FROM PERVERSION TO POLICY:

KNOWING AND NOT-KNOWING IN THE EMERGENCE AND MANAGEMENT OF CRITICAL INCIDENTS

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Abstract

Through studying the report of a public enquiry - the *Report of the committee of the inquiry into the Personality Disorder Unit, Ashworth Special Hospital* (DoH 1999a) - and a detailed analysis of interpersonal processes in professional consultations with forensic practitioners through the 'lens' of a psycho-analytically-informed paradigm, a critical link is demonstrated between clinical interpersonal processes with patients in perverse, antisocial states of mind and professional performance. The study shows unconscious processes attacking reality and thinking, 'nudging' professionals into acting out of role in ways known to contribute to the emergence of critical incidents. It is grounded in an enquiry that effected changes in legislation, policy, clinical practice and the delivery of social care in secure psychiatric settings.

Social work is conducted within a social arena of contemporary concerns about risk and its prediction and management. When things go tragically wrong, events are scrutinised in the form of internal and public formal enquiries with emotive media commentary. Recent examples – Victoria Climbie, Baby Peter – demonstrate the way the public imagination can focus on perceptions of professional failings. The explosion of private events such as these into the public domain results in changes to structures, processes and political understandings in relation to risk, danger and fear.

Such enquiries illuminate professional conduct with hindsight, foregrounding decisions that may appear misguided and are popularly held as evidence of incompetence. However, rarely do they ask why apparently 'ordinary decent' professionals appear to have acted in extraordinary ways and usually sensible people sometimes do foolish things. This forensic study suggests that a psychoanalytic paradigm is a useful means of achieving a depth of insight in this context. It proposes widely applicable understandings of the types of personal qualities and management structures necessary to delivering high risk, high profile, anxiety-driven services in a social climate of fear.

Declaration

This thesis represents my own research and original work. It cannot be attributed to any other person or persons.

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Contents

The paedophile is the bogeyman of our age. The very word itself has become a conduit for fear and public loathing, often beyond all moderation. Indeed, despite the fact that the overwhelming majority of paedophiles are male, commentators reach easily for parallels with a reviled figure from a bygone age – the witch. While we haven't yet reinvented the ducking stool or trial by water, we have found a pretty effective 21st-century equivalent in trial by newspaper. And, after being named and shamed, the "guilty" are hounded from the community by a mob baying for blood. (Silverman & Wilson 2002: 1)

Chapter 1: Introduction: "Favouring fright over facts" (Gostin 2002)

These crimes are sickening. It is against this backdrop that one must ask why this child was allowed to visit these men, frequently unsupervised, at all, let alone on any ward, but particularly on this ward housing patients with serious personality disorders, all of whom had serious criminal histories, including murder, rape and sexual assaults against children. (DoH 1999a: 3.11.3)

…the professional isolation of the Social Work Department vividly demonstrated in the Hospital's approach to child protection, which appeared to reflect almost complete ignorance of the Children Act 1989 and its guiding principles. We shall see an example of the lack of clarity over the social work role when it came to vetting visitors. We shall also see the problems caused by a particular autonomous professional who neglected core social work duties for therapy; whose record-keeping was poor; and whose general approach to his social work duties demonstrated poor standards and reflected poor supervision. (DoH 1999a: 1.32.13)

...Before 1989 no sensible lawyer, doctor, social worker, psychologist, hospital administrator, or responsible member of the public would have thought it appropriate to expose young children to paedophiles, particularly paedophiles with known criminal histories. Before 1989 responsible members of the public would have been horrified by the knowledge that such exposure was allowed on the basis of it being therapeutically advantageous for such criminal paedophiles, who were not even close family members. That this occurred is something for which no one involved in Ashworth Hospital can escape a degree of criticism…. (DoH 1999a: 3.31.16)

Introduction

The above quotations from the *Report of the committee of the inquiry into the Personality Disorder Unit, Ashworth Special Hospital* (DoH 1999a) represent the 'headlines' of a series of critical incidents at Ashworth high secure hospital that appeared to indicate extraordinary levels of professional thoughtlessness, potentially amounting to incompetence and negligence, that reflected particularly badly on the discipline of social work. This research project was inspired by the notion that, although professional incompetence is a possible explanation for such events, there may be dynamic pressures arising as a feature of the specific organisational task that create vulnerability that can fatally undermine the capacity to think in even the most competent and experienced worker.

The aim of my research was to foreground and **show** these unseen, unconscious processes happening in moments in which the capacity of 'ordinary decent professionals' to think independently and maintain their effectiveness within their professional roles could be seen to be compromised – with potentially dangerous outcomes.

Background to the research project

Ashworth, Broadmoor & Rampton, the three British high secure psychiatric hospitals, provide settings for the detention and treatment of people who have demonstrated uniquely antisocial and perverse behaviours and states of mind. Their capacity to be dangerous presents particular challenges to those working within these institutions and the primary task of delivering treatment comprising integral elements of both therapy and security to manage risk within the organisation and to society. Such professionals are similarly confined in these total institutions, locked within inter-personal relationships with the patients, the boundaries and intensities of which vary according to their roles within the organisation.

Events at Ashworth Hospital during the 1990s were the subject of two substantial public enquiries that provided opportunities to observe these challenges and the kinds of dangerous situations that can arise within these closed communities. It is the second of these – the so-called Fallon Enquiry - that was the inspiration for this research project.

The enquiry was the springboard for a succession of changes to national policy and legislation that irrevocably altered approaches to security in this context, the development of services for patients with primary diagnoses of personality disorder and the delivery of social care in these settings, culminating in the reform of the Mental Health Act in 2007.

The Fallon Report gave a good account of untoward events within the Personality Disorder Unit at Ashworth Hospital and the challenges to clinical and managerial processes. However, much less evident was any real attempt to understand how or why some of the professionals concerned had appeared to act in extraordinary ways, whether this could be understood within the context of their coexistent institutionalisation with the patients, and how this might be reflected in the structures for managing clinical and operational processes.

The psychoanalytic paradigm provides a means of understanding the difficulties engaging with patients in antisocial states of mind through the suggestion that they employ regressive unconscious strategies within interpersonal relationships to control and defend against primitive, overwhelming anxieties. As an operational manager, I found it useful to think about how such paranoid-schizoid functioning might be enacted within the organisation and how this could create difficulties in thinking and in maintaining the fabric of reality sufficiently to perform the complex custodial/therapeutic primary task. I believed that such unconscious processes could undermine professionals' functioning and their capacity to maintain roles that are appropriate and grounded in reality and that their compromised performance could result in failures of clinical containment and risk management that:

1. potentially enabled eruptions into untoward events;
2. serious enough to be considered critical incidents;
3. potentially of sufficient scope to become the subject of public enquiries;
4. ultimately influencing overarching policy changes as an outcome.

These ideas are well-established in the literature: the aim of my research was to show such processes happening: to try to capture moments in the lives of professionals when they appeared to be 'swerved off course' and 'derailed' in their performance of the primary task, demonstrating a link between those moments and the specific

interpersonal context of working with forensic patients in antisocial or perverse states of mind. Having captured these moments, I set out to cross-reference them with the already-documented critical incidents described in the Fallon Report and scrutinise them through the particular paradigmatic 'lens' of the extant body of psychoanalytic literature.

My purpose was not to challenge the efficacy or conclusions of public enquiries, but to suggest that if the question 'why?' is asked within a wrong or narrow kind of paradigm, only partial answers may be found, more concrete than might emerge through the application of a psychologically-informed approach that could provide an additional depth of understanding to the experience of providing services for patients in perverse states of mind.

Below, I will expand upon the background and context to the research before describing the structure of this thesis.

Context to the research

The history of high secure psychiatric services and their transition from Home Office oversight to the mainstream NHS reflects the essential tension implicit in their organisational task that prevails to this day – and can be summarised as the apparent paradox in the need to provide both ethical, effective psychiatric treatment and secure detention. The deleterious history of these hospitals, punctuated by their various scandals and enquiries, has been well documented (NHS Hospital Advisory Service 1988; Mental Health Act Commission 1989, 1991, 1993, 1995; DoH 1992) along with regular calls for their closure: they have been the subject of critical external scrutiny since 1980 and such reports "paint a picture of insular, closed institutions whose predominantly custodial and therapeutically pessimistic culture had isolated them from the mainstream of forensic psychiatry" (DoH 1999a: 1.19.7).

The report of the Fallon Enquiry describes the high secure hospitals and their particularly challenging function:

> Mr Kaye went on to say that his 30 years' experience as a professional manager in the Health Service... had not prepared him for the dimensions of

the special hospital world. He wanted "to stress very strongly that it was a different world"...

> "every patient who enters a special hospital is adjudged to be dangerous clinically, physically dangerous;
>
> every patient who enters a special hospital is very ill, with a severe mental illness or a personality disorder of an extreme nature, or a combination of illnesses;
>
> every patient who enters a special hospital has exhausted every other type of care.
>
> These individuals have been through the whole gamut of health services, social services, the criminal justice system, the whole gamut of what is on offer, and none of that has had a significant effect on their condition;
>
> these hospitals are the end of the line for these individuals;
>
> ... They [patients] are forced to be there, they are forced to have treatment, and most of them do not want treatment. The whole milieu, the whole ethos, is radically different from anything you are going to see in the Health Service. Until you accept that and take that as your base line for looking at special hospitals, what they do, what problems arise, you will not understand at all what is going on within those institutions." (DoH 1999a: 2.1.19)

On 4th March 1991, the Channel 4 television series *Cutting Edge* screened a documentary entitled *'A Special Hospital'* depicting allegations of the mistreatment of patients by staff: specifically kicking a patient to death. Louis Blom-Cooper QC led the ensuing enquiry, predominantly upholding the complaints, highlighting failings in clinical and managerial leadership and coherent clinical models of care (DoH 1992; Murphy 1997).

On 7th February 1997, the Secretary of State appointed the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, led by Peter Fallon QC, to investigate the functioning of the Personality Disorder Unit at Ashworth Special Hospital in response to allegations made by a former patient, within these terms of reference:

> (i) to investigate the functioning of the Personality Disorder Unit at Ashworth Hospital following allegations about misuse of drugs and alcohol, financial irregularities, possible paedophile activity and the

availability of pornographic material within the Personality Disorder Unit;

(ii) to review, in the light of these investigations:
   a. the policies, clinical care and procedures of the Personality Disorder Unit;
   b. the security arrangements for the Personality Disorder Unit;
   c. the management arrangements at the Hospital for assuring effective clinical care, appropriate security for patients and arrangements for visiting on the Personality Disorder Unit;

(iii) to submit a full report to the Secretary of State for Health and to make recommendations for action. (DoH 1999a: 1.2.2)

In the *Report of the committee of the inquiry into the Personality Disorder Unit, Ashworth Special Hospital* (DoH 1999a), Fallon reported that conducting the enquiry was a "challenging, often depressing, but also fascinating task" revealing a "so fundamentally flawed" system. The relevant findings of concern were extraordinary and can be summarised:

- Allegations made by Steven Daggett, in '*My Concerns*' were upheld. Pornography was available to patients. Patients were involved with commercial businesses. Hospital policies were unclear and inconsistently observed. Physical, procedural and relational security was inadequate, inconsistent and not integrated into clinical processes.
- There had been inappropriate, unsupervised contact, between an eight year old girl and patients including those convicted of sexual offences and offences against children. Clinical staff failed to make appropriate assessments of risk or take requisite action. It was concluded that 'Child A' was being groomed for paedophile purposes.
- The PDU was described as a "deeply flawed creation" providing inadequate care.
- Management was considered "dysfunctional": senior managers "secretive, out of touch and totally unable to control this large institution".
- Four internal reports were suppressed and Ministers misled with inadequate information on at least two occasions.

- "It is time for a decisive change. Ashworth Hospital should close in its entirety at the earliest opportunity". (DoH 1999a: 7.3.21)
- Judgements were made on the conduct and performance of named individuals. (DoH 1999a)

The Fallon Enquiry contextualised itself within the implementation of the earlier enquiry report (DoH 1992) that had recommended liberalising patient care and relaxing institutional regimes. Although these recommendations had not been fully implemented before the Fallon Enquiry was established, the latter enquiry was critical of the implementation of the former, particularly the lack of recognition of the differing clinical needs of mentally ill patients as opposed to those with a primary diagnosis of personality disorder and the absence of strong clinical and managerial leadership. Much consideration was given to the specific needs of personality disordered patients and the challenges presented to staff involved in the provision of such services. The team believed that the task of transforming Ashworth into a 'centre of excellence', without "realistic prospect of it ever recruiting and retaining sufficient numbers of high quality staff who can be proud of the place at which they work" and the "negative, defensive and blame ridden culture" was beyond the capacity of "even the most talented management team" (DoH 1999a: 7.3.21). The difficulties implicit in the primary organisational task were consistent themes:

> …has the pendulum swung too far the other way, creating institutions which, although more like hospitals and less like prisons, now sit uneasily in the middle, unable to balance security and therapy appropriately? (DoH 1999a: 1.19.9)

> …we feel the conclusion is inevitable: the functions of hospitals and prisons as far as personality disordered offenders are concerned are dreadfully confused and need to be disentangled. Hospitals are being used as surrogate prisons because we lack the means to detain a category of dangerous offender indefinitely… (Ibid: 1.43.7)

Subsequent developments in national and local policy relating to forensic health and social care largely derive from these enquiries and developments in criminal justice legislation have particularly impacted on personality disordered patients. The Fallon Enquiry was especially critical of social workers "for their ignorance of basic child protection arrangements" (DoH 1999a: 4.8.1). Leadership was criticised, as were named individuals, and an absence of proper and appropriate professional supervision

highlighted. It specifically concluded that social workers had lost appropriate focus and clarity of role and were therefore unable to make appropriate contributions to multi-disciplinary working that promoted what should have been their areas of expertise. Social work in high secure hospitals was the subject of a formal review, reporting as the Lewis Report (DoH 1999b). Accordingly, developments in policy relating to these settings have made specific reference to social work in addition to security and the development of services to treat personality disordered patients (DoH 1999b, 1999c, 2000a, 2000b, 2000c, 2001a, 2001b, 2002a, 2002b, 2003, 2006a, 2009; DoH & Home Office 1999, 2000; DoH/NIMHE 2003, 2004; Home Office 2001) including the Mental Health Act (2007).

An outcome of the Lewis Report (DoH 1999b) and NHS reforms was merger of the high secure hospitals with existing NHS trusts, forming single focus mental health trusts providing a full range of services: responsibility for the social care services became that of local authorities in order to address the need to strengthen the identification with an appropriate social work role. *National standards for the provision of social care services in the high secure hospitals* (DoH 2001a) aimed to underline this by defining measurable activities – 'core tasks' that could be demonstrably delivered consistently.

The Tilt Report (DoH 2000a) acknowledged that the scrutiny of the high secure hospitals and subsequent service developments took place within a social context of increasing public concerns about the management of potentially dangerous mentally disordered offenders and sex offenders in the community and the risk of harm to the public. That report also described the central dilemma or tension in working within a high secure psychiatric hospital and holding in mind a primary task the components of which were integrated:

> The high security hospitals have clear twin security and therapeutic objectives. The security objectives include the protection of the public, by seeking that patients do not attempt to escape or abscond, and the provision of a safe environment for staff and patients within the hospitals. The therapeutic objectives include the need to do everything possible to provide therapy for patients so that their illness/disorder can be treated and their behaviour made less dangerous for others and themselves. It was clear to the Review Team from the outset that security and therapeutic issues were so closely interrelated that security could not, and should not, be dealt with in isolation. It is also important to state clearly that maintaining high levels of security is the responsibility of all staff in a high security hospital, not just the security staff, and that good security and therapy will be seen as

> integrated concepts rather than opposite ends of a spectrum. (DoH 2000a: 5)

A number of well-reported enquiries into homicides committed by mentally disordered offenders (Richie, et al 1994; Gabbott & Hill 1994; Asthal et al 1998) and the murders of Lynn and Megan Russell by Michael Stone in 1996 prompted ever-increasing social and public fears that appeared to elevate disproportionately and be fuelled by "unremitting, usually negative, media interest" (DoH 2000a: 5). Social concerns amounting to moral panics are reflected in legislation and criminal justice policy that increasingly provide for risk management and public protection (Cohen 1973; Showalter 1997).

After qualifying as a social worker in 1991, I worked as a probation officer, specialising in work with sex offenders, mentally disordered offenders and particularly high risk offenders, including those subject to life sentences. I was appointed as a senior social worker in a high secure hospital in June 2000. As a psychodynamic, clinically-oriented social worker I found myself 'tainted' by the way in which the Fallon Enquiry had reflected on social work. Whilst the national standards aimed to define, standardise and measure social work performance, they lent themselves to rigidity and simplification of a necessarily complex task. It seemed impossible to understand that there could be a psychodynamic approach to social work that was effective and supported the role of a social worker: the inference was that a psychodynamic social worker could not distinguish clinical social work from therapy. Whilst new to this idiosyncratic setting I found it reassuring to have a paradigm within which to frame my thinking and understand the organisation. I was struck by the extent to which the Fallon Enquiry shaped service developments and my experience of apparent suspicion of a thoughtful model of social work. This motivated my proposal for research.

Social concerns appear less engaged with the experiences of professionals working within such settings and the dynamic link between the professional/therapeutic relationship, the systemic context and the containment (or not) of dangerousness. Along with patients, professionals in these settings become 'embodied selves' (Goffman 1961; Foucault 1977; Chambon 1999), trying to balance the coexistence of care and control, equally subject to the imprints of the institution and its regulatory balances. They are inextricably bound within relational processes and their actions cannot be held in isolation to this. Where containment fails, the 'fabric' of the reality of tasks and roles

and the potency of appropriately-held authority is attacked, the capacity of professionals to think independently and function appropriately within their roles is compromised and critical incidents inevitably arise, exploding into the public domain. The subsequent process of enquiry impacts on policy-making at local and national levels.

The purpose of my research was to demonstrate these processes at work and show these attacks on thinking in relation to individual practitioners.

The thesis

The thesis is structured in the following chapters:

Literature review

I review the existing literature in relation to different approaches to thinking about total institutions, systems, boundaries, perversion and the social and policy context. All these areas are central to a process of thinking about the experience of working in secure forensic institutions and/or with patients in perverse or antisocial states of mind. I propose the psychoanalytic paradigm as particularly helpful to an understanding of dynamic processes as outlined above and that although there is a body of literature that applies such thinking to forensic institutions, the literature is not rich in this area, does not identify and show these 'moments of compromise' in minutiae and does not make good links to the required quality of structural processes available to manage these institutions.

Methodology

This is qualitative research, within a tradition of clinical scholarship, contributing to the emerging developments in psychosocial research at the Tavistock Clinic.

I will describe the process of this research project, locating my chosen methods of enquiry within the existing theoretical framework in relation to qualitative and psychoanalytic research methodologies. I outline the recruitment of the research participants and the ethical framework of the research before describing the conduct of the fieldwork and the process and challenges of the different stages of the data

analysis. It will be seen that some of the central themes were emerging from the outset.

I describe my approach to understanding the Fallon Report through a psychodynamic 'lens' and the way in which I engaged with the difficulties and frustrations of identifying evidence in my fieldwork for processes that cannot be seen.

Appendices are attached, showing examples that enable the entire process of the analysis to be seen.

Data analysis

The data analysis section is organised into a number of vignettes: stories that take the form of extracts of fieldwork data deriving from a single or cross-section of sessions of clinical consultations with one of the participants. Because of the volume of data gathered, it has been difficult to meaningfully reproduce extracts that give enough information to support emerging findings without being overwhelming. I have chosen to do this by producing a narrative analysis of what I observe, without reproducing the entire vignette and early stages of analysis. Verbatim extracts from the process recordings, denoted by italics, are included as illustrations, keeping the analysis grounded in the fieldwork data. Each illustrates a theme that links to those that emerged from the analysis of the Fallon Report (DoH 1999a).

Each vignette is preceded by a title page taking the form of a relevant extract from the Fallon Report showing similar themes, grounding the fieldwork into the framework of an existing account of a critical incident.

The vignettes are presented in this order:

Vignette 1 Ms A: *'The Primary Task'*.

Vignette 2 Ms A: *'First Amongst Equals'*.

Vignette 3 DC B: *'The Ugandan Man'*.

Vignette 4	DC B: *'The Foster Carer'*.
Vignette 5	DC B: *'The Police Officer'*.
Vignette 6	Ms A: *'Z and the Smell of Alcohol'*.
Vignette 7	Ms A & Mr C: *'Supervision: protective or perverse?'*
Vignette 8	DC B: *'The Impact'*.

Findings

I describe the way in which the data demonstrates unconscious dynamic processes attacking professionals' thinking and capacity to act in role. I suggest two approaches to thinking about the data as a 'bigger picture' or 'higher order' of understanding. Firstly as a series of single case studies, describing processes in relation to face to face encounters with offenders in which the unconscious pressures on thinking can clearly be seen. Secondly as case studies of three practitioners that can be understood through their relationship to their work and differing capacities to engage with the protective possibilities of the supervisory/professional consultation.

The findings are exclusively based on my original fieldwork data. Again, each section is preceded by an extract/s from the Fallon Report showing the kind of issues illustrated by the sequence as a contextualising feature from the report of actual critical events.

Conclusion

I discuss what I conclude from the findings of the data analysis about the way in which this analysis supports the hypothesis framed in my research question. I explore the applicability of what I have found and suggest possibilities for further enquiry.

Postscript

I outline some of my reflections on the process from my current position of hindsight.

Appendices

Appendix 1	Information given to participants about the project.
Appendix 2	DC B – Table of attendance. Data analysis tool demonstrating DC B's withdrawal from the consultations and his work.
Appendix 3	DC B – Summary of sessions, themes and breakdown of DC B's defences. A linear summary: data analysis tool.
Appendix 4	The nature of the patients. Direct quotation from the Fallon Report describing the 'typical' patients detained in the setting.
Appendix 5	Methodology example - DC B: *'The Neglected Baby'*.
Appendix 6	Methodology example - Ms A: *'The Ambiguous Message'*.
Appendix 7	Glossary of terms and abbreviations.

> **Whether represented as a pathetic specimen of a man (1950s), sex fiend (1970s) or serial paedophile (1980s), the shadowy figure of the child abuser was portrayed as unstoppable, incapable of treatment and worthy only of prison. (Bourke 2005: 328)**

Chapter 2: Literature review

I locate my study in an area of 'unchartered territory' within the existing literature. My study shows unconscious processes within interpersonal relationships causing unseen pressures on the capacity of professionals to function and effectively manage risk. When the containment of risk fails and critical events take place, ensuing enquiries fail to ask how such things happen in the right kind of way and the psychodynamic paradigm is helpful in gaining such understandings. The focus of the study is on high secure psychiatric hospitals containing particularly dangerous individuals – total institutions that present a unique challenge to the definition of a primary organisational task. The study shows that an inability to maintain boundaries around appropriate roles undermines the pursuit of the primary task in the service of dangerous enactments that can result in critical incidents. Organisational systems and processes can be used perversely in this context and a psycho-social approach to policy-making in relation to forensic institutions is not well established in the existing literature. My project foregrounds the connections between the 'micro' interpersonal forensic clinical processes governing relationships with patients in perverse, antisocial states of mind and the 'macro' process of structuring policy and legislation within a particular social context of media-fuelled fear.

Total institutions

Since the work of Goffman (1961) and Foucault (1977), contemporary thought relating to total institutions has emphasized the corrective and transformative properties of such institutions, describing the institutional imprints on 'embodied' professionals working therein (Williams & Bendelow 1998). Goffman in particular described how staff struggled to maintain professional neutrality, leading to a "false and difficult relationship" for both staff and inmates (Goffman 1961: 368-70, cited by Grieg 2002: 23). However, this approach does not greatly attend to the nature and quality of relationships within such institutions, nor does it consider the experience of professionals managing relationships within the context of detention of such disturbed, perverse and dangerous individuals.

Main (1946, 1957, 1989) and more recently Hinshelwood (1993); Hinshelwood & Skogstad (2000), Day & Pringle (2001), Saunders (2001), Doctor (2003), Morris (2004) and Parker (2006) have all described dynamic processes within in-patient or secure custodial or therapeutic settings. Hinshelwood (2001) applies his seminal experiences of therapeutic communities to an exploration of relationships between groups, individuals and their social surroundings in the context of mental health care. O'Shaughnessey (1992) and Skogstad (2001) described a risk that, instead of helping patients with internal and external world relationships, in-patient settings can create an environment that colludes with patients in avoiding engaging with the reality of these relationships and effecting change. Such an environment may be equated with what Steiner (1993) termed a *psychic retreat* – a concept that I have found particularly helpful.

Antisocial states of mind: psychopathy

An early definition of psychopathy or 'moral insanity' (Pritchard 1835) suggested that some people behave in criminal ways despite an intellectual knowledge of right and wrong. This definition is resonant with that of perversion – a word specifically used by Pritchard – in that it suggests that an individual could be intellectually sane but morally/emotionally insane, with coexisting but split elements of sanity and insanity. This introduced a continuing debate about the relationship between psychiatry and the criminal justice system that is reflected in the complex primary task of forensic institutions. The contemporary meaning of the term is more resonant with 'antisocial personality' but it continues to have moral and pejorative resonance. The famous phrase "a convincing mask of sanity" (Cleckley 1941) powerfully evokes the differing presentations in the internal and external worlds of the 'psychopathic' subject.

Cleckley's work in relation to personality traits was developed by Hare (1999) who elaborated the concept of a 'psychopath' as someone who poses risk to others through impulsivity, lack of empathy and a general disregard for rules. 'Psychopaths', as measured by Hare, are significantly represented amongst those detained in secure settings following violent offences: they are considered particularly challenging to treat because of their specific difficulties within interpersonal relationships - notably contempt for those who offer help and those who need it – raising questions about the experiences of staff delivering treatment and the impact of such difficult interpersonal relationships on the provision of care.

Behaviours reflecting disturbed interpersonal relationships and the "mask of sanity" disguising the reality of the internal world further resonate with the concept of perversion.

Antisocial states of mind: perversion

'Perversion' is a term that describes a particular mode of thinking which is then manifest in compulsive behaviour and can be understood as a state of mind that denies reality and attacks life. Such states of mind may involve objects (including other people) that are used to control the anxiety, loss or grief that underlies the perversion (Stoller 1986). Such behaviour may become antisocial when the compulsivity leads to crime and a minority of perversions involve sexualised behaviour which may be (although rarely) tragically violent.

Psychoanalytic theory contributes much to an understanding of perverse behaviours and unconscious dynamics. Steiner (1993), citing Freud (1919), suggests that "perversion, like neurosis, is a compromise formed from the conflict between impulse, defence and anxiety" (1993: 90). These ideas were developed by various authors such as Meltzer (1973). Kernberg (1992) distinguishes three groups of formulations in the psychoanalytic literature:

1. Freud wrote extensively about developing sexuality (1905, 1919, 1927, 1931) and a range of perverse behaviours enacting residual aggression and hostility arising from a failure to integrate infantile sexual impulses, characteristic of 'normal' development, into the adult self, described as a "permanent and obligatory deviation from the normal in the sexual aim and/or object required to achieve orgasm" (Kernberg 1992: 263).
2. British object relations theorists such as Klein (1945) and Winnicott (1953) who "stress preoedipal contributions to its psychodynamics, psychopathology in the mother infant relationship, and the central role of preoedipal aggression" (Kernberg 1992: 263).
3. The French psychoanalytic school, notably Chasseguet-Smirgel (1985) who emphasised the ubiquity of perversion as "... a means to push forward the frontiers of what is possible and to unsettle reality... a temptation in the mind common to us all" (1985: 1) and McDougall (1995). These latter authors

> foreground the omnipotent use of denial inherent in perversions amounting to a near total denial of reality – notably of difference, particularly that between generations and genders.

