

***Working with Offenders with
Personality Disorder:
It's more than just the Offender***

***by
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Abstract

This thesis considers the experiences of those working with offenders with personality disorder (PD) and explores factors that impact upon their experiences. The first chapter introduces the concept of PD and identifies the aims of the thesis. The second chapter comprises of a systematic literature review of the psychological consequences of working with offenders with PD. The evidence identified suggests that working with offenders with PD can result in staff 'burnout', feelings of professional isolation, reduced self-efficacy, and negative emotional lability. However despite the dominance of negative consequences from working with offenders with PD, positive experiences were also identified including feeling professionally challenged in their work alongside feelings of satisfaction.

The third chapter explores specifically the experiences of professionals working within a pilot unit ('Unit A') for offenders with PD and personality difficulties located within a high security prison. The results suggest that a multiplicity of factors impact on the experiences of professionals working with offenders with PD, including the prison environment, the synergy of the workforce, the level of support they perceived themselves to need, the knowledge level of the professional, and their own personal perceptions. In addition to this, the by-product of personal change was identified from working with offenders with PD, and this in turn influenced their experiences of their work on 'Unit A'. This research demonstrated that numerous factors influence a professional's experience of working with offenders with PD, most of which are seemingly external to the challenging personality traits of the individual.

As the results of the study described in chapter three highlighted the significant influence that the location and resulting environment have on a professional's experience, chapter four provides a critique of the Essen Climate Evaluation Schema (EssenCES;

Schalast et al., 2008). Findings suggest that the EssenCES has an emerging research base which supports its rise as a valid and reliable measure of social climate. The chapter highlights the strengths of the EssenCES but also highlights the psychometric limitations of the measure.

In the final chapter the findings of each chapter are discussed with reference to the need for further research and the implications for current practice.

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Phew.....it's over!

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CHAPTER 1

Introduction to Thesis

1.1 Introduction

In 1998, personality disorder (PD) was reported to be present in 64% of male sentenced prisons in a UK prison population, and 78% of male remand prisoners (Singleton et al., 1998). These figures have remained relatively consistent over the years; Fazel and Danesh (2002) conducted a systematic review of 62 studies researching mental disorders in prison and found that PD was prevalent in 65% of offenders housed in prisons in western countries, and more recently, Stewart (2008) estimated that PD affects approximately two-thirds (Figure 1) of the prison population in the UK.

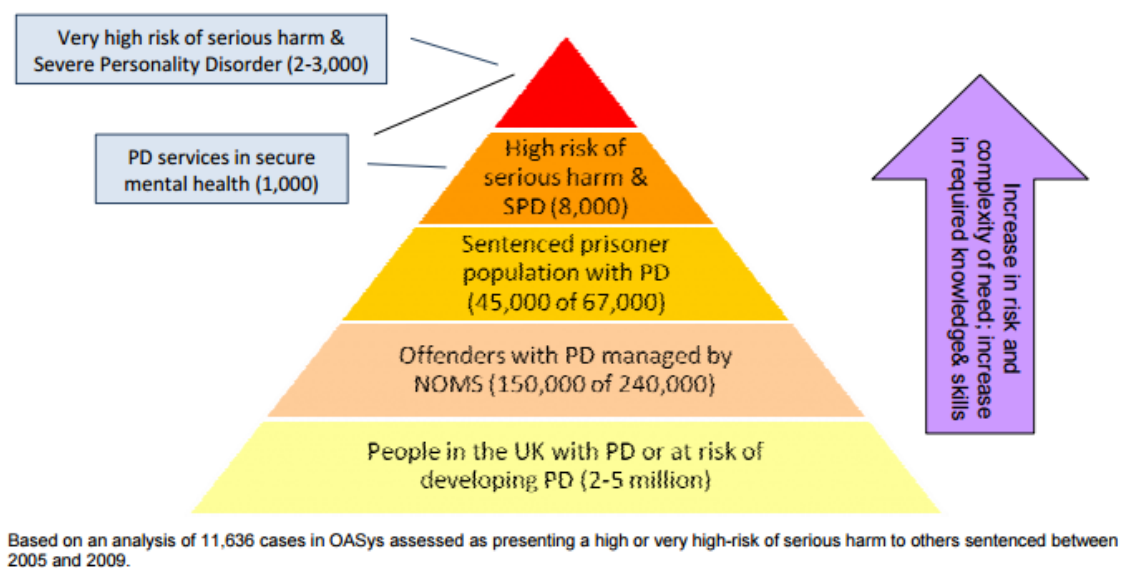


Figure 1: Estimated number of people with personality disorder

The relationship between personality disorder and offending is so well recognised that the presence of PD has been integrated into structured risk assessment tools, for example, the Violence Risk Assessment Guide (Quinsey et al., 2006) and the Historical Clinical Risk Management-20 (Webster et al., 1997). Moreover, the Hare Psychopathy Checklist-Revised (PCL-R) has become well established as an actuarial tool for predicting the risk of violent

reoffending for those diagnosed with psychopathy, a particular subtype of antisocial PD (Hare, 1991).

What is clear is that PD is a pervasive problem across UK prisons that impacts a high proportion of prisoners of which figures have been relatively consistent over the past 20 years. What is less clear is the impact on professionals of working with offenders of a high risk and high harm nature.

1.1.1 Definition of Personality Disorder

Personality is considered to be a “dynamic organisation within an individual of those psychophysical systems that determine their characteristics behaviour and thought” (Allport, 1961, p. 28). Personality is considered to be disordered when traits become maladaptive, cause significant harm, are inflexible, and are persistent (American Psychological Association [APA], 2000). Current psychiatric diagnostic guidelines in the *International Classification of Mental and Behavioural Disorders* (ICD-10) describe PD as “deeply ingrained and enduring behaviour patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations.” These behaviour patterns have to be present in two areas or more of cognition, affect, impulse control, and interpersonal functioning. Furthermore, these patterns have to be inflexible and pervasive across a broad range of social contexts. Similarly the DSM-IV defines PD as “an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.”

The DSM-IV TR (APA, 2000) organises ten PD diagnoses into three clusters. The clusters are organised by the similarities displayed in the PD diagnoses within them. Cluster

A contains disorders considered to be ‘odd or eccentric’; cluster B includes ‘dramatic, emotional, or erratic’ disorders; and cluster C contains those disorders defined as ‘anxious or fearful’.

1.1.2 Personality Disorder: The complexities of ‘treating’ the diagnosis

Until recently, the prognosis for those diagnosed with PD was negative and it was deemed “untreatable” (Ministry of Justice, 2011). More recently, the National Institute for Mental Health in England (NIMH(E)) published an article entitled ‘*Personality Disorder: No Longer a Diagnosis of Exclusion*’ (2003) which has increased interest in the treatment of individuals with PD. To inform the article, a questionnaire was sent out to all NHS Trusts providing mental health services in England. Of those that replied, only 17% of Trusts provided a dedicated PD service, 40% provided some form of service and 28% provided no service at all. The results of the questionnaire indicated that to some Trusts, PD was not a priority or a main focus of intervention (Snowden & Kane, 2003). Considering the prevalence of PD among offenders and their high rates of recidivism, it has recently been noted that a suitable and focussed pathway is necessary in order to reduce reoffending (Ministry of Justice, 2013).

In the UK, the medical view that antisocial behaviour (offending) may stem from a psychological abnormality, discrete from mental illness, and that it may be appropriate to redirect offenders diagnosed with PD to the mental health system for treatment as opposed to punishment has been widely accepted (Lee, 1999). However within this agreement, there has been little research into exactly what works with offenders with PD (Howells et al., 2007). Both pharmacological and ‘talking therapies’, including psychodynamic, cognitive, and behavioural approaches have been implemented when working with those with PD diagnoses

(Howells et al., 2007). One factor which is broadly agreed upon is the significance of a strong therapeutic relationship between offender and therapist (Castonguay & Beutler, 2006). However, the difficulties that those with personality difficulties have interpersonally can disrupt the formation of a strong therapeutic relationship. When considering these difficulties alongside the pervasive and enduring patterns of behaviour that denote PD, it is clear that considerable intervention is required to challenge an individual's persistent and persisting behaviour patterns. Furthermore, as the rate of PD has been shown to be high in prisons, more research is required to bolster confidence in what effective treatment looks like when working with PD populations; ultimately reducing risk of harm and recidivism.

1.1.3 Working with offenders who have Personality Disorder

Spending time with individuals with PD can be an emotionally draining experience (Aiyegbusi, 2009; Cox, 1996). Personality Disorder arises from the complex interplay of psychosocial factors (usually physical, sexual, and/or emotional abuse) which results in an interpersonal disadvantage (Moore, 2012). When this is coupled with offending, offenders with PD can be viewed simultaneously as “fearsome perpetrators and traumatised victims” (Adshead, 2008, p. 304). Valliant (1994) suggested that the behaviours displayed by those with PD are simply a means of trying to cope with their reactions to unbearable people in the past or present time. It was also noted that these people usually tended to be in a caregiver role. As a diagnosis of PD requires the behaviours to be pervasive and persistent across a number of lifestyle domains (MoJ, 2011); their interpersonal difficulties are not allayed by arrest and residence in the criminal justice system. Their interpersonal difficulties are instead played out in their relationships with those who now ‘care’ for them. It is, therefore, not surprising that powerful feelings between patients and their professional carers are an

inevitable aspect of the therapeutic relationship; nor is it surprising that these feelings are not always positive (Hayes, 2004).

The different diagnostic clusters of PD described previously often elicit different reactions in professionals. Individuals with Cluster A disorders (Paranoid, Schizoid, Schizotypal PD) often provoke detachment and distance due to their difficulties engaging in treatment (Moore, 2012). Those with Cluster C disorders (Avoidant, Dependent, or Obsessive Compulsive PD) may either struggle to seek and utilise help, or may become overly dependent and engage obsessively with support offered (Moore, 2012). There is a general clinical agreement that individuals with Cluster B disorders (Borderline, Histrionic, Antisocial or Narcissistic PD) have a considerable impact on the professional carers of those working with such individuals (National Institute for Mental Health in England, 2003b; Perseus, 2007). Intolerable feelings (e.g. guilt, depression, jealousy, hostility, neediness) from the individual can be projected onto the professional carer. Staff can become the target of intolerable feelings. In a forensic medium security unit, Clarke and Ndegwa (2006) observed patterns of emotional abuse of staff by patients. It was noted that staff often found it difficult to remember patient pathology when experiencing abuse, and were vulnerable to reacting to this abuse punitively. In addition, female staff were sometimes challenged with sexual harassment, or provoked to behave flirtatiously to charm away hostile behaviour.

1.2 Conclusions from research

The literature explored in the introduction indicates the high prevalence of PD in forensic populations and highlights the need for effective treatment. There is a wealth of literature which indicates the challenges professionals experience when working with

offenders with PD and the resultant impact on the professional. What is less apparent is what factors mitigates these experiences, or indeed amplifies them. There is also little research into the impact of therapeutic environment on the professionals working with offenders with PD. Lastly, despite the need for effective treatment for offenders with PD being clearly demonstrated in the literature, there remains a lack of guidance regarding how to work effectively with this population.

1.3 Aims of thesis

In light of previous research, this thesis aims to further add to the knowledge base regarding professionals' experiences of working with offenders with PD, however will go beyond this to provide a more in depth exploration of external factors impacting on such experiences. To achieve this aim, the following objectives have been identified:

- To understand the psychological consequences experienced by those working with offenders with PD by conducting a review of previous literature.
- To investigate the experiences of professionals working within a pilot unit for offenders with personality disorder and difficulties located within a high security prison.
- To develop a substantive model of one unit and stage in the new Offender Personality Disorder Pathway strategy from a staff perspective and to set a research agenda to develop ideas and their application to current practice.

1.4 Current thesis (summaries of chapters)

To achieve these aims, chapter two comprises of a literature review of negative experiences of professionals working with offenders with PD. The intention was to explore the accuracy of the suggestion that professionals experience more burnout and emotional distress when working with offenders with PD.

Research conducted in a specialist unit, located in a high security prison in a large UK city is reported in chapter three. The research considered the experiences of those professionals located on the unit and aimed to distinguish between differences in responses between different staff groups. The intention was to develop a preliminary descriptive model of the experiences of professionals working with offenders with personality disorder by identifying the key contextual, environmental, and affective components that impacted an individual's experiences.

In the interest of better understanding the influence of location and environment on a professional's experiences, the fourth chapter is a critique of the Essen Climate Evaluation Schema (EssenCES, Schalast et al., 2008). The aim of this chapter was to analyse the reliability, validity, and practical utility of this tool. Challenges regarding the measurement of an environment as therapeutic are discussed alongside the importance of such measurements. The thesis concludes with a general review of findings and potential implications for future intervention and research.

CHAPTER 2

A Literature Review Following a Systematic Approach

What Psychological Impacts do Employees Experience when
Working with Individuals with Personality Disorder?

2.1 Abstract

Aims:

To systematically review the literature regarding the psychological consequences of working with individuals who have a diagnosis of personality disorder (PD). More specifically, to identify the negative impact on staff members resulting from working with individuals with a diagnosis of personality disorder.

Method:

A search of electronic bibliographic databases was conducted using a systematic search strategy. Identified studies were subject to predefined inclusion/exclusion criteria and a quality assessment. Eight studies were found to be suitable and all studies were deemed good quality with quality assessment scores ranging from 58% to 88%. Of these, six were qualitative studies, one was quantitative, and one adopted a mixed methods design.

Results:

All studies identified a range of negative psychological consequences of working with individuals with personality disorder. Studies identified burnout, high levels of negative emotion, discord in staff relationships, and feelings of inadequacy as key negative consequences of working with this client group. Alongside the psychological impact of working with individuals with personality disorder, professionals also highlighted the positive experiences such as finding the work stimulating and satisfying.

Conclusions:

The results confirm that working with this client group is challenging and results in psychological difficulties, but also positive experiences. However, it is unclear as to the extent to which professionals experience negative consequences when working with

personality disordered offenders. The uncertainty of the results suggest that further research is required into how professionals experience working with offenders with PD; from this, support structures and training strategies can be implemented for those who work with individuals with PD to aid workforce satisfaction and staff retention.

2.2 Introduction

A strong workforce is a necessity when delivering high quality mental health treatment. Recently concerns have been raised about the difficulty of retaining staff working in mental health services (Evans et al., 2006). Much research has been conducted to try to identify what aspects of working in a mental health service are especially taxing and how they impact on the employee. The concepts that have been identified include ‘burnout’ (Maslach & Jackson, 1986), compassionate fatigue (Figley, 1995) and vicarious traumatisation (Kadambi & Ennis, 2005), as well as well-known psychological difficulties such as stress (Jenkins & Elliott, 2004) and anxiety (Jones, 2003). Compassion fatigue has been described as the ‘cost of caring’ for others in emotional and physical pain (Figley, 1982) and is characterised by deep physical and emotional exhaustion and a reduction in the professional’s ability to feel empathy (Mathieu, 2007). Vicarious trauma has been described as “the stress and personal damage caused by helping or wanting to help a traumatised person” (Conrad, 2011, p.1). Burnout has been defined as ‘a psychological syndrome in response to chronic interpersonal stressors on the job’ (p.399) and has three key dimensions: overwhelming exhaustion; feelings of cynicism and detachment from the job; and a sense of ineffectiveness and lack of accomplishment (Maslach, Schaufeli, & Leiter, 2001). Maslach and Jackson (1986) developed the Maslach Burnout Inventory (MBI) to assess burnout levels of employees and it has frequently been found that mental health professionals have higher levels of burnout than other populations (Oliver & Kuipers, 1996). An area that was identified as particularly challenging was working with individuals who present as aggressive or have suicidal tendencies (Melchoir et al., 1997).

Aggression, self-harming behaviour and suicide attempts are especially prevalent among individuals with a diagnosis of personality disorder. Personality disorders are described in the *International Classification of Mental and Behavioural Disorders* (ICD-10)

as “deeply ingrained and enduring behaviour patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations.” Individuals who are diagnosed with PD have often been the victim of childhood abuse (physical, sexual, emotional) which has had a negative impact on their psychological development (Gunderson et al., 2000). Diagnoses of PD are becoming increasingly commonplace within mental health settings and studies estimate that 24% of primary care patients meet the criteria for PD (Moran et al., 2000) and between 40 and 60% of people in contact with secondary mental health services (Birmingham et al, 2010). Since the publication of the National Institute for Mental Health in England’s (NIMHE) article *Personality Disorder: No Longer a Diagnosis of Exclusion* (2003a) there has been increased interest in the treatment of individuals with PD and also the needs of professionals working with the client group. It has been argued that working with individuals with PD can be extremely challenging due to the complex nature of their disorder and their temperamental attitude towards therapy (Dingfelder, 2004). Moreover, the self-harming behaviours exhibited by many individuals with PD can also be distressing for professionals and *National Institute for Health and Clinical Excellence* (NICE) guidelines stipulate that staff should have thorough training to aid their understanding (2004). Although the difficult behaviours of individuals with PD have been identified, less research has been conducted into the impact these behaviours have on the professionals who work with them. Studies have found that professionals often develop negative attitudes towards individuals with PD (Lewis & Appleby, 1988) but there has been little research conducted investigating the levels of burnout or additional negative consequences experienced by staff working with personality disordered individuals.

Identifying the negative psychological consequences of working with individuals with PD on professionals would aid the development of essential training and supervision in order to enhance job satisfaction of the professional and, subsequently, improve treatment for

patients. In addition, it could contribute to the retention of expert staff working in specialist services focussing on the treatment of individuals with PD.

2.2.1 The current review

The aim of the current review is to systematically evaluate the psychological consequences experienced by professionals working with individuals with personality disorder. First, a scoping search was conducted to identify any previous systematic literature reviews that had been published in this area.

2.2.2 Existing reviews

Prior to the systematic review, scoping searches were conducted on Cochrane's Database of Systematic Reviews (CDSR), Campbell Collaboration, and Centre for Reviews and Dissemination (DARE) in April 2014 to investigate whether there were any existing literature reviews regarding the psychological impacts experienced by staff working with individuals with PD. An up-to-date review into the literature researching the negative impacts experienced by professionals who work with personality disordered individuals following a systematic approach would be a helpful addition to the emerging literature base in this area.

2.2.3 Aims and objectives

The aim of the current review was to systematically identify literature that explores the psychological effects of working with individuals with a diagnosis of personality disorder. Specifically, the main objective of the review was to explore the negative

psychological impact of engaging with personality disordered individuals in a mental health or forensic setting. The review will focus on the negative consequences of working with personality disordered offenders as these have been identified in previous literature as impacting on practice and staff retention (Blom-Cooper, 1999; NIMHE, 2003b).

2.3 Method

2.3.1 Sources of Literature

Based on a preliminary search the following inclusion and exclusion criteria were developed. A population, intervention, comparator, and outcome (PICO) framework (Richardson, Wilson, Nishikawa, & Hayward, 1995) was not constructed for this review due to the studies related to the topic not having a clear comparison group.

The inclusion/exclusion criteria (see Table 1, page 16) were applied to the remaining studies after duplicates had been removed. The full text of the studies which met the inclusion criteria, based on the title and abstract were obtained through elibrary at University of Birmingham and by directly contacting the authors.

Table 1:

Inclusion and exclusion criteria

<u>Inclusion Criteria</u>	<u>Exclusion Criteria</u>
Population must be professionals (see below for search criteria) employed to work with individuals with personality disorder.	Publications related to the impact of personality disorder interventions on the client.
Must examine the negative impacts experienced by those who work with personality disordered individuals.	Exclude editorials, book chapters, case studies, commentary, expert opinion papers, dissertation theses, systematic or literature reviews and any secondary studies.
English Language only.	Studies focussing on children or adolescents.
1946 – 2014	Studies focussing on transference or the therapeutic alliance.
	Studies suggesting training for employees.

2.3.2 Search Strategies

The format of the search terms and their entry into the search field was adapted depending on the requirements of each database (see Appendix 1). The individual search terms of the review were:

(personality disorder).

AND

(employee* OR staff OR worker OR therapist* OR psychologist* OR psychotherapist* OR nursing staff OR prison staff).

AND

(negative impact* OR consequence* OR effect* OR result* OR issue* OR psychological effect* OR well being* OR trauma* OR depressi* OR anx* OR fatigue OR burnout OR job satisfaction).

The following search strategies were employed:

- a) A search was conducted using the above search terms on four electronic databases; OVID PsychINFO (1987 to week five April 2014, completed on 4 May 2014), OVID EMBASE (1974 to week eighteen 2014, completed on 4 May 2014), OVID Medline (1946 to week four April 2014, completed on 4 May 2014) and Applied Social Sciences Index and Abstracts – ProQuest (completed on 4 May 2014). The total number of hits were 1191 publications, 49 duplicates were removed leaving a total of 1142 publications. From this amount, a further 1108 publications were removed after the reading of their abstracts as they did not meet the inclusion criteria. This left 34 articles; from these articles, 26 publications were excluded as they did not meet the inclusion criteria. As a result, eight studies were left for the quality assessment.
- b) The references of articles were examined to identify any further publications appropriate for the review, however no studies meeting the inclusion and exclusion criteria were found.

2.3.4 Quality Assessments

The final eight papers that met the criteria for inclusion needed to be quality assessed to ensure that the design of the study was appropriate for the study objectives. Firstly, the research design of the papers had to be established and it was identified that there were six qualitative papers, one quantitative paper, and one paper which adopted a mixed methods

design. A quality assessment was designed based upon a tool taken from Critical Appraisal Skills Programme (CASP, 2010) and was subsequently used to assess the publications. The questions covered areas including a clear aim of the study, selection bias, measurement bias, and the clarity of the findings. For each question in the quality assessment, a scoring guide was implemented; a score of two was given if the condition was met, a score of one was given if the condition was partially met and zero was given if the condition was not met. 'Unsure' was given if there was insufficient information given to answer the question. A high number of unsure responses would indicate less precise reporting.

As there was only one quantitative study and one mixed methods study, after careful examination of the publications it was felt that these could be assessed using the same quality assessment (see Appendix 2) but with additional questioning regarding the measures used. The total score possible was 26 (24 for qualitative studies); the score for each article was then converted into a percentage. Higher percentages indicated better quality papers.

During the quality assessment process a second researcher assessed 50% of the papers and a good inter-rater reliability was reached on all assessed papers; any differences of more than 5 points were resolved via a discussion where an agreement of an appropriate score was found. A cut-off score of 50% was identified through previous experience of the academic supervisor and the researcher and the aims of the study to capture as many high quality studies of interest as possible.

2.3.5 Data Extraction

Relevant data from each quality assessed study was extracted and recorded using a specifically designed data extraction form. This form enabled the researcher to record

information on items such as methodology and results. There were independent subheadings for the qualitative and quantitative studies (see Appendix 3). .

2.4 Results

2.4.1 Description of the publications included in the review.

The final eight publications consisted of six qualitative papers, one quantitative, and one mixed methods design (qualitative and quantitative). Figure 2 illustrates the process used to reduce the amount of publications from the original figure found by conducting the database searches to the final eight used in the review.

