapists surveyed in Australia. Particularly prevalent symptoms were intrusive flashbacks, images and dreams; avoidance of disturbing thoughts and feelings, detachment from others; and hyperarousal; increased alertness to threat and difficulty sleeping. These symptoms did not reach clinical level but they add weight to findings indicating that the work can have significant, negative affect upon therapists. In particular, the finding of hyperarousal support Farrenkopf's (1992) report that therapists became more suspicious and Scheela's (2001) report that therapists became more concerned about their security, putting into place protection systems for themselves and their family.

There are however, other research findings that do not support the hypothesis that therapists typically experience negative psychological symptoms as a result of working with offenders. For example, Sheehy Carmel and Freelander (2009) found few symptoms of secondary traumatic stress amongst therapists surveyed in America, but did find high levels of compassion satisfaction. They interpreted their findings as indicating that having a sense of confidence and satisfaction with the work was the most important single factor in therapists' perceptions of their relationships with clients and focusing on the importance of their work was a protective factor against secondary trauma symptoms.

Amongst the coping strategies reported in the literature, therapists and nursing staff have often reported that supportive colleagues help them to deal with the challenges of the work (Kurtz & Turner, 2007; Scheela, 2001; Slater & Lambie, 2011; Walsh, 2009). Further reported coping strategies include Walsh's (2009) finding that nurses working in prison consider it important to separate their work and home lives in order to cope with stress of work.

The research which investigated the impact of working with sex offenders suggests there is potential for therapists to experience negative psychological symptoms although it is to be noted that participants included in these studies typically worked directly with the offence of their client. Few researchers have directly investigated the impact upon therapists working with prisoners without an offence-focus; however some challenges and negative repercussions are suggested in the literature investigating nurses' experiences. There is little understanding as to how therapists working with prisoners feel about the risks to themselves. There is a growing body of literature concerned with the positive aspects of the work and it has been suggested that the presence of benefits from the work is

important in balancing the potential negatives, though this has not been much investigated amongst prison therapists.

1.2.8 THEORETICALLY FRAMED LITERATURE

Huffman (2006), observing the absence of literature in the USA regarding therapists working in prisons suggests it may be due to a perceived lack of common experiences amongst prison therapists and a lack of common language to express them. The most prolific writers on the topic of providing therapy to offenders generally are those who frame their experiences within the language and theory of psychodynamic/analytic schools, for example there is a significant body of work from the discipline of forensic psychotherapy. Literature presented here is from the discipline of forensic psychotherapy and from authors who present the experiences of therapists with reference to psychodynamic/analytic theory.

The impact upon the therapist of working with offenders receives much attention and is explored with reference to theories regarding counter-transference experiences. Authors are unanimous in their belief that attendance to counter-transference when working with sexual and violent offenders is very important particularly because the counter-transference has the potential to be disturbing (Gordon & Kirtchuk; 2008; Knoll, 2009; Meloy, 2007; Roundy & Horton, 1990; Ruszcynski, 2010; Twemlow, 2001). It is believed to have the potential to damage the therapist, the client and the therapeutic process (Walker, 2004).

Roundy and Horton (1990) have compiled one of the most comprehensive accounts of how therapists may be affected by conducting work with sex offenders in the community, summarising the potential for therapists to feel intimidated, seduced, imitated and invalid. Similarly, Mothersole (2000) stresses the importance of processing experiences in supervision, describing common problematic counter-transference experiences as being characterised by feelings of repulsion and helplessness. Gordon and Kirtchuk (2008) refer to the 'psychic assaults' therapists might experience. They describe the potential for therapists to fear imminent violence when working with clients who have already acted violently and suggest that part of the therapist's task is to manage the terror of becoming the patient's next victim. Similarly, Hale (1997) writes of unconscious anxieties that may be triggered in forensic institutions, including the anxiety of becoming a victim of the offender

through being coerced, seduced, or deceived. Therapists are therefore suggested to consciously or unconsciously identify with their client's victim (Aiyegbusi, 2009b).

Amongst the strategies authors cite therapists adopting to cope with strong counter-transference experiences, is the strategy of mentally 'bracketing off' the offence from the person of the offender (Gordon, Harding, Miller & Xenitidis, 2008) enabling an identification with the often traumatised victim in the client. Van Velson (1997) suggests that forensic psychotherapists must strike the balance between validating the offender's experiences of victimisation and confronting offender-patients with the way they have victimised others. She argues that not all traumatic experiences are victimising and warns against "locking the person into their position as a victim" (1997, p. 134). It is in the combination of these dynamics that the roles of perpetrator and victim are offered unconsciously to and from the therapist and patient.

A few personal reflections of working in prisons have been published in which the dynamics of the prison culture have been explored with reference to psychoanalytic theory. Hinshelwood has written in some depth on the topic of therapists working in prison in two articles (1993, 1994) and was particularly influenced by Isabel Menzies Lyth's theories on the defence systems of social institutions (see 1960) and object relations theory, which he uses to explore relationships within the prison. Hinshelwood observes an institutional culture in which the prisoners and prison staff for different reasons, strongly defend themselves against feeling weak and vulnerable. As a result, the therapist is left to act as a receptacle for the 'soft', tender feelings that are disavowed and denigrated by the officers and prisoners; this means that the therapist role is also denigrated, devalued and "ridiculed" (1993, p. 431). His personal experience of the setting resulted in great frustration and doubts that prison could ever facilitate effective therapy. He observed therapists adopting a 'friend' role to the prisoner rather than providing traditional psychotherapy, under influence from the prisoners and staff. He also identified officers and therapists alike as defending themselves against being 'conned' by prisoners. Hinshelwood's accounts have been hugely important in understanding the dynamics in prisons and the experiences of those who exist in them. His application of psychodynamic theory to the prison setting has been cited by many, including Smith (1999) who reflects upon her experience of providing drug and alcohol counselling to female prisoners. In agreement with Hinshelwood's perceptions, she goes on to outline a psychodynamic interpretation of her fear and tension experienced and her overwhelming preoccupation

with survival both physical and psychical. She believes the psychological defence strategies adopted by all those in prison to cope with strong and primitive anxieties impede the development of meaningful relationships, including therapeutic relationships. Referencing object relations theories and Klein in particular, she refers to the splitting she encountered from the prisoner's perspective; the prison officers were classed as 'bad' and she as 'good'. Smith reflects upon the strong counter-transference she experienced in contrast to, and because of the 'shutting off' of emotions by prisoners and officers. It is a deeply personal piece of writing, a valuable account that enables one to understand more fully what it feels like to be a therapist in a prison setting.

These authors' accounts are echoed by Huffman (2006), who describes the prison environment as a very different setting in which to provide therapy, or in his words "a different world" (2006, p. 325). He observes the traditional therapeutic dyad to be invaded by frequent intrusions of noise, reminders of loss of liberty, the gaze of watchful guards or interruptions from staff. He suggests that the therapeutic alliance is of increased importance in such an atypical setting and suggests this is where prison therapy has an opportunity to inform the discipline of therapy more broadly, by providing a deeper understanding of the dyadic attachment between client and therapist. In contrast to Hinshelwood's (1993, 1994) and Smith's (1999) writings, he is positive about the work and describes providing the best therapy he can given the limitations of the environment.

It is notable that there is little exploration of working with prisoners from other theoretical positions. Proctor (2004) provides a person-centred perspective of working within an NHS forensic health service. In particular, she advocates the client's individual distress must be focused upon and separated from concerns about their potential to harm others, and more broadly, a separation between mental health services and criminal justice and social control systems. The reason, she argues is that the presence of external powerful and controlling forces removes the client's control, power and responsibility, reducing their potential to create lasting change. Citing the potential for therapists to identify with the victim of the offender when the crime is brought into the therapy, she suggests this makes it more likely the therapists might want to control and punish the client rather than fully understand them; this again may affect the effectiveness of the therapy.

Whilst the accounts of therapist's personal experiences are valuable, they are processed experiences, presented to the reader in relation to theory. What the reader does not

access therefore, are the aspects of therapists' experience that may not be explained by theory or that the therapist may still be processing, or indeed the aspects of experiencing that feel too difficult to disclose in a public arena.

1.3 Rationale for the current study

There is very little research investigating therapists' experiences of working with prisoners. The literature that has been explored, including that from the related fields of nursing and community-based therapy with offenders, suggests that there are significant challenges to the work whilst the gains from the work are little documented. There are further gaps in the research that might be important to our understanding of therapists' experiences. In particular, there has been little in-depth investigation of how therapists in prison might experience their client's offence when they are working with the aim of addressing mental wellbeing rather than reducing crime. Research from the nursing discipline and offence-focused practitioners suggests this is a complex phenomenon. It would be important to understand if the client's crime features in therapists' experiences and if so, in what way. Additionally, the research has indicated that it is difficult for practitioners to connect emotionally in their relationship with offenders when the offence is known by the practitioner (Jacob & Holmes, 2011; Rose et al., 2011). Understanding how therapists develop a therapeutic relationship with this client-group could immensely benefit our understanding of the skills required and used by therapists. This may be particularly relevant given consistent research findings that show the therapeutic relationship is as important in generating client improvement as the methods used (Norcross, 2011).

Additionally, there has been little research that has captured therapists' emotional experiences when working with prisoners, although theoretical literature and professional practice guides warn of potentially emotion-laden experiences which might negatively affect the therapeutic relationship. Fear and vulnerability has been found to be suppressed or minimised amongst nurses and some therapists working in prison and forensic psychiatric settings; research investigating this aspect of experience would further our understanding.

Therefore, there are numerous areas to be investigated concerning therapists' experiences of working with prisoners and this research will endeavour to extend our understanding of the following:

- How therapists experience themselves in their work with prisoners
- How therapists experience the prisoner and the crime of which they have been convicted
- The aspects of the work therapists consider to be challenging and those which are positive or beneficial

The review of the literature indicates that there are many gaps in our knowledge which research could fill to add to our understanding of the field. The parameters of the research need to be established and there is a distinction that can be made between a therapists' experience of the physical prison setting, and their experience of working with the prisoner-client including their experience of the relationship. Typically, research appears to have particularly focused on the therapists' experiences of working in prisons rather than on their experience of working with prisoners (for example, Bertrand-Godfrey & Loewenthal, 2011; Harvey, 2011). Therefore, this research will focus specifically upon the latter in an attempt to generate more in-depth understanding. I do not wish to imply however, that the former can be fully eliminated nor that is an unimportant topic. The context of the therapists' experiences which they consider relevant to their therapeutic work will be attended to in order to generate a full understanding of their accounts.

1.3.1 The relevance of this research to counselling psychology

This research sits within a professional practice portfolio within the division of counselling psychology and the focus of this research has perhaps also been influenced by the values of counselling psychology, in which the experiences of the subjective person are valued and people are understood to be relationally embedded (Cooper, 2009). The research will be relevant to counselling psychologists working in prisons; it is hoped it will also benefit therapists from other disciplines and in other settings. Information generated from the present research about the benefits therapists' experience as a result of working with prisoners might inform those considering working in the prison setting or with offender client groups elsewhere. This seems to be particularly timely given the changes to mental healthcare services in UK prisons and the increased opportunities for therapists to provide non-offence focused psychological interventions (Harvey & Smedley, 2010). Furthermore,

understanding of the potential challenges encountered may facilitate the development of self-protection and coping strategies, thus going some way to protect therapists' well-being. Understanding how non-offence focused therapists manage information about their client's criminal conviction may serve to guide therapists in the field and clarify the role of a counselling psychologist in prison, and how it might be similar or different from psychologists providing other psychological interventions.

1.3.2 Research aim

The research aim is to explore the experiences of therapists working with prisoners, particularly their experience of being in relationship with the prisoner-client. Attention will be paid to their emotional experiencing and to how they experience the criminal behaviour for which their client is imprisoned.

Chapter Two - Methodology

2.1 Research design introduction

The topic of therapists' experiences of working with prisoners was investigated using qualitative methods. Specifically, data was collected from a small number of therapists via semi-structured interviews and analysed using Interpretative Phenomenological Analysis (IPA).

2.2 Rationale for qualitative methodology

The aim of this study was to further our understanding of the experiences of therapists who conduct individual therapy with prisoners. In-depth accounts were sought which identified the features of the work that therapists considered to be of significance, their thoughts and feelings in relation to these and an understanding of how they made sense of their experiences. It could be argued that given how little previous research has been done

on this topic, it would be illogical at this stage to pursue quantitative research with an aim to quantify or measure these therapists' experiences. This could be likened to attempting to count cherries without understanding the nature of cherry. Rather, research that generates knowledge about the nature of therapists' experience is indicated and qualitative methods seem most suited to eliciting this information (Silverman, 2005; Willig, 2008).

Interpretative Phenomenological Analysis (IPA) was chosen because it seeks to engage with a person's reflections on their experiences and how they make sense of them (Smith, Flowers & Larkin, 2009). This study was particularly concerned with how participants understood and processed their experiences and the significance they attributed to them. IPA's ideographic nature also means that it is suited to capturing the complexity of human experiences (Smith et al., 2009); human relationships, in this case the therapeutic relationship, can certainly be described as a complex phenomenon. This research was also concerned with participants' emotional, physical and cognitive experiencing. IPA has frequently been used to study the experience of emotions (e.g. Eatough and Smith's 2006 study of the experience of anger) and the methodology is influenced by philosophical theory concerning embodiment (Smith et al., 2009). Therefore IPA seemed well suited for exploring these multi-dimensional aspects of participants' experiencing.

A number of alternative methodologies were considered and subsequently ruled out as a means of investigating this topic. Foucauldian Discourse Analysis was considered; it is concerned with participants' construction of their experience through language and discourse (Willig, 2008). Its theory is also concerned with power and social processes and Foucault himself had reflected upon the dominant discourses surrounding the treatment of criminals and imprisonment (Foucault, 1977). Foucauldian Discourse Analysis however, challenges the notion of experience, citing it to be a discursive construction (Willig, 2008); this would therefore seem to be an inappropriate approach to use for investigating experience. Additionally, criticism levelled at the Foulcauldian approach was taken into account, particularly regarding the power it ascribes to discourse in the construction of experience (Willig, 2008). Grounded Theory was also considered, however its concern with identifying social processes from data and the generation of explanatory theory appeared incompatible with the research aim (Willig, 2008), which was to explore the nature of therapists' experience rather than seeking to explain it. Willig argues that

phenomenological methods are more suited to the exploration of the nature of experience (2008).

2.3 Introduction to Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis is influenced by the phenomenological philosophy inspired by Edmund Husserl at the beginning of the twentieth century. It focuses on a person's conscious experiencing of the world. Phenomena are studied precisely as given or experienced by a person (Giorgi, 1997) and there is an emphasis on the meaning that the phenomena has for the experiencing subject, rather than considering the phenomenon as an objective reality. In phenomenological psychological research, the researcher attempts to 'get inside' someone else's experience by studying the participant's own account (Willig, 2008). There are two main branches of phenomenological research, descriptive and interpretive. The descriptive branch, influenced by Husserl and championed by Giorgi (see 1997, 2008), endeavours to remain true to the philosophy of phenomenology by describing peoples' experiencing and perception of the world in order to access the content of their conscious experience (Smith et al., 2009). Giorgi (1997, p. 7) states that descriptive phenomenological research "limits itself to what is given" of a person's account of experiencing. Giorgi (1997) separates interpretation from description, believing interpretation brings a perspective to the given experience; however he acknowledges that both description and interpretation have their place.

Interpretative phenomenologists, influenced by the philosopher Martin Heidegger, argue that all description constitutes an interpretation because the act of describing something involves interpreting it into language (Willig, 2008). Heidegger's view of the human is that of a person in context, always interacting with the world whilst the world interacts with the person - a concept termed inter-subjectivity (Smith et al., 2009). Heidegger's theory was that a person's experiences may have meanings on two levels; that which is latent and that which is obvious. To get a full grasp of a person's experiencing, interpretation and analysis is required to reveal it and make sense of it (Smith et al., 2009). It is within the interpretive camp of phenomenology that IPA is located.

Interpretative Phenomenological Analysis aims to enter into and understand the life-world of the participants and this is facilitated through open-ended and non-directive explorations (Willig, 2008). Semi-structured interviews are frequently utilised for this purpose. IPA's ideographic influences mean that it is concerned with the particular and the sense of detail; in IPA this means developing a deep understanding of typically small groups within a particular context and thus does not make claims that are generalisable across large populations (Smith et al., 2009). IPA has two levels of analysis; descriptive and interpretative. Gathering a descriptive account involves identifying the aspects of participants' experience which are important to them (Smith et al., 2009); the interpretative level aims to reveal the meaning these might hold to the participants, taking into account their context within a wider cultural and social world (Larkin, Watts & Clifton, 2006).

It is also recognised that the researcher's interpretations and analysis are affected by their own interaction with the wider world; they are influenced by their own learning and experiences. The IPA researcher is therefore considered to be active in the research process by making meaning out of the participants' meaning-making (Smith et al., 2009). IPA is influenced by the philosophy of hermeneutics; Smith et al. refer to the philosopher Gadamer who posited that although one's preconceptions will influence understanding, we will not know what they are until we are engaged in the process of meaning-making. In this way there is a dialogue between "what we bring to the text and what the text brings to us" (Smith et al., 2009, p. 26). In IPA, the research process is considered to be a two-way interaction between participants and researcher (Larkin et al., 2006). IPA does not consider it possible or desirable for the researcher to remove themselves from their thoughts and meaning system in order to gain an objective account of the participant's experiences (Larkin et al., 2006) but because of the subjectivity the researcher brings to the process, interpretations are made cautiously and should not overpower the participants' account of their experiences (Reid et al., 2005). The text (a participant's account) should remain embedded in the research report (Smith et al., 2009). In keeping with the IPA research model, extracts from the participants' accounts are included in this report.

Because of the role that the researcher plays in the process, the knowledge that an IPA study produces will be therefore be dependent upon the researcher's standpoint (Willig, 2008). This introduces the notion of reflexivity, including the necessity of stating the researcher's epistemological position.

2.4 EPISTEMOLOGY

The philosophical bases of qualitative research - Epistemology i.e. the philosophy of knowledge; what knowledge is and how we can know something, and Ontology i.e. the philosophy of being and the nature of reality, affect everything from the question the research addresses to how the data is analysed (Nagy Hesse-Biber & Leavy, 2010). Willig (2012a) outlines the importance of identifying the researcher's epistemological stance because only through making clear what knowledge the researcher set out to generate is it possible to judge whether the research has been effective. Accordingly, in this section I describe my epistemological basis in order to make transparent my perspective on the relationship between people and the world, the knowledge I sought to generate, and my understanding of the role of the researcher.

Willig (2012a) suggests that the assumptions that are made about how participants interact with the world will directly affect the way the data is analysed and the type of data produced. IPA's philosophical background locates the participant in the context of their world; hence the person can only be understood as a function of their involvement in that world (Larkin et al., 2006). The present research assumes that the person and their context are inseparable and that this applies to both researcher and participants. I have identified numerous contexts associated with the topic of the present study, it concerning criminality and imprisonment. There is the immediate context of the prison environment and the cultures contained within; there is the context of a prison system that is located within a political and social context; and differing cultural contexts within which the participants and researcher exist.

There are a variety of ontological positions conceptualising research knowledge. For example, realist positions hold that there is a reality that is independent of our thinking (Kirk, 1999) and that this can be accurately captured by research investigations (Guba & Lincoln, 1994). Within this position, moderate critical realists acknowledge that research data is not a direct reflection of reality but the outcome of interpretation, allowing the possibility that there are differing claims to the nature of 'truth' (Willig, 2012a).

At the other end of the ontological continuum, the relativist position considers reality to be constructed by peoples' beliefs, thoughts and language (Guba & Lincoln, 1994). From this perspective, there is no 'one truth' about reality, but many possible truths. Various Social Constructionist positions lie within relativism. Willig (2012a) describes how these vary from

radical social constructionists, who argue that there is no reality bar that which is constructed by a persons' language, to moderate social constructionists, who are likened to critical realists in their outlook.

The latter is the position adopted in the present research; it is the position of a critical realist with affinity to the position of a moderate social constructionist. It is assumed that there is a real, wider social world with political and social structures that shape the way both participant and researcher construct meaning (Willig, 2012a). Participants and researcher position themselves within their contexts and are subject to discourses surrounding specifically, crime and imprisonment. Their experiences are influenced as a result of their contexts and the data generated is not necessarily an accurate depiction of an objective truth. Harper describes critical realist social constructionists as believing in the importance of "going beyond the text in order to add a further layer of interpretation – by setting what is said in a broader historical, social and cultural context" (2011, p. 92). I have endeavoured to present data that accurately capture and represent the participants' (subjective) reality and experiences, though I acknowledge it cannot have been perfectly apprehended (Guba & Lincoln, 1994).

Broadly, the type of knowledge the study sought to generate was phenomenological knowledge, revealed through the dual analytical processes of IPA (Larkin et al., 2006; Reid et al., 2005; Smith et al., 2009). These processes aimed to generate descriptive and interpretative insight into the phenomena under investigation; therapists' experiences of working with prisoners. Within the phenomenological approach, information is sought that captures the nature and quality of the participants' experience and no claim is made as to the 'objective' truth or accuracy of their reality (Willig, 2012a).

Further, the participant's experience is interpreted by a subjective researcher who draws out underlying meaning (Willig, 2012a); in this way, the researcher is not an independent, detached observer but an active investigator with a biographical presence (Smith, 2004). Therefore, the knowledge generated is presented alongside reflexive statements acknowledging the researcher's influence on the process and data (Willig, 2012a).

2.5 Personal reflexivity

IPA recognises there is a personal lens through which the researcher sees and interprets the participants' world (Smith et al., 2009) and here I discuss the more personal influences affecting this research, including for the sake of transparency my reasons for choosing this research topic (Yardley, 2000).

I am a White British woman, aged thirty and have long been interested in social, political and psychological perspectives on crime and punishment, particularly the needs and welfare of prisoners. I believe it important to enable individuals to understand why they have committed crime, setting aside judgement or condemnation and with validation of any contributory experiences of trauma and deprivation. Whilst I consider the main aim of my work to be the reduction of distress and mental illness in the client, I am also aware that providing individuals with knowledge and skills might subsequently reduce the likelihood that they may harm others. These are the values I hold in my work with those who have committed crime and as will be apparent, I share some common ground with the values of the participants in this research.

A number of personal experiences led me to this topic as the subject of my research. Prior to starting my training in Counselling Psychology, I worked in a prison for four years; first employed by the Prison Service to assess prisoners and subsequently by the Probation Service as part of a team delivering a psychologically-based offending behaviour programme. I continued to work within a prison as a trainee counselling psychologist, providing individual therapy to prisoners. I have therefore been exposed to different professional cultures within prisons and made aware of various perspectives regarding imprisonment, punishment and the treatment of prisoners. In my role as a trainee counselling psychologist in prison, I developed an interest in being a practitioner 'in context'; in particular, I became interested in the effect of the setting on the role of a therapist and the therapeutic relationship. I found myself often having to handle situations that I found ethically and professionally challenging, most commonly regarding confidentiality and the reporting of risk. After a traumatic experience with a prisoner-client that threatened my safety and affected me greatly, I became interested in how therapists were affected by being in a therapeutic relationship with prisoners. I was particularly interested in therapists' counter-transference experience, that is, their emotional, cognitive, psychic and physical experiencing of and towards their prisoner-clients.

Furthermore, I was interested to know how they processed and made sense of their experiences. These areas of interest, shaped and refined by an exploration of the existing literature, resulted in the focus of the current research project.

Subsequent in-depth reflection on my experience drew my awareness to unconscious driving forces that influenced the focus of the research. As I came to understand, whilst I initially positioned myself within the prison context as a helper and social agent, my experiences caused me to view and position myself as a victim; victimised by the prison, the prisoner and my own counter-transference experiences. This research was perhaps initially and unconsciously motivated by an attempt to reposition myself into a more comfortable role of researcher and 'champion of therapists' working in this 'difficult' environment. I was perhaps driven by a need to protect other therapists from what I had experienced, and I recognise that initially my assumption was that all therapists working in prison are exposed to material and people that might negatively affect them. It is clear to see how this was very much based on my own experience at a time when I had not fully gained perspective or processed my experiences.

Research supervision has been essential in uncovering my assumptions and influences and at times challenging them, in order to reduce their effect on the process. I was able to gradually move from a position of 'passionate champion' to one of 'curious researcher'. To facilitate continual openness and sensitivity to my own process and influence on the research, I kept reflexive notes throughout. This was particularly useful as an outlet for personal feelings and thoughts engendered at different stages in the process; indeed, the notes were often akin to a personal diary. I believe this assisted me to remain embedded in the participants' experiences and prevent my own knowledge and experience from dominating.

My developing identity as a therapist undoubtedly affected me throughout the research process and I think I felt it most keenly whilst conducting interviews. Here, I was very aware of trying to 'shut off' the part of me that was actively interpreting throughout the interview, as I was used to doing in my role as a therapist. In addition, I was aware at times that I had certain beliefs and assumptions about how therapists 'should' work within a prison setting, based on my training and the influence of psychologists I have worked with, not to mention my own personal beliefs. In the first couple of interviews, I found myself comparing to a certain extent my practice with that of my participants, perhaps in an

attempt to understand more fully my own experiences of working in a prison. From my first awareness of this comparison dynamic, I have sought to limit it and attempted to respond to participants' accounts with equal curiosity regardless of whether they were reporting similar experiences to my own.

The word 'interpretation' is inextricably linked with the practice of psychoanalysis and indeed, IPA literature makes reference to its theoretical influence in research analysis (see Smith et al., 2009). This project led me to think about the use and nature of interpretation in psychological research. As recommended by Smith et al. (2009), I sought to limit the influence of knowledge and theory whilst conducting the analysis. This was not always easy, for example it proved to be particularly challenging to avoid making interpretations influenced by psychoanalytic theories on defense mechanisms. Supervisory input, extensive reading and reflection enabled me to resist this instinct and make interpretations in line with the aims of phenomenological research (see Willig, 2012b). My learning with regard to this issue and its impact upon the methodological process is further reflected upon in the discussion chapter.

2.6 Participants

2.6.1 Inclusion and exclusion criteria

Within IPA, samples are relatively homogeneous and Smith et al. (2009) advise that the sample is limited to those to whom the research aim is meaningful and who can offer an insight into the particular topic under investigation. Clearly there is room for a great deal of subjective interpretation of this guideline and whilst it is useful to have participants who are similar, setting tight limits as to the uniformity can be practically restrictive. The practical restrictions in this case were the anticipated difficulty in identifying and contacting therapists who worked in prisons. There is not an organisation that oversees all the therapeutic activity within prisons and the provision of therapy differs in each prison. From my personal experience I was aware that therapy is carried out by a variety of providers including but not restricted to internal psychology departments, the NHS, charities and faith based organisations, and practitioners might be psychologists, counsellors or psychotherapists.

Therapists of any theoretical orientation and both qualified and in-training therapists were invited to participate. Recruitment was not limited to those working in one theoretical modality or those from one professional discipline as, whilst these factors may have affected the way participants understood their experiences, it was essentially their human experience of being a therapist to prisoners that was under investigation. Additionally, therapists often utilise multiple therapeutic approaches in their work; to exclude these practitioners would have significantly reduced the pool of potential participants.

In summary, with practical and theoretical considerations in mind, the inclusion criteria were:

- Therapists who had experience of one-to-one therapy in prisons
- At least three months experience working in a prison
- Qualified therapists and those in training

Excluded were therapists who conducted group work, practitioners who provided psychologically-based interventions with prisoners such as manualised offending behaviour programmes and therapists who used another medium besides themselves in their work, for example drama, visual arts, or music. The reasoning for this was that it reduced the homogeneity of the sample unnecessarily. Potential participants' compatibility with the inclusion criteria was ascertained during email or telephone contact prior to arranging the research interview. Eight therapists met the inclusion criteria and subsequently participated in the study.