In a seminal work that aimed to define the underlying meaning of perversion, as distinct from describing behaviours that may be considered perverse, Stoller (1986) described it as "the result of an essential interplay between hostility and sexual desire..." (1986: xi), formulating his famous definition: "the erotic form of hatred" (1986: 4). Stoller emphasised the centrality to perversion of underlying hostility and a wish to harm the object, having its origins in early trauma and the outcome of triumph over the trauma through revenge. He described the role of excitement – through the introduction of manageable risk – and the eroticisation of the triumphant outcome over a "dehumanised object" as the "trauma is turned into pleasure, orgasm, victory" (1986: 6). The perversion is repeated "because repeating now means that one will escape the old trauma and because revenge and orgasm deserve repeating. Those are reasons enough" (1986: 7).

Glasser (1979) described a 'core complex': a dynamic psychic organisation of "inter-related feelings, ideas and attitudes" (Glasser 1979: 278) that can be negotiated as a phase of normal development. The 'core complex' describes a conflict between a longing for the most intimate closeness with an object – to the degree of merger – and conversely the terrified flight from this object as the union is experienced as overwhelming and permanent and threatens the self with annihilation. The painful feelings of loss associated with flight and narcissistic withdrawal from the object, or intense self-preservative aggression aroused by the experience of threat, result in the conflict being re-enacted in a repetitive cycle. The perverse 'solution' arises as sexualisation addresses all of the most disturbing components of the complex – notably aggression, abandonment and annihilation - and the nature of the relationship to the object distinguishes the perverse from the violent subject. Like Stoller, Glasser highlights the role of revenge in the sadistic interplay with the object.

More recent clinical psychoanalytic contributions to the literature include Ross (2003) and Morgan & Ruszczynski (2007) who give helpful accounts of the treatment of such patients – harnessing clinical material to explore and suggest some understandings of the challenges presented within the interpersonal therapeutic relationship. Ruszczynski

(2007) suggests an understanding of clinical perversion as "fundamentally defensive, achieved primarily by deception and disavowal of reality, with the purpose of fending off unbearable affects that would otherwise have to be known and experienced" (2007: 33). He also reviews the psychoanalytic literature, suggests that "what is perverted is knowledge of reality, both internal and external" and that "the successful disavowal of reality requires sadistic control of the object and a splitting of the ego, creating an unconscious object relationship based on control and misrepresentation. Hence such relating is primarily sado-masochistic, perverse and based on corruption of truth" (2007: 27).

Ross's (2003) monograph describes perversion as "a structural organisation of the psyche that people can move in and out of with varying degrees of flexibility". She gives a helpful review of aspects of perversion on the psychoanalytic literature, citing Kaplan's (1991) description of perversion as a "mental or psychological strategy" the aim of which is "to deceive or to mislead" (Kaplan 1991: 9, cited in Ross 2003: 6). Ross describes a particular set of "characteristics" that come together to distinguish the "particular character of perversion" from other psychopathologies, promoting her view of the importance to the strategy of deception.

Kleinian theorists describe perversion as a manifestation of the death instinct that may also be externalised as aggression (Hinshelwood 1991; Hyatt Williams 1998): this is helpful in understanding behaviours that, whilst not overtly sexual, are perverse in that they deny reality and attack life. Perelberg (1999) cites Glasser (1979, 1985), suggesting that the 'core complex' is particularly helpful in understanding the wider aspects of perverse behaviour and this has been developed in relation to suicide by Campbell & Hale (1991) and Chabrol & Sztulman (1997). Other authors have described aspects of perverse behaviour that are not necessarily overtly sexual: Laufer (1995); Cordess & Cox (1996); Malan (1997); Welldon & Van Velsen (1997); Hyatt Williams (1998); Perelberg (1999) (in which can be found an excellent review of the psychoanalytic literature relating to violence and suicide); Gilligan (2000); McCluskey & Hooper (2000); Costello (2002). Nobus & Downing (2006), with a more politicised contribution, provide a counterpoint by presenting a dialogue of perspectives from psychoanalytic theorists and those who work with or critique psychoanalytic theory, challenging the reductive outcome of the pathologising of perverse sexual behaviour.

Kernberg (1984, 1988, 1989, 1992) has written much about perversion, the treatment of personality disordered patients, and the institutional issues in this context, from a psychoanalytic perspective – notably the particular unconscious defence mechanism of projective identification. Bateman & Fonagy (2004), writing about the clinical treatment of patients with borderline personality disorder, describe particular challenges to therapeutic engagement when externalisation of unbearable states of mind arouses powerful countertransference. They consider that staff treating such patients need "a high degree of personal resilience and qualities that enable them to maintain boundaries whilst offering flexibility, survive hostility without retaliating, and manage internal and external conflict without becoming over-involved" (2004: 150).

Steiner (1993) described a particular configuration of the internal world that he termed a 'psychic retreat': a clinical concept describing a constellation of unconscious defences against anxiety. Steiner situated this retreat at the borderline between the traditionally held Kleinian concepts of the paranoid-schizoid and depressive positions, describing a **perverse** form of defence between the psychotic and neurotic in which the subject has a particular, challenged, relationship to reality:

> One of the features of the retreat that emerges most clearly in perverse, psychotic and borderline patients is the way the avoidance of contact with the analyst is at the same time an avoidance of contact with reality. The retreat then serves as an area of the mind where reality does not have to be faced, where phantasy and omnipotence can exist unchecked and where anything is permitted. (Steiner 1993: 3)

Steiner emphasises the important protective function that such states of minds serve to defend against knowledge of the truth that would be experienced as catastrophic. He likened the relationship to reality that was a feature of the retreat to that which is a characteristic of perversion: highlighting the ways in which the denial of reality – and the consequent creation of a perverse misrepresentation of reality - is useful in understanding perverse behaviours that are not necessarily sexual. I have found his work particularly helpful in providing a way of thinking about some of the processes I have observed.

Like Kernberg (1992), Steiner cites the contribution of the French analysts in foregrounding perverse relationships to reality and the denial of differences - notably those between genders and generations. Set into the context of Freud's position, Steiner

discusses the work of Money-Kyrle (1968, 1971) who importantly proposed that there were three primal 'facts of life' that were "aspects of reality which seem particularly difficult to accept and without which no adequate acceptance of other aspects of reality is possible" (Steiner 1993: 95) that Steiner viewed as essential to the experience of the reality of loss and therefore likely to arouse powerful defences. These facts of life are: "the recognition of the breast as a supremely good object, the recognition of the parents' intercourse as a supremely creative act and the recognition of the inevitability of time and ultimately death" (Money-Kyrle 1971: 443, cited in Steiner 1993: 95). They correlate to the recognition of the difference between genders and generations and illuminate the disregard for rules and other boundaries that are implicit in perverse behaviours.

The key to this is the idea that, although not a psychotic break with reality, a perverse state of mind is one in which "a special relationship with reality is established in which reality is neither fully accepted nor completely disavowed" (Steiner 1993: 88) and "contradictory versions of reality are allowed to coexist simultaneously" (ibid: 90). Steiner emphasises that it is not the coexistence of contradictions that is necessarily perverse, but that the perversion arises when integration threatens to prevent the contradictory beliefs from being held separately and a perverse rationalisation becomes necessary to misrepresent the reality of the difference between the assumed and observed realities. Under these circumstances, he proposes three possibilities:

1. The underlying assumption is gradually challenged and replaced by reality, anxiety is experienced and mental health is eventually achieved.
2. An attack on perceptual apparatus results in survival of the assumption at the expense of observed reality: this is the psychotic solution.
3. The underlying assumption and observed reality are held separately through the introduction of a perverse, 'artful', rationalisation in which insight is used to misrepresent reality.

Thus, Steiner distinguishes perverse and psychotic retreats from reality (whilst not suggesting that perversion is not manifest within psychotic organisations).

Steiner illustrates two different methods of supporting this state of mind. In the first, a kind of failure to engage curiosity is employed in which the subject is in possession of

the information needed to see the truth but fails to make the links necessary to achieve knowledge, resulting in a decision to *"turn a blind eye"* (ibid: 116), supporting a type of ignorance, creating a state of mind in which reality is both known and not known. The second depends on a *"retreat from truth to omnipotence"* (ibid: 116 – emphases in original) in which it is not the facts of reality that are denied but the responsibility and therefore the consequent guilt.

Perversion represents an internal vertical split in the mind and attendant capacity to engage with two conflicting realities; denial of reality supported by the violence of internal world splitting and projective identification, used as a means of controlling the object. This is not a psychotic state of mind: reality and some relationship to the truth are preserved, if obscured. Ruszczynski (2008) emphasises the importance of this split in keeping the perverse/violent separate from the non perverse/violent parts of the personality suggesting that it is useful to understand this vertical spilt superimposed on the horizontal structure of differentiating neurotic, borderline and psychotic parts of the personality. Hence it is possible to understand perverse structures as a feature of all these states of mind. Di Masi (2003) summarises the relationships between perverse defences and borderline structures, psychosis and criminality, drawing a distinction between actual perversion and perverse pleasure employed as a defence against persecutory and annihilation anxieties in borderline pathology, and the escape from a persecutory sense of guilt experienced by psychotic patients.

Understandings of the role of pleasure, excitement and revenge, and the denial of differences in perversion can be transposed onto the organisational context in order to understand denial of roles within organisational authority and collusion with such denial. As will be seen, it is the wider applications of such theory in understanding the manifestations of perversion that have been of interest to me – particularly the 'artful' capacity for knowing yet not-knowing, the denial of difference that enables the transgression of boundaries and the breaking of rules and the way in which such dynamic features can be seen to undermine legitimate organisational authority and the primary task by colluding in ensuring that the truth remains obscure.

Psychoanalysis and countertransference

Melanie Klein (1946) termed a concept 'projective identification' within the context of her description of a state of mind known as the 'paranoid-schizoid position'. Bion (1962a, 1962b, 1970) further developed the idea of the difference between normal and pathological projective identification and the belief that psychic development depends on the availability of another human mind capable of transforming experiences and unbearable states of mind into meaning.

The idea of projective identification has been further developed underpinning the role of countertransference in understanding such unconscious communications (Winnicott 1947; Heimann 1950; Bion 1959, 1962a, 1963; Racker 1968; Joseph 1985, 1988; Kernberg 1988; Sandler 1988; Bott Spillius 1992; Feldman 1992; Hinshelwood 1994; Wollstein 1988). The concept of countertransference is invaluable to an understanding of therapeutic engagement and dynamic pressures that challenge staff and can result in confused roles and boundaries, undermining of creative thought and transference re-enactments. The contemporary view of countertransference as a means of communication between patient and therapist, being an emotional response in the therapist to the patient's transference and material communicated by the patient through projective identification, is summarised well by Anastasopoulos and Tsiantis (1996).

In the forensic institutional setting there are likely to be particular interpersonal difficulties relating with patients who may be in antisocial and perverse states of mind. They can be extremely challenging to work with, arousing strong and often negative feelings in staff: countertransference is a vital aid to an understanding of the unconscious processes underpinning such feelings and risk (Cox 1996). If such processes are not fully understood, there is particular danger of sadistic and abusive re-enactments and defensive behaviours that can undermine therapeutic relationships (Milton 1997).

In the forensic context, the link between physical violence and a failure in mentalisation, or attacks on thinking (Perelberg 1999; Fonagy & Target 1999) finds its parallel in the undermining of creative thought that is the outcome of unconscious transference and projective processes. I.e. the use of violence as a means of controlling the object is enacted through the unconscious dynamics. Ruszcynski (2008) describes

the way in which, in the absence of the experience of containment, such patients cannot develop a 'psychological self' and therefore only bodily experiences are available to relieve mental distress. He notes the difficulty in sustaining relationships demonstrated by patients suffering severe personality disorder, psychosis or psychopathy, as their way of relating to others involves intrusively encroaching on the mind of another. Further he suggests that this absence results in little sense of separate others and reflected in absent 'moral code' or internal authority. The centrality of such processes to working with forensic patients has been described by Cox (1996), Milton (1997), Hyatt Williams (1998) and Gordon & Kirtchuk (2008).

These ideas have significantly underpinned my understanding of the processes I have observed. I believe that my contribution is to **show** them taking place.

Psychoanalysis, systems and organisations

There is a strong tradition of relating psychoanalytic and systems theory to understanding organisations (Rice 1963; Miller 1993; Armstrong 2005). Such studies emphasise the unconscious world of the organisation as well as those of its constituent members, suggesting that intolerable conscious and unconscious anxieties lead to the development of defensive processes and behaviours enabling avoidance of painful and threatening emotions, and that institutions and social groups, like individuals, develop such defences. Seminal work includes Menzies Lyth's dynamic study of a teaching hospital (Menzies Lyth 1988, 1989). Obholzer and Roberts (1994) and Foster and Roberts (1998) have made substantial, psychoanalytically oriented contributions to the understanding of public sector organisations, particularly in the areas of health and social care. Hinshelwood and Skogstad (2000) adapted Bick's classic model of infant observation (Bick 1964) to observational studies of health care organisations. In a more recent addition to the literature, Susan Long (2008) examines the nature of perversity and its presence in corporate and organisational life and the functioning of groups in this context. Long explores a level of complicity with perversion in the collective and the meaning of envy in hierarchical organisational structures – as well as the more 'democratic' systems that may emerge as a defence against envy.

These are significant contributions, however there is less in the literature that applies this paradigm specifically to scrutiny of long-term forensic institutions – making links

between unconscious dynamic processes, the experience of maintaining the professional task and roles and the particular challenges to management. Existing literature does not cogently explore links between clinical processes, the structures for managing those processes, the experiences of individuals in such settings and the wider social context.

Boundaries: ethical, clinical and interpersonal

Malin (2000) suggests the setting, definition and maintenance of boundaries is central to the operation of professionalism and in some professions "boundaries are particularly hard to maintain" (2000: 1), emphasising the importance of training and professional self-regulation through bodies that protect academic qualifications and status. Regulation operates within an ethical framework including codes of conduct and standards of good practice (GMC 2006a, 2006b; NMC 2008; BPS 2006, 2008; HPC 2008; CRHP 2008a, 2008b, 2008c). Such guidance generally highlights aspects of behaviour related to management of interpersonal boundaries, some of which are easy to measure with a level of objectivity, others requiring a little more thought. A review of research by Halter, Brown & Stone (2007) concluded that greatest care needed to be taken when delivering psychiatric or 'talking therapies' and by those working in long-term care settings.

Management of interpersonal boundaries is crucial to professional relationships that require thoughtfulness, reflexivity or containment. Gabbard has written extensively on the topic of boundaries in the psychoanalytic literature, but for a comprehensive review see Gabbard & Lester (1995) who cite Wilden's (1972) description of a boundary "as the basis, or a condition, of all self-other communication" (1995: 12). Object relations theorists such as Winnicott (1984) developed thinking in relation to the nature of interpersonal relationships and their role in the development of mental representations of self and other underlining the importance of boundaries to the reality of separateness and independent thought.

Whilst there is much in the literature promoting the necessity of boundaries to contain therapy and ensure that it does no harm, there is little that really scrutinises **how** interpersonal boundaries come under attack and the way in which such intra-psychic assaults can undermine independent thinking and push professionals out of role. Also, whilst the negative impact on patients of boundary violations and the potential for

exploitation is well-documented, the possibility of danger or lasting harm to **professionals** appears to be much less evident in the literature.

A 'false sense of security': structural boundaries

Lewin (1947) and Miller and Rice (1967) developed open systems theory into a way of thinking about organisations: suggesting that a living organism could survive only by operating as an open system - maintaining material exchanges with the external environment. Such functioning requires certain properties, notably a concrete boundary, defining the system and its subsidiary sub-systems, across which such exchanges take place. Rice (1963) proposed that, in order to succeed in its relationship to the external world, the organisation must have an agreed and identified primary task determining its construction and resourcing. Managing boundaries is crucial to achieving that task: where the system depends on a set of internal sub-systems, each must have a boundary, the management of which enables their contribution to achieving the primary task of the whole.

This is helpful in thinking about the management of security in forensic institutions: as a concrete feature of the external environment: physical security; as an operational activity: procedural security; and as a clinical process: relational security. Security is operationally managed through a series of policies and procedures locally formulated and centrally imposed (DoH 1999c, 2000a, 2000c, 2001b, 2002a, 2002b, 2003). Management of physical, procedural and relational security should be integrated and reflected in a primary task that delivers both treatment and secure detention. However, the complex interplay of these different aspects of the task is hard to balance and arguably a high secure hospital is a perverse institution: at the same time both a hospital and a prison (Deacon 2004). This paradox lends itself to defensive confusion about the nature of the primary task of the organisation.

Supervision

Reflective clinical supervision as a means of monitoring boundaries and achieving clinical depth is particularly important in forensic settings, not least because of the risks to professionals, and its development has been influenced by models from disciplines with established practices (Kadushin 1976; Ford & Jones 1987; Hawkins & Shohet

1989; Inskipp & Proctor 1993). Social work supervision has developed alongside the evolving case management approach (Browne & Bourne 1996; Morrison 1993), influenced by the ascendancy of 'marketisation' and the growth of state managerialism. Useful contributions to this literature can be found in Mattison (1992) and Hughes & Pengelly (1997).

Codes of practice (e.g. GSCC 2002; NMC 2008; HPC 2008) tend to refer to the duty to provide rather than receive supervision although the Chief Nursing Officer's review of mental health nursing (DoH 2006b) outlines an objective for all mental health nurses to receive clinical supervision "from a suitably trained supervisor". It is widely-accepted as an essential part of a framework of support and continuing professional development. However, there is an absence in the literature of coherent thought that addresses the risks concerned with models of supervision that split clinical processes from the structures in place to manage them and the means by which supervision can best be delivered in order to achieve clinical excellence within a framework of organisational accountability.

Social systems

The notion of 'dangerousness' has been used, historically, to set limits on the individual's place within society (Greig 2002). In a wider social context, Jaques (1955) wrote about ways in which social institutions are used by their members to reinforce individual mechanisms of defence against, in particular, paranoid and depressive anxieties resulting in a process of scapegoating a minority. Sheath (1990) and Sampson (1994) have both written about the uniquely punitive response of the criminal justice system to containment and punishment of sexual offenders – Sampson particularly helpfully (although this work is now some years old, predating developments in legislation) - building on seminal work on social scapegoating and 'deviancy amplification' (Wilkins 1964; Cohen 1973; Showalter 1997). Following a series of well-publicised events in the wake of the murder of 8-year-old Sarah Payne in 2000, Silverman & Wilson (2002) update Sampson's work to look at more modern concepts of 'naming and shaming' and 'trial by newspaper'. They describe the role of the media in underpinning scapegoating processes, skewing perceptions of risk and the relationship to the community and social in/exclusion. Other commentators such as

Bourke (2005) have described the ubiquity of fear of sexual crime and increasingly pervasive social experiences and definitions of abuse.

This is particularly helpful in understanding the symbolic role of high secure hospitals in the wider social context i.e. as containers of society's unwanted, feared attributes and characteristics – and their capacity to serve this purpose as an additional primary task.

Risk and the influence of fear on policy

Over years, there has been a shift in the primary concern of health and social welfare services from the assessment and management of need to the assessment and management of risk (Parton 1996) and an emphasis on the judicial has increased at the expense of the therapeutic (Howe 1996; Eadie 2000). Risk management has become central to contemporary thought, legislation and policy, giving rise to a body of predominantly sociological literature describing the cultural context of risk and fear (Beck 1992; Pritchard & Kemshall 1996, 1997; Furedi 1997; Langan 1998; Culpitt 1999; Lupton 1999; Parsloe 1999; Edwards & Glover 2001; Wilkinson 2001, 2008; Bourke 2005, 2007; Carson & Bain 2008) suggesting that "fear has become the emotion through which public life is administered" (Bourke 2005: x).

Social focus on the prominence of risk and danger, fuelled by the media, has been mirrored in developments in clinical practice and the administrative and procedural systems supporting clinical processes. Through scrutiny of a particular case study, Grieg (2002) portrays a challenge to the depiction of "a docile body to be coaxed, transformed and improved with the economy of therapeutic effort which Foucault requires" (2002: 37, citing Foucault 1977: 137-8) in an account of a discourse between psychiatry, law and politics at the boundary of 'madness' and 'badness', freedom and restraint. Developments in legislation such as indeterminate sentencing, the 'preventive detention' debate, the emergence of specialist Dangerous and Severe Personality Disorder services and the Mental Health Act (2007) can be seen clearly within this context and the increase in 'risk aversion' and the apparent need for redress has arguably been reflected in the prolific number of public enquiries into health and social welfare services since the early 1990s (Prins 2005) that have been reviewed by Peay (1996), Grounds (1997), Eldergill (1999), Parker & McCulloch (1999), Reder & Duncan (1999), Stanley & Manthorpe (2001, 2004).

These processes impact on service and policy developments in forensic settings in that such developments are conducted and evolve under unforgiving scrutiny largely driven by fear.

Towards a psychological approach to political understandings

Holmes (1996) cautions about the counter-productive outcomes of the vilification of scapegoating and suggests the value of a psychologically-informed approach to social policy; Hoggett (2000) utilises psychodynamic ideas to link an understanding of the human subject to the development and achievement of social and welfare goals. In a sociological context, Cohen (2001) charts the personal and political ways in which members of society avoid uncomfortable realities, resonant with the manifestations of denials of reality employed by patients in perverse states of mind. Cohen reviews the conceptual origins of denial, suggesting that "only psychoanalysis comes near to the elusive quality of the concept" (2001: 24). Other authors (Rustin 1991; Samuels 1992; Kraemer & Roberts 1996; Parton 1996; Chamberlayne et al 1999; McCluskey & Hooper 2000; Froggett 2002) have also called for a psychological approach to the political world to highlight the relationship between the individual and society and give greater depth to the experience of political enquiry. Richards (1984, 1989, 1994, 2007) has written extensively on the psychosocial dimensions of politics and popular culture, the role of the media, and the need for political leadership that can be sophisticated in its approach to emotions and fear held by the public.

Overall, this area is substantially less evident in the social sciences literature. However, developments in the criminal justice system including the introduction of the Offender Management Model (NOMS 2006) appear to indicate a shift in thinking and service delivery towards interventions addressed at individuals, emphasising the value of a relationship as a conduit. Similarly, there has been a recent interest in complex subjectivity within criminology: Smith (2006) describes a "revival of attention to the individual biographies of people who offend, to their inner, sometimes unconscious, experiences, and to the importance of emotion as a source of action" (2006: 361). In this context, Gadd & Jefferson (2007) and Jones (2008) have made particularly welcome contributions to the literature.

Conclusion

It is impossible to separate these high secure hospitals from their political and social context and the symbolic function they perform for society. When critical incidents take place, the conduct and outcome of a public enquiry is located within this context and tasked with scrutinising the events in a particular kind of way. From these enquiry processes, new structures emerge in the form of policies, procedures and legislation.

To this literature, I can add a perhaps rather unsettling account of the way in which professionals, despite their best efforts, are swerved off course when acting within interpersonal relationships in dangerous forensic settings in which they are challenged by the particularly "toxic emotional processes" (DoH 1999a: 4.4.23) generated within the dynamics of the organisational unconscious of a total institution. I show ways in which the processes established to deliver governance in these settings can be helpful in preventing dangerous events and conversely can be used perversely. Whilst a psychoanalytic perspective has an established place in the literature, there is little that actually shows, in minutiae, the moments in which individual professionals struggle with their roles and their ability to think, to the detriment of the organisational task.

This perspective enhances the predominantly sociological thinking in this area, adding a different dimension to understanding experiences and relationships that take place within these settings in the pursuit of the primary task. Applying a theoretical approach that illuminates that which is held obscure enables important insights into the role and experience of the individual within the wider political process of policy formation and this further contributes to an understanding of the political transformations of that which, as a society, we fear.

> **The inquiry report tells a story. It is a narrative account replete with human drama and action. Every inquiry report has its heroes, villains and victims but, for the reader, the outcome of their interactions is known at the outset. The dramatic tension of the story told by the inquiry report resides in the judgement delivered by the inquiry team. The reader is invited to identify with the lofty perspective of the inquiry panel and to pass judgement upon the actions of the protagonists with the benefit of hindsight. This is essentially a moral judgement about whether professionals have done the job expected of them and whether they have adequately protected those they were charged to protect. (Stanley & Manthorpe 2004:2)**

Chapter 3: Methodology: "Without memory and desire" (Bion 1970: 41)

The research proposal

Based on my early readings of the Fallon Report (DoH 1999a) and emerging from my observation of the prevalence of events or phenomena described in the report that seemed extraordinary - either explicitly held as so by the author, or by me - I had a relatively simple question to which I wanted to suggest an answer or way of understanding:

How are experienced 'ordinary decent' professionals prevented from seeing things that to the 'man on the Clapham omnibus' would be obvious?

It was not so much that such events had taken place that interested me, but **how** this might have happened. I suggested:

It is possible to capture and demonstrate moments in which dynamic unconscious processes can be seen to impact on professionals, undermining their capacity to think and act effectively in role in relation to the performance of the primary organisational task. This may lead to critical incidents, public enquiries and eventual developments in both local and national policy.

This suggestion linked with well-established pre-existing theoretical assumptions – notably:

- that there are such processes within interpersonal and organisational relationships;
- that such processes are unconscious and unseen;

- that they can undermine thinking;
- that they can result in unhelpful enactments if not understood;
- that this can contribute to risk.

Although there is a body of theoretical literature that illuminates these assumptions, there is a fundamental difficulty in identifying and understanding phenomena that cannot be seen. I intended to contribute evidence to this literature that would demonstrate actual moments in which professionals could be seen to be struggling within their roles. It was the experiences of individual practitioners within these contexts – the 'freeze-framing' and illumination of moments of individual compromise – that were of interest to me. Accordingly this is not a study of institutional dynamics as a whole, but of an aspect: a close and detailed scrutiny of micro-processes within an institutional context, dynamics that occur within institutional settings, contribute to the wider organisational processes and may not be fully understood outside those contexts, but nevertheless capture the experiences – and potential isolation - of individuals on the frontline of work with perverse people.

Posing a question about the psycho-social domain constituted within organisations providing services to dangerous patients in perverse states of mind required a methodology that could reasonably be expected to provide access to the kinds of processes of interest to me and to sufficiently enable their study to identify and validate evidence of the impact of such unseen processes. It was a challenge to formulate a methodology that was flexible enough to allow the application of imaginative creativity to the complexities of conceptual research whilst supporting sufficient objectivity and reliability to address issues in relation to ontological and epistemological questions. Dreher (2000) has discussed this tension in a critique of a research project that aimed to evidence the existence and nature of transference in clinical processes that, in her view, compromised validity in favour of research design and objectivity.

I decided that it was likely to be within the reflexive spaces established to think about this work that conscious and unconscious difficulties converge and there is thought given to dynamic processes. Therefore it was logical to assume:

1. that the evidence of the impact of unconscious processes on professional agency might be located within supervisory processes and

2. systems in place for providing clinical and management supervision of staff could offer opportunities for understanding the operational experiences of such settings as well as the impact on staff therein.

I acknowledge this as research within a particular paradigm reflected in an already established extant body of literature. However, the study was designed to generate fresh new material that I could scrutinise in detail and illuminate such processes in a new way by actually showing them and their impact in action. The research therefore sits between an observational study and a hypothesis-testing study within which I wanted to maintain as open and receptive a mind as possible: this is why the research question was only 'loosely' framed.

I suggested that it was possible to study unconscious processes and show them happening, using both primary and secondary sources of data, by:

1. Interrogating the *Report of the committee of the inquiry into the Personality Disorder Unit, Ashworth Special Hospital* (Fallon Report) through a different 'theoretical lens', highlighting evidence of a dynamic processes underpinning the critical events.
2. Observing an aspect of the here-and-now operation of a similar organisation, through a detailed analysis of professional behaviour as seen within supervision/professional consultation.