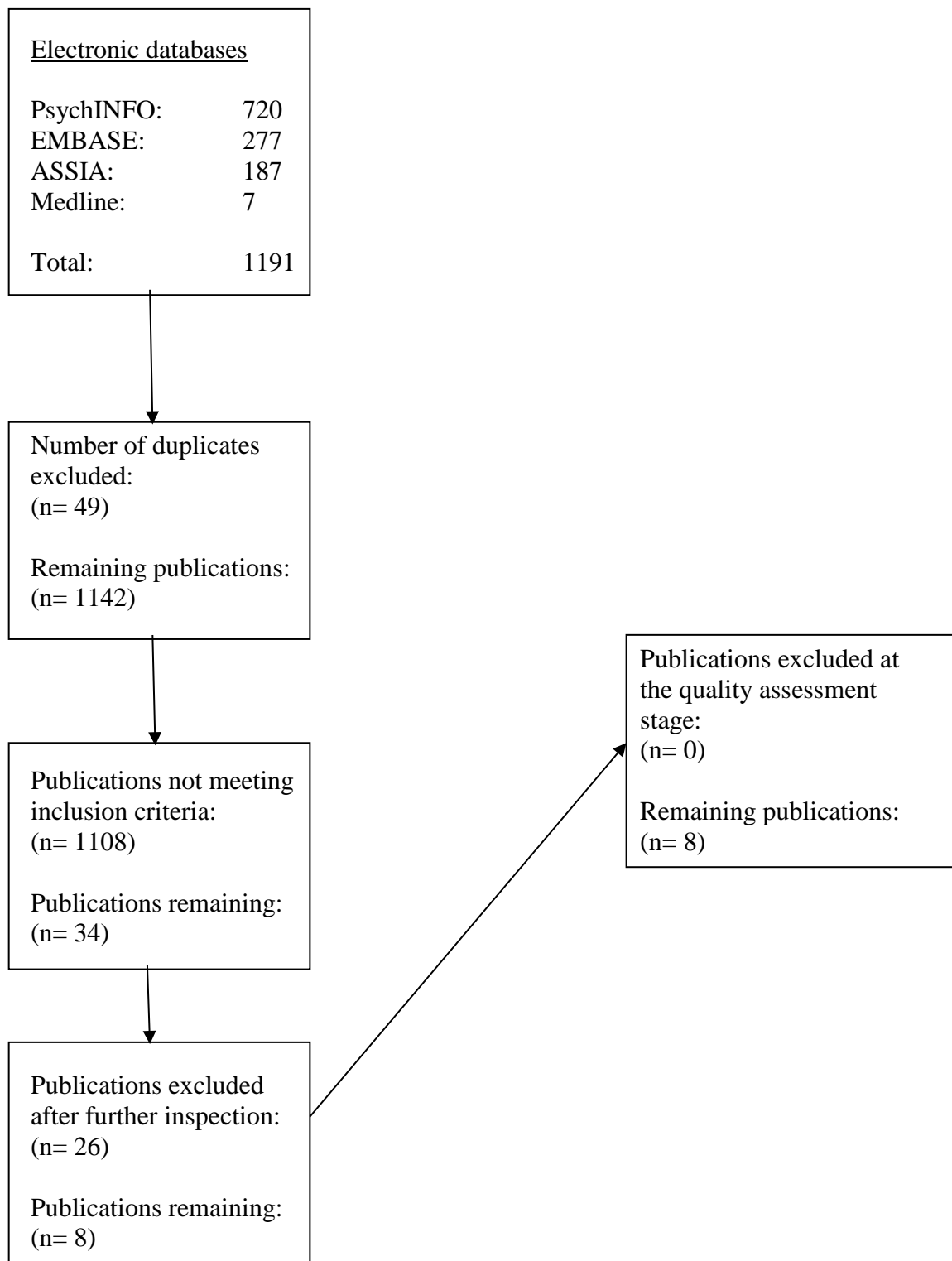


Figure 2: Flow chart of the search results

2.4.2. Included studies

All included studies met the minimum threshold criteria. All eight articles were given an identification number (see Table 2).

Table 2

Characteristics of included publications

<u>Study ID</u>	<u>Title of study</u>	<u>Authors</u>	<u>Year of publication</u>	<u>Country of study</u>
1	Therapeutic Burnout Among Borderline Personality Disordered Clients And Their Therapists: Development and Evaluation of Two Adaptations of the Maslach Burnout Inventory	Marsha M. LINEHAN Bryan N. COCHRAN Corinne M. MAR Eric R. LEVENSKY	2000	USA
2	An exploratory study of the needs of staff who care for offenders with a diagnosis of personality disorder	Arabella KURTZ, Keith TURNER	2007	UK
3	A Qualitative Investigation of the Clinician Experience of Working with Borderline Personality Disorder	Amanda J. COMMONS TRELOAR	2009	New Zealand
4	Job Satisfaction and Burnout Among Staff Working in Community-Based Personality Disorder Services	Mike J. CRAWFORD, Toyin ADEDEJI Katy PRICE Deborah RUTTER	2010	UK
5	An evaluation of new services for personality-disordered offenders: staff and service use perspectives	Zoe FORTUNE Diana ROSE Mike CRAWFORD Mike SLADE Ruth SPENCE David MUDD	2010	UK

		Barbara BARRETT Jeremy W. COID Peter TYRER Paul MORAN		
6	‘Everything contradicts in your mind’: A qualitative study of experiences of forensic mental health staff in two contrasting services	Arabella KURTZ Nikki JEFFCOTE	2011	UK
7	‘There’s always a sense of failure’: an interpretative phenomenological analysis of primary care counsellors experiences of working with the borderline client	Rosemary RIZQ	2012	UK
8	Trying to make sense of the chase: Clinical psychologists’ experiences and perceptions of clients with ‘borderline personality disorder’	Humera MILLAR David GILLANDERS Jannat SALEEM	2012	UK

2.4.3 Characteristics of included studies

Table 3

Summary of the characteristics and principal findings of the 8 studies included in the review.

ID	Hypothesis/Aim	Population	Measures/Design	Findings
	Quality Score			
1	<p>1. To examine changes in therapeutic burnout for clients and therapists during the first 4 months of therapy.</p> <p>2. Subsequently to relate these changes to pre-treatment characteristics of both the client and the therapist.</p> <p>3. To revise and evaluate the psychometric properties of the Maslach Burnout Inventory as a tool to measure burnout in both clients and therapists</p> <p>61%</p>	<p><i>(Only the therapist sample will be detailed as this is the relevant population.)</i></p> <p>30 participants; 19 psychotherapists; 11 cognitive-behaviour therapists.</p> <p>Mean age: 43.3 63.3% female.</p>	<p>Quantitative:</p> <ul style="list-style-type: none"> Researcher modified version of the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1986), named <p>The researcher modified the MBI; references to work or the job or recipients were changed to references to working with clients.</p> <p>Speilberger State Trait Anger Expression Inventory (STAXI; Speilberger, Jacobs, Russell & Crane, 1983)</p>	<p><i>(Only the findings relevant to the current review will be detailed here.)</i></p> <p>The analysis of the modified MBI-T suggest that although there are many difficulties when working with individuals with PD, therapists still feel their work is beneficial and positive.</p> <p>The highest factor analysis correlation scores on the MBI-T related to item 6 – working with my clients is a real strain for me (0.85); item 16 – working with my clients directly puts too much stress on me (0.92) and I feel I treat some of my clients as if they were impersonal objects (0.93).</p> <p>When comparing therapist burnout when working with individuals with PD to Maslach’s mental health professional sample norms, the study found that the therapist sample had a lower emotional exhaustion (12.6, $p < 0.01$) and depersonalization (4.03, $p < 0.05$) than the mental health sample, and they had higher personal accomplishment scores.</p>

ID	Hypothesis/Aim	Population	Measures/Design	Findings
Quality Score				
			Qualitative: Self-report questionnaires	
2	<p>1. What is the relationship between stress and job satisfaction in staff?</p> <p>2. Does clinical work with offenders with a diagnosis of personality disorder have a negative psychological impact on staff?</p> <p>3. What are the characteristics of staff's relationship with the external environment?</p> <p>4. Is there confusion in relation to a complex task?</p> <p>5. How do staff and patients experience control?</p> <p>70%</p>	<p>13 employees from Unit Z.</p> <p>64% female</p> <p>100% white</p> <p>British.</p> <p>Participants were from a variety of professional backgrounds.</p>	<p>Qualitative: Semi-structured interviews analysed in line with grounded theory.</p> <p>Credibility was checked by feeding back findings to staff on Unit Z and all but one of the lower order were validated.</p>	<p>The core category identified was staff feeling at risk of isolation from the outside world.</p> <p>Higher order categories included:</p> <ul style="list-style-type: none"> - Tension in the relationship with outside. - Complexity of the task. - A desire for more meaningful contact. - Contradictory attitude towards openness. - Feeling physically safe but emotionally vulnerable. - Ambivalence towards structure and control. - Emphasis on staff relationships. <p>The authors suggest that the participants' responses focussed on emotional features of the setting rather than the practical. Furthermore, that they highlighted the employees' feelings of vulnerability in response to perceived hostility from external colleagues.</p>
3	<p>1. To provide clinicians with an opportunity to make comments about their experiences when</p>	<p>140 registered health practitioners.</p> <p>65 % female.</p>	<p>Qualitative: Participants were requested to provide comments to the following</p>	<p>Four emergent themes were identified:</p> <ul style="list-style-type: none"> - BPD patients generate an uncomfortable personal response in the clinician. - Specific characteristics of BPD that contribute

ID	Hypothesis/Aim	Population	Measures/Design	Findings
	Quality Score			
	working with patients diagnosed with borderline personality disorder (BPD) 58%	Participants came from a variety of professional backgrounds.	question: -please provide some comments about your experience or interest in working with patients diagnosed with BPD. Answers were analysed using a thematic analysis procedure.	to the negative clinician and health service response. - Inadequacies of the health system in addressing BPD patient needs. - Techniques and strategies needed to improve service provision with BPD. Results indicate that some clinician attitudes towards individuals with BPD are negative and derogatory, and suggested that this may be due to the clinicians' personal discomfort due to their limited understanding of how to respond to the needs of the BPD patient.
4	1. To examine the levels of burnout among staff working in community-based services for individuals with personality disorder. 2. To explore factors which increase or lower the risk of burnout among people working in such services. 79%	87 participants from eight community personality disorder services; 62.5% female. Participants were from a variety of professional backgrounds.	Quantitative: Maslach Burnout Inventory (MBI; Maslach & Jackson, 1986) Qualitative Two waves of in-depth interviews.	Quantitative: 32.2% of respondents met the threshold for high emotional exhaustion, 14.9% for depersonalization and 8% for a low sense of personal accomplishment. The levels of depersonalization ($t = 2.5$, $p = 0.01$) and emotional exhaustion ($t = 2.5$, $p = 0.01$) were lower and the level of personal accomplishment ($t = 3.4$, $p < 0.01$) was higher among those working in Personality Disorder services than has previously been found in other studies investigating mental health workers working with different populations. Key themes from the interviews included: - Feelings that staff have about working with individuals with PD. - Importance of certain personal qualities

ID	Hypothesis/Aim	Population	Measures/Design	Findings
	Quality Score			
				<p>required to work effectively with people with PD and to reduce burnout.</p> <ul style="list-style-type: none"> - Factors that can help maintain a healthy working environment. - Highlighted the positives of working with individuals with PD. <p>Challenges included:</p> <ul style="list-style-type: none"> - Remaining detached. - Boundary breaking. - Staff splitting.
5	<p>To obtain the perspective of service users and staff on:</p> <ol style="list-style-type: none"> 1. The experience of receiving treatment. 2. The experience of delivering treatment. <p>77%</p>	<p>22 staff members; 12 male, 10 female.</p> <p>Participants consisted of a variety of disciplines</p>	<p>In-depth interviews which were transcribed and analysed adopting a thematic approach.</p>	<p><i>(Only the findings relevant to the current review will be detailed here.)</i></p> <p>Staff reported underestimating the emotional impact of the work, and described it as “relentless and draining”. Staff reported being afraid of service users. Difficulties recruiting and retaining skilled staff.</p>
6	<p>1. To explore staff experiences in two contrasting services</p> <p>79%</p>	<p>25 participants; 13 staff from a mainstream NHS medium secure units; 12 staff from a specialist PD Unit</p>	<p>Qualitative:</p> <p>In-depth interviews which were then independently analysed using grounded theory. The two separate analyses were then synthesised utilising thematic analysis.</p>	<p>Six main themes under two main headings:</p> <p>Experience of the Clinical Task</p> <ul style="list-style-type: none"> - Difficulty in achieving task integration - Motivation to build relationships, work through difficulty and bring about change - Minimal sense of risk and anxiety at the centre <p>Experience of the Organisation</p> <ul style="list-style-type: none"> - A distant and difficult relationship with outside

ID	Hypothesis/Aim	Population	Measures/Design	Findings
	Quality Score			
				<ul style="list-style-type: none"> - Preoccupation with staff relationships - Feeling unsafe
7	<p>1. To explore how counsellors experience working with borderline personality disordered (BPD) client in a primary care setting.</p> <p>2. To identify what might be needed to support or enhance counsellors' work with BPD clients.</p> <p>88%</p>	<p>5 NHS primary care counsellors with clients identified as diagnosable with BPD.</p> <p>60% female 100% white</p>	<p>Qualitative: A semi-structured interview schedule</p> <p>Interviews were analysed using Interpretative Phenomenological Analysis (IPA; Smith & Osborn, 2003)</p>	<p>Three master themes became apparent from the analysis:</p> <ul style="list-style-type: none"> - Recognition and implications. - Managing feelings of inadequacy. - Managing dilemmas in the primary care setting. <p>The counsellors' responses showed a sense of failure and that no matter what they did or how 'good' a therapist they were, it would not be enough, and that the patients would always expect more of them.</p> <p>Responses also showed an indication that the counsellors felt that their clients' extreme amount of emotional neediness resulted in their feelings of being overwhelmed or 'sucked dry'. These feelings formed a major part of the counsellors' feelings of inadequacy.</p> <p>Participants highlighted the importance of supervision and additional support and advice, and suggested that this was more vital when working with borderline clients than clients with an alternative diagnosis.</p>
8	1. To explore clinical psychologists' experiences and perceptions of clients with	16 NHS Clinical Psychologists Participants were a mixture of	Qualitative: Participants took part in a focus group.	<p>Eight themes emerged:</p> <ul style="list-style-type: none"> - Negative perceptions of the client. - Awareness of negativity. - Undesirable feelings in the psychologist.

ID	Hypothesis/Aim	Population	Measures/Design	Findings
	Quality Score			
	borderline personality disorder (BPD). 83%	trainees (n = 9) and qualified (n = 7) staff. 12 participants had direct clinical experience with the client group.	The focus groups transcripts were analysed using Interpretative phenomenological analysis (IPA; Smith, 1996).	<ul style="list-style-type: none"> - Improving our role. - Positive perceptions of the client. - Trying to make sense of the chaos. - Desirable feelings in the psychologist. - Working in contrast to the system. <p>Undesirable feelings identified included feeling overwhelmed, confused, frustrated and anxious and the participants had low feelings of self-efficacy.</p> <p>Participants appeared aware of the negative perceptions of clients with BPD, and actively try to manage them, more so than other professions.</p> <p>The findings of the study suggest that clinicians at different stages of their careers may experience and perceive patients with BPD differently; qualified staff gave fuller representative of 'desirable feelings in the psychologist' and 'positive perceptions of the client'.</p>

2.4.4 Descriptive Overview of Results

2.4.4.1 Methodology and population of studies.

The total number of participants across the eight publications was 338. This included 121 males and 217 females. The years of experience of working with individuals with PD ranged from no experience to over 10 years. The studies varied in location with six studies conducted in the UK (Crawford, Adediji, Price, & Rutter, 2010; Fortune et al., 2010; Kurtz & Jeffcote, 2011; Kurtz & Turner, 2007; Millar, Gillanders, & Saleem, 2012; Rizq, 2012;), one in the USA (Linehan, Cochran, Mar, & Levensky, 2000) and one in New Zealand (Treloar, 2009). A wide range of professions were included in the studies including psychologists (studies 3, 6, 7 & 8), primary care counsellors (study 4), mental health nurses (studies 3, 5, 7 & 8), and occupational therapists (studies 7 & 8). The sample sizes recruited for each study also showed noticeable variation, ranging from 103 (study 5) to just 5 (study 4).

2.4.4.2 Measures and demographics of studies.

All publications aimed to examine the effects of working with individuals with personality disorder (PD). The quantitative studies (studies 1 & 2) both used the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1986) to assess therapists' levels of burnout. Four of the qualitative studies (3, 4, 7 & 8) utilised semi-structured interviews to gather information and opinions from the participants regarding their engagement with individuals with PD. Study 6 conducted focus groups with participants and finally study 5 provided participants with a demographic questionnaire (including gender, primary occupation and completion of training in borderline personality disorder) with a final open comment question regarding their experiences of working with patients diagnosed with borderline personality disorder.

A variety of qualitative data analysis techniques were used in the studies reviewed. Studies 4 and 6 both used Interpretative Phenomenological Analysis (IPA; Smith, Larkin, & Flowers, 2009) to analyse their collected data. Three studies utilised a thematic framework (studies 1, 5 & 8) to identify emerging themes. Studies 3 and 7 line-coded the qualitative data gathered in accordance with the Grounded Theory method (Charmaz, 2003; Strauss & Corbin, 1998) and then underwent ‘constant comparison’ (Pidgeon & Herwood, 1996).

2.4.4.3 Themes within the literature.

A variety of themes were explored within the eight studies included in the review. Given the varied nature of these themes and the studies themselves, it is difficult to combine these to compare. This review has grouped the findings within common themes to aid understanding of the results.

Negative emotional lability.

All studies reported psychological difficulties experienced by those who work with patients with a diagnosis of PD, although the extent to which individuals experienced these difficulties varied. All studies were consistent in the suggestion that working with personality disordered individuals brings about many challenges. Most studies described high levels of emotion evoked in staff members by the patient group. In the interviews conducted by Crawford et al. (2010) a participant highlighted “the most challenging thing is the emotions that they bring out in you and how you manage those emotions and where you take them”; this was supported by 32.2% of participants meeting the MBI threshold for emotional exhaustion. Linehan et al. (2000) found that

42% of the sample met the criteria for emotional exhaustion. Kurtz and Turner (2007) identified an 'Area of Concern' as *Feeling physically safe but emotionally vulnerable*. This theme was actually related to their feelings of vulnerability regarding colleagues outside of the Unit, but was a result of their employment working with individuals with PD. It was also found that staff members had to deal with their own personal difficulties (unrelated to work) to enable them to separate a patient's problems from their own and this could be an emotional task. This was supported by Rizq (2012) who identified '*using and protecting the self*' as a subtheme and suggested that working with a PD population can lead to an influx of emotion and staff would need to be self-aware to manage this. Indeed, Fortune et al. (2010) reported participants describing their work as "relentless" and "draining" and commented that they had underestimated the emotional impact of the clinical work. Treloar (2009) speaks extensively of the uncomfortable feelings that are generated in the clinician through their work with BPD and highlights frustration and feeling overly challenged in their work as key difficulties experienced. Miller et al. (2012) also identified frustration as a result of working with clients with BPD. Moreover, prevalent in all focus groups was the experience of high levels of anxiety as a result of work with individuals with BPD. For some, the anxiety they felt conveyed a sense of danger and feelings of being at risk during intervention with clients. Feelings of anxiety were also expressed by participants included in the study by Kurtz and Jeffcote (2011) and Fortune et al. (2010) found nearly all participants reported moments when they have felt afraid of service users.

Depersonalization was highlighted in some studies. Crawford et al. (2009) found participants describing the need to maintain a level of 'humane detachment' to ensure that professional boundaries were maintained. Furthermore Rizq (2012) found

that a high source of anxiety for employees was the feeling that they had been emotionally ‘invaded’ by patients and in order to avoid this staff may depersonalize their clients. Miller et al. (2012) found that participants appeared to distance themselves from their clients and used descriptions that highlighted their ‘*them and us*’ feelings.

‘Burnout’.

Crawford et al. (2009) did not indicate that burnout was higher for professionals who worked with personality disordered individuals than those who worked in general mental health settings. Two of the studies specifically investigated the levels of burnout experienced by professionals working with individuals with PD. Crawford et al. (2009) investigated professionals working in a community-based service and found that 32% of participants met the threshold for emotional exhaustion and 14.9% for depersonalization. The researchers compared these with 12 previous studies investigating burnout among mental health workers and found that only two previous studies had lower scores for emotional exhaustion and depersonalization suggesting that working with personality disordered individuals does not necessarily increase levels of burnout among workers. These findings were supported by the work of Linehan et al. (2000) who compared therapists’ scores on the MBI-T to Maslach’s mental health employee norms and found that participants showed less emotional exhaustion and depersonalization than the normative sample. Moreover, Crawford et al. (2009) and Linehan et al. (2000) found that individuals scored higher on the Personal Accomplishment scale (indicative of low burnout levels) of the MBI than mental health professionals working with other populations.

Kurtz and Turner (2007) interviewed staff about their experiences and found that staff expressed feelings of burnout such as “it’s sad really (laughing). I’m a sad person’ and ‘it hit an all-time low to be honest erm when the atmosphere became very bad and we lost several staff members”. Rizq (2012) identified a subtheme of “feeling swamped and drained” where participants felt overwhelmed by their interactions with their clients. One described her clients as “they latch onto you and it’s like suck, suck, suck, suck,” which Rizq explains as the participant’s belief that she will be “ruthlessly exploited”. Furthermore she found that participants described the “draining and exhaustingness of it all.” Miller et al. (2012) also found high levels of feeling overwhelmed in their research and this was found across all focus groups.

Although the quantitative studies found comparatively low levels of burnout among staff when considered alongside mental health professionals working in non-PD settings, burnout was still present among staff and all other studies included in the review identified burnout when working with individuals with PD.

Personal ability and accomplishment.

Three of the studies included in the review found that working with individuals with PD impacted on the participants’ sense of personal efficacy. Participant responses in Rizq’s study (2012) indicated that they constantly had to manage their feelings of inadequacy regarding their interventions with PD patients, and they felt that any therapy they could offer would always be lacking in one capacity or another. Treloar (2009) identified one of the components of the theme ‘BPD patients generate an uncomfortable personal response in the clinicians’ as professionals feeling inadequate; participants felt insufficiently prepared to be able to deal with the problems presented by BPD patients thus resulting in limited confidence to be able to engage effectively. Miller et al. (2012)

found that all participant groups felt overwhelmed by clients with BPD and some participants expressed feelings of incompetence and powerlessness.

Professional relationships.

Four studies acknowledged an impact on professional relationships as a result of working with individuals with PD. Kurtz and Turner (2007) found that employees felt isolated from the rest of the world. Although employees identified a strong team, they felt that colleagues from other units did not understand the nature or the difficulty of their work. Specifically, one employee described being ‘alienated’ from her colleagues when working on a mental health ward. In contrast to the cohesive nature of the team, when things went wrong professional relationships were found to suffer and staff described feeling vulnerable and isolated from the rest of the team. Treloar (2009) found that team conflict regarding treatment would arise more frequently when the patient in question had BPD. Moreover, they found that staff noticed colleagues who would refuse to treat individuals with BPD, and this caused ruptures within the staff team. Rizq (2012) found that primary care workers felt as if they were a ‘last resort’ for their BPD patients. When their transfer referrals to specialist services were rejected participants felt indignant about what they believe to be a lack of responsibility by other professionals. Finally, Fortune et al. (2010) reported that the challenges of co-working between disciplines had resulted in “bitter power struggles” relating to who was to have overall control of the unit.

Support for employees regarding the impact of their work.