2.6.2 Demographic information

As the number of therapists who work in prisons is relatively small compared to those working in the NHS for example, and there is a degree of networking amongst prison therapists, I was acutely aware of the need to protect the participants' identity and maintain their anonymity. The information presented here about the participants has been selected with this in mind, the aim to inform the reader without compromising confidentiality. I do not believe that limiting the demographic information is to compromise the research. It is the participants' experience that is under investigation, not the interaction between their experience and variables such as their gender or length of experience, as might be the case in quantitative research design; furthermore, it is not in

line with the phenomenological philosophy to attempt to explain their experiences in light of their demographic variables (C. Willig, personal communication, May 26, 2011).

Participants themselves provided information that enabled me to establish that the majority of them were counselling psychologists by profession with a minority being CBT therapists. The majority were qualified therapists, as opposed to being in-training. Participants worked in both male and female prisons. Most described themselves as working predominately within CBT approaches whilst drawing from other theoretical approaches, often referring to psychodynamic theories.

2.7 PROCEDURE

Silverman (2005) stresses the importance of outlining procedure in qualitative research to demonstrate its validity. Yardley (2000) identifies procedures for ensuring the quality of qualitative research, one of which is the principle of transparency. One way in which this can be achieved is by clearly detailing the process of the research. Whilst describing the procedure used in this research might give the impression that a recipe was followed, it is important to stress that IPA itself is a flexible approach and its application is likely to be slightly different within different research studies (Smith et al., 2009). The issue of research quality is addressed later in this chapter.

2.7.1 PILOTING

Smith et al. (2009) remark on the usefulness of pilot interviews for developing an interview schedule, as well as for enabling the researcher to feel comfortable with the process of interviewing others. Two pilot interviews were conducted, both of which had a significant impact on the focus of the research and on the structure and content of the interview schedule. The two pilot participants were recruited using personal contacts. Both worked in male prisons; one was a trainee, the other a qualified counselling psychologist. The pilots were conducted at the stage when I was unsure as to what language to use in the interview schedule and therefore enabled me to refine the language and order of the interview schedule, as well as practise my interviewing style.

2.7.2 Recruitment

Therapists working in prisons may be from any one of several organisational departments and professional disciplines. Recruitment was therefore first directed towards professional groups. Counselling psychologists were targeted via the Division of Counselling Psychology E-Newsletter and via a network group of Counselling Psychologists in Forensic Settings (CoPiFS). A charity that trained and placed therapists in training (counselling psychologists and psychotherapists) in prisons was also contacted. Personal contacts were utilised to maximise the word-of-mouth potential. The snowballing method as described by Smith et al. (2009) was used in an effort to use early participants to recruit others and this proved to be the most successful recruitment method.

Smith et al. (2009) write that the main aim of IPA is to achieve a detailed account of human experience; the aim is for quality not quantity. Because of the depth of analysis involved in IPA and the complexity of the subject, they recommend a small sample size; eight to ten participants is typical (Smith et al., 2009). It is important to note the IPA does not intend to create generalisable theories that would describe many people's experiences. Its idiographic influence means that it aims to understand in detail the perspectives and experiences of a particular group of people (Larkin et al., 2006), in this case therapists who work with prisoners. With this in mind, I sought to interview between eight and ten participants and gather rich data that would enable a deep understanding of participants' experiences.

2.7.3 Interviews

The interviews were arranged by email or phone and were conducted at various locations to suit the participants. Participants were sent a briefing sheet (Appendix B) in an email prior to the interview and asked to sign the consent form (Appendix C) before the interview began. Interviews typically lasted an hour and fifteen minutes before approximately fifteen minutes was spent at the addressing any concerns or questions and discussing the debriefing sheet (Appendix D).

The interviews were semi-structured, with some questions used to shape and guide the interview (see Appendix A) and participants were prompted for further elaboration or clarification at times. Additionally, the semi-structured design gave participants an

opportunity to discuss what was important to them at whatever length and to whatever depth they chose (Arskey & Knight, 1999).

2.7.4 Transcription

The interviews were audio recorded with the participants' consent and the tapes were transcribed verbatim. Various guidelines exist for the transcription of interview data. Smith et al.'s (2009) guidelines for transcribing IPA data were followed, therefore both interviewer and participants' utterances were transcribed and pauses and non-verbal communication were noted. Highly detailed transcriptions including pronunciations or lengths of pauses were not made, in line with the focus of this research being on the psychological themes and experiences of the participants rather than on the language used to construct their experience (as in Discourse Analytic methods, for example).

2.7.5 Analysis

The analytic process within IPA is characterised by an immersion in the participants' accounts in order to achieve "the insiders' perspective" (Reid et al., 2005, p. 22). This is achieved by a systematic process of descriptive and interpretative annotation of the individual transcripts, the result of which is a set of themes which reflect key features of that participant's experience (Reid et al., 2005). Subsequently, the themes from each participant's account are considered together in order to identify commonalities in experience (Reid et al., 2005). The end result is a set of master themes and constituent sub-themes.

Smith et al. (2009) provide in-depth guidelines for analysis within an IPA approach, although they also state that these are not intended to be prescriptive. I followed these guidelines closely, engaged in some non-essential tasks suggested by Smith et al. (2009) and developed personal complementary techniques to aid the process.

At the beginning of the analysis process, I found it helpful to read through the transcript whilst listening to the recording as this gave me a deeper understanding of the participants' accounts and grounded my subsequent annotations. In addition, and as suggested by Smith et al. (2009), I recorded any immediate personal responses including emotions, beliefs, or theoretically-driven interpretations in my reflexive diary in order to prevent them contaminating my subsequent interaction with the transcript.

In the early stages of analysis, I varied in the extent to which my annotations were descriptive and interpretative as a result of my relative inexperience with the method. I subsequently returned to my early transcripts to add commentary or bracket off (Smith et al., 2009) interpretations that I later identified to have been influenced by extant theory or knowledge; this was to achieve a consistency of commentary. For a sample section of an annotated transcript see Appendix F.

I tried different methods of identifying and examining the emergent themes from individual transcripts before adopting the method of writing them on separate pieces of paper. This enabled me to move them around on my desk explore the connections, links and contradictions (Smith et al., 2009). Upon identifying the themes for each participant, I found it helpful to write a summary of each participant's account in my research journal, explaining the themes and how they were linked. This reinforced the hermeneutic, cyclical process of returning the thematic 'parts' of the account back to the 'whole' (Smith et al., 2009). I sought to analyse each transcript in the same way, though I was mindful to approach every transcript with openness to enable new themes to emerge (Smith et al., 2009).

At the next stage of identifying recurrent themes across cases, I constructed a table and highlighted themes that were present in the majority (four or more) of participants' accounts. It was at this point in the process that I attempted to balance IPA's ideographic focus on the individual with an account of what is shared (Reid et al., 2005). The process of grouping these recurrent themes into master themes was assisted by writing each theme on a piece of paper and exploring different ways of configuring the data. Further refinement of the master themes involved deciding which elements of the participants' experiences to focus on in order to make the information coherent and to reflect the shared aspects of experiencing whilst accommodating individual variations within the data set (Reid et al, 2005). To facilitate this, I often asked myself which aspects of the themes were important to the participants, which shed light on something previously neglected by existing research, and importantly, which addressed the research aim. Within the analysis chapter, I occasionally make reference to individual experiences that were not shared by the majority by way of shedding light and deepening our understanding of the shared experiences (Smith et al., 2009). Reflective of the hermeneutic dialogue within IPA, this phase in the analysis is also concerned with meaning-making as the researcher endeavours to make sense of the shared experiences of the participants (Smith et al., 2009).

The master themes are presented in the analysis chapter. It is typical in IPA research for the analysis chapter to be distinct from the discussion of the findings to enable the participants' voices to be heard without the imposition of extant theory and literature (Smith et al., 2009). The discussion chapter is also interpretative as the findings are explored and enriched with reference to existing knowledge and theory in an attempt to increase our understanding (Reid et al., 2005).

2.8 Improving validity

Yardley (2000) outlines indicators of quality within qualitative research. Various features of IPA enable good quality research; these, and the steps taken to ensure the quality of the present study are presented here.

The quantitative use of triangulation to ensure objective data is produced becomes meaningless in what is inherently, a subjective methodology that has the researcher's interpretations at its heart (Yardley, 2000). Reid et al. (2005) therefore refer to the necessity that results are plausible (as opposed to 'true'), as considered by a supervisor and readers. In this research, the integration of extracts from the transcripts into the research report increases transparency and allows the reader to judge whether the interpretations and conclusions are plausible. Both the annotated transcripts and the process of developing the themes were overseen by the research supervisor, thus proving an important quality control function in checking for plausibility.

Willig (2012a) suggests that the quality of research can also be assessed by the extent to which it increases readers' insight and understanding of the topic. I have endeavoured to acquire knowledge that fills a gap in the existing body of research and the findings appear to add to our understanding of the subject. Willig (2012a) also points to the need to assess the internal coherence of the study, that is, the extent to which the analytic narrative hangs together without any internal contradictions and here I have consulted my research supervisor to assist in identifying any such inconsistencies.

Transparency has been increased by the inclusion of reflexive statements within the report, aimed at informing the reader to my biases and influences as well as the reasoning behind decisions. In this chapter, I have sought to describe comprehensively how I went about the

research, including providing illustrations of work, for example through the presentation of annotated transcripts.

An additional method by which I sought to ensure the research quality was through participation in a dedicated and confidential IPA peer research group. Within this group, I discussed the research process, clarified my understanding of IPA theory and practice; shared and accounted for decisions I made at different stages and discussed good practice and the latest developments within the IPA community. This group has played an important part in maintaining the quality of this work.

In line with IPA guidelines (Reid et al., 2005; Smith et al., 2009), participants who were experts in the research topic were selected; that is they all had relevant experience of working with prisoners to enable them to shed light on the matter which they were willing to share. This was another way in which I endeavoured to ensure the quality of the data generated.

2.9 Ethical considerations

Ethical issues were considered fully throughout the research process. Ethical approval was obtained by City University Psychology Department (see Appendix E) and British Psychological Society's (2009) ethical principles for conducting research with human participants were followed.

2.9.1 Confidentiality

Security is a high priority within prison settings; security of the data provided by participants and their anonymity was given similarly high priority. Participants were allocated a pseudonym and any identifying details within the transcripts were either removed (e.g. names of prisons if disclosed) or changed if removal would have altered the meaning of the text. Participants had the option to be sent their transcripts to confirm that they could not be identified. The audio recordings were stored on a PC protected by a password and will be destroyed after the doctoral portfolio has been passed and any amendments made. Consent forms with participants' names on were stored separately from any other documents and in a locked cabinet.

2.9.2 Consent

Informed consent was sought from each participant. Participants were given a briefing leaflet about the research at the recruitment stage (Appendix B), and in interview they were asked if they had read it and were invited to ask questions. The procedure of the interview was explained and the consent form (Appendix C) presented to the participant to sign.

2.9.3 Managing distress and debriefing

Although I considered the risk to participants to be minimal, I nevertheless took into account the possibility that participants might become distressed by describing difficult emotional experiences. At the start of each interview, different support options were discussed should participation in the study have necessitated their use. Given the participants' profession as therapists and with respect for their expertise, I did not wish them to feel patronised through the provision of helpline telephone numbers, in addition to the fact that such helplines may not have been appropriate given the topic of discussion. It was therefore felt that identifying personalised support structures was a more respectful and appropriate measure. I ensured there was time at the end of the interview to debrief the participant and check their well-being. If any had reported being distressed, I would have used this time to reaffirm avenues of support. Participants signed a debrief form to confirm that they were not distressed and that I had conducted the research in a professional manner (see Appendix D). I left them with a copy of the debrief form which included my contact details. A few days after each interview I made contact with the participant to thank them again and to give them the opportunity to let me know if they had become distressed.

No participants reported feeling distressed at any stage and all confirmed through signing the debrief form that they felt the interview had been conducted professionally and with regard to their welfare.

CHAPTER THREE - ANALYSIS

3.1 INTRODUCTION TO THE ANALYSIS

Four main recurrent themes, referred to as master themes, emerged from the analysis of the data. This chapter outlines the four master themes and their constituent sub-themes which together capture the distinct features of the participants' experience of working with prisoners. The themes are described and illustrated with extracts from the transcripts of the participants' interviews. Extracts were chosen because they communicated something important about the theme or summed the theme up entirely (Smith et al., 2009).

Rarely, utterances have been extracted from the quotes because they were not directly relevant to the theme being outlined and it was felt to be distracting; this will be identifiable by three dots in parentheses […]. Pauses in speech and other observations about the delivery of the speech are placed in brackets, for example: (short pause). Very brief pauses or hesitations are indicated by a dash [-]. Explanatory notes are put in square brackets [ ]. In the quotes, words participants stressed are underlined. Otherwise, the quotes are included directly as they were spoken, enabling the reader to get a sense of each participant. Quotes are labelled with the participant's name followed by the page number then the line numbers of the transcript from which it was taken. For example (Emma, 18,9-10). When the quote spans two pages, the page and line numbers will be presented as follows: (18,9-19,3).

On the following page is a list of the master themes and their constituent sub-themes.

LIST OF THE FOUR MASTER THEMES AND CONSTITUENT SUB-THEMES

1. Aligned to the prisoner

    1.1 "*Not an officer*"

    1.2 Being "*in the middle*"

    1.3 Disclosure rules mean therapists are an *"us and a them"*

2. Threat is all around

    2.1 Threat of manipulation

    2.2 Threat of physical harm

    2.3 Protecting from the danger of psychological or emotional disturbance

    2.4 Protecting the self in and through the relationship

3. The Distanced criminal

    3.1 "I don't want to know what they've done"

    3.2 Seeing the victim, not the criminal

    3.3 Mentally separating the 'inside' from the 'outside' world

4. Psychological gains

    4.1 Enjoying the challenge of complex clients

    4.2 Pleasure in providing a unique relationship

    4.3 Satisfaction in strength

    4.4 Greater awareness

3.2 Master theme one: Aligned to the prisoner

This theme concerns the nature of the therapists' role and stance in respect to their clients, both within the therapeutic dyad and beyond it in encounters with prison officers. When describing their role to the prisoners, the majority of the participants conveyed their raison d'etre as being to provide a supportive ally to vulnerable prisoners in a harsh relational landscape. In the first sub-theme, "not an officer", the therapists described their allegiance to the prisoner and differentiated themselves from the role and approach of the prison officers. In the second sub-theme, Being "in the middle", the therapists described interactions with staff in which they adopted a role as a protector or advocate for their clients. In this way, the therapists became a bridge, a conduit between prisoners and officers, whilst remaining aligned to the prisoners. In the third sub-theme, the responsibility to communicate issues concerning risk and security meant therapists were "*an us and a them*". The therapists described how the requirement to disclose information to prison authorities was a source of stress and a potential threat to the therapeutic rapport, it symbolising to the prisoner that their allegiance was less than complete. Therapists sought to maintain their human-centred stance towards their clients when dealing with information-disclosure.

3.2.1 Sub-theme one: "Not an officer"

The therapists frequently described their prisoner-clients as having multiple and complex needs, observing that they had often been deprived of healthy, supportive and loving relationships. The therapists saw this deprivation as continuing in the prison environment in which prisoners' liberty was restricted and the opportunity for healthy and positive relationships limited. As a result, the participants saw a key part of their role as providing prisoners with supportive relationships to counteract their negative or abusive experiences. The therapists stressed the qualitative difference between the relationships they had with their prisoner-clients and the relationships that existed between the officers and prisoners.

Emma observed that a distinctive feature of her role was providing a uniquely "*nurturing*" relationship to prisoners:

> *I suppose you do offer, to a certain extent, a kind of you know, nurturing, supportive relationship, and sometimes that's the only place in the whole prison that that individual gets that. Where am I going with that?* (Long pause) *I suppose, well yeah,*

> *I suppose sometimes there's a kind of, a lot of demands on you, erm,* (short pause) *you know, you've got your one session a week but you might be caught in the Wing by a client saying "can I just check in with you" or, or "will you meet me to run something by you", or "can we just have a quick chat"* (Emma, 18,12-19,4).

Emma reflected on how being the sole provider of this "*supportive"* and "*nurturing"* relationship could also be quite challenging; it placed a degree of pressure upon the therapist as the prisoners became attached to, and possibly reliant upon, the comfort it offered.

For Lucy, providing a supportive relationship was important in an environment where other staff, particularly officers, were seen by prisoners as instruments of the penal system rather than working in the interests of the prisoners. She identified a distinctive aspect of her role: "*So I think the fact that there's one person that they see on a regular basis, who's there purely for them - Erm, I think that for them, that's really quite special"* (Lucy: 14,11-14). Lucy described herself as "*purely for them*", stressing her orientation to the needs of the prisoners rather than working 'for' the prison.

Participants considered themselves also to be distinct from prison officers in the attitudes they held towards the prisoners. The therapists adopted what could be described as a human-centred approach, as exemplified by Helen:

> *I can give them a choice because that's the nature of it, and in a sense that's like an empowerment for them, in a place where they probably haven't got any empowerment, or, it's soon taken away if they think they have. Erm, and, it's about control as well, choice is about control. And prison, very little control they have, you know they have to do certain things at certain times, erm, and it's giving them a bit of, I suppose it's a humanity really, erm, they're having that bit of humanity, from me, and I think that's important because they're not treated as humans. They are treated as criminals* (Helen: 17,18-18,7).

Treating prisoners "*like humans*" was particularly identified as being an important and key feature of their approach, one which Helen conveyed to her clients by offering them choice and seeking to empower them. In her extract, we got a sense of her deliberate motivation to offer this to the prisoners in the awareness that they were deprived of it outside of the therapeutic relationship. Similarly, Lucy observed that all other staff saw the label

'dangerous prisoner' before seeing the person beneath and as such, she believed her contrasting, human-centred approach was "*the most precious thing*" (33, 11) about the relationship she offered.

Belinda set out to empower the prisoners in her relationships with them. She told them to call her by her name rather than addressing her as 'Miss', as they did with the female prison officers, because she didn't "*want that power thing*" (Belinda, 30,8) in the therapeutic relationship. This was a further example of the way in which she and the other participants sought to separate themselves from the role of the officers. Helen went on to explain why this approach was so important:

> *Well simply because if you treat them as a number in prison, then you will, then you become part of the establishment, rather than someone that is there to give them some guidance in how they can help themselves. So, erm, it's very, in prison, it seems err, I've only worked in prison a few years but it seems like it's an us and them situation, and as a therapist you are sometimes privileged to not being us or a them, but to be a someone in-between. Erm, and I think, that's, that's the thing about being in, having a therapeutic alliance with someone is that the fact that they can do, they can see that* (Helen, 3,16-4,5).

It appeared important to be distinct from the establishment, as being one of "*them*" was experienced as being incompatible in their role as a therapist or "*guide"*, as Helen saw herself. She appeared to say that it was important that prisoners saw that she was not a "*them*", she was not part of the "*establishment*" like the officers, but neither was she a prisoner.

Similarly, participants also sought to distance themselves from the officers because the prisoners had a negative view of the prison authorities. Indeed, Emma passionately described the effort it took when first working within the prison as a therapist to establish her identity as distinct from the officers:

> *I think a lot of people imagine that you are going to be seen automatically - as authority. Erm, and if that were the case, then yes, that would impact massively on trust, but I think I've worked hard, to you know, to emphasise, that I'm not an officer, and I'm not part of the erm, you know, kind of punitive authoritarian kind of discipline, that I'm very separate from that* (Emma,15,12-16).

Emma judged that a separate identity from officers was essential for gaining the prisoner-clients' trust and therefore to developing a therapeutic rapport. Other participants also reported that demonstrating trustworthiness was an important aspect in their work. Several participants described a process whereby prisoners appeared to vet the therapists to establish whether they were "*on their side*" (Belinda, 9,15) and therefore whether the prisoner was prepared to enter into a therapeutic relationship. Barbara said that if you weren't considered trustworthy, "*word would soon spread round the prison*" (8,12). Belinda reported sensing quite severe consequences were she not deemed trustworthy and essentially on the prisoners' side:

> *The women, erm, smell it, they just seek, they will know. If they don't sense that you do want to help them and you've got their interest at heart they will sense it, and they will have you, you, you'll be mincemeat*
>
> **R: *In what way mincemeat?***
>
> *Well they are incredibly manipulative, they can be incredibly manipulative. Erm, and I, I think that they'd probably cause such aggravation that you'd be asked to go* (Belinda,2,2-7).

Belinda appeared to experience a sense of limited options being open to her; either serve the prisoners' interests or face being dismissed from her job. This extract suggested that her allegiance and orientation to the prisoners was affected by more threatening influences: *"they will have you"*. She perceived the prisoners as "*smelling*" out her loyalty, much like animals used their senses to identify fellow pack members or threatening outsiders. Her use of the word "*mincemeat*" and its reference to the saying 'make mincemeat out of you' also conveyed her perception of the prisoners' potentially destructive power. Perhaps because of this, Belinda later indicated that whilst she was "*on their side*" (9,15), she maintained a distance between her and her client:

> W*e weren't officers right, so therefore we were, we weren't their friends, and you had to keep very distant boundaries, but we were somebody they could go to for help, somebody they could talk to, somebody, yeah we weren't* (short pause) *we weren't going to report them, we weren't going to put them on a charge, we weren't going to, judge them* (Belinda,5,5-8).

This extract reinforced the notion of Belinda defining her therapeutic role in terms of being different from the officers but also highlighted her awareness of maintaining some safe distance. Whilst she may be "*on the side*" (9,15) of the prisoners, she is not in their side with them.

Another dimension in which participants experienced their difference from officers was in their acceptance and containment of prisoners' emotional vulnerability. Typically, prison officers were perceived by the therapists as being unable to deal with the prisoners' emotional needs because they were too busy, inadequately trained, or unwilling. It is important to say here that the majority of the therapists took care to state that they did not experience all officers this way. Nevertheless, seven out of the eight participants felt that officers were at times unhelpful, insensitive or deliberately persecutory towards the prisoners. As such, the therapists experienced their interactions with prisoners in distress as being qualitatively different from those of the officers. Sarah gave an example of this by describing prison officers' behaviour whilst she was trying to contain a very distressed prisoner:

> *There were two male members of staff stood at the door tapping their watches, erm, making it very, very apparent that I needed to be winding up that discussion even though I had a lady literally breaking down in tears in front of me* (Sarah,14,19-22).

By tapping their watches the officers communicated that, 'there is no time for distress or emotion'. The officers appeared to adopt an emotionally unresponsive stance, leaving Sarah to put together the pieces of the prisoner who was "*breaking down"*.

Emma disclosed how hard it was to maintain connection with the prisoners' emotional vulnerability when officers displayed so little sensitivity:

> Y*ou might go to an office with them, with the officers and you know, they want to hand over about their level of self-harm and it's all just kinda spoken about, "well yeah it's all about the past abuse isn't it, she's got flashbacks at the moment", it's all spoken about so casually, that I think sometimes it's hard as a therapist to, to hold on to the horror of their experiences* (Emma,8,6-10).

Emma wanted to be able to *"hold on"* to the horror of the experiences in order give the prisoner clients an empathic response, reflective of her desire to remain emotionally available to prisoners in a way the officers were not.

Helen conveyed the difference in perspective between her and the officers in respect of a client who suffered from Obsessive Compulsive Disorder (OCD):

> *This particular chappy I had who had OCD he um, it was horrendous because the, the, the um officers thought he was putting it on, and he was so crippled by it. I've never seen anyone so crippled by it. A lot of, lot of work there was needed with him. Erm, and what was sad was that they moved him from somewhere that was getting him the help, which didn't make sense to me at all* (Helen, 27,16-21).

Helen described that it was visually apparent ("*seen*") that her client was "*crippled*" by his OCD; her perspective being that he was obviously suffering and in need of therapeutic work. She appeared to find it hard to make sense of, and was saddened by the officers' cynical interpretation of his disorder and subsequent unhelpful actions. This extract is indicative of the way in which the therapists appeared to observe and respond to prisoners' vulnerability, in contrast to officers who appeared either to fail to notice it or fail to respond sensitively.

Indeed, some prison officers were seen as being dismissive of therapy. Belinda (14,1) referred to a belief that therapy was "*fluffy bunny rabbits and white clouds*" and Sarah said there was a myth in prison that therapists left prisoners in a worse state:

> *There is sometimes erm, quite unfortunately this label attached to therapists working with prisoners, is that we're going to open up all these cans of worms and that you know we're going to leave these individuals in a really distressed state, and you know we're not going to, I suppose close down the material that we had been working on* (Sarah, 10,18-21).

In several important ways, participants appeared to experience a clear distinction between their role and the relationship they offered to prisoners and the role and relationship offered by the officers.

3.2.2 Sub-theme two: Being "in the middle"

The therapists described extending their commitment to their clients in their interaction with prison staff by adopting a protective or advocate role. This appeared to be in response to witnessing the client's vulnerability and the threat they perceived the officers or prison authorities as posing. As such, participants appeared to take up a middle position from which they attempted to increase the opportunity for the needs of the prisoners to be met. This gives a second meaning to Helen's explanation of her role: "*It seems like it's an 'us' and 'them' situation, and as a therapist you are sometimes privileged to not being 'us' or a 'them', but to be a someone in-between"* (Helen, 4,2-3). It could be seen that Helen was identifying herself as being between two, often opposing sides. This perspective was shared by a number of the participants who linked the hostility between officers and prisoners to their desire to offer the participants some protection. For example, Belinda described a situation in which she acted as a protective intermediary when a client of hers was being transferred to another prison:

> *When she was transferred, I was asked to stay on to erm, to help her through, and when she was told she was moving, they, the officers and those three* [three officers] *was incredibly antagonist, and I was really glad that I was there because […] oh boy was he, you know, trying to stir her up, and I think he was wanting a fight, I really do. I think some of the officers wanted a fight. And err so anyway I nipped that in the bud, by saying "ok, so and so* [prisoner], *I'm going to help you". Right, and they couldn't do anything then and she, she sort of went down and we packed her stuff* (Belinda, 6,12-18).

This extract very powerfully conveys Belinda's sense that she needed to protect the prisoner both physically and emotionally. She linked her offer to help the prisoner as being the shield that prevented the officers from doing anything further to antagonise her client – "*they couldn't do anything then*". She also aided the officers, helping them to achieve their task of moving the prisoner, though it is clear that she was primarily motivated by her orientation to her client's needs. Belinda went on to say "*sometimes we were used as a bridge. And that's fine*" (24,14); demonstrating a clear awareness and acceptance of this aspect of her role in the middle.

Barbara adopted an intermediary role that was similarly protective in nature but in contrast to Belinda, there was no recognition of her also serving the officers' side. Her middle

position was akin to that of a translator, helping prisoners to understand and interact with the officers. Here, she gives an example of how she cautions a prisoner to beware officers' unforgiving behaviour:

> *I sort of remind him that, you've to be careful with interaction, particularly with officers, because one wrong thing written in your personal file by an officer can follow you around, and if they've got a grudge against you and after all they're only human and you know, "I'll 'ave him" and they'll write something in the file* (Barbara, 13,15-18).

There is a sense that Barbara accepted the officers' malicious behaviour as inevitable, part of their innate fallibility of being "*only human*". She attempted to draw her client's attention to this in order to keep him safe in prison and later she went on to describe how she extended her intermediary role further by actively developing prisoners' assertiveness skills in order to empower them in their interactions with the officers.