Public enquiries are conducted within a particular style of discourse, with the benefit of hindsight, inviting "essentially a moral judgement about whether professionals have done the job expected of them and whether they have adequately protected those they were charged to protect" (Stanley & Manthorpe 2004: 2). The Fallon Report described its aim and process:

> A public Inquiry such as this is not like a civil or criminal trial which are adversarial in nature. A public inquiry which is inquisitorial, is aimed primarily at establishing the truth rather than proving guilt or innocence. (DoH 1999a: 1.4.2)

This suggests that the function of such enquiries is perceived as a means of establishing a kind of factual reality – a 'surface', one-dimensional, truth that does not necessarily encompass or posit a level of understanding. I intended to apply a different theoretical

paradigm to a reading of this text to identify a 'deeper' understanding – i.e. of dynamic processes - available even if not pursued.

I gathered primary data in the form of fieldwork (Burgess 1984) that drew on psychoanalytic observation, the process of which was separated into three distinct stages:

1. the actual observation (i.e. the interview session);
2. the recording of the material;
3. the interpretation of that recorded material (Skogstad 2004).

This fieldwork was initially undertaken with two participants:

1. Ms A - a drama therapist

A member of the Creative Therapies Department of a high secure psychiatric hospital, Ms A had been acting head of the small department for a few months. She worked twenty-four hours over three days (eventually reducing her hours to fifteen over two days) and maintained a small clinical caseload as well as management of the department. We aimed to meet for one hour fortnightly but actually met on a total of twelve occasions between November 2004 and September 2005. In May 2005, the process became complicated by my promotion to a role that included line management of Ms A and her team. I remained in this seconded position for the remainder of our work together. I used my own supervision and access to my group of research peers to consider the impact of this on the research and reflect on my decision to continue to use her material. The supervision ended when Ms A left the organisation.

2. DC B – a police officer

DC B was an officer from Police Service 1 working in a specialist child protection and sexual crimes unit. Relatively new in this role, at the outset of the project, he demonstrated enthusiasm and a level of libidinousness towards his work. I engaged DC B in a series of professional consultations, based on a model of psychodynamic clinical supervision. During each session, he was

invited to present an account of an interview with a suspect – preferably material that he had found difficult in some way. Beyond this, the process was completely unstructured and led by his material and presenting concerns. We aimed to meet for one hour fortnightly and actually met on nine out of a scheduled sixteen occasions between February 2005 and May 2007. The series of consultations came to an informal premature end when DC B was absent from work through illness and effectively lost contact with me in December 2005. We re-established contact and met to formulate an ending and review in May 2007.

This process introduced a concept to an organisation unfamiliar with engaging in reflective practice in this way. I chose to work with a police officer for a very specific purpose. The task of the police is different to that of clinicians; however, it is undertaken with a similar forensic population. Because the police are not managing a clinical process or analysing dynamic factors, I supposed that this might enable me to observe the processes of interest in a more 'unprocessed' way. Thus I might gain access to similarities or differences within the material that could enable greater insight into the dynamics and strengthen the validity of any findings in relation to the functional link between the states of mind of forensic subjects and the professionals concerned in their care. This was in order to support the focus of the study on individual practitioners and help me to think about the applicability of findings outside the institutional context.

I anticipated that if I applied a grounded theory-type approach (Glaser & Strauss 1967) to the analysis of the data, it was conceivable that emerging themes would suggest further directions for scrutiny. Indeed, as the analysis of the data progressed, it seemed useful to introduce into the data set material already gathered through an earlier period of clinical supervision:

3. **Mr C – an art therapist**

Mr. C was a senior art therapist in a high secure psychiatric hospital two days per week. At the time the data was gathered, he had worked within the institution for seven years. We met weekly between March and December 2002 for one hour of supervision. In turn I received weekly supervision from my

clinical supervisor at the Tavistock Clinic. Mr C left the organisation at the end of this period of our work together.

My work with Mr C had inspired my research in that the experience had convinced me of the usefulness of a supervisory encounter as a 'psycho-social field' in which to observe processes that put pressure on thinking and swerve professionals off-course. The initial reason for including his data was to provide a depth of understanding of the potential risks presented by forensic patients as they can be seen in supervision. Retrospectively, I think that it has been a useful aid to validity to have observed material relating to participants in different yet similar roles within the same organisation (Skogstad 2004).

Between the three participants, the fieldwork consisted of a total of some fifty-two hours of recorded supervisory consultations.

This form of psycho-social research is not well-established in the literature. I intended that an additional benefit of the project would be elucidating methods of systematic research in this context adding to the methodological literature.

Data production - the fieldwork participants

It is worth saying a little more about how the participants came to the project and how this may have influenced their expectations of and their approach to the process.

Ms A: requested clinical supervision from me and readily agreed to inclusion in the project on the basis that there would be no financial charge for supervision. An established clinician in this environment, she was familiar with and supported the activity of research within the organisation. Our history of working together as peers set the tone for an emerging pattern of boundary difficulties. Ms A was experienced in engaging with the reflective process of clinical supervision and worked within a discipline in which failure to participate in supervision would be considered negligent.

DC B: was nominated by his Inspector whom I had approached after delivering some training to his team. He was much less conversant with the activity of (particularly qualitative) research than Ms A and did not preoccupy himself with the aims,

boundaries or ethical issues beyond establishing the temporal framework. He impressed as glad to be chosen, eager to please, and the sanction given to my work by his senior managers appeared sufficient to alleviate any concerns in relation to the process and ethics. DC B had no established template in his mind for clinical supervision as there was no comparable process available to him within his organisation. I wondered to what extent his engaging with the re-named 'professional consultations' reflected my clear association with his senior officers in his most hierarchical organisation.

Mr C: requested psychodynamic clinical supervision from me having been working with a supervisor with a predominantly cognitive approach. We also had previous knowledge of one another as peer members of a multi-disciplinary, psychotherapy-led clinical supervision group. Like Ms A, Mr C worked within a discipline within which the concept of reflexivity through supervision and its protective capacity were well-precedented.

Ethical considerations

There were a number of institutional safeguards to ethical considerations:

- DC B's involvement was agreed by his Detective Inspector.
- I attended clinical supervision within the institution with two clinical supervisors during the process of the research. This gave me the opportunity to draw on their experience both of research and the forensic setting.
- The project was peer reviewed at the Tavistock & Portman NHS Trust where it is registered as a research project.
- The Tavistock Clinic provided a research supervisor who was willing to meet with colleagues if considered helpful to ethics applications, although this was never taken up.
- Ethical approval was given by the University of East London Ethics Committee.

There was never any intention to engage patients as subjects or use material directly derived from their clinical records: Ms A's material proved to be much less clinically focussed than I predicted: however, I acknowledged patients and suspects as secondary subjects. I was aware of the context as being a particular focus for voyeuristic attention on the part of the media and public (Bowers 2002; Deacon 2004): this is a particular

disadvantage of research in such high-profile settings. Such patients represent a contemporary 'moral panic' (Cohen 1973) and are open to abuse and discrimination: I was mindful that this should not be re-enacted in research. I found myself particularly preoccupied with confidentiality in relation to patients whose offences are frequently unusual in their design and execution. As such, even with care to anonymise the material, they are particularly easy to identify so the identities of the participants and their host organisations have been obscured as far as possible.

Both initial participants in the project were informed that they were not subjects of the research, but the conduits of the processes of interest to me. The agreement to participate made explicit that it was never the intention of the project to evaluate the quality of the participants' work only in as much as it might be possible to observe impediments to their performance of the task that could be considered evidence of unconscious processes. Accordingly they were not selected to participate against any criteria other than their willingness. That said, the process of enquiry relied upon the participants being 'ordinary decent professionals' and I would have actively avoided including anyone whose competence or practice could be questioned or left me needing to intervene to manage risk. Although Mr C's participation was retrospective and related to data already gathered, he had previously consented to the material being supervised and assessed as part of the taught component of this Professional Doctorate.

All were provided with written information about the research project and their right to withdraw consent without notice and they signed letters of consent (Appendix 1). After the lapse in my contact with DC B, when we met on the last occasion, his consent for his data to be included in the project was formally re-established.

Data production - the fieldwork process

Fieldwork data was gathered through a process of face-to-face, supervision-like consultations with each of the participants, subsequently recorded by me. I drew on my prior experience of working within the Tavistock observational model, based on that described by Bick (1964). The written accounts took the form of un-theorised, narrative-style, process recordings – factual accounts of the verbal and non-verbal content and my recollection of my experience of the interviews and the interview process. I avoided theoretical formulations, concentrating on the factual content as near

and verbatim as I could depict it, avoiding assumption, inference or interpretation. I acknowledge this data as an account of - not a raw experience.

On my becoming Ms A's line manager, her sessions necessarily took on a function that related to managerial accountability for service level and quality whilst reflecting on clinical process. It was therefore essential to maintain an accurate record that noted agreed actions: I adopted the practice of taking minimal task-focused notes at the time – copied to Ms A – writing up a fuller, process-oriented account afterwards.

Data generated in this way was stored securely within the requirements of the Data Protection Act (1998). Mr C's retrospective data had been gathered by the same means but recorded handwritten, stored securely and anonymised.

The 'Tavistock' method of observing infants, described by Bick (1964) as a training exercise for child psychotherapists, was latterly cited by Rustin (1989, 1997, 2002) as a research method and further developed for the organisational context by Hinshelwood and Skogstad (Hinshelwood 1989, 2002; Hinshelwood & Skogstad 2000, 2002). Such disciplines of observation depend on the capacity of the observer to maintain a state of 'open-minded attentiveness' throughout the session that is the subject of the observation, after which the material is written up from memory, in as much factual detail as possible, avoiding theorising or interpretive inference. Bick explains the reason for this, highlighting the way in which it is difficult to separate the activity of observation from that of thinking: assigning language to experience, therefore, is loaded with interpretive inference. Importantly, Bick emphasises the value of this as "it teaches caution and reliance on consecutive observations for confirmation"; stressing the significance of the context and the necessity for open-minded uncertainty, despite the existence of any preconceptions, advocating this method as eventually promoting greater flexibility in thinking and enabling students to "learn to watch and feel before jumping in with theories" (1964: 565).

My data collection and analysis relied heavily on such methods, although my participation as supervisor/consultant (necessitating that I offer contributions) alters the process from pure observation, defining my role as a participant, within the ethnographic 'participant-observation' tradition and placing me closer to the emergent 'facts'. I acknowledged the inevitable difficulty in suspending presuppositions -

particularly whilst researching in my own professional setting, compounded by it being a closed institution and my familiarity (through direct clinical practice) with the processes and experiences I chose to research. Hammersley and Atkinson (2007) define the "primary goal" for researchers as the production of knowledge (2007: 15), emphasising the inherent reflexivity of social research and the inevitability that social researchers are part of the social world that they study. They refreshingly accept that "reliance on common-sense knowledge and methods of investigation" is inevitable and that social researchers "are able to reflect upon ourselves and our actions as objects" in the social world that we both inhabit and study. Therefore all social research may be considered as a form of participant observation and the boundaries around ethnography will be necessarily unclear.

Myself as participant-observer

When formulating the research proposal, I was employed as a Senior Social Worker in a high secure hospital being later promoted to Assistant Team Manager, managing a team of social workers whilst maintaining a clinical role of my own. During the fieldwork, I was seconded into the NHS Trust that managed the hospital as a Service Manager, eventually being substantiated in that operational position. This gave me a completely different role within the hospital management structure and my job included overall responsibility for a number of male in-patient wards and devolved services as I took up a position of some authority within that hierarchical organisation. Therefore, during the course of the research I had a rich, varied personal experience of working within different operational and clinical roles in that setting within which to contextualise my thinking.

I had been interested to study the institutional dynamics although I quickly became more focussed on the experiences of individuals that work within such contexts and/or with people in such states of minds. This may have reflected changes in my relationship to the institution and the project throughout its duration. Initially, I think that I was seeking ways of supporting my own development in understanding and making sense of the complexities of a strange and uncomfortable institution. As the project progressed and my role within the organisation changed, I became much more knowledgeable about the hospital, its structures, processes and nuances. By the end of the fieldwork and data analysis, I had developed an intricate knowledge of the systems

and processes of an extraordinarily complex environment. It is impossible to 'uncouple' this familiarity with the institution from the fieldwork undertaken in that setting and I acknowledge its influence. However, this is not a study of institutional dynamics per se and the scope of the project did not permit the application of much of the wealth of additional material that this knowledge and experience enabled me to access. This boundary aroused a certain amount of anxiety in me and I took care to regulate it and to ensure that the material used within the project conformed to the proposed methodology that had been ethically approved.

Boundaries quickly emerged as a dominant theme. Using supervision processes in this way placed me firmly within the interpersonal field within which the data was generated. Inevitably, this process has required a level of self-disclosure and potential vulnerability that has been difficult to regulate and my thinking in relation to the focus of the research took place within the context of my own professional development in the setting. This notion of self-exposure and the 'positioning' of the researcher has been considered in the ethnographic literature (Coffey 1999) and the application of the psychoanalytic 'lens' to the material – particularly the live material – requires an informed and reflexive use of the self in order to understand transference processes and achieve a deeper dimension of understanding. Coffey has also written about the particular experience of ethnographic research in settings that may, for whatever reasons, be overtly sexualised and the potential impact on boundaries and the researcher who "emotional and embodied, cannot help but have a sexual positionality" (1999: 78). This is helpful in thinking about the process and experience of research where the particular underlying preoccupation was with the impact on professionals of working with individuals in perverse states of mind: where "settings and organisations not explicitly sexual have been sexualised... The cultural importance and centrality of sex may make it more difficult to establish and recognise the boundaries between the personal and the professional, the fieldworker and the self" (1999: 83-87).

It was necessary for me to contribute a level of understanding to the material generated in the room – beyond neutral facilitation of data production. Hollway and Jefferson (2000) in describing the methodological indebtedness of their research to psychoanalysis, highlight a distinction between the *clinician* who makes interpretations *into* the encounter and the *researcher* who is careful not to do so but who interprets *out of* the encounter and whose interpretive work is held separate from the participant or

subject, having a different audience (2000: 77). I suggest that the contributions I may have made as clinical supervisor may be held as 'micro' interpretations and that the 'macro' interpretation necessary for the activity of research is dependent on the wider picture to which Hollway and Jefferson have referred as the *'Gestalt'*.

Clearly my role as supervisor/consultant and the developmental progression of my career and changing roles within the high secure institution define my role within the process as more 'participant' than 'observer'.

Data analysis

> Theorising at too early a stage by observer or seminar group is more likely to be a defence against the pain of emotional experience or ignorance that a means of real understanding. (Rustin 1989: 52)

As my role within the organisation changed, so did my relationship to organisational processes and my responsibility for critical incidents and their management. At times I found it difficult to really engage with and immerse myself in my data. To some extent this reflected the overwhelming volume of information I gathered between the content of the two volumes of the Fallon Report and the process notes of my fieldwork. However, it was suggested, reasonably I think, that there may a link between my difficulties in engaging with the data and my day-to-day experiences - in that the former could be considered almost 'tame' in comparison to the increasingly lurid events to which I was subjected on a virtually daily basis.

There were times I when I felt utterly overwhelmed by the task of finding evidence to support the operation of processes that cannot be seen. I had frequent 'crises of confidence' within the context of one of the most powerful experiences of living with uncertainty that I think I have ever had. I found it difficult to apply a methodical approach to data analysis and locate coherence in my work and I sought refuge from the uncertainty in premature theorising. I have come to understand some of these affects as a necessary part of the process of theory-generating using a grounded theory-type approach (Glaser and Strauss 1967).

My methodology can be summarised as a means of psycho-social research, derived from practices associated with psychoanalytic observation and ethnographic participant-

observation, within which the principles of grounded theory have been applied as a means of capturing social complexities (Hammersley & Atkinson 2007). The main tenet of grounded theory is that the study should proceed by inductive rather than deductive means. Therefore, the interpretation of the data and the understandings posited are underpinned by the clinical 'evidence' and the eventual, more abstract, formulation 'emerges' whilst remaining sufficiently rooted in the clinical encounter to keep the experience 'live'.

The interpretive 'gap' between experience and language or conceptualisation – and the relative 'status' of different scientific methodologies - have been the subject of enduring debate within the social research literature: a good reflection on psychoanalysis and the philosophy of science may be found in Rustin (1991). Hammersley & Atkinson (2007) provide a useful summary of the relationship between the development of ethnography as a social science research method and other methodological approaches and theoretical ideas including the competing philosophical positions of 'positivism' (privileging quantitative methods, favouring structured experimental designs) and 'naturalism' (privileging qualitative methods, notably ethnography). They describe how qualitative research methods have been criticised for their subjectivity and lack of 'scientific rigour' (2007: 7). At the heart of such critiques of both positivist and naturalist approaches is their relationship to and the validity of the concept of 'realism' – i.e. the underlying assumption that it is the task of social research to "represent social phenomena in some literal fashion" (2007: 10).

Along with other commentators (Rustin 1991; Hammersley 1992), Hammersley & Atkinson (2007) cite the pivotal influence of Thomas Kuhn (1962 – reprinted 1996) in reframing the underlying assumptions of both positivist and naturalist positions in relation to realism and the problem of subjectivity, supporting the implication that "…judgements of the validity of scientific claims are always relative to the paradigm within which they operate are judged; they are never simply a reflection of some independent domain of reality" (2007: 11). This suggests that there is never a theory-neutral 'uncontaminated' objective reality against which to test theories and that all knowledge is mediated by the context and presuppositions arising from particular paradigms. They further contest that "what both positivism and naturalism fail to take into account is that social researchers are part of the social world they study" (2007: 14,

citing Hanson 1958) and that therefore all data is generated within a context of presuppositions.

This supports the position that there is an inevitable level of subjectivity and theoretical predisposition, inherent to the researcher's reflexivity, which can be 'managed' in the useful production of knowledge as long as the assumption that knowledge must be based on an absolutely secure and objective foundation is abandoned. Accordingly, this allows for a position in which:

a) research may take place within a paradigm;
b) the underlying tenets/pre-existing theories of that paradigm provide an acceptable context that is not being challenged by the research and
c) the researcher's reflexivity and capacity to understand the relationship between observer and what is being observed become an integral part of the methodology.

Rustin (1989) cited by Skogstad (2004), goes a step further, providing a useful analysis of the required capacity and possibility of being able to hold in balance inevitable preconceptions and open-minded curiosity that enables the experience of the observation to be an additional source of data:

> They cannot know in advance which of the conceptions of which they are already aware will turn out to have useful application. Nor can they be sure that any of their preconceptions will fit. They may be confronted with experiences that, initially at least, fall together outside the bounds of their ability to understand them. What this method requires of its practitioners is the ability to hold in mind a loose cluster of expectations and conceptions, while remaining open to the experiences of the observation as it develops. (Rustin 1989: 57, cited in Skogstad 2004: 74/5)

This description of what is required of practitioners can usefully be applied to the necessary state of mind of the researcher throughout the process of the research – both data gathering and analysis. Thus it is possible to accept a process of enquiry that is theory-driven yet generates new material and understandings through the reflexivity of the researcher.

Data analysis - the Fallon Report

Drawing on the principles of discourse analysis (Potter & Wetherall 1987) I suggested that the report of a public enquiry does not constitute reality per se but a representation of reality constructed from a particular frame of reference. From such constructions the external world is, in turn, constructed – i.e. public enquiries generate policy that constructs the boundaries around the external world in a concrete sense. I wanted to review this text, drawing on a different frame of reference, in order to try to elicit a link or absence of links, via the conduit of unconscious dynamics, between the patient population and the policy outcomes.

In practice the process of working with the Fallon Report proved more challenging than I anticipated in that the report consisted of two hefty volumes - a large amount of material. Similarly, my clinical fieldwork generated more material than I had expected. As data analysis progressed, I found myself more focussed on my fieldwork data than I had planned and concentrating on the 'live' data seemed more relevant. Thus the focus of the project changed and I have drawn much more heavily on field data, using the Fallon Report to provide a context or reference point.

I had intended a methodical deconstructing and 'coding' of the report. In practice, I adopted a similar approach to that which I applied to the fieldwork. Initially I read through the report, annotating the text with comments representing my free associations to what was there. I applied a 'commentary' to the data that looked at the text and made crude observations through the theoretical 'lens' of the psychodynamic paradigm. Themes emerged that appeared consistent with theoretical concepts described in the literature in relation to psychoanalytic theory and perversion. It was then possible to 'map' the themes emerging from the fieldwork data onto these themes to enable comparisons to be drawn between organisational processes taking place within the context of a known critical incident, and the processes demonstrable in the fieldwork that might have the potential to develop into critical incidents.

Data analysis - the fieldwork

My role as supervisor/consultant was supported by my receiving supervision from my research supervisor at the Tavistock Clinic in order to introduce the element of

'triangular space' necessary to reflect on the process, evaluate the data and counter my subjectivity. This was in addition to my workplace clinical supervision. As the fieldwork progressed, it was possible to secure further triangulation by asking research peers to consider the texts, suggest interpretations and formulations, or comment on mine. This process was grounded in the tradition of 'clinical scholarship' that involves participation in 'work discussion' groups in which material recorded by the 'participant-observer' (clinician) is presented and discussed within a group of peers, usually led by a more experienced practitioner or tutor, with the aim of achieving a greater depth of understanding through collective thinking. This can contribute to both the personal development of the clinician in the training context, and conceptual development within a paradigm in the research context within a community of clinicians.

A parallel process between psychoanalytically informed clinical methods and research methods can be understood. Within a clinical encounter, the clinician will be observing and attendant to a number of factors:

- The patient's verbal communications.
- The patient's non-verbal communications.
- The patient's apparent state of mind and affect state.
- The clinician's own affect state.
- The clinician's verbal interventions.
- The clinician's theoretical 'repertoire' or paradigm within which to conceptualise these experiences.
- Most crucially, the relationship between all these factors.

The presentation of such observations within a clinical session underpins clinical formulations and interpretations that can be inferred from this 'evidence'. Such a process of observation and inference, when employed within a context that can be explicitly defined in terms of generating new or deeper understandings about the nature of particular psycho-social realities, may be procedurally framed in a way that supports its use as a type of 'naturalist' research methodology – or 'conceptual research' (Dreher 2000). However, the pressures on such recording must be explicitly recognised as must the fact the data available for analysis is not, therefore, the immediate experience of the researcher, but the representation of that experience – inevitably subjective, albeit with the conscious aim of neutrality and fidelity to the experience.

In an account of the use of mutative metaphor in psychotherapy, Cox & Thielgaard (1997), citing Bateson (1979), suggest that language can never be an adequate vehicle to describe ultimate experience. They explore an aesthetic process of discerning "the pattern which connects" (1997: 3) from the verbal and transferential material presented by patients, in order to access repressed experience. It is a good account of the 'leap of imagination' that is required in a creative process of enquiry. Dreher (2000) emphasises the value of inductive (as opposed to deductive) methods of knowledge generation to conceptual research. She describes two variants of induction that may be employed in the process of knowledge generation: 'simple' or 'enumerative' induction – a process of generalisation based on a finite series of observations; and 'intuitive' induction – the use of a series of observations to infer patterns or principles thought to be intrinsic to the observed phenomena and the harnessing of the creative capacities of the researcher. She says:

> While the first variant of induction may lead to "learning from experience", the second holds an important creative potential that can be relevant to conceptual research; for in the second variant the fantasy and intuition of the researcher are called upon, as well as his working out of a suspected common pattern in several of the observed cases… A further helpful element to this second variant is the formation of analogies, whereby concepts or theoretical ideas from one known area are transferred to another. (Dreher 2000: 25)

The use of the self in the service of generating knowledge and bridging the 'interpretive gap' between experience and language poses questions of considerable epistemological difficulty and importance in the field of psychoanalytically-informed social research. Genders & Player (1995) have written about participant methodologies and the ways in which the 'social skills' and reflexivity of the researcher are key to the success of the project and the inevitability therefore that this style of methodology is unlikely to conform neatly to a pre-ordained design, however carefully crafted. Skogstad (2004) has written further about psychoanalytic observation and particularly the role played by the mind of the observer – and the collective minds of peers - as research instruments in this context. This use of the "subtlety and intuition" of the researcher (Hollway & Jefferson 2000: 68) implies a creative and imaginative use of the self in both clinical and research endeavours more active than Hammersley & Atkinson's (2007) acknowledgement of the reflexivity of the researcher, and more closely associated to the notion of the *'Gestalt'*, allowing for the inevitable influence of the researcher's imagination, intuition and idiosyncrasies.

My approach drew on the principles of grounded theory (Glaser & Strauss, 1967), working inductively from the material towards a formulation – a clinically-informed understanding of particular phenomena apparently manifest that emerged from the texts/data. In the context of working with so-called 'defended subjects', Hollway and Jefferson (2000) have written about the difficulties working with subtleties, complexities and the unseen dimensions of individual experience as represented by an interview-based method of data production. They emphasise the importance of the *'Gestalt'* – "the whole in understanding a part" (2000: 57) or the whole being "greater than the sum of the parts" (2000: 68) and the potential for fragmentation of data and resulting loss of complexity implicit in approaches that rely on coding and retrieving data. They cite Richards and Richards (1994), highlighting the shortcomings of electronic methods of qualitative data analysis as unsuited to the subtlety and intuition required in relation to psychosocial subjects. Similarly, they emphasise the way the *Gestalt* can represent an internal capacity for holding data together in the mind as opposed to the externalisation of a computerised means of storing data, without necessarily thinking about it, undermining the possibility of making links, strengthening narrative coherence. Thus the use of electronic tools, whilst potentially supportive of 'simple' or 'enumerative' induction seems to have potential for lending itself to defensive use: as a defence against really engaging with and thinking about the material – with the attendant risk of rendering the complex more simple. For these reasons I felt validated in my view that using electronic data analysis methods was counter-intuitive and rejecting such tools on this basis.

I acknowledge a tension between my posing research questions and hypotheses and yet proposing the use of the inductive approach of grounded theory: I would argue that grounded theory allows for the theoretical sensitivity of the researcher and therefore can appropriately be applied to research that is theory-driven. The similarity between the activities of psychoanalysis as an exploratory process and qualitative research, and the usefulness of the psychoanalytic interview as a model for such research as is described above has also been suggested in the literature (Kvale 1999; Hollway and Jefferson 2000). I appreciated the kind of symmetry that this lent to the process – particularly with respect to the "tolerance of paradox and uncertainty" (Hollway & Jefferson 2000: 78).

Data analysis - the fieldwork: stage 1

Having generated data from the primary sources, I scrutinised the texts, using them as raw data, for evidence of the kind of pressure on reality-based thinking that my clinical experience and knowledge of relevant theory suggested should be present. My intention was that this would be done in a systematic way, initially by asking a number of questions of the data to enable a distilling of aspects of the record that appear to be interesting and relevant:

- What was the overall 'atmosphere' of the session?
- What were my striking emotional responses?
- What evidence is there of successful reflection on primitive emotional material?
- What evidence is there of less successful or confused reflection on primitive emotional material?
- Is there evidence of enactments or parallel processes?
- Is there evidence indicative of unconscious processes?
    - Splitting.
    - Projective identification.
    - Transference.
    - Countertransference.

In practice the process required reading and re-reading the data numerous times in a state of open-minded uncertainty. As I was looking for something unseen it was impossible to know how I might find it. This process of reading and re-reading resembled a 'working through' during which at times I could do little more than hope that patterns from which I could formulate some understandings might emerge. I had supposed that behaviours or tendencies towards behaviours would manifest in a structure or particular construct of 'thinking and feeling' and it was this in which I was particularly interested and that I ultimately hoped to capture.