Five studies identified that professionals strongly expressed that they needed higher levels of support when working with individuals with PD and that they felt

without it they would not be able to cope. Crawford et al. (2010) found that staff wanted whole team supervision which enabled them to manage the high levels of emotions, especially anxiety, generated in them by the patients. Kurtz and Turner (2007) suggested that supervision should include all members of the multi-disciplinary team and would provide a space for staff to think about the impact of their clinical work. Strong evidence for the high levels of support needed when working with this population was found by Rizq (2012) who identified a subtheme of ‘you can’t wait to see your supervisor: needing support and advice’. Participants described the need for supervision as imperative and said ‘the client’s out to drive me mad really’; with beliefs such as this the need of supervision was clearly deemed a necessity to maintain work efficacy and emotional stability. Treloar (2009) suggested that supervision was the most significant method to address the uncomfortable personal responses of clinicians in contact with BPD individuals. Finally Miller et al. (2012) found that supervision was essential, especially for those with less experience, to manage the challenges of the client population. They also suggested that it would aid interventions as any negative feelings towards the client would be managed.

Positive experiences.

Although this review focussed on the negative impact of working with individuals with PD, it is prudent to note that in most qualitative studies participants were keen to highlight the benefits and positive experiences they gained from working with individuals with personality disorder. Crawford et al. (2010) and Kurtz and Turner (2007) both found that participants found their work stimulating, ‘never boring’ and a professional challenge. Miller et al. (2012) found that working with BPD clients elicited positive feelings in staff members, such as empathy, and that psychologists had

a great interest in working with the population and thus derived satisfaction from their work.

2.4.5 Limitations of the studies

Biases

The studies included in this review showed limited controls for bias. All studies required participant consent, and as a result are subject to selection bias; the views of those who declined to engage in the studies have not been captured and it is possible that they may have very different experiences to those included.

Sampling bias is also present in the studies included in the literature review. For example, participants in the study conducted by Rizq (2012) were all individuals who were recommended to the researcher. In addition, all participants in this study were professionals working for the same service; likewise, so were all participants in the studies conducted by Kurtz and Turner (2007), Millar et al., (2012), Kurtz and Jeffcote (2011) and Fortune et al. (2010). In addition, sampling bias may have skewed the results in the study conducted by Crawford et al. (2010); they collected their data in the first few operational years of the new PD services, and so it is possible that the positive results found were a result of the enthusiasm of the new staff and this subsequently suppressed their levels of burnout.

The study conducted by Treloar (2009) did not control for exposure bias. Participants consisted of clinicians who were employed across emergency medicine and mental health service settings, and it is likely that participants were exposed to patients with disorders other than BPD. With no measures in place to formally identify those with BPD, it is possible that responses given may not have been an accurate reflection of their work with patients who only have a diagnosis of BPD.

Finally, response bias may have been influential in the findings of those studies where the researcher was also well-known to the participants.

Validity

The majority of the studies focussed on the experiences of one particular service, and thus the external validity of the studies are limited as the participants all had experiences of the same clients during the same time period.

Three of the studies included in the review aimed to only investigate the experiences of individuals working with patients with Borderline Personality Disorder; consequentially the results are severely limited in their generalisability to professionals working with patients with other PD diagnoses.

Small sample size

Although the number of participants in studies varied, six of the included studies had fewer than 30 participants, thus limiting the generalisability of the results. This is especially pertinent for the study conducted by Rizq (2012); this study only explored the impacts experienced by five primary care counsellors, thus the findings may not be generalisable to other professions who work with this client group.

Methodology and analysis

Linehan et al. (2000) conducted factor analysis to ascertain if the modified MBI was valid; three factors failed to load on the same factors as Maslach's sample which could suggest that the modified instrument did not fully measure what it intended to. Moreover due to the small sample size ($n = 30$) and only a 22 scale instrument a number of concerns are raised regarding the appropriateness of this form of analysis. In

addition, the development of the MBI-C and MBI-T were not detailed adequately so the study is not repeatable and their validity and reliability were not assessed.

Crawford et al. (2010) were unable to account for the multiple factors that influence burnout and so were unable to definitively attribute the low levels of burnout to working with the PD population and not the differences in any of these other factors.

One large limitation of the study conducted by Miller et al. (2012) is that some of the participants had no experience of working with individuals with PD however their comments were not identifiable within the report. Although the paper focussed on perceptions of patients with BPD in addition to professional experiences, clearer depiction of which comments came from whom would have been beneficial to this study. This is also true for the study conducted by Treloar (2009); the researcher did not indicate which professions gave which responses. This could be pertinent as previous research has found that emergency medicine clinicians report more negative attitudes towards BPD patients than mental health professionals (Commons, Treloar, & Lewis, 2008) and so it is possible that they could have stronger negative experiences of working with BPD individuals. In addition, Treloar's (2009) data collection methodology allowed participants to provide comments of their experiences at the end of a questionnaire. As a result 30% of participants gave limited information about their experiences; a more structured qualitative data collection method may have been more effective at capturing employees' opinions.

Finally, the varying methodologies in the studies included in the review make the comparison of results challenging. In addition, studies that utilised quantitative methodologies (Crawford et al., 2009; Linehan et al., 2000) did not allow participants to give explanation for their answers. It is plausible that with this opportunity participants may have described feelings in contrast to their answers on the psychometric. In

addition, those included in the qualitative studies had the opportunity to discuss their answers and were able to express both positive and negative experiences of working with clients with PD despite the focus in interview being on the challenges of the work.

2.5 Discussion

The review findings indicate all publications found professionals who work with patients with PD are negatively impacted as a result of their work. All qualitative studies included in the review highlighted how emotionally drained professionals felt as a result of their work with individuals with PD. Furthermore, included studies identified key negative emotions of fear, anxiety, and frustration experienced as a result of engaging with individuals with PD. Fortune et al. (2010) reported that participants had not anticipated the full extent of the emotional cost of their work, and that the work was emotionally draining. These findings were supported by the qualitative results of Crawford et al. (2010) and Linehan et al. (2000) who found that many participants met criteria for emotional exhaustion, which support the notion that working with individuals with PD can have a detrimental effect on employees (Adshead, 2001).

In addition to the reported high impact on emotions, included studies also placed emphasis on the resultant low levels of self-efficacy that the professionals felt as a result of their work and the tensions within staff teams. Rizq (2012) identified a theme of ‘managing feelings of inadequacy’ as something the participants found challenging; it was reported that staff members felt “swamped” by their clients and overwhelmed by their needs which left them with feelings of high anxiety. To try and manage these feelings of anxiety, staff members would attempt to access as much support as possible

from their supervisor; this high need for supervision and support was echoed by the findings of the majority of the included studies. The implications of these findings are clear; without sufficient levels of supervision, a staff team may feel ineffective and redundant, consequentially impacting on their ability to support clients and potentially resulting in them ending their employment within a service (Lunenbergs, 2011).

However, an obvious challenge is being able to identify the correct level of supervision which will contain the anxieties of a workforce whilst allowing them autonomy to practice. These findings were consistent with previous literature which identified the emotionally draining nature of working with individuals with PD (Aiyegbusi, 2009), and the detrimental effect work of this nature can have on professionals (Grubin & Duggan, 1998).

Four studies reported on the challenges placed on professional relationships when working with individuals with PD. Participants described feeling isolated from the rest of the world and their peers external to the PD service, instead highlighting the importance of their close peer relationships (Kurtz & Turner, 2007). However, Kurtz and Jeffcote (2011) found that placing such emphasis on the importance of these peer relationships resulted in avoidance of professional conflicts and further isolation from staff in different professional groups. In addition, Fortune et al. (2010) and Treloar (2009) spoke of ruptures within teams working with individuals with PD. Included studies appear to suggest that working within individuals with PD can have a detrimental impact on an individual's professional relationships. Having poor professional relationships may inhibit an individual's ability to engage fully in supervision and other support structures which are reported to be necessary for effective working with individuals with PD. As such, poor professional relationships have the potential to severely impair an individual's capacity to work to the best of their ability.

However, the review included two studies that provided comparator statistics (Crawford et al., 2009; Linehan et al., 2000), and their results suggest that although negative professional experiences are prevalent when working with patients with PD, levels of emotional exhaustion are not higher than in professionals working with patients with other mental health diagnoses. These findings do not support the generally held notion that working with individuals with PD has a particularly detrimental effect on staff (Lavendar, 2002). Indeed, the included studies report that despite these negative impacts, levels appeared to be at a manageable level and staff appeared to gain considerable satisfaction from their work, finding higher levels of personal accomplishment than have been reported in previous surveys of staff working within general mental health settings. The included studies in the review did not give a consistent picture of how professionals were impacted by their work with individuals with personality disorder, and indicate that experiences vary widely.

2.5.1 Strengths and weaknesses of the review

When considering the methodology of the review, the strict inclusion/exclusion criteria could have resulted in some relevant studies being unintentionally excluded. Similarly, only English language studies were included in the review (due to time constraints) and this may have introduced a source of bias. Moreover, the literature presented in this review consisted only of published studies and as a result some relevant studies may not have been included.

The relatively small number of studies included had a variety of data collection methods, making direct comparisons between studies more difficult. Also, the dependence of the studies on self-report data collection techniques relies upon

participants being aware of and being able to accurately describe their experiences. In addition, participants may be reluctant to disclose any negative impacts they have experienced for fear of negative reactions in their workplace which may have introduced social desirability bias. This may have been more problematic in study 6 as the participants were colleagues and so this bias may have had a stronger impact on their responses.

The measures used in the studies were relevant to the research aims. However the reliability and validity of the measures was not always discussed and in the quantitative studies, the norms were only available in one of the articles. Furthermore qualitative analyses, such as IPA used in studies four and six are subjective and unless credibility checks are employed it is not possible to confirm that the researchers' interpretations of the participant's responses are accurate.

The majority of the studies included in the review were from the UK, which makes generalising the results easier to other populations within the UK, however it should be noted that the healthcare and criminal justice systems in other countries may differ from the UK, so experiences may differ and not apply to UK professionals in similar posts. Despite this, it is beneficial to include studies conducted in different countries as the overall sample will represent a greater range of professionals working with personality disorder.

Three of the included studies focussed on professionals' experiences of working with individuals with borderline personality disorder; although this focus provides a greater opportunity for a more in-depth understanding of the impact working with individuals with BPD has on a professional, it means that findings are less generalisable to professionals working with individuals with a different personality disorder

diagnosis. In addition, the remaining included studies did not clarify which experience was derived from which personality disorder diagnosis, and thus it is hard to ascertain the differing impacts of different PD diagnoses.

Crawford et al. (2009) compared results to professionals working with other client groups and Linehan et al. (2000) used Maslach's normative sample as a comparator. Other studies did not have a comparator and as a result it is difficult to ascertain the extent to which the difficulties experienced by staff are a result of working with individuals with PD. However as this review is only investigating the negative impacts of working with PD and not whether they are experienced to a higher or lesser extent than when working with other client populations, this need for this comparison is trivial.

An advantage of the review was that the search terms were varied and utilised a broad language base which represented the aim of the review. The databases searched ensured that a range of disciplines were included which increased the variability of the search results. The subsequent quality assessment applied to the relevant studies was designed to highlight potential biases and to measure the extent to which the methodology adhered to the study aims and the clarity of the findings. It was beneficial to have another individual quality assess 50% of the studies as this helped to increase the reliability of the assessments and ensure that the studies included in the review were of a good quality.

Despite the limitations to the review there are implications for clinical practice. Professionals working with individuals with PD need to be self-aware and able to identify the impact their work is having on them. This may reduce the levels of burnout and other psychological distress experienced and enable a good therapeutic relationship

with the client and effective intervention. The findings of the review indicate that utilising supervision is a key factor to reducing the negative impacts of working with this challenging client group.

2.6 Conclusion

It is apparent that professionals experience negative consequences when working with personality disordered individuals, however the degree to which different professionals are impacted is not clear. It is noted that negative consequences are experienced alongside positive outcomes.

Future research should continue to investigate what the impact is of working with personality disordered individuals and the factors that lead to their distress. With the Offender Personality Disorder Pathway being implemented throughout the UK, it may be beneficial for future studies to investigate the experiences of professionals working within this new strategy, to attempt to understand their experiences and subsequently ensure that they are sufficiently supported in their work with this challenging client group. It would also be useful to investigate variation in the psychological impact of working with offenders with PD across a range of specific job roles.

Rationale for Chapter 3.

The results of the literature review highlight a paucity of published research regarding the experiences of staff working with personality disordered offenders. Although reports have focussed on the experiences of the professionals, none have centred on two separate professional disciplines in a Multi-Disciplinary Team (MDT). Likewise, little is known about how staff attitudes relate to wider institutional factors including the environment and ethos of the workplace. Finally, as no studies have been conducted in secure prison establishments, the experiences of prison officers have not been captured in the literature. It is proposed that an integrative theory of institutional and emotional experience would allow for an insight as to how to enhance the experiences of professionals working with offenders with personality difficulties. Literature suggests that the impacts experienced by staff working with offenders with PD contributed to their closure (e.g., Ashworth Hospital (Blom-Cooper, 1999)). As such, insights into professional experience could reduce employee drop-out and enable the offenders to access a consistent and supportive service consequently reducing recidivism.

CHAPTER 3

Research Study

How do professionals experience working with offenders
diagnosed with Personality Disorder within a prison
environment?

3.1 Abstract

Aims: To further existing knowledge by exploring the different experiences of a Multi-Disciplinary Team professional population working with offenders diagnosed with PD. Furthermore, to produce a substantive model of one unit and stage in the new Offender Personality Disorder Pathway strategy from a staff perspective and to set a research agenda to develop ideas and their application.

Method: Fourteen participants were recruited from 'Unit A' located within a high security prison in a large UK city. Semi-structured interviews were conducted and the data collected were analysed using constructivist grounded theory. Initial interviews were rigorously coded and emergent themes were then tested during subsequent analysis.

Results: A model was constructed depicting the experiences of those working with offenders with PD, as well as factors which may have impacted upon said experiences. Main themes identified were: the prison environment; synergy of the workforce; understanding of the client; individual perceptions; support; and personal change. It was of note that, although there was enough similarity within the participants' responses to consider them to be a homogenous population, there were some noticeable differences in trends of responses evident between the two sub-groups of clinical staff (psychologists, psychiatrists, and occupational therapists) and discipline staff (senior prison officers and prison officers) as expressed in the model.

Conclusions: There is considerable interplay between factors which influence an individual's experience of working with offenders with PD. It is clear that how a member of staff experiences working with offenders with PD depends on more than just the nature of the client and the challenges they pose. Furthermore, these influencing

factors external to the client group appear to have a significant impact on the professional and their emotional experiences of their work.

3.2 Introduction

3.2.1 Problems of working with offenders with personality disorder

Those diagnosed with PD can often exhibit challenging behaviours such as aggression, self-harm and sexual aggression. Behaviours such as these have the potential to disrupt the achievement of therapeutic objectives (Howells et al., 2007). Furthermore, considering that PD is characterised by an ingrained pattern of maladaptive behaviours that damage the individual or those around them (MoJ, 2011), it is understandable that working with this client group can elicit strong emotions and opinions from those working with them. In addition, as the individuals' patterns of behaviour are enduring and have often become apparent in adolescence persisting into later life, it is difficult for these patterns to be modified, often resulting in high rates of reoffending which can often be a demoralising experience for staff (MoJ, 2011).

When faced with the polarised behaviours that individuals with PD can exhibit, practitioners can experience a range of feelings such as puzzlement, frustration, irritation, fear and of being manipulated (MoJ, 2011). These feelings, in addition to general day-to-day stresses, can result in an individual's emotional responses becoming amplified. There is now an evidence base opinion that people-centred work is a stressful form of employment and a large body of research has been conducted to investigate this (Coffey & Coleman, 2001). Atkinson (1988, p. 58) describes stress as "an excess of demands over the individual's ability to meet them". "Burnout" is often used to describe the outcome of chronic stress (Cushway et al., 1996). Burnout has been described as "a syndrome of emotional exhaustion, depersonalisation, and reduced personal accomplishment that occurs among individuals who do 'people work;' of some kind" (Maslach & Jackson, 1997, p. 192). Emotional exhaustion has been explained as a feeling of being emotionally fatigued and drained by one's work, whilst

depersonalisation refers to the development of cold, negative attitudes towards service users (Maslach & Jackson, 1997). Reduced personal accomplishment refers to a propensity to negatively evaluate oneself, particularly in reference to one's work with clients. Linehan et al. (2000) suggest that providers of psychotherapy services are likely to experience burnout as a result of treating "difficult" clients. If an individual has negative attitudes towards their clients or is emotionally exhausted, it is likely that this will impact on the quality of care they are able to provide.

Another psychological phenomenon that can have an impact on a workforce (and subsequently the quality of care offenders with PD received) is counter-transference. The term counter-transference refers to the range of emotions, reactions, and responses that a therapist has towards their client (SAMHSA, 2000). McIntyre and Schwartz (1998) found that individuals with Borderline PD were perceived by psychotherapists to be dominant and hostile. Furthermore, strong reactions that professionals can have to offenders with PD can leave them feeling helpless, intimidated, or "pinned against the ropes" (Evans, 2011). In these situations, professionals were found to either act out in response to patient provocations or distance themselves for fear of acting out. Individuals with PD can become vigilant for interpersonal signals that 'confirm' their beliefs of how others treat them and so may provoke reactions from staff members; if an employee is unable to manage any counter-transference and subsequently mistreats the offender this can have a significant impact on therapy.

3.2.2 Why do we need specialist units?

The needs of offenders with PD are identified in terms of individual dysfunction (Howells et al., 2007). Livesley (2003, 2007) identified this dysfunction as an individual's impairment of their organisational, integrative and self-regulatory processes that are required to meet the basic evolutionary tasks of: 1) stability of the self system, 2) reasonable interpersonal functioning, and 3) social integration in the form of pro-social behaviour. In short, an individual may have a personality which may be highly abnormal when compared to societal norms, however it may not be dysfunctional in that the individual is still able to meet their basic evolutionary needs. It is these three needs that are the focus of treatment for PD.

Offenders diagnosed with PD have highly complex psychological needs that present challenges in terms of management, treatment, and maintaining a safe working environment for staff. Haddock et al. (2001) found that the majority (88%) of psychiatrists interviewed in their study felt that this client group's needs could not be met using the current workforce, indicating that a new, specially trained workforce was required to successfully treat this complex client group. They suggested that the needs of individuals with PD are different from those of a population diagnosed with mental illness, and so should be managed in separate units. Due to the diversity of the dysfunction that an individual with PD can present, it is not unreasonable to assume that any workforce that is to care for and support this client group will need specialist training. The training received by those who work within a general prison population and those who work with offenders with mental illness may not prepare staff for the challenges that they are to face when working with offenders with PD. The reluctance of psychiatrists to work with offenders with a diagnosis of PD (only 20% of participants in Haddock et al.'s study would work in a new specialist service for offenders with PD)

perhaps highlights the complexities of the challenges that are associated with this client group and further support the need for specialist intervention and training for staff (Lewis & Appleby, 1988). Further support for the specialist nature of staff recruited to support and care for offenders with PD comes from a Research Summary completed by the Ministry of Justice (2011). The summary highlighted the value of recruiting a workforce with relevant qualifications but also those who have interpersonal qualities that enable them to relate, interact and engage effectively with the offenders. It also highlighted the importance of good communication within staff teams and emphasised the importance of good multi-disciplinary working. Indeed, Crawford et al. (2007) deemed that personal qualities of staff were more important than professional qualifications when working with offenders with PD. They identified high emotional maturity, high personal resilience, and the ability to accept one's own limitations as high priority personal characteristics required by potential staff members. Moran et al. (2008) found that professional qualifications provided little prediction for suitability for posts, and highlighted personal qualities such as having clear boundaries and the ability to communicate well with the client population as more important. The precedence given to personal characteristics over professional qualifications perhaps highlights the different nature of working with individuals with PD than those with other diagnoses.

3.2.3 Previous specialist provisions

In 1999, the government announced its proposal to introduce the Dangerous and Severe Personality Disorder (DSPD) pilot programme (Feeney, 2003). It is thought that this was a direct response to the conviction of Michael Stone, an individual diagnosed with PD, for the murder of a mother and her child in 1998. Although diagnosed with

PD, psychiatrists responsible for his care did not consider the disorder treatable and so did not detain him under the Mental Health Act 1983 (Howells et al., 2007). To enhance the protection of the public, the DSPD pilot introduced a new legislative framework which they hoped would account for previous faults. DSPD units were opened in four high secure units (Broadmoor and Rampton high-secure hospitals, and Frankland and Whitemoor high-secure prison establishments) to try to focus intervention on this previously neglected client group. After just over a decade the DSPD units eventually closed. Much research has been conducted into the effectiveness of the scheme and the successes and failures have been discussed throughout the literature (Duggan, 2011; Scally, 2012; Tyrer et al., 2010). The successes include investment in a neglected population, development of treatment and research into PD (Tyrer et al., 2010). However, a number of 'failures' were highlighted, including the huge expense of the pilot. Up to 2010 the total cost recorded was over £400 million and there was little research to evidence if the substantial funding was sagacious in terms of improvements in outcomes. Furthermore, it was deemed that there was an inadequate knowledge of treatment as there was no satisfactory evidence base from which to recommend treatment for individuals with DSPD. Tyrer et al. (2010) concluded that although great strides had been made in the focus on individuals with PD, future interventions needed to focus on individuals who were motivated to engage in treatment and determined to overcome their propensity to engage in anti-social behaviour and offend.

3.2.4 Current specialist provision

Subsequent to the closure of the DSPD units, the Department of Health and National Offender Management Service (NOMS) developed the next phase of strategic development for the management of offenders with PD, namely the Offender Personality Disorder Pathway (OPDP). The strategy was developed from principles derived from research and practice evidence, the learning from the DSPD pilots and the guidance from the National Institute for Clinical Excellence (NICE, 2009a, 2009b).

The pathway has a number of aims: to improve early identification and case formulation for those with PD; to improve risk assessment and case management when offenders are in the community; to provide new intervention and treatment services in secure category B and C establishments and community settings; to improve high secure prison treatment units and Therapeutic Communities (TCs); to introduce new progression environments in prisons and Approved Premises for those who have already completed treatment where they can be provided with support whilst being monitored and tested to encourage safer community management; and to develop the skills of the workforce by providing them with the necessary skills and attitudes to work with this group of high-risk offenders (Joseph & Benefield, 2012).

A key feature of the pathway is to provide a consistent and cohesive process of offenders transitioning through a range of different criminal justice and perhaps health interventions from custody to the community. Figure 3 illustrates the five principle stages of the pathway.

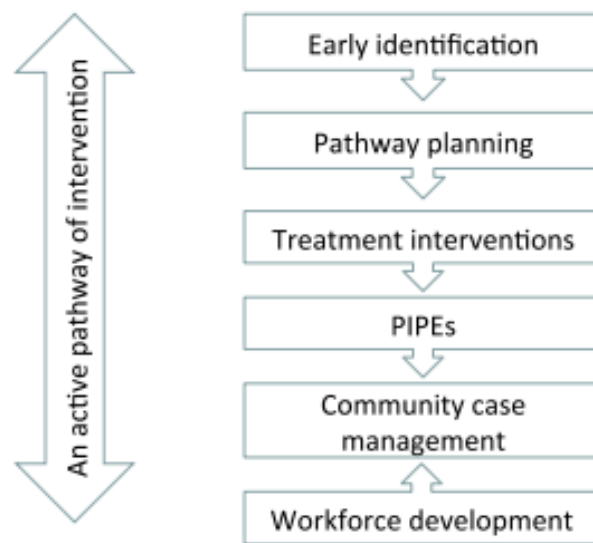


Figure 3. The personality disorder pathway.

