How do professionals experience working with offenders diagnosed with personality disorder within a prison environment?

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

Abstract

Aims: To explore the different experiences of a Multi-Disciplinary Team working with offenders diagnosed with Personality Disorder (PD) and produce a substantive model of the Offender Personality Disorder Pathway strategy from a staff perspective.

Method: Fourteen participants were recruited from 'Unit A' located within a high security prison. Semi-structured interviews were conducted with participants and the data collected were analysed using constructivist grounded theory.

Results: A model was constructed depicting the experiences of those working with offenders with PD. Main themes identified were: prison environment; synergy of the workforce; understanding of the client; individual perceptions; support; and personal change. 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 health service based clinical staff and prison staff as expressed in the model.

Conclusions: There is interplay between factors which influence an individual's experience of working with offenders with PD. 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. These factors external to the client group appear to have a significant impact on the professional and their emotional experiences of their work.

Introduction

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." 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, Krishnan, & Daffern, 2007). Furthermore, considering that PD is characterised by an ingrained pattern of maladaptive behaviours (including offending behaviour) that damage the individual or those around them (Ministry of Justice, 2011). However, it should be noted that there may be considerable variation in manifesting behaviours between those who differ in their sub-types of PD.

It is understandable that working with this client group can elicit strong emotions and opinions from those working with them. In addition, as 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 extreme 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 can result in an

individual's emotional responses becoming amplified. There is now an evidence based opinion that people-centred work is a stressful form of employment (Coffey & Coleman, 2001). For example, 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, Tyler, & Nolan, 1996; Maslach & Jackson, 1986, p. 192). 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.

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. 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 violent offending - including murder, serious sexual violence, and sexual violence against children - offenders with PD can be viewed simultaneously as "fearsome perpetrators and traumatised victims" (Adshead, Bose & Cartwright, 2008, p. 304). 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; Perseius, Kaver, Ekdahl, Asberg & Samuelsson, 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.

Haddock, Snowden, Dolan, Parker and Rees (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. 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) highlights the complexity of the challenges that are associated with this client group (Lewis & Appleby, 1988). These complexities are likely to be compounded when considered alongside the high co-morbidity rates of within individuals with PD and other more general mental illness diagnoses.

Subsequent to the closure of the Dangerous and Severe Personality Disorder units (DSPD) (Duggan, 2011; Scally, 2012; Tyrer et al., 2010) , 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 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 1 illustrates the five principle stages of the pathway.

Insert figure 1 about here

'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. Offenders located on 'Unit A' have a variety of personality disorder diagnoses, including Antisocial, Borderline, and Dependent. 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 as a Multidisciplinary team 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.

Aims

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. 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.

Method

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). In the current study, fourteen participants were recruited and interviewed (See Table 1). Nine were female (aged between 20 – 50+) and 5 were male (aged between 20 – 50+). Participants interviewed represented 78% of the total participant population and all job roles within the MDT (see Table 1 for details).

Insert table 1 about here

Design & Procedure

Participants were informed of the research at their weekly team meetings. Those who chose to participate in the study were asked to sign and date a consent form, complete a questionnaire and then took part in a semi-structured interview.

Interviews were conducted utilising a semi-structured approach which encouraged a narrative response. The interview schedule (Figure 2) provided a guide to the topics being covered in the interview. The study received NHS (National Health Service) Research and Development approval and NOMS and ethical approval.

Insert figure 2 about here

Data Analysis

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.

The data was analysed using the suggested coding paradigms of Strauss and Corbin (1998). The coding was conducted by the first author who is trained in grounded theory techniques. 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. Four interviews were conducted and transcribed and subject to the grounded theory coding process. Emergent codes were discussed with an independent coder 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 analysis resulted in the development of a number of over-arching categories and subcategories.

Results

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 (Table 2). 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 3).

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.

Insert figure 3 and table 2 about here

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 2.

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).

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).

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.

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" (CS 3) 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). . Participants also mentioned the difficulties the unit staff had integrating into the rest of the 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).

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 were generally positive albeit with some expressed challenges.

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

'Unit A's philosophy was considered to be 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 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. 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.

However, discipline staff noted the challenges raised by working with offenders with PD in a therapeutic manner.

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, "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).

Although positive opinions were expressed, more negative experiences of co-working were discussed with some vigour. Discipline staff felt that clinical staff were condescending. 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.

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.

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.

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.

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' (removal from 'Unit A') 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)

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'.

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.

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).

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).

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.

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" (DS 4).