The first stage of the data analysis was to add annotations representing my initial freely-associated thoughts to the text of the transcribed process recordings. I highlighted areas resonant with themes that appeared to link with both my initial reading of the Fallon Report and the literature in relation to psychoanalysis and perversion. At this stage, I kept the material whole. At the end of each process recording (each of which

represented a consultation) I made a list of the apparently dominant themes. This process of 'immersing' myself in the data, reading and re-reading and talking through ideas with my tutors and peers was absolutely key to my formulations. Like water filtering through limestone, the process enabled me to 'distil' ideas and find different ways of seeing the material, making links and 'trying out' ideas and possible ways of understanding, whilst acknowledging the risk of inappropriate subjectivity and the challenge of 'selecting' the relevant facts.

On at least one occasion, I worked with my peer research group at the Tavistock using a random, uncontextualised sample of material. We took a hypothesis-generating approach to the material using the biographical interpretive method as described by Chamberlayne (2000). This gave me the opportunity to test my thinking and its validity with an external peer group.

The volume of material at this stage was large and unwieldy. Having initially taken care to work with the entirety of the texts, it appeared that a number of coherent 'stories' emerged from individual sessions or across a number of sessions. I was then able to assemble these stories into vignettes that had coherence and appeared to demonstrate processes that impacted upon thinking in extraordinary ways.

Data analysis - the fieldwork: stage 2

Hollway and Jefferson (2000:70), whilst acknowledging "the importance of creativity and intuition (important features of subjectivity)", caution against waiting "for a bolt of inspiration" and at times I felt as if this was exactly what I was doing. It became necessary to apply a more structured and systematic approach to this 'distilling' of my initial impressions of the material.

The above authors helpfully suggest:

> The four core questions associated with analysing any qualitative data are:
>
> What do we notice?
> Why do we notice what we notice?
> How do we interpret what we notice?
> How can we know that our interpretation is the 'right' one? (Hollway & Jefferson 2000: 55)

I found this a helpful way of framing the enquiry and therefore applied these questions in a systematic way to each of the vignettes.

"What do I notice?" enabled a factual record of literally what I had noticed, from the initial reading of the texts and then again from a closer scrutiny, often just lifted verbatim from the text. It could be argued that a level of subjectivity would generate inevitability to the areas of interest that I would identify, relating to my particular theoretical sensitivity and preference for a particular paradigm. However, I remained consciously aware of this particular tension and was careful to approach the material in as neutral and 'open-minded' a way as possible.

"Why do I notice what I notice?" invited me to make un-theorised suggestions as to why I had noticed these particular factors. At this stage, the reflections on this question still represented a surface 'descriptive' view of why the chosen aspects of the texts had resonated with me and been noticeable – and what had interested me in this context. This aspect of the analysis included the application of 'common sense' observations about the possible reasons for noting the phenomena (as distinct from their meanings).

"How do I interpret what I notice?" required me to adopt a sceptical position that posited potential 'simple', 'surface' or 'obvious' explanations for the various phenomena that emerged from the material within each vignette and either seemed to be potentially indicative of the pressure on thinking of interest, or resonated with me for reasons I did not understand.

This was the point at which the application of theory provided a framework for a possible means of understanding the significance of what had appeared to me to be noticeable or interesting.

"How can I know that my interpretation is the 'right' one?" was by far the most difficult question, raising the question of how one can select and interpret 'facts' in relation to processes that can neither be seen nor are being consciously experienced. I have already referred to the way that facts can be seen as a representation of reality, dependant on perspectives deriving from factors such as cultural contexts, paradigms etc., and the role of the minds of researcher and peers in selecting facts. The status of a clinical fact - i.e. a 'truth claim' made within the context of a clinical encounter – has

been explored in the literature by O'Shaughnessy (1994), Sandler & Sandler (1994) and Tuckett (1994) in relation to its components, its validity, and its capacity to describe and deepen understandings of subjective - particularly unconscious - meanings. These clinicians described the process of constructing a clinical interpretation that is 'grounded' in the evidence of clinical facts within a boundaried analytic framework with which inductive, hypothesis building research methodologies have direct parallels. This is useful thinking in the context of how to suggest an interpretation of qualitative data that can be confidently made and is an acceptable (if not necessarily the only possible) interpretation that can be demonstrated to be reasonably inferred from the available data. Tuckett makes the parallel with grounded theory explicit in his exploration of forming a 'grounded hypothesis' and its validation – the way in which the interpretation can be shown to be the best 'fit' with the material compared to alternative ways of understanding: Hollway and Jefferson (2000) describe this in practice.

Having identified the possible 'common-sense' or 'surface' explanations for the phenomena of note, I explored them, both in isolation and in relationship to each other, before finally concluding that, in isolation, each could perhaps be partially understood through such surface explanations. However, the presence of a number of different dimensions to these factors and their presence together:

1) undermined the plausibility of the surface explanations;
2) strengthened the 'case' for depth and a 'higher order' theoretical understanding of the complexity that finally
3) elevated them to the status of acceptable evidence of the pressure on thinking arising from unseen and unconscious processes.

Data analysis - the fieldwork: stage 3

Ultimately, I found it helpful to apply the principle of the '*Gestalt*' as described above. Holding in mind a whole, and looking at the apparent themes of the vignettes, the whole could be argued as literally representing something greater than the sum of the parts in that, whilst 'common-sense' explanations can perhaps be applied to single individual phenomena, it is more credible to make a case for a 'higher order' theme where a series of examples can be observed as potentially complementary in contributing to an

understanding of structures of thinking and/or feeling that are underpinning particular behaviours and appear to be 'driven' by unconscious processes linked to the particular population of patients.

Data analysis - the fieldwork: stage 4

The above method was the means of distilling depth from the material derived from the process recorded supervisory notes - 'vertically', so to speak. However, in order to formulate a useful comparison with the themes emergent from the Fallon Report, it was also helpful to have a means of capturing themes that ran through the material taken as a whole series or collection of sessions – 'horizontally'. I did this in two ways. For each session, I made a brief summary of what seemed to be the dominant themes. I then created a spreadsheet that enabled me to chart these themes across the sessions for DC B and Ms A. This enabled a visual comparison of the themes arising from the material of the two principal participants, so that I could see the similarities and differences. A further spreadsheet enabled me to chart the themes that emerged from the Fallon Report and measure whether, and if so to what extent, the broad themes evident in the fieldwork were consistent with those associated with that enquiry.

DC B's material, taken as a whole appeared to chart a process over time during which his defences could literally be seen to break down, leading to physical and psychological illness and his withdrawal from his work. It was helpful to depict this in tabular fashion and I compiled a table that provided a visual record of the dates of the sessions, the vignettes appearing in each session, the themes apparent in each session and the integrity of his defences during each. I attach this as Appendix 3.

Appendices 5 and 6 are two short whole vignettes, with comments in situ, attached to illustrate the process of data analysis stages 1-3. These vignettes are in an unfinished form and are included both because they are particularly interesting examples of the processes of interest and in order to show the actual process of analysis.

> **It is well known that the qualities of the whole are not merely a simple sum of the qualities of its subsystems. In the formulations of the gestalt-psychologists: the whole is more than the sum of its parts. This is illustrated by the relation between water and ice. An understanding of the altered characteristics of water, when frozen, cannot be derived from an understanding of its chemical components. (Cox & Thielgaard 1997: 191)**

Chapter 4: Data analysis

> Each of us is aware in ourselves of the workings of denial, of our need to be innocent of a troubling recognition. (Bollas 1993: 167)

The vignettes are presented in the following order in which they have a thematic relationship to each other. Each is preceded by a relevant extract from the Fallon Report (DoH 1999a) that shows a similar theme in the context of a documented critical incident.

Vignette 1 **Ms A: *'The Primary Task'.***

Vignette 2 **Ms A: *'First Amongst Equals'.***

Vignette 3 **DC B: *'The Ugandan Man'.***

Vignette 4 **DC B: *'The Foster Carer'.***

Vignette 5 **DC B: *'The Police Officer'.***

Vignette 6 **Ms A: *'Z and the Smell of Alcohol'.***

Vignette 7 **Ms A & Mr C: *'Supervision: Protective or Perverse?'***

Vignette 8 **DC B: *'The Impact'.***

In terms of the overall 'architecture' of the project, the vignettes are thematically connected in the following way:

'The Primary Task' introduces the recurring theme of difficulties in both defining and effectively engaging with a primary task in a high secure hospital. It shows a team of therapists whose behaviour appears entirely defensive as task-focussed activity diminishes until they can be seen to be nudged out of role and configured as if their primary task were to receive supervision.

'First Amongst Equals' expands this theme, demonstrating the role of leadership denied in a way that serves to support the defensive behaviours in *'The Primary Task'*, suggesting that in this setting authority is necessarily experienced as abusive leading to an inability to operate within appropriate roles.

'The Ugandan Man' picks up the theme of confusion between the legitimate use of authority and abuse. It demonstrates projected hostility moving around an interpersonal system resulting in DC B being literally unable to maintain his capacity for independent thought.

'The Foster Carer' further illustrates attacks on DC B's capacity to think, as he again gets 'recruited' into a particular point of view and way of relating with a suspect that can be seen to prevent him effectively engage with questioning him. He feels persecutory and the attack on his thinking, and his resulting confusion, is seen to be an effective defence against the suspect's persecutory anxiety.

'The Police Officer' continues the theme of attacks on thinking as a defence against persecutory anxiety. A 'perceptual fog' of confusion can be observed that effectively prevents the 'crux of the matter' of an interview from being explored: the truth remains obscure and the suspect does not engage with responsibility.

'Z and the Smell of Alcohol' develops the theme of attacks on thinking creating a muddle of confusion. Ms A's inability to believe the evidence of her own senses in relation to a team member's alcohol use is extraordinary in its intensity and amounts to a denial of reality in which she is unable to accurately assess and contain risk.

'Supervision: Protective or Perverse?' links to *'Z and the Smell of Alcohol'* and describes the way in which Ms A uses the potentially protective systems available for supervision in a way that is perverse in that it serves to perpetuate a dangerous situation. This is contrasted with an account of Mr C who, when nudged into a potentially dangerous enactment, made use of a reflective space to make symbolic links enabling him to think previously intolerable thoughts and more effectively assess risk.

'The Impact' is a short summary of DC B's experience of his work over time, in which it can be seen that he is subject to intense emotional processes of such toxicity that they invade him in a concrete and unsymbolised way such that he withdraws from his work through physical illness. This links with *'Supervision: Protective or Perverse?'* in that it completes an account of the differing approaches of the three research participants to the professional consultation process.

Management… is based on a wide range of actions, albeit hopefully thoughtful actions. The role of the manager is inseparable from action of some kind. Managers, even those who began their careers as clinicians, do not on the whole spend much time thinking about their emotional responses to situations. The world of the manager generally precludes much detailed care for the relationships within organisations, and thinking is mostly considered a cognitive matter only.

An outcome is so often a requirement for managers that, at its worst, the means of achieving it can seem not to matter. Although one could say that action without thought would be a sign of not knowing what one is doing, managers are vulnerable to the view that doing nothing is not an option, or to the prejudice that thought is synonymous with inaction. First thoughts are considered better than second thoughts because there is no time. Competence can be judged by speed. (Mercer 2008: 63)

Vignette 1 - Ms A: *'The Primary Task'*

In paragraph 10.6 the [Rowe] Report identified four important features which undermined therapy on Forster ward:

1. POA insistence on minimum staffing levels for internal escorting duties. They insisted on escorting patients to physical education where they just waited around or used the appliances themselves.
2. Bitter inter-departmental rivalry which has existed for a long time before 1990 between nursing staff and physical education staff. It disrupted the physical education programme. The nursing staff were dictating the running of the Hospital.
3. The attitude of some of the nursing staff. One member of staff apparently described himself to patients as a "lunatic attendant". Some apparently swore at patients with obscenities and exchanged oaths with them.
4. The industrial action by the POA adversely affected therapy on the ward. (DoH 1999a: 2.5.22)

Professor Gunn, addressing "treatability", also pointed out that very few medical conditions are totally curable and medical treatment on the whole is not about "curing". And that is certainly so in longstanding disorders. Ameliorative interventions are common in general medicine, but are often not regarded seriously in psychiatry with respect to personality disorders. He referred to the "bizarre notion" that because they are seen in moral as well as medical terms they can be dealt with as "bad people" and punished and then as "sick people" and healed. (DoH 1999a: 6.8.15)

***'The Primary Task'* - analysis**

I have described the way in which the primary task of a high secure hospital is difficult to define – notably in the tension between the need to provide therapy and control. The Fallon Report (DoH 1999a) makes the confused roles of hospitals and prisons explicit, expanding the debate about whether it is possible to successfully treat patients with certain kinds of personality difficulties. Numerous examples of the breakdown of multidisciplinary working and splits between groups of staff had the outcome of undermining the task both in relation to therapy and security and were clearly at the heart of the critical events that prompted the enquiry.

'The Primary Task' illustrates a consistently observed phenomenon in relation to Ms A and her team who increasingly appear to do less and less work directly related to their role and task within the organisation. As a team of therapists, their primary task could be described, in simple terms, as to engage patients in thoughtful, therapeutic encounters: Ms A's task being similar - with the additional component of managing the service and its interface with the wider institution and organisation. There is compelling evidence in the material that they are not doing this – rather, it is impossible to locate evidence that they are. Their diminishing clinical service is located within a rational explanation of an absence of support staff to manage security whilst the therapy takes place. Despite the absence of task-focused work, the team are seen to be widely engaged with the systems of support and containment of their clinical work such that they begin to configure as if their primary task is to receive supervision. This is compounded by an increasing sense of delinquency within the team whose personal difficulties begin to be much more evident than any sense of their clinical focus. It will be seen that the nature and extent to which their service dwindles goes beyond the rational explanation, undermining their clinical credibility within the wider organisation.

I suggest that it is reasonable to understand these as defensive behaviours and that the underlying anxiety arises from a sense of hopelessness that challenges the efficacy of the primary task and what may be entirely reasonable, yet rarely-expressed, fear of the dangerous patients in the setting.

The diminishing primary task

The extracts derive from seven of twelve supervision meetings with Ms A. She spoke of her clinical work in only three sessions and only in the first two of those was the work 'live'. Ms A described a process of reducing clinical work: initially her own 1:1 work with patients, moving on to relate difficulties that undermined the on-task activities of the whole team. At the outset of the fieldwork, I was seeing Ms A as a clinical supervisor but by the session of 25/05/05, my role had changed to that of her line manager, significantly shifting our relationship as I assumed a level of responsibility for her service and the performance of her team and a role that carried explicit authority in relation to her.

Ms A described compelling 'surface' explanations for the reducing number of therapy sessions undertaken by her team. The most persuasive was the absence of dedicated escorting staff who, unlike the therapists, are trained in approved techniques for physical intervention (PMVA) and who:

a. Escort patients through the hospital from the wards to the creative therapy facilities.
b. Provide a function in relation to security/health and safety by observing the session from outside, being easily available in the event of a patient becoming agitated or aggressive towards the therapists.

Therefore, one can see that without such support:

a. The patients would be unable to attend the sessions at all.
b. There may be a risk of physical harm to the therapist.

Discussions around these difficulties came to dominate supervision, excluding all other material. Initially, as clinical supervisor, I found it easier to be sympathetic and support Ms A in thinking about what pressure might be exerted on the institution, via organisational policy structures, to provide additional resources. However as line manager, with an increasing awareness of institutional 'politics', limited resources and performance monitoring processes, I can be observed to be much more focussed on trying to measure the activity of the team and directive in my endeavours to motivate

and mobilise task-focussed activity even if it meant a compromise to 'good enough' as distinct from 'best' practice. The absence of work was mirrored by the absence of systems and processes in place to record that work and other team activities such as their working hours and Annual Leave (A/L).

Ms A chose to end some of her therapeutic relationships and services rather than risk cancellations: there is some logic to this – although it is an approach that does not recognise the need sometimes for flexibility to accommodate the challenges of such an unusual setting:

Ms A from 07/02/05:

…The escort issue was dominating the team's agenda in various ways… Ms A said that the dept was now only offering 9 sessions per week and that she had thought it prudent to suspend various activities rather than cancel on an ad hoc basis. Some patients clearly require an escort of 2. Work with admissions patients is completely suspended.

There is evidence that where potential solutions emerged, they were neither appropriately embraced nor expedited: most clearly seen in Ms A's reluctance to accept a solution offered by Dr Y, the 'reasons' she finds to avoid resuming direct work with patients, my eventual need to direct her to accept and her apparent reluctance when she does - on a conditional basis - with the proviso of a future 'review':

Ms A from 25/05/05:

One of the RMOs… emailed Ms A and offered to provide escorts for her to resume some clinical work with one of her patients. Ms A had turned the offer down, had been uncharacteristically sharp with the Dr, and there had been some tension between the two. She said that now she "didn't know what to do". She had been worried that the arrangement might not be consistent and that she would resume patient work only to be forced to withdraw and let patients down again. She had also been mindful of her plans to leave – it seemed irresponsible to resume clinical work when she thought she might leave. However, now she had definitely decided to stay…

...I said that this seemed to me to be a win-win scenario: she would get an interim escorting arrangement that would facilitate some clinical work and she would demonstrate her capacity to be flexible, the Dr concerned would have an experience of being helpful and moving things along, and a patient would get a resumed service that had clearly been missed. I suggested she pop her head around the Dr's door to informally smooth over any residual tension.

Ms A from 22/06/05:

We confirmed that Ms A has accepted Dr Y's offer of escorts enabling 2 patients to recommence in therapy with her. She told me that there had been some confusion as a third patient may be able to be accommodated, but this patient is from a different ward. The CNM from that ward had also offered to assist with escorts... Ms A had been very clear with all parties, including patients, that there may be some limitations to the above arrangement and that it would be reviewed in September. She had informed them in advance of dates when she would not be available through training or other reasons.

Despite a paradoxical resumption of referral meetings, there is evidence that the patients are difficult to think about:

Ms A from 07/02/05:

She spoke of her department referral meetings – that for a time (when they had had their difficulties as a department) had fallen by the wayside – been pushed aside. Now they were reinstated and she was pleased at how the service had regained its patient focus. I was contemplating the paradox of reinstating referral meetings when their capacity to provide therapy was so reduced…

...Despite her assertion that their service was getting more patient–centred, I thought that there was evidence that it was actually very difficult to think about the patients in this context. This evidence could be seen in the diminishing service, her comment about not thinking about her patient from one session to the next and the focus of her time on this issue of escorts that had appeared to have been completely split off from a notion of providing a service to patients – I

reminded her that almost her first words to me had been that she wanted to speak about Patient 1 today and yet we had not done so and it was the end of the session.

The clinical work continued to diminish and, on behalf of their team, Ms A issued a memo, sent by email to key senior managers and clinicians (with the notable exception of me) *"reluctantly suspending the service"*:

Ms A from 21/02/05:

On entering the room, Ms A started talking once again about the escorting situation. It has not improved. Indeed, the creative therapists have now suspended almost all their service... They are now only providing services on a Thursday…

…When I returned to my desk, Ms A had emailed me the team memo announcing their suspension of service. It had been sent to the most senior of hospital service and clinical managers and it wasn't exactly neutral or tactful. It came to be known, outside their department, as "'the Creative Therapists declaring UDI' email".

The absence of direct contact with patients extended to an inability to engage with any directly clinically-related work at all and Ms A further reduced her potential clinical contribution by dropping her hours:

Ms A from 16/03/05:

Ms A said she has been trying to encourage the team to attend Clinical Team Meetings. Strangely, it seems that they are consistently unable to do so. However, attending CTMs could be an important way of remaining 'visible' to the clinical teams…

…She had asked this male member of staff to attend a particular CTM and he had countered that he had paperwork and a report to write up. She had told him that,

in the 3 days he works here, with so little clinical work, it should be possible for him to attend 2 CTMs.

...She has dropped Mondays, now working only 2 days per week. I found myself wondering what space was left for clinical work between the meetings/supervisions she has to attend. She has 3 separate forums for clinical supervision that I know of, as well as line management supervision. I was increasingly preoccupied with wondering exactly how this team were spending their time.

Ms A from 25/05/05:

She described the way in which she had tried to persuade the team to attend CTMs – particularly whilst not doing clinical work. She gave an example about how one of them had said that he was unable to find the time to do so as he had a report to write. She had told him that, as normally he would have been expecting to undertake a certain number of clinical sessions per week in addition to writing that report, she expected that, in the absence of the clinical sessions, he should be able to attend some CTMs.

Conversely, the team spent significant time receiving clinical supervision. They attended two weekly sessions of clinical supervision, one of which was for their team, the other as part of a wider multi-disciplinary group. Each member had individual supervision monthly and 1:1 meetings with a manager. In addition, they had referral and departmental meetings weekly. The need to safely support other activities on the wards, notably meal times and administering of medication, limits the clinical session times in which therapy can take place. Logically, this should mean that administrative meetings are held in the times patients are not available. However this was not the case:

Ms A from 06/07/05:

...I reminded Ms A that it seems to me that her team between them are using 8 clinical sessions between the department meeting and their team clinical supervision. She explained that their clinical supervisor could only move their slot to one that clashed with their other group supervision time. I reminded her of

the need therefore to move the department meeting. Ms A said that she had thought about my comment that the team appeared to be using a great deal of time in supervision. I gave feedback from my earlier impressions during our supervision. I said that there had been one occasion on which I had asked Ms A specifically how her team were spending their time. Despite me asking several times, I was left with no idea as to how they spent their time. The impression that I gained was that the team were behaving as if their primary task was to receive clinical supervision.

Further examples of non-clinical team activities in the material are mandatory training and the team 'away-day'. Ms A commented that all are up-to-date with their mandatory training and described their attendance at the 'Breakaway' training course (safe means to escape if physically attacked). However, by 22/06/05, despite their reduced workload, she is cancelling mandatory training:

Ms A from 22/06/05:

As we walked, Ms A commented that she had had a productive day. The team had been booked on some mandatory training and she had cancelled it, believing there were "better things to do".

The nature of the *"better things"* or her *"productive day"* is not evident in the material. The team away-day fares better, taking place as described in the session of 16/03/05. But I gained no idea of an agenda, purpose, structure or outcomes of the day and their activities gave a sense of filling the time with play-like activity - with a child-like quality. Her reflection that her Service Manager (SM) had, disappointingly, not commented on their "productivity" appears naïve, highlighting ways in which the team appear to seek the approval of those in authority but cannot seem to locate the appropriate means of doing so. Paradoxically, the away-day that might have been an opportunity for team building and service development is depicted as a diversionary episode that takes them no further forward towards re-establishing potent, task-focused activity. Nor do they appear to have used an opportunity to develop their relationship with the wider organisation through the Service Manager:

Ms A from 16/03/05:

She spoke of their department away-day. I was wondering what sort of focus they would have been able to find – increasingly getting this sense of a department who have lost sight of their task and, as the clinical work has trickled away, are almost trying to find ways of killing time. She said that they had made some art work together in the morning and that she thought that they had been very creative. They had attached this art work to the wall. The SM had joined the meeting during the latter part of the morning. Ms A had hoped that she would have noticed their art work and commented on their creative and productive morning. She was rather disappointed that she had not done so, commenting that "to some people, it must just seem like a series of unusual colours and shapes". I was wondering exactly what experience the SM might have had of joining their away-day and what the actual impact of their art work might have been on her… Their team away-day seemed to have been a golden and lost opportunity to regroup and think together about defining their service to patients.

A sense of their delinquency is reflected in my need to be very directive to Ms A about implementing systems for recording the team's working hours and Annual Leave and managing her concerns in relation to the sickness absence of one member and a suspicion that he is not attending training whilst on day release – i.e. that she should establish some very basic boundaries necessary to the effective management of the service.

It is apparent that Ms A is aware and engaged with difficulties arising in her team's personal lives that impact on their work such that they increasingly fill the supervision space in place of the patients - as if it is their delinquency, rather than that of the patients, that is the focus of our thinking. This adds to the difficulty in engaging with task-focussed work as they all appear to be looking outwards from the institution instead of inwards and on task:

Ms A from 16/03/05:

She spoke of the various individuals in the team. A female art therapist – 'I know she regrets not taking a full year off for maternity leave, and she'll continue to

regret it until that year is up; she's sharing a room with a colleague and struggling with that – feeling claustrophobic, a situation that is compounded by their spending so much time in their office as they are doing so little clinical work… A male music therapist who has a "major life-changing situation" going on in his personal life and has a lot of time off sick… Most of the team were talking about the possibility of leaving and working elsewhere. She spoke of the difficulties in supervising people whilst knowing so much about their personal worlds…

The team appeared to be struggling to think about their task within the hospital. There was talk of people leaving and a concentration more on personal world difficulties. Either they can escape the institution, as it were, or perhaps they might be able to begin to think about regrouping and redefining their task in a way that puts the patients at the centre. At the moment, they seem to be taking up a position of ambivalence about where they belong and what is their task and role.

Ultimately, the withdrawal from patient contact appeared to have the effect of further marginalising a small and already marginal specialist team leaving them vulnerable to processes of scapegoating. Their 'declaration of UDI' email was not well-received and it seemed that those outside of their service were experiencing a childlike, delinquent aspect to their behaviour (a countertransference) that prompted an austere and infantilising response from the wider organisation. The perceptions of this team held by the wider hospital had the effect of further marginalising them and further reducing their clinical potency.

Hopelessness and fear

If the primary task of this team can be seen as to engage patients in the hospital in thoughtful, therapeutic encounters, what can it mean when a team such as this fail to do so?

During my previous period of clinical supervision of Mr C, we frequently reflected that the nature of the institution and the complex unconscious defences enacted therein consistently raised the question of what could really be understood as the primary task

of any therapist there. (I will expand on this work below in Vignette 7: '*Supervision: Protective or Perverse?*') Powerful feelings of uselessness and professional impotence were aroused in Mr. C and much of our work together involved sharpening the focus on the reality of what could be known about patients' risk. We likened the clinical task to that of palliative care, considering the unconscious dynamics in this context and suggesting that defensive behaviour could be seen as defending against professional inadequacy, impotence and hopelessness arising from feelings of guilt projected into therapists by patients (Mercer 2008). There is evidence of this in Ms A's material:

Ms A from 24/01/05:

*I was green. I thought **everybody** could be rehabilitated. Now I accept that there are some people who will live in institutions for the rest of their lives". It made her think about what her job was about and where was there room for hopefulness. It made her think about "quality of life" issues.*

The consistent avoidance of the task in Ms A's material can be understood as defensive: I suggest it not only defends against this kind of 'therapeutic nihilism' but, crucially, against **fear**. It seems logical that patients detained within this institution are, quite simply, frightening. They have demonstrated a capacity to harm others at the extreme of our spectrum of understanding and, in order to manage day-to-day encounters with such people, this reality is little thought about. In anecdotal terms, it is highly unusual to hear professionals of any discipline in this setting speaking about fear.

There is supporting evidence in the data. The issue of the availability of escorting staff illustrates fears and concerns about the safety of the therapists. As time goes on, the emphasis appears to be on the difficulty in getting patients to and from the therapy rooms. Ms A is critical of both escorts' competence and not confident of their capacity to safely manage the physical security of a clinical session. Although she expresses these concerns, the fear of what the patients could do to them in the relatively isolated setting of the therapy rooms is never really articulated – although there are hints:

Ms A from 29/11/04:

Finally, I said I thought some thought needed to be given to the risk in the room and the identification of Ms A with Pt 1's victims. She said she knew them to be women in their 30s. This, I think, needs to be thought about – what is Patient 1 remembering when he is with Ms A? She acknowledged that that is what she is worried about when his eye contact slips and he seems to "drift away": "what's he remembering…?" There seems to me to be a strand of grandiosity/omnipotence running through the account given in this session. I highlighted a possibility, as women, of a grandiose denial of our identifications with victims and vulnerability… I felt protective of her. I spoke of the potential experience, in the setting, as women, of keeping what we fear behind locked doors, under control.