Early identification

Offenders who may benefit from accessing the pathway are identified post-sentence to ensure that they meet the criteria to engage with the pathway and to enhance the amount of time the individual will have to utilise the expertise and support offered.

Pathway planning

Following on from the early identification stage, the pathway planning strategy builds upon this to focus on case consultation and formulation and also the development of the workforce to increase the aptitude and confidence of staff. The consultation aspect of the strategy can be to answer a request for assistance or it can be achieved through collaborative meetings focussing on a specific offender. The formulation is provided to aid the planning of an offender's transition through the pathway. Although the formulation does not take a specific form, it has a number of functions: 1) to identify an offenders criminogenic needs, 2) to develop a narrative of the offender's life which combines their personality development and offending behaviour, 3) to identify the

perpetuating factors and motivations that underlie the offending behaviour, 4) to identify the needs of the offender and to develop a comprehensive desistance plan that can meet these needs and inhibit offending behaviour, 5) to suggest and implement recommendations for future treatment and support. The case formulation is a dynamic process and is constantly modified to include developments and progress made.

Treatment interventions

Following on from the findings of Tyrer et al. (2010), motivation and willingness to engage in the pathway are imperative to an offender's engagement in interventions. Individuals will have access to accredited offending behaviour programmes, high-secure prison units, NHS provided secure services, new prison-based specialist PD services in category B and C prisons and community-based treatment services (including offender management).

Psychologically Informed Planned Environments (PIPEs)

Staff members are provided with additional training to enable them to deliver a treatment package based on psychological principles on a day-to-day basis. The intention is that staff members will be able to better understand their interactions with offenders to enhance the offenders' experiences of a safe and facilitating environment that supports them to consolidate and maintain the progress they made in the previous stage of the pathway. This specific environment will also allow for the offenders to be tested in a contained environment to assess whether behavioural changes have been maintained. PIPEs are available in prison wings, Approved Premises, and secure hospital wards.

Recent qualitative research conducted by Turley, Payne and Webster, (2013) suggests that PIPEs lead to positive outcomes in a variety of areas, such as more pro-social behaviour exhibited by offenders, and improvements in relationships with both staff and peers. However as their research was conducted soon after the introduction of PIPEs, their suggestions are tentative. Further research is needed into this and other stages of the pathway strategy to investigate effectiveness.

Community Case Management

A new development from the DSPD pilot is the inclusion of community services to support individuals to help them maintain their behavioural changes upon release. Furthermore, case management is strengthened to appropriately manage any ongoing risks. Again a focus is placed upon workforce development as individual Offender Managers will be identified to undergo enhanced training in order for them to become PD specialists with a smaller caseload to enable them to work with those with the most complex needs (Joseph & Benefield, 2012).

Workforce Development

The Offender Personality Disorder Pathway (OPDP) aims to provide staff with the skills and competencies required to effectively communicate and interact with offenders with PD. Developing the skills of the professionals working within the Pathway underpins the strategy and is achieved through training designed to change attitudes towards PD, and develop the skills and confidence of those working with individuals with complex needs. A workforce with enhanced knowledge about working with this complex client group will better be able to manage the intricacies and challenges that are experienced as a result (Joseph & Benefield, 2012).

3.2.5 Prison as a therapeutic environment

Many offenders may have ‘treatment’ mandated as part of their sentence plan; in essence, they are coerced into engaging in therapeutic interventions. It could be argued that therapeutic change will be unlikely to happen in an environment where an individual is forced to engage, however Howells and Day (2003) found that this coercion did not inform an offender’s readiness to change or treatment outcomes.

However, aspects of the prison environment that could limit the effectiveness of therapeutic interventions have been identified. Investigations into the experiences of offenders residing in prisons identify a range of concerns regarding their personal circumstances. Prisoners have reported feelings of powerlessness, the extreme controls over their behaviour, and fear for their personal safety (Toch & Adams, 2002). Living in an environment which is perceived as unsafe or disempowering is likely to have a significant impact on an individual’s ability to meaningfully engage in treatment (Davies, 2004). It is unlikely that an offender will be able to concentrate on the intensity and complexities of a therapeutic intervention if they are in constant fear of harm. Furthermore, the provision of therapy is not typically considered a primary aim for prisons (Day et al., 2010), and there is a considerable gap between the correctional policy of prison institutions and their rehabilitative practice (Day et al., 2011). The ultimate function of a prison is the protection of the public by securely controlling the movement of its prisoners. Prisoners are frequently over-exposed to the punitive nature of prison establishments without experiencing the therapeutic aspects of rehabilitation (Benson, 2003).

3.2.6 ‘Unit A’

‘Unit A’ considered in this study is a service located in a high security prison in a large UK city and is part of a new partnership working model within the city. ‘Unit A’ is part of the Offender Personality Disorder Pathway and partnership working occurs between it and various mental health trusts. ‘Unit A’ is a service for men with personality difficulties and histories of violence who are ‘stuck’ in their sentences or at risk of future offending upon release. All men should have a realistic prospect of a progressive move within two years. ‘Unit A’ utilises its own prison staff, who have volunteered for the role and have received specialist training. Officers and clinical staff work in collaboration to build relationships with prisoners and develop an understanding of the offenders’ strengths, difficulties, and progression needs. Fortnightly ‘keywork’ sessions are central to the work undertaken on ‘Unit A’. A key work team of a prison officer and a psychologist work closely with the offenders to develop a collaborative formulation of offending, and a robust desistance plan. In addition, courses are provided to assist prisoners to progress through their sentence and prepare for life in the community. More recently, individual psychological sessions have been introduced to ‘Unit A’. ‘Unit A’ is integrated into the wider prison and most men who are resident go to work and access other available courses from the wider prison. The unit has close links with the community, including probation, health services and third sector charities and agencies.

3.2.7 The Research Project

With an ever-growing focus being placed upon the treatment and management of offenders diagnosed with PD (alongside the growing population of offenders

identified with personality difficulties, and the introduction of increased provisions including a new strategic movement for the treatment of such individuals), it is clear that analysis of the effectiveness of this strategy is essential. Furthermore, when considering the significance the strategy places upon having a competent workforce (i.e., one that is knowledgeable and highly skilled thus enabling them to conduct interventions and support behaviour changes in offenders) identifying areas for development is essential.

Taking the above into consideration, this research aims to further existing knowledge by exploring the different experiences of a multi-disciplinary professional population working on a specialist progressive unit for those with personality difficulties housed in a prison setting. Furthermore, it aims to identify how different individuals may experience 'Unit A' when compared to their colleagues. It is hoped that the research will provide valuable information about the difficulties and positive experiences of those working with offenders with PD. Subsequent to this, the results of the study may inform the development and maintenance of subsequent PD units and identify strategies to aid staff support and retention in these units whilst maintaining high standards of care for prisoners. The ultimate intentions of the study are to provide a substantive model of one unit and stage in the new OPDP strategy from a staff perspective, to set a research agenda, and to develop ideas as to how the findings can be applied to practice.

Expected Benefits of the Research

The research can be viewed as a crucial addition to the evidence base and, as such, may aid in developing a portfolio of ideas about what professionals experience

when working with offenders with personality difficulties. It is hoped that this study will inform future research to develop specific training packages and support structures to aid staff in the wider offender manager personality disorder strategy. Being able to secure a trained, motivated and engaging staff team will, in turn, potentially enable the successful treatment and reduction in risk of those with personality difficulties who are cared for under the PD pathways strategy. Individual participants in this study will also have the opportunity to express their opinions about working on 'Unit A' and have those opinions listened to and considered by the researcher and the wider population after publication.

3.3 Method

3.3.1 Sample

Participants were recruited from 'Unit A' located in a high security prison in the UK. Participants were members of the multi-disciplinary team which consisted of Prison Officers, Senior Prison Officers, an Occupational Therapist, an Assistant Psychologist, Clinical Psychologists, Forensic Psychologists, and a Psychiatrist. Participants were required to have worked with the population for a period of at least three months; this was to try and ensure that participants had enough experience to be able to reflect on their work and to limit the influence of initial enthusiasm of professionals employed in a new pilot scheme.

The research aimed to collect as many participants as possible until saturation of data is reached. Morse (1995, p. 147) observed that "saturation is the key to excellent qualitative work" but noted that "there are no published guidelines or tests of adequacy

for estimating the sample size required to reach saturation.” In the current study, fourteen participants were recruited and interviewed (See Table 4). Nine were female (aged between 20 – 50+) and 5 were male (aged between 20 – 50+). The potential number of participants available for inclusion in the study was 18, as such, the participants interviewed represented 78% of the total participant population and all job roles within the MDT.

Table 4

Study participants

Population	Job Role	Number	Total
Discipline Staff (DS)	Senior Prison Officer	2	7
	Prison Officer	5	
Clinical Staff (CS)	Occupational Therapist	1	7
	Assistant Psychologist	1	
	Forensic Psychologist	3	
	Clinical Psychologist	1	
	Psychiatrist	1	
Overall Total			14

3.3.2 Design & Procedure

Stage 1: Recruitment and Consent

Participants were initially informed of the research at their weekly team meetings. The research and their role as potential participants was outlined and explained and the opportunity to ask questions was provided. Subsequent to this, prospective participants were provided with an information sheet and informed to approach the investigator if they would like to participate.

Interested participants were invited to attend an individual meeting where a verbal description of the research was given and another opportunity to ask questions was provided. Subsequent to this meeting, participants were given 24 hours to consider if they would like to participate. Those who chose to participate in the study were asked to sign and date a consent form (see Appendix 4) and subsequently to complete a questionnaire and attend the interview.

Stage 2: Data Collection

Once consent was obtained, participants were asked to complete a questionnaire (see Appendix 5), the results of this questionnaire were linked to the participants' pseudonym so that responses given in the interview can be analysed alongside their questionnaire responses.

Participants then took part in a semi-structured interview (see Figure 4). Participants were interviewed once in a private interview room located near 'Unit A'. Interviews were audio recorded and then later transcribed by the researcher.

Interview Schedule

Interviews were conducted utilising a semi-structured approach which encouraged a narrative response. Open ended questions were used to facilitate staff to speak expressively about their experiences on 'Unit A', and prompt questions were guided by the responses given. The interview schedule (see Figure 4) provided a guide to the topics being covered in the interview, brought about by the sensitising concepts (mentioned below), whilst allowing participants to freely respond to questions in whichever way they felt most appropriate.

By following an emergent approach which was guided by the principles of grounded theory, the open approach to the interview allowed the researcher to be guided by the responses of the participants, rather than imposing their ideas upon the participants and subsequent data being collected (Glaser & Stauss, 1967).

- 1) Why did you choose to work on the Unit? Motivations?
- 2) Tell me about a typical week working on the Unit
- 3) What is your strongest memory of working on the Unit?
- 4) What emotions do you feel you experience most when working on the Unit?
- 5) What is different about working on the Unit than on other spurs?
- 6) In general how do you feel about working with this client group?
- 7) Is there anything that could help you to enjoy your position here more?
- 8) Are there any challenges related to working on this unit?
Only to be asked if no challenges have been raised.
- 9) Is there anything else you would like to tell me about working here that I haven't asked you about?

Figure 4: Final interview schedule

Debrief

Participants were informed in the information sheet that if they found recalling details of working on 'Unit A' distressing, they had the opportunity to have a debrief session facilitated by a Forensic Psychologist employed by NOMS. Participants were

provided with details of Occupational Health and the Psychologist so that they were able to arrange a meeting if they felt the need for extra support. Participants were given the opportunity to receive a summary of the findings once the research has been completed. They were also provided with a contact (University) email address, in case they had any questions regarding the research.

3.3.2.1 Sampling.

A mixture of purposive and theoretical sampling was used in this study to best recruit participants. Purposive sampling has the benefit of strategically identifying participants that are most relevant to answering the research questions being posed (Bryman, 2008). Using a purposive sampling method participants were chosen based upon their job title to gain a broad variation in experience. Subsequent to this considerations were made for gender, age, and time in post. After data collection had begun, theoretical sampling was used to explore properties of emergent conceptual categories. Theoretical sampling is a key principle in grounded theory, however utilising purposive sampling in the early stages of data collection can enhance the discovery of emerging themes and offer direction for further sampling (Coyne, 1997).

3.3.3 Ethical Considerations and Reflections

3.3.3.1 Ethical approval.

Ethical approval was sought and granted from the University of Birmingham Science, Technology, Engineering and Mathematics Ethical Review Committee on June

1st 2015 (see Appendix 6). The study received NHS Research and Development approval on July 31st 2015 and NOMS and ethical approval on 16th September 2015.

3.3.3.2 Confidentiality.

All participants were allocated a unique identification (ID) number which was used instead of their name on all collected data. Use of ID numbers was deemed necessary if data provided by the participant needed to be identified in the case of their withdrawal or their loss of capacity to consent to participate in the study. The research database is held in line with the Data Protection Act 1998. The database that was created for this research was both confidential and anonymous. All information was stored on the investigators personal, password protected laptop computer. All audio files were encrypted and saved onto the same laptop computer after each interview. Only the main researcher had access to these files. Participants will be made fully aware of the above prior to their engagement in the study.

Regarding the individual interviews, participants were informed prior to gaining consent and again at the beginning of each interview, that information discussed in interview was confidential *unless* information is divulged regarding malpractice. It was explained that if such information is revealed, only the necessary professionals will be informed so that the situation can be managed appropriately. Participants were also informed that they were given a pseudonym and that quotes may be attributed to that pseudonym in the research report.

3.3.4 Personal Reflections of the Study Process

Prior to the commencement of a grounded theory research study, the researcher needs to recognise and be aware of their assumptions to what their view is of 'reality' and how this 'reality' impacts their ability to perform as an objective researcher. It is through supervision and my utilisation of it as an iterative, reflective process that I have been able to manage my own perspectives to reduce the impact of potential researcher bias.

The key factor that I think influenced this research study was my dual role as a researcher and also as a student previously on placement in the unit where the study took place. I had worked with my participants for the previous ten months, and had come to know each participant on a professional and personal level. I believe this had both positive and negative impacts on the research study. One positive aspect was that participants were perhaps more willing to engage in the study as they felt comfortable in my presence; I noticed this especially with one participant whom I had assumed would not be willing to participate, however did in fact choose to engage. I feel that my previous role on 'Unit A' and my established relationships enabled me to get a perspective that would have eluded an 'outsider', which is considered a strength of this research. There were however drawbacks to my dual role; for example, one officer with whom I had a challenging relationship during my time as a student chose not to participate in the study, and I believe that this was a result of our difficult relationship rather than a disinterest in the study.

In addition, my previous role on 'Unit A' had been as a Trainee Psychologist, and so I was anxious that some officers would view me with a certain sense of distrust and would be concerned that I wouldn't keep what they said in interview confidential

and might share information with my previous clinician colleagues. I also wondered how able they would be to speak freely about any difficulties they had found working on the unit that might relate to co-working with clinicians. In interview, I did not find this to be the case and all participants appeared able to speak with me openly and honestly. In fact, I was struck with how honest participants were in interview, and talked about their personal feelings and emotions in relation to their work on 'Unit A'. I was also taken aback by some of the comments made by the discipline staff; in interview they described strong emotions about the welfare of the men, engaging in their own individual learning, and feeling unsupported by the clinical team, and this was in contrast to some of the presentations I had seen on the unit. Officers were usually the quicker of the two groups to encourage deselections (removal of prisoners from 'Unit A') which could be interpreted as feeling less empathic towards the men. The proactive nature of engaging in personal learning in their own time came as a surprise to me as monthly training sessions were offered by the clinical staff, but discipline staff attendance was frequently low.

I had also had concerns that participants might hold some reservations about engaging openly in interview, due to fears regarding being identifiable in the study write up. After reading the consent form, many of the discipline staff confirmed that they would not be named in the study report and asked how this would be achieved. I wonder if this relates to the systemic pressures from the wider prison, and fear of losing their job if they spoke negatively about the establishment.

3.3.5 Data Analysis

3.3.5.1 Introduction to grounded theory.

The data were transcribed and subject to grounded theory analysis (Strauss & Corbin, 1998). The main aim of grounded theory is to develop a theory or model from participants' own experiences in areas where there is little guidance or existing theory. Generally, there are three forms of grounded theory, namely objectivist, post-positivist, and constructivist (Charmaz, 2011).

Constructivist Grounded Theory.

Constructivist grounded theory was proffered by Charmaz (2011) as an integrated alternative to the previously mentioned forms of grounded theory. Charmaz (2011) states, "constructivist grounded theory views knowledge as located in time, space and situation and takes into account the researcher's construction of the emerging concepts" (Charmaz, 2011, p. 365). Constructivist grounded theory acknowledges the interactions between the researcher, participants, data, and prior knowledge as influencing the processes of data collection, analyses, and also the presentation of findings. In short, theories and findings are considered to be mutually constructed via the researcher's knowledge, perspective, and understanding, as well as from those of the participants and what is learnt from their narratives. Furthermore, researchers must be aware of their own philosophical and disciplinary position and be sure to communicate this with transparency to their audience (Charmaz, 2011). It is argued that although researchers may endeavour to be objective, this can never be fully achieved. It is thought that the researcher is encouraged to take an open, curious approach to data collection and be guided by the responses of the participants, they are simultaneously guided and influenced by their prior knowledge, theoretical frameworks and previous

literature in which their research is embedded. A constructivist grounded theory approach was considered best suited to this research study as it allows for data to be considered in relation to literature surrounding personality disorder and professional burnout and low self-efficacy, whilst remaining open to new ideas and theory regarding the experiences of different members of the MDT.

3.3.5.2 Grounded theory procedure.

The data was analysed using the suggested coding paradigms of Strauss and Corbin (1998). The coding was conducted by the author who is trained in grounded theory techniques. The author was supported by a Professor and Doctor of Psychology who are both also familiar with grounded theory. The first stage of analysis is termed *open coding* and is defined as the breaking down, naming, comparing, and categorising of data (Strauss & Corbin, 1990). In order to remain sensitive to the data and ensure data was not prematurely over-generalised, Charmaz's (1995) suggestion of line-by-line coding was incorporated into the open coding of the transcripts. For the purpose of this study, all sentences or statements were considered to be a 'line'. Incomplete sentences or utterances were disregarded from the analyses. These individual line codes were then abstracted into more general meaning units by assigning a descriptive label that represents the meaning behind the line code. These general meaning units were then allocated to a second stage analysis which was category based on their conceptual meaning derived from the inferences obtained from the general meaning unit. Grounded theory involves a continual process of constant comparison between the emerging categories and themes, and there is a process of reconceptualising categories throughout analysis; new data analysed is compared with existing data and categories

are added or refined accordingly. Four interviews were conducted and transcribed and subject to the coding process outlined above. Emergent codes were discussed with the main research supervisor who corroborated their use as initial codes. The semi-structured interview was then slightly amended in line with emerging themes to test their relevance. Subsequent to the second stage coding, links were made with other categories based on similarities in the context within which the code is embedded and the causal conditions that give rise to it; this is commonly known as *axial coding*. The resultant product is a number of major over-arching categories and subcategories are developed to give contextual meaning where relevant. This stage is particularly analytical and requires the researcher to interpret participants' narratives to gain an understanding of the phenomena being investigated (Strauss & Corbin, 1998). Once again, codes were discussed with the research supervisors and the researcher reflected upon their emergence and the analytical process.

3.3.5.3 Sensitising concepts.

Sensitising concepts was introduced by Blumer (1954), who posed that a sensitising concept “gives the user a general sense of reference and guidance in approaching empirical instances” (p. 7) and Charmaz (2003) referred to sensitising concepts as “those background ideas that inform the overall research problem” (p. 259). The sensitising concepts grounding the context of the study include the context and positioning of the researcher, the systematic literature review, the location of the study, and the experiences of the researcher working in that location.

3.4 Results

The primary aim of the research was the development of a preliminary descriptive model of the experiences of professionals working with offenders with personality disorder in this setting by identifying the key contextual, environmental, and affective components that impacted an individual's experiences.

From engaging in, listening to, transcribing, reading, and re-reading the interviews and subsequent transcripts, it became apparent that staff experiences of offenders with personality disorder are impacted by six main themes, see Table 5. These influences and interactions occur on a continuum and the variety of interplay between the factors that influence a professional's overall experience of working with the client group in question. Links/interplay between identified themes are represented in a model (see Figure 5, page 96).

It is of note that all of the interviews yielded emotional responses from the participants, and as a result each theme will have a subcategory of emotion within it. It is thought that these emotional reactions are both an experience in themselves, but also an influencing factor on the experience of a professional working with offenders with personality disorder.

Table 5

Summary of Themes and Subthemes

<u>Theme</u>	<u>Subtheme</u>
1 The prison environment	1.1 The restrictive nature of the prison
	1.2 The hierarchical employee structure of the prison
	1.3 The unsupportive nature of the wider prison
2 Synergy of the workforce	2.1 The philosophy of the model and their own

		motivations with regards to working on the unit
	2.2	The novelty of co-working between two embedded organisations
3	Understanding of the client	3.1 Impact of client knowledge
		3.2 Required skills
		3.3 Training
4	Individual perceptions	4.1 Perceptions of client group
		4.2 Attitude to work
5	Support	5.1 Supervision
		5.2 Peer support
6	Personal change	6.1 Psychological growth
		6.2 Professional development

Theme 1: Prison Environment

During interviews, the participants frequently described the prison environment and the bearing it had on them being able to do their job well. This theme has therefore been further divided into three sub-themes for ease of exploration and understanding as outlined in table 5.

1.1) The restrictive nature of the prison.

Throughout interviews, both discipline and clinical staff would refer to the restrictive nature of the high security prison and how it impeded their ability to uphold the premise of the unit whilst working with the client group. One principle of the unit is to rehabilitate prisoners through the utilisation of a variety of psychosocial interventions; however these methods were in conflict with the high levels of security in the establishment. Participants would describe feeling as though they were unable to try anything new that wasn't in-keeping with the general ethos of the prison, "There was so

much resistance to anything.....[the prison] is not somewhere that embraces change” (CS 4).

Indeed, the emotions that were felt as a result of the restrictive nature and the impact it had on processes within ‘Unit A’ were described by many participants, “The rigmarole of everything’s gotta go through security, even the tiniest thing has gotta go through security, and security – because there isn’t a security department anymore – it was obviously slowing it up. Frustration more than anything” (DS 1).

Participants also spoke about the restrictive environment impacting on the ability for prisoners to build relationships with external agencies in the community, “....so that's frustrating. Also, trying to do some of the things in a Cat A prison is difficult, so having some external people come in, that’s quite difficult” (CS 5).

The restrictive nature of the environment, and the lack of explanation that was given about decisions, was clearly outlined by one participant who described their lasting memory from working on the unit, “Standout negative would just be the constant no.....and it’s having no rationale to say no to things” (CS 4).

1.2) The hierarchical nature of the environment.