The participants generally experienced their middle role as being important and valuable, particularly to the prisoner; Helen described it as a "*privilege*" (4,2) to be in this position. Emma identified challenges associated with this aspect of her role:

> *They* [officers] *might, you know, ask you to have a word. Erm, because they know that you've got a good rapport, or relationship with that individual and I think it's very hard* (short pause) *to sometimes keep a firm grasp of your identity […] it was kinda discussed in our team that we were also kinda advocates for the client, erm, in a place where their autonomy was being erm, kinda taken away from them, to a certain extent* (Emma, 14, 14-20).

Emma spoke of the difficulty of retaining a firm identity and role as a therapist because of the pull to assist officers who benefit from the rapport the therapists have with the prisoners. She saw the position of advocate as one that was adopted by the group; therapists see the role as necessary because prisoners' autonomy is being "*taken away"*. She went on to say that because other staff were not helpful in assisting prisoners with practical problems, it *"requires you to step in"* which places a further "*question mark over your identity*" (Emma, 15, 8-9). In identifying needs on both sides, she experienced difficulty remaining in the middle rather than being pulled more to one side or the other and also difficulty in retaining her identity as a therapist.

In experiencing the challenges associated with being "in the middle", other participants rejected the intermediary role or explicitly attempted to limit the amount to which they were used as an advocate by prisoner-clients. Maria described a process whereby she initially felt the pull to assist prisoners with their practical problems in the absence of help from other staff helping the prisoners:

> *I'd kind of feel like I have to like contact people for them and do things, so I'd end up running around, and now I've kinda learnt that I'm just really boundaried with that and I say this is my role […] if they were just getting in to - we're like the social worker, which does happen, to try and be a kind of a bit more boundaried about that I think* (Maria, 7,14-19)

Maria had learned over time to become more role-boundaried and explicitly explained the limits of her role to prisoners in order to limit her activities to those of a therapist. Rob chose to separate himself as much as possible from the prison regime mainly in order to decrease the role-conflict he would otherwise experience. Here, he describes how his identity would come under threat, limiting his capacity to work as a clinician:

> *Kinda, your role gets, you know, you're not seen just as a therapist you're seen as, a bit more when, you know, you get ingrained into the environment, so, you're going to ACCT* (self-harm) *reviews and you're having to comment on this and that, whereas here* [from a psychologically distant position] *I can just kinda step back, and not do that*
>
> ***R: And what are the advantages of being able to do that?***
>
> *Erm,* (short pause) *I guess for me, it helps me to kinda keep my therapist skills more on therapy, so for example, prisoners don't go and talk about, "oh I'm having this problem on the wing" and stuff like that, cos I won't just won't touch it, I'm just like "right what are you going to do about it, rather than expecting me, that I'm going to be able to do something about it".* (Rob, 35,13-36,8).

Rob's separation of himself from the staff and the environment of the prison enabled him to limit the demands from both sides that would otherwise blur his role as a clinician and therapist.

3.2.3 Sub-theme three: Disclosure rules mean therapists are an "us and a them"

The therapists frequently referred to the requirement to disclose risk and security information as being a source of conflict, anxiety or stress. Sarah described confidentiality issues as having *"an immense impact on therapy"* (17,19). The requirement to disclose risk appeared to be symbolic of an alliance to the prison authorities and thus it posed a threat to the therapist's identity as an ally to prisoners. Maria described the awareness of her responsibility to prison security as being like wearing "*another hat all the time"* (2,4-5), something she experienced as detracting from her relationship with the prisoner. Maria felt fearful of prisoners' angry reprisals that might result from a disclosure to the prison authorities, although she considered that in the event they *"tend to be alright"* (6,4). Here she describes her conflicting feelings about the issue:

> *The issue of erm, trying to stick to the rules erm, and kind of regulations I guess erm, and trying to be transparent to the client about that, but then maybe feeling a bit fearful or a little bit tiptoeing, walking on eggshells around that really. I don't know, you kinda feel like the institution or the prison's breathing down your neck, or it's there, at one hand it's, I suppose on one hand, it's a kind of security in a way around you, it kinda contains you on the other hand it can add extra pressure on your working with prisoners* (Maria, 4,13-19).

Maria seemed haunted by the presence of the prison institution "*breathing down her neck"* increasing the pressure on her through their rules to disclose. She conveyed the difficulty and discomfort of the situation, appearing to feel both a victim of and protected by the institution. Maria was not alone in experiencing or fearing reprisals from prisoners when they had to disclose; some participants described occasions in which they experienced abuse or rejection as a result of disclosure. The disclosing of information was considered to have the potential to create a "*huge rupture"* (Rob, 13,15) in the therapeutic relationship, destroying the trust the prisoners had placed in the therapist. When considering whether he was ever at risk from his clients, Rob identified that disclosing information to prison authorities had the potential to trigger an assault from a client.

Sarah described how a prisoner became highly aggressive and abusive when Sarah told her that she had to disclose the prisoner's intention to set fire to herself and her cell:

> *Obviously she was aware that I was going to have to go back and speak to members of staff and let them know, and I did say this to, to her, I said, "I'm going to have to let them know that you've got a lighter, and that you've said you're going to do what you are going to do in terms of harming yourself". And that was another reason why she started calling me a grass* (Sarah, 16,7-11).

The prisoner calls her a "*grass"*, prison slang for informant, indicating the disloyalty the prisoners were typically reported as experiencing when their therapists had to disclose risk. As a result of the tension and conflict experienced in relation to confidentiality, all participants spoke of the importance of being transparent with prisoner-clients about confidentiality and the therapist's responsibilities to the prison. Helen described it as *"setting out her stand" (5,12)* in which she conveyed the limits to confidentiality and therefore the limits of her allegiance to the prisoners. She clearly linked the issue of confidentiality to the concept of conflicting responsibilities and her position in "*the middle"*:

> *Cos in one respect you are an 'us' and a 'them', because the officers want to know what's going on, and the prisoners want to know what's going on, but you're in the middle, and there are certain things you can't say, but if you're setting out it all in the beginning, "if you tell me about this, then I will have to tell the authorities, or the officers". **Yeah** Erm, and if you say to the officers "I won't tell you anything unless it's to do with the security of the prison" […] and that's how you start off really, and that's how you become, erm, become in the middle, because they know then what they can say and what they can't* (Helen, 5,14-22).

In being transparent about their responsibilities, the therapists are maintaining their human-centred stance and their desire to operate distinctly from the officers, as Helen exemplified:

> *I mean if they know where you're coming from, say for instance when I start talking to someone I'll say, "this is confidential, but you start telling me stuff about prison, you know, you're doing drugs, or you're tunnelling out, then that information I will share, and I will tell you that I am going to share it, but I will share it". So, that's what I mean by meaning honest and treating them as a person, erm, as I said, most pe- well not most, my, my experience the prisoners are not treated particularly as*

> *individuals, er, and their own person, by a lot, not all because there are some good, erm, some good professionals there but um, they are treated as, "you are a criminal this is what you deserve", sort of attitude.* (Helen, 4, 6-14).

Whilst Helen described fulfilling her responsibilities to the authorities by keeping rules about disclosure, she does so in a way that is in line with her desire to treat the prisoner as a "*person"*. This was common amongst the therapists, some taking their allegiance to the prisoner further by adopting a tactic of warning clients when they were approaching territory in which the therapist may have to make a disclosure to the authorities:

> *I mean if anything, if anything going to be said in the session that I think – would have to be disclosed I do sort of cut them, and say "before you say any more, remember that if you do or say X you, I then I have to", so they can either carry on disclosing what they want to disclose knowing what the procedure would be up to that or they just don't* (Barbara**,** 9, 16-20).

This appeared to be a way of handing the responsibility to the prisoner, thereby empowering them with choice and control. Maintaining their human-centred approach in this way also reaffirmed their distinction from the officers, potentially providing some protection to the therapeutic alliance. The issue of disclosure reflected the therapists' dual and conflicting responsibilities and positioned them 'in the middle' of two opposing sides.

3.3 Master theme two: Threat is all around

This theme captures the participants' perception of prisoners posing multiple threats to them; each participant described experiences of either being wary of their clients or scared of them at some point. The sub-themes explore the nature of the threats participants' experienced and the strategies utilised to reduce risk: sub-theme one explores the Threat of manipulation, sub-theme two the Threat of physical harm, and sub-theme three is entitled 'Protecting against the danger of psychological or emotional disturbance'. Sub-theme four entitled 'Protecting the self in and through the relationship' explores the way in which therapists' allegiance to the prisoner appeared to contribute to a sense of safety.

3.3.1 Sub-theme one: Threat of manipulation

All participants reported being conscious of the potential for prisoners to manipulate them or be operating out of "*ulterior motives*". Examples of prisoners' ulterior motives included trying to get a positive court report from the therapist and prisoners doing therapy to satisfy parole boards. Many therapists' recounted warnings they received from officers to beware prisoners' manipulative behaviour, and Maria and Helen below spoke of the "*guard"* that they had to put up:

> *Erm, also you get told things about certain prisoners, like they're manipulative or they're erm, they'll you know, they'll try and get things out of you, that kind of thing. So again, it's, you kind of got another guard up when you're working with them in a sense that you're thinking about that* (Maria,2,5-8).

> *You have to be on guard, in the sense that they are very manipulative, or can be very manipulative. Not because they're being nasty, because they see you as a means to an end. You might be able to get something that perhaps makes their life better in prison* (Helen,4,15-17).

The language Maria and Helen used was reflective of the participants experiencing prisoners as coming to therapy 'wanting' something; Maria spoke about them "*getting things out of her"* and Helen of her ability to "*get things"* for the prisoners. Thus there was a dynamic conveyed of the therapists having something valuable which they needed to protect to prevent it being 'taken' through manipulation.

The other aspect of manipulative threat participants' experienced was the potential for the therapist to be deceived by the client. Barbara talks of the setting up of a false intimacy created by prisoners' duplicity:

> *They might be grooming you so to speak, to get sort of close to you and get sort of a nice, friendly relationship with you going and then they'll pounce and say do you think you could bring this in for me, or do you think you could take this out for me and so you always have to be careful from that point of view* (Barbara, 3,7-10).

Barbara's language indicated that she perceived prisoners as being deliberately predatory, *"grooming"* her into colluding with them before "*pouncing*" like a bird of prey on its catch.

The therapists identified that a potential consequence of being deceived was that the authorities would perceive the therapist as corrupt, and would punish and remove them from their work. The therapists also feared they would be left feeling victimised, naïve, vulnerable and embarrassed. Sarah spoke of her loss of confidence in herself and trust for her client when probation officers shared some information with her and she realised her client had misled her:

> *But I suppose it did sort of make me erm, less confident at times, you know to want to, you know, to assert my opinion quite so assertively. Erm, you know, in case I was sort of shot down by you know other professionals sat round that table* (Sarah, 31,9-11).

Sarah appeared to feel shamed at realising she had been deceived, further compounded by experiencing the professionals as less than understanding; she feared being "*shot down"* by them. Naïvety was seen as something that would not be tolerated by prison staff and this attitude to be shared by the therapists. Barbara frequently emphasised experience as being important in identifying potential manipulators. She described her thoughts when it dawned on her that a prisoner was trying to deceive her as being, "'*oh here we go again, what a waste of time', you know, and part of you thinks, they must think I was born yesterday"* (Barbara, 21,11-12). Barbara was scornful of the idea that she may be manipulated and her irritation was evident, an emotion many participants reported feeling towards the "*time-wasters*" as these prisoners were frequently called. Frustration was triggered when therapists felt their time was being taken away from others who needed them and who were genuinely interested in therapy, but frustration was also generated by the prisoner's desire to trick them and the assumption that they might be 'stupid' enough to fall for it.

Participants described developing strategies to identify which prisoners were there for *"the right reasons"* (Barbara, 3,19), and who were *"timewasters"* who "*wanted*" something. These strategies appeared to be ingrained; Lucy referred to the "*standard response" (26,4)* she activated upon realising a prisoner may have ulterior motives and Barbara said she would put her "*professional hat on and go through the motions"* (24,5) when she thought a prisoner was there to manipulate her. Establishing a prisoner's motives occurred very early in the therapy, as Lucy described when speaking of the challenges of the work:

> *The challenge is actually the first meeting, who are they going to be, what do they want, erm from therapy, what are their understandings, erm you know, and what are the ulterior motives* (Lucy, 24,19-25,2).

Barbara spoke of identifying timewasters quickly:

> *But you can usually very quickly weed those out from the start once you've got a bit of experience you can, you can see that they're not, they're not there for the right reasons* (Barbara, 3,16-18).

These strategies were spoken of in a matter of fact, almost detached and dismissive tone, each participant apparently recognising that dealing with 'timewasters' is an inevitable part of the work. Barbara's process of *"weeding out"* included setting the prisoner homework to test his commitment to therapy and motivation to change. Just as participants experienced prisoners as having the potential to pounce like a bird of prey, they avoided becoming prey by 'sniffing out' and testing the prisoner's motives. Helen captured this in her explanation of how she responded to prisoners who seemed to have ulterior motives: "*and then it becomes like a game of sussing out what they do want from me. Which I find intriguing. I shouldn't say that, should I, but I do"* (Helen, 29,17-18). Helen frankly described playing the prisoners at their own "*game*" by manipulating them into giving away what it was they were trying to "take" from her and she described enjoying this detection game. It was apparent however, that she felt this was something she should not admit to. Other tactics to deter potential 'timewasters' were described, for example therapists reported stating at the beginning of therapy what they could and could not offer, thus disarming potential manipulators with their openness, a directly contrasting behaviour to that of their potential clients.

3.3.2 Sub-theme two: Threat of physical harm

Participants described safety as always being in the back of their minds. The majority described an occasion when they felt scared of their client or when they had been aware of their client's potential to harm. Only a few described situations in which they had been verbally abused, a couple reported that clients had been aggressive or damaged property in front of them but none reported having been physically or sexually assaulted. Participants referred to practical self-protection strategies they used as a matter of course; sitting close

to the door, knowing where the officers are in case of emergency, carrying a personal panic alarm.

Maria, like other participants, reported feeling most fearful when she first started working at the prison:

> *I guess going back to the erm, kinda of fear thing, erm - if you kinda upset them or make them annoyed or whatever, erm*, (pause)*. When I first started I remember that was definitely, like a concern for me* (Maria, 12,9-11).

Emma described her experience of feeling fearful around prisoners and aware of the potential for danger:

> *You might get like a big large group of males walking towards you, and, and I felt nervous in that situation and I feel, I felt that I would erm, really kinda harden to a certain extent where I'd kind of, hold myself, you know, quite erm […] I would hold myself upright, and, and you know, erm, I suppose try and kinda illustrate that I'm not intimidated* (Emma, 3,15-21).

Common to the majority of participants is the use of the body in self-protection; in Emma's case she adjusted her posture to convey an impression of strength. The participants' monitoring of their bodily experiences is also linked to trusting their intuition if something 'feels' unsafe. Lucy gave a vivid example:

> *I've only ever - refused work with two clients* (short pause) *in the last seven years, and - they have both been when I have sat in a room, and felt completely frozen from head to toe. As if,* (short pause) *something - dreadful - was going to happen. I, I don't know that I've ever really felt a fear response - like it and it, it is almost,* (short pause) *I kind of feel it is akin to, if you look at a dog in a situation where they're frightened and the hackles you can see visibly maybe cats too, the furs standing up, it kinda feels like that. And,* (short pause) *literally though it's like your whole body, for me, literally feeling like ice was pouring - through my veins, and actually thinking to myself,* (pause) *I think this is dangerous I think that there is an ulterior motive, and I don't want to work with this client, literally seeing hatred completely,* (she swallows audibly) *and feeling it (Lucy, 21,13-22,11).*

Participants also reported observing client's bodily cues to detect danger, as Lucy described:

> *Erm, and so I suppose it's watching for everything. It's watching their body - language, very, very closely, keeping a real eye on what's going on in their, in their face, their muscles, their eyes, erm, because some of them can move quite quickly. And always, always, being closest to the door. It's kind of, when you see that glint in somebody eyes, it's figuring out, how quickly can I get off this chair if I need to.* (Lucy, 20,4-10).

Just as Barbara conveyed the predatory nature of prisoners who may pounce, Lucy appeared to portray the prisoner as a dangerous animal that *"can move quite quickly".* In the moments in which they detected danger, the therapists were aware of the potential to become their client's victim and sought to minimise the risk.

3.3.3 Sub-theme three: Protecting against the danger of psychological or emotional disturbance

Several participants reported that they were aware of the danger of vicarious traumatisation resulting from repeated exposure to their client's harrowing histories. Given that the participants' work involved hearing and 'taking in' distressing narratives, it was striking that Belinda distinguished between the need for an inner resilience rather than an outer toughness:

> *Erm, I think you do get more resistant, as you get on, I think also there is a danger of you being traumatised because you hear it, and you hear it, and you hear it. So you've got to be quite a tough person […] When I'm talking about toughness, I don't mean being hard and nasty and unkind, I mean an inner resilience if you like, ok (Belinda, 1,14-2,12).*

Having "*inner resilience"* suggested having a sturdy core but a permeable, soft membrane which allowed her to be touched by the client.

Two participants reported symptoms of traumatisation relating to feeling victimised in their contact with prisoners; this was exacerbated by what they described as a lack of containment from colleagues and the prison authorities. Sarah reported suffering

flashbacks after she was threatened by an aggressive, out-of-control prisoner-client. Identifying with the victim of the prisoner also caused distress, as Rob here described:

> *Just the way that this guy was looking at me just really kinda creeped me out, erm, because he was a sex offender, and, he was, his crimes, I was aware that his crimes were against males, so it just really kinda freaked me out the way he was looking at me, erm, so yeah that was uncomfortable.*
>
> **R: What was the sensation?**
>
> *Erm,* (pause) *a bit of fear and disgust, yeah, yeah, a mix of the two - I guess then it was personalised to me, compared to the other times it wasn't, it was out there you know, they'd committed a crime against XYZ person, whereas this time that guy was looking at me, and I'd interpreted that in a certain way (Rob, 23,7-24,8).*

Rob felt "*uncomfortable*" because he perceived himself to be in danger, as opposed to perceiving the danger to be directed to others, "*out there*". Emotional disturbance occurred as a result of him imagining himself to be a potential victim, suggesting that an actual assault need not occur in order for someone to feel victimised.

Maria reflected on the difficulty of protecting herself from emotional disturbance:

> *There hasn't been anything to make me think that I'd be at physical risk, I mean it's a prison and you always are going to be, but erm, yeah I think it's more emotional safety trying to keep myself protected and not letting it spill over, and I think, erm - I think that affects the way you might work with prisoners as well, because you're kind of erm, erm, maybe trying to protect yourself or whatever, it can be quite traumatising* (Maria, 13,5-9).

Maria tries to keep herself protected and not let her emotions "*spill over*", but as a result of trying to protect herself from traumatisation she felt that her work with prisoners was affected. Maria appears to suggest that managing the balance between attending to both self-protection and the client can itself be "*quite traumatising*".

Lucy also reflected on the challenge of attending to her powerful physical sensations and trying to stay connected to her client whilst being conscious of safety:

> *I'm not going to say it's fear, because it's not fear. I think there's a - sense that you can feel your own heart beating though. You really, you sense your own body, you sense that kind of awareness. It's - an almost - imperceptible - preparation for flight, you know the fight or flight response is there and you do, you notice - occasionally, heart beating faster, shallower breathing, you're sensing - yourself very, very clearly, and yet you're trying to stay with what the clients saying. So you're, you really are, in those two spaces staying with the client staying with yourself and aware of, when fear happens* (Lucy, 21,3-12).

Lucy had a strong awareness of her bodily sensations which she understood to be the physiological threat responses of 'flight, fight or freeze'. She described "*two spaces*" as a dual attention on the possible need to distance herself from the client who posed a threat, and the need to maintain the connection. She was initially reticent however, to label her response as fear, only at the end of the passage does she say "*when fear happens*", in a way that suggested acknowledgement of the presence of this emotion. Possibly, this reticence reflects an attempt to prevent her emotion 'spilling over' in the way Maria described above, so she could "*stay with the client*".

3.3.4 Sub-theme four: Protecting the self in and through the relationship

Participants often found it hard to articulate exactly what they did to reduce the threat prisoners posed and to maintain their safety. They identified however, that their allegiance and connection to the prisoner was related to their sense of safety. Belinda associated the fact that prisoners knew she was *"on their side"* to her belief that she was less likely to be attacked by a client than the officers were:

> *I never felt really scared but I knew that some of them were quite violent towards other staff. Erm, and yet I didn't really ever feel scared. Erm, I know once when we weren't allowed to go in to a wing, wishing that I could go and talk to the girl because I knew her and I thought she won't do that with me* (Belinda, 4,17-5,2).

Belinda conveyed a sense of immunity which she linked to her relationship with the client ("*because I knew her*") and her trust in the relationship to protect her. Helen also considered herself to be less at risk compared to the officers:

> *I've seen people on a three man unlock, which means that three officers are present when you unlock the door. And I see those sort of people by myself. Erm, but I think that's to do with howww, what the prisoners sees the meaning of the officers and see the meaning of me. He sees me, I think, as someone to manipulate and to get on his side. And at that point the officers are there to keep him in order. (Helen, 13, 3-7).*

Helen identified that she felt less at risk of the physical assault than officers because the prisoner believed there was potential for her to be on "*his side*". That did mean however, that there was greater risk that the prisoner might try and manipulate her. It appeared that there was a link between the nature of the therapist's relationship with the prisoner and the potential for risk and danger. Some participants described using their allegiance with the prisoner to reduce the risk to themselves, as was evident in Barbara's extract:

> *I'll say to them, "look, I'm here for you, I'm on your side, um, and therefore this session is all about you and what you want to bring to the session. You're in the driving seat and I'm here to help you make the most of it", so just appearing non-threatening and certainly non-judgemental and um, and er, not fee-, not displaying any kind of, um, negative reaction to anything they might disclose, that they would be expecting you to* (Barbara, 31,15-32,2).

Barbara reinforced her alliegance ("*I'm on your side*") and stressed her intention to provide the prisoners with choices. Empowering them in this way and communicating her allegiance to him enabled her to "*appear non-threatening*" which reduced the risk to herself. Barbara seems to begin to say that she must not even "*feel"* anything negative towards her client. Participants appeared to suppress their feelings of fear, disgust, or judgment so they could retain their role as a supportive ally, which contributed to their sense of safety in the relationship.

Rob also explained how the establishment of a good therapeutic rapport was associated with safety:

> *When I've had therapy with people they're there to get some help for, from you, and therefore I've never kinda seen - aggression in any way. Erm, I've seen aggression in terms of they might be shouting or they might be very passionate about what they're saying, but it's never been towards me.* (Pause) *Cos, I guess it's*

about once you've built that therapeutic relationship, they're very unlikely to, unless you do something huge, they're very unlikely to do anything (Rob, 13,5-10).

3.4 Master theme three: The distanced criminal

This theme captures participants' interaction with the crime for which their clients had been imprisoned. To differing extents, participants sought to distance themselves from the offence the client committed and their criminal propensity. For example, the majority of the participants chose not to research their clients' index offence[1] prior to meeting them and those that chose to know had particular ways of managing that information. Whilst the criminal within the prisoner-client was distanced, the victim within the client was focused upon. The sub-themes are entitled: "I don't want to know what they've done"; Seeing the victim, not the criminal; and Mentally separating the 'inside' from the outside world.

3.4.1 Sub-theme one: "I don't want to know what they've done"

Several participants stated that the offence was not the focus of their work and that it was not necessarily discussed in therapy. Lucy, in describing the nature of therapy with prisoners said: *"in essence, you're still working with the human. It's not about their crime"* (Lucy, 1,10). Barbara explained why she did not ask her clients about the offence that had brought them to prison:

> *My remit there is not as a forensic psychologist, mine is as a counselling psychologist and whatever their issue that they want to bring to the session, they're in the driving seat and I will be like the instructor, kind of thing* (Barbara, 17,6-8).

Barbara distinguished her role from that of a forensic psychologist to explain why she did not enquire about her client's crime. She appeared to use the analogy of a driving instructor to present her role being to empower the client and work collaboratively. The implication is that a forensic psychologist may 'drive the agenda' which is crime focused. A

[1] Index offence refers to the offence for which people are currently imprisoned; as opposed to offences of which they may previously have been convicted.

couple of the participants reported discussing offending behaviour only if initiated by their client; this way they remained focused on the needs of the client and their needs.

As well as being a reflection of how participants conceptualised their role, the decision not to focus on the criminal behaviour may also have been motivated by their own preference for the focus of the therapy, as Helen indicated:

> *I think that's why I don't, maybe that's a defence of mine, I don't see what they've done, I don't want to. In a way I don't want to know what they've done, I want to know what they want to change. That's my focus* (Helen, 31,12-14).

Helen preferred to focus on her clients' capacity and motivation to change the future rather than explore past criminal events. She also sensed that her choice of focus was a defence, although she did not say what she was defending herself from.

Whilst some specified that they did not see the offence as being part of their focus, virtually all of the participants attempted to distance the offence or offending behaviours from the therapy and from themselves. This was done in a variety of ways; one participant chose to know the details of the offence but by applying psychological theory to it and including it in his formulation of his client, he felt he was able to think *"a bit clearer"* (Rob, 29,2) and as a result, his emotional response was reduced. Barbara reported forgetting the offence, suggesting she was able to block out the details:

> *More often than not, the offence, will pop up somewhere but I don't usually remember what it is, I don't really, it doesn't really – it doesn't really figure in the therapy at all because that's not usually why they're there. It's um, it's for something else completely* (Barbara, 16, 12-15).

Barbara's distancing of the offence extended to the conceptualisation that the offence was not the reason why the offender had come to therapy; the fact that it was why he is in prison was side-stepped.

The majority of participants attempted to reduce or manage the information about the crime their client committed. For example, several participants described trying to manage their exposure to outside 'others' perspectives on their clients, such as reports in the media when they were working with high-profile clients:

> *I would never find out what they were as a, and that was a deliberate thing, because I wanted to be able to accept […] Like for instance the paedophile that we had I didn't read any papers, because I thought no it's not fair because I don't want to know, not that I didn't want to know, because I had a jolly fair idea* (Belinda, 27,4-12).

Belinda made clear that the reason for not reading the newspaper reports was because she felt on some level that it might have reduced her ability to accept the prisoner-client, however she stopped herself from saying that she did not want to know. This might suggest that she felt the need to hide or protect an underlying sensitivity to the offence details. Alternatively, perhaps she was self-conscious about her choice; indeed the participants frequently appeared to be uncomfortable discussing their choice not to know. Sarah's hesitation in explaining why she turned off the television and didn't look at newspapers featuring her clients was perhaps further evidence of the conflict experienced:

> *I suppose I tried to erm, you know, protect myself and the therapeutic relationship from being erm, I don't know if polluted is too strong a word, but erm, I didn't want you know that information filtering through* (Sarah, 32,1-3).

Sarah's use of the word "*polluted*" vividly captured the way in which offence information was perceived to potentially contaminate the relationship and herself. This distancing of information led to the sense of an 'out-thereness' of the crime, which the therapists preferred not to bring 'in' to their minds or the relationship. A couple of participants created this separation by relying on officers or managers to research and hold the information about the offence. In this way, the participants felt protected because someone was managing the risk, but they were distanced from knowing the nature of the risk.

Lucy stayed distanced from her client's criminality by not reading professional reports about a prisoner-client. The reason she cited was that she did not want her perspective of the client clouded by others' opinions:

> *So I like to go in to things completely, with a tabula rasa where I only have the person sitting in front of me. To me, that's about, their humanity. It's about they're not just a sum of all the other things that have been written about them* (Lucy, 33, 6-9).