In the extract from 07/02/05, there are a number of places in which fear can be seen; however this is only observable through examples of the aggression demonstrated by the staff – including Ms A herself. There is evident aggression in the material in Ms A's description of her belief that the male escort – X - has been bullying his female counterpart and of her response to this and him – shouting at him, recognising her own projection to some extent, and in her comment about their attitude in general:

Ms A from 07/02/05:

The female escort has suddenly left. This, she believes, is as a result of bullying by X…

...She went on to talk about her belief that X had been bullying his female counterpart "in a subtle way" for some time. She regretted not taking action to address the problem – had offered to do so but the woman had declined…

…Ms A spoke of X in a disparaging way, saying that she "wanted to bully him back" and that she had previously had 2 confrontations with the man that had on both occasions resulted in her shouting at him – "I never normally do that – not here, anyway". She said that she recognised some of herself when she had been at school – a bully…

…The escorts had been hostile – X had sat with his arms folded. It seemed that they had found the experience very persecutory…

The possibility of the therapists learning PMVA techniques themselves appears to be symbolic of the question of should they – or not - equip themselves to be able to deal with the unthinkable that in reality might happen and it is clear that, at a conscious level, Ms A has been preoccupied with the availability of help from elsewhere in the hospital should they need it. It is notable that one of the possible solutions to the problem relies on a rather skewed analysis of risk:

Ms A from 07/02/05:

…Ms A said that she had considered the ethical implications of "having a patient face down on the floor" and also that she would not feel confident to use such techniques in such an isolated building – even though she knew that it takes only 15 seconds or so for nurses to respond to alarm bells "I've timed it"…

…The Service Manager had also suggested that 'parole patents' (i.e. patients who have been risk assessed for limited movement within the hospital with minimal escort requirements) could be selected for therapy… However, I… thought that this would mean selecting patients for creative therapies on the basis of risk rather than on the basis of need and I wondered what responsibility for the safety of the encounter would inappropriately be located within patients.

Throughout our work it was striking that aggression and attendant fear were described in relation to colleagues or Ms A herself: the evident hostility, aggression and capacity for dangerousness amongst the patients was never explicitly raised. In the next three extracts, there are further oblique references to aggression in the system and explicit references to fear as she wonders about her team's difficulties:

Ms A from 29/11/04:

We have done a little work around patients – she told me of a very difficult experience facilitating an anger management group after which (in the evening)

she had her "first ever as an adult" experience of a physical fight with someone – "and I started it".

Ms A from 16/03/05:

She said the eventual reply from the Service Director had been "rude and dismissive". It had made Ms A and her team "very angry" and had felt like "the last straw". Ms A had forwarded the communication to the others to read. One of the team, "usually a man of few words", had come to her office and said "this is outrageous". He had returned some minutes later, saying "I feel I need to say some more about this". Her female art therapist colleague "gradually goes red"...

...Ms A thought that the email had been "unprocessed", that it represented the raw anger, raw materials...

Ms A from 16/03/05:

Ms A returned to the subject of the difficulty in getting the team to attend CTMs, they seem almost afraid to do so… I said that I also wondered about the reality that actually, most of the patients are frightening and I wondered to what extent this might be reflected in the difficulties in thinking about redefining a task that has engaging with patients at its centre.

Ms A from 25/05/05:

She wondered if the team were "afraid" to return to the wards. She recalled a time, when first working in the setting, when she felt "a bit afraid" and she gave an example of how, in wandering through the hospital, she had accidentally opened the wrong door, finding herself facing the interior of a cupboard, not the ward she had expected. Although embarrassed, she had merely closed the door, carrying on "as if nothing had happened".

Ms A's material was notable for the absence of descriptions of her direct clinical work. However, the following extracts demonstrate her difficulty acknowledging and

engaging with appropriate fear of a male patient and, finally, to the anticipated outwardly expressed hostility of the patients with whom she had suspended and resumed therapy:

Ms A from 20/04/08:

We revisited the subject of where hopefulness is located for this patient and also where is the danger. I said that I noted throughout our discussion of Pt 3 this morning we had been struck by feelings of confusion and compassion and the impulse to protect him – I had described a 'soft spot'. It seemed to me that his capacity for cruelty was notably absent from the material and I reminded her that he is a man who has demonstrated the capacity to suddenly kill or inflict serious harm with his bare hands. Yet between us, we were unable to remember whether he had taken one life or two. Ms A said that if she "saw Pt 3 in a pub with a pint in front of him" she would "be afraid". So where, I wondered, does his murderous capacity go in the therapy?

Ms A from 22/06/05:

Ms A has seen the patients with whom she has resumed therapy. She commented that the resumption of the sessions had been smooth without any hostility being expressed towards her.

Ms A's difficulty in taking up a role with requisite authority in relation to her management of her staff is discussed elsewhere as further evidence of unconscious processes, but in this arena also, there is evidence of fearfulness. In a moment when she can almost acknowledge her avoidance of exercising authority she says:

Ms A from 06/07/05:

Ms A said that she thought that she was moving out of her "fearful position".

However, she must finally address and manage the difficulties posed by a staff member her fear emerges and, although not articulated, can be seen in her physiological response and being reassured by my presence:

Ms A from 17/08/05:

She had asked him to go to Occupational Health and told him that she would be informing me and would be sending him home. She sounded hesitant, her voice shaking… When I got there, she was shaky and either on the brink of tears or had been crying. I asked her if she was OK and she said that she felt better - "now you're here". I thought she was going to cry.

Formulation

The reduction of therapeutic service offered by this team is evidence of their withdrawal from the primary task. The absence of escorting staff presents a real obstacle to the practicalities and safety of their service; however the impact on the primary task is extraordinary in the following ways:

- the extent to which the service diminishes;
- the reluctance to embrace solutions;
- the conditional nature of resumed activity and suggested 'review';
- potential clinical sessions being used for non-clinical activities;
- the away-day appearing little more than a means of 'killing time';
- the preoccupation with the practicalities of recruiting escorts;
- the avoidance of engaging with other clinical activities such as CTMs;
- the inability to use opportunities to reorganise;
- the deteriorating relationships with the wider organisation;
- the way in which the team is perceived by the institution;
- the level of inflexibility demonstrated by the team;
- the increasing focus on the personal circumstances of the team members;
- the presence of activities that appear both symbolically and actually delinquent;
- Ms A's decision to decrease her working hours;
- the absence of sensible management structures for measuring performance;
- the filling of available time with processes of supervision that appear to increase as the clinical work decreases;
- yet the absence of clinical material in my sessions with Ms A.

Each of the above bullet points can be attributed a rational explanation: however, the best explanation, that illuminates not only all the above points but the presence of them all together, is that they illustrate collective defensive behaviours serving the purpose of undermining the primary task of the team, nudging them out of their roles within the institution. This argument is underpinned by my proposal that such behaviours defend against the anxiety aroused by the fear that arises from the nature and presentation of the patient population. The defensive outcome for the staff is that they are protected from experiencing feelings of hopelessness and fear in the performance of the task. The perverse outcome for the patients is to perpetuate an environment where the therapeutic component of the primary task is undermined and the need for them to engage with uncomfortable realities is avoided.

The specific difficulties experienced by Ms A in taking up an appropriate role with sufficient authority to steer the team to perform within the primary task are expanded in the next vignette: *'First Amongst Equals'*.

The links which bind the organisation together are often sado-masochistic and involve a cruel type of tyranny in which objects and the patient himself are controlled and bullied in a ruthless way. Sometimes the sadism is obvious, but often the tyranny is idealised and develops a seductive hold on the patient, who appears to become addicted to it, often gaining a masochistic gratification in the process. (Steiner 1993: 12)

Vignette 2 - Ms A: '*First Amongst Equals*'

…There must be clear delineation of the clinical, managerial and professional roles of all members of staff in order to increase awareness of and understanding of roles, to improve communications and to clarify responsibility and accountability… (DoH 1999a: 2.8.7.3)

…A hospital such as Ashworth cannot be run as a glorified 'therapeutic community'. No army could be efficiently managed without officers, non-commissioned officers and troops. (DoH 1999a: 2.25.8)

To work well in such an environment, teams have to have above all strong leadership. By this we do not mean an autocratic RMO, but someone who can give the team a consistent sense of direction, who will stick by agreed policies and confront unacceptable behaviour by patients (and indeed by staff). Second, clarity of philosophy, roles and policies is vital. Third, good communication is essential, in particular between the PCT itself and the ward-based staff who will rarely attend PCT meetings. And fourth, realism: forensic patients in high security are there because of their potential danger… (DoH 1999a: 4.10.2)

'First Amongst Equals' - analysis

There are many places within the Fallon Report (DoH 1999a) where an absence of clearly delineated roles, strong leadership, a breakdown in authority - and appropriate relationships with authority - can be observed and identified as relevant to the emerging critical incidents.

Whilst *'The Primary Task'* illustrates an erosion of the primary task as a defence against experiencing hopelessness and fear, *'First Amongst Equals'* depicts the role of leadership and authority undermined in a way that amounts to denial and compounds the erosion of the primary task. In *'The Primary Task'* I suggested that the behaviours described served as a defence against the underlying fear of working with patients who are in reality frighteningly capable of acts of extreme violence: *'First Amongst Equals'* demonstrates a complementary set of defensive behaviours denying the institutional reality of the need for leadership.

This has the outcome of supporting the off-task behaviours in that these are not identified, challenged, nor contained (either pragmatically with structural boundaries or usefully understood): rather they are rationalised.

The legitimate role of leadership denied

Ms A has the role of leader of the team of creative therapists: a drama therapist by discipline she was seconded on a temporary basis into the role. She described the team to me as being challenging with some history of discord – particularly in their relationship with management - and clearly expressed her ambivalence about the role. On the departure of their previous Head, the team initially asked if they could be left without a manager at all – a request that appears at best a naïve denial of the different roles within the team and of a role for leadership and authority. They also suggested that they could 'rotate' in the role – sharing the position - positing a model of management by the collective:

Ms A from 24/01/05:

She is considering saying to her line manager "thank you so much for the opportunity and I have valued the experience. However, perhaps someone else would like the opportunity for the next year".

Ms A from 21/02/05:

She said that when Mr C and their previous Head had left, the team had asked the Service Manager if they could be left alone for a while to regroup as a team… At first, the team had thought they could manage without anyone in the role that they "could divide up the tasks".

In the event, Ms A was effectively 'elected' by the remainder of the team. She is not explicit about exactly how she came to get what she terms *"the top job"*, the exact nature of what she describes as *"very democratic process"*. However, she alludes to the absence of her female colleague, intimating that she would have been the more obvious choice. This suggests that the avoidance of competition in Ms A's selection may also have defended against a feeling of rivalry experienced as dangerous. It is clear that she gained her position through the nomination of her team and not through external selection: this deprives her of external sanction and legitimacy within both the managerial structure of accountability in the organisation and her peer group, leaving her task, role and sanction unclear:

Ms A from 21/02/05:

It does seem that her role is set up with some question about from where her authority derives, offering a sense of her representing this "very democratic" group of peers rather as a sort of 'form captain' amongst this group who have such 'playful' tasks.

It also effectively leaves the team as if they were without a leader as they had originally asked. Thus, Ms A's 'acting' role is given a further fraudulent twist as the team maintain a denial of the need for the role of a leader and Ms A maintains a denial of her

capacity to hold authority. She describes herself in role as *"like the tea boy getting the top job"* – denigrating herself and misrepresenting her gender.

The 'acting' position could be seen in a 'surface' way as expedient – a 'stop-gap' interim arrangement. However, it also compounds the trend in this team towards 'off-task' activity and engagement with defensive behaviours. Without anyone confidently taking up a leadership role, there is also no-one to contain and interpret their off-task behaviour or steer them towards a sharper focus on the task.

There is evidence for this: Ms A acknowledges her difficulty in giving feedback to the team that could be perceived as negative. Not only this, but in a topsy-turvy way, describing her role as their manager, she places converse emphasis on her confidence that they could comfortably give her negative feedback about her performance if necessary, at the same time suggesting a link between being in charge of this team and 'illness', paradoxically suggesting that they might recognise pathology in her whilst they are unable to engage clinically with patients:

Ms A from 18/05/05:

She talked of her role as their manager, saying that she was confident that communication between them as a team was such that if she "was unwell or not managing well, I'm confident they'd feel able to tell me". I noted that she often refers to the idea that she might be "unwell" – and that she is referring to their previous service head – W – who, in her analysis, had "become unwell" and was not functioning as a manager. There had been acrimony between the team and W who had eventually left the hospital.

...Again she returned to the possibility that the team might doubt her competence.

...I said that she seemed to be giving a lot of thought to the likely response of her team should they feel she was incompetent. However, it seemed to be much harder for her to consider the question of how she would respond if they were failing. She blushed visibly and agreed.

Ms A from 25/05/05:

Ms A said that she had been thinking about my comments the previous week about the difficulty she had in giving the team what might be perceived as negative feedback. She referred again to the comments made by my predecessor about the team that she had not shared with them – despite agreeing with her to some extent.

Similarly, she accepted that basic structures around the management of the team were not in place and that this was reflected in their behaviour in relation to using Annual Leave (A/L), time off in lieu of additional hours worked (TOIL) and their timekeeping and attendance at external training:

Ms A from 28/09/05:

We talked a little about how difficult this process had been for her and, generally, how hard the last few months had been in terms of putting structures around the team.

There is much evidence in the material of the nature of Ms A's relationships with the team and I have referred in *'The Primary Task'* to the way in which their needs increasingly eclipse those of the patients. It is clear that she has had a friendship with one of the members, that she has had a difficult relationship with a second, and that she is very aware of the issues pertinent to each of them in their personal lives and them of hers. Although there is a level at which some degree of personal knowledge may be appropriate, this particular boundary requires careful thought if a manager is to maintain sufficient distance from their team to be able to function effectively in a leadership role.

At times Ms A seems to be entirely enmeshed with her team, struggling to put a boundary around herself and achieve a sufficient degree of separation to be a useful, thoughtful resource to them as a leader. As my role in relation to her changed, I took up a far more prescriptive approach that, although it enabled me to guide her through establishing of some of the structures and processes she needed as a managerial boundary, also facilitated attribution of the authority role to me, as Ms A implemented according to my guidance:

Ms A from 22/06/05:

Ms A commented that she had felt like she "had a rod up her back" after the last session with me – demonstrating by pulling herself bolt upright in her chair. She said that she had gone away feeling motivated to complete the action points agreed. I don't know why, but I felt the need to explain to her that I had entered into my role as her new line manager feeling rather anxious about the situation in her dept and its position in the wider organisation. I spoke again about my commitment to supporting her to develop as a leader in this context, having established that she has sound clinical skills. I was feeling guilty, wondering if I had been rather bossy and directive on the previous occasion. Ms A's use of the word "threat" earlier was making me wonder if there was something coercive in the dynamic…

… Ms A said that she had been careful to try to meet as many of the action points from the last supervision as possible. Indeed, she had resolved or progressed them all. I gave her this feedback, saying that I thought she had done well and made real progress over the last month.

There is a 'surface' reality that Ms A lacks experience as a manager. However, in this context, she tends not to frame her relative naïveté in terms of her inexperience of management, but makes a number of references to feeling *"like a child"*. Not only does this add greater depth to her inexperience, but the implied regression adds an additional dimension to that depth.

Ms A from 24/01/05:

She commented that she feels disempowered, and like a child.

Ms A from 21/02/05:

I reflected this back to Ms A. I thought that it might go some way to helping us to understand some of her feelings of being "like a child" in her role.

Ms A from 25/05/05:

Ms A agreed, saying that she had now had enough "of being a child" in the role.

I will later present a further vignette - *'Z and the Smell of Alcohol'* that continues exploring the issue of the legitimate use of authority in this context, again illustrating Ms A's denial of her role in relation to authority, locating it instead within me and, in so doing, failing to appropriately manage a member of staff and colluding with a scenario that had extremely dangerous potential.

Formulation

Ms A's performance in her role as team manager may be attributed to her lack of experience, training in management or competence. However, I argue that a number of factors add depth to the quality of the denial of the leadership role:

- the team's suggestion that they would not have a manager at all;
- or that they could rotate in the role;
- the *"very democratic"* but unspecified process of Ms A's selection to the role;
- Ms A's denigration of herself in role: *"like the tea boy getting the top job"* with echoes of gender confusion;
- Ms A's persistently feeling *"childlike"*;
- her feeling *"fearful"*;
- the confusion implicit in her reluctance to give the team difficult feedback but, conversely, Ms A's belief that they will appraise her performance and feedback – particularly her shortcomings - to her;
- the absence of even the most basic management structures and boundaries around the team;
- Ms A's dependence on me to give direction and effectively hold the role of leadership and authority without her having to think about it;
- Ms A's confused use of the different supervision processes available – see *'Z and the Smell of Alcohol'*;
- the management of the personal/professional boundary and her enmeshment with the team;

- the ongoing diminishing performance of the team in relation to the primary task;
- the context of the defensive behaviours described in *'The Primary Task'* and *'Z and the Smell of Alcohol'*.

Although each of the above factors can be reasonably explained, their entirety elevates them to evidence of defensive behaviour that I suggest:

a) enacts a perverse dynamic in the denial of difference and of maintaining appropriate boundaried roles and need for authority and
b) acts as a defence against legitimate authority perversely experienced as abusive.

The denial of that role can be seen as logical in order to support and enable the defensive avoidance of the primary task as described in *'The Primary Task'* – and to allow Ms A also to use that defence: she clearly articulated her ambivalence about the role from the outset and denigrated herself in role. However an additional factor contributes to this particular kind of defensive behaviour, i.e. there is something to be understood about the way in which legitimate authority is experienced in this particular setting an inevitably abusive. By denying the role of leadership and authority, Ms A is protected from experiencing herself in identification with the patients: in the role of an abuser. The team are enabled to continue the defensive behaviours described in *'The Primary Task'* and again the outcome for the patients is that they are not engaged in thoughtful, reality-based therapy.

There is further evidence that authority in this context is inevitably experienced as abusive in a later vignette – *'Z and the Smell of Alcohol'*.

The next vignette – *'The Ugandan Man'* – picks up the theme of the relationship between authority and abuse and clearly shows a professional experiencing difficulty maintaining independent thought.

At these times omnipotence is so much sought after by all of us that we are ready to accept as a hero what in normal circumstances we would recognise as a madman. (Steiner 1993: 130)

Vignette 3 - DC B: *'The Ugandan Man'*

Mr Kendrick then noted that trust was one of the themes which emerged during the Inquiry. Patients used it as a very effective weapon to manipulate and pressurize staff, in a similar way to that used by terrorists within the penal system. If staff say "no" patients immediately translate that into "not being trusted". Even when it means breaching Hospital policy the manipulation is very subtle. Developing trust may be a fundamental part of treatment, but it is a mistake to give trust actually and unconditionally.

In his oral evidence to us Mr Kendrick, a highly experienced prison governor by background, expanded on his comparison between personality disordered patients and terrorist prisoners. Both, he pointed out, use trust to manipulate staff and make them feel they are in the wrong if they do not extend that trust unconditionally. (DoH 1999a: 3.3.23-24)

We found that Lawrence Ward had been allowed to pursue its own course, untroubled by Hospital policies that conflicted with the PCT's view of life. The PCT demonstrated a dangerous belief in their own special status. The Ward policies were half-baked and poorly implemented; the staffing levels were inadequate. Yet staff were caring for a collection of highly dangerous individuals, some of whom had attained their privileged position by guile and manipulation. Thanks to the lack of overt trouble nobody reviewed the basic philosophy of the ward, what it was trying to do, and how it was trying to do it. We find it astonishing that within the context of a high security setting, a number of the patients on Lawrence Ward were considered to be of low dependency.

Lawrence Ward was a "low dependency ward" but by no means all of its patients were pre-discharge. Low dependency does not equal low risk. There was a crucial confusion in the minds of the PCT. (DoH 1999a: 3.12.23-4)

***'The Ugandan Man'* - analysis**

The Fallon Report (DoH 1999a) shows many instances of unthinking behaviour amongst professionals and there are numerous references to decisions being insufficiently thought through, muddled thinking and staff being 'recruited' into apparently bizarre ways of thinking and behaving. All of this indicates a level of attacks on thinking that result in dangerous decisions and omissions that contributed to the critical events.

The vignette below is taken from one interview with DC B and shows him having an absolutely concrete experience of not knowing his own mind. He tells me about an interview he has undertaken with a particular suspect: a Ugandan man accused of committing a serious physical assault of his 15-year-old daughter whom he had described as difficult to manage, drinking alcohol and refusing to do her homework. He presents DC B with a view that moral values are good and should be upheld but he is accused of using violence to enforce them: for DC B this is a confusing paradox.

Just as he has used violence to control his child, the man uses the violence of unconscious projection to control DC B and I will describe the process and language used in the interview in detail in order to evoke the persistent quality of DC B's resulting confusion and repeated struggle to maintain independent thought.

The essential paradox

DC B describes the allegation and interview:

> *DC B from 17/07/05:*
>
> *The man was accused of assaulting the girl by hitting her about the head and shoulders with a shoe in the context of a dispute over her schoolwork. It was suggested that such over-zealous disciplining was a regular feature of family life and that the suspect regularly used a stick to beat his children. On this occasion, he had asked one of the other children to get his stick but they would not do so...*

...The man denied the assault. He accepted slapping the girl with an open hand but rejected the suggestion of the use of a shoe or of such beatings being a regular occurrence.

DC B from 17/07/05:

...this man had been at pains to present himself as an upstanding citizen. He had described his own childhood in Uganda and being the recipient of regular beatings, presenting this as culturally acceptable. DC B thought that he had spoken "almost fondly" of his memories of his own experiences of being beaten.... He had talked at great length, describing his moral values and what he aspired to for his children. He had also spoken of the role of discipline as a means of fostering respect in his children. He expected them to respect him, to be well-mannered and to work hard. He spoke about these things lengthily.

The suspect dominated the interview from the outset: two references to him talking *"at great length"* and *"lengthily"* show his presence filling the interview with his assurances of his status as an *"upstanding citizen"*. The allegation as described suggests a capacity to use an everyday, seemingly innocuous object as a weapon to attack a child, hitting her about the head in what must be considered to be a vicious, potentially fatal assault. However the seriousness of the allegation is lost from the interview that has become dominated by the suspect's account of his *"moral values"*.

DC B then reflects on his experience of the interview:

DC B from 17/07/05:

...DC B said "the trouble was I found myself agreeing with him. Actually, I agree with such values. However, I had to think to myself 'hang on a minute – this isn't right, he has used a weapon to assault this child and this is probably not a one-off incident; this is probably a feature of the daily lives of all these children'".

DC B has a momentary lapse of objectivity. He 'finds himself' agreeing with the man who has presented such an apparently reasonable account of his moral framework. However, his use of the phrase *"the trouble was"* indicates that at some level he is

aware that something unusual is happening; he seems to recover quickly, speaking to himself and reality-testing for himself the reasonableness or otherwise of the man's view. However, DC B's position in relation to reality is not stable:

DC B from 17/07/05:

He spoke again of how he had found himself drawn in by this man's explanation and how his values had seemed to be so reasonable… He gave the example of his own children… He explained that he has a 17-year-old stepson, then referred to his 2 younger children saying that they had little jobs in the home that were expected of them. I asked their ages – I really don't know why. "2 & 4" he replied, then laughed "not really! 7 & 9". Again he spoke about how he had been drawn in by this man's descriptions of his moral values and expectations of his children and how he had needed to remind himself of this man's alleged actions that were in contrast to his apparently plausible explanations.

Firstly, DC B is aware of agreeing with the man: *"I found myself agreeing with him"*. Then he performs his first 'reality-test': *"hang on a minute – this isn't right"*. However, in the next sentence, he is once more drawn to the man's view, speaking *"again of how he had found himself drawn in by this man's explanation and how his values had seemed to be so reasonable"*. He then 'backs up' his identification with the man by giving examples of his allocation of *"little jobs"* to his children. There is a bizarre moment in which he exaggerates his position, saying that his children are much younger than they are. However his description of the *"little jobs"* does not quite have the same timbre as the suspect's view of *"the role of discipline as a means of fostering respect in his children"*, and his view that they should *"respect him… be well-mannered… work hard"*, set within the context of his history of *"being the recipient of regular beatings"*. For a third time, DC B states that he had found himself agreeing with the man and needing to remind himself of the deficit between his actions and his explanations.

Something exceptional about the continued shifting between these positions suggests that DC B was finding it especially difficult to maintain reality. I note my own comment, recorded during B's description of the allegation: *"I was still conscious of finding it difficult to listen and, indeed, now I'm finding it difficult to remember"*. This

is an unusual position for me: there is something in the material that is difficult to take in and think about. I offered DC B a way of understanding this process that seemed to resonate:

DC B from 17/07/05:

After a while, I said that it sounded as if DC B had found it very difficult, when faced with this man, to maintain his own independent opinions. He agreed – the man had completely convinced him for a while that there was nothing in what he said that DC B would particularly disagree with.

And for a fourth time, he speaks of the way in which he had to 'talk himself into' accepting this man's probable capacity for cruelty and violence. Again he reality-tests, with a little help from me, and agrees that it has been hard for him to engage with this man's potential for dangerous behaviour:

DC B from 17/07/05:

... Again DC B spoke of the way in which he had to remind himself what he believed the man had actually done and his belief that actually this was a man who was more than capable of disciplining his children using weapons and that he had probably done so every day of their lives. I said that this man's capacity to get DC B preoccupied with his rationalisations appeared to have made it hard to explore the cruelty of his alleged actions and he agreed that the action of hitting a child around the head/chest was potentially very dangerous.

The Ugandan man described a particular fear regarding his daughter that has two components:

1. That she will *"use alcohol"* - a means of altering reality and having an influence on control.
2. That she will *"rebel against his authority"*.

These suggest he fears her alcohol use will change the reality of his authority in the context of her growing up and developing a capacity for independence in thought and deed. He will, therefore, be less able to control her.

"Fair is foul, and foul is fair" (*Macbeth:* 1:1:11): the control of DC B

DC B's initial description of the interview is striking in four ways:

1. The description of the Ugandan man speaking *"at length"* – there seems to be something coercive about this:
    a. He fills the space with his moral position.
    b. Accordingly he dominates and controls the process.
2. Although DC B says that he has denied the allegation, the material is dominated by his 'moral position'; his 'moral position' does not support his denial but DC B does not engage with this.
3. He is presenting a confusing paradox: dangerous behaviour used as a means of strengthening moral values and respect.
4. There is a further implicit contradiction: although he denies this allegation, the man generally advocates the use of physical discipline as a means of control, *"presenting this as culturally acceptable"*, and offering as examples *"his memories of his own experiences of being beaten"*, of which DC B *"thought that he had spoken 'almost fondly'"*.

In DC B's first example of his agreement with the man, he says: *"the trouble was I found myself agreeing with him"*. The first phrase – *"the trouble was"* - indicates that he has some level of awareness that something is amiss, that there is something unusual going on – he is troubled. The second phrase – *"I found myself agreeing with him"* – seems to deny DC B's capacity for independent thought: there is an implicit passivity. It would have been a different, active, assertion had DC B said "the trouble was, I agreed with him". However, he doesn't, he says *"the trouble was, **I found myself** agreeing with him"* as if the unspoken words are *"despite my best intentions"*. This is the first clue that there is something happening in this material below the surface explanation that DC B independently agrees with the Ugandan man's 'spare the rod and spoil the child' values.