Participants were concerned about the hierarchical structure of the prison environment and the impact it had upon their ability to do their jobs. Participants spoke about the rigid employee structure in the prison system and the systemic importance of ensuring one does not step out of rank. Participants felt that the strong hierarchy presence in the prison system sometimes resulted in a loss of focus on the unit and instead a focus on adherence to hierarchy, for example, a member of clinical staff

commented “I think sometimes we get lost in the yes sir, no sirs, protecting egos and saluting to rank, when actually it’s not what this is about.” (CS 2).

An example of this was given by a discipline staff member participant who commented about officers being unable to utilise their problem solving skills due to the constraints placed upon them, “Issues (they) aren’t allowed to solve because of ‘rank structure’ and all that”. (DS 6)

Participants from the clinical team also spoke about the impact the strong hierarchical nature of the prison had on their ability to be recognised as a professional within the MDT. They felt that their professional structure was more flattened and so people were less influenced by someone’s position in the team, but this was not transferable to their work on the unit, “Wanting to have gravitas, and wanting to be able to make an impact on the team is quite a challenge because people don’t know where to position you within the [prison] hierarchy, and so that’s quite hard”. (CS 5)

Clinicians also felt the hierarchical nature of the prison impacted on team dynamics and they felt that lower grades of clinical staff were undervalued by discipline staff and their views were viewed as insignificant because their role did not fit into the rigid hierarchical nature of the prison environment. They wanted a more flexible system where employees of different grades were able to participate in discussions freely. It was felt that clinical staff would have more opportunity to be respected as a professional if the prison system operated on a more flattened hierarchy and they felt they would be able to engage more, “[In a flattened hierarchy] I think there’s less opportunity to be shut down”. (CS 2)

1.3) The unsupportive nature of the wider prison.

Many of the participants who were interviewed expressed concerns regarding the lack of understanding of the wider prison external to 'Unit A'. They felt the external discipline staff didn't understand the ethos of the Unit, thought officers were "care bears" for the offenders, and failed to appreciate the complexities of their job role. These external views impacted their ability to work effectively, complete outreach work, recruit staff, and negatively affected their emotional wellbeing. The lack of understanding of the model by other staff in the prison meant that the wider prison did not fully comprehend the intense nature of the work resulting in some officers experiencing high levels of pressure, "I couldn't get off, I weren't allowed to leave!.....You can't say you're stressed because stressed is a bad word in prison. They can sack you for saying you're stressed because you then can't cope with what you do." (DS 4).

Participants also spoke about the conflict found between 'Unit A' and the wider prison. A number of them mentioned the wider prison's view of the unit, "People said I was mad to apply for it. All very 'fluffy', and this, that, and the other" (DS 7). They described how this impacted the ability to recruit new staff, "No one wants to come over here anyway" (DS 6).

Participants also mentioned the difficulties the unit staff had integrating into the rest of the prison. When considering the lack of support from the wider prison, one participant commented on the external psychology department, "They've been less supportive than they could have been and they've been quite territorial....and we think we're offering additional help. Whether they feel encroached upon or threatened or whatever, that's been tricky" (CS 7).

Some participants wondered if the unsupportive nature of the wider prison had resulted in the closure of the unit, “I think [the lack of support from the wider prison] meant the review of the unit...was triggered earlier, and we had less time to plan what we wanted to do with the unit” (CS 5).

This theme and subthemes highlight the importance of the environment on a professional’s experience of their work with offenders with PD. Feeling restricted by the levels of security within the establishment, the rigid job roles, and how able one is to access support from colleagues external to the unit severely impacted the professionals working on ‘Unit A’. From this it is possible to infer that participants felt that the high security establishment within which ‘Unit A’ was housed, was not the correct placement for the unit, and it hindered them from being able to complete their work and support the offenders to the best of their ability.

Theme 2: Synergy of the workforce

The participants frequently spoke about the innovative nature of ‘Unit A’ and the difference in structure between it, and the rest of the prison. Participants’ views of the effectiveness of the workforce was generally positive albeit with some expressed challenges. It was clear that the effectiveness of the workforce, and how each participant understood their place within the MDT influenced the way they experienced their work in general. This theme has been further divided into three sub-themes (see Table 5).

2.1) The philosophy of the model and their own motivations with regards to working in the unit.

‘Unit A’s philosophy was considered different from the wider establishment ethos and many of those interviewed who had previously held a discipline role highlighted the desire for a change as a motivation for working on the Unit. There appeared to be a sense of despondency about the nature of the wider prison system and the implication that a new method of working with prisoners was needed to affect change:

You deal with mental health issues all the time in prison, but you are not given sufficient training in order to help them in the correct way. And sometimes the prison environment isn’t the most conducive environment for people with personality disorders to be in, because they’re very much neglected. So it’s a learning experience – broadening your own experience working with different people, the right way. (DS 4).

Their positivity about the philosophy of the model was further shown through their thoughts about the model being rolled out across the wider establishment, “I think the way we work is better; I think the whole prison should be like that.” (DS 3)

The difference in ethos provided by ‘Unit A’ appeared to be a motivating factor for applying for the role, “It’s more intense, more interesting, so that was the main factor I suppose, just the nature of it.” (DS 2).

However officers felt the competing ethos of the prison service and the NHS made their role more challenging. Specifically relating to facilitating courses, the inconsistencies with regards to the rota made them more of a challenge:

Well you was coming in and out and they'd be talking about stuff that they were talking about in the last session and you wasn't in it so of course you missed it and you lose track of it sometimes. (DS 6)

All participants felt that the main principles of the unit were a positive way of working with offenders with personality disorder. One of the main principles of the model is providing the offender with a 'key work' team, who will be his primary source of support whilst on the unit. A key work team will work closely and collaboratively with an individual to construct a robust recidivism plan. One participant commented:

You actually know what help they do need. You can actually find out – rather than say, 'right you've got to go to education, you've gotta do this', you can actually find out what help they do need to help them progress to go out. (DS 5)

It was also highlighted how offenders with PD are often forgotten about, or stuck, and that 'Unit A' filled a gap in current provisions:

The idea of a progression unit addressed the problem that we've had for years, which was that prisoners were being released at the end of their sentences from very distant prisons, without good relationships, with their probation officers without often having the opportunity to do any work on their PD, and it just made a lot of sense the model for the unit. (CS 7).

However discipline staff noted the challenges raised by working with offenders with PD in a therapeutic manner. Furthermore they highlighted the difference from their usual methods of working. The following individual describes this difference when working with someone who is behaving in a verbally aggressive manner:

An intervention would be ‘you’re going behind your door’then it would be a restraint. But here it’s more let them flare up and that, and deal with it differently....I think it’s more difficult to do it that way, just stand back and start thinking ‘why is he doing this?’ (DS 2).

2.2) The novelty of co-working between two embedded organisations.

Co-working between different disciplines was identified as a large difference between ‘Unit A’ and the wider prison. Participants acknowledged the differences in training and viewpoints, however there appeared no clear pattern as to why some viewed co-working positively, and others more negatively. Many participants felt that co-working was beneficial and an effective way to provide offenders with the support they required, “Getting a different view I suppose, from the perspective of people who aren’t prison officers.” (DS 2).

And that’s really helpful that both people are involved with the prisoner and I find that really helpful on a day-to-day basis. Because if it works effectively then the prisoner will go to both the officer or the psychologist, and we can then share our views of things we see; we both have really good understandings of the prisoner and officers will see lots of things that we don’t see from a discipline point of view, so then we can bring that to key work and challenge that, so I find the model really helpful in that sense. (CS 6).

But I think, my strongest memory is learning from the officers about how they’ve spent most of their careers managing prisoners who have severe PD.

How they do things differently, how they use security and the regime to contain people who have severe PD. (CS 7).

Although positive opinions were expressed, more negative experiences of co-working were discussed with some vigour. These negative opinions also highlighted the lack of a coherent, collaborative narrative for the unit and the conflict in trying to embed two established organisations (the NHS and the prison system) into a new collaborative method of working with offenders. Discipline staff felt that clinical staff were condescending, “I sometimes get the feeling that clinicians might look down on discipline staff, because they’re ‘not that educated’, I’m not that sure, but I’ve had that feeling with certain people, which I’ve found not fair.” (DS 1). They also considered them naive, “Can be hard work sometimes.....well they’re civilians aren’t they, they don’t understand prison.....it’s just they don’t really understand it.” (DS 7) Clinical staff felt that discipline staff could undermine therapeutic interventions,

If an officer was to say something in your mind you felt was anti-therapeutic, or maybe even damaging, and how to manage that in that situation can be quite typical. I find myself feeling quite shocked by some of the things that are said to the men. (CS 2)

In addition, they found communication a challenge due to the perceived reduced reflective capacity of discipline staff,

There is the potential for splitting and I think sometimes due to different backgrounds and areas of knowledge and experience, I think that sometimes there are very different views of the same behaviour of a prisoner. And I think that can create challenges in the sense that

communication, although it should always be open sometimes doesn't always feel that open and I find that a bit tricky. (CS 3)

Regarding emotional experiences of work, the challenges to co-working evoked negative feelings from participants:

I felt really angry about that because I was told my decision, there was one individual in particular told me that my opinion was irrelevant and was very heavy handed with the way he spoke to me in my view and I felt really angry and very, very powerless. (CS 2)

Despite the difficulties experienced as a result of the co-working within an MDT, the majority of participants seemed to feel that the team had joint aims, was strong, and any ruptures could be overcome.

It works fine as in, there's no conflict, there's no ruptures that we can't work together or anything like that, there's just some behaviours that won't change and you just have to accept that. (CS 6)

Most people are on the same page with things, the officers, and even the psychologists as well – pretty much on the same page and everyone is working towards the same goal. Whereas on the house block it can be....people working in different ways. (DS 6)

The struggles experienced by the participants working on 'Unit A' are strongly depicted in this theme and subthemes; it appears that participants valued the ethos of 'Unit A' and were invested in its success, however the disparity between the two competing organisational ethos caused difficulties and tensions between the two staff groups. Despite these challenges, it is clear that

professionals valued the co-working element of 'Unit A', however the frustrations felt as a result of professional difficulties negatively impacted on their experience of their work as a whole.

Theme 3: Understanding of the client

This theme highlighted the differences in the levels of theoretical understanding that different participants had, and also the impact that it had on their ability to work with the client group, and also their own emotional reactions to the offenders and the work. The theme has been broken down further into three sub-themes (see Table 5).

3.1) Impact of client knowledge.

All participants commented on the positive impact increased knowledge of the client had upon their understanding of the client, their ability to do their job well, their enjoyment of their role, and their belief that they were skilled at their job. Discipline staff really highlighted how they were able to utilise this understanding to work more therapeutically with the offender, "If you know them, if someone's being aggressive and you know they're not normally aggressive, it helps you in the way that you deal with them" (DS 6). They also spoke about how they enjoyed the experience of working on 'Unit A' more because of their interactions and understanding of the clients, "Forming relationships with the guys, learning about them and what their difficulties are, what their dreams and hopes are. Rather than just locking and unlocking day in day out, this gives me a bit more fulfilment" (DS 2). They also spoke positively about the how the understanding they gained about the client whilst working on 'Unit A' was different to their experiences from working in the wider establishment

You know the majority of the time, they're not gonna swing for you because you can talk to them, you can say 'what's going on here?' So there's always – that's a massive difference, that you can actually communicate and talk it through. On other house blocks you won't get a chance to do it – you just do not get the chance. [The result of that is] less aggression....you know where the prisoner is coming from. (DS 1)

Although a greater understanding of the client was highlighted as helpful and part of the OPDP pathway, some discipline staff commented that they felt they did not have enough knowledge and were unsure how to react during challenging times, "It's dealing with them appropriately, that's the challenge" (DS 2).

A consequence of a lack of knowledge was frustrations felt by the clinical team; they felt the reduced theoretical understanding of PD from the discipline members of the MDT resulted in a higher the rate of 'deselections' from the unit than they felt necessary:

But rather than working with that as a part of his pathology, he was removed from the unit.....we have replicated things that have been quite painful and traumatic for them in their past, without working on it with them first or going through some kind of due process to work on those difficulties.

Unfortunately for me those are the things that have been the biggest issues and the things that have caused the most difficulty. (CS 2)

Indeed, discipline staff reported finding the deselections a relief and believing that decisions could have been made sooner, "It was a relief to see him go.....I think he should have gone earlier" (DS 3).

Clinical staff participants felt the lack of knowledge from the discipline members of the team negatively impacted their emotional experiences of working on 'Unit A', "I'm so angry with them, that decision, and that feeling of utter uselessness, like there's no point in me being here" (CS 2).

3.2) Required skills.

Participants invariably brought up the skills that they felt working on the unit required. Participants reported the need to be able to communicate effectively, remaining open minded and non-judgemental, and valuing the client. Some discipline participants believed that unique skills were required for their role, and felt that they had been selected for the role due to their skills, whereas other participants did not feel that their work required any novel skills, "Maybe someone saw something in me that I didn't realise I had" (DS 1). This quote could explain the views of the participants who felt that no special skills were required – it is possible that participants were unaware of their specialist management techniques and skills in communication, however their acceptance to work on 'Unit A', in-keeping with the OPDP recommendations, suggests that these skills are imperative, necessary and not held by all establishment employees.

One interesting factor within this subtheme was the continuum of emotional detachment felt by participants, and this varied from feeling extremely detached to strong emotional reactions to situations on the unit. All qualified clinicians described an emotional response to the client group and felt that their work was impacted by their experience of emotion and didn't consider emotional resilience a necessary skill, but did value being able to mentalize and having a space to reflect:

When there are difficult situations, everyone seems to react really strongly to it, and then everyone has an opinion and there's a lot going on..... sometimes I need to just distance myself....I think if I don't do that I find myself going with it, and then thinking I need to take five, it's getting a bit much. (CS 6).

It takes a lot of rationalising in your own mind to try and keep a healthy perspective on it. Constant checking things and trying to understand the function of things and trying to understand your transference and counter-transference and what part you play in it so I think you need to be a really self-reflective, open person who is open to feedback from others because I think sometimes it can bring out stuff in you that you don't necessarily expect. (CS 3).

Discipline staff highlighted the importance of emotional resilience in their work, suggesting that it was a skill that was necessary to work on the unit, and minimised the impact working with the client group had on their emotions, "[Regarding feeling very frustrated] I don't think it affects me, I don't think it affects my work" (DS 1). Some wondered if they were too unemotional in their work,

So unless someone has really pushed my buttons then I kind of feel indifferent about it. I know that they've got issues that they're working on so you just got to be neutral about it. Yeah I just deal with it as it comes, indifferent. I don't know if that's a good or a bad thing – it might be seen as emotionally cold. (DS 4)

3.3) Training.

One consistent area where staff were striving to develop their understanding of the client was in their expressed need for further training. Many participants expressed views that indicated that there were a number of training needs, with almost all participants commenting that a lot of their learning happened on the job.

When you're working with them you're literally learning as you go. They present you with an emotion and it's like, 'OK, let's see if this technique works, well that doesn't work, it's made them worse....let's try something else!' (DS 4)

Some participants felt that a lack of theoretical knowledge impacted on the way that they were able to complete their role, and how their work affected them. When specifically talking about facilitating psychological courses, officers said, "It's difficult.....You're just in there trying to catch up I suppose. The course work, I didn't understand it, the courses" (DS 2) Another said, "I hated it.....You're pretty much the same as [the prisoners] – they're learning as well as you, as well as facilitating it" (DS 4).

A general need for more training to increase the knowledge, specifically of discipline staff, was highlighted as something necessary for 'Unit A'. Clinical staff mentioned that a large part of the role was supporting the officers to better understand their work with the offenders, "Trying to work with the officers so they understand that, the crisis from a more empathic view and understand what's going on behind it – that's quite a big part of the job" (CS 2). In addition, discipline staff described how they would have to engage in their own learning outside of work, "So you'd be going home looking at books and on the internet of how to deal with someone with borderline

personality disorder and what skills you could possibly challenge them with” (DS4). They also spoke about where they felt training had been lacking since their time working on the unit, “I think a bit more training on personality disorder, have a real class or session on narcissism or borderline personality, and really go into each one” (DS 2). Finally, clinical participants emphasised the lack of support and training they had observed for discipline staff on the unit, “I think there are some fantastic individual staff on the [‘Unit A’] but they haven’t been supported or given the training or given the opportunity to be the staff that they are or could be” (CS 4).

This theme and subthemes highlighted the impact of the disparity between the two participant populations. It appears that the clinical participants, with higher levels of theoretical knowledge and understanding, were able to recognise the specialist skills they required in their work, and they felt adequately trained in their role. In contrast, the discipline staff participants recognised areas where their knowledge was lacking, felt that they did not have any specialist skills to help them in their work, and felt that they required more training to complete their job to the best of their ability.

Theme 4: Individual Perceptions

Participants’ perceptions of the client group appeared to impact the way they experienced their work and how they felt about their role. Their different perceptions of the emergent subthemes appeared to impact on whether they experienced their work generally positively or negatively. It is noted that overall perceptions were positive to the extent that no participant expressed belief that they would leave ‘Unit A’ as a result of the work or the client group.

4.1) Perceptions of the client group.

In this subtheme what was of interest was the largely positive view of the client group given by clinicians in comparison to the views given by discipline staff. Clinician participants commented more on the high functioning nature of the client group, their motivation to engage, and their humour as reasons why they enjoyed working with the client group: “They’re generally a rewarding group of people to work with because you get a lot back” (CS 2); “I love the fact that they want to engage with you in prison, they’re desperate to engage, they want to learn they want to do new things, I really enjoy their banter, they’re funny you can have a bit of a joke with them.” (CS 4); “They’re very perceptive, they’re very intelligent. Some of them more intelligent than others, but they can be quite perceptive.” (CS 6).

However the discipline staff gave more negative views of the client group, highlighting their challenging nature, their “erratic” behaviour, and how they found them “draining”: “Yeah I obviously knew people could be like that but not for some of them it’s constant, every day is a struggle, and that’s quite hard” (DS 3); “Can be very frustrating, demanding, draining, and I think pain in the arses – I’ve got other words, but I won’t use them” (DS 1); “What you’re dealing with, it’s just the intensity of who they are as individuals” (DS 4).

Despite the noticeable difference in the strong opinions given by different disciplines, all participants commented on the challenges of working with the client group and the pervasive and engrained nature of their behaviour was highlighted as a frustration for all:

“You go to keyworker sessions and you have a talk and the person is getting the idea about their behaviour, and then suddenly the next stressor comes

out and it's like they go back to their default setting and they go straight back to the way they were before and you think 'Nooo.....why?!'" (DS 2)

"I find the sabotaging of treatment really difficult, so no matter how much I understand the reasons for that, of why people are finding it difficult to accept help, or are struggling with the intensity of the treatment, I think people undermining or sabotaging treatment is a really tricky thing." (CS 7)

"Well when you're speaking to somebody who – you're thinking, 'you're old enough to know better', and they can't see your point even though it's a simple point, and that's quite frustrating, because you're laying something out quite clearly for them, and it's like they're ignoring the point on purpose. And I find that frustrating." (DS 6)

Furthermore all participants commented on the strong emotional reactions they would have as a result of their work with the client group, many citing feelings of despondency, inadequacy, and failure: "I do feel like I'm questioning myself and my capabilities a lot." (CS 2); "Working with personality disorder in general, and working with the prisoners I would say a sense of therapeutic despondency. Am I making a difference? Is anything changing?" (CS 5); "You do despair, you think 'what can I do to make a difference?'. It can be quite disheartening – I wouldn't say you feel like giving up, but sometimes you do get quite low with it." (DS 3)

4.2) Attitude to work.

A subtheme that emerged that influenced participants' overall perceptions was their attitudes to work; these attitudes varied between the two sub-groups. Attitudes towards tasks that had to be undertaken influenced the way they experienced the client group; for example, discipline staff who found psychological tasks a struggle, felt more stressed about their work, "It was completely new, I'd never done a group before.....I hated it!" (DS 4). They also found the dual-nature of the role a challenge, "You're kind of balancing between a prison officer and everything else that you do on [Unit A], like a mother or a carer or a parent." (DS 4)

In contrast, participants who expressed more interest in the psychological aspects of the role, for example the courses facilitated on 'Unit A', felt better about their role on the unit and their place within it: "I quite enjoy it.....it gives me insight into the how the fellas on the spur think and react." (DS 1); "Oh I really enjoy them, it's really challenging, it's really interesting. It's good fun!" (CS 6)

However all participants commented on how they enjoyed the variety and busy nature of the role and enjoyed their work. They commented that seeing progression in the men was heartening and a motivating factor for working on 'Unit A' and completing tasks, "You actually have done something – maybe affected a change. In only a small way, but in 24 years this is the only time – last 12 months – I've done anything, that way, really. [It feels] really good". (DS 2)

Furthermore, participants who experienced their work with negative emotion found this to be a de-motivating factor, "It can be disheartening, I wouldn't say you feel like giving up, but sometimes you do get quite low with it." (DS 3)

Overall, this theme highlights the significant role an individual's perceptions play in how they experience their work with offenders with PD. Those who placed value in their role and the tasks they undertook experienced their work more positively, and appeared better able to manage the emotional toils of the work. The differences in responses between the two participant populations appear to support this; clinical staff had more positive perceptions of the client group and generally placed more focus upon the positive characteristics of the offenders.

Theme 5: Support

Participants' opinions on the amount of support they felt they needed and received appeared to impact on their experience of their work. Those who felt they had adequate support appeared better able to highlight the positive aspects of their work, whereas those who felt unsupported gave more negative descriptions of their work.

5.1) Supervision.

A subtheme that emerged with regards to support was level of supervision received. In general, the clinical team described feeling supported and were provided with weekly individual and group supervision by senior clinical staff members:

We have supervision, if there's anything more serious or more pressing we can always go to our clinical manager as well. We have the Psychiatrist who comes in twice a week, and that can be really helpful as he doesn't have a caseload, he's not here on a daily basis so he can be more objective about things and that's really helpful. (CS 6).

This participant appears to suggest that they felt better supported by individuals who were able to maintain a sense of detachment from the service, someone who is less emotionally involved with the offender population.

Discipline staff varied in their accounts of the amount of support they received. Most participants in discipline roles felt that they did not receive enough support, “I weren’t [supported]. In the 3 years that we’ve been open I’ve had two supervision sessions, and I didn’t get one when I burnt out” (DS 4). This quote perhaps suggests that support wasn’t given or the individual didn’t feel able to access it even when in great need. In addition, DS 4 went on to say that their ability to cope with the demands of the client group was impacted by the level of support they received, “It’s all about the support you get” and that limited staff members and therefore less opportunity for support had contributed to their experience of “burnout”.

5.2) Peer support.

Although the official support for discipline staff may have been lacking, all participants commented on the importance of utilising their team for support: “Colleagues. That’s the most important one I think really. If you’ve got any problems just speak to people, people that are around.” (DS 6).

I do feel that this job if the staff that I work with weren’t supportive and weren’t the people you could go to with ‘this is what I’m worried about, what are your thoughts on it’, I think this job would, could, break you in terms of being really anxious or being really avoidant. (CS 3)

This theme and subthemes suggest that for a professional to experience work with offenders with PD as positively as possible, they have to feel supported by their team, and that a lack of support can result in an individual struggling in their professional capacity.

Theme 6: Personal Change

Most participants felt that they had achieved some change through their work on the unit. Participants commented about being able to mentalize, being more tolerant of others, being more resilient, and being less confrontational. Personal change was considered both a by-product of their work on 'Unit A', but also an influential factor on how they experienced the unit. Those who had achieved positive personal growth were better able to recognise the value and importance of their role and subsequently gained more positive experience from the job.