This theme and subthemes highlighted the impact of the disparity between the two participant populations.

Theme 4: Individual Perceptions

Participants' perceptions of the client group appeared to impact the way they experienced their work and appeared to impact on whether they experienced their work generally positively or negatively.

4.1) Perceptions of the client group.

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); "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": "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).

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, for example, "I do feel like I'm questioning myself and my capabilities a lot." (CS 2).

4.2) Attitude to work.

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).

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,

Overall, this theme highlights the significant role an individual’s perceptions play in how they experience their work with offenders with PD.

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.

5.1) Supervision.

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).

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.

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:

> 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 but also an influential factor on how they experienced the unit.

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). 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.

Participants spoke about an increased professional confidence

Responses from clinical staff are potentially indicative of their previous therapeutic experienced 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.

Insert Figure 3 about here

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.

Discussion

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 resultant model based on the analysis of the interviews, (figure 3), 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 research into stress and burnout in healthcare staff and mental health nurses (Carson et al., 1995; Onyett, Pillinger, & Muijen, 1997). 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. 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." For the OPDP 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 consider this. Consideration should be given to the influence of prescribed roles and organisational pressures in prison establishments. If the overarching expectations of the organisation are to function as a custodial and deterrent facility (Day et al., 2010); to expect prison officers to deviate from their role as a security enforcer whilst working in an integrated unit seems a challenge. 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. 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 carries important implications regarding the ability of the professional to provide adequate care and containment for the offenders on 'Unit A' as supported by Bion's (1962) psychodynamic concept of container/containment. Furthermore, parallels can be drawn between these anxieties and the experiences of nursing staff in mental health units; in times of heightened stress and diminished emotional capacity, staff can become preoccupied with activity and performance data and detached from their caring role (George, 2016). This lack of support from the wider prison establishment was demonstrated by the closure of the unit before the end of its contract, and its transfer to a 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 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'. 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 study 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.

Although 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. 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, prison officers 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. 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 experience. Alternatively, perhaps the prison officers feel the "draining" effects of the offenders more intensely due to their increased amount of contact time, a suggestion that is supported by a service evaluation conducted by Moran et al. (2008). 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 believed to be less empathic. The clinical staffs' perceptions of the discipline staff's lack of empathy were not supported by the study; 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 lack of theoretical knowledge, 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. Furthermore, it could be suggested that the recommendation for all discipline staff to attend generic PD training is another organisationally driven, task-oriented attempt to 'problem solve' the lack of understanding of the staff. A contrast to healthcare professionals who are encouraged to explore their reactions to offenders and develop their understanding of the intricacies of an individual's behaviours. 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. 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 (Murphy & McVey, 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. 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. Finally, it could be argued that the lack of supervisory uptake is another enactment of organisational defence against exploring emotions, for fear that analysing them may be overwhelming and ultimately destroy the team. 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). This also supports the previous suggestion of the influence of prescribed roles within the prison service, and that accessing emotional support is not considered necessary in this setting. 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. 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.

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 participant's 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.

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. The interviews utilised a semi-structured approach, and biases associated with self-report measures are acknowledged. . 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).

Implications for practice

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 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. Utilisation of the model to assess an establishment and its systems could enhance the likelihood of a successful placement of a PD Unit. In addition, using the model as a tool to support reflection upon professional experiences could aid the identification of areas of poor functioning (themes), thus hopefully encouraging teams to collaboratively work together to improve the identified underperforming area (theme).

Finally, although the research study specifically investigated the experiences of professionals working on a unit housing offenders with personality disorder, the

prevalence of personality disorder within prison establishments (Stewart (2008), estimated that PD affects approximately two-thirds of the prison population in the UK), the findings of this study carry implications for all prison staff, not only those working within a specialist service.

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Figure 1. The personality disorder pathway.