By focusing on the person of the prisoner-client rather than their crime, Lucy maintained her human-centred approach. Several participants spoke of this, and in doing so conveyed a separation of person and action, as if the criminal acts of their clients were not part of the person. This was also evident in Helen's extract: "*One thing I don't tend to do, whether this is right of wrong, I'm not sure, is I don't look at their past forensic history. I very much keep it to that person"* (Helen, 1,13-14). Helen appeared to be unsure whether it is "*right*" to separate the offending from the person.

In focusing on the person, participants reported finding it difficult to integrate information about the offending when it did emerge. Emma described how she found it difficult to "*marry up*" the offender and the vulnerable person in front of her:

> *There's been times when a client has shown me photos of their victim, like covered in blood and god knows what else, and I suppose, I suppose maybe there's a level of disbelief because it's hard to imagine that the person in front of you who's now clean and desperately trying to get their life back and is, or was capable of that offence. So I suppose maybe there's, you know, a bit of an inner conflict if you like, of you know, trying to marry the two images up* (Emma, 30,13-18).

So successful was she at distancing the crime that attempting to then reconcile the offence with the person created "*inner conflict*". She "*disbelieves*" that the person she knew could be capable of the crime; it is as if the criminal disappeared.

Some participants explored in more depth the self-protective function of distancing the criminal in their client. For Helen, knowing that a client had abused children would make close therapeutic contact impossible "*because of my feelings to my children I, I know whatever he was saying that it would be my children there, not the children that he erm, abused" (Helen, 17,7-8).* Belinda identified that not knowing about the offending enabled her to retain a professional, non-judgemental approach, but she also explained her reason as: "*That's a safety thing, I think, isn't it"* (Belinda, 28,3). Describing the choice not to know the offence as a "*safety thing*" suggested she perceived the information to have a dangerous power. This was also indicated by Maria who describes what happened to her when she researched on the Internet, her notorious client's crimes:

> *I kinda made the mistake of looking him up and things and then saw the horrific things and* (short pause) *I think it was just too much for me to kind of digest or take*

in, but I couldn't feel anger, I couldn't feel sad, like I just couldn't feel, cos some of the stuff that they were describing, you know, they said that police were so disturbed by what they'd seen, and what they'd found in his flat, that they'd be signed off work for PTSD [Post Traumatic Stress Disorder], *this kind of thing, and it's the worst case they'd seen in years and I think* (short pause) *erm, a few times with that it's kinda like I erm, I think it takes a particular person, er, or strength to kinda work with him, because I kinda found that I didn't, I just closed my feelings off and I couldn't connect* (Maria, 23,4-12).

Maria described her client's offence as so horrific that police officers, typically perceived as tough and hardy, were deeply affected. It conveyed the power of the offending behaviours to make strong people weak, to contaminate anyone who came into contact with it. Maria seemed to position herself as weak because she was unable to hold the information and emotionally engage with the client at the same time. She seemed to be saying 'it destroyed even those hardy people, how was I to cope with that'. The effects on her appeared to be an inability to process the traumatic details of the offence – "*too much to digest"*, an emotional numbing and a retreat from connection.

The concept of knowledge being contaminating was picked up below by Lucy who made a link between considering her clients' propensity for crime and examining her own propensity for such acts. She had been talking about how she was affected when she learned the details of her client's offence:

It's really hard, I kinda want to say to you that I don't think it does change the relationship, (pause) *but of course* (sigh) *well I suppose there are always you know there's that human moment, w-which if you think about anybody's offence, it doesn't matter whether it's paedophilia or anything else quite honestly, if you actually think about the offence, as - somebody other than the person in the room with whom I'm doing the therapy, there's that kind of natural - good lord, you know, you, you did that. Erm, and I suppose that's that, you know, that human element of - why? How did you do that, how could you have done that, and then youuu, but you know it's, it's a split second and often it's not when you're in the room with them, it's, if you're thinking about it afterwards because you're writing something you think god, you know, how did they get to that point? What, I suppose you know there's that what on earth possessed them. Erm, you know, or*

(pause, sigh) *maybe the question often I ask myself is,* (short pause) *could I have done that. In that same situation, if my background had been the same, could I have done the same thing?* (Lucy,38,3-19).

There were several things in Lucy's extract that shed light on participants' distancing of the offending information. Firstly, it was difficult for her to admit that she was affected by knowing the offence; possibly being affected did not fit with the role she and other participants sought to adopt in which they were entirely non-judgemental and experienced full positive regard for the client. The second was the recognition that to be affected was a human, therefore understandable reaction "*that human moment".* This suggested a separation of her human-self and her therapist-self. It was her human-self that had such moments of shock and incomprehension, not her therapist-self. A further important note was that this "*human moment*" rarely came when she was in contact with the person, suggesting that when she was with the prisoner, the criminal aspect of them was successfully distanced. In attempting to understand how the person could commit the crime, she referred to an idea that the person was 'possessed' when committing the offence ("*what on earth possessed you*"); indicating a level of disbelief that the person she knew could have committed such an act were it not for some invading spirit (another participant talked of how drugs are the force that turns the vulnerable client they see into a harmful criminal). Finally, Lucy was brought to the point whereby she had to consider whether she herself could commit the same act that shocked her.

The experience of knowing the offending information prompted many questions in Lucy about her client, herself and about human nature; this experience was perhaps similar to the "inner conflict" that Emma referred to experiencing and what was hard for Maria "to digest".

In contrast, three of the participants sought to protect themselves by knowing the detail of their clients' offending. The reasons they gave were to be aware of physical or sexual risks the client might pose to them or to make it harder for less honest clients to manipulate or deceive them. Maria and Sarah recognised that knowing would affect them in some way, but for them, it was better to know than not. Maria reflects on why she chose to know the offence despite the effect on her:

> *I suppose if you look at someone and they've got a long history of violence and they've been disruptive on the wing and they've erm, raped, you know, had numerous accounts of rape and stuff, then you're going to go in a bit more fearful, or suspicious, or, maybe not suspicious but erm, a bit more fearful then when you go with someone who'd only had one account of theft, or fraud or something. Erm, I don't know if that's just a natural human response but, I mean, for me I would say I'd probably erm, yeah, I mean, you know, we should be saying we go in and we see the person and all that kind of stuff, but I think, I don't think in this situations, I think you need to protect yourself and it's what I was talking about before I guess, making sure I feel safe and contained otherwise, erm, you know, you're not going to be able to do the work anyway* (Maria, 27,3-14).

Maria felt that solely "*seeing the person"* was not safe in this environment; she went on to say that to go in '*blind*' was naïve and made her vulnerable. It is interesting to note that the three who chose to know the offence of their clients were those who identified as a victim during the course of their work.

3.4.2 Sub-theme two: Seeing the victim, not the criminal

Participants conceptualised their client as predominantly being a victim rather than a criminal. This was achieved by focusing on the often traumatic and horrifying past experiences. In this way, their criminality was put into context, making it understandable to the participants.

> *He'd been an alcoholic and abused all sorts of drugs and everything under the sun for donkeys years, had very difficult very dysfunctional childhood where he'd been rejected by his family and brutalised and all the rest of it, and you could see, why wouldn't you be like that really, cos you think what's so bad about me* (Barbara, 15, 9-12).

Barbara reflected on the difficulties her client had experienced when attempting to understand how he might "*be like that*" – behave criminally. She often experienced her clients being stuck in "*victim mode*" (14, 3), and whilst she agreed that they were victims, her perspective was to attempt to move them out of it: *"They feel quite sorry for themselves and they view themselves as victims, which of course they are, but they can rise above that"* (Barbara, 29, 5-6).

Belinda reflected on her perceptions of the prisoners when she first started working in the prison:

> *Erm, and I can remember my supervisor at the time saying to me very matter of fact, well of course most of the women here are er, survivors and they're victims, and most of them have actually erm, been abused in one way or another, and I can remember thinking, yeah yeah, right. Erm, and then I realised that she was absolutely right* (Belinda,3,1-4).

Belinda's extract indicated that she did not initially see prisoners as victims rather than criminals, and was rather cynical of this perspective. With exposure to the details of prisoners' lives, she came to see the victim within the prisoner. This was common to other participants, who described that the victim in the prisoner became dominant in the therapists' perception of them. Similarly, Lucy indicated that prisoners' crimes become 'smaller' in comparison to the 'huge' trauma they have experienced:

> *You know many of them have had the most horrendous backgrounds, stories that you can't actually get your brain to compute, and they survive. And actually some of the crimes they've committed are nothing in comparison to what they've been through* (Lucy, 16,4-7).

Lucy's choice of language dismissed the significance of the crime ("*are nothing*") in comparison with the prisoners' life histories. Describing the trauma their clients had experienced evoked great and obvious empathy in the participants, the expression of which was accompanied by a reinforcement of their human-centred and non-judgemental stance. The participants stopped themselves from casting moral judgements on the criminality of their clients and instead attempted to understand how they had come to be in their situation. In doing this, the therapists took into account decades of their client's life, as opposed to just considering the criminal action in one isolated moment in time. This was reflected in Helen's explanation of her perspective: "*Moral doesn't come into it, it's about understanding their process. They're a human being, they took this route er, they might have took that route cos that's how they, survived their life"* (Helen, 35,2-4). Helen viewed the criminal act not as a bad or evil one but as a feature of their journey through life. Common to both Lucy and Emma's extracts were references to their clients being survivors as well as victims and this was something to be admired: "*you just have this sense*

of, you know, awe that they could be so strong. […] That these women have all survived, regardless of what they've been through" (Lucy, 16,1-3). Admiration for the survivor takes precedence over judgement of the criminal.

Emma also spoke of understanding the context of the prisoner's criminality:

> *But I think when you are privileged to the bigger picture, and, you hear about what's going on for that individual, erm, you're able to set aside those judgements and those labels and all those kind of things, and* (pause) *I don't know, if I suppose, if I was, if I had access to the pre-sentence report and heard graphic accounts of, of what the victim had gone through, maybe that would be very different but I suppose I'm not seeing it through the victims eyes, I'm seeing it through the offenders eyes* (Emma, 30, 7-12).

Understanding the context enabled Emma to "*set aside*" the judgements and see through "*the offender's eyes*". She recognised that there were other perspectives; however she was connected to the victim in the offender rather than the offender's victim.

3.4.3 Sub-theme three: Mentally separating the 'inside' from the 'outside' world

Further to distancing the client's criminality in the therapeutic relationship, the majority of the participants attempted to create a mental distance and separation between 'inside' and 'outside' life. Participants' spoke of 'switching off' and those who succeeded at doing this conveyed almost a separation of minds, as Helen described:

> *"When I come out of the prison […] I'm not with them. If someone mentions their name, I wouldn't know the name without – letting myself go back and connecting that up […] So I suppose it's about detachment really* (Helen, 20,3-7).

Helen spoke of having to "*connect that up*", as if she mentally detached information about the prisoners from her other mental activities. Rob talked about how the work had affected him and he touched on how he also attempted to detach himself from his knowledge of crime and peoples' capacity for harm:

> *It's made me realise that people aren't as nice as they seem, erm, that people can think and do things that might not be, that might be, you know, quite awful. Erm, yeah, people can act out their thoughts, no matter how kind of, crude they might be*

> *[…] I try and switch off - from it. Not that it's that easy to switch off because now and then, you know when I'm talking and thinking, I think as a psychologist and not as - I used to* (Rob, 26,14-27,4).

Rob attempted to "*switch off*" his awareness that people can act out their "*crude*" or awful thoughts, but he appeared not always to be successful. This suggested that there is a burden associated with possessing such knowledge; once exposed to the inner workings of an offender's mind and the details of crime, the way one thinks about and perceives others is changed. He knew that people do not always control their criminality and the potential for crime was experienced as being ever-present. This experience was linked to his attempts to maintain a separation in his mind between prison and the outside world.

The ability of therapists to detach themselves from their knowledge of their prisoner clients and crime was reported as being something that developed over time. Maria reflected on an event that caused her to place greater importance on separating her "*prison world*" from her "*personal world*"; she was victim to a crime that involved the invasion of her home:

> *It kind of brought erm, the two worlds together, erm, my personal world and the world of the prison, and that was a real challenge for me working there with the prisoners because erm, it was really hard for me to get over that […] when I was listening to them* [prisoner-clients] *kind of talk erm, and I, yeah I guess for a, like, the first few weeks, I would kind of relate them to the crime. So it was hard to untangle the two worlds, I think, it was over-spilling and also erm, my safety I guess, physical safety of erm, oh my God, people are coming in and invading my home, and so maybe that's why I probably am more fearful because it was like the two worlds meeting* (Maria, 14,16-15,7).

Maria felt greatly disturbed by criminals, who were otherwise contained inside the prison, breaking into her outside world and her home. The invasion of her personal space was accompanied by an invasion of her mind; in her therapy work she linked her clients to the crime she had been victim to. The two worlds, otherwise separated mentally and physically, had "*spilled-over*" into each other and as a result she described feeling greater levels of fear and symptoms of trauma. Later, Maria spoke more generally about how the knowledge of criminality had affected her in her outside life:

> *Some of them are quite vulnerable and quite erm, loose cannons I guess, and hearing a lot of their stories, and just thinking, you know they're on the bus next to us, you know, they're everywhere, erm, so just being aware of that I guess and yeah, I think it's affected me* (Maria, 19,6-9).

This excerpt suggested that it was difficult to compartmentalize fully her knowledge relating to the "*inside world*". Criminals were seen as being "*everywhere*" and potentially close to her without her knowing ("*On the bus next to us*"); there was a sense she could not escape from criminality and the awareness that at any moment, the "*loose cannon*" could explode.

Other participants also reported experiencing hyper-vigilance to crime in their personal life as a result of their work. Lucy for example, described being extremely protective of her anonymity in order to keep herself safe outside prison:

> *I'm very aware of - the fact that people can - hurt each other quite badly, I'm aware of how easy it is for your identity to be stolen, erm, your life to be turned upside down. So, erm, yeah. I can be quite suspicious of people's motives for doing things.* […] *I, I'm very conscious of - what people can do. And, and how easy it is for people to get in to your life* (Lucy, 55,1-9).

Lucy's suspicious mentality of others' motives appeared to be necessary to preserve her life and her personal identity. She linked this to her awareness of peoples' propensity to harm. In the second extract, she conveyed the ease with which she believed criminals could "*get into her life*" and therefore had actively adjusted her mentality in order to maintain a separation of the two worlds.

3.5 Master theme four: Psychological gains

This theme presents the motivating factors and psychological gains experienced by the participants in their work with prisoners. The majority of the participants spoke of the highs of their work; the things that motivated them to continue despite the challenges and dangers they faced. Their commitment and passion for their work with prisoners was very

strong, as evidenced by their expression of "*love"* for the work (Lucy, 14,18), and how they "*missed"* the prison when they worked elsewhere (Rob, 34,18).

This master theme has four sub-themes: Enjoying the challenge of complex clients, Pleasure in providing a unique relationship, Satisfaction from strength, and Greater awareness.

3.5.1 Sub-theme One: Enjoying the challenge of complex clients

All participants spoke of the prisoner-clients' multiple and complex problems which were beyond those encountered in clients on the 'outside'. This seemed to be an aspect of the therapy that the participants relished, it posing a challenge to their therapeutic skills and engaging them in work which they frequently described as 'interesting' and 'fascinating'.

> *The interesting thing about the prison obviously is that they're that more intense and they're that more, because, um, because where on the outside you might get a bored housewife, or a, or a retired businessmen or something, in there it's, always, blood and guts kind of thing, you know, you get your teeth into, and of course 80% of them have personality disorders of one sort of another so you've really, you've got your work cut out and you've virtually guaranteed an interesting time, you know it makes you work to deal with the issues that come up* (Barbara, 10,8-15).

Barbara clearly linked the intensity and extent of the client's problems to her experience of the work as "*interesting*". Her reference to having her *"work cut out*" indicates that she enjoyed the challenge presented and her use of the term "*blood and guts*" suggested that she felt she was dealing with fundamental issues. Belinda shared this experience:

> *I think knowing basically that you do some good. I think it is fascinating, I mean I loved it - it was really gritty, it was really challenging, really stretches you, if you can work there, you can work anywhere. Erm, the issues are - sad, but it's sort of what I would call meaty counselling, it does stretch you, you do think oh my god what am I going to do with this, how can I help her* (Belinda, 16, 1-7).

Beyond knowing that she did good, Belinda enjoyed being stretched by the presenting problems of her clients. Her term "*meaty counselling*" for the work involving serious and challenging difficulties conveyed her conceptualisation of them as interesting and

engaging. Maria felt the breadth and depth of her client's difficulties provided her with excellent experience:

> *It kind of prepares you for working with erm,* (short pause, short laugh) *you know, I guess in one sense in terms of training it prepares you, it's like a placement that prepares you for all sorts of you know, issues, erm, and you can work with five clients and have covered, you know, a hundred issues in, so I think it's a positive in that sense* (Maria, 37,14-18).

When reflecting on the rewards of the work, Rob also conveyed a positive perspective on his experience working with the challenging client group:

> *It's given me a sense of* (pause) *erm,* (pause) *I guess in my abilities to work with a challenging group, it's helped me to kinda reinforce that, erm, and the fact that I've continued it for such a long time now* (Rob, 25,8-9).

Rob appeared to suggest that not only had he gained an awareness of his ability to work with the challenging client group, but he also appeared to experience some satisfaction from his knowledge that he had sustained such work over a period of time.

3.5.2 Sub-theme two: Pleasure in providing a unique relationship

Participants reported gaining pleasure from offering through the therapeutic relationship, something prisoners would not otherwise experience. For Lucy, it was the therapeutic relationship itself which was a unique opportunity: "*I absolutely love the fact that you are giving them an opportunity to have something that they would not have had - on the outside at all"* (Lucy, 14, 18-20). Lucy clearly enjoyed being in a position to offer a service and meet a need in the prisoners that would not otherwise be met. Being uniquely able to meet the needs of the prisoners was typically experienced as rewarding, as Barbara reflected:

> *He just said "oh, I tell you that because I trust you, I know I can trust you 100% but I wouldn't say it to anybody else". Um, and um, and I think that's nice, you know, that, that, they they do know that you're you're sort of there every week and you turn up regardless of the weather and that you're always, you know that you*

> *maintain, you're consistent and predictable, positive and supporting and all that so* (Barbara, 33, 8-12).

Barbara appeared to be pleased that the unique trusting ("*I wouldn't say it to anybody else*") and consistent relationship was recognised and appreciated by the prisoner. Belinda also reported feeling positively when a challenging client recognised that their relationship was different from others:

> *When she was going […] she actually had the audacity to write on her thing* [feedback form], *'I made your life really difficult Belinda, you're the only one who's bothered finding me, looking for me, or bothering to bother about me', ok. And I remember thinking, you little rat bag, but I was quite touched that she'd - had that need and somehow I'd filled it, you know, even though I'd be thinking, err, wretched child* (Belinda, 21, 10-22).

Belinda was "*touched*" at having met this client's need in providing her with a unique relational experience; in this case of not giving up and rejecting the client. Experiencing reward from being in relationship with challenging clients who have been rejected by others was also something Emma identified:

> *But I think what really stands out* [as a reward of the work] *is you know, these people who are labelled as monsters, or criminals or kind of scum of society or whatever, erm, there's something - quite rewarding I suppose about being able to establish a relationship with them, and work with them through something. Erm, - and on the whole I would say it's quite a privileged position because you get to see the real individual that many people don't, because it's clouded by substances misuse or whatever* (Emma, 25,4-11).

Emma's derived pleasure from her ability to "*establish*" a relationship with people who were socially denigrated and outcast, and then maintaining it in order to "*work with them through something*". She also appeared to feel rewarded by discovering through the relationship, the "*real individual*" who was hiding behind "*substances*", not often seen by others.

Rob also referred to providing a relationship with someone who is "*damaged*" and stigmatised by society:

> *Well it's working, for me personally, it's working with someone who's so damaged, who's got, kind of, you know, the majority of the people that I work with do have some form of personality disorder, erm, so for me, its kinda really rewarding to kind of elicit some form of change, within people that have had a huge, quite a hard tough time but also quite a stigmatised group, that not a lot of people want to work with or, you know, labelled as a failure or, or antisocial, or whatever have you. That's one of the rewards for me* (Rob, 14, 5-10).

In addition to a sense of achievement from eliciting change in his clients, Rob appeared to experience satisfaction that this was achieved in the context of them being written off by the rest of society as failures. He derived reward from providing a relationship that was unlikely to be provided elsewhere.

3.5.3 Sub-theme three: Satisfaction in strength

Many of the participants spoke of discovering or developing through their work, a confidence, courage or mental strength.

> *I'm quite proud that I do it. Quite proud of myself. Quite surprised of myself, I sometimes think God, you were talking to some of the nastiest women in, in the entire thing, erm,* (pause) *I think at the time it gave me quite a lot of confidence* (Belinda, 34, 15-18).

Belinda expressed her surprise and pride that she was able to work with some of the "*nastiest women*" in the prison, and this ability increased her self-confidence. It was notable that when describing their sense of their strength, participants positioned themselves in relation to the dangerous criminal within their client, rather than the victim within their client.

Emma also described discovering a courage and strength when two male prisoners started fighting in front of her:

> *I got in and intervened and defused the situation, kind of, you know, separated them and sorted it out, and I don't think I would have ever have thought that I would react in that way. Erm, at all, so I think, you know, maybe I'm, maybe I'm*

stronger than I thought I was, and I think maybe I'm more confident (Emma, 31,15-19).

Rather than feeling that she developed strength and courage through the work, Emma appeared to have discovered traits that were always there but of which she was previously unaware. This extract suggested that her experience of the work caused her to adjust her self-perception, as had Belinda in "*surprising herself*" with new aspects of herself. Similarly, Maria said:

I do think, I must, you know, not many people could kind of work in this setting and you know, erm, I've kind of, I'm working in it and I'm developing [therapeutic] *groups and doing these kind of things and I think, ok, well it's set me up for future employment, and maybe I have more strength than I think* (Maria, 35, 10-14).

Maria's discovery of a strength she didn't think she had appeared to be linked to her perception that "*not many people*" could tolerate the environment. Lucy too, seemed to experience a sense of being stronger, braver than others in being able to work with this client group when she considered her work through the eyes of others:

Talking to colleagues over the years, about clients that I work with - and, it strikes me at times that people look at me and they seem absolutely aghast at the kind of work I'm doing. Erm, that you know, that there are clients who have suffered this, or that I'm working with clients who are so dangerous. And it's only then that it occurs to me that actually some of the challenges I face are not challenges that anyone else would ever face, but I never think about it like that, which is really weird, I walk around and, I don't, I'm not frightened in a prison, and, and yet I'm talking to, you know, colleagues who I respect and who've done extraordinary work, they'll say, you know, "God, how do you do that". Erm, "cli- the clients that you work with are so dangerous, how on earth do you form a relationship with them?" (Lucy, 16,13-17,15).

Lucy seemed to take her courage and resilience for granted until she was provided with feedback from others that suggested to her that she was 'different' from other therapists. At this point, she experienced her courage as being admired by colleagues whom she respected, suggesting there is perhaps some reward in being perceived by others as being strong enough to work with "*such dangerous clients*". Similarly, Rob spoke forthrightly

about the gains he experienced from being able to engage with dangerous people: "*it - does a lot for my ego knowing that I've done, you know - I'm working with, the most high end risky kind of, group of people that a lot of people aren't willing to work with" (Rob, 34, 6-8).* It would appear that Rob's feelings of self-esteem were increased by positioning himself as unusual in being willing to work with dangerous, high risk clients. He went on to say why he chose to consider this aspect of the work as a benefit:

> *So I kind of think of it like that rather than, you know, I'm, in a way, my cognitive bias to focus on that rather than, the negatives, that can get you down really. […] That's what you find, you know, if I'm focusing on that that's when I'm going to get burnt out, and not want to work in this environment* (Rob, 34,8-13).

It appeared important to Rob to focus on the satisfaction he got from his strength in order to prevent himself becoming burnt out or feeling negatively about working in prison. In this way, having awareness of the gains from his work appeared to build his resilience.

3.5.4 Sub-theme four: Greater awareness

Participants described gaining as a result of their work, a greater awareness of the ills of society and the challenges that people, prisoners in particular, experienced in their life. This knowledge was related to their perception of their clients as victims who had experienced much deprivation. Emma explained that her work had increased her awareness of social problems and of how difficult it was to change the criminal lifestyles of prisoners:

> *I think it's opened my eyes to - erm, to the problems in society, and the impact erm, that parenting, and attachment, and all those kind of issues have on an individual.* […] *You might think that you, by helping that one individual that you can erm, that's there's, a high probability that you can kind of enable them to kind of change their lifestyle but, but ultimately they're going back to that family unit and to break away from that family unit no matter how destructive it is, erm, is incredibly challenging, so I think, it's erm, I suppose it's made me more aware of the struggles that people in society face* (Emma, 32,11-33,4).

Emma said that her eyes had been "*opened*", indicating the change that had occurred in her perception. The knowledge gained appeared to have increased her empathy and understanding of the difficulties involved in changing the lives of those who have

experienced problematic family relationships. Lucy felt that her greater awareness meant she was more likely to treat people with understanding:

> *I suppose I, I do feel that sometimes people are not always aware of what it is that goes on in other people's lives. I suppose, I, I feel, that I see a side of life that most people never see. And, I'm probably more willing to give people the benefit of the doubt, it, at times.* (Lucy, 53, 10-15).

Lucy's extract highlighted a common experience amongst participants; that their knowledge from their "*side of life*" was not shared or seen by most people. This caused them to experience themselves as being different from the public, whom they believed to have more judgemental views:

> *Erm, but I think, I think as well, it has made me more accepting, maybe I sounded quite like judgemental throughout the interview but, I think apart from those times that they kind of, you know,* [that they threaten her] *I think it has made me erm, realise what some people go through and I guess generally compared to the average person, I can be more accepting and non-judgemental of people that are in prison. So I think it's given me that kind of a gentle view, from the Daily Mail type view* (Maria, 37,4-9).

Despite feeling scared and angry towards the prisoners, Maria felt her exposure to information about prisoners' background enabled her to be more empathic and understanding than the average person.

Helen also associated her increased knowledge to the development of a more understanding attitude towards prisoners. She described her feelings about the people in the world that she used to inhabit: "*I get frustrated that people can't see the bigger picture, erm, but then again, that's the world I moved out of anyway*" (Helen, 41, 5-6). Existing in this 'new world' is experienced positively by Helen; she and other participants appeared to feel privileged to have access to information which has developed their understanding and empathy.

Belinda reflected on the knowledge she had acquired and described how she sought to share this with those who were less informed:

> *I'm always with people who are going on about prison system, I always say "yeah well, actually, you know a lot of those women shouldn't have been there in the first place, they should have been given help years and years ago* (Belinda, 35, 17-20).

Belinda also exemplified participants' feelings of satisfaction with their enhanced knowledge about the lives of prisoners and the causes of crime:

> *Some of the childhoods you hear about, you just think oh my God, you know, erm. So it certainly teaches you about life and I'm really, really glad I did it* (Belinda, 35, 21-22).

CHAPTER FOUR - DISCUSSION

4.1. INTRODUCTION AND SUMMARY OF MASTER THEMES

This study aimed to extend our knowledge of the experiences of therapists working with prisoners, there being little previous empirical research on the subject. The research interviews produced a great deal of rich data, from which four master themes emerged. This chapter first explores the relationships between the themes and identifies the key findings, which are discussed with reference to the extant literature. Subsequently, the findings are synthesised and two overarching experiential concepts are presented. The first concept concerns the significance of the gains the therapists reported, the second conceptualises therapists as traversing binary opposite experiences in their work.