The second clue is the number of times DC B describes going through the process of agreeing with the suspect and then checking himself to a reality-based position. There are five references to this in the material - as if DC B gets 'recruited' into a view of the Ugandan man's behaviour as good and reasonable from which he has to keep extricating himself yet is repeatedly pulled back. His sense of confusion is evident. He agrees with one half of the paradox – moral values and respect are good - and has to remind himself of the other half – violence as a means of instilling them. His capacity to think is being attacked; overall, he is able to maintain his ability to check himself, but the interview is a constant struggle for him to 'hold his own mind' – a constant battle to hold on to sanity and reality.

It is not DC B's task to understand the emotional complexity of the encounter. However, in order to do so it would be necessary to get drawn into the confusion in this way in order to identify and learn from the experience. It **is** DC B's task to get as close to the truth as possible: as with *'The Police Officer'* his confusion hampers the process, despite his efforts, and he does not take up with the suspect the contradiction between his denial, and yet his advocating, of violent discipline.

Somehow, through this process, the nature of the allegation against the Ugandan man in its entirety is hard to hold in mind. The paradox ('discipline/violence – fosters respect') is strengthened by the reality that real damage could have been done to this child, elevating the allegation from one of inappropriate physical punishment to one of serious assault.

A parallel emerges between the alleged offence and DC B's experience of trying to hold an objective opinion whilst interviewing this man.

1. The Ugandan man was concerned that as the alleged victim *"became a teenager she would start to use alcohol and rebel against his authority"*.
2. She *"began to be difficult to manage, drinking alcohol and refusing to do her homework"*.
3. The Ugandan man *"was accused of assaulting the girl by hitting her about the head and shoulders with a shoe in the context of a dispute over her schoolwork"*.

4. The Ugandan man *"had been at pains to present himself as an upstanding citizen"*.
5. *"He described his own childhood in Uganda and being the recipient of regular beatings, presenting this as culturally acceptable"*.
6. *"DC B thought that he had spoken 'almost fondly' of his memories of his own experiences of being beaten"*.
7. *"He had talked at great length, describing his moral values and what he aspired to for his children"*.
8. *"He had also spoken of the role of discipline as a means of fostering respect in his children"*.
9. *"He expected them to respect him, to be well-mannered and to work hard"*.
10. *"He spoke about these things lengthily"*.
11. *"Eventually, DC B said 'the trouble was, I found myself agreeing with him...'."*
12. DC B thinks to himself: *"'hang on a minute – this isn't right, he has used a weapon to assault this child and this is probably not a one-off incident; this is probably a feature of the daily lives of all these children'."*
13. *"He spoke again of how he had found himself drawn in by this man's explanation and how his values had seemed to be so reasonable"*.
14. *"Again he spoke about how he had been drawn in by this man's descriptions of his moral values and expectations of his children and how he had needed to remind himself of this man's alleged actions that were in contrast to his apparently plausible explanations"*.
15. *"I said that it sounded as if DC B had found it very difficult, when faced with this man, to maintain his own independent opinions"*.
16. *"He agreed – the man had completely convinced him for a while that there was nothing in what he said that DC B would particularly disagree with"*.
17. *"Again DC B spoke of the way in which he had to remind himself what he believed the man had actually done and his belief that actually this was a man who was more than capable of disciplining his children using weapons and that he had probably done so every day of their lives"*.

Formulation

I propose a way of understanding DC B's experience of this process. The Ugandan man finds his fears about his diminishing authority over his daughter realised and they have

"a dispute over schoolwork" that precipitates the alleged offence. This may be seen as a difference of opinion – a disagreement between them. The man is accused of taking an ordinary object and committing an extraordinary assault against the child. When faced with the reality of her separate and independent view, which differs from his, he employs violence as a means of asserting his will over or controlling her: he attempts to force her to his view. Specifically, he attacks her head – her capacity for independent thought – being reckless as to her survival. He is not just using force to control her behaviour – he is trying to effect some change in her internal world capacity for *"respect"* and *"moral values"*.

This process is re-enacted when, in the interview, DC B represents a different point of view in relation to the Ugandan man's actions. DC B's capacity to hold in mind a conflicting point of view is attacked as the man tries to control the interview and DC B's thoughts. This time, the violence is in the internal not the external world and the outcome is to make it difficult for DC B to maintain sufficient objectivity to fully engage the man in an exploration of the truth.

The emotional complexity of the encounter can also be observed as a sadomasochistic context: at one moment the Ugandan man is describing the enjoyment of being the victim of a beating and then, in another moment, his enjoyment of being the perpetrator of a beating is clearly evident. He does not arouse DC B to be sadistic towards him but he does arouse DC B to identify with his sadism towards someone else. Such enactments have been observable throughout the observational material relating to both DC B and Ms A and manifested in retaliatory states of mind, references to 'bullying', or observable incidences of aggression or hostility apparently moving through the system.

The next vignette – *'The Foster Carer'* picks up the theme of muddled thinking and again shows DC B being 'recruited' by a suspect into a particular point of view.

When a feeling of guilt impinges upon a personality structure that cannot bear the psychic pain involved, there are several possibilities. The situation may be repressed or split off, or manic mechanisms may take over, or there may be a combination of all three processes. In general, the neurotic individual deals with what he cannot bear by repression. If the quantity of repression accumulates, there may be other consequences that cannot be dealt with here. The splitting processes may be multiple, shallow or deep, or varied. If deep splitting occurs, what results is two or more selves, or virtually so. One of these may have the characteristics of a Dr. Jekyll; the other, that of a Mr. Hyde. Manic mechanisms consist of projective identification, splitting, idealisation, denial, or omnipotent control of objects, that is, people in the life of the individual or represented as images in the psyche, or both. (Hyatt Williams 1998: 110)

Vignette 4 - DC B: '*The Foster Carer*'

…Mr Kendrick went on to say Mr Arnold was out of his depth and lacked the strength of character and maturity in his management post to deal with highly intelligent, manipulative and devious people such as those on his ward. He was totally unsupported by the RMO and PCT regarding this problem. Mr Kendrick added:

> "It also appears within the evidence that he was extremely naive in that he fell into the trap of trusting patients. He was clearly fooled by patient SD on 18 June 1996 [when he acted as his escort] and I suspect that he was also used as a "patsy" by SD during the transactions involving the finances for the patients' shop". (DoH 1999a: 3.3.21)

To describe Lawrence Ward as pre-discharge is misleading. A number of the patients on Lawrence Ward were highly dangerous and not going anywhere else for a very long time, although they were perfectly compliant with the ward regime. This is typical of the muddled thinking about the nature of the ward. (DoH 1999a: 3.17.3)

***'The Foster Carer'* - analysis**

Continuing the theme of attacks on thinking and reality demonstrated in the Fallon Report (DoH 1999a), in a similar way to *'The Ugandan Man'*, this vignette illustrates the kind of pressure on thinking that can occur when the fabric of reality is compromised by unconscious defensive processes.

DC B describes an allegation that a sixty-four year-old male foster carer has sexually assaulted a fifteen year-old girl in his care. From the outset, unusually, he forms the view that he is innocent and that he is too vulnerable to survive the legitimate pursuit of the enquiries, but his view does not appear to be based on supporting evidence. As with the preceding vignette, DC B's struggle to maintain independence of thought and objectivity can clearly be seen. A pivotal moment in the interview reconnects DC B to reality as the man gives a particularly ambiguous response to a question and DC B is astonished when, at the conclusion of the process, he suddenly experiences the man's previously apparently absent rage.

It is not my intention in any vignette to illuminate the guilt or otherwise of the alleged perpetrators – it is the quality of the way in which DC B 'finds himself' recruited into a view of something that is either perverse or lacks evidence that I will attempt to describe and evoke here in order to show how unconsciously projected hostility defends against persecutory anxiety.

DC B doing something he wouldn't usually do

DC B describes the allegation of sexual assault against the man: the complainant is now fifteen – her age at the time of the alleged assault remained unclear. From the interview outset, DC B forms a particular view of the suspect as:

a) of good character;
b) vulnerable.

The language he uses is definite and emphatic and he notes that the man's appearance as *"elderly and frail"* was not commensurate with the reality of his age:

DC B from 30/03/05:

DC B said it was clear "that he had never been in trouble in his life. He was terrified of the police station. Clearly very mortified… Protesting his innocence. DC B spoke of the man's physical appearance. At 64 "he'd be about the same age as my dad – but he looked 20 years older". The man had clearly given the impression of being elderly and frail.

DC B goes on to describe his experience of interviewing the man in this context:

DC B from 30/03/05:

In the interview, it had been very difficult to engage the man in talking about the sexual aspect of the allegations. The suspect had denied the allegations but acknowledged that he had been "stupid" to have taken the girl home alone. He insisted that he usually took great care "never to be alone with the girls" and that his wife would always accompany him if he needed to drive them anywhere. He was very particular in this respect. He would never "kiss and cuddle the girls". "What about his own children?" they asked. He said "No, he would never kiss and cuddle them, either". His explanation of the incident was that, whilst he was taking the girl home, she became upset and he had pulled over into the lay-by "to comfort her". DC B commented that "on paper, it certainly looked like he hadn't done anything – the Crown Prosecution Service advice was to NFA it".

DC B is forming a confident view that the man is innocent although there is nothing in the material that suggests this. Having described the alleged victim as *"convincing in interview, making her disclosure in a 'matter of fact way', apparently without additional embellishment"*, he is now swayed by the man's denial and seems confident of his view, although he goes on to say:

DC B from 30/03/05:

… it had been exceptionally hard to engage the man in talking about the sexual nature of the allegations and his nervousness was so pronounced. He had

consistently given minimal answers to questions – usually "yes" or "no". Would not expand on anything.

DC B appears comfortable with his view and accepting of the man's denial, despite this minimal engagement. He does not question the reason for the man's *"pronounced"* nerves: it is possible to infer some link between the *"nervousness"* and DC B's view, expressed above, that he was *"mortified"*. Similarly, he had not questioned why the man is *"terrified of the police station"* – but decided this suggested his innocence.

"Let not light see my black and deep desires" (*Macbeth:* 1:4:51): the pivotal moment

DC B from 30/03/05:

They asked the man "did you find this child attractive?" DC B said "what we were looking for was a 'yes' or 'no' answer because that's what he had been giving all along. In fact, specifically, we were looking for 'no'. However, what he said was ***"no more attractive than any other child"****. This answer changed everything. It was completely different to what had gone before. Meant we had to look into it further".*

The suspect seems highly defended and, through his minimal answers, in control of the process – as was the Ugandan man in the previous vignette. It seems as if DC B has moved into a position where, rather than open-mindedly seeking the truth, he is seeking to confirm his view that the man is innocent raising interesting questions about how you find 'the truth' in such contexts and how you know what you think you know. The requirement to *"look into it further"* appears to be based on the fact that this response differed from the established pattern – not the way in which this was the case. He says they were *"looking for"* the answer "no" which implies that they did not want to hear him say "yes".

DC B then reflected on his experience of the interview process:

DC B from 30/03/05:

DC B reflected on the way that this comment had changed the way that he viewed the allegation. In this case, he said, he had found himself "doing something I don't normally do". I asked what that was and he said that he had "formed a prior opinion, decided the man's innocence before he had even opened his mouth"... I said that it seemed like DC B had had an experience of this man giving a model that if they went anywhere near even spelling the word ***'s-e-x'****, it would do him irrevocable damage... "Yes, that's exactly how it felt" said DC B… "I usually enjoy interviews, but I didn't enjoy this one. I didn't feel that I did very well." I asked him how he felt he had not done very well. He said that, unusually, he had opened the interview by going straight to the matter of the allegation that was immediately denied… He was disappointed and felt he'd messed up.*

He is troubled in a number of ways and he can see that he has acted in a way contrary to his usual approach in interviews although he does not offer a reason or articulate explicit curiosity about why he might have done so:

1. He identifies that he has acted unusually: *"he had found himself 'doing something I don't normally do'"*.
2. Specifically, he *"formed a prior opinion, decided the man's innocence before he had even opened his mouth"*.
3. Although he usually enjoys interviewing, he did not enjoy this one.
4. He did not feel he did well. *"He was disappointed and felt he'd messed up"*.
5. He appears to make a link between his opening the interview straight at 'the heart of the matter' (i.e. the allegation) and the immediate denial. This was contrary to his usual interview strategy.

DC B later tells me further evidence has emerged implicating the man and that these *"inconsistencies"* correspond to some of the difficulties in the interview process:

DC B from 15/04/05:

When they next interview him, they have two elements of the previous enquiry that have inconsistencies – his response to the question about finding the child attractive, and his insistence that he never kissed or cuddled the girls when Social Services staff had seen him doing so. Also these were the two areas in which he had given the most definitive answers as opposed to the "yes" or "no" approach.

However, despite the emergence of doubt as to the consistency of the man's story, DC B is still preoccupied by not knowing what to think:

DC B from 15/04/05:

He went on to say that he still did not know what he thought about whether this man has done anything or not. He recalled the man's anxiety on interview – that he had clearly never been in a police station before – much less in custody. That his responses in interview had been so minimal, that it had been so hard to approach the sexual aspect.

By the time we next met and again discussed this case the Crown Prosecution Service had decided not to proceed. However, it is clear in this session that DC B still cannot know his own mind with regard to the matter and he says he is still not sure what to think. Although the man seemed more able to elaborate on the circumstances of his being alone with the alleged victim, conversely DC B seems less convinced of his innocence and there is further ambiguity in the fact that the investigation by the Social Services Department has yet to reach *"a satisfactory conclusion"*.

The final 'twist' to DC B's investigation comes when the foster carer suddenly allows his anger and hostility free reign:

DC B from 26/04/05:

DC B explained how he had telephoned the man… He had explained to him that the matter was not to proceed. The man had been ***so*** *relieved, and then "he just fell to pieces on the phone", he said "it was really funny", before correcting*

himself – "sorry, 'funny' is not the right word". He went on to say how the man had thanked him for everything he'd done before becoming angry – he had asked DC B if this meant he could go home now. However it doesn't, as Social Services have yet to conclude their investigations. DC B explained this to the man, "reassuring" him, telling him that the Social Services Department would continue to investigate "until they reached a satisfactory conclusion". The man had been grateful and reassured on the telephone but had "just switched" into being angry. DC B was really taken aback – "it was as if he had two different personalities".

I am not suggesting that the fact of the foster carer's anger per se is of note. Rather, I am questioning:

1. its apparent previous absence;
2. the impact on DC B and his description of it.

Despite having given the man good news that he will not be criminally charged, DC B still notes some affect when the role of Social Services is raised, and is again under pressure to provide *"reassurance"* in a conciliatory way. The eruption of the man's overt anger appears to come as a complete shock to DC B. His phrase *"it was really funny"*, reflects his experience of the strangeness and suddenness of this explosion of rage from the man he had perceived as so *"elderly and frail"* and with whom he had been going to such lengths to avoid confrontation for fear of causing him catastrophic harm.

How can this be understood?

The immediately available surface understanding is that DC B was having an 'off day' when he interviewed the man. However, he does not offer this as an explanation or as any part of his reflection about the experience. There are a number of factors that I believe, when assembled, are evidence of pressure on DC B arising from the process of interviewing this man.

He begins with a statement of the apparent credibility of the victim's evidence; however, on meeting the alleged perpetrator, he forms very concrete views about him based on scant, ambiguous information:

- *DC B said it was clear "that he had never been in trouble in his life".* He does not say how it is clear.
- *He was terrified of the police station.* This could infer either innocence or guilt. But DC B uses it as part of his framework for thinking he is innocent.
- *Clearly very mortified…* He does not say how it is clear.
- *Protesting his innocence.* The word "protesting" could imply a level of defensiveness.

DC B then goes on to speak of his observation of the man's physical appearance:

- *DC B spoke of the man's physical appearance. At 64 "he'd be about the same age as my dad – but he looked 20 years older".*
- *The man had clearly given the impression of being elderly and frail.*

Clearly his experience of him in this respect is not neutral in that he reminds him of his father and has set the agenda for DC B to think of him as *"elderly and frail"* when in reality this is not the case.

He noted that it was particularly difficult to engage with the sexual context of the allegation (*"In the interview, it had been very difficult to engage the man in talking about the sexual aspect of the allegations"*). It is probably never easy to engage someone in talking about sexual offending. However, to what extent is this compounded by DC B's experience of his physical self in which:

  - a transference relationship is implied in his linking him to his father;
  - the foster carer is 'fostering' the entirely false impression that he is *"elderly and frail"*?

The implication being that DC B found himself trying to talk about a sexual offence as if to his *"elderly and frail"* father.

The suspect denies the allegations although, in contrast to the alleged victim's *"convincing"* statement, his position is ambiguous and there does not seem to be anything concrete in the proffered material that supports the fact that *"he hadn't done anything"* any more than there was to prove that he had.

DC B is clearly very struck by the difficulties presented by the man in the room:

- *DC B repeated that it had been exceptionally hard to engage the man in talking about the sexual nature of the allegations…*
- *…his nervousness was so pronounced.*
- *He had consistently given minimal answers to questions – usually "yes" or "no".*
- *Would not expand on anything.*

I suggest the experience DC B has of this man as being *"elderly and frail"* and like his father, **concretely** affects his capacity to think objectively about whether he might be guilty of the sexual assault of a child before he has even tried to engage him on the subject. The man's presentation is assumed by DC B to indicate his innocence and the possibility of defensiveness against the anxiety of the truth of his guilt is not in DC B's mind. He acknowledges the way in which his approach to the man was unusual and he identifies that he did not follow his usual method which enabled the monosyllabic engagement through which the suspect appears to take control of the interview. DC B was left with strong and uncomfortable feelings about the process in which his expressed level of disappointment and his feeling he has *"messed up"* infers a level of guilt and superego function.

It appeared as if the man generated an unspoken warning that to approach the sexual context of the allegation and put pressure on him in that regard would risk causing him irrevocable damage. This is confirmed in DC B's next encounters with this man and his network as subsequently described to me:

DC B from 15/04/05:

I've had his wife on the phone, his solicitor on the phone, he's suicidal now… He went on to say that he had had a conversation with the suspect on the telephone and "reassured him". The man was in a bad way…

I asked how DC B knew the suspect was suicidal. He said that he had been told this by the man's wife and solicitor not the suspect himself. He hoped that he had been able "to reassure him" and that he would approach the next interview

"more relaxed" and engage better with the questions. I asked what DC B made of this suggestion that the man was suicidal? He said that he just seemed to be completely devastated by this process…

The man has not directly expressed any suicidal intent – it is articulated by those close to him; just as, in the sequences above, he had not directly expressed any anxiety – it all seemed to be inferred and held by DC B. This indicates the suspect's capacity to arouse anxiety in other people – including DC B who twice refers to his endeavours to *"reassure"* him – conflicting with the reality that he cannot meaningfully reassure him as he does not know what will happen. 'Reassurance' therefore contains DC B's anxiety, rather than that of the suspect. His final comment – *"he just seemed to be completely devastated by this process"* - underlines the suggestion that this man is making him feel as if the pursuit of his enquiries will cause him irrevocable harm.

When the man finally makes his hostility overt: '*DC B was really taken aback – "it was as if he had two different personalities"'.* This is a real indication of the psychological complexity of the encounter. The first half of the phrase registers DC B's countertransference. The second half measures the extent of DC B's shock – this aspect of the man's affective range and functioning had not previously been observable by DC B – far from it. There is a moment here when it is as if DC B is actually experiencing the foster carer as two separate people as his repertoire of expressed emotional presentation is almost impossible for DC B to reconcile in his mind: just as he does not know what is in his own mind in relation to his belief about his culpability for the alleged assault.

Formulation

From the outset of his encounters with this man, DC B has an experience of acting unusually that has a particular quality to it. As with his encounter with the Ugandan man, he gets preoccupied with a belief – in this case of the man's innocence – that flies in the face of his primary task that is to seek evidence of the truth. We can clearly see how this man makes DC B feel that to get anywhere near the truth will do him irrevocable damage and the way in which DC B continues to be unable to know his own mind – to know what to think – even as the available information and evidence

emerges. As with the previous vignette – it is the persistence of DC B's inability to know his own mind that is of unique significance.

DC B consistently feels that his enquiries are hostile and dangerous to this man who is so fragile and passive in his presentation. The emergence of the man's sudden, outwardly-expressed hostility is a shocking revelation that shows him in a different light. This suggests that his hostility has been projected into DC B in order to avoid the uncomfortable experience of DC B getting near the truth which arouses severe persecutory anxiety in the man. Instead, the anxiety and persecutory feelings are experienced by DC B who is troubled by fear that his enquiries will hurt him and accordingly finds it hard to pursue them with his customary rigour.

The next vignette – *'The Police Officer'* continues to show the way in which externalised hostility can attack thinking – creating a muddle in which the primary task is not pursued and the truth remains obscure.

Consider these common expressions or phrases:

Turning a blind eye
Burying your head in the sand
She saw what she wanted to see
He only heard what he wanted to hear
Ignorance is bliss
Living a lie
Conspiracy of silence
Economical with the truth
It's got nothing to do with me
Don't make waves
They were typical passive bystanders
There's nothing I can do about it
Being like an ostrich
I can't believe this is happening
I don't want to know/hear/see any more
The whole society was in deep denial
It can't happen to people like us
The plan called for maximum deniability
Averting your gaze
Wearing blinkers
He couldn't take in the news
Wilful ignorance
She looked the other way
He didn't admit it, even to himself
Don't wash your dirty linen in public
It didn't happen on my watch
I must have known all along… (Cohen 2001: 1)

Vignette 5 - DC B: '*The Police Officer*'

We agree that personality disordered patients can give reliable evidence. However, the more manipulative they are, and many of the patients we were concerned with were not only manipulative but also intelligent, the greater is the need for care in evaluating their evidence. If, for example, they can spend years creating an aura of respectability and trustworthiness so as to gain privileged status, so they can be selective with the truth. We took the view that our hearings should not be delayed by wrangles over the credibility of individual patient witnesses. Of greater importance in judging the credibility of the patient witnesses is that we had an abundance of other evidence. (DoH 1999a: 1.12.2)

***'The Police Officer'* - analysis**

This vignette continues to demonstrate the way that unconscious interpersonal processes can attack clarity of thought, resulting in a 'perceptual muddle' with the outcome of obscuring the truth.

The account derives from a description given by DC B of an informal interview of an officer from Police Service 2 accused of assaulting his twelve year-old stepson by pushing him down the stairs. Although neither under arrest nor caution, the Police Officer attended the interview with an 'entourage' consisting of his partner (mother of the alleged victim), a representative from the Police Federation and a solicitor. They approach the process in a particular kind of way that puts DC B and his colleague under pressure from the outset with the outcome of preventing a thorough exploration of the critical events.

This is an example of the way in which an interpersonal process can be undermined by what is absent from the material. I.e. the way in which anxiety that remains un-thought about and unsaid, and the defences against such anxiety, can undermine and 'skew' an interpersonal process, or an organisational role or task, enabling an evasion or manipulation of the truth or of the areas of experience or reality in which the truth might lie.

The experience of interviewing the Police Officer

On the surface, it seems understandable that a police officer, in a potentially embarrassing situation, might gather moral and legal support; however, as the vignette unfolds, it depicts a scenario in which the Police Officer and his supporters employ a level of aggression as a defensive strategy. He arrives 'mob-handed' and the collective approach the interview in a particular kind of way – 'upping the ante' forcing formality on what had been intended to be an informal interview:

DC B from 15/04/05:

Despite the informal nature of the interview, the solicitor was proceeding as if it was an interview under PACE. She was "unnecessarily aggressive"...

...He returned several times to the matter of the solicitor's aggression, saying that it had been really difficult to keep on top of the interview and highlighting her aggression as incongruous – her presentation not consistent with the informality of the interview with this man who had not been charged.

They appear to be 'taking on the system', suggesting that there is an implicit level of rivalry between the two different police services that will inevitably motivate a persecutory approach to the investigation:

DC B from 15/04/05:

...the solicitor and girlfriend had been hostile – the girlfriend suggesting that they were "out to get him – because he's Police Service 2 and you're Police Service 1". There was "an exchange" at the beginning between her and the Sgt. The Sgt had asked her... why she was there and she had immediately said "I don't have to answer that" but had proceeded to give an answer like a prepared statement...

Prior to the man being interviewed, his girlfriend had been very angry with them and had refused to be interviewed. She thinks we are "out to get him – but I don't care what job you do..."

There is evidence that DC B feels unsettled from the outset and that this persists:

DC B from 15/04/05:

...it was "one of the strangest interviews" he had ever undertaken...

...At the end of the interview "it was the strangest ending to any interview that I have ever experienced" – the solicitor gave a summing-up of the interview "as if it had been in court" – it was really, really strange...

...He returned several times to the matter of the solicitor's aggression, saying that it had been really difficult to keep on top of the interview...

And that, at a conscious level, retrospectively at least, he acknowledged the particular difficulty in interviewing a fellow police officer and the impact that might have on his performance in a comment that also implied a level of identification with the suspect and a potential for rivalry:

DC B from 15/04/05:

...it was always going to be difficult to interview another police officer "who knows exactly what it's like to be on this side of the table".

As the interview progresses, it is clear that DC B is under pressure. Initially there is evidence that he is conscious of the need to hold on to his objectivity, and he does. However, eventually he nearly gives way – taking up the challenge presented by these people who have apparently 'thrown down the gauntlet' - provoking him to a retaliatory enactment:

DC B from 15/04/05:

DC B said that this solicitor had been so aggressive during the interview and it had been very frustrating, such that he had at some stage thought to himself "we should stop this interview right now and arrest him, continue under PACE".

We are introduced to the Police Officer as a man who is particular about the organisation of aspects of his external world and who is perceived by others as being rigorous in maintaining control:

DC B from 15/04/05:

The officer concerned had previously been in the military. He was known to be very particular about certain things. In particular, he had a drawer at home in which he kept his passport, driving licence and such in meticulous order. On this particular occasion, he had gone out and on his return home, gone straight to this drawer… and found his documents missing. He went downstairs to his girlfriend who offered him refreshment, and said "and while you're at it, you can bring me my passport and driving licence"…

...She had made much of the fact that her partner had this drawer in which he kept his effects and the meticulous order with which he insisted the effects were arranged in the drawer. She took a long time describing this, really dwelling on it…

...However, she would not concede that they were having a row or argument of any sort, she insisted that what had taken place was a 'debate' and emphasising that her partner had not, at any time, lost control....

...DC B particularly remembered how she had insisted her partner had not lost control.

During the sequence, there are numerous references to aggression being enacted amongst the assembled company, including DC B:

DC B from 15/04/05:

...DC B described the interview… the solicitor and girlfriend had been hostile…

...Despite the informal nature of the interview, the solicitor was proceeding as if it was an interview under PACE. She was "unnecessarily aggressive". There was "an exchange" at the beginning between her and the Sgt…

...DC B said that this solicitor had been so aggressive during the interview and it had been very frustrating, such that he had at some stage thought to himself "we should stop this interview right now and arrest him, continue under PACE". He returned several times to the matter of the solicitor's aggression, saying that it had been really difficult to keep on top of the interview and highlighting her aggression as incongruous – her presentation not consistent with the informality of the interview with this man who had not been charged…

...Prior to the man being interviewed, his girlfriend had been very angry with them...

There is also evidence of aggression denied and/or displaced – particularly in relation to the Police Officer:

DC B from 15/04/05:

The officer did not accept that he had pushed the child down the stairs. He spoke of his relationship with the children, insisting that it was his girlfriend, not he, who was responsible for discipline. If his girlfriend said something that he did not agree with he would not contradict her, but he might discuss it with her later…

…When she spoke of the incident, it was clear from her account that the matter had become quite heated and she acknowledged that it had been confusing. However, she would not concede that they were having a row or argument of any sort, she insisted that what had taken place was a 'debate' and emphasising that her partner had not, at any time, lost control...