6.1) Psychological growth.

An emergent subtheme related to personal change was the psychological change experienced by some participants, and changes of this nature tended to be more prevalent within the discipline participants, "You kind of open your eyes a bit more as a prison officer and take a step back....I didn't think that I'd probably grow as a person doing it." (DS 4). Discipline staff spoke about how their emotional experiences in their private lives had also been changed, "I think now that rather than just having an emotion or feeling a certain way, I actually think, why am I feeling that way?" (DS 2). Conversely, clinical participants described more negative emotional changes, such as

higher levels of “anger” (CS 2) and anxiety, “I find that I do worry about things outside of work....I do worry about a few things probably more than I would normally” (CS 3).

6.2) Professional development.

In addition to the psychological changes experienced by participants, other experiences of change were also described. Participants spoke about an increased professional confidence, “I feel I’ve got a better handle of what treatment approaches work best with what prisoners, so I’m feeling more confident.” (CS 7). In addition participants commented on their improved ability to interact and engage with other staff members “I think I’ve become less militant about my views.” (CS 5).

Responses from clinical staff are potentially indicative of their previous therapeutic experience having resulted in less psychological impact of their current work with offenders with PD. However, it was evident that the prison environment was able to elicit negative emotional change. Clinical staffs’ experiences within a new, more restrictive setting allowed them an opportunity to develop professionally. Whereas for discipline staff who had more experience in the ‘anti-therapeutic’ environment of the prison, their individual changes were manifested in personal psychological growth.

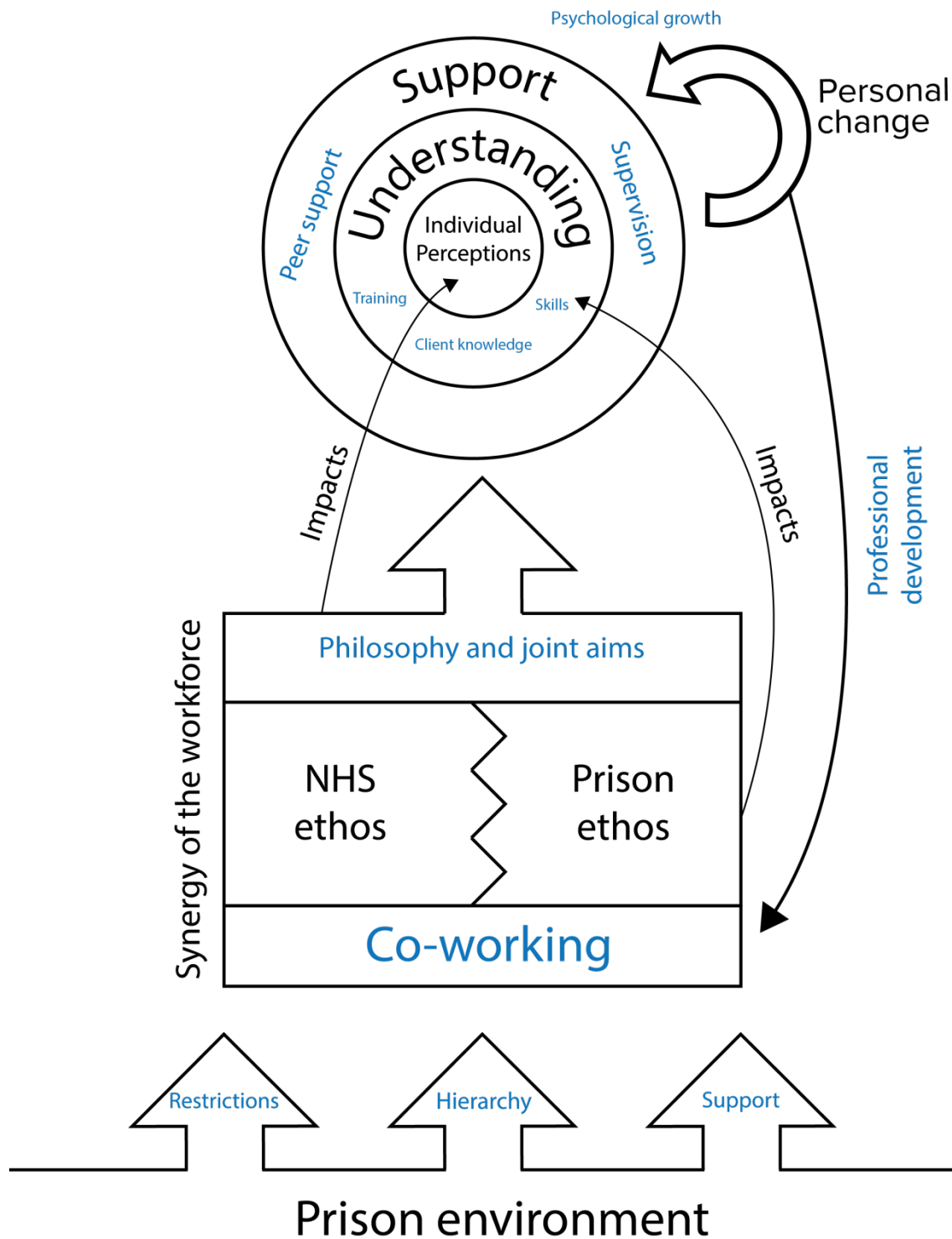


Figure 5: A grounded theory model of how professionals experience offenders with a diagnosis of personality disorder within a prison setting

The prison environment impacts on all professionals working with the offenders. Within the prison environment, the conflicting ethos of the NHS and the prison interact, whilst professionals co-work and have joint aims regarding their work on the unit. The embedded organisation that exists within the professional impacts on their level of knowledge, the amount of support they believe they receive and finally their view of the client. The relationship between a professional's understanding of the client, had a bearing on their experience of the novelty of co-working; discipline staff who acknowledged a limited knowledge base felt more supported by their clinical colleagues thus positively influencing their experience of co-working. The perceptions participants had of the client group were influenced by the primary organisation within which they worked (NHS or prison). Further to this, the primary organisation of each participant also influenced the amount and nature of personal change that they experienced; those from the prison service appeared to make more psychological gains. Conversely, clinical participants experienced more negative psychological changes, potentially impacted by the restrictive nature of the prison setting and also the difficulty co-working with non-clinicians. Working on the unit and working with offenders with PD in an innovative and novel way, results in a positive by-product of personal change; such changes may, in turn, impact upon an individual's perceptions and level of understanding.

3.5 Discussion

3.5.1 The aim of this study was to create a substantive model which could express how professionals working with offenders with personality disorder experience their work in a prison setting in a specific element of the Offender Personality Disorder

Pathway (OPDP) which, in turn, increases our understanding of their experiences. The research was undertaken in a unique stage of the OPDP, and thus provides insight into the experiences of professionals working within a high security prison establishment as part of an MDT. The study findings suggest there are numerous factors that influence how a professional experiences their work with offenders with PD, namely the prison environment, the synergy of the workforce, an understanding of the client, individual perceptions, and support.

The resultant model based on the analysis of the interviews, suggests that the experience of professionals working with offenders with PD is impacted by numerous factors with considerable interplay. A professional's experience is also fluid in nature and can vary day-to-day depending on how much exposure they have to each theme. What is clear is that the environment, in which a unit for offenders with PD sits, plays a vital role in the experiences of the professionals who work on it, and to some extent can have greater influence on a professional's experience of their work than contact with offenders with PD. These findings are in line with previous literature into the effects of working with individuals with PD (Kurtz & Jeffcote, 2011), and wider research into stress and burnout in healthcare staff and mental health nurses (Carson et al., 1995; Onyett et al., 1997). The prison environment in which 'Unit A' was located was perceived as quite unsupportive of the ethos of the unit; this lack of support was twofold, in the restrictions imposed by the very nature of the high security prison, a factor which could not be flexible, and in the viewpoint of the wider prison regarding the ethos of the unit. Officers on 'Unit A' were considered "fluffy" and mocked by officers from the wider prison for being "care-bears." Furthermore, the lack of understanding of the nature of 'Unit A' meant that officers felt pressured to complete their tasks even in times of distress and burn out, for fear of losing their job. This lack

of support was demonstrated by the closure of the unit before the end of its contract, and its transfer to another lower security prison. It was noted that interviews conducted soon after the news of the closure was circulated tended to have more pessimistic and negative undertones in comparison to latter interviews. The higher levels of negative emotion shown in the initial interviews perhaps illustrate the strong sense of powerlessness felt by the participants as a result of being governed by external individuals who lacked the understanding of the ethos of 'Unit A'. They also highlight the disappointment about the closure of the unit which although present throughout the interviews, appeared to be felt more intensely soon after the news emerged. The later, more reasoned interviews perhaps were a result of the additional time that participants had been given to reflect, and participants were more able to highlight the positive experiences and benefits of 'Unit A'.

Although overall there is enough similarity in responses to consider the participants a homogenous population, there were disparities in experience between the clinical team and the discipline team. One noticeable difference was the experience of offender deselections (removal from 'Unit A'). Clinical staff found deselections particularly stressful, and expressed heightened feelings of frustration and anger directed towards discipline staff in relation to their apparent keenness to remove offenders from the unit. Conversely, when the same deselection was considered by prison officers, they described feeling relieved, and said that it was a source of MDT tension for them when clinical staff did not deselect challenging offenders. As both populations generally experienced the client group in a positive way, it would be interesting to consider the reason behind the disparity in certain experiences. It is important to consider the influence of response bias as potentially all participants may have wanted to present themselves in a positive light. Alternatively, the model suggests

that a professional's knowledge influenced the way they felt about and experienced an offender; if they did not understand the individual they experienced the offender's behaviour as "erratic," found them challenging, and felt relief when apart from the offender. In contrast, clinicians described viewing an offender's challenging behaviour as part of their formulation; their increased theoretical knowledge enabled them to better reflect upon their interactions and manage their emotional reactions to that offender (Tate & Sills, 2004). This suggests that future PD services would benefit from experienced staff members who will be able to support and contain the anxieties of their colleagues who have less prior experience. Alternatively, perhaps the prison officers feel the "draining" effects of the offenders more intensely due to their increased amount of time spent with them, a suggestion that is supported by a service evaluation conducted by Moran et al. in 2008. Discipline staff have little respite whereas clinicians spend time thinking about behaviour and formulating away from the individual prisoners. Lastly, the disparity in experience may be an enactment of the 'punitive' prison institutional view of challenging prisoners; the officers' quick deselection response is a result of the embedded organisational role within them influencing their decisions.

Another potential enactment of the different ethos of the two participant sub-groups, and a source of conflict, was the perceived lack of knowledge of the other sub-group; clinicians were "naive" and didn't understand the prison system, and officers were unable to appreciate the formulation of an offender's behaviour and were subsequently believed to be less empathic. The clinical staffs' perceptions of the discipline staff's lack of empathy were not supported by the study, and all officers expressed a great deal of empathy within interview and, in addition, placed significant importance on the needs of the offender population on 'Unit A'. However discipline

staff did identify a lack of theoretical knowledge within interview, and also described the negative emotions they experienced as a result of this gap. All discipline participants had attended Knowledge and Understanding Framework (KUF) training (specific training regarding working with offenders with PD) in accordance with the facet of ‘workforce development’ in the OPDP strategy, and so it is questionable as to how adequate this training is for professionals working with complex individuals within a prison environment. What this study does show is the importance of adequately training professionals due to the impact increased knowledge has on an individual feeling skilled, influential in their role to support change and experiencing their work positively. It is noted that the training gap identified in the study was not identified with by all participants, indeed it was only discipline staff who suggested areas for future training, and so it is hypothesised that this difference accounts for the disparity between the perceptions of the two participant sub-groups.

Despite difficult interactions and behavioural challenges presented by the offenders on the unit, the study participants experienced them as a rewarding, interesting, fun, and high functioning population; these findings are supportive of literature suggesting that strong emotional resilience is a key personality characteristic of professionals who successfully work with individuals with PD (Fortune et al., 2010). Participants’ perceptions of an offender influenced the way they experienced them, and in general the clinicians gave a more positive view of the offenders, whilst the discipline staff placed more focus on the challenging behavioural traits. In addition, participants’ attitudes to work also impacted on their experience of ‘Unit A’; for example, participants who found courses to be interesting, generally felt less negative emotions and experienced them positively.

Finally, the support a participant felt they received had an impact on their experience of the population within a prison setting. Most officers felt that they did not receive as much support as they needed and felt that this was an area that was lacking. In contrast, the clinical staff felt well supported via individual and group supervision and reflective practice. It is noted that a form of group supervision was offered every Monday morning in the team meeting, but this was not valued by most of the discipline staff interviewed who did not highlight it as a form of support or a useful exercise. This could be explained as an interplay between a lack of knowledge and lack of support for the officers; anxieties about potentially saying something ‘incorrect’ and feeling that they would not be supported by clinicians could have resulted in their non-attendance to group supervision offered. Alternatively it may be that the very nature of discussing offenders to try to understand their behaviour is not in-keeping with the prison ethos of mistakes must be punished regardless of the underlying cause; indeed it could be part of the wider existing societal ethos of punishment rather than treatment being effective and appropriate for offenders. The identification of the theme of support is in-keeping with the findings from previous literature; Kurtz and Turner (2007) identified the value of regular group supervision which would place focus on staff relationships and also the therapeutic work and interactions with patients in addition to individual supervision for each member of staff. Lastly, responses from both clinical staff and discipline staff suggest that prison ethos and culture does not value supervision, which is consistent with previous literature (Johns & Freshwater, 2009), and participant engagement in these sessions could confirm their “fluffy” stereotype to their discipline colleagues external to ‘Unit A’. However the lack of support be understood, what is clear is that the level of support felt by professionals working on ‘Unit A’ influenced their experience of their work; these findings support previous research which highlight the

significance of receiving regular supervision, and also whole MDT reflective supervision (Crawford et al., 2010; Kurtz & Turner, 2007). The interviews conducted with discipline staff appeared to reflect their ability to speak openly and honestly and it could be posited that the researchers detachment from 'Unit A' enabled discipline staff members to feel more comfortable to disclose opinions; it would perhaps be prudent for future PD services to consider the impact of who facilitates supervision and supports the wider team.

From the interviews it is clear that working with offenders with PD is both a challenging and rewarding experience. The rewards are shown through the by-product of positive personal change experienced by all participants; participants cited being more tolerant and more reflective as gains from their experiences working with offenders with PD. These personal gains appeared to be rooted within the ethos of 'Unit A' however and not a direct result of the population; the nature of the work helped them to build skills and spend time communicating with, supporting and understanding the offenders on their caseload.

What is clear from the research is that the themes that have emerged all have significant interactions and interrelations with one another and appear to be fluid in nature; indeed, participants commented that "every day is different." The findings of the research can be seen to add to the knowledge base on the topic of working with offenders with PD. As will be discussed in chapter five, such knowledge can help inform decision making in the development of staff training and in recruitment strategies.

3.5.2 Methodological limitations

As the study was conducted once the future closure and relocation of the unit had already been decided and announced, it is likely that resulting strong negative emotions expressed about the closure of the unit may have influenced participants responses in interview. However, it could be argued that the closure of 'Unit A' provides good insight into the perceived unsupportive nature of the prison. In addition to this, the interviews were conducted over a period of seven months, and therefore circumstances on 'Unit A' are likely to have changed in that time influencing the responses given by participants; for example, offenders had already been transferred out due to the closure, and so perhaps this resulted in a reduced amount of stress felt by participants. With reference to the closure of the unit, it is possible that participants' interviewed towards the end of the study had been able to reconcile their difficult emotional reactions regarding the closure better than those who were interviewed in the initial stages of the study.

Participants were recruited using a purposive, self-selecting sampling method. As a result of the participants self-selecting to be involved in the study, considerations must be given to those who chose not to participate; the reasons behind this and also the perspectives and experiences that were not captured as a result. Furthermore, the study focuses on a specific unit in a specific prison location, as a result there are limits to the generalisability of the findings to other professionals working with offenders with PD in other prison locations. Future research could utilise a more quantitative methodological approach to enable better generalisability.

The interviews utilised a semi-structured approach, and biases associated with self-report measures are acknowledged. Furthermore it is possible the potential

direction of the interview may have been limited in comparison to if interviews had been unstructured. However a semi-structured design provides a focal point from which to conduct and analyse the interviews, which is in line with a constructivist approach to grounded theory (Charmaz, 2011). The researcher acknowledges that had alternative methodological design or analyses been used, the findings of the study may have been interpreted differently. However, the approach taken was considered to be the most sensible to achieve the research aims. In addition, the interviews were conducted, transcribed, and analysed by the author who had previously been a student on 'Unit A'. It could be argued that this could have limited the ability of the researcher to maintain an objective stance due to high levels of investment in the study, and also high levels of exposure to the interview data, however it is felt that through regular supervision with an individual external to the unit, researcher bias was reduced to an acceptable level.

3.6 Conclusions

The study has shown that the experiences of professionals working with PD in a prison setting are affected by many more factors than just the high risk, high harm nature of the offenders. There is a considerable amount of interplay between all factors, with the experience of one factor having an effect on the experience of another. There also appears to be trends within sub-groups of clinicians and prison staff that show disparity between the experiences of these sub-groups.

Overall, the sample is considered to be of a homogenous nature, as despite inconsistencies in experience, all participants had a common aim, highlighted that the work was enjoyable, and the client group would not cause them to leave the unit. Many cited difficulties in co-working relationships as the most likely factor that would cause

them to leave, highlighting the significant impact that these relationships between staff have on an individuals' experiences of work.

The current study intended to better understand the experiences of professionals working with PD in a prison setting, and it appears to have achieved this. Prior to this, no study had focussed on the experiences of professionals within a high security prison setting when working with offenders with PD, under the new Offender Personality Disorder Pathway (OPDP); as such, this study is novel, and has added to the literature and knowledge base about this population. It is hoped that the model and themes can be used to inform practice for PD units, and may be used as a basis for further research.

CHAPTER 4

Critique of a Psychometric

The Essen Climate Evaluation Schema (EssenCES)

Schalast et al. (2008)

4.1 Introduction

It has long been recognised that however much establishments try to attain a ‘normal’ environment for therapeutic settings, there are always observable deviations from a life lived in society (Moos, 1975). The term ‘social climate’ has been coined to describe the unique environment within a therapeutic setting. Schalast and Redies (2005, p. 15) define social climate as “the interaction of aspects of the material, social and emotional conditions of a ward, which may – over time – influence the mood, behaviour and self-concept of the persons involved.”

Much research has been conducted to explore the social climate of psychiatric and forensic settings. Significant relationships have been found between the social climate of a psychiatric setting and numerous clinical and organisational outcomes. For example, Beech and Hamilton-Giachritsis (2005) found that patient treatment outcomes were significantly affected by the social climate of the environment in which treatment was facilitated. Their findings were supported by studies that found that levels of treatment readiness, participant motivation, and the perceived strength of the therapeutic relationship between a patient and therapist were also significantly higher when an environment was assessed as having a positive social climate (Beazley & Gudjonsson, 2011; Day et al., 2011; van der Helm, Beunk, Stams, & van der Laan, 2014). Furthermore, higher rates of verbal and physical aggression have been found to be associated with more negative social climates (Long et al., 2011). Considering the body of research that lends strong support to the influence social climate has on residents, it is reasonable to suggest that social climate will also have an impact on staff members. Indeed, a more positive social climate has been shown to be related to higher levels of staff satisfaction, performance, and morale (Bressington et al., 2011; Moos & Schaefer, 1987).

It is clear that research into the climate of therapeutic and prison settings has highlighted its importance; the World Health Organisation (WHO; 1953) asserted that atmosphere is “[t]he single most important factor in the efficacy of treatment” (p. 17) when considering the treatment of psychiatric patients. If the environment in which an individual resides has a significant impact on their ability to utilise any treatment offered, then it is imperative that the environment provides a climate in which progress can be achieved and supported. This is perhaps especially important when considering a prison environment, which is often considered to be obstructive to therapeutic gains (Davies, 2004). Bottoms (2003) emphasised the importance of climate on prison-based interventions; he highlighted that social climate and interventions to change behaviour occur as an interaction between staff and prisoner attitudes, beliefs and values. If the social climate of a setting is a negative one, this can have a detrimental effect on the interventions delivered. A climate that is viewed as unjust or capricious can elicit feelings of resentment which can have a highly negative impact on the implementation of any interventions offered. Additionally, the multifactor offender readiness model (Ward et al., 2004) highlights social climate in forensic settings as a condition of external readiness and programme responsivity that has an influence on treatment engagement. As interventions for a forensic population have the ultimate aim to reduce reoffending, it is clear that a positive social climate is imperative to effectively tackle recidivism.

As the literature supporting the link between a positive social climate and therapeutic outcomes continues to grow in strength, and when the constant advancements in knowledge regarding therapeutic engagement and desistance are considered, it is not surprising that there is now widespread monitoring of social climate in secure settings. Specifically, the Royal College of Psychiatrists (2008) recommended

that routine monitoring of social climate should be implemented as typical practice in therapeutic communities. Furthermore, the National Health Service (NHS) and private healthcare providers routinely assess the social climate of more than 30 forensic secure settings using the Essen Climate Evaluation Schema (EssenCES; Schalast et al., 2008). In fact, 1.5% of the income of those hospitals is currently dependent on units monitoring their social climate regularly (between every six to twelve months) (Tonkin, 2015).

If the social climate of an environment is considered to hamper movement towards achievement of its aims, (i.e. patient treatment, reduction in risk and subsequently reoffending) it is important to have as positive a social climate as possible. There is a necessity to be able to identify if the climate of an environment is improving; it is therefore logical to assume that to improve a climate, it is necessary to have a measure of how the environment is currently performing. In the report mentioned previously, the WHO claimed that climate was “intangible” (p. 17). If this is the case, consideration must be paid as to how improvement will be recognised if it cannot be measured. Lastly, if a hospital’s funding depends on the routine monitoring, measurement and performance of social climate, any scales used must be a valid representation of the environment that they are assessing. It has been argued that by improving the social climate of an environment, the treatment alliance can be improved, thus improving patient outcomes (Johansson & Eklund, 2004), and so to ensure that patients/prisoners are provided with the optimal care and therapeutic engagement possibilities, robust measures must be used to assess social climate and identify areas for improvement.

The Essen Climate Evaluation Schema (EsseCES; Schalast et al., 2008) has been chosen to be reviewed in this chapter due to the essential aim it attempts to serve in

evaluating the social climate of environments. Additionally, it will be critiqued in relation to the fact that it is becoming more widely recognised as the ‘go-to’ measure of social climate as a result of the NHS and private healthcare services adopting it as their measure of choice to assess social climate.