Following the exploration of the findings, suggestions are made for future research and professional practice before concluding with an evaluation of the study, including reflections on the analytic process and methodology.

4.1.1 KEY FINDINGS IN THE CONTEXT OF EXTANT LITERATURE

The findings have increased the body of empirical research regarding the experiences of therapists working with prisoners. Some findings supported those reported by other researchers whilst others were at odds with the extant literature; this creates opportunities

for new understanding. In particular, this research has expanded our knowledge of the satisfactions that therapists gain from working with prisoners – an under-researched topic (Slater & Lambie, 2011). Similarly, it has shed light on how therapists other than offence-focused therapists experience their prisoner-clients' criminality. Research into nurses' experiences of working with the same and similar populations appears to be very relevant to the findings, as is discussed below.

Participants in the current study reported a strong commitment to meeting the relational needs of their prisoner-clients through providing a nurturing, empowering and accepting relationship; they observed that this orientation was typically at odds with the role and approach of the prison officers. This supported the literature reporting that both healthcare and therapeutic cultures are incompatible with prison culture which prioritises security and containment (Brodsky, 1980; Collins & Nee, 2010; Doyle, 1999; Flanagan & Flanagan, 2001; Hardesty et al., 2007; Pont et al., 2012; Walsh, 2009). Such research within the therapeutic profession has conceptualised the distinction as being between a 'treatment' versus a 'control' approach to managing prisoners (Appelbaum et al., 2001; Hinshelwood, 1993, 1994; Kenning et al., 2010; Weinberger & Sreenivasan, 1994). However, therapists in the present study did not express a 'treatment' orientation to their prisoner-clients; instead their orientation was more akin to that of nurses whose culture is to 'care', albeit typically through tending to physical wounds rather than psychological ones. Nursing literature similarly documented nurses' role and orientation as being at odds with prison staff whose primary concern is for containment of prisoners (Doyle, 1999; Maeve, 1997; Weiskopf, 2004). Such research has shown prison culture to affect negatively nurses' retention of their caring stance towards prisoners (Doyle, 1999; Hardesty et al., 2007; Maeve, 1997; Weiskopf, 2005). In contrast, participants in the present study appeared to retain their therapeutic orientation, despite acknowledging its opposition to the culture of the officers, suggesting they had confidence in the importance of their work and felt sufficiently empowered to maintain their stance. Related to this, participants sought to offer caring, healthy relationships to prisoner-clients, perceiving those relationships to be important in themselves but also valuable because such relationships are otherwise absent within the prison setting. This finding is apparently not documented elsewhere.

The therapists' dual responsibility to client and to prison and the resultant opportunity for dual roles is identified as an ethical concern (Brodsky, 1980; Pont et al., 2012). Participants

in the present study however, appeared to be consciously aware of their dual role only when managing their obligation to disclose risk information to prison staff. This was experienced as challenging by the therapists because it threatened the therapeutic relationship; this concern exemplified their primary allegiance to the needs of the prisoner. It is notable that when this discomfort has been observed within the literature, it has been amongst therapists' providing offence-focused therapy who have described themselves fulfilling "Jekyll and Hyde" roles (p. 318) of both challenging criminality and providing a helpful, supportive relationship (Collins & Nee, 2010). Therefore it is possible that a strong allegiance to the prisoner, combined with a role concerned with prisoners' emotional well-being and their belief in the importance of this role, protected therapists from feeling affected by dual responsibilities and ethical dilemmas.

The significance of therapists' belief in the importance of their roles and the way they manage the potential dual-role conflict is further illustrated by the reported experiences of clinical psychologists in the United States Army. These clinicians are deployed on the frontline to prevent and treat mental illness in Army personnel whilst also serving as trained soldiers (Moore & Reger, 2006). The authors, themselves Army clinical psychologists, were aware of the ethical dilemma these dual roles posed but they rationalised their position in their belief that providing psychological services to their clients was morally right: "the profession of clinical psychology owes the fighting men and women of our country the opportunity to return home as free from psychological and emotional problems as possible, Moreover, not doing so [providing psychological treatment in the war zone] presents ethical and moral questions in itself" (Moore & Reger 2006, p. 402).

A feature of the therapists' experience in the present study was their adoption of a protective stance towards prisoners based on a shared perception of the officers as being hostile and punitive either deliberately, or by the nature of their role. Previous literature also reported officers as being perceived in this way and of a negative relationship between prisoners and prison officers (Collins & Nee, 2010; Doyle, 1999; Meek, 2011; Nurse et al., 2003; Weiskopf, 2004). There are few accounts however, of therapists acting to protect prisoners physically and emotionally in response. Bertrand-Godfrey and Loewenthal (2011) reported one incidence and discussed how this may be an expression of the therapist's experience of power and agency in contrast to that of prisoners. In contrast, one particularly striking piece of research from the USA documented nurses choosing to ignore

officers' abusive behaviour towards prisoners, identifying closely with officers' values at the expense of their caring values (Hardesty et al., 2007).

In the present study, participants' overt or covert acts to protect and empower prisoners occurred in the context of perceiving the prisoners as having little control, being deprived and vulnerable. Theoretical literature from the psychodynamic school contains references to therapists' counter-transference including protective feelings towards perpetrators; Roundy and Horton (1990) for example describe the tendency for a therapist working with incest perpetrators to experience a need to rescue their clients in recognition of the abused child within. Viewed through a psychoanalytic lens, the therapists' acts of protecting could be interpreted as enactments of identification with a protector (Aiyegbusi & Tuck, 2008).

Karpman's Drama Triangle theory (1968) also appears pertinent here. The theory posits that within relationships, people adopt a role of victim, perpetrator or rescuer based on their previous relational experience, their self-perception and beliefs about others. Players can switch to another position or sometimes adopt mannerisms of two positions simultaneously. This relational dynamic in work with offenders is documented by Gordon (2009) in his account of how splits occurred between staff groups working with personality-disordered offenders in a high secure psychiatric ward.

In the present research, therapists appeared to conceptualise their prisoner-client as victims and the prison officers as perpetrators, adopting a protective, rescuer role toward their clients. Their drama triangle is illustrated below:

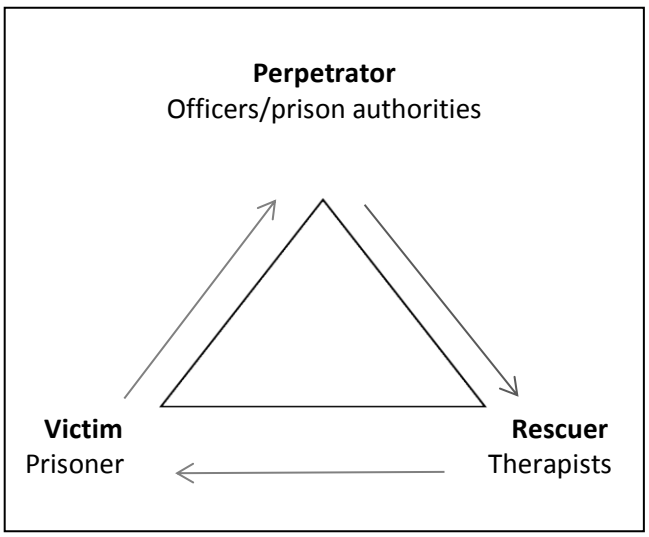

Fig. 1; The dominant positions occupied in the prison drama triangle, adapted from Karpman, 1968

At other times participants experienced their clients' capacity to act as perpetrators, feeling fearful as a victim might and reliant upon the officers to rescue them, reflective of a change in positions on the drama triangle.

It is suggested that the relational dynamics within the prison may have affected the values therapists perceived to be important in their work with prisoners. Their 'human-centred' approach was characterised by 'seeing the person, not the criminal'; the empowerment of the client in an environment which by design restricted their capacity for self-agency; and a focus on the therapeutic relationship. It is striking that these values are those of humanistic psychology, specifically of the Rogerian Person-centred therapeutic approach (Rogers, 1967). None of the participants identified themselves as working within a Person-centred model, however they considered the underlying values to be important in their work with prisoners. The principles of Humanistic psychology result in a reversal of the politics and power that has traditionally been ascribed to the therapist, placing the agency and power with the client (Elkins, 2009). Aware of the prisoners' experience of deprivation both in and out of prison, the therapists wished to offer their clients a therapeutic relationship in which the power was more equally balanced; focusing on the client's agenda was one way in which they did this. Providing this relational experience gave the therapists satisfaction, perhaps breaking a societal pattern in which the prisoners are frequently the 'have nots' and the educated professionals the 'haves'. Furthermore, aware of the power imbalance between prison officers and prisoners, therapists attempted to modulate the existing power dynamic by giving clients skills and support to empower them in their interactions with the officers.

An additional source of satisfaction for the therapists was the opportunity to protect or advocate on their prisoner-client's behalf. It is suggested that this provided them with an opportunity to feel effective and see the immediate results of their labour; indeed there was a sense of pleasure gained from the active nature of the work. Another source of satisfaction was the challenging nature of the work, as was the opportunity to assist with important events in a client's life. Research into nurses' job satisfaction reports similar findings; nurses treating patients in an acute care ward enjoyed the exciting, challenging and fast pace of the work (McNeese-Smith, 1999); satisfaction was also derived from having the opportunity to be involved in major events in a patient's life (McNeese-Smith, 1999).

Research conducted by Senter et al. (2010) may further extend our understanding of therapist's job satisfaction. Their study found that a stronger sense of professional identity amongst prison psychologists was associated with lower levels of emotional exhaustion and higher levels of personal accomplishment. It is suggested that the participants in the present study had a clearer conceptualisation of their role and professional identity as a result of differentiating themselves from prison officers. This clarity may be a contributory factor to the satisfaction they gained from their work.

That therapists in prisons could experience satisfaction and a sense of efficacy in their work is in contrast to some published accounts. Hinshelwood (1993, 1994) believed the role of a psychotherapist to be ineffective within prison due to the dynamics between therapists, the prisoners and officers and the social defence system in place. Hinshelwood suggested that officers and prisoners unconsciously projected into therapists the 'weak' feelings which neither could own in the prevailing culture of toughness and brutality. This projection was made possible because the therapists' role was associated with tender feelings and concern for the human. The therapists' role was therefore devalued and perceived as 'weak' by prisoners and officers alike. The findings from the present study both supported and made problematic aspects of Hinshelwood's (1993, 1994) theory. Participants did experience some officers as denigrating the work of therapists; this finding has also been reported elsewhere (Bertrand-Godfrey & Loewenthal; 2011; Smith, 1999). Rather than feeling weakened and disempowered by this however, the therapists generally conceptualised themselves as 'strong' and effective protectors and it was the prisoners who were perceived to be vulnerable or 'weak'. In contrast to Hinshelwood, the therapists in the present study believed their role to be effective and valuable.

Therapists' perception of their clients as vulnerable was challenged when they occasionally became aware of their clients' capacity to harm them. A dominant part of their experience of working with prisoners was managing the danger that prisoners might manipulate or deceive them. This supports the existing literature in which both therapists and nurses have reported finding this aspect of prisoner behaviour challenging (Garland & McCarty, 2009; Hinshelwood, 1993, 1994; Walsh, 2009; Bertrand-Godfrey & Loewenthal, 2011). The present study contributes to a deeper understanding of therapists' experience of manipulation, the extant literature lacking detail about what this means for the therapist.

Participants suggested that if successfully manipulated by a prisoner into believing or advocating on their behalf a point of view that was later identified as untrue, they experienced professional shame and felt personally victimised. The sense of professional shame was related to negative judgement from other professionals and accusations of naivety and inexperience. Hinshelwood (1993) described prison officers as needing to be confident and suspicious in order to remain abreast of any potential manipulation on the part of the prisoners, because to be gullible invoked weakness which is despised within the prison culture. Nurses have also been found to be extremely vigilant for manipulative prisoner-patients (Maeve, 1997; Weiskopf, 2005); falling victim would incur the wrath of superiors and derision from colleagues (Maeve, 1997). The desire not to be seen as gullible in the prison setting perhaps sheds light on the participants' emphasis on their experience and their ability to identify and dismiss potential manipulators. Nurses working with prisoners emphasised the importance of robust assessment techniques to ensure that their clinical judgements were not adversely influenced by deceitful prisoners seeking secondary gains (Weiskopf, 2005). This supports findings in the present study that therapists saw the assessment of prisoners' motives as important when they presented for therapy. "Weeding out time wasters" from therapy could be interpreted as protecting their professional reputation within the prison.

Participants' robust defences against manipulation were part of a wider armory of strategies, both psychological and physical that therapists adopted in order to avoid becoming victims. Although there is little literature about therapists' use of self-protection strategies, there are nursing studies which describe nurses as being continually on their guard (Weiskopf, 2005). Research investigating nurses working in secure mental health units also found that they reported having a dual attention for security and patient care (Jacob & Holmes, 2011), similar to the experience of therapists in the present study who described trying to stay safe whilst remaining connected to their client. A particular strategy adopted by participants in the present study but only briefly documented elsewhere (Walsh, 2009), is the separation of the inside prison world from the outside personal world. This strategy appeared to be related to the psychological distancing of the offence from the therapeutic relationship but also apparently served as a self-protection strategy; any spilling over of the criminal world into their personal world was experienced as traumatising. The effectiveness of this strategy has some empirical support from Senter et al., (2010) who found that whilst prison psychologists had less job satisfaction compared to psychologists in other settings, they did not report less life satisfaction. The authors

concluded that the structural separation of their work behind bars prevented work-stress and burnout seeping into the psychologists' personal world. In the literature, it is often reported that therapists' appreciate the support from their colleagues and staff team in helping them cope with the adversities of the work (Kurtz & Turner, 2007; Scheela, 2001; Slater & Lambie, 2011; Walsh, 2009). Whilst this was occasionally referred to by participants, it notably did not feature as a significant part of their experience.

The present study contributes to our understanding of how adopting and communicating an allegiance to the prisoner-client has the additional benefit of being a self-protection strategy. Participants' allegiance to the prisoner was at times associated with feelings of immunity from hostile behaviours that were directed towards the officers. The extent that their allegiance was assumed by choice is perhaps brought into question by the participants' accounts of feeling that they had to demonstrate trustworthiness and a willingness to help prisoners, or face rejection. This finding appears not to have been documented in previous research. It suggests that despite the therapists' best attempts to prevent themselves being manipulated, they remain subject to very strong but subtle pressures from prisoners.

Similarly, there is little in the literature about therapists stressing allegiance to the prisoner to reduce threat, although inter-personal theorists outline the importance of the therapeutic alliance in reducing risk of violence from psychiatric patients (Daffern, Day & Cookson, 2012). A good relationship between nurses and mental health in-patients has been found to of some protective value as greater knowledge of the patient enables nurses to detect behaviour changes and understand their significance (Trenoweth, 2003).

Although participants did not report having been victims of physical assault by their clients, they did report strong emotional experiences when becoming aware of their client's potential to harm or victimise them. Participants gave vivid accounts of physiological and psychological states of fear induced by the awareness that they may be physically attacked or harmed in the same way as their client's victims. For a couple of participants, the fear of assault had become traumatising, affecting their sense of safety both in prison and out; this has also been documented amongst nurses working on psychiatric units following assaults (Kindy et al., 2005). The potential for the details of the client's offending behaviour to be disturbing, even traumatising, was identified by some participants. This too has also been reported in the literature, particularly amongst workers with sex offenders (Collins & Nee, 2010; Farrenkopf, 1992; Sheehy Carmel & Friedlander, 2009). This finding could also be

considered to support literature from forensic psychotherapy and psychodynamic schools which documents the potential for work with offenders to induce disturbing counter-transference experiences (Gordon & Kirtchuk, 2008; Ruszczynski, 2010).

Participants' detailed accounts of their vulnerability to emotional experiences in their work, including fear, perhaps goes some way to filling a gap in the existing research. Previous investigators have reported participants as unwilling to share such experiences (Bertrand-Godfrey & Loewenthal, 2011) and other studies have found that nurses working in prisons (Walsh, 2009) and on secure psychiatric wards (Jacob & Holmes, 2011; Kurtz &Turner, 2007) consciously and unconsciously hide, minimise or project onto others, experiences of fear during their work. The experience of fear amongst the therapists in the present study appears be a complex one. They presented some contradictory accounts, denying they felt fear then describing primal bodily fear responses, the monitoring of which was perceived as important to maintain their safety. The participants felt that letting their fearful responses 'spill over' would be unhelpful, and that staying connected to their client when experiencing such emotions was challenging. It is suggested that the therapists attempted to manage their experiences of fear to retain their therapeutic connection to their client in order to provide effective therapy. Additionally, successful management of fear would keep intact their perception of the client as a vulnerable victim rather than a dangerous criminal to be feared. This in turn enabled them to maintain their professional self-concept as a 'human-centred' practitioner and their distinction from the prison officers.

Walsh (2009) described nurses' emotional detachment and denial of feelings as a defense against anxiety which enabled them to retain their caring role. Walsh also identified that expression of such feelings appeared to leave nurses feeling more vulnerable to attack or manipulation. Similarly, therapists in the present study appeared to associate suppression of judgemental or negative emotions towards their client with increased safety within the therapeutic relationship, as it was important to be seen by the prisoner as unthreatening. The result was de-escalation of threat on both sides, and a strengthened therapeutic alliance.

Therapists' experiences of fear, allegiance to the prisoner-client and therapeutic connection may be interlinked. The relationship between these experiences is depicted in figure two.

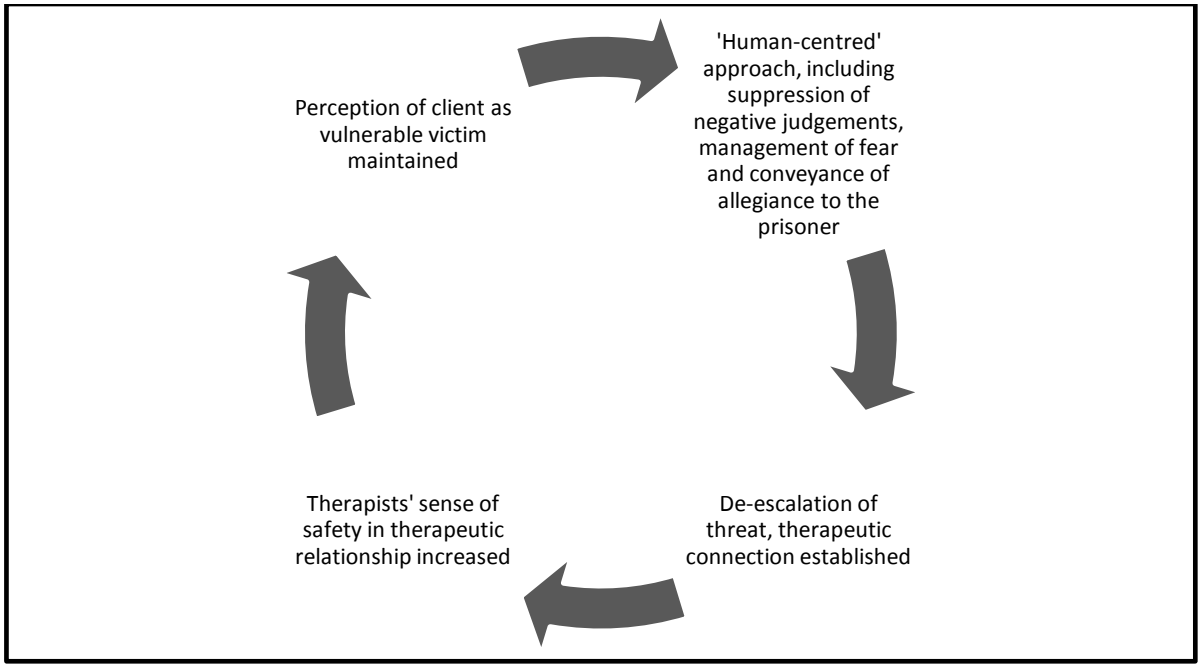

Fig. 2, Graphical depiction of the relationship between 'human-centred' approach, therapeutic connection, and therapists' sense of safety.

Whilst clients' dangerousness was on the one hand something participants attempted to protect themselves from, participants also referred to the satisfaction of having contact with those who others may experience as frightening or intimidating. Participants referred to having a sense of increased confidence or strength as a result of being able to tolerate their client's threat, and identified this as a gain from their work. They felt that not many people could tolerate work with prisoners and additionally felt proud of providing a service to a group in society that is often outcast and stigmatised. Participants in Bertrand-Godfrey and Loewenthal's research (2011) reported similar satisfaction from their work, the authors describing participants' self-perception as involving a degree of 'specialness' for being able to work with prisoners. Similarly, therapists working with sex offenders have referred to their work being prestigious and specialist, identifying that not many would want to do it (Slater & Lambie, 2011). This finding appears to contrast findings from other studies of therapists experiencing a 'stigma by association' for working with a disliked and outcast group in society (Lea et al., 1999), and was also reported amongst nurses in prison (Doyle, 1999).

That therapists valued their sense of strength and confidence is supported by research that found nurses endorsed the notion that being psychologically 'strong' is important when working with prisoners (Walsh, 2009) and that it takes courage to do the work (Weiskopf,

2005). It is interesting to consider this finding in light of Hinshelwood's (1993, 1994) assertion that strength is the idealised characteristic within prison culture. Indeed, Jacob and Holmes (2011), refer to the notion of staff becoming masculinised within the forensic healthcare environment which prizes control and strength over typically female characteristics of softness and vulnerability. It is possible that therapists in the present study adopted a similar preference for strength, this having obvious benefits when faced with many threats.

The findings showed that the therapists experienced their clients as both potential perpetrators and vulnerable victims but struggled to integrate these two aspects of the prisoner; this has also been reported by nurses and therapists working with offenders (Jacob & Holmes, 2001; Kurtz & Turner, 2007). Participants prioritised working with the 'human' which in practice meant working with the parts of their client which were vulnerable and had often been victimised. Scheela (2001) similarly found that identifying their client's experience of victimisation enabled therapists to put the criminal behaviour in context; this is reported by participants in the present study who experienced their client's crime as less significant in the context of their horrific histories of abuse and deprivation. The distancing of their client's offending as a strategy to avoid experiencing disturbing emotions or visual images is also a strategy adopted by nurses working with prisoners (Jacob & Holmes, 2011). Participants in the present study identified that clients' histories were distressing, and attempting to integrate information pertaining to both the victimised and victimising aspects of their client had the potential to be traumatising. Therefore, it is possible that managing the amount of distressing information known and reducing the cognitive load was an emotional self-protection strategy, as has also been reported by Lea et al. (1999).

A further finding from the present study was that attending to the criminal aspects of their clients appeared to challenge participants' professional or personal values. Participants were found to value a human-centred approach, by which it was conveyed they saw their client as a 'human' rather than a 'criminal'. This was observed to be at odds with officers who saw the prisoners' as 'criminals' and treated them as 'a number'. Jacob and Holmes (2011) found that trying to see the human regardless of the crime was a professional value of nurses and this value was protected when the crime the client committed was contextualised or avoided. Participants in the present study similarly reported that distancing information about the offence enabled them to retain a non-judgemental

approach, suggesting that this enabled them to work in line with their professional values and retain their focus on the human within their client, rather than the criminal. The effectiveness of this strategy may be supported by research that found therapists working on sexual offending behaviour programmes in which the details of the offending are worked with in order to reduce reoffending, struggled to disconnect the offence from the offender resulting in negative perceptions of their clients (Collins & Nee, 2010). The authors warned that this could negatively impact upon their ability to establish an effective person-centred approach and engender client change.

Some participants said they did not attend to the criminal aspects of their clients because they did not perceive it to be their role. Bertrand-Godfrey and Loewenthal (2011) reported similar perspectives amongst prison therapists, who associated addressing offending behaviour as an agenda of the prison service, something with which they did not wish to collude. It would appear that bringing the offence into therapy is associated with punishment and control. This perception has also been reported by mental health staff who believed such an agenda was not their role, or at best, a secondary aspect or by-product of their work (Kurtz & Turner, 2007).

Synthesis of the findings and extant literature offers a possible further interpretation; by distancing themselves from the crime, therapists are also distancing themselves from association with a powerful authority which casts judgment on criminal behaviour and who may be perceived by the prisoner as trying to annihilate that aspect of the client's self. Removing that association from the therapeutic relationship may facilitate the client's collaborative engagement and reduce the chances that the therapist will be perceived as a judgmental authority figure to be fought. As a result, the therapist may feel safer and the therapeutic relationship preserved. This rationale receives support from research identifying that those in positions of authority who are perceived to be controlling are more likely to be attacked by patients (Duxbury, 2002); additionally, shame generated as a result of negative judgment from another is identified as a trigger for violence (Gilligan, 2001).

4.1.2 The importance of satisfactions and gains

There is very little research investigating the satisfaction and gains from working with those convicted of crime, in contrast to the large body of research documenting the adverse effects on the therapist (Slater & Lambie, 2011). The findings from this research support

those found elsewhere; that there are both gains and losses to be experienced in working therapeutically with offenders (Slater & Lambie, 2011; Senter et al., 2010). The majority of research studies have focused upon the negative ways in which therapists have been affected; the dominance of the benefits for therapists in the present study suggests that previous researchers have neglected to investigate the full extent to which therapists are impacted.

The gains reported by participants in the present study were: an increased sense of strength and confidence; increased empathic understanding; a sense of being actively challenged in their work; and pleasure from providing a relationship that was perceived as necessary and worthwhile. Participants also identified that they experienced challenges in the work that can be linked to potential losses: loss of their professional standing, loss of emotional stability and psychological health; loss of safety. As was also found by Bertrand-Godfrey and Loewenthal (2011), participants generally appeared to thrive on the challenges and had a passion for the work. Although the losses were potentially extreme, even life threatening, the gains were experienced as significant.

Potential losses and victimisation were strongly defended against by participants in the present research, as evidenced for example, by the adoption of a firm, perhaps ruthless approach in their management of potential "timewasters". More subtle strategies were also identified, such as therapists' emphasising their allegiance to the prisoner which may increase their safety in their work and enable them to work in line with their professional values. Such strong defences and protective strategies may suggest that therapists worked hard to maintain a position of 'gaining' in their work, to avoid the potentially high losses. This appeared to be reflected in participants' language particularly when discussing manipulation; describing prisoners as 'wanting something' from them instead of, or in addition to, a therapeutic relationship. In their initial assessments, participants identified what they were willing to 'give' and what they wanted to keep, typically their integrity as professionals and their safety. There was a lexicon of 'give' and 'take' associated with the process of therapy with prisoners and maintaining control over what they gave appeared to be related to therapists' experience of their work as broadly positive.

The polarisation of gaining versus losing was also seen in the participants' reporting of their experience of increased knowledge of criminality; knowledge of the context of crime was considered to provide them with greater empathy and understanding and thus experienced

as a gain from the work, whereas knowledge of peoples' propensity for crime and ease with which harm can be caused was associated with increased suspiciousness. This finding appears to be leant support by Huffman who, in an unpublished Master's thesis (as cited in Slater & Lambie, 2011) reported a recurring theme that clinicians working in community and prison settings constantly sought to balance the negative with positive aspects of their work. This concept appeared in Rob's account of how attending to the gains from his work prevented him from feeling overwhelmed by the negative aspects of the job and prison.