…She commented that she had thought there might be little point in going to hospital – they would only conclude he had a broken toe and strap it up. DC B particularly remembered how she had insisted her partner had not lost control.

The Police Officer himself is curiously absent from DC B's account that is dominated by his descriptions of his experiences of the other parties. The only description of the Police Officer's presentation during this interview is of him being *"very composed"*, as if he is able to remain that way whilst those around him are acting out aggressively. Despite this description, I have a notably powerful experience of disliking this man, with a fixed visual image of him in my imagination. This could be nothing but my imagination 'colouring in' the account. However, having explored the potency of my image and dislike of the man during a tutorial, I understand this as a countertransference experience of the way that DC B feels and of some of the aggression projected into me too.

"Hover through the fog and filthy air" (*Macbeth:* 1:1:12): the 'moment of truth'

If such behaviour on the part of the Police Officer and his entourage is a defence against anxiety, is it possible to find evidence in the material for the source of the anxiety? There is a moment in the interview (second paragraph quoted below) that appears pivotal in relation to the primary task of the interview (i.e. of discerning the truth about what happened to the Police Officer's stepson):

DC B from 15/04/05:

They were on the landing and "it got heated". The stepson came out of his room and the argument continued. The account was confusing and I don't know if my record is accurate. It is then suggested that the policeman pushed his stepson, causing him to fall down the stairs. The boy had been taken to casualty where he was found to have a broken toe and said that his stepfather had pushed him down the stairs...

...The officer did not accept that he had pushed the child down the stairs... ...DC B said that ***the officer was able to give a very clear and certain account of what had happened that day – up until the moment the boy fell down the stairs. That moment, he apparently couldn't remember, insisted he couldn't remember touching the boy.*** *He then said that he had followed the child down the stairs to see if he was OK – but later his girlfriend said that she had done so. He was very composed, DC B said he "gave textbook answers to textbook questions, I suppose"...*

...When she spoke of the incident, it was clear from her account that the matter had become quite heated and she acknowledged that it had been confusing...

...She could not remember how her son had fallen.

This sequence appears to be of central significance in that, despite *"giving textbook answers to textbook questions"*, the one question that DC B appears to find impossible to ask and the Police Officer (or indeed anyone else) equally finds impossible to answer is that which would address exactly what happened to his stepson at the top of the stairs.

Therefore, the 'moment of truth', becomes obscured such that it is actually a moment in which the truth does not emerge and nor are the facts further explored. I suggest that my noting that the account was confusing and I was not confident that I had made an accurate record is no coincidence and that this reflects a level of confusion present during DC B's interview with the Police Officer that provided a kind of 'smokescreen', effectively obscuring the truth, preventing DC B (and anyone else) from knowing.

Formulation

DC B describes this interview as *"one of the strangest"* and as it progresses, he cannot achieve the primary task of directly addressing the question – nor does he explicitly acknowledge this in his description to me of what happened.

In the previous vignette – *'The Foster Carer'* I suggested that projective identification could be seen to be operating in order to protect the suspect from the arousal of anxiety associated with blame. Such a process can be seen at work during the interview with the Police Officer. It is reflected in DC B's descriptions of the 'strangeness' and in the Police Officer's apparent absence from the material and 'composure' – suggesting that the other people (including DC B) are enacting his projected aggression, leaving him depleted by the absence of the hostility he has projected. Such projection can create a kind of confusion. The mechanism of projection implies being dishonest with oneself through denial of the unwanted attribute: similarly, when acting on a projection the subject is enacting something belonging to someone else which is also a position in which truth/reality is compromised. DC B's investigative task places him in the role of the punitive superego and the Police Officer takes an approach that implies that to hold a different view of things will necessarily result in a hostile encounter in which the denouement serves to obscure or deny rather than promote the truth. The charged atmosphere in the room creates a context in which it becomes difficult to maintain a role (that is explicitly challenged by the girlfriend) with enough confidence to take up appropriate authority. Ultimately DC B is unable to engage with the direct conflict that asking the crucial question would imply.

The next vignette – *'Z and the Smell of Alcohol'* – develops the theme of denial of reality creating an inability to see what should be abundantly clear and to use available resources to take action to prevent risk.

His ignorance was made possible by the fact that neither he, nor Creon, Jocasta or the elders of Thebes chose to pursue enquiries, and this arose from their reluctance to know the truth. Instead they dealt with unwelcome reality by *turning a blind eye*...

It seems to me clear that not only did all the chief characters turn a blind eye but that an unconscious or half-conscious collusion took place, since if any one of them had exercised their curiosity the truth would easily have come out…

Mechanisms such as *turning a blind eye* which keep facts conveniently out of sight and allow someone to know and not to know simultaneously can be highly pathological and lead to distortions and misrepresentations of the truth, but it is important to recognise that they still reflect a respect and a fear of the truth and it is this fear which leads to the collusion and the cover-up. This mechanism is related to those used for dealing with the truth in perversions and can be thought of as a perversion of the truth leading to distortions and misrepresentations of it. Oedipus adopts a state of mind which can be thought of as a psychic retreat from reality and a defence against anxiety and guilt… (Steiner 1993: 120-121/129 emphases in original.)

Vignette 6 - Ms A: '*Z and the Smell of Alcohol*'

…Staff Morale and Complicity

Morale deteriorated as the staff became more compliant with patient demands. Patients traced this to the Ashworth [Blom-Cooper] Report after which the emphasis changed from custody to therapy leaving staff fearful that any stand against a patient would leave them vulnerable to complaints from patients or the disciplinary process and hence loss of employment. The result was that staff either turned a blind eye or participated with patients and, in effect, "crossed the line".

Staff must have been aware of alcohol consumption. One patient had been taken to hospital following taking drink; on occasions others had taken so much they could hardly walk. Home brew kits were widely used on the Ward although they were difficult to disguise. Many patients regularly smoked cannabis and had abandoned attempts to hide the smell by using air fresheners. Yet no action was taken. A small number of staff were said to be providing drugs and alcohol, and a few were alleged to be involved in trading goods with patients. (DoH 1999a: 2.14.18)

***'Z and the Smell of Alcohol'* – analysis**

The Fallon Report (DoH 1999a) records that significant to the explosion of the critical incidents was the availability of drugs and alcohol within the hospital, the attendant attacks on reality, and the role of the staff and their relationship to the management of the problem manifested at best as complicity ('turning a blind eye') or at worst collusion.

This vignette develops the theme of the preceding three in that it again depicts an attack on thinking and a denial of reality and returns to the earlier theme of denial of the role of leadership and the legitimate use of authority. It comprises extracts of material, over a series of different sessions, showing Ms A's approach to managing performance issues in relation to a member of her team. Z, a male music therapist, has been noted to be smelling of alcohol whilst at work. However, although this had been widely observed amongst the team over time, it had never been addressed. The vignette will show Ms A resolutely unable either to engage with the reality of his difficulties and the attendant risks – despite the evidence of her own senses – or to use the available structures and processes to support her in managing the situation.

Z and his performance deficits

Ms A from 23/05/05:

Ms A said that she had "an issue" she would like to raise with me about a member of the team. She named one of the men – a music therapist - and said that she thought he "might have a problem with alcohol". He had been noted by various members of the team, clearly for some time, to be smelling of alcohol. She said "I've thought about saying to him – you regularly smell of alcohol but I thought it seemed confrontational. And yet, role-playing saying it to you just then, I can see that it's not confrontational".

Above, the matter is introduced in a rather understated way. Ms A highlights what seems to be the obvious, common-sense starting-point for an intervention and briefly offers a surface explanation for why she has not challenged the member of staff. It works fleetingly – capturing the awkwardness of the likely encounter. However it does

not account for the legitimacy to Ms A's role within the team nor an attendant duty upon her to ensure that they approach their primary task in a safe and effective way and that the welfare of all members, and the patients, are safeguarded. Z is arguably at risk and through this behaviour is putting his colleagues and patients at risk. The collusion with this situation, by his colleagues and his manager, constitutes an extraordinary 'derailing' of their practice.

Associated difficulties with Z's performance at work indicate an almost total disregard for Trust policies or any sense of his responsibility - either to his colleagues or his patients. He appeared to have effectively ceased to have any heed whatsoever for the requirements of his post or his responsibilities as a contracted employee, to an arguably fraudulent extent, and he managed to consistently evade what attempts Ms A made to ensure his accountability.

It is clear from her descriptions that over a substantial period of time the team had colluded with Z's behaviour. In a collective denial of the seriousness and potential consequences of such behaviour, they *"used to joke about it all the time"*; one of his colleagues had refused to share an office with him *"because he stinks"*. It had become *"a standing joke"* that they are collectively holding as a secret: a dangerous secret. However, the risk and ethical implications of him smelling of alcohol and possibly being intoxicated or otherwise incapable of effective work were completely absent from the material as were any references to the clear breaches of Trust policies or the code of conduct required by the Health Professions Council (HPC 2008). Similarly, Ms A does not acknowledge the aggression and denial of reality implicit in his behaviour with the outcome that Z's potential risk is not taken seriously. In response I felt it necessary to introduce a framework of boundaries into the sessions, to clarify her role and to be prescriptive with her as to what actions she should take in order to avoid the service being further compromised by this man both in the short and long term.

Ms A offers four 'surface' explanations of her inability to challenge Z's behaviour and performance:

1. ...*"for fear that the staff member would leave and the post be frozen"*.
2. That the remainder of the team, should they find out, *"would be likely to group together and support him against her"*.

3. That she *"had, as yet, been unable to locate the relevant policy"*.
4. That she has not received sufficient support from HR.

They seem reasonable until they are 'unpicked'.

1. There is no evidence to suggest that Z will leave, nor that his post would automatically be frozen should he do so. This rationalisation suggests that Ms A is less anxious about her compromised service and risk than she is about losing a dysfunctional member of staff and also fails to acknowledge her authority in role.

   This explanation hinges on fear and inevitability – Ms A's fear of 'killing off' Z's post and the inevitability of a hostile and confrontational conclusion.

2. Ostensibly, this is more persuasive: for any new manager, the prospect of facing a wholesale dispute with an experienced team would be daunting. There is evidence elsewhere in the material that they have previously 'ganged up' against a former manager in support of a colleague (in a way that she found mutinous) and that as individuals they can be challenging to manage. However, this explanation rests on Ms A's perceived position within the group as a peer and denies her role as manager of the team and the attendant legitimate use of authority and requisite boundaries.

   This explanation also seems to rely on fear – Ms A's fear of the collective power of the group – perceived as her peer group – 'ganging up' against her.

3. On the surface, it may be possible to accept that Ms A has been unable to locate the relevant policy and is therefore unable to implement it. However Ms A has generally demonstrated resourcefulness in compiling information. There are many references to this in the material.

4. This could be seen as a denial of her responsibility, in role, to take up authority and set boundaries through policy. Further, without an administrative framework for monitoring performance, even if she knew the content of the

policy, she has no way of knowing, evidencing, or being accountable for the performance of her team.

Ms A qualifies this latter explanation by saying that it was *"nothing to do with avoidance"*. However avoidance, albeit as an unconscious defence against anxiety, seems the most likely understanding.

There is evidence that I am more concerned than Ms A about Z and his capacity for dangerous behaviour and that it is within me that the appropriate anxiety and the volition for addressing the situation is located. This is enacted by my need to ensure that I have been sufficiently directive and to clarify with absolute certainty that she knows what to do in the event of a repetition and that I would be available to support her. Despite my reasserting the boundaries and restating my concerns, it soon became clear that Z had again attended work smelling of alcohol, yet no action had been taken by Ms A despite the fact that she had secured an objective opinion about the smell:

Ms A from 06/07/05:

He had "just about" made it to work for 11am and their group supervision space. There had only been Ms A and Z present and she had found it a useful opportunity to talk about his absences. She commented that he had talked insistently, "filling the space". He had described a patient who talked at length and about whom Z had reflected that he was unsure whether he was being conned, seduced etc. Ms A said "I felt like saying 'that's exactly how I'm experiencing you now'". She said also that he smelled of alcohol "every time he moved his head, I was getting a whiff", commenting that she had later spoken to their supervisor who had confirmed this.

Having told me this, she did not stop speaking, continuing resolutely, "filling the space" exactly as she had described Z above. She did not give me the opportunity to speak until:

Ms A from 06/07/05:

As Ms A talked lengthily, I was experiencing a mounting sense of irritation as I needed to return to the issue of Z smelling of alcohol. I had previously been very explicit about the fact that Z must be sent home if smelling of alcohol. I had recorded this in Ms A's supervision notes.

At which I became slightly 'confrontational' – to echo her language used above:

Ms A from 06/07/05:

I asked her "what prevented you from sending Z home?" She went on to speak about her uncertainty that he really smelled of alcohol and she talked about this for some time whilst also reminding me of her previous experience working with substance misusers. Eventually, she said that, after their clinical supervision, she had asked their supervisor could she stay behind, just for a minute, and ask him one question. She would guarantee not to do it again. She had asked him for his opinion. He had agreed that Z smelled and she had asked if he thought she should send Z home. He said that he thought it should be noted.

Ms A offers three surface explanations about why she has not addressed this issue with Z – now in conflict with a direct instruction from me:

1. She experienced 'uncertainty' that he really smelled of alcohol.
2. She has previous experience of working with substance misusers.
3. She canvassed their team's clinical supervisor for his opinion.

These have much less internal logic than the previously suggested explanations, and in 'unpicking' them, it must be remembered that, unlike the first four explanations, these three were offered after Ms A and I discussed both the unacceptability and dangerousness of Z's behaviour and I gave her a very prescriptive framework for what action to take and the policy and role for her sanction to do so.

1. It is understandable that Ms A might not want to believe that Z would come to work smelling of alcohol. However, the assertion that she cannot believe the

evidence of her own senses despite the substantial history of similar difficulties confirmed by her colleagues is extraordinary.

2. On the one hand, Ms A defensively asserts her previous experience in the field of substance misuse. On the other, she does not engage with the fact that despite this experience she does not know what to believe or how to act. She even describes her previous experiences of this phenomenon:

   Ms A from 06/07/05:

   She reminded me of her experiences again, telling me of an occasion on which she had been convinced by someone that the alcohol she could smell was his aftershave and, on another occasion, disbelieved a positive reading on a breathalyser machine – though she immediately had to evict the individual concerned…

3. There is logic to Ms A seeking advice/an opinion from a third party: this gives her opportunity to reality-test her disbelief. However, her chosen source of advice is interesting: rather than seek advice and support from her line manager, she seeks guidance in the forum of clinical supervision. I will not expand on this further here as this is the subject of a further vignette.

Despite us exploring the difficulties with Z, and a very prescriptive strategy in place to address performance, risk and accountability, Ms A remains unable to engage with this issue, her 'surface' reasons for not doing so having become markedly less reasonable and with less integrity throughout the process. Conversely, my responses to this information are increasingly directive and the more Ms A struggles to take up authority, the more directive and prescriptive I become.

She then offers one final surface explanation:

Ms A from 06/07/05:

Ms A said that, retrospectively, she could see it may not have been the ideal action to take. She spoke about being unsure about contacting me – whether I

was in or out of the hospital – and what if she disturbed me in something important and I didn't think the issue as so urgent? I was experiencing a mounting sense of irritation. On the previous occasion we had reviewed the various means of contacting me and I had previously made it very clear how seriously I took this issue.

I had been very clear with Ms A about my view of the urgency and seriousness of the issue and the actions I would support in order to address it. The notion of her disturbing me in doing *"something important"* underlines her view that this matter is **not** important. Accordingly, this explanation has considerably less validity than the others and prompted a direct instruction from me in the passage below in which my exasperation is clear:

Ms A from 06/07/05:

I said that perhaps I should clarify exactly what Ms A should do in the event of a repetition. Firstly, I said it was perfectly acceptable to try to contact me under any circumstances and I would offer her my full support… Secondly, she should believe the evidence of her own nose. I told her I was aware of the capacity of such people to make others think they must be wrong and to doubt their relationship to reality…

… I said that I was aware how difficult this might be and that perhaps some avoidance was reflected in her decision to consult the clinical supervisor rather than me (I had every reason to believe that she knew exactly what I would tell her to do).

At which, Ms A appears to further question the reality of Z's situation:

Ms A from 06/07/05:

She commented again how strange it was that the other members of the team appeared to no longer notice the difficulties with Z that had in the past been such a talking point for them all.

How can this be understood?

It has been suggested to me, that this sequence can be understood as representing nothing more unusual than Ms A's naïveté and lack of experience or competence as a manager. However, I argue that this is not the case and that, for the following reasons, this situation is an example of the kind of 'extraordinary' behaviour, enacted by 'ordinary decent professionals', that I had hoped to identify and deconstruct:

1. Ms A is a confident professional, familiar with the setting. There is no reason to suppose that she is incapable of the kinds of common-sense approaches that are useful in maintaining the boundaries of management.
2. Her 'shortcomings' do not merely relate to failures in administrative management processes.
3. Her inability to address the problem of Z attending work whilst smelling of alcohol represents a different level of ineffectiveness for the following reasons:
    a. A member of staff attending work whilst noticeably smelling of alcohol is unusual.
    b. If he smells of alcohol he may be intoxicated.
    c. This is not an isolated incident but a pattern of behaviour, observed in Z over a substantial period of time, yet never addressed.
    d. Even in discussion with me, there is no engagement in thinking about risk in this context.
    e. An entire team of mature, experienced clinicians have observed this behaviour and never challenged Z or their manager.
    f. Far from challenging Z, his behaviour was not merely ignored but inspired various 'in-jokes' – indeed a *"standing joke"* amongst the group. The group have colluded in denial of the seriousness and risk inherent in Z's behaviour.
    g. It is clear that other factors that may also be related to Z's alcohol use are unusual and problematic in the professional setting. However, they are not addressed and are also the subject of departmental 'humour':
        i. Z has been noted to be sleeping in the music room.
        ii. His colleagues observe that he smells.

h. There are other factors relating to Z's performance (that may also be related to Z's alcohol use) that breach Trust policy and compromise the service:
    i. Timekeeping.
    ii. Unacceptable levels of sickness absence.
    iii. Sickness absences not evidenced by medical certification.
    iv. Failures to comply with management requests.

4. Z is persistent in his disregard for and failure to comply with reasonable requests made by his manager - e.g. to provide medical certification evidencing his illness – although he is well-aware of the requirement that he should do so. There is a particularly 'slippery' quality to his evasion of engaging with her attempts at holding him accountable. He 'side-steps' all her attempts to pin him down.
5. Ms A has demonstrated prior competence as a clinician and is undertaking a clinical supervision course. She is therefore, in her conscious mind, aware of the requirements of professional registration and ethical frameworks.
6. She has previous experience of working with substance misusers yet cannot connect to the evidence of Z's behaviour, nor usefully engage him.
7. This state of mind persists even after I have prescriptively made the issues and actions explicit.
8. Not only does she fail to follow the direct instructions given by me, but she continues to question the reality of her observations of Z's behaviour.
9. Ms A seeks advice from an alternative and inappropriate source.
10. The parallel between Z's difficulties and the prevalence of substance misuse amongst the patients is not acknowledged.
11. Ms A's difficulty locating relevant policy does not accord with her overall level of resourcefulness.
12. Ms A's inability to directly raise the issue with Z is contrary to the organisational duty to offer appropriate support to staff.
13. There is consistent evidence of her difficulty taking up and maintaining a role as leader of this team with requisite authority. (See *'First Amongst Equals'*).
14. There is a context in which the team as a whole are failing or avoiding engagement with their primary task in a defensive way. (See *'The Primary Task'*).

No one factor in isolation sways my view. Rather it is the quantity and combination of the factors listed above that form the bedrock of my opinion that the avoidance of both the team and their manager to address the dangerous performance of one of their number may be held to be extraordinary. They are all 'ordinary decent professionals' and their failure to engage with and address Z's potentially dangerous behaviour is something more than a failure of systems, processes or competence.

Countertransference: further evidence

There is further evidence supporting this in my feelings and responses to Ms A. The impact of my countertransference gives potency to the notion that there are processes evident within the data that are impacting on the functional capacity of this team:

Ms A from 23/05/05:

***I was alarmed** by this disclosure... Apart from anything else, this is a security hazard in high security. It seems untenable to have a therapist working in such a perverse setting whilst clearly struggling with reality. **I was worried** about how long this situation might have been causing difficulty – sounded like it could have been some time. What had my predecessor known/done about it?*

Ms A from 06/07/05:

*As Ms A talked lengthily, **I was experiencing a mounting sense of irritation**...*

*...**I was furious** with both of them... **I could scarcely believe what I was hearing**...*

*...**I was experiencing a mounting sense of irritation**. On the previous occasion we had reviewed the various means of contacting me and I had previously made it very clear how seriously I took this issue.*

I have highlighted in bold passages where I recall a marked affective response. My anxiety to have the situation safely contained is such that I am nudged into holding the authority directively at the expense of investing time reflecting on Ms A's difficulties in

taking up the role. It is almost impossible for me to get this matter registered with any level of seriousness in anyone else's mind. By 05/07/07 my irritation with Ms A is explicit as I twice describe a *"mounting sense of irritation"*. More strongly, I describe being *"furious"* and that *"I could scarcely believe what I was hearing"* as if reality for me had been suspended.

My responses directly contrast to Ms A's demeanour in relation to the problem. Her description of the issues relating to Z are characterised by minimisation from the outset and there is nowhere in the material in which she expresses anxiety or concern; in contrast, she makes several references to the way in which the team have joked about him. Concern and anxiety seems to be entirely located in me. Perhaps I merely experience a level of appropriate anxiety: however, the extent and prescriptiveness of my direction to Ms A demonstrates an exaggerated level of concern indicating my countertransference reflecting my own (appropriate) anxiety and that projected into me by Ms A and therefore not available for her to express and reflect on. Some of my 'irritation' and 'fury' may be a reflection of Ms A's experience of being enabled by me to see what she is trying so hard to deny, being held as responsible for managing Z and of my attempts to construct a boundary within which she can take up an appropriate role.

Further evidence of countertransference (again highlighted in bold) can be seen later in the sequence as Ms A finally sends Z to the Occupational Health Department to wait for her to locate me:

Ms A from 17/08/05:

I went and met Ms A in her office. When I got there, she was shaky and either on the brink of tears or had been crying. I asked her if she was OK and she said that she felt better - "now you're here". I thought she was going to cry…

…I didn't think I was anxious but clearly ***something had got into me****…*

When I arrived at her office, Ms A was visibly distressed: on seeing me, she immediately reported feeling better. I noted that although not consciously anxious, *"clearly something had got into me"* and I spent some time checking and confirming

my authority to take the prescribed course of action – as if I needed to reality-check. In doing so, I have noted that Z's office smelled of alcohol – as if further needing to confirm the evidence of my senses – before going with her to Occupational Health:

Ms A from 17/08/05:

...By this time, Ms A had calmed down considerably... ...As we walked ***I was conscious of feeling exasperated****... I felt that* ***I was not in control*** *of my time and working arrangements. As we walked, Ms A commented again that giving a 10 minute timescale had not been a great idea. She said that Z had left her office rather abruptly, getting his coat and slamming his door. Now he had had some time "to stew on it" he might be quite angry.* ***"I'll give him angry" I said, instantly regretting it****.*

As Ms A *"calmed down considerably"*, conversely, I was *"conscious of feeling exasperated"* and *"not in control"* and the material suggests that I momentarily lose control of my capacity to contain my hostility. My frustration at the intrusion on my time explodes into an aggressive expression of rage (*"I'll give him angry"*) that places me 'in competition' with Z for 'entitlement' to anger (the unspoken sentiment being 'what right does Z have to be angry?'). Of course it could be argued as logical and appropriate that I would experience some anger at being placed in this situation. However my delivery was explosive, without thought, and my awareness of *"instantly regretting it"* confirms this as an enactment as opposed to a reflective expression of a legitimate feeling.

Formulation

The sequence above describes a process that can be reorganised (using the session transcripts verbatim) into a linear sequence thus:

[Ms A] *had seen Z who smelled strongly of alcohol → she asked him to go to Occupational Health and told him that she would be informing me and would be sending him home → Z left her office rather abruptly, getting his coat and slamming his door → I went and met Ms A in her office → she was shaky and either on the brink of tears or had been crying → she said that she felt better -*

"now you're here" → I thought she was going to cry → I didn't think I was anxious but clearly something had got into me → by this time, Ms A had calmed down considerably → I was conscious of feeling exasperated → I felt that I was not in control of my time and working arrangements → now [Z] *had had some time "to stew on it" he might be quite angry → "I'll give him angry" I said, instantly regretting it.*

A thread of uncontained hostility can be seen moving around this sequence, originating in Z, being first projected to Ms A and then into me.

Despite substantial evidence, including her sensory observations, those of others, and Z's performance deficits, Ms A is persistent in her disbelief that Z has been attending work in a condition in which his use of alcohol is discernible. I believe this represents a denial of reality in which Ms A occupies the perverse position of both knowing and not-knowing. There is - in reality - no way in which Ms A could possibly have been uncertain that Z smelled of alcohol. However, to allow this knowledge into her conscious mind, to know what she knows, would mean that she would have to follow up that knowledge with the use of authority. I have already suggested (in *'First Amongst Equals')* that the experience of authority in this setting is inevitably punitive. Ms A's reluctance to use her authority further evidences this. In using her authority, she may experience herself as abusive: this may also reflect a fear of her capacity for sadism and the resulting possibility of identification with the abusive patient group with whom her team are largely disengaged.

Thus, within the denial of reality, is a denial of her capacity for sadism – and her denial of the reality of Z's drinking serves a powerful purpose as a defence against this anxiety. *'The Ambiguous Message'* – a vignette attached as an appendix to illustrate methodology - gives a further example of a clinical encounter in which reality is compromised such that Ms A tells her patient that she is a man.

An additional dimension to Ms A's position can be observed in the team and their collusive collective denial of Z's behaviour. That it has become a *"standing joke"* within the team suggests that one way of understanding this is as a manifestation of the excitement and pleasure that can underpin perverse behaviours. Steiner (1993) above describes the unconscious collusion of those around Oedipus as arising from their

reluctance to know – suggesting that it suited them not to know. Working within an organisational context that was bound by structured rules and conventions, I suggest that this joking concealment may be understood as a level of arousal associated with the undermining of institutional rules. I have suggested that authority in this setting is experienced as inevitably abusive: keeping Z's behaviour secret could therefore be seen as representing a triumphant 'getting one over' on parental authority as it is experienced in the organisational transference through management roles. Accordingly, collusion serves the gratifying purpose of providing the excitement of vicarious (therefore manageable: Stoller 1986) risk-taking (through Z's intoxication) along with the attack on authority represented by the group's implicit collective delinquency. Such dynamics can also be observed in *'The Primary Task'* and *'First Amongst Equals'* and addressing this would mean also addressing their identifications with the delinquency and perverse behaviours of the patients.