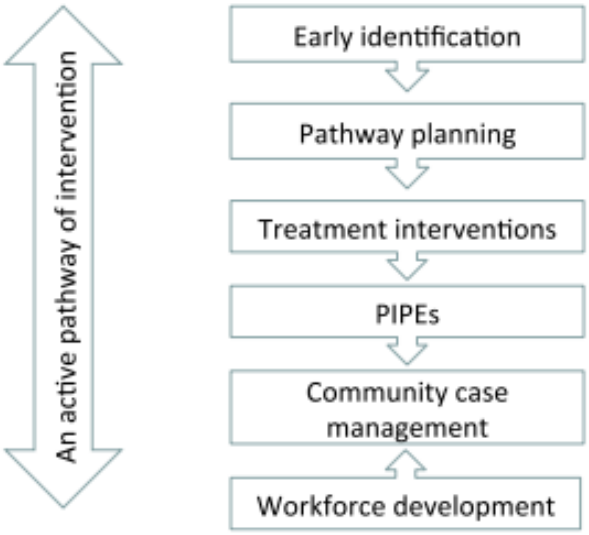

Figure 2: Interview schedule

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

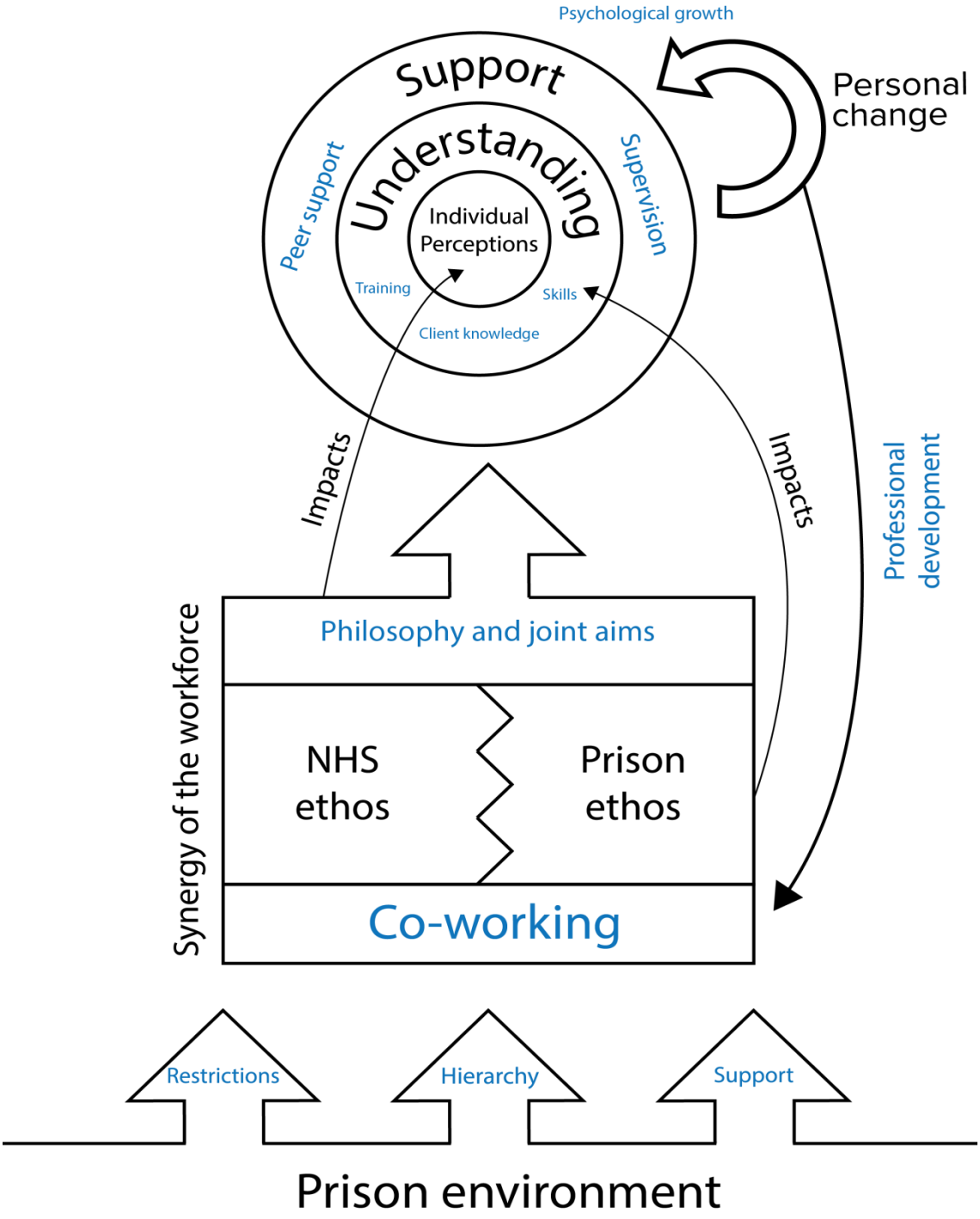

Table 1

Study participants

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

Table 2

Summary of Themes and Subthemes

	Theme		Subtheme
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