It is atypical, controversial perhaps, for therapists to ask themselves 'what do I get out of this' (Sussman, 2007). It is notable therefore, that the therapists in the present study could clearly articulate the aspects of their work which gave them satisfaction. It is suggested that maintaining an awareness of the satisfactions and gains from the work contributed to their sense of resilience when facing potential threats and challenges. Literature on the concept of resilience has identified the contribution of finding positive meaning in adverse situations (Tugade & Fredrickson, 2004) and this has been suggested as relevant to nurses who demonstrate resilience in challenging working conditions (Jackson, Firtko & Edenborough, 2007). Previous research focusing on vicarious trauma and compassion fatigue amongst therapists working with offenders is undeniably important for facilitating an understanding of how therapists may be negatively impacted. The findings from present study suggest however, that solely focusing on the negative psychological effects is to neglect what therapists can gain from working with this client group.

4.1.3 Conceptualisation of the experience being dominated by binary opposites

The therapists' experience of gains and losses in their work introduces an over-arching theme that was observed throughout; that therapists' work with prisoners features binary opposite experiences. A number of directly oppositional experiences can be observed; these are reflective of attitudinal, emotional and behavioural responses to their clients.

Participants predominantly operated from a position in which they experienced their clients as vulnerable humans, seeing the victim within and perceiving some need for empowerment and protection. Participants stressed they were non-judgmental and typically conveyed great passion and commitment to meeting the needs of the prisoner-client. They demonstrated an allegiance to their prisoner-client, considered officers to be persecutory and felt predominantly safe within the therapeutic relationship.

In contrast, at times participants experienced their clients as perpetrators or potential manipulators; their language describing manipulative prisoners included striking animal analogies with references to prey and predators, and they described feelings of frustration, anger or fear. They indicated they may have negative emotional responses, including traumatisation and judgement, when aware of their client's crime. During these times, participants found it hard to sustain a connection to their client and respond to the human. It appeared to be these experiences that necessitated the adoption of physical and psychological self-protection strategies. These included emotional detachment and a hardline approach to prevent manipulation, psychological disturbance or assault.

Participants sought to stay in the human-centred sphere in line with their values and conceptualisation of their role. Their attempts to do this appeared to be woven with the more subtle strategies to ensure their safety, such as emphasizing their allegiance to the prisoner. It was also suggested that these efforts involved managing fearful or other emotions associated with the secondary sphere of experience. When experiencing potential for assault however, participants became more focused on self-protection. At these times, unable to maintain their relationship with the prisoner that was qualitatively different from that provided by the officers, they appeared to move closer to the stance adopted by officers; more detached and focused on risk. This would support research by Kindy et al. (2005) who found that nurses working on psychiatric units and at high risk of assault were unable to prioritise or fulfill their nursing and caring role when feeling unsafe.

It is suggested that a feature of therapists' work with prisoners is the traversing and management of these binary opposite experiences, necessitating a fine attention to their own internal experiences. At times, this appeared to result in a high cognitive load and great stress and to have a negative impact on their ability to attend to the client. For example, participants' spoke of their security awareness impeding on their therapeutic response to their client and described having to be in two spaces at once. The experience of adapting and responding quickly depending on circumstances arguably contributes to the sense of the work being highly active and vital, as opposed to predictable or dull.

Within the nursing literature, researchers have variously described nurses' experiences of these oppositional spheres. Rose et al. (2011) investigated forensic nurses' respect towards their patients and identified two forms of expression: care respect when nurses could relate to the human-ness of their patients and Kantian-like respect, which has a detached

quality. The latter was dominant and was seen as a practical compromise in order to carry out their work. Mason (2002), identified six binary opposite experiences for forensic psychiatric nurses including fear versus confidence, win versus lose. Hardesty et al. (2007) identified typologies of nursing styles within prisons that described on a continuum of how nurses interacted with prisoner-patients. At one end were nurses who had a strong orientation to prison culture and adopted a security perspective, with negative attitudes towards prisoners who were seen as undeserving of care. At the other end were nurses for whom the nursing culture was dominant and who did not view their patients as prisoners but as people needing care; these felt opposed to the culture of prison officers. Walsh (2009) in her study of nurses in prisons, and Lea et al. (1999) refer to personal versus professional ways of responding to offenders; the professional response characterised by a suppression of emotion and judgmental or negative attitudes towards the prisoner, triggered when workers came into contact with the disturbing crimes of their clients. This literature seems to lend support to the concept that working with prisoners presents the opportunity for therapists to experience their clients in qualitatively different, and often contradictory, ways. All researchers spoke of the difficulty in fully detaching from personal experiences and questioned the extent to which fully effective care was possible. In contrast, therapists in the present study did not generally identify with the punitive or security-orientated values of prison staff. They maintained their human-centred stance unless they perceived the prisoner to be a threat, at which point they became focused on their need for safety rather than the needs of the client.

The distinction between the approaches of therapists and officers appears to be particularly relevant to the concept of splitting, as outlined by object relations theorists within the psychoanalytic field. The notion of splitting, originating from Klein's description of the paranoid-schizoid position as an early defense against anxiety, has frequently been observed as prevalent amongst offenders and the organisations that work with them (Aiyegbusi & Clarke-Moore, 2009; Cordess & Cox, 1996) and has been observed within prisons by Smith (1999). From this theoretical perspective, the splitting of the prisoner-client into the victim, who is worked with and the criminal who is not, would be seen as a defense against anxiety. Specifically, sources of anxiety that might be aroused from coming into contact with clients' crime might include anxiety of being judgemental and therefore a 'bad' therapist (Roundy & Horton, 1990) or the fear that their client could repeat their crime upon them (Gordon & Kirtchuk, 2008). The information that causes anxiety is 'split off' and held by another; in the present study this would typically be the prison officers,

enabling the therapist to work in greater psychological comfort. Hinshelwood (1993, 1994), Smith (1999), Aiyegbusi (2009a, 2009b), Cordess (2000), are amongst the authors who have written about how staff are vulnerable to adopting this defense when working with people who have committed crime and particularly those who are also psychotic or personality disordered. Similarities may be observed between therapists' experience in the present study and that presented by Smith, who described feeling it "easy to have a 'good' relationship with individual prisoners, leaving prison officers to carry the 'bad' relationships" (1999, p. 434).

4.1.4. SUGGESTIONS FOR FURTHER RESEARCH

In light of the findings, there are numerous areas for potential further research. Firstly, I believe it would be immensely enriching to the field to hear the voices of the prisoner-clients themselves. Such research could investigate, for example, how they construct the role of their therapist in the context of the relationships available in prison. Such information may be used to understand further the relational dynamics within the environment and how these may affect the nature of therapy. Similarly, it would be interesting to discover how therapists' experiences of working with similar client groups in the community compare; this may shed light on the effect of the prison setting. An under-researched area that has been identified as significant to therapists' work with this client group is the management of their client's criminality. Further research in this area may shed light on how therapists working with a variety of client groups experience and manage aspects of their clients to which they have strong negative emotional reactions. Similarly under-researched are the psychological self-protection strategies therapists develop and maintain. It would be interesting to explore this in relation to the concept of resilience and whether such strategies may be related to the finding in the present research of therapists' experiencing satisfaction as a result of increased self-confidence and strength.

4.2 IMPLICATIONS FOR PROFESSIONAL PRACTICE

A number of implications for the discipline of counselling psychology and for individual, professional therapeutic practice may be drawn from this research. The findings are relevant to counselling psychologists working in prisons but will also be of interest to other

professionals, including from other disciplines, who work with prisoners, offenders or people with challenging behaviours.

4.2.1. The relevance of the study to the discipline of counselling psychology

Crighton and Towl (2008) and Towl (2010) have referred to the dominance of the specialism of forensic psychology within prisons and the narrow provision of psychological services which have mainly focused upon prisoners' criminogenic needs and reducing re-offending rather than attending to their general well-being. Towl (2008) welcomed the introduction of NHS mental health services, it bringing an opportunity for psychologists from other disciplines, including counselling psychologists, to work in prisons. It is hoped that the present study contributes to this area of counselling psychology practice at a time in which the discipline's presence in the field has the potential to be increased. It is hoped that counselling psychologists new to working in prisons or those considering the work, may be able to make an informed choice and benefit from the findings of this research.

The findings suggest two particular areas of relevance to the discipline of counselling psychology. One concerns the approach therapists in the present study took towards the convictions of their clients, the majority preferring to distance themselves from information about the offence. Some participants felt this to be the right approach, others expressed some doubt, whilst a couple took an opposing view and chose to know the details of the offence. The discipline of counselling psychology appears not to have a uniform or articulated approach as to how a client's criminal history might feature in therapy, if at all. This is not necessarily a drawback; indeed it may well reflect the ethos of counselling psychology that respects individual differences (Cooper, 2009). It has also been observed that the choice not to focus on the crime of the client may be informed by humanistic values which similarly underpin the values of the discipline (Cooper, 2009). Other established disciplines such as forensic psychology and forensic psychotherapy have a clear approach to how they work with the client group. Forensic psychologists seek to reduce a prisoner's risk of offending through OBPs (Crighton & Towl, 2008). The discipline of forensic psychotherapy, informed by psychoanalytic theory, considers the crime to be an enactment of the client's mental and emotional state (McGauley & Humphrey, 2003) therefore the offence is not considered to be separate from the mental distress of the client. In contrast to the aim of forensic psychologists, the aim of a forensic psychotherapist is to treat psychological disturbance and mental illness (Cordess & Cox, 1996), but a

reduction in the client's offending is considered a positive benefit (McGauley & Humphrey, 2003).

There are those who argue that an integration of a client's criminal history in the work of therapy is not beneficial. Person-centred practitioners have argued for the separation of the offending behaviour from therapeutic work on the basis that it invokes a separation from criminal justice and societal control systems, both of which potentially reduce the control, power and agency of the client thus reducing the effectiveness of the therapy (Proctor, 2004). Furthering the debate, Hill (1995) writes explicitly of the need to integrate the crime of the client into the therapy, arguing not do so risks increasing reoffending. What is more, he suggests that to ignore the criminal parts of the client is not only naïve but also unethical and neglectful of therapists' societal role; whilst he does not specify what this role is, given the context it is assumed to involve the protection of fellow humans from harm. This poses an interesting question as to whether it is an ethical or moral obligation to integrate a client's criminality into the therapy.

Counselling psychologists might question why they should integrate offending information into their practice, particularly if it could negatively affect their therapeutic work. It appears that personal preference, choice of therapeutic model and individual variations in resilience contribute to a therapist's decision about attending to the criminal behaviour of their client. There appears to be little disciplinary debate on the subject and I suggest that some of the findings in the present research present a case for the discipline to consider this topic further.

If counselling psychologists in prisons were able to articulate to other staff, including prison officers, their ethos and approach to working with the client, it might reduce tension that results from a lack of understanding (Appelbaum et al., 2001). Additionally, it might enable other staff to understand the differences and similarities between the work of a counselling psychologist and other psychological practitioners; this may be particularly relevant during this time of change for psychological service providers in prison. Being able to express one's perspective requires understanding of one's personal and professional views on the topic. Given the findings that some therapists experienced some challenging emotional reactions in response to knowledge of their client's offences and that this in turn could impact upon the therapeutic relationship, it might be beneficial for the practitioner to consider how he

or she might approach the issue. This would be in line with a commitment to reflective practice and prioritisation of the needs of the client (Cooper, 2009).

The research findings suggest a strong influence of the prison culture and societal culture on therapists' experience in their work. For example, the differing perspectives of therapists and prison officers towards prisoners appear to reflect the divided societal discourse regarding those convicted of crime; some advocate rehabilitation and for offenders' criminogenic needs to be met whilst others advocate tougher punishments and deterrents aimed at shaming offenders (Pratt, 2000). The finding that the prison officers were dominant in therapists' experience of themselves and their client prompts reflection upon Huffman's (2006) observation that the therapeutic dyad in prison is frequently invaded by aspects of the prison, including security cameras and noise from other prisoners. He suggests that working in such a setting provides us with an opportunity to learn more about the therapeutic alliance; indeed findings from the present study suggest that it might feel more of a 'triad' than dyad.

It is suggested that the emphasis within counselling psychology on the client's context is most relevant to therapeutic work with prisoners. Cooper (2009) writes that a core value of the discipline is: "an understanding of the client as a socially- and relationally-embedded being, including an awareness that the client may be experiencing discrimination and prejudice (versus a wholly intrapsychic focus)" (p. 120). It is not suggested that this value is unique to counselling psychology, rather it is suggested that this concept draws practitioners' attention to the ways in which the therapeutic relationship is itself embedded within the relational dynamics of the prison culture and within wider societal discourse on the treatment of people who have committed crime. Counselling psychologists might wish to consider how these dynamics might affect the role they adopt in relation to the prison staff and prisoner, including how the focus of therapy might be influenced.

4.2.2 Implications for individual's professional practice

That therapists can experience prison officers as hostile and cold towards prisoners is not a new finding (e.g. Hinshelwood, 1993,1994; Smith, 1999) and although participants stressed that it did not apply to all officers, this behaviour was observed and at times participants believed it could become more persecutory. This would suggest that it is important for counselling psychologists working in prison settings to consider how they might respond to

incidents in which they perceive their client's mental and emotional well-being to be adversely affected by prison staff. Familiarisation with local and national guidelines on bullying would be advisable and it might be important to enquire about the nature of clients' relationships with staff in order to assess the impact on mental health. The issue presents practitioners with an opportunity to provide prison officers with training and education about how their inter-personal style might affect a prisoner's coping in prison and their mental health. Such training has been found to improve officers' attitudes towards mentally ill prisoners and improve relationships between healthcare and discipline staff (Bowers et al., 2005).

The present research supported existing reports that managing prisoners' attempts to manipulate them is a feature of working with this client group. It might therefore benefit psychologists new to the environment to be aware of this, the potential impact on the therapeutic relationship, and the potential for such behaviour to cause feelings of frustration. It was also suggested that alignment to the prisoner might be bought about by more subtle, intimidating methods employed by the client group and lack of awareness of this might compromise the therapist. Participants had adopted strategies to deal with manipulation, including being very clear with clients at the beginning of therapy what they could and could not provide, the boundaries to the therapeutic relationship and the therapist's role. Additionally, and as reported in the nursing literature (Weiskopf, 2005), the first meeting with a new client was particularly important for assessing the prisoner's motivation for engaging in therapy. It could be useful to formalise such assessment procedures to enable therapists to target services appropriately but without inadvertently excluding clients on the basis of instinct.

The findings indicated that psychological self-protection strategies, as well as physical ones, were extremely important. This suggests that it would be beneficial for therapists working with prisoners and indeed other client groups, to consider how they can ensure psychological health and resilience as well as their physical safety. Therapists in the present study found mentally separating prison and all that it contained from their personal life to be extremely important. They also appeared to consider the therapeutic relationship as being inextricably linked to their sense of safety and this suggests that therapists might attend to micro-details within the relationship to enhance their safety. Finally, whilst therapists might adopt different approaches to the criminal histories of their clients, working with the client group means that it is likely that at some point they may encounter

offence details which are distressing. It would appear that psychodynamic/analytic psychotherapy has a language with which to understand and normalise the experiences of the therapist when working with offending clients; strong emotional reactions are framed as counter-transference or projective identifications and considered as part of the therapy with such client groups (Gordon & Kirtchuk, 2008). Subsequently, there is also clarity on how these experiences should be dealt with and managed, offering some containment for the therapist and likely, the prisoner in turn. Regardless of whether the offence is addressed in the therapy and the theoretical orientation of the therapist, it might be beneficial for therapists working with the client group to have an opportunity to explore their feelings and reactions to their client's criminality. This might subsequently reduce the likelihood that the therapist's reactions to their client's offence could affect the therapeutic relationship (Ruszczynski, 2010).

4.3 Evaluation of the work

The research achieved its aim in generating in-depth information about therapists' experiences of working with prisoners. This was a topic that was not much explored in the literature and had been particularly under-researched; the findings therefore extend the existing body of knowledge. The research topic itself developed over time and some findings emerged more strongly than anticipated, for example, the gains participants reported experiencing in their work became particularly dominant.

Similarly, data was provided by participants that did not directly address the research aim but which supported findings from extant literature. In particular, all participants spoke about their experience of being in the physical environment, the resources within the prison and their perceived impact on the therapy. This data was excluded at the stage of identifying the four master and constituent themes in order to generate a coherent narrative that addressed the research aim. Therapists' relationships with prison officers emerged as an unanticipated and significant finding. It appeared that they were a significant part of the cultural and relational context of the therapists' experience of themselves and their prisoner-client, and therefore this data was considered to be highly relevant to the research aim.

The rest of this section provides an evaluation of the study, attending to the quality of the work and concluding with personal reflections upon the process and method.

4.3.1 Research quality

This research offered an interpretation of the participants' experience of working with prisoners. By quantitative research standards, the sample was extremely small but it was appropriate given the depth of the analysis conducted (Smith et al., 2009; Yardley, 2000). Claims of replicability are not made as these experiences were unique to the individuals. As has been noted however, there are similarities in experience to those documented elsewhere and it is possible that other therapists working with prisoners share some similar experiences with the participants. As referred to in the methodology chapter, I have attempted to ensure the quality of this research by attending to recommendations set out by experienced qualitative researchers - Yardley (2000) and Smith et al. (2009). Yardley (2000, p. 219) outlines qualities that 'good' qualitative research should possess, and I shall now outline how I have endeavoured to encompass them.

I endeavoured to remain sensitive to context throughout the research process. For example, in the Introduction chapter, I endeavoured to provide the reader with a review of literature that was relevant to the research topic and put the findings in context of what is already known on the subject. I attempted to bracket off my existing knowledge of the topic when analysing the transcripts (Smith et al., 2009) and I did not make references to theory and research in the analysis chapter itself. This was in order to retain sensitivity to the data (Yardley, 2000) and to prevent the participants' accounts being shaped or skewed by such knowledge (Smith et al., 2009). Further demonstration of my sensitivity to context comes from deep consideration of the exact meaning of words when constructing themes from the data. For example, I took great care to understand the difference between the words 'threat' and 'danger' when describing and labelling participants' experiences of their clients, aware that the words convey slightly different meanings and could alter the context of the results and deviate from the participants' experiences. Finally, the experiences of the participants were analysed with reflection upon the context of the prison culture and the wider social and political discourse surrounding crime and punishment. Related to this, reflective of my epistemological standpoint outlined in the Methodology chapter, the experiences of the participants were analysed in the context of the prison culture and the wider social and political discourse surrounding prisoners and their treatment.

My commitment to the topic is demonstrated in my engagement with the subject first-hand through my personal experience as a trainee counselling psychologist working with prisoners and offenders in the community, and also as a researcher of the topic for the last three years during which many months were spent immersed in the data. A couple of the interview transcripts were read by the research supervisor who considered the data generated to be of adequate depth to ensure rigour in terms of completeness of data collection (Yardley, 2000). Rigorous analysis of the data was conducted and I discussed my analytic process with peers in a research group in order to ensure it was of a high standard. The group was also used to explore emergent themes with reference to some anonymised examples of the data; this was to ensure I had remained grounded in the data rather than being overly influenced by pre-existing knowledge or being too descriptive, as outlined by Smith et al. (2009). I have enclosed a portion of annotated analysed transcript to enable the reader to see an example of my analytic working of a transcript (see Appendix F). I have attempted to be transparent throughout this research report by providing detailed accounts of my methods and the research process, as well as outlining my personal views and influences in the reflexivity sections (Yardley, 2000).

I have previously explored how I hope this research will impact and benefit the discipline of counselling psychology and indeed, therapists from other disciplines who work with prisoners or people with a criminal history. Additionally, I hope it might inform those within the wider therapeutic community and beyond of the significant satisfactions to be gained from working with prisoners. In considering the role this research might play in wider society, it is perhaps relevant that participants' typically took up a stance they considered to be contrary to that of wider society's stance towards prisoners: they observed that where the public called prisoners 'monsters', they called them traumatised humans or victims. This reminds us that our work as therapists is not just shaped by the processes within the therapeutic dyad but that our actions and choices in work may be influenced by societal factors.

There are inevitably some limitations to the present research. Despite constructing the interview schedule carefully to facilitate participants' open responding (Arskey & Knight, 1999) it is possible that certain factors such as my age, gender and experience may have affected interviewees' responses. In particular, I am aware that my trainee status may have resulted in qualified or more experienced practitioners feeling less comfortable about disclosing vulnerabilities. Whilst the findings include significant exploration of participants'

vulnerable experiences, it is not possible to ascertain what might have been discussed had I been qualified. Relatedly, it is possible that my trainee status had the opposite effect and engendered greater disclosure.

The use of semi-structured interviews, whilst constraining participants' responses less than a questionnaire (Arskey & Knight, 1999), nevertheless may have shaped participants' responses. I constructed the interview questions around aspects of the topic I had previously identified and this might have limited participants' disclosure about their experience. To manage this potential limitation of the method, I asked participants at the end of the interview if they had anything further they would like to discuss about their experience. An unstructured interview technique would possibly have matched IPA's inductive epistemology more fully (Smith et al., 2009), as the participant could have led the interaction and introduced dimensions of their experience unaddressed by the interview schedule. I had taken Smith et al.'s advice however, not to attempt unstructured interviews as a newcomer to IPA.

I also considered whether the fact that participants came from different stages of training and disciplines, might have affected the coherence of the findings. This sample came about following consideration of participants' ability to provide accounts which addressed the research aim (Smith et al., 2009), in addition to practical restrictions on time and availability. Whilst it might have been neater to have had a homogeneous group of counselling psychologists, the mix of professional disciplines does not appear to have resulted in markedly different experiences. I further reflect here upon Sussman's (2007) observation that perhaps sheds light on this: "it is the person of the therapist that constitutes his or her primary tool" (original author's emphasis underlined, 2007, p.3). The findings therefore reflect peoples' experience as therapists working with prisoners, rather than therapists' experience of working in a particular modality.

4.3.2 Process and methodological reflexivity

In this section, I shall reflect on my personal experience of the research process and my own interaction with the research findings. This is in line with the transparent approach that I have endeavoured to adopt throughout the process in order to increase the quality of the research (Yardley, 2000).

The research as a whole has evolved from how I envisaged this work when I started, as have my views and understanding of the topic. I recognised early in the process that I was driven by largely unconscious needs to process my own experience of working with prisoners and specifically one particular experience with a prisoner-client which was frightening and disturbing. Subsequently, I was acutely aware of the potential for my personal experiences to influence the process and took steps to limit this. For example, during the interviews, I was careful to avoid depicting an assumption that there are significant challenges inherent in the work. I sought, with the help of my supervisor to ensure that my questions were designed to enquire about the positives as much as the challenges. It was important to make room in the interviews for participants to tell me how they see their world, rather than me seeing their experiences through my lens (Willig, 2012a), and I believe this was achieved.

My emotional and psychological experience was similar to that reported by Maria and it was therefore emotionally uncomfortable and methodologically challenging to analyse her transcript. I was acutely aware of the need to separate my own experiences from hers and stay embedded within her perspective; to facilitate this, I took frequent breaks and used my research diary to reflect on my emotional and cognitive responses. Whilst this delayed the process, it enabled me to bracket off (Smith et al., 2009) my experiences from the analytic process. In the methodology chapter I explained that I was aware that I had started the research process feeling a victim of my experience and believing that working therapeutically with prisoners potentially poses great risk to therapists' well-being. I came to understand that I was perhaps driven to document, warn and protect other therapists. The slow, methodical process of research itself in addition to research supervision and personal therapy, has helped me to move from feeling a victim to feeling more like an objective researcher and resilient survivor.

I have been delighted to have been put back in touch with what inspired and motivated me to do the work in the first place; this was an unexpected gain from the research process. I was particularly interested to realise from reflecting on the participants' accounts that I too, felt an increased sense of my own strength and confidence as a result of working with prisoners. I have also developed, as a result of the research process, a greater understanding of the theory of psychodynamic/analytic psychotherapy and organisational dynamics from a psychoanalytical perspective (and conversely am more aware of how little I know). The latter was a complete revelation to me, not previously having encountered it

and the former has resulted in a deep appreciation for psychodynamic theory and its applicability in modern therapeutic activity.

I have found it particularly interesting to engage in a deep reflection on the methodological process of interpretation. Analysing the transcripts and exploring the different levels of interpretation caused me to consider how interpretation within research is different to interpretations made in the context of therapy. Early on, I struggled to understand what phenomenological interpretation within research looked like and found myself straying towards more psychoanalytically informed interpretations that considered causality and latent meaning. I initially understood this to be the product of my therapeutic training, however was further enlightened upon reading Willig's (2012b) distinction between 'suspicious' and 'empathic' interpretation. Willig likened suspicious interpretation to the deductions made by Sherlock Holmes, who takes a suspicious approach to a hat in order to uncover the owner's identity. Additionally, this approach is likened to the practice of psychoanalysis, which seeks to uncover the latent meaning of that which is manifest. Having realised this was precisely, but quite unintentionally my approach to research interpretation, I considered how my suspicious approach became so ingrained and realised it is the product of my experience working within prisons. I had been trained by prison staff to be suspicious of others' motives and this mind-set had become ingrained without my full awareness. I was trained to assess risk by drawing conclusions from past events and current situations; I make interpretations about the possible latent meaning behind peoples' actions and communications in order to protect myself. This mind-set is associated with safety. The realisation was extremely important to my understanding of my approach to interpretation within research; as a result, I endeavoured to direct my suspicious approach towards my acts of interpretation in order to ensure my interpretations were empathic and restricted to the phenomenon of participants' experience (Willig, 2012b). This learning has reinforced my appreciation of the centrality of the researcher and the hermeneutic circle within IPA research (Smith et al., 2009). In order to understand the parts of myself that were engaged in research analysis, it was necessary to understand the whole of my personal experience; just as I impact the research process, the research process impacts on me. I observe that my suspicious mind-set and concern with threat is similar to that conveyed by some of the participants. This causes me to reflect on the curious process of research which creates complex relationships between the data and parts of myself. As a researcher I seek objectively as possible, to understand and interpret the participants'

experiences, the 'data'. As a fellow human being, I recognise similarities in experience and so in effect, I am also understanding myself.

CHAPTER FIVE - CONCLUSIONS

This research sought to investigate therapists' experiences working with prisoners, a much under researched topic. This study was considered to be particularly timely given the recent and on-going changes to the provision and availability of mental healthcare within prisons, which are aimed to provide services equivalent to those available in the community (Crighton & Towl, 2008). It has been suggested that these changes will increase opportunities for counselling psychologists and other therapists to work with prisoners (Harvey & Smedley, 2010). In light of the paucity of research on this topic, the literature on nurses' experiences in prisons and working with patients in psychiatric secure and forensic settings was considered, in addition to literature concerning therapists working with offenders in the community and the theoretically framed literature. The review enabled the identification of particular aspects of therapists' experiencing to be further understood and which were therefore explored in the current research. These aspects were: how therapists experienced themselves in their work with prisoners; how they experienced the prisoner and the crime for which the client had been imprisoned; and the aspects of the work therapists considered to be challenging or beneficial.

As the research was principally concerned with generating an in-depth understanding of therapists' beliefs, perceptions and feelings within and towards their experiences, Smith et al.'s (2009) Interpretative Phenomenological Analysis was identified as an appropriate methodology. The analytical process of IPA has been clearly described (Larkin et al., 2006; Smith et al., 2009) and this facilitated a rigorous and consistent approach to the data, which took the form of transcripts from semi-structured interviews with eight therapists. Four master themes emerged from the participants' accounts which reflected their shared experience of working with prisoners. These themes were entitled Aligned to the prisoner; Threat is all around; the Distanced criminal; Psychological gains.