4.2 Overview

The Essen Climate Evaluation Schema (EssenCES, Schalast et al., 2008) is a 17 item questionnaire (15 valid items and 2 positively worded questions that are not scored) that provides a score related to the social climate in forensic settings along three dimensions: *therapeutic hold* (perceptions of the extent to which the climate is supportive of therapy and therapeutic change), *patients’ cohesion and mutual support* (whether mutual support of a kind typically seen as characteristic of therapeutic communities is present) and *experienced safety* (tension and perceived threat of aggression and violence). The *therapeutic hold* dimension was based upon Rogers’ (1961) notion that “‘hold’” is a vital feature of any therapeutic relationship or setting. The *patients’ cohesion and mutual support* subscale was developed from Kelly et al.’s (2004) concept of ‘therapeutic community’ and study findings suggesting that patients’ cohesion in group psychotherapy is strongly related to treatment outcomes (Beech and Fordham, 1997). Lastly, the *experienced safety* dimension reflects the idea that ‘safety’ is a basic human need (Maslow, 1943) and that violations of this need can have an impact on treatment especially in forensic settings (Schalast et al., 2008). For the prison version of the EssenCES, minor alterations have been made to the language used (e.g. “wing” instead of “ward”) and the climate dimensions are: *hold and support, inmates’ cohesion*, and *experienced safety*. Participants are required to rate, using an ordinal response, how much they agree with statements posed about the climate of the

environment in question (see Appendix . The response options are: 0 (I agree not at all), 1 (I agree little), 2 (I agree somewhat), 3 (I agree quite a lot), and 4 (I agree very much). Responses are then summed to produce three sub-scale scores which can be aggregated to produce a total score. There are currently versions for both mental health settings and prison settings and the EssenCES can be completed in German, English, Dutch and Finnish. The EssenCES can be completed by staff members and residents, and there are separate questionnaires for both populations.

A manual for the EssenCES has recently been published (Schalast & Tonkin, 2016) and contains an overview of the EssenCES followed by detailed advice on how to administer it and score results and finally how to interpret findings. It also contains the reference norms from various countries and types of institutions. There is currently a German project report that is available online to assist with the administration, scoring, and interpretation of the EssenCES (University Duisberg-Essen, 2010)

4.2.1 Development of the EssenCES.

There have been numerous measures developed to try to assess the social climate of an environment. Two of the most widely recognised are the Community-Oriented Programs Environment Scale (COPEs; Moos, 1972) and Good Milieu Index (GMI; Friis, 1986a; Rossberg & Friis, 2003a) however there is limited empirical evidence for the psychometric properties of both of the measures. Indeed, Brunt and Rask (2011) found that the short version of the COPEs was not sufficiently reliable for measuring the psychosocial environment as the results of their research found that only

two of the COPES subscales attained an acceptable Cronbach's alpha in the resident sample, and only one subscale is in the staff sample.

The largest body of scientific research into social climate was conducted by Rudolph Moos and was completed over a period of 30 years, in numerous service settings, including psychiatric and correctional facilities (e.g. Moos, 1973). From his research he developed the Ward Atmosphere Scale (WAS; Moos and Houts, 1968) for use in psychiatric establishments and the Correctional Institutions Environment Scale (CIES; Moos, 1968) for use in prisons; both aim to measure the social climate of an environment. The WAS is a 100-item scale which claims to measure ten aspects of social climate within a unit or institution. The measure is available in different forms for different settings and is completed by both staff and patients/prisoners. The WAS and the CIES were the first and most commonly used measure of social climate, however despite their widespread use, there have been criticisms about the statistical properties of the measures, and the evidence to support their psychometric properties is varied. Criticisms of the measures suggest that the language used in them is outdated (Rossberg & Friis, 2003a) and as a result of advances in psychiatric institutions some items are not relevant now (e.g. 'One may interrupt the doctor'). A further criticism of the WAS is that at 100-items it is extremely time-consuming to complete and can result in higher rates of participant attrition (Schalast, et al., 2008), especially within unmotivated forensic populations. Finally, criticisms regarding the measures' psychometric properties suggest that it has not been possible to confirm the 100-item factor structure of the WAS/CIES by statistical means; the WAS subscales show considerable inter-correlation and several of the subscales do not achieve a satisfactory internal consistency (Ajdukovic, 1990; Rossberg & Friis, 2003a, 2003b; Wright & Boudouris, 1982). Rossberg and Friis (2003b) suggested a revision of the WAS

removing 23 items whilst retaining the 10-item structure. Although the psychometric properties of the revised version were to some extent improved, Rossberg and Friis (2003b) did not consider them to be at a satisfactory level, for example, they noted that 20 of the items correlated more strongly with other subscales than the intended subscale.

In response to the criticisms outlined above, Schalast et al. (2008) produced the Essen Climate Evaluation Schema (EssenCES) which was intended to be a short and psychometrically robust alternative to the WAS/CIES. Schalast (1997) initially composed a list of 15 items which outlined the work environment. Subsequent to this, statistical analyses were conducted on the emerging scale, and results identified three prospective climate dimensions; “experienced safety”, “quality of the living environment” and “feeling of success in therapeutic work.” Further statistical testing was conducted including scale and factor analyses which were used to select the appropriate items and identify traits that were stable across different population samples (Schalast, 2000; Schalast, 2008). A total of 43 “candidate” (Schalast & Tonkin, 2016, p. 6) items were examined in the scale development process. From these analyses a 15-item scale emerged and two filler items were added to complete the EssenCES.

4.3 Characteristics of the EssenCES

4.3.1 Level of Measurement.

The level of measurement used in the EssenCES is an interval scale. Participants are asked to rate, using an ordinal scale, how much they agree with statements about the social climate that they work/live in. Scores are calculated from

the responses and numerical differences between subscales can be identified which is helpful in the subsequent analysis of the results (Field, 2009).

4.3.2 Self-Report.

The EssenCES is a self-report measure. It relies upon the participant to report their own behaviours, thoughts, or feelings. It is noted that there are no differences in the questionnaire items for the separate population groups, and this could pose difficulties regarding accessibility to the item for individuals with intellectual disabilities. An advantage of self-report measures is that the researcher can obtain information that may not be otherwise observable. However, as with any self-report measure there are questions regarding the honesty of the participants' responses, whether they are able or want to respond truthfully, and this has implications for the reliability of the results.

Research has shown that those interviewed in the workplace about their organisational environment may respond in a biased manner (Donaldson & Grant-Vallone, 2002). In general, research participants want to respond in a manner which makes them look as good as possible. To achieve this, they under-report behaviours or opinions viewed as negative or derogatory and over-report behaviours viewed as appropriate and positive. This bias is magnified when conducting research using self-report measures in places of employment as staff members often believe there is a slight chance that their employees might gain access to their responses (Moorman & Podsakoff, 1992) and so to avoid the potential of any negative repercussions they answer more positively and potentially less truthfully to questions.

Studies have found that some individuals (e.g., offenders with personality disorder) respond to self-report measures in a manner known as ‘faking bad’ or ‘malingering’, in the hope that they will receive more assistance (Cima & van Oorsouw, 2013; Heinze & Vess, 2005). Malingering is classified in the DSM-V as “the intentional production of false or grossly exaggerated physical or psychological problems” (2013, p. 331). These kinds of responses would impact the reliability of the results of any measure. However a critical review of the literature suggests that there is no strong evidence to support the suggestion that higher antisocial traits or psychopathy scores equate to higher levels of ‘faking bad’ (Niesten et al., 2015). Indeed, research has shown that convicted offenders are likely to give true self-report information as they have already been incarcerated (Craig, Thornton, Beech, & Browne, 2007), thus supporting the use of self-report measures to gauge opinion in this population.

Although there are difficulties when utilising self-report measures, it has been found that socially desirable responses are minimised when using a Likert scale for responses rather than dichotomous options (Sorenson & Taylor, 2005).

4.4 Psychometric Properties of the EssenCES

The EssenCES is well established and has been used in numerous published articles across various countries (e.g. Day et al., 2011; Schalast et al., 2008) which have confirmed that it has good reliability and validity.

4.4.1 Reliability.

Reliability is fundamental to psychological measurement. A test which is deemed 'reliable' is one in which the 'observed' score is close to the 'true' score. In essence, the smaller the error found, the higher the reliability of a test.

4.4.1.1 Internal Reliability.

Internal reliability examines the internal consistency of a test, i.e. to what extent do the items measure the same thing (Spearman, 1907). The internal consistency of a scale is determined by Cronbach's α (Cronbach, 1951) and Corrected Item-Total Correlation (CITC). It is accepted that scales used should reach a Cronbach's α of 0.70 or higher (Bland & Altman, 1997; Nunnally, 1978), and a CITC above 0.50 is considered high (Helmstadter, 1964; Rossberg & Friis, 2003a). The original study conducted by Schalast et al. (2008) calculated the alpha coefficients to see how well items loaded onto each scale. Results indicated that the three scales had acceptable to good (ratings established by George & Mallery, 2003) internal consistency scores for both patient and staff populations: $\alpha = 0.79$ to 0.87 for patients, 0.73 to 0.78 for staff, and 0.78 to 0.86 for the whole sample. The CITC coefficients ranged from 0.49 to 0.75 . Rossberg and Friis (2003a) suggested the removal of items only with a CITC of less than 0.20 , and on this basis it appears that all items are adequate indicators of the scale they are assigned to.

Since the original study, further research has been conducted in numerous countries with a variety of settings and populations. In the UK, Howells et al. (2009) found that in a high-secure establishment Cronbach's α ranged from 0.72 to 0.82 . They

found CITCs ranged from 0.18 to 0.69; this indicated that PC3 (“most patients don’t care about their fellow patients’ problems”) should be removed as it fell below the 0.20 cut-off score. The exclusion of this item increased the α value for the *patient cohesion* scale from 0.76 to 0.84, however it was found that when all the EssenCES items are included in the analyses, the removal of PC3 did not significantly impact on the overall α score for the scale. In Australia, the study conducted by Day et al. (2011) revealed a similar pattern to Schalast et al. for both staff (Cronbach’s $\alpha=0.72$) and prisoners (Cronbach’s $\alpha=0.64$). When compared to the results found by Schalast et al. (2008), it could be argued that the prison version of the EssenCES is not as reliable as the version for use in hospital settings. More recently, Milsom et al. (2014) conducted a study to provide preliminary normative data for UK medium-security hospital settings and found Cronbach’s α scores of 0.79 for patients, 0.81 for staff and 0.79 for the total sample. They found CITC values for the subscales incorporating both samples (staff and patients) ranged between 0.34 and 0.74. The total CITC value for the total EssenCES scale ranged from 0.15 to 0.61, the lower end of which is below acceptable cut-off (Helmstadter, 1964). They found two items in the *experienced safety* subscale had CITC scores below 0.20, however when either or both of these were removed from analyses, there was no significant impact on the overall internal consistency for either the EssenCES total or the *experienced safety* subscale. The lack of impact of the removal of these items could suggest that this scale does not have strong internal reliability.

More recently, Tonkin (2015) conducted a systematic review of studies evaluating the EssenCES. He compared the results from seventeen studies and found that of the ten that reported on the internal consistency of the EssenCES, only 7 out of 69 α values fell below 0.70, and only 7 out of 120 CITC values fell below the

recommended minimum 0.20. Thus there is strong empirical support for the internal consistency of the EssenCES.

4.4.1.2 Test-Retest Reliability.

This examines the degree to which the results of a study can be replicated and are consistent and stable over time, with the same test subjects. The test-retest reliability of a psychometric test is crucial as if the measure fails to yield the same score for a subject (with no intervention or change), it could be assumed that the items do not measure what they are intending to. There is very little evidence regarding the reliability of the EssenCES across samples and time and so no accurate representation of the test-retest reliability of the EssenCES can be given here. However when considering social climate, the question of how appropriate test-retest reliability is to examine the psychometric properties of the scale is an important one. Social climate is considered a dynamic construct which can be influenced by a multitude of factors (e.g. incidents of aggression, staff changes, mental state and time of year), and can fluctuate over time (Milsom et al., 2014). As a result it is difficult to determine what an appropriate interval is to examine test-retest reliability (Tonkin, 2015); this could account for the lack of research conducted into this form of reliability.

4.4.2 Validity.

The concept of validity was devised by Kelly (1927, p. 14) who asserted that a test is valid if it measures what it claims to measure.

4.4.2.1 Face Validity.

Face validity examines the degree to which a test appears (at face value) to be measuring what it aims to be measuring (Nevo, 1985). It is the least sophisticated measure of validity and it is possible for a measure to have good face validity whilst lacking in general validity. Face validity also relates to how scale items are worded (e.g. clear, too complex or confusing), which may bias responses. Schalast et al. (2008) suggested that although they did not base the questionnaire's dimensional structure on any particular theoretical background, the three subscales appeared to have a good level of face validity. Currently no further research has been conducted into the face validity of the EssenCES and so it is not possible to evaluate this in depth, however it could be argued that although the three subscales may have a good face validity, they may also cover domains not relevant to the EssenCES.

4.4.2.2 Concurrent Validity.

Concurrent validity concerns the extent to which a measure correlates with other tests aimed to assess the same construct. If a new test can be validated by a comparison with an already existing measure it is concurrently valid, however this is only useful if the comparison measure is truly valid (Kline, 1986). The EssenCES was found to have generally 'very good' concurrent validity when correlated with the Good Milieu Index (GMI; Friis, 1986a; Rossberg & Friis, 2003a), Ward Atmosphere Scale (WAS; Engel et al., 1983; Moos & Houts, 1968) and 'Experiences on the Ward' (EW; Sammet & Schauenberg, 1999) questionnaire (Schalast et al., 2008). The EssenCES *therapeutic hold* subscale was found to have statistically significant correlation ($p < 0.01$) with the EW for 'Relationships with Staff', $r = 0.78$. Relationships for *patient cohesion and*

mutual support of the EssenCES were also established with a maximum correlation coefficient of $r=0.60$ for 'Group climate' found in the EW. However the correlation coefficients were considerably lower for the *experienced safety* subscale with no correlations being found above $r=0.33$. There is little evidence reported on variations between staff and patient versions of the EssenCES, and so support for concurrent validity can only be given to the patient version.

4.4.2.3 Construct Validity.

Construct validity refers to the validity of the theoretical concept that is being tested and the extent to which a test captures the theoretical construct (Cronbach & Meehl, 1955). Fox et al. (2010) found that the construct of social climate was measured to varying degrees depending on the security of the establishment tested and also the perceived therapeutic alliance and patient motivation to change.

Tonkin et al. (2012) measured the EssenCES's construct validity via an assessment of its *convergent validity*. A scale demonstrates convergent validity if it is comparable to alternative measures of the same construct (Campbell & Fiske, 1959). Tonkin et al. compared the EssenCES to the Working Environment Scale (WES-10; Rossberg & Friis, 2004). Their three hypothesised relationships between climate and working environment, climate and institutional aggression and climate and security level of the establishment were all supported, and suggested good convergent validity; however these results were not significant. Statistically significant relationships have been found between the EssenCES and other instruments measuring milieu, ward atmosphere, the working environment of secure settings, and relational security (Day et al., 2011; Schalast et al., 2008; Schalast & Groenewald, 2009). Day et al. (2011)

completed a correlation between total scores on the EssenCES and the Corrections Victoria Treatment Readiness Questionnaire (CVTRQ; Casey et al., 2007) for the prisoner sample and found a significant positive association between scores on the two measures, $r(111)=0.23$, $p<.05$. To assess the convergent validity of the prison staff version of the EssenCES, Day et al. conducted a correlation between scores on the EssenCES and those on the WES-10. A significant positive association was found between the two measures, $r(109)=0.45$. These results both support the notion that the EssenCES has good convergent validity with the CVTRQ and the WES-10. Howells et al. (2009) further support the idea of convergent validity within the EssenCES and found statistically significant positive correlations with the Good Milieu Index (GMI), the Ward Atmosphere Audit Measure (WAAM), and statistically significant negative correlations with the WES-10. However the strength of these relationships varied between subscales of the EssenCES. *Therapeutic hold* showed the strongest convergent validity, followed by *experienced safety*. The validity of these subscales was consistent with expectations and was generally comparable to those reported by Schalast et al. (2008) in the original validation study. However, Howells et al. (2009) did not find statistically significant correlations for the subscale *patient cohesion* and related constructs and wondered if this was due to the loading of PC3 onto the *experienced safety* subscale. Furthermore, Quinn, Thomas, and Chester (2012) investigated the use of the EssenCES with individuals with intellectual disabilities, and inconsistent results were found between patients residing on low secure units and those residing in medium security units; however it is noted that results were suggestive of construct validity. As the results did not replicate the findings of Schalast et al. (2008), it could be suggested that this difference represents a cultural difference in the social climate construct (Quinn, Thomas & Chester, 2012). However, when Milsom et al. (2014) evaluated the

construct validity of the EssenCES they used the revised and reworded version and subsequently found a strong correlation between PC3 and the other items within the *patient cohesion* scale.

4.4.2.3.1 Content Validity.

Content validity refers to the appropriateness of the included items to test that construct and whether a measure represents all facets of a given social construct. If any aspect is lacking, then the measure will not truly represent the concept being assessed. For example, the EssenCES must include all possible aspects relating to the social climate of an environmental setting. The EssenCES was developed in response to several criticisms of the WAS, including its failure to assess one essential aspect of social climate in forensic settings – perceived safety. Schalast et al. (2008) recognised the importance of this aspect as a measure of social climate and so its inclusion as a subscale in the EssenCES strengthens the measure's content validity. To try to ensure the EssenCES had strong overall content validity, the first stage of its development included Schalast et al. conducting three studies investigating different aspects of perceived ward climate. Subsequent to this, the use of scale and factor analyses indicated the relevant characteristics which were pertinent in different clinical and institutional settings. Finally the 15 item instrument was designed with three climate features of *therapeutic hold, patients' cohesion and mutual support, and experienced safety*.

4.4.3 Factor Structure.

Factor structure is the correlational relationship between a number of variables that are said to measure a particular construct. The EssenCES adopts a three-tiered factor structure, with each factor (subscale) consisting of 5 items (questions). For the factor structure of a measure to be a solid one, it is important that each item load onto the intended factor to enable accurate analyses. Schalast et al. (2008) used factor analysis to test the EssenCES dimensionality. Items assigned to one subscale loaded onto one factor, and all items attained a loading of at least 0.60 up to 0.86 on the ‘right’ factor and no item reached 0.40 on the ‘wrong’ factor, which is indicative of a robust dimensional structure.

In 2009, Howells et al. found all items attained a loading of at least 0.66 on the factor previously established in the original German study, lending support to their findings of a solid factor structure. An exception to these findings was PC3 which cross-loaded 0.55 onto *experienced safety* instead of the expected *patient cohesion*. Subsequent to this finding, this item was amended and the EssenCES updated. This three-tiered factor structure has been supported in all subsequent validity studies of the EssenCES (Tonkin et al., 2012; Milsom et al., 2014).

Currently, only Tonkin et al. (2012) has investigated the factor structure of the EssenCES whilst accounting for the hierarchical nature of social climate data. Previous studies’ analyses have assumed that each data set collected was in isolation from the responses of the other participants (Kinnear & Gray, 2009), whereas in fact social climate data is organised in a hierarchical manner, with individual staff and residents located in specific wings or wards. As a result, the assumption of statistical independence is violated as it is possible that individuals who reside or work in the

same specific setting may have more similar views of the social climate of that setting than individuals from different wings or wards. To account for this structure, the study examined the factor structure of the EssenCES using confirmatory factor analysis within the intricate survey design function of *Mplus*-6 (Muthén & Muthén, 2010) with ward as the unit of cluster. Their results demonstrated good fit for the three-factor oblique model with items loading significantly onto their target factors. Furthermore the study considered the fit of the three-factor oblique model to the data from (1) prison versus hospital settings and (2) staff versus residents; they found that factor structure and loadings were comparable across these analyses.

4.4.4 Normative Samples.

Normative samples give a reference of scores obtained from a ‘normal’ population. Using these as a reference, scores attained from the sample under investigation can be compared to the ‘norm’ peer group to assess how expected the results may be. Without ‘normal’, comparative levels, the scores obtained from the measure may be less meaningful.

Currently there are statistical norms for German forensic psychiatric population (Schalast et al., 2008). These norms are based upon data collected from 46 forensic wards (333 staff and 327 patients). The authors note that these norms are not a reliable frame of reference to interpret findings with other versions of the instrument. Furthermore, they advise caution when using the norms to appraise findings in other settings (e.g. prisons) and generally suggest that the norms should be used as a source of comparison for interest only.

There is also preliminary normative data for UK high-security forensic psychiatric populations (Howells et al., 2009), Australian prison settings (Day et al., 2011), and UK medium-security forensic psychiatric populations (Milsom et al., 2014). The recently published manual provides normative data for international prison settings; averaged norms are provided from research conducted in four different countries with the results being pooled to provide the norms. There are currently no normative samples for adolescents, females, low-secure units, units containing individuals with an intellectual disability or UK prison settings.

4.5 Conclusion

The EssenCES has an emerging research base which is supporting of its recognition as a valid and reliable measure of social climate. It is short and easy to administer, and has already been modified to fit different environmental settings in a variety of languages.

The original German version of the EssenCES was found to be a valid and reliable measure of social climate. More recently, the English version of the EssenCES has been validated in multiple settings and the psychometric properties of the measure have remained stable, supporting the notion that the EssenCES is an acceptably valid measure of social climate. It consistently receives empirical support for its three-factor structure, and some studies have shown it to have good internal consistency for its three subscales. There is support for the reliability of the scale across different samples (prison settings, forensic psychiatric hospital settings, staff, and residents) however results are inconsistent. *Therapeutic hold* has consistently achieved the lowest internal consistency score, however Cronbach's α score has always been of an acceptable level.

Howells et al. (2009) found a CITC score below the acceptable 0.20 cut-off in the *patients cohesion* subscale, and CITC scores as low as 0.15 were found by Milsom et al. (2014) in the *experienced safety* subscale. Both studies removed the low scoring items and conducted the analyses again; both found that there was no significant impact on the overall internal consistency of the EssenCES. The lack of impact of the removal of these items may indicate that the scale does not have strong internal reliability.

Although there are areas of strength in the reliability and validity of the EssenCES, it is not possible to argue that the EssenCES has test-retest reliability. Very little research has been conducted in this area, and if we cannot guarantee that the a measure would yield the same results if it were used to assess social climate at another point in time, can we really be sure that it is an effective measure of the milieu of a setting? It seems reasonable to argue that social climate is a dynamic factor that can change day-to-day, however one must agree that the general ‘feel’ of a ward or unit is a relatively stable construct that does not experience acute changes on a daily basis. Thus, if it is to be assumed that a social climate is relatively constant, any test of social climate needs to show temporal stability and so it is not unreasonable to argue that further research into the test-retest reliability of the EssenCES is necessary to confirm it is a consistent and reliable measure of a social climate.

The studies that have evaluated the psychometric properties of the EssenCES (aside from Schalast et al., 2008, Day et al., 2011, and Tonkin et al., 2012) have not made any clear differentiation between the staff and patient questionnaires. In addition, any differentiations made are not consistently analysed. The validity and reliability statistics reported do not indicate if the levels of significance are stronger in either population, indeed it is rarely commented on. It may helpful for future research to focus on the differences between the populations. Furthermore to this, future research should

be conducted focussing on different patient populations. Although a variety of populations have been used in research, the more extensive research studies do not discriminate between populations in their analysis, instead just commenting on the levels of reliability and validity as a whole. As the EssenCES has been rolled out as the measure used to assess social climate in numerous NHS and private healthcare settings, further evidence to support its use in all these populations is necessary as if reliability varies from population to population, more discretion may be necessary when choosing which measure of social climate to use in different settings. In addition, further validation is required in low secure units, adolescent units, female only units and units containing individuals with an intellectual disability. Quinn, Thomas, and Chester (2012) investigated the use of the EssenCES in a secure service for individuals with an intellectual disability and results were inconclusive as to whether or not the scale was valid for a population of this kind (however it is noted that results did suggest that the EssenCES could potentially be considered a valid concept for use with individuals with intellectual disabilities). When considering this study, it is important to note the small sample size and further research into this area could provide more robust results.