The study found that therapists' experience of themselves was characterised by an empathic, protective human-centred stance towards their clients whom they perceived as

vulnerable and deprived. The therapists' role and identity were strongly influenced by the relational landscape of the prison culture, in which they positioned prison officers as typically cold and unwilling or unable to provide prisoners with nurturing relationships. Such was the influence of the context, the therapeutic dyad appeared to have been extended to a triad, as therapists sought to protect and advocate for their clients. Another finding indicated that therapists' demonstration of allegiance to the prisoners and their efforts to monitor and manage any negative emotional experiences contributed to the sense of a therapeutic alliance and additionally, a sense of personal safety. This finding perhaps draws our attention to the many functions of the therapeutic relationship; it is not only a vessel to enable effective therapy and change within the client, but perhaps also has a role in sustaining and protecting the therapist in work with clients that might at times be experienced as challenging or threatening.

The present study found that therapists had often conflicting emotional and perceptual experiences of their prisoner-clients. At times, clients were experienced as survivors of great trauma and victimisation, at other times, therapists described an awareness of their client's capacity to harm them. It was observed to be very challenging for therapists to attend simultaneously to the needs of their client and their own internal responses, including instinctual fear responses. Various psychological protection strategies were observed. One of these was the distancing of information about the crimes for their client had been convicted. This choice also appeared to relate to therapists' perception of their role within the prison culture and their preferred orientation to the client. Whilst challenges were reported, therapists identified strong rewards to be gained from their work. For example, it was found that a particular feature of the work that could be perceived to be challenging or intimidating - working with clients who are considered to be potentially dangerous, was actually perceived as a benefit because it gave therapists a sense of strength. The finding that numerous benefits were identified in the work supports those such as Slater and Lambie (2011) who call for a more balanced viewpoint on the impact on therapists working with those with a criminal conviction.

Two broad conceptualisations of the findings were suggested. These concerned therapists' experience of the gains and potential losses from their work, which were considered part of a wider lexicon of 'give' and 'take' in their interaction with prisoner-clients. It was suggested to be important for therapists to maintain an awareness of the gains in order generate a sense of resilience in the face of the potential serious losses. The second

conceptualisation concerned the striking binary opposite experiences that appeared to feature in therapists' accounts of their work.

This study has contributed to the body of knowledge on the topic, supporting and extending some previously reported findings and problematising others. Implications for the practice of counselling psychology were identified. In particular, it emerged that whilst some other disciplines such as forensic psychotherapy have a unified and clear ethos regarding how they work with a client's criminal convictions, counselling psychology does not. Whilst the development of a unified approach is unlikely, nor indeed be in keeping with counselling psychology's ethos of respect for individual difference (Cooper, 2009), it was suggested that therapists working in prisons might privately reflect upon their perspective upon the crimes for which their clients are convicted and additionally, how the discourses that surround crime and imprisonment might affect the position they adopt within the prison culture. Further, they might consider how they would articulate their therapeutic approach to other staff within the prison.

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APPENDIX A: INTERVIEW SCHEDULE

Q Imagine you're meeting a therapist who is new to working with prisoners, what would you tell them about the experience of working with prisoners?

Q How does your experience of working with prisoners compare to your experience of working with other client groups in other settings?

Q What are the positive aspects of working with prisoners?

Q What are the challenges of working with prisoners?

Q How does the client's knowledge of his/her offence affect the way he/she approaches the therapy, if at all?

Q How does the knowledge of the client's offence affect – if at all –your experience of working with him/her?

Q Does this experience change during the course of therapy?

Q Could you describe an occasion in which you had a particularly strong emotional or physical sensation in a therapy session?

Prompt - Did any images, memories, urges, or sudden thoughts come to mind?

Q How did you respond to this experience?

Prompt – How do you use or manage them

Q How do you make sense of these experiences?

Q How – if at all, has working with prisoners affected your view of yourself?

And what about your view of others?

And your view of therapy?

Closing questions:

Q Are there any further aspects of working with prisoner-clients which you would like to talk about?

Q Was there anything you were expecting me to ask or think I should include?

APPENDIX B: BRIEFING SHEET

CITY UNIVERSITY LONDON

Briefing sheet for participation in the research project:
'Understanding the experiences of therapists who work with prisoners'

Thank you for your interest in this research

Why this research?

Whilst working with this client group is frequently thought of as being uniquely challenging and interesting, there has been little actual research into therapists' experiences. I hope to extend our understanding of how therapists work with prisoner-clients. This research also creates an opportunity to share with other professionals, the work of prison therapists.

What does this research involve?

I will ask you to reflect on and explore your experiences in a confidential interview that will last approximately an hour. The interview will be arranged at a time and location to suit you. Examples of lines of enquiry in the interview include the therapeutic relationship with prisoner-clients and your use of self in your sessions.

I'm looking for therapists of any theoretical orientation and they can be qualified or still in training.

What happens to the information you provide?

The interviews will be audio recorded then transcribed and typed up. Snippets of the transcript and will be presented in the final write up of the research. The audio tape will be deleted once the research has been written up. All data shall be kept securely. You can stop the tape at any point.

The research has been ethically approved by City University. Strict ethical guidelines will be followed.

Anonymity and confidentiality

The interview is confidential and I take very seriously your right to anonymity.

You will be allocated a fake name; your transcript and your drawing will be labelled with that fake name only — your real name will never be on them.

Only the researcher, Bryony Farrant, will know your identity. The research supervisor will not know the identities of the participants.

All identifying details in the transcript will be replaced.

For example, if you refer to the prison you work in, I will remove the name of the prison.

If you wish, for your peace of mind I will send you a copy of your transcript for you to read and confirm that your identifying details have been removed or concealed. All the information you provide will be treated in confidence by the researcher and your identity will be protected in the publication of any findings.

Benefits to participating

I hope that exploring your thoughts and experiences will be as interesting for you as it will for be me. You may clarify existing beliefs you have about your work or you may generate new ideas and perspectives.

Any travel costs will be reimbursed.

Risks involved in participating

I do not anticipate any risks involved in participating. We will have some time after the interview to talk about the study; if you are left with any difficult feelings or thoughts, we can discuss sources of support and further information.

About the researcher

This research is part of her Professional Doctorate in Counselling Psychology at City University. You can contact her on Bryony.Farrant.1@city.ac.uk.
Telephone: 07*** ******
The research supervisor is Dr. Cristina Boserman; Cristina.Boserman.1@city.ac.uk

APPENDIX C: CONSENT FORM

CITY UNIVERSITY LONDON

Consent form for participating in the project:
'Understanding the experiences of therapists who work with prisoners'

This research project has been granted ethical approval by City University.

- I confirm that I have read and understood the briefing sheet. I have asked any questions that I have.
- I understand that I can withdraw my consent at any time, at which point the data that I have provided (audio-record of the interview and its transcript) would be destroyed and not included in the write-up of the research.
- I understand I can stop the tape and terminate the interview at any point.
- I understand that only Bryony Farrant will know my identity as a participant.
- I understand that all information I give will be treated in confidence.
- I give my consent to be interviewed
- I give my consent for my data to be included in the results and in future publications.

Signed ……

Print name……..

Date ……..

Thank you very much for your valuable participation!

This consent form shall be kept securely and separately from research data and shall not be included in the write up.

Researcher - Bryony Farrant: Bryony.Farrant.1@city.ac.uk

Supervisor – Dr. Cristina Boserman: Cristina.Boserman.1@city.ac.uk

APPENDIX D: DEBRIEF FORM

CITY UNIVERSITY LONDON

Debrief form for participating in the research project:
'Understanding the experiences of therapists who work with prisoners'

Thank you for participating in this research project. I hope you have got something from the experience.

We now have 15 minutes to discuss the study and your experience of the interview. I can also be contacted on the details below if afterwards, you remember anything you would like to add.

Please let me know if you feel that the interview has brought up difficult thoughts or feelings in relation to your experiences. We can talk about sources of support, for example you may find it helpful to discuss these with your supervisor or personal therapist.

I confirm that this interview has been conducted in a professional manner, that the interviewer took care to check I was not in distress upon leaving and that I'm happy for the research to proceed using my material.

☐ I would like the transcript to be sent to me so I can be sure that identifying details are removed or disguised.

Name…….

Signature ……

Date …….

☐

Researcher - Bryony Farrant
bryony.farrant.1@city.ac.uk
07*** ******
Research supervisor Dr. Cristina Boserman, City University

APPENDIX E: ETHICS RELEASE FORM

Ethics Release Form for Psychology Research Projects

All trainees planning to undertake any research activity in the Department of Psychology are required to complete this Ethics Release Form and to submit it to their Research Supervisor**, together with their research proposal**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department of Psychology does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2004) Guidelines for minimum standards of ethical approval in psychological research (BPS: Leicester) should be referred to when planning your research.
- **Trainees are not permitted to begin their research work until approval has been received and this form has been signed by 2 members of Department of Psychology staff.**

Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

BSc ☐ MPhil ☐ MSc ☐ PhD ☐ DPsych ☒ N/a ☐

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project
Understanding the Experiences of Therapists Working with Prisoners
---

2. Name of student researcher (please include contact address and telephone number)
Bryony Farrant, **********
---

3. Name of research supervisor
Dr. Cristina Boserman
---

4. Is a research proposal appended to this ethics release form? **Yes**
No

5. Does the research involve the use of human subjects/participants? **Yes**
No

If yes,

a. Approximately how many are planned to be involved? 4-10----------

b. How will you recruit them? Via personal contacts, poster advertising and word of mouth.

c. What are your recruitment criteria? They must have one year's experience of working in a prison environment.
(*Please append your recruitment material/advertisement/flyer)*

d. Will the research involve the participation of minors (under 16 years of age) or those unable to give informed consent? Yes
No

e. If yes, will signed parental/carer consent be obtained? **N/A**

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? *(If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).*

To attend a preliminary meeting. Do draw a picture following a therapy session in which they experienced notable internal experience. To then attend an interview lasting approximately one hour.

7. Is there any risk of physical or psychological harm to the subjects/participants?
Yes
No
If yes,
a. Please detail the possible harm? ----------

b. How can this be justified? ----------

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?
Yes
No

(*Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)*

9. Will any person's treatment/care be in any way compromised if they choose not to participate in the research?

Yes
No

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?

Yes

No

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

An audio recording of the semi-structured interview, the transcript of this recording.
12. What provision will there be for the safe-keeping of these records? They will be kept securely in the researchers home. The consent form containing the name of participants will be kept separately from their picture and transcripts and audio recording.

separately from their picture and transcripts and audio recording.

13. What will happen to the records at the end of the project? The drawings shall be anonymously included in the write-up of the research; the tapes shall be destroyed after the analysis of the transcripts is complete.

14. How will you protect the anonymity of the subjects/participants? All identifying details shall be removed from the transcripts. Participants will be given pseudonyms. Participants will be sent the transcript for their approval of its anonymisation.

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

With the participants consent, I shall contact them after the interview to check on their well-being. I shall advise participants to arrange clinical supervision for shortly after the interview so any new learning or concerns about their internal experiences can be processed. In addition, if the participant is in personal therapy themselves, I shall remind them of the potential support available from that.
(*Please append any de-brief information sheets or resource lists detailing possible support options)*

If you have circled an item in bold print, please provide further explanation here:

Signature of student researcher ---------- Date 7/7/10

Section B: To be completed by the research supervisor

Please mark the appropriate box below:

☑ Ethical approval granted
☐ Refer to the Department of Psychology Research Committee

☐ Refer to the University Senate Research Committee

Signature ---------- Date 07/07/10

Section C: To be completed by the 2nd Department of Psychology staff member
(Please read this ethics release form fully and pay particular attention to any answers on the form where bold items have been circled and any relevant appendices.)

☑ I agree with the decision of the research supervisor as indicated above

Signature ---------- Date 8/7/10

But I think, I think what the women smelt out if you like, or felt, was that - the fact that you really did want to help. You weren't going to patronise them, you weren't going to judge them and it again gives the core conditions. Right. So erm, yeah.

Smell & felt - basic instincts & senses

She had something to give & an attitude of non-judgemental & respect.

08.34

How, how did you put that across to them?

(Pause) I don't know.

Erm, *(short laugh)* I don't know, how, how do you do that with any client, I suppose it's erm, it's your body language, it's looking in your eye, it's smiling at them, it's...

I mean don't get me wrong, I never condoned, and I will quite often say to them, particularly drugs because as I worked there more erm, the more irritated I got with drugs, having seen the damage it did, I became stronger anti-drug when I worked there.

Erm, how did I... (*thoughtful*) I don't know, it's just, I cared. I think, because I did care. And you see a lot of them had had...awful lives, really awful lives and then also the ones that hadn't and I'm thinking really of like, erm, there was a girl, er woman there who was quite, quite high, media, was put in to where we were, for her own protection. Erm, and I can remember looking at her and thinking, if you've done what you had been accused of, and actually I don't think there's much doubt erm, then obviously you're not a very nice lady, but I still, well why, what made you do that, why did you do it, what's happened to you to make you do that, you know. And I think that's what I used to my curiosity, if you like, took over.

These skills would use for any client.

Non-verbal communication of core-conditions.

Careful not to position herself as condoning their actions.

She cared & was able to show it

Prisoners had awful lives

Orientation of not judging extends to her not assuming quite before trial.

Very mild understated opinion. No emotional response.

Curious as to her life history & context to the crime.

From a negative emotional response & judgement.

Thinking head took over, an emotional or moral head.

This is the end position of the transformation in attitude to Prisoners.

Erm, and you know most of the women I do feel, and I still feel, and I'll still argue the point with people who say 'lock them up, throw away the key', that most of the women they needed help, they didn't need... censorship. So... yeah.

10.43

You mentioned a while back that you, you were aware of the scary things that they'd done, the capacity for violence but that you never felt scared yourself. Could you say a bit more about, about that, that dynamic?

(Short laugh) erm, I don't know, erm, why did I, how did I never feel scared? I think, I think, ok when you, I remember when I first went there my big boss said if the women don't like you then they'll let us know, ok, and they won't work with you. And I can remember thinking 'oh my god, I really want them to like me', and all this ok, and then, you see when you're in a session you sort of forget, because you focus, I remember my tutors also saying, focus on the client, so that's what I use to do. Erm, and therefore, I think word also got around the prison that you're ok. And you see the women themselves will sort of, it goes round, the wing and all that, you know, she's ok, right. Or she's a pain in the bum, or she's whatever. So it obviously went around that I was ok. Erm and then, I don't know why I never scared because some, I mean I can remember there was one, there was one that I had, that I got given by my, there's one woman who looked incredibly scary, she was a big woman, quite butch looking. Erm, she really, she

shaved her head, right, quite overweight, she was scary, you know in the street, I'd have crossed the road. And I can remember passing her with my boss who's seeing her and making some comment about the fact that it was a lovely day and that the aeroplanes were flying, and I said 'oh I wonder where he's going, I wish I was in New York or some throw away comment like that. But she latched on it and when, because my head boss, woman, didn't, she only saw so many, and so she had to be found a therapist, and she said 'I'd like to work with Belinda.' Erm maybe I shouldn't have said that...

She was intimidated by some of their appearances.

- Smalltalk - as a normal person interaction - Not a stand offish therapeutic distance. So she's not a threat to them.

The requested to work with her - sought after - must feel good. give a sense of feeling approved :. safe?

It's ok I'll edit it out...(12.54) – [change her real name to pseudonym]

Erm, so erm, so I remember thinking 'god she scares me to death', right, she did, and I thought I don't want to work with her, but I thought well I've got to work with her. but actually, when you actually, and again it taught me, not to go on appearance right, erm, she'd had awful, awful abuse. And just hearing it, and I must admit sometimes, well I can remember with about three clients, that I did, I really showed that I was moved, because the dreadful things and it would make me want to cry, you know. I mean I don't think I did ever cry but I think my eyes would have filled with tears and I think my face would shown, yes this is dreadful, and I would have said 'yes this is dreadful'. And I can remember one of them saying 'my parents should be in jail really and not me', and I remember saying, 'yeah you're absolutely right, they should be, and it's not fair', and, you know all that.

So I think yeah, it's sort, it's, the funny thing is that when some of them had, erm, had a bad day, and some of them would. I mean I can remember being in a group, and because

Intimidated, scared of her client, didn't want to work with her.

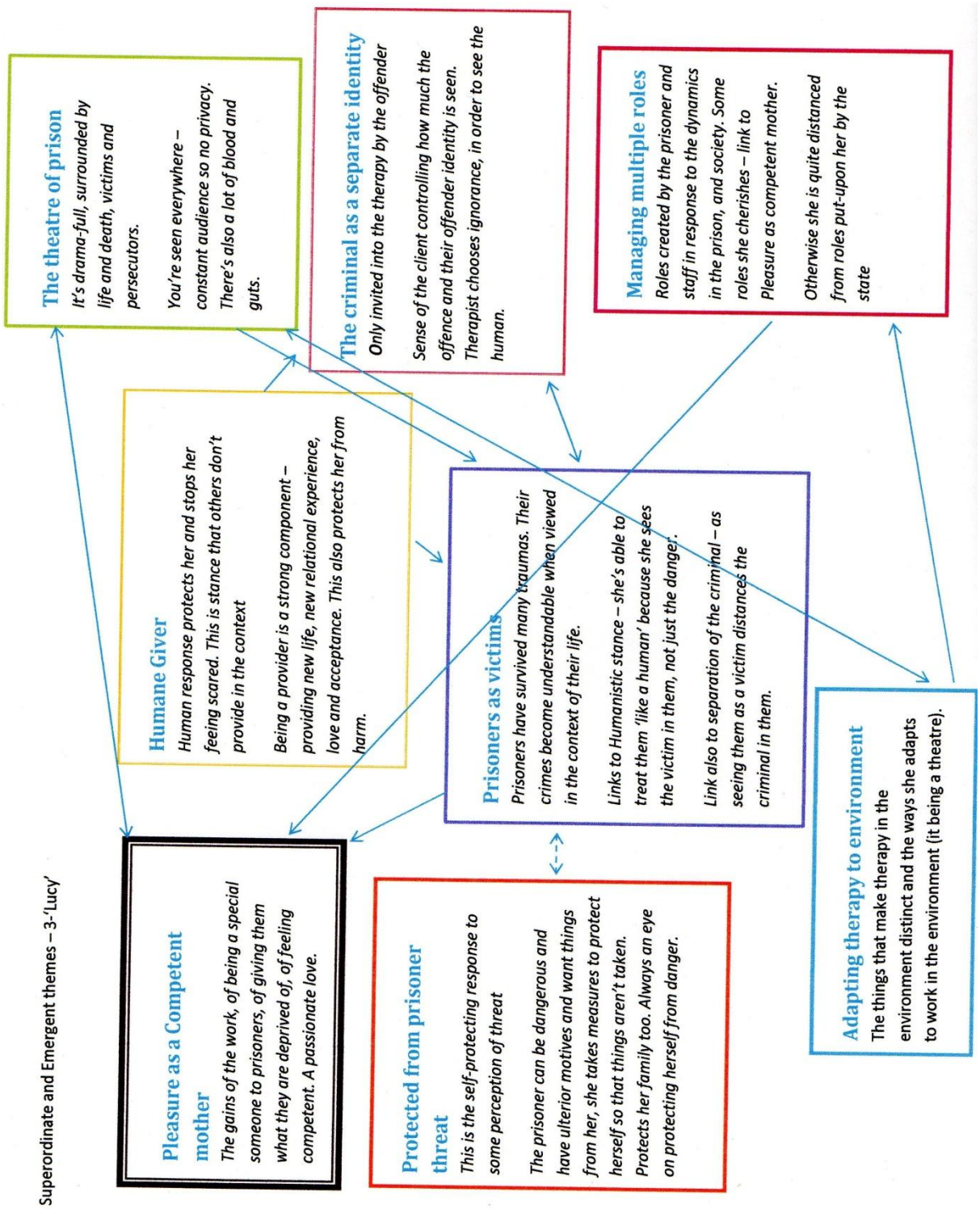
Saw beneath clients intimidating appearance to the victim beneath & really empathised with the victim.

Her deeply moved. Her inner human touched by her clients. Showed - why?

- Showing her human, not hiding behind a mask. Acknowledging their pain, their victim experience.

So seeing & connecting by with the clients inner victim, stopped them being intimidating & protected her.

APPENDIX G: EXAMPLE DIAGRAM OF THE EMERGENT AND SUPERORDINATE THEMES - 'LUCY'



APPENDIX H: TABLE OF SUPERORDINATE THEMES – 'BARBARA'

Emergent theme	Descriptions	Transcript page numbers
Attachment to the environment	*Why she was drawn to it, and her feelings towards it* • She was needed in the prison (sought after) • Work interesting • Challenging blood and guts work • She loves the setting • Prison is niche pg 1 "you either love it or hate it" • Prison exclusive work setting opportunity	Pg 1 Pg 2 Pg 10 Pg 13 Pg 22 Pg 33
Managing the timewasters	*Active management of them by 'weeding out' keeps the experience a positive one for her too, as she works with those who she can make progress with.* • Active "*weeding out*" of timewasters • Time wasters • Threat of manipulation • Prisoners ulterior motives (wants) • Negative emotions related to the manipulative time wasters • Danger of naivety – need experience (to protect against manipulation)	Pg 3 Pg 10 Pg 7 Pg 11 Pg14 Pg 21 Pg 30
Distancing offence behaviours	*Doesn't see the offence as part of her job as a counselling psychologist, so she doesn't engage with it. Her trusted colleague looks up and knows the risk information; she works with the motivated client who wants to move forward. Linked probably also to her alliance to the prisoner not the state, so she isn't risking the alliance by addressing the offending behaviour.* • Offence doesn't feature/isn't relevant • Bad, "*silly"* behaviours excluded from therapy • Difficult to think of offence • Knowledge of prison necessary for safety (another holds this knowledge)	Pg 15 Pg 16 Pg 17 Pg 20 Pg 29
Self-survival	*Attitude of self-survival means that she's firm and possibly quite detached in her approach. She doesn't aim to be liked and she relies on instinctive self-protection strategies to not get hurt.* • Lots of potential clients (doesn't matter if you lose one – "*Plenty more where that came from"*) • Not being likeable • Aware of need to protect self pg 29 "it's every man for himself" • Self-protection strategies are instinctive • Importance of trusting intuition (i.e. self-reliance) • You need to be active pg 4 "*reign in the client*" tell them she's going to make them work hard	Pg 3 Pg 4 Pg 24 Pg 29 Pg 30 Pg 32

Alliance linked to self-protection	*She is allied to the prisoner over the state and has little to do with the prison system. She is prepared for being tested by prisoners but is known by the prisoners as 'ok'. She aims to be non-threatening and gains their trust through keeping confidentiality. This alliance serves as a self-protection strategy and also means that she is more able to make progress with them.* • Alliance and positive rapport reduces threat, increases co-operation • Her non-threatened and threatening stance • Her alliance to prisoner, helping them to manage officers • Prisoners don't know what to expect of therapy – they're pleasantly surprised that she's on their side • Gaining trust through keeping confidentiality • Being tested by prisoners • Separation of professional mode and hidden personal experiencing (Her reactions to their offence disclosure hidden, so she demonstrates she's non-judgemental)	Pg 3 Pg 7 Pg 8 Pg 9 Pg 10 Pg 13 Pg 15 Pg 31
Awareness of physical threats	*She has a general awareness that the prison is a dangerous environment in which to work, and that other staff also can't be relied up on to keep her safe.* • Other staff put her at risk • Aware of danger/threat that other prisoners pose	Pg 7 Pg 13 P 30

PART C: CRITICAL LITERATURE REVIEW

All Burned Out: A review of the literature on how counselling psychologists experience and manage burnout.

1.0 INTRODUCTION

It has been suggested that the average therapist has a productive professional lifespan of ten years (Grosch & Olsen, 1994, p. x). So what causes counselling psychologists to become unproductive and burn out? How do they cope with the demands of the work and prolong their productivity? This review will evaluate the literature on the prevalence, causes and experience of burnout amongst counselling psychologists. It will also incorporate literature which studies the relationship between burnout and the use of self-care and coping strategies. There is not a large body of research on the topic; to the best of the author's knowledge, this review covers the vast majority of the available research.

The review of the literature considers not only research with counselling psychologist participants but also research with clinical psychologists, counsellors and psychotherapists. These professionals are primarily engaged in providing therapeutic interventions and therefore it was considered that their experience of burnout may shed light on our understanding of the experience of counselling psychologists. The generic term 'therapist' will be used in this review. The closely related topics of wounded healers or vicarious traumatisation are not included in this review as this would broaden its scope quite considerably.

First, a brief and selective account of the development of the concept of burnout, explanatory theories and a review of widely used measures are presented. This summary is intended to put the subsequent review of the literature on therapist burnout into context. Next, literature documenting the coping strategies used to manage and reduce burnout is

considered and the review concludes with an examination of the trends and gaps within the research, suggesting future directions researchers might take.

1.1 General literature on burnout

The concept of burnout was developed in the mid-1970s. Herbert Freudenberger is widely acknowledged as being responsible for the term after he observed that volunteers in a healthcare agency experienced a gradual emotional depletion and loss of motivation and commitment (Barnett, 2007; Maslach & Schaufeli, 1993). As such, it has been used specifically to explain the experiences of workers who "do people work" (Kristensen, Borritz, Villadsen, & Christensen, 2005, p. 192). By the 1980s, burnout had become such a fashionable research topic that Golembiewski, Munzenrider and Stevenson described it as the "psychological equivalent of venereal herpes" (1986, p. 1). Burisch described it as a concept that has been "over explained" (1993, p. 75). Burnout research has its roots in qualitative studies on care-giving and public service occupations (Maslach, Schaufeli & Leiter, 2001) and over time, the phenomenon became viewed as a type of job stress with links to job satisfaction and staff turnover (Maslach et al., 2001). Burnout research methods are now predominantly quantitative and the vast majority of research is still conducted in the USA.

1.2 What is burnout?

Early literature on burnout used varying definitions (Golembiewski et al., 1986). Christina Maslach, a founding and prolific researcher of the topic, created this widely acknowledged and cited definition of burnout: "a prolonged response to chronic emotional and interpersonal stressors on the job […] defined […] by the three dimensions of exhaustion, cynicism and sense of inefficacy" (Maslach, 2003, p. 189). The most central of these three components is emotional exhaustion, considered to be a basic stress response to demands placed upon the worker. The cynicism component (sometimes referred to as 'depersonalisation') is the hallmark of burnout, setting the condition apart from job stress, in which depersonalisation does not appear to feature. This component refers to the negative, callous or excessively detached response to clients and aspects of the job which

workers with burnout display (Maslach, 2003). The third component of inefficacy involves a reduced sense of personal accomplishment or professional competence.

Maslach (Maslach et al., 2001; Maslach, 2003) describes the way in which these components interact with one-another, suggesting that some workers become emotionally exhausted by their demanding work and to cope, they moderate their compassion for clients and become emotionally distant. This leads them to respond to clients in negative, callous and dehumanising ways; this is considered to be a maladaptive coping response. Inefficacy emerges when workers feel they do not have the resources, emotional or practical (for example, inadequate time), to get the job done and thus do not experience a sense of accomplishment.

Maslach and Schaufeli (1993) identify five characteristics of the 'state' of burnout which distinguish it from other psychological conditions. Firstly, it is associated with dysphoric symptoms such as depression; secondly, there is an emphasis on mental and behavioural symptoms rather than physical ones; thirdly, burnout symptoms are work-related; fourthly, the symptoms manifest themselves in 'normal' persons who did not previously suffer from psychopathology; and fifthly, decreased effectiveness and work performance occur because of negative attitudes and behaviours.

Freudenberger and North (2006) subsequently identified a cycle of burnout consisting of twelve stages which depicted the temporal nature and accounted for individual variation in the experience of burnout. This model depicted burnout as developing gradually over time with people spending different lengths of time in each phase. The model also identified pre-burnout conditions within the individual, notably a compulsion to prove oneself. This echoed Weiss's observation that common pre-existing conditions included over-working and over-enthusiasm (2004).

More recently, Schaufeli, Leiter and Maslach (2009) in a review of thirty-five years of research and literature on the topic, suggest that in line with the trend for positive psychology, burnout could be rephrased as an erosion of engagement in work. They suggest a continuum of employee well-being on which burnout sits at the opposite end of employee engagement. Over the years, researchers have challenged Maslach's construction of burnout and proposed changes to the model. For example, Kristensen et al. (2005) point to repeated findings that personal accomplishment is an independent rather than a core feature of burnout and Gil-Monte (2012) has suggested that guilt is a significant

factor in the development of burnout; workers who feel guilty about their cynical approach to clients and poor work performance may either become more depressed, or seek to relieve guilt by improving their performance.

An alternative perspective was provided by Cherniss (1995) who conducted a longitudinal study of burnout in American human service professionals including therapists, teachers and poverty-lawyers. He suggested a correlation between the development of staff burnout and societal values. Many of his participants experienced burnout early in their careers and of these, some decided to switch to higher status, better paid jobs that produced more immediate rewards. He placed this behaviour in the context of a highly individualistic society in which workers struggled to see individual effort as part of a larger evolving social process. He proposed the phenomenon of burnout to have evolved as a result of society's moral-religious paradigm being replaced by a technical-scientific paradigm in which a detached, analytical attitude to the world is fostered. Whilst participants found their work helping individual people meaningful, he suggested that burnout prevails partly because the nature of human-service work is at odds with the current dominant societal culture.

In short, whilst individual responses to work have been identified as factors in burnout, societal and organisational factors are also considered to play a role although these have not been investigated to the same extent. Indeed, Norcross and Guy (2007) suggest that burnout should be seen as being caused by an interaction between the two.

1.3 Burnout measures

The most common measure of an individual's burnout is the Maslach Burnout Inventory (MBI), created by Maslach and Jackson in 1981. Originally designed for use with human service professionals, it has since been adapted for a variety of occupations (Maslach, 2003) and its items are designed to assess the three burnout components. Extensive test-retest reliability checks have been carried out on this measure, supporting its convergent and discriminant validity (Rupert & Morgan, 2005); it is also found to have internal consistency (Schaufeli, Enzmann & Girault, 1993). There remain however, drawbacks with the measure. Schaufeli et al. (1993) identify that individuals' perceptions of their burnout are measured but not their perceptions of relevant organisational factors. This differs from the Psychologist's Burnout Inventory (PBI), developed by Ackerley, Burnell, Holder and

Kurdek (1988). The PBI includes items which measure perceived control at work, perceived support in work setting, types of negative clientele and over-involvement in clients; factors the authors consider to contribute to burnout.

More recently, the Copenhagen Burnout Inventory (CBI) was developed by Kristensen et al. (2005), partly in response to criticism of the MBI from participants in Denmark who felt some questions were "too American" in style and irrelevant to Scandinavian culture (2005, p. 195). The CBI has three subscales measuring the domains of personal burnout, work related burnout and client related burnout and the core concept of burnout is emotional and physical fatigue and exhaustion (Kristensen et al., 2005). The same authors claim the CBI has strong predictive validity for sickness absence, sleep problems and intention to quit. These burnout measures are all self-report measures which can cause problems when used exclusively as at least part of the variance in results has to be attributed to method variance (Schaufeli et al., 1993); additionally participants may be influenced by the perceived social desirability of their responses (Podsakoff & Organ, 1986).

1.4 The implications of burnout for counselling psychologists and other therapists

Therapists' work is thought to be affected by the nature of their inner experience (Farber & Heifetz, 1981); consequently there is concern for the impact of therapist burnout upon clients (Brady, Guy & Norcross, 1995; Vredenburgh, Carlozzi & Stein, 1999). There is also concern for the mental health and work satisfaction of therapists (Coster & Schwebel, 1997; Farber & Heifetz, 1981; Kirk-Brown & Wallace, 2004; Kramen-Kahn & Hansen, 1998; Stevanovic & Rupert, 2004, 2009). In the wider research, reference has been made to the effect of staff burnout on the economy through the cost of absenteeism (Maslach, 2003; Maslach et al., 2001). There are potentially therefore, significant implications of therapist burnout. Barnet (2007) refers to the ethical imperative that therapists pursue psychological wellness through on-going self-care; indeed, the British Psychological Society state in the Code of Ethics and Conduct (2006) that psychologists should monitor themselves for signs of impairment, seek help if they become impaired and if seriously so, refrain from practice.

In comparison with other human service professionals, counselling psychologists may be particularly vulnerable to developing burnout because their work involves a combination of intense human interaction, difficult client behaviours, the need to maintain ethical practice

whilst managing the demands of bureaucratic organisations (Coster & Schwebel, 1997; Edwards, 1995; Farber & Heifetz, 1981; Raquepaw & Miller, 1989; Rupert & Baird, 2004; Stevanovic & Rupert, 2004).

2.0 CRITICAL REVIEW OF LITERATURE INVESTIGATING THERAPISTS' EXPERIENCE OF BURNOUT

Compared to the amount of literature on burnout in general, there is a not a large body of literature focusing on therapists' experience of burnout and the majority of research there is comes from the USA. The topic as a whole has undergone two distinct phases; initial research conducted in the 1980s in parallel with the wider trend for research on the burnout phenomenon and a second phase from the late 1990s onwards, marking a trend towards investigating the wider aspects of therapist burnout, for example the effects of therapist burnout on the family and how therapists' coping strategies affect burnout. Each theme in the therapist burnout literature is reviewed here.

2.1 THE EXTENT OF THERAPIST BURNOUT

There is little research that investigates purely the prevalence of burnout amongst therapists. Two early pieces of research compare therapist burnout rates with rates of other professionals and their results are inconsistent with one another. An early study from Ackerley et al. (1988) found that the majority of the sixty-eight Texan psychologists sampled experienced high levels of burnout compared with mental health workers; the highest scoring area was emotional exhaustion. This study was clearly limited by the size and scope of its sample. Subsequently, Raquepaw and Miller (1989) found that 562 therapists experienced low or moderate levels of burnout compared with other human service personnel. Mahoney (1997), found that less than half of his sample of 155 reported experiencing personal problems, though it is noteworthy that amongst the most frequent personal problems reported were two components of burnout – emotional exhaustion and doubts regarding their efficacy. Mahoney's participants were recruited at a conference, potentially reducing the generalisability of the findings as arguably, burnt-out therapists

might be less likely to attend and complete questionnaires. None the less, Mahoney's findings have been more recently supported by studies reporting that therapists typically experience low or average levels of burnout compared to mental health workers, with therapists reporting higher levels of personal accomplishment than emotional exhaustion and depersonalisation (Rupert & Morgan, 2005; Rupert & Scaletta Kent, 2007). The participants in both of these studies were experienced therapists, practising for seventeen years on average and therefore the results should be considered in the light of other research that suggests more experienced and older therapists experience less burnout (discussed later). Taken together, these studies suggest there are relatively low levels of burnout amongst therapists.

Amongst their findings, Rupert and Morgan (2005) reported that although therapists endorsed feeling emotionally exhausted as a result of their work, this did not generally co-exist with the other dimensions of burnout. Lee, Lim, Yang and Lee's (2011) work may shed light on this; their meta-analysis included seventeen published studies which had used the MBI to identify significant antecedents and precedents correlated with burnout amongst American therapists. They reported that over-involvement with clients was associated with the emotional exhaustion component of burnout but unexpectedly, was additionally positively associated with personal accomplishment. The authors suggested that whilst over-involvement was draining, it was also a source of personal satisfaction. They additionally found that whilst burnout was correlated with an intention to quit, it was more strongly correlated with job satisfaction. The authors suggested that these finding may be unique to therapists and theorised that burnout may have less effect on therapists' intentions to quit because of strong feelings of obligation to their clients. Meta-analyses come with numerous drawbacks, including for example, that errors made in the original studies may skew results of the meta-analysis. Lee et al. (2011) urge caution when interpreting their results, citing the heterogeneity of the samples used within the meta-analysis.

Further light is shed on the overall quality of therapists' work experience by considering research which investigated the rewards and stresses of therapists' work. Therapists have repeatedly reported gaining more rewards and satisfaction from their profession than stress (Kramen-Kahn & Hansen, 1998; Rupert & Baird, 2004; Stevanovic & Rupert, 2004). In these studies, high ranking satisfactions reported were helping troubled people and being socially useful. Highest ranking sources of stress included: economic uncertainty

(Stevanovic & Rupert, 2004); external constraints on services and paperwork (Rupert & Baird, 2004); business and economic demands (Kramen-Kahn & Hansen, 1998); time and workload pressures (Kramen-Kahn & Hansen, 1998; Mahoney, 1997).

These studies varied in their quality and style. Kramen-Kahn and Hansen (1998) used a questionnaire they developed for the purpose which therefore lacked proven reliability. Their results however, have been supported by the other authors cited here. The vast majority research reviewed so far has been cross-sectional in design (the exception being Rupert & Baird's, 2004). Given the temporal nature of burnout, a cross-sectional 'snap-shot' of professionals' mental states may not fully capture the prevalence and experience of burnout. This is particularly exacerbated when the research samples are limited; for example, the majority of participants sampled were older therapists with over ten years' experience (Farber & Heifetz, 1981; Kramen-Kahn & Hansen, 1998; Rupert & Morgan, 2005; Rupert & Scaletta Kent, 2007; Stevanovic & Rupert 2004; Rupert, Stevanovic & Hunley, 2009; Stevanovic & Rupert, 2009). Whilst similarities in experiences have been found, arguably each individual's experience is unique, limiting the relevance of a generalised account of burnout. These quantitative, survey-based studies only enable understanding of the prevalence of burnout at one moment in time and in selected populations. In contrast, combined longitudinal and qualitative methods could enable researchers to capture the process and development of burnout. This knowledge would be an asset to the extant literature on the topic.

It may be concluded from the literature that burnout levels are generally low to moderate amongst therapists and although therapists appear to be at greatest risk of the emotional exhaustion component (Rupert & Morgan, 2005), satisfaction in the profession is high. The review will now consider specific factors linked to the development and experience of therapist burnout.

2.2 Age differences

Early research by Ackerley et al. (1988), found that younger therapists reported more emotional exhaustion, suggesting that over time therapists may learn to conserve emotional energy. This finding has since been replicated by numerous researchers with age being amongst the most consistently reported correlates of therapist burnout (Lim, Kim, Kim, Yang & Lee, 2010). For example, Kramen-Kahn and Hansen (1998), Rupert and Morgan

(2005), Rupert and Scaletta Kent (2007) and Vredenburgh et al., (1999) all found that older therapists tended to report less emotional exhaustion and less depersonalisation, yet greater personal accomplishment.

Researchers have suggested tentative theories to explain the impact of age on burnout. For example, Kramen-Kahn and Hansen (1998) posit that therapists might either habituate to the stresses inherent in the work or leave the profession, meaning that those with greater experience who are surveyed are likely to be those with more resilience. Vredenburgh et al. (1999) suggest that differences in work habits and expectations could serve as possible explanations in the inverse relationship between age and burnout. This concept was considered in greater depth by Cherniss (1995) in his longitudinal study of human service workers, including therapists; he observed that the first year of practice was most likely to result in burnout. High expectations of their new jobs and an all-consuming commitment to the profession were observed by Cherniss to be common amongst newly qualified and less experienced professionals. As they gained experience and the toll of over-working caught up with them, workers started to doubt their organisations, their clients and then their own competence, thus developing burnout. Those that overcame their burnout and continued in their professions did not generally regain their idealism and as a result of their experience, their expectations were considered to be more realistic. More experienced workers also had better work-life balance and greater self-efficacy than they did early in their careers. Cherniss' longitudinal study is particularly helpful in understanding how experience and age mediate a therapist's burnout and recovery; however his findings require replication by studies using a homogeneous sample.

With age comes a greater exposure to difficult life events. Cherniss (1995) suggests that greater life experience may reduce the chances of work stress developing into burnout. This has yet to be investigated in the burnout literature and researchers have not apparently considered it as a variable, perhaps due to difficulties in defining and measuring a 'difficult life experience'. It is therefore not possible to understand how the participant's life experiences may account for variations in burnout.

In summary, the research indicates a clear relationship between young age and low experience, and burnout. Absent from some of the research (Rupert & Morgan, 2005; Rupert & Scaletta Kent, 2007) is consideration of the relationship between ageing and burnout beyond a simple reporting of the correlates. There is opportunity for deeper understanding of the significance of these factors in the development of burnout.

2.3 TRAINEE THERAPISTS AND BURNOUT

To the best of the author's knowledge, there has been only one published paper documenting burnout amongst trainee therapists; its authors (Clark, Murdock & Koetting, 2009) remark that there is a paucity of research on this area. They found that trainees had relatively low levels of burnout; this result may be surprising given aforementioned findings that youth and inexperience are strongly associated with burnout. Factors identified as predictors of burnout amongst trainees included high levels of global stress; low levels of a sense of community; and most statistically significantly, perceived low levels of advisor[2] support. They hypothesised that trainees may experience symptoms of burnout if they feel they are not living up to their advisor's expectations or feel they are lacking in direction or support from their advisors. The authors recommend that training establishments emphasise the trainee-advisor relationship and seek to generate a strong sense of community to protect against burnout. Their findings need to be treated with caution until replicated, partly because the measure used did not measure cynicism, one of the three components of burnout, but also because they excluded trainees in their first year. First year trainees may be less experienced and therefore at greater risk of burnout; including this population in the sample might have altered the research results. This paper, whilst not without its limitations, seeks to break into uncharted territory and provides an initial understanding of trainee therapists' experience of burnout.

2.4 GENDER DIFFERENCES IN BURNOUT

In recent years, findings concerning gender differences in the experience of burnout have been consistent; depersonalisation appears to be the only component that is experienced differently. Males exhibit moderately higher levels of depersonalisation of clients than females (Maslach & Jackson, 1985; Rupert et al., 2009; Rupert & Scaletta Kent, 2007; Vredenburgh et al., 1999). There have been few attempts to explain this gender difference. Maslach and Jackson (1985), in apparently the earliest research to investigate gender as a variable, proposed that the findings were in line with societal sex roles which see men typically adopting a detached, unemotional response to others and therefore being more

[2] The authors state that 'advisor' refers to the faculty member who has the greatest responsibility for helping the trainee through the programme.

likely to respond in depersonalised manner under stress. Their study found that women reported higher levels of emotional exhaustion and also linked this to the influence of female sex role which encourages women to be more empathic and emotionally involved with others. Interestingly, there has been no further evidence that women experience higher levels of emotional exhaustion than men (Lim et al., 2010). There is no explanation for this in the literature; whilst it may be explained by improved measures, perhaps there has been a change in the sex roles of women in the workplace that has impacted on their reporting of emotional exhaustion. It may also be important to consider the impact of race, ethnicity and culture upon gender differences; the vast majority of participants have been Caucasian American and variance in gender amongst other populations might be considered in light of alternative cultural sex roles.

The research investigating gender has moved on to consider the variance in burnout between men and women working in different work settings, with inconsistent results. Across three studies, each paper was unsuccessful in replicating the earlier paper's findings. The suggestion that men experienced higher levels of emotional exhaustion in group private practice compared to other settings (Rupert & Morgan, 2005) was refuted by Rupert and Scaletta Kent (2007), who did not find any difference in the prevalence of male burnout across settings. Both of the above papers found that women in agency[3] settings experienced higher levels of emotional exhaustion than women in independent practice settings; however this finding was not replicated by Rupert et al. in 2009.

The authors struggled to account for the inconsistency in their findings and despite repeated analyses, could only offer hypotheses, for example, suggesting that women's family commitments made agency settings more demanding (Rupert & Morgan, 2005). All the authors cautioned against generalising beyond their sample and called for further replication of their studies as this was a new focus for research. Further research may shed light on the interrelationships between burnout, gender and work setting, and perhaps where quantitative methods have failed, qualitative methods would produce descriptive and explanatory data from the therapists themselves.

[3] Agency settings is an American term, typically referring to counselling centres, psychiatric or general hospitals, community centres, and outpatient clinics.

2.5 BURNOUT AND WORK SETTINGS

Early research identified work setting as a factor accounting for variance in therapists' levels of burnout (Ackerley et al. 1988; Farber & Heifetz, 1981; Hellman et al., 1987; Raquepaw & Miller, 1989). Consistently, recent literature has shown that therapists who work in private practice report a greater sense of personal achievement, more satisfactions and fewer stresses than those who work in agency settings who, in contrast, were found to have higher levels of burnout (Rupert & Morgan, 2005; Rupert & Scaletta Kent, 2007; Vredenburgh et al., 1999).

Researchers considered aspects of private practice work that contributed to lower levels of burnout. Solo and group private practice respondents reported greater control over work activities and less negative client behaviour than those working in agencies (Rupert & Morgan, 2005; Rupert & Scaletta Kent, 2007). Additionally, those working in private settings worked fewer hours, had greater client contact, spent less time doing administrative tasks such as paperwork and spent less time giving and receiving supervision (Rupert & Morgan, 2005; Rupert & Scaletta Kent, 2007). Interestingly, Vredenburgh et al. (1999) replicated Ackerley's et al.'s (1988) earlier findings that a high client load was linked to a higher the sense of personal accomplishment but not to higher levels of emotional exhaustion or depersonalisation. They speculated that the cause of this was that as client load increases, therapists may perceive that they have greater opportunity to help others and earn more money.

The above pieces of research are very thorough; compounding variables are accounted for and there is significant space dedicated to the implications of the findings, more so than in other areas of the field. However, Rupert and Scaletta Kent (2007) acknowledge their small sample and both Rupert and Morgan (2005) and Rupert and Scaletta Kent (2007) excluded participants who worked in more than one location. It would be interesting to see how therapists working in two or more settings fared in comparison to those who worked in just one. The applicability of these findings from the USA to other countries must be considered with awareness that the agency settings referred to are specific to the healthcare system in the USA. Whilst it may be possible to generalise the findings regarding private practices to other countries, it may not be possible to generalise the findings concerning agency settings, as the United States managed care system is very different from the British NHS, for example.

2.6 Burnout and family life

More recently, Rupert et al. (2009) have investigated the effect of therapists' family life on their experience of burnout. They found that family support is important for therapists' wellbeing at work as where there is a supportive family compared to one which is demanding of the therapist, emotional exhaustion at work decreases. Rupert et al. described a cyclical pattern with regards to the impact of family life upon therapists' experiences of burnout; the existence of work resources such as control over activities appeared to reduce the extent to which work negatively influenced family life which in turn reduced emotional exhaustion at work. This research shed some light on the possible process by which burnout may be increased or decreased by the interaction between work and family life. This study is ground-breaking in its focus (and as such, the results require replication) however the research methods are the same as Rupert and colleagues used to investigate other aspects of burnout; the distribution of questionnaires amongst a large sample of psychologists registered with the American Psychological Association and then analysis of co-variance. Our understanding of the topic could be enriched were new aspects of therapists' burnout to be investigated using alternative methodologies.

3.0 Reducing and managing burnout

The interest in therapist burnout, in addition to research investigating therapists' personal problems and impairments, has resulted in a large amount of literature reporting how therapists can and do care for themselves. This has been followed by papers and books offering advice to therapists on the subject (e.g. Brady et al., 1995; Dryden, 1995; Norcross, 2000). These differ in style and include self-help 'handbooks' such as Weiss (2004) and Norcross and Guy (2007). The literature contains a variety of terms used to describe self-care strategies including career sustaining behaviours (CSBs), coping strategies and factors related to well-functioning.

To the best of the author's knowledge, the only research that has focused on the relationship between therapists' levels of burnout, work stress and career-sustaining behaviours (CSBs) has come from Kramen-Kahn and Hansen (1998) and Stevanovic and

Rupert (2004). The findings are consistent; therapists who perceive less stress and fewer hazards in the job also report using the most career-sustaining behaviours. Kramen-Kahn and Hansen (1998) consider the chicken-and-egg style dilemma in these results: does not using CSBs cause therapists to perceive greater stress, or do those who experience greater stress become paralysed and so endure stress without using CSBs? Stevanovic and Rupert (2004) conducted more analyses on their data than Kramen-Kahn and Hansen (1998), the results of which suggested that more satisfied therapists who experienced fewer hazards prioritised a balanced life between work and family and friends (Stevanovic & Rupert, 2004).

Despite the fact that the findings were consistent with one another, more research is needed to confirm their generalisability as both samples were from the USA. Additionally, both researchers relied heavily on measures they designed for the purpose of the research; therefore their reliability cannot be fully guaranteed. Stevanovic and Rupert's (2004) paper does not consider the implications of their findings but does identify further areas of research. In addition, these studies investigated the correlation of CSB and work stress and burnout, as such they do not reveal which strategies might be applied at different stages of burnout to relieve symptoms. They also do not provide an account of the process of recovering from or preventing burnout, for example how therapists established a balance between work and personal life.

Cherniss' (1995) longitudinal study which included therapists captured the process of recovery from burnout and the facilitating factors. These factors included: finding work meaningful and finding special interests or projects within work which were fulfilling; greater autonomy and professional support in work; and possessing or developing individual characteristics such as more realistic expectations, resilience, negotiation skills and career insight, i.e. knowing which work you enjoy. As the sample included teachers and solicitors as well as therapists, there needs to be research purely focused on how therapists prevent or recover from burnout.

It has been argued that locating responsibility for preventing and curing burnout with the therapist, neglects the responsibility and role that organisations have (Stevanovic & Rupert, 2004). Many authors make recommendations for how organisations can change in order to protect therapists from burnout. For example, there have been calls to educate trainee therapists on the nature of burnout, prepare them for working in demanding agencies where burnout is most prevalent and inform them about the importance of self-care

(Barnett, 2007; Brady et al., 1995; Cherniss, 1995; Coster & Schwebel, 1997; Dryden, 1995; Kramen-Kahn & Hansen, 1998; Norcross & Guy, 2007; Weiss, 2004). Lee et al.'s meta-analysis (2011) found that higher levels of job support were linked to greater personal accomplishment despite the presence of higher levels of emotional exhaustion and depersonalisation. This suggests that employers could increase work satisfaction and reduce worker burnout by increasing support structures in the workplace. Shapiro, Brown and Biegel (2007) found that trainee therapists who participated in a mindfulness-based stress reduction programme reported significant declines in stress and anxiety and significant increases in positive affect and self-compassion; it has yet to be established if such training could prevent or reduce the effects of burnout specifically.

4.0 SUMMARY

Despite a number of inconsistencies in research findings, the literature provides some understanding of therapists' experiences of burnout. Firstly, the available evidence suggests that burnout is not highly prevalent amongst therapists. The majority report satisfaction in their profession and where emotional exhaustion or depersonalisation is experienced, it seems that this may not negatively affect therapists' personal accomplishment or commitment to their work. It appears that there are higher levels of burnout amongst young and less experienced therapists and those who work in agency settings. Aspects of the working environment have been found to increase the potential for burnout; large amounts of paperwork, less autonomy and low colleague support have all been cited as risk factors. Those therapists who use more self-care strategies report feeling less stress and more satisfied with their work.

Areas where inconsistencies remain are in the interaction between gender, work setting and burnout and the impact of the family on burnout. Some areas need further research to replicate existing findings, notably gender difference in the prevalence of burnout, the impact of the family on burnout, how therapists cope with burnout. There are also gaps in the literature. Firstly, all of the above research was conducted using participants from the USA. There appears to be no published research investigating how therapists in the United Kingdom, or indeed other countries, experience burnout and of how different cultures might construct and understand the burnout experience. Also, apart from gender

comparisons in which men are in the minority in the samples, there is no consideration of how minority groups in the profession may experience burnout; does being Asian, homosexual or transgender for example, make burnout more or less likely? Whilst we have some understanding as to how therapists cope with work and the factors which may reduce its prevalence, there is little evidence of what actually relieves burnout in therapists. Little attention has been paid to exploring the intra-psychic, attitudinal and life experiences which might contribute to the experience, its onset and therapists' recovery. Finally, methodologically, the vast majority of the research is quantitative, cross-sectional in design and utilises self-report measures.

5.0 CONCLUSION

From the review of the literature on burnout, several conclusions emerge. The methodology used to date has been limited and lacks a theoretical basis, there has been a lack of research into the experiences of UK-based therapists and there are implications for professional practice and training that have yet to be addressed.

Some aspects of the topic are better understood than others and it is clear that a select group of researchers are dedicated to increasing our understanding of burnout (e.g. Rupert, Stevanovic). The disadvantage of the field being led by so few is that their preferred research methods dominate. It could be argued that research on therapist burnout is stuck in a rut. Quantitative methods have been intermittently successful in establishing prevalence and correlations between variables. The inclusion of qualitative methods would add richness and depth. It would be interesting for example, to use interpretative phenomenological analysis (IPA) to understand what meaning therapists make of their experience of burnout and how they perceive the relationship between identified variables and burnout symptoms. It would be of even more value if this research were also longitudinal, tracking the meaning participants made of their experiences over time and uncovering the processes that they go through. Although IPA studies use small homogeneous samples (Smith & Osborn, 2003), such research could deepen our understanding of the experiences of particular groups and give a much needed voice to therapists themselves. Rupert and Scaletta Kent (2007) opine that theoretically-driven, comprehensive research examining factors related to burnout among psychologists is

lacking. A theoretical understanding of the subject would ultimately help therapists to understand their burnout experience better and potentially therefore become happier, healthier and more efficient. Research using grounded theory methodology, with its principal aim of theory generation (Strauss & Corbin, 1997), would enable such an understanding.

As already noted, there is a paucity of therapist burnout literature in the UK and because the US healthcare system is so different from our own, we cannot be certain how therapists working in UK agencies such as NHS hospitals, general practice surgeries, or prisons, are affected by burnout. It has been widely reported that the public sector services are suffering from a reduction in resources. Going on the existing research that indicates therapists in agency settings experience the most burnout, it would be interesting to investigate how a reduction in resources might further impact on therapists' burnout.

Regardless of setting and client, it is an ethical imperative that therapists attend to their psychological wellness in order prevent causing harm to clients (Baker, 2007) and there exists various literature providing guidance to therapists on how they might achieve this and prevent or reduce the effects of burnout (e.g. Norcross, 2000; Norcross & Guy; 2007; Weiss; 2004). There is also a call for organisations, employers and professional bodies to consider their attitudes and response to therapists who experience burnout (Barnett, 2007) and this might prevent the syndrome being attributed to deficits in individual therapists and subsequently reduce the potential for workers to feel blamed and stigmatised. Such moves are supported by research which suggests that burnout is a result of interactions between personal and work-related factors (Norcross & Guy, 2007); it would therefore follow that both parties have responsibilities for its prevention and management. Many authors have called for self-care and other burnout prevention strategies to be incorporated into therapist training programmes (Baker, 2007; Brady et al., 1995; Clark et al., 2009; Elman, 2007; Schoener, 2007). This could equip trainees with information to help them spot signs of burnout and cope with the demands of the profession, both in their traineeship and subsequent careers. This would help to ensure the on-going health of the profession.

More recent research appears to suggest that burnout may not result in a wholly negative work experience for therapists; for example, emotional exhaustion might co-exist with personal satisfaction and an on-going commitment to the work. It is suggested that this is related to therapists' strong commitment to their clients (Lee et al., 2011). This requires

further investigation; such a line of enquiry would follow the trend within the wider research on burnout which has been influenced by positive psychology (Schaufeli et al., 2009). Furthermore, there is opportunity to explore how the potentially challenging experience of burnout might contribute to therapists' resilience and the evolution of their personal and professional identity.

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