A manual for the EssenCES has recently been published (Schalast & Tonkin, 2016), and this provides some useful information for its application and interpretation. Although the manual includes some international reference norms for prison settings, the norms from four countries (Australia, UK, Germany, and Singapore) are pooled and averaged to generate preliminary normative statistics. However, the norms from Singapore are derived from only one institution and therefore its ability to be representative of the national prison system is questionable. This limitation is also relevant to the norms for the Australian correctional system which are derived from just two institutions. Finally, it seems unreasonable to consider that the social climate of

institutions housed in four separate countries can be represented by one statistic, and Schalast and Tonkin's argument that all are Western countries and so are "basically comparable" (p. 91) is weak.

Finally, although the EssenCES is felt to be an efficient measure of social climate (containing a mere 15-items), it is not unreasonable to suggest that it perhaps does not give an in-depth view of social climate. For a scale to have sufficient validity, its factors must have a good bandwidth to be a true representation of the construct in question (Clark & Watson, 1995). It could be argued that the EssenCES does not have sufficient breadth as each factor only containing five items, therefore it does not give a comprehensive account of the elements which contribute to a social climate. As a result of this, there may be times when a more detailed insight into the social climate of a therapeutic environment may be more beneficial, and in these instances perhaps some of the longer (although less empirically supported) measures could be more appropriate.

CHAPTER 5

Discussion

5.1 Aims of the Thesis

The thesis aimed to consider the experiences of staff working with a forensic PD population. Firstly it aimed to explore the literature surrounding the challenges and psychological impact of working with offenders with PD. The intention was that if this suggestion was supported, it may develop understanding of what aspects of a forensic PD population present the most challenges and how these impact on a professional's capacity to enjoy their work and feel satisfied.

Following this, the thesis aimed to investigate the experiences of professionals working with personality disordered offenders in a specialist unit located within a high security prison. The intention was to produce a substantive model of one unit and stage in the new Offender Personality Disorder Pathway strategy from a staff perspective aiding our understanding of their experiences, and to set a research agenda to develop ideas and their application.

Finally, the thesis critiqued the psychometric tool the Essen Climate Evaluation Schema (EssenCES; Schalast et al., 2008). The intention of this chapter was to investigate the availability of a tool which is able to measure the therapeutic milieu of an environment, and subsequent implications for the scarcity of such a tool.

5.2 Main Findings Relevant to the Literature

5.2.1 Chapter 2: What psychological consequences do employees experience when working with individuals with personality disorder?

Chapter two comprised a literature review following a systematic approach. A total of eight studies were included in the review. Studies indicated a variety of

psychological consequences experienced by staff working with personality disordered offenders, including negative emotional lability, staff 'burnout', feelings of professional isolation, and reduced self-efficacy. However, despite the dominance of negative consequences from working with offenders with PD, positive experiences were also identified including feeling professionally challenged in their work alongside feelings of satisfaction.

The studies cited consistently identified the psychological consequences of working with offenders with personality disorder, and supported the general consideration that individuals with PD are difficult to manage and have a negative impact on staff. High levels of burnout were described, however these were lower than levels reported by the mental health professional sample norms from Maslach and Jackson (1986) and when compared to previous studies investigating burnout in mental health professionals (Benbow & Jolley, 2002; Carson et al., 1999). These results were unexpected and indicate that currently research into the impact of working with individuals with PD is inconsistent at best.

Although the results of the review support the notion that working with offenders with PD has a negative impact on staff, a limitation of the papers included in the review was that not all considered factors external to the challenging personality traits of the individuals, (e.g. the impact of the service environment), and none of the studies focused on professionals working within a prison service. The results of the review highlight the importance of understanding the experiences of staff who work with people who have PD, and therefore indicate that a focus on trying to understand professionals working in the context of a new organisational pathway is required.

5.2.2 Chapter 3: How do professionals experience working with offenders diagnosed with Personality Disorder within a prison environment? What factors influence differences in responses?

The third chapter consisted of an investigation into the experiences of professionals working with offenders with personality disorders and difficulties on 'Unit A' located in a high security prison establishment. 'Unit A' is a pilot service and is part of the Offender Personality Disorder Pathway. It is novel in its approach to working with offenders with personality disorder and currently there is no known research evaluating the implementation of this new strategy.

The OPDP strategy was developed from principles learned from research and practice evidence, the learning from the DSPD pilots and the guidance from the National Institute for Clinical Excellence (NICE, 2009a, 2009b). A large focus was placed upon workforce development, and the training and support required for staff working within the pathway. With this in mind, it was felt useful to conduct a study in one specific service offered by the OPDP to ascertain how professionals were experiencing their work.

Overall, the results of the study indicate that professionals' experiences of their work with offenders with PD can vary. However one over-arching influential theme indicated by the study was the prison environment. The study confirmed previous literature which acknowledges the challenges placed upon staff by organisations (Kurtz & Jeffcote, 2011). Both clinical and discipline staff experienced frustrations more as a result of the environment, than from contact with the offenders. However this finding was in contrast to previous literature in which staff found the organised, structured nature of the environment more favourable than other mental health settings (Kurtz &

Turner, 2007). Although the impact of the environment was not a wholly surprising theme, its prominence in the study suggests that the new OPDP strategy has yet to account for the uncomprehending nature of the wider prison service within which the new pathway sits. This lack of understanding is shown by the subthemes of ‘the unsupporting nature of the wider prison’ and ‘lack of knowledge’. The wider societal attitude towards offenders with PD has previously been described as “ambivalent” (Lavender, 2002), however this study found that participants felt wider prison employees were unsupportive of the work on ‘Unit A’ and held negative beliefs about the offenders on the unit and supports previous literature (Kurtz & Turner, 2007). For the pathway to develop its workforce through provision of training designed to change attitudes towards those with personality disorder, the pathway first needs to have a bank of staff willing to work in the pathway, and this study highlighted the lack of staff from the wider prison establishment willing to even consider this; this was mentioned in all of the discipline staff interviews, and is supported by the researchers knowledge of ‘Unit A’ being consistently understaffed during its commission. As the findings of the study suggest, a key component of the success of the OPDP pathway will be the broader training of those in contact with offenders with PD – especially those working in prison establishments who perhaps have a more limited theoretical knowledge of the pathologies of the disorders.

In-keeping with previous literature that highlights the importance of staff feeling supported when working with offenders with PD (e.g. Crawford et al., 2010; Kurtz & Turner, 2007), an emergent theme within the study related to ‘support’. The results of this study indicate that despite the implementation of group supervision, and monthly clinical supervision for discipline staff, the majority of discipline participants felt that the level of support was inadequate or felt it held no value. Indeed, one participant

described how they did not feel supported at a time when they described feeling “burnt out.” Participants reported that a potential causal factor that would result in them leaving ‘Unit A’ would be the breakdown of relationships within the staff team and a lack of support, and the findings of this research suggest that maintenance of strong support structures when working with offenders with PD seems to be a necessity. Currently there is no research focussing on the effectiveness of the support structures and interventions in place to support professionals working with offenders with PD, and a focus for future research would be to assess the usefulness of such interventions. Research into this area would help to identify what elements of the support structures are effective, but also what is holding professionals (in this study specifically discipline staff) back from engaging in the support offered. This knowledge could help to inform decision making in the development of staff support and training. Research focussing on the impact of the prison ethos on its employees in relation to reflective practice and supervision could highlight training needs which would help to encourage professionals to seek more regular, psychologically informed support in addition to highly valued peer support.

A key finding from this study was the seemingly different experiences of the clinical staff and discipline staff. Previous studies have not considered the varying experiences of different members of an MDT, and therefore the inclusion of the theme “synergy of the workforce” is an addition to the knowledge base on what impacts a professional’s experience of working with offenders with PD. This raises important questions with regards to the applicability of situating the new pathway into the potentially ‘punitive’ or ‘anti-therapeutic’ prison environment, and the ability to integrate the pathway into the embedded prison ethos. Further to this, the research highlighted the difficulties experienced by professionals co-working within an MDT

comprised of two separate organisations (NHS and prison service). The conflict experienced as a result of the differing knowledge bases and reactions to offender behaviour can cause ruptures within staff teams, amplifying their negative experience of their work. This study suggests the potential for difficulties that may arise from the breakdown of professional relationships when working with offenders with PD, supporting previous literature which emphasises the importance of peer support in work of this nature (Kurtz, 2005; Kurtz & Turner, 2007), however no identifiable solutions or effective practice were acknowledged through the research. Through the researcher's experiences interviewing participants, it is clear that both staff sub-groups valued the co-working nature of 'Unit A'; perhaps supervision sought from a source external to the service may enable individuals less familiar with giving and receiving feedback on practice to feel more comfortable with discussions of this nature. This would hopefully enable more effective reflective practice sessions within teams where a safe environment was upheld thus encouraging open communication.

Previous literature (Crawford et al., 2009; Kurtz & Turner, 2007; Miller et al., 2012) highlighted the positive experiences professionals garnered from working with individuals with personality disorder. This study supports previous literature and illustrates positive experiences achieved by professionals on 'Unit A' via the theme of personal growth. Participants felt they had grown psychologically and developed professionally. Future research into what elements of working with offenders with PD are rewarding would be beneficial. This could inform future provisions to enable the strengthening of these practices to enhance the experiences of professionals thus potentially improving the service provided to prisoners.

Finally, the research produced a grounded theory model of how professionals experience offenders with a diagnosis of personality disorder within a prison setting.

The model aims to be potentially inform practice through highlighting important issues relating to work of this nature that need to be considered when working with offenders with PD. The interplay between the themes and subthemes, for example the challenges experienced as a result of co-working and its influence over an individual feeling supported should be considered in future PD services.

5.2.3 Chapter 4: Critique of a psychometric; The Essen Climate Evaluation Schema (EssenCES; Schalast et al, 2008).

The critique of a psychometric used to assess the therapeutic milieu of a clinical environment is beneficial to this thesis with regards to informing future research into professionals' experiences when working with offenders with PD. The EssenCES has been widely acknowledged as the 'go-to' tool to measure the therapeutic climate of an environment and has an emerging evidence base for its psychometric qualities. The EssenCES was developed in response to the criticisms of the WAS and CIES, and was intended to be a short and psychometrically robust alternative.

The EssenCES was considered to be a generally valid and reliable tool to assess the therapeutic climate of an environment, and has been translated into multiple languages. However, the validity of the EssenCES is questionable in relation to its factor bandwidth, as each factor only contains five items and so it could be argued that this does not sufficiently represent the construct of social climate. Another pertinent short fall of the EssenCES is the lack of test-retest validity evidence. In relation to this thesis, when one considers the impact the environment has on the experience of professionals working within it, a tool that is able to differentiate between experiences over a continuum of time, would be vital to assessing and improving that environment.

Bottoms (2003) emphasised the importance of climate on prison-based interventions and highlighted that social climate and interventions to change behaviour occur as an interaction between staff and prisoner attitudes, beliefs and values. If these factors are unable to be assessed on a longitudinal scale, the development and improvement of an environment, and subsequently the experiences of both professionals and offenders, will be hindered.

5.3 Thesis Strengths and Limitations

This thesis was successful in identifying gaps in the knowledge base around working with offenders with PD, specifically, focussing on experiences within a prison setting since the implementation of the new Offender Personality Disorder Pathway, and has provided a preliminary analysis of the experiences of professionals working within this pathway.

The research was conducted on a specific unit within a specific high security prison, despite the advantages to this that have been outlined above, the specificity of the research has consequentially limited the generalisability of results to professionals working in other establishments. The closure of 'Unit A' also has implications; it could be argued that this provides evidence for the influence an environment can have on professionals working with offenders with PD, conversely the closure may have had a more significant impact on the results of the study than if the research had been conducted in an alternative prison environment.

Subsequent to completion of the research study, a systematic literature review has been obtained; Freestone et al. (2015) conducted a review of literature investigating

the impact of working with personality disordered offenders. The results of their review support the findings of this thesis and identified negative impacts of working with personality disordered offenders including: stress, burnout, negative attitudes, and negative counter-transferential experiences. Two of the identified studies detailed positive impacts of job satisfaction and excitement. The review included studies focussing on professionals working within prison environments, however did not include any investigations into the new OPDP strategy or studies which examined MDTs.

The result of this study has identified future research areas and shows potential for informing future personality disorder services with regards to training, support, and location.

5.4 Application of Findings

This thesis has shown that working with offenders with PD results in complex psychological and psychosocial experiences for professionals. Further to this, the environment within which a PD service sits also has implications for how a professional experiences their work. It is useful to consider these findings when reflecting upon the ‘failure’ of the DSPD strategy and also the closure of ‘Unit A’ subsequent to this research; consideration must be given as to why these strategies were unsuccessful. Lewis and Appleby (1988) were the first to indicate the need for specialist training when working with offenders with PD, and although this may be sufficient to increase the knowledge base of professionals with regards to the psychopathology of offenders, it would appear that it does not adequately account for factors external to the challenging personality traits of the offenders that also influence how a professional

experiences their work. The findings of this thesis suggest that encouraging the development of knowledge in all aspects of PD offender rehabilitation appears necessary for professionals to feel supported by the wider establishment and also by their peers external to the OPDP. In addition, this increase in understanding could potentially help foster motivation to work with and support offenders with PD, thus resulting in a stronger, more comprehensive workforce.

The findings of the research study suggest that increased communication, potentially in the form of whole team reflective practice sessions, could help to address the negative views each participant sub-group held towards the other. An environment which aims to enable more open communication to allow for ruptures and disagreements to be discussed, and stereotypes to be challenged, could potentially result in a more cohesive and resilient staff team. It would also be of benefit for the staff team to consist of numerous experienced staff members who would be able to contain the anxieties of those less experienced.

The Ministry of Justice (2011) published guidelines relating to working with offenders with personality disorder. These guidelines were published when the DSPD initiative was still being implemented, and so do not incorporate findings from subsequent research. In addition, the findings in this thesis suggest that professionals within the prison service experience their work differently to clinical staff employed by the NHS, and so published guidelines may not be relevant to all professional groups and environments. The findings of this thesis suggest that evaluation of a therapeutic environment could be of benefit to analyse professional experience within the prison system, and also to support implementation of new strategies for support. Greater understanding of the difference between the prison ethos of offender rehabilitation and NHS ethos could support the identification of suitable prison establishments to house

novel and innovative PD services such as ‘Unit A’; for example, it could be inferred from the findings of this thesis that high security establishments may not be the optimum location for PD services due to the restrictions imposed on units that are in conflict with the longitudinal rehabilitative aims of the OPDP. Based on the findings of the research project regarding the impact of prison ethos, it may be prudent for PD services to be housed in establishments that have a previous record of hosting therapeutic interventions, or are seen to hold value in more therapeutic, less punitive measures of offender rehabilitation.

5.5 Future Research

The findings of this thesis have identified areas for future consideration in this topic area. Research into this area is often of a qualitative nature to enable a researcher to collect as comprehensive a picture of a professional’s experiences as possible. Future research would be minded to adopt a longitudinal, quantitative approach to study so that findings could be analysed over time, or compared against findings into professionals’ experiences with different offender populations. It may also be of benefit for future studies to be conducted using methodology that allows for a larger number of participants to be included. Lastly, if possible, it may be helpful for professionals who chose to leave the OPDP to be included in research studies, to enable better understanding of their decision, thus potentially providing useful information for training and support structures.

The Offender Personality Disorder Pathway was developed from the key learning points from the literature, from the closure of the DSPD pilot units, and guidance from the National Institute for Clinical Excellence (NICE, 2009a, 2009b). It

highlighted the importance of a strong, cohesive workforce to deliver interventions and support offenders with PD. The findings of the research study indicates that, despite these guidelines being acknowledged and implemented, professionals working with offenders with PD still, to some extent, feel unsupported, experience times of professional inadequacy, and experience high levels of emotional reactions to the client group. In response to this, what is needed from future research is analysis of the effectiveness of the support structures in place for professionals working with offenders with personality disorder. It is expected that research will need to be replicated within different environments of the OPDP (e.g., prisons, PIPES, and the community). The findings would enable support structures to be modified to fit the needs of the professional population in question, thus hopefully benefitting the individual offenders through a stronger, more effective workforce.

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APPENDICES

Appendix 1 –Search term syntax

Applied Social Science Index and Abstracts – Proquest (ASSIA)

Personality disorder*

AND (Employee* OR staff OR worker OR therapist* OR psychologist* OR psychotherapist* OR nursing staff OR prison staff)

AND (Negative impact* OR consequence* OR effect* OR negative* OR psychological effect* OR well being OR trauma* OR depression OR anx* OR fatigue OR burnout OR job satisfaction)

PsychINFO – 1987 to week two June 2016

1. exp Personality disorder
2. exp Personnel
3. exp Health Personnel/ or exp Medical Personnel/ or exp Psychiatric Hospital Staff/
4. exp Therapist*/
5. exp Psychologist*/ or exp Clinical Psychologist/
6. exp Psychotherapist/
7. exp Psychiatric Nurses/ or exp Nurses/
8. exp Prison Personnel/
9. 2 or 3 or 4 or 5 or 6 or 7 or 8
10. exp Major Depression/ or exp Well Being/ or exp Adjustment/ or exp Role Perception/
11. exp Stress/
12. exp Mental Health/ or exp Psychological Stress/ or exp Stress Reactions/ or exp Mental Disorders/ or exp Self Esteem/
13. exp Emotional Trauma/ or exp Trauma/
14. exp Depression (emotion)/
15. exp Anxiety/ or exp Anxiety Disorder
16. exp Fatigue/
17. exp Occupational Stress/
18. exp Job Satisfaction/
19. 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18
20. 1 and 9 and 19

OVID EMBASE – 1974 to 10 June 2016

1. exp Personality Disorder/
2. exp Employee /
3. exp Staff/ or exp Nursing Staff/ or exp Medical Staff/ or exp Staff Nurse
4. exp Worker/
5. exp Psychologist/

6. exp Psychotherapist/
7. 2 or 3 or 4 or 5 or 6
8. exp Quality of Life/
9. exp Psychological Aspect/ or exp depression/ or exp anxiety
10. Injury/ or exp Psychotrauma/
11. exp Fatigue/
12. exp Burnout/
13. exp Job Satisfaction/
14. exp Well Being
15. 8 or 9 or 10 or 11 or 12 or 13 or 14
16. 1 and 7 and 15

OVID MEDLINE – 1946 to week one June 2016

1. exp Personality Disorder/
2. exp Medical Staff/ or exp Nursing staff/ or exp Medical Staff Hospital/ or exp Nursing Staff Hospital/
3. Stress Disorders/ or exp Post-Traumatic/
4. Wounds & Injuries/ or exp Shock, Traumatic/
5. exp Fatigue/ or exp Mental Fatigue/
6. exp Anxiety/ or exp Anxiety Disorders/
7. exp Depression/
8. exp Burnout/ or exp Stress, Psychological/ or exp Job Satisfaction
9. 3 or 4 or 5 or 6 or 7 or 8
10. 1 and 2 and 9

Appendix 2 – Quality assessment form

Question	Yes (2)	Partial (1)	No (0)	Unsure	Comments
AIMS OF THE STUDY					
Is the aim of the study clearly stated?					
SAMPLING AND SELECTION BIAS					
Does the sample represent the population?					
Are key personal characteristics of participants reported?					
Was the recruitment strategy appropriate to the aims of the research?					
Is there any mention of ethical procedures implemented?					
STUDY DESIGN					
Was the research design appropriate for the aims of the research?					
Is there a discussion about why the methods were chosen?					
Were the measures used appropriated for the aim?					
Have the validity and reliability of the measures been discussed(if relevant)?					
RESULTS AND FINDINGS					
Have the appropriate statistical measures been used (if relevant)?					
Is there a clear statement of findings?					
Are the implications for practice reported and discussed?					
Has future research been considered?					

Appendix 3 – Data extraction form

Author(s):

Title:

Year:

Journal:

Method

Type of study:

Recruitment process:

Sample size:

Participant characteristics:

Quantitative

Measures used:

Validity of measures used:

Qualitative

Data collection method:

Analysis method:

Results/Analysis

Quantitative

Statistical tests:

Qualitative

Analysis methods:

Findings:

Main themes:

Overall findings:

Quality Score:

Percentage:

Appendix 4 – Consent Form

Consent Form

Title of the Proposed Study

How do professionals make sense of their experiences when working with offenders with personality difficulties? What factors influence differences in responses?

Statement of Understanding/Consent

- I confirm that I have read and understand the participant information leaflet for this study. I have had the opportunity to ask questions if necessary and have had these answered satisfactorily.
- I understand that my participation is voluntary and that I am free to withdraw without providing reasons. However, I understand that if I wish to withdraw I must do within a month of participating in my interview.
- I understand that my contribution to the research will be kept confidential and I will be assigned a pseudonym that will be attached to any quotes reported. I understand that direct quotes from my interview may be published in any write-up of the data, and used for training purposes, but that my name will not be attributed to such quotes and I will not be identifiable by my comments.
- I understand that if I disclose any acts of malpractice which may result in potential harm to others the interviewer has a responsibility to report it to management.
- I understand that my personal data will be processed for the purposes detailed above, in accordance with the Data Protection Act 1998.
- Based upon the above, I agree to take part in this study.

Name, Signature and Date

Name of Participant

Date

Signature

Name of Researcher

Date

Signature

Appendix 5 – Participant Questionnaire

1. Your current job title:.....

2. How long have you been in your current job?

Less than 6 months

between 6 – 12 months

12 – 18 months

more than 18 months

3. How long have you worked with individuals with personality difficulties

Less than 6 months

between 6 – 12 months

12 – 18 months

more than 18 months

If longer than 5 years, please state

4. Age range: 20 -30 30 – 40 40 – 50 50 +

5. Are you? Male Female

6. Are you? Living on own Living with partner/married

7. Do you have any have any dependent children living with you?

Yes

No

8. Have you completed KUFF training?

Yes

No

9. Have you completed any other training since joining the LPPU?

Yes

No

If yes, please state

Appendix 6 - Ethical approval from University of Birmingham

The approval letter is redacted to protect confidentiality.

Appendix 7 – R & D Approval

31st July 2015

Letter of NHS Permission for Research

The permission letter is redacted to protect confidentiality.

Appendix 8 – The Essen Climate Evaluation Schema (EssenCES)

EssenCES Questionnaire
for Forensic Psychiatric Hospital Settings

UNIVERSITÄT
DUISBURG
ESSEN

Essen CES®
Essen Climate Evaluation Scheme

LVR
Qualität für Menschen

I agree

	not at all	little	somewhat	quite a lot	very much
1 This ward has a homely atmosphere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 The patients care for each other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Really threatening situations can occur here	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 On this ward, patients can openly talk to staff about all their problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Even the weakest patient finds support from his fellow patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 There are some really aggressive patients on this ward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 Staff take a personal interest in the progress of patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 Patients care about their fellow patients' problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 Some patients are afraid of other patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Staff members take a lot of time to deal with patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 When a patient has a genuine concern, he finds support from his fellow patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12 At times, members of staff are afraid of some of the patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13 Often, staff seem not to care if patients succeed or fail in treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14 There is good peer support among patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15 Some patients are so excitable that one deals very cautiously with them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16 Staff know patients and their personal histories very well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17 Both patients and staff are comfortable on this ward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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The questionnaire is available for download from www.forensik-essen.de as a printable color pdf document (click on "EssenCES" in the frame on the right-hand side. Different language versions are available.)