When Ms A seeks a 'second opinion', this has some logic: however, her choice of her clinical supervisor as source and her decision to follow his advice do not. This is also a denial of reality and the need for authority and an attack on Ms A's capacity to think that led her into an error of judgement and a dangerous decision. Her apparent inability to permit me, in my managerial role, to enable her to take appropriate action underlines her part in the collusion. My increasing countertransference feelings of anger and frustration suggest her experience of my authority as coercive and her collusion with the 'cover up' of Z's pathology enables a triumph over my authority that allows her to identify with the exciting delinquency of the group. I will not expand on this further here as this aspect of this scenario, and the way in which the use of supervision paradoxically supports a dangerous course of action is the subject of the next vignette *'Supervision: Protective or Perverse?'*

Strongly perverse object relationships occurring… in the therapeutic encounter are technically particularly hard to handle. By their very nature they are strongly loaded with seductive, erotic power that can be hard to stand back from and notice. The therapist may become caught, as the patient is caught, in entrenched, repetitive patterns that feel inevitable, obvious, 'right' in some way, while at the same time indefinably uncomfortable or worrying. There is often unusually great pressure to break analytic boundaries; to offer more time, reveal personal details, even to touch or hold the patient. There often seem quite compelling reasons why *this* patient should be a special one, given special consideration and not treated harshly and unsympathetically by sticking to 'rigid rules'. On the other hand, the therapist may find himself feeling and reacting uncharacteristically harshly, even cruelly. One way and another the therapist may feel himself caught up in a situation of *suffering* in the work, whether it is his patient's, his own, or perhaps both. (Milton 1997: 189)

Vignette 7 - Ms A & Mr C: '*Supervision: Protective or Perverse?*'

… realism: forensic patients in high security are there because of their potential danger. Staff must avoid both therapeutic pessimism, which turns staff into glorified jailers, and over-optimism, which encourages staff to take their eyes off the ball. (DoH 1999a: 4.10.2)

As we gathered evidence surrounding this problem, it became clear that we were not so much concerned with personality disorder or personality disorders, but with the degree of risk of danger to others possessed by offenders who have personality disorders. Setting aside self-harm which, of course, is not unimportant, it is this factor which determines the need for compulsory segregation from society whether in hospital or prison... The Dutch espouse the concept of the "therapeutic community" with perhaps more realism than has been the case in this country. They have faced the inevitable fact that some personality disordered offenders cannot be changed to a point where they cease to pose an unacceptable danger to society. So they are building a number of small special units dedicated to the purpose of humane containment. (DoH 1999a: 6.6.7)

…It is one thing to say that relational security, founded upon an intimate knowledge of the changing characteristics of individual patients, is a central feature of good security in the forensic field and can only be determined by those working with patients at the ward level. It is another to treat other aspects of security in the same fashion. For relational security to be effective it needs to operate within a clear framework of standards and rules that everybody understands. This framework needs to distinguish between those rules that are mandatory in all circumstances, and those which may be tempered by a professional judgment about the needs of an individual patient. (DoH 1999a: 2.8.4)

***'Supervision: Protective or Perverse?'* - analysis**

The quotations from the Fallon Report (DoH 1999a) above give a 'snapshot' of the recurring theme of the need for and absence of appropriate supervision processes to ensure clinical effectiveness and support the management of the particular affective difficulties in treating personality disordered forensic patients – including omnipotence and therapeutic pessimism. In determining my methodology, I suggested that the phenomena of interest to me might be readily observed in the domain of supervision. The research participants differed markedly in their approaches to the supervision/consultation and their capacity to engage with a helpful process. These differences appeared to link with the 'overarching narratives' that characterised each in their relationships to their work: an alternative way of understanding the material as three case studies of practitioners and their respective defences emerged.

I will describe something of the experience of supervising Ms A and Mr C – therapists from the same discipline and setting – to illustrate their very different uses of the potentially containing supervision process. I will use a lengthy extract from Ms A's data to show the potentially protective activity being used perversely – in the service of supporting, not illuminating, defensive behaviour and therefore contributing to a dangerous situation. Extracts from Mr C's data demonstrate his constructive use of supervision to reflect on the nature of the primary task and its relationship to risk, the presence of countertransference and the potential to make symbolic links that enable knowledge. Mr C can be seen to come perilously close to being pulled out of his role and into a dangerous situation with a patient. This is a vivid illustration of the potency of the risks in forensic settings when boundaries and roles are attacked and the relationship with reality breaks down. We can clearly see the way a supervision process that reflectively enables links to be made and available to conscious thinking can be highly effective not only in increasing the depth of understanding of the internal worlds of the patients but crucially attending to the reality of the risk to the therapist in the external world.

Ms A – *'Supervision used perversely'*

> **In the forensic field more than any other – apart from work with torture victims – there is an augmented possibility that the patient may need to disclose material involving, say, savage mutilation or sadistic dismembering, which even the best-trained therapist may find difficult to receive, particularly when attempting to adopt the traditional psychoanalytic posture of 'hovering attentiveness'. We then find ourselves recalling Macbeth's words:**
>
> > **"Take any shape but that". (*Macbeth,* III.4.101)**
>
> **Which is to say, I can hear anything but 'that', when 'that' comes too close to an experience I have endured or which I dread. Such issues arise during training and, *par excellence*, during forensic supervision. (Cox 1996: 200)**

Ms A's initial indication of the kinds of domain she wanted to explore in supervision suggested a level of openness hovering at the boundary of self-awareness and self-disclosure:

Ms A from 29/11/04:

In particular, she told me that she was keen to explore the impact of the work on our personal lives in general especially the link between our work and sexuality. Ms A told me that she is gay. She blushed visibly in telling me, commenting that it wasn't easy to disclose although she knew that I would find it acceptable if she did so. I too felt some discomfort, although I think, in some part of my mind, I knew and was not surprised at her disclosure, although, perhaps unsettled by her apparent discomfort.

There were explicit challenges to boundaries: we had worked in the setting for some time; we had previously been peers in a supervision group that Ms A continued to attend; we had a mutual personal friend; we had both attended the same university (although not at the same time); we had worked clinically with some of the same patients (Patient 3); at the outset we had the same clinical supervisor.

In *'The Primary Task'* I described the creative therapists configuring **as if** their primary task was to receive clinical supervision: it was difficult to reconcile the absence of clinically-derived material with their receiving so much supervision. Increasingly, Ms A's focus in supervision became performance issues within the team, largely arising

from a tension at the boundary of their personal and professional lives rather than clinical challenges. I have argued that off-task behaviour and a defensive relationship with authority are observed: Ms A's use of the potentially protective process of receiving supervision also seemed to be defensive.

Ms A demonstrated a capacity to pull me out of my role as a supervisor and a tendency to remind me of things that she knew rather than use the time to reflect on what she did not know. Sometimes this felt competitive - suggesting rivalry and envy. In May 2005, I accepted a secondment that made me Ms A's direct line manager. Whilst I would hope never to be considered a 'thoughtless' manager (Mercer 2008), the need for solutions and the pressure to act, particularly in a forensic setting where risks are so pronounced, is marked. Inevitably, my approach to Ms A's supervision changed as did my accountability for her department and service; of necessity I became more directive and task-oriented. Correspondingly, in the transference, I felt 'bossy':

Ms A from 22/06/05:

Ms A commented that she had felt like she "had a rod up her back" after the last session with me – demonstrating by pulling herself bolt upright in her chair. She said that she had gone away feeling motivated to complete the action points agreed… I was feeling guilty, wondering if I had been rather bossy and directive on the previous occasion. Ms A's use of the word "threat" earlier was making me wonder if there was something coercive in the dynamic…

Ms A from 06/07/05:

She referred again to her feeling that I had given her a lot to do via supervision – that she had gone away feeling… – she demonstrated physically – drawing herself up straight and taking a deep breath. She had gone to her desk and said to herself "right, now focus…"

I was aware of difficult countertransference - feeling 'all at sea', finding it hard to be helpful in contrast to the *"helpful"* group supervision. Ms A would talk insistently, excluding me, making it hard for me to gather my thoughts and be helpful. I thought,

particularly in the context of the diminished clinical service, that she was over-supervised:

Ms A from 18/05/05:

…Suddenly she said "I think I've just waffled on for ages". I thought so too. I had noted that she appeared to be talking without focus and that her responses to me had borne little resemblance to what we had been thinking about and had effectively excluded me from engaging. This was my moment to say that it felt difficult for me to be helpful to her – and I missed it.

Ms A was receiving clinical supervision from a number of sources: clinical supervision with me (weekly); team supervision with a psychoanalytic psychotherapist (weekly) and she attended a multi-disciplinary, psychotherapy-led peer supervision group (also weekly). She had received management supervision from my predecessor. She was not unusual in following the prevailing model within the hospital of the provision of 'management' and 'clinical' supervision separately. There was no mechanism for a flow of information between the two parallel processes and the provision of clinical supervision to the team as a group added further complexity. There is evidence of her struggling to manage the boundaries of these processes, and there was potential for the group supervision to be used by them all to raise matters more appropriate for individual supervision, risking confidentiality.

On a number of occasions, I wondered about the level of rivalry implicit in this parallel process, the further 'twist' being that the supervisor also acted in that role for me, noting I: *"felt inadequate. I can't imagine that my input in any way compares favourably to his".* This was compounded by his decision to suspend his work with me after I became Ms A's line manager, leaving me without psychodynamic support at a time when I felt vulnerable in my new role:

Ms A from 25/05/05:

I had my own clinical supervision. My supervisor… now thinks that to continue working with me would leave him with a conflict of interests – particularly given his history of working with them through their experiencing management as

difficult - and we therefore ended our supervision arrangement to be reviewed towards the end of my secondment. He commented "wouldn't it be great if you could move to a position of attending the Creative Therapists group supervision?" I didn't think it would be particularly great… The sudden ending even extended to him ending our session before the end time – by getting up and leaving the room.

This was the first time we had discussed his potential conflict of interests and I, for the first time, experienced someone I had always experienced as supportive as punitive... I felt extremely uncomfortable and actually quite upset.

The rivalry and risks inherent in the split between clinical and line management supervision are well-illustrated by the following example. Ms A described a long-standing difficulty with a team member, Z, who had been noted to be smelling of alcohol. Despite performance difficulties the issue had never been addressed and no-one had ever challenged Z about his behaviour or the potential risks associated with attending work whilst possibly being under the influence of alcohol: it had become a *"standing joke"*. I was concerned and prescriptive about the necessity and how Ms A should resolve the various aspects of the situation: I have described this in *'Z and the Smell of Alcohol'*.

The sequence below begins as Ms A describes attending the group clinical supervision session with Z:

Ms A from 06/07/05:

She said also that he smelled of alcohol "every time he moved his head, I was getting a whiff", commenting that she had later spoken to their supervisor who had confirmed this.

…She commented that he had talked urgently throughout their supervision. She, however, had chosen to say little – her awareness that he smelled of alcohol raising her anxiety…

As Ms A talked lengthily, I was experiencing a mounting sense of irritation as I needed to return to the issue of Z smelling of alcohol. I had previously been very explicit about the fact that Z must be sent home if smelling of alcohol. I had recorded this in Ms A's supervision notes.

I asked her "what prevented you from sending Z home?" She went on to speak about her uncertainty that he really smelled of alcohol and she talked about this for some time whilst also reminding me of her previous experience working with substance misusers. Eventually, she said that, after their clinical supervision, she had asked their supervisor could she stay behind, just for a minute, and ask him one question. She would guarantee not to do it again. She had asked him for his opinion. He had agreed that Z smelled and she had asked if he thought she should send Z home. He said that he thought it should be noted.

I was furious with both of them. Ms A for following the guidance of her other supervisor and him for acting out of role and giving her inappropriate advice. I also noted the history of my thinking that there was some level of competition between myself and the other clinical supervisor. This was now being enacted in a managerial role as well as a clinical role. I could scarcely believe what I was hearing.

…I then said that I thought we should think about her decision to take a steer from a clinical supervisor without consulting a manager, as it seemed to me that Z had also succeeded in getting some confusion about boundaries and roles into the encounter. Ms A said that, retrospectively, she could see it may not have been the ideal action to take…

...I said that I was aware how difficult this might be and that perhaps some avoidance was reflected in her decision to consult the clinical supervisor rather than me (I had every reason to believe that she knew exactly what I would tell her to do).

Certain decisions and actions need to be shared for accountability, support and mentorship and it is reasonable in these circumstances that Ms A would seek to consult someone with greater experience. However, she avoids the agreed, organisationally-

sanctioned course of action, a pivotal aspect of which was to confer with me. Instead, she consults her clinical supervisor who does not support her in following the action she knows she should take, but advises *"it should be noted"*. It is perhaps immaterial that this was, in my view, not the correct advice. In so doing, Ms A leaves herself vulnerable as her clinical supervisor has no level of formal accountability or responsibility for her work. Her decision prevents me from being helpful and separates her from the organisation's framework of accountability. It is therefore a dangerous decision.

Formulation

Ms A was operating within a model in which the systems for supervising clinical and managerial processes are split into reflective, clinician-led, confidential spaces and more structured management processes that hold the organisational accountability for performance and governance. This model has some strength in that it ensures that reflexive time is protected and not effectively sidelined by the need to demonstrate structural accountability. However, when the primary task being managed is a clinical process, then the quality of that clinical work, of necessity, becomes the legitimate business of managers. Where oversight of clinical processes becomes split from the management of a service and there is no 'sideways' communication it is possible for potentially dangerous practices to remain split from the structure of the organisational accountability. The issues presented by Z, whilst clearly impacting on his clinical practice, are manifestly performance issues that are the legitimate concerns of a manager. However, Ms A chooses to consult with their clinical supervisor, breaching the boundary of their supervisory space in order to do so. His response represents a profound epistemological doubt: what is right in front of them, available to their knowledge and senses, gets denied. This is further evidence of collusion with something dangerous, a denial of the legitimacy of role and the need for authority and a denial of reality.

Mr C – *'Supervision used protectively'*

> **The forensic psychotherapist will be involved in the patient's projective field and will be the recipient of many transference displacements of affect. Thus his countertransference response to the patient's reactivated externalised hostility means that he will come to learn how to distinguish between countertransference distortion and prudential fear… In my view, the skill of disentangling countertransference phenomena and prudential fear is one of the most important components of developing professional expertise which a forensic psychotherapist can ever attain. (Cox 1996: 205)**

In previous vignettes, I have illustrated difficulties in undertaking the primary task: a consistent focus of my work with Mr C was how to really understand the primary task of a therapist in the high secure forensic setting and the intrinsic difficulty in even defining the task. Powerful feelings of uselessness and professional impotence were frequently aroused in Mr C. We thought about them carefully in terms of how to take up a role, within an appropriate boundary, in relation to these particular patients in this particular institution:

Mr C from 24/04/02:

Mr C spoke of feeling disheartened during his sessions with patients, of questioning "how good a therapist am I? What right have I got?"

Mr C from 01/05/02:

"How do I see my task? My task is not to cure them – I know I can't cure them. I'm not a doctor. But if I can give them an experience of someone listening and offering time to think about them, be witness to their stories, then that might make a difference".

Mr C from 08/05/02:

...Mr C described the organisation as "hierarchical" and "paternalistic", controlling and infantilising patients in a powerful denial of the reality of their adulthood. He said the organisation was "wanting to make sure everyone is OK". This seemed to me to highlight the central difficulty that everyone in this

*hospital is demonstrably **not** OK and therein lies the muddled question of what it means to be a patient, or indeed therapist, here.*

We frequently likened the task to palliative care and it became possible to see a distinction between the uncertain capacity to effect substantial long-term change in patients and the value of providing here-and-now containment and identifying evidence to support ongoing assessments of risk. The last extract above is an important example of the use of denial as an institutional defence against thinking about the reality of risk - *"wanting to make sure everyone is OK"* - and collusion with perverse transferences. This can be understood as a defence against overwhelming feelings of hopelessness, projected by patients into the clinicians who experience it as 'therapeutic nihilism'.

Evidence of countertransference was apparent throughout. Mr C often spoke of wondering what *"got into"* him and going home at times *"feeling quite mad"*. The kinds of feelings evoked by his patients can be seen to undermine his capacity to think:

Mr C from 08/05/02:

Whilst discussing a patient who had committed necrophilia Mr C said "he did a painting today that was full of perspective and I nearly fell asleep whilst he was doing it – I've never had that experience before"

Mr C from 02/10/02:

Mr C felt exhausted at the end of the day, went home, said "hello" to his wife and went straight to sleep. He felt guilty... "some superego effect".

In the first example, he is barely able to stay conscious. In the second, Mr C tells me that he *"felt exhausted"* at the end of a working day and *"went straight to sleep"* as if his capacity to think is literally extinguished. Rather than reflect on what this might mean, he describes *"feeling guilty" – "some superego effect"*. He had previously told me about a patient who had made him feel *"quite mad"*. The frequency of these references enables me to understand them as representing 'contagion' in a process that seems to be a constant struggle between sanity and madness, to maintain the boundaries around a role sufficiently to 'keep your mind' – i.e. the capacity to think. Mr C's

exhaustion is like a feeling of annihilation as a result of receiving massive, assaultative amounts of unprocessed unconscious communications. Sleeping would give his internal world the opportunity of a restorative process.

Attacks on Mr C's thinking can be seen to result in his avoidance of and difficulty with the material below:

Mr C from 15/05/02:

The patient had told Mr C about her dream, the content of which she had written down. He asked her to read it to him and, in turn, he read it to me. Having read the dream, Mr C commented that it was "very unpleasant". It was. He went on to say that he had found it almost impossible to think about this dream – it was ***so*** *horrible. He was effectively unable to let it into his mind. He was glad of the patient's music (ambient – whale sounds) playing in the background. He had said to the patient that he wondered if she were the bird in the dream – and the bird represented freedom… I said that I wondered if, in the retelling, Mr C was the bird who had lost the freedom that is made possible through thinking. He had been unable to let this dream into his thoughts, it was so horrid. He had been conscious of his resistance to thinking about it. The patient's music – like the sounds experienced in utero – was soothing but undemanding, requiring no intellectual engagement or thought. Mr C spoke further of his feelings of discomfort on hearing his patient's dream. He had felt "smothered" and "claustrophobic". Could hardly bear it. Even in telling it now, he felt almost unwell and was relieved to talk about it. He might have carried this all week.*

The way and frequency with which he describes the experience of being unwilling and unable to think about this material elevates it to evidence of a process of communication that is almost physical. His comments move from addressing his reluctance to think about this *"unpleasant"* dream and his need to keep it out of his mind - a cognitive experience - to describing a physical experience, that he associated with the same material, that became intolerable, resulting in him feeling *"almost unwell"*, as if the process is so concrete and unsymbolised as to cause him actual physical harm that might, indeed, have endured *"all week"*.

In order to achieve some form of transformative process with a forensic patient, a therapist must stay in touch with seemingly unthinkable emotional experiences – cruelty, sadism, murderousness: supervision should be a process that supports the capacity to think about such unthinkable things. Countertransference feelings as described above - if recognised as such and their meaning thought about - can help achieve a greater depth of understanding of the patient. However, if not fully understood, they can result in enactments within the relationship that may be at best unhelpful and at worst dangerous.

I will now describe a process that illustrates this point – and the value of supervision in enabling symbolic links to be made that prevented a dangerous situation.

Mr C from 08/10/02:

Mr C talked, at length… about the difficulties of finding evidence for his views about his patient – particularly in the context of the forthcoming CPA case conference that is scheduled for next week. He said that he was mindful of evidence-based practice and not sure about what the relevant research or evidence base might be. He went on to tell me about something that had happened to him in the past. A consultant psychiatrist [Dr. X]*, from a private-sector medium secure unit, who is expected to attend the case conference, formerly worked in our hospital. Mr C had worked with her, on a ward on which a number of high-profile patients were detained... There had been difficulties on the ward that Mr C described as "leading to a great deal of splitting and the scapegoating of Dr. X". He believed that he had been supportive of her during a time that had been difficult for her and had resulted in her "having a breakdown"... Mr C described Dr. X... as "attractive". I queried this and he amplified – she seemed vulnerable, not like Dr. G* [another female psychiatrist] *who was also attractive, "sexy", with "long legs"; but "vulnerable", almost "child-like". He said "men find that attractive – at least I do."*

Mr C described the way in which a serious assault, by one patient on another, resulted in a conflict between himself and Dr. X, relating to the nature of judgments, risk assessment and decision-making. Mr C had concerns about the risk represented by the patient, based upon his experience of him in therapy. Dr. X had taken a different view

and a serious incident took place that had an adverse effect on the morale of the team. Mr C described a context in which it appeared that the process of risk assessment was experienced as persecutory – "judgemental" – undermining the need for and efficacy of judicious risk assessment. In a parallel with the question of the validity of this research, we thought about countertransference, its relationship to the making of judgments about risk and its status as evidence for such assessments.

Two weeks later, Mr C talked about Ms 4, a woman who, as a late adolescent, had committed a particularly sadistic and gruesome premeditated murder of an older man whom she had drugged, tortured and mutilated, notably by sealing his eyes, nose, ears and mouth with 'superglue':

Mr C from 23/10/02:

Mr C began to talk about Ms 4 and how uncomfortable she had made him feel during their session the previous week. He had wondered, was there something sexual going on? He was not aware of thinking about her sexually. There was talk about her having gender identity difficulties: it was said that she wanted to be a man. I asked "What is she like?" "Like a child" said Mr C, "Like a 7 or 8 year old child. That's how I think of her". I reminded him that these were almost his exact words in describing what he found attractive about Dr. X. He looked stunned – as if something had come into his mind with great impact. He said "I must tell you something that will make me squirm – but I must tell you". I recalled that "squirming" was the word he had used to describe the discomfort he had felt during Ms 4's last therapy session, and I also noted its sexual connotation.

I had highlighted the symmetry of Mr C's language in describing both Dr. X (whom he found sexually attractive) and Ms 4 as *"child-like"*. By bringing the two comments together, I suggested that it was impossible to uncouple the part of him that was attracted to the child-like quality of Dr. X from the child-like quality of Ms 4. This made explicit a hitherto unthinkable symbolic equation that, if he could be attracted to the child-like quality of Dr. X, then he might also be attracted to the child-like quality of Ms 4. This thought had been intolerable at a conscious level. By linking those two

thoughts, previously held so separately in Mr C's mind, I enabled him to share with me something that had been both intolerable and unthinkable.

He went on to describe difficulties he had experienced in trying to establish a new therapy group. He spoke of his line manager: all his team, he said, had *"issues"* with her, around *"authority and control"*. Mr C had felt infantilised (*"an independent professional being treated like a child"*) by her insistence on being involved in the process of setting up the group. He had an art therapy session scheduled with Ms 4 who had not attended. Then he had a session with Ms 5:

Mr C from 23/10/02:

Mr C was aware that he was still "full of rage, fuming", as he worked with Ms 5, and she "was in a funny mood". She spoke of the importance of trusting people and yet of how difficult it was to trust. People here were not trustworthy: staff, nurses, etc. Eventually, Mr C had said to her: "It must be difficult for you to feel that you can trust me". "Of course", she said, "you could be a paedophile". Mr C and I immediately registered the link to his descriptions of Ms 4 and Dr. X as "child-like". He spoke of how he felt, using uncharacteristically sexual language: "oh fuck! Oh well, she's fucking mad, anyway". It had shaken him. After the session, he had been alone here. He had had to carry that alone. It was lunchtime and he thought "fuck this place" and went home.

When Ms. 5 suggested that Mr C *"could be a paedophile"* he found the idea so intolerable that he was almost literally unable to formulate a response and he could not usefully think about it. Now, however, Mr C had made the knowledge of the possibility of sharing in the patients' perversions more explicit through his use of language enabling me to link the things that had been split in his mind in order to defend against that thought. Ms 5 had raised a question about the possibility that Mr C had a perverse and abusive sexuality. He tells me of it in language that is *"uncharacteristically sexual*". Three times he uses the word *"fuck"*. He describes a physical impact of her suggestion – he is *"shaken"* – and that, *"alone"*, he had *"to carry"* it – as if it is a tangible physical experience. The nature, quality, insistence and unusualness of the language, combined with his comment that the experience *"had shaken him"* and his feeling *"alone"* with it, elevates this to evidence of pressure on Mr C's thinking:

- *…uncharacteristically sexual language.*
- *…"oh fuck..."*
- *"…Oh well, she's fucking mad, anyway".*
- *It had shaken him.*
- *After the session, he had been alone here. He had had to carry that alone.*
- *It was lunchtime and he thought "fuck this place" and went home.*

We discussed Ms 5's comment that had such an impact on Mr C. He thought something of the absent Ms 4 *"had seeped into the room".* We reflected on this and, as a result, systematically read through Ms 4's case notes, reminding ourselves of the actual and horrific details of the homicide she had committed, allowing all the facts to 'seep into our minds' more fully than before. This enabled us to return to material we had discussed in the previous week's session to review the content and its relationship to risk. That material was as follows:

Mr C from 16/10/02:

Mr C was not sure what to present... I reminded him that during the last three sessions, he had spoken of wanting to present Ms 4 because of a session in which she made him feel uncomfortable. Yet he had not done so. "I wonder what is being avoided" he said, and decided to present her to me.

At first, his account was very confused/confusing. His work with her had initially been successful although she was a patient who had essentially been "written off" by other professionals as being non-compliant and beyond help… Mr C was pleased and felt "like a guru".

Recently, Mr C had visited Ms 4 on the ward. He did not like going to the wards to see patients. He has a therapeutic space established in the art room. It feels like breaching a boundary. I became confused – had he conducted an art therapy session on the ward? Or just interviewed the patient? Mr C confirmed the former. There had been no nurses available to escort the patient from the ward to the art therapy room.

On this occasion, on the ward, Ms 4 had said to Mr C that she would like to do some role-play. She would like to be the therapist whilst Mr C would role-play the patient. Mr C declined, suggesting that she might like to role-play being her own therapist and they agreed to do so on the next occasion. In the subsequent session, in the art room, Mr C reminded Ms 4 of this. She said that she didn't want to do it and he pressed her to "give it a try", setting out the chairs. She remained resistant, and Mr C demonstrated for me her sullen body language as she hung her head and would not give him eye contact, saying "I don't know what to say". He suggested that perhaps she start by thinking of a memory. She continued to say that she couldn't think of anything.

Mr C said that he felt more and more uncomfortable. His discomfort grew until he was "squirming". Ms 4 would not give him eye contact, looking down, fleetingly up, then down again. Then she said "I don't like bullies"... She said that everyone in her life had bullied her and let her down "except W". Mr C told me: 'Then I made my big mistake. I said "who's W?" W was someone of whom Ms 4 had previously spoken and Mr C had not remembered. She became more hostile, saying to him that he never listened – wasn't interested in her, Mr C's discomfort grew further. He said that he knew that somehow the Index Offence was being re-enacted. He felt that he "needed to get glue into the room" (glue had a prominent part in the Index Offence) so he said "I think we're stuck".

Mr C's description of his discomfort was extremely powerful. I questioned what was being communicated unconsciously by Ms 4 and what 'got into' Mr C, suggesting it might be helpful for him to think about the two moments in the session in which he felt that he acted unusually, as well as thinking about his discomfort. Firstly, his breach of a physical boundary in conducting his art therapy session on the ward is interesting. Whilst it had a surface pragmatism, it seemed as if Mr C had been 'tempted' out of his safely contained therapeutic environment into a potentially dangerous place. This seemed to enable Ms 4's suggestion that they breach their interpersonal boundary by reversing their roles in a role-play scenario – also dangerous territory. Her suggestion that they play each other's roles would involve a denial of the reality of her status as a patient and his as therapist as she took control. Her suggestion had sexual connotations - like playing 'mummies and daddies' - that deepened the perverse context. Secondly, the moment in which, *"squirming with discomfort"*, Mr C asked *"who is W?"*

suggested something about hearing and not being heard that resonated with Ms 4's Index Offence in which she had put glue in the ears of the victim.

I suggest that it is Ms 4 who is the 'bully' in the room, attacking in Mr C her projected hostility. Just as she sealed up the senses of her victim in reality, she can be seen to prevent Mr C from hearing what he is told and from seeing the danger he is in. She has prevented him from thinking. I noted the sexual context of her Index Offence and the fact that, like Mr C, the victim had been an older man. It is clear that Mr C had been nudged out of his role and tempted into a dangerous enactment without being able to think about the risk to him.

There is something qualitatively different about the work described above that illustrates a unique kind of toxicity: the projection of something concretely murderous and unsymbolised. It was literally almost impossible for Mr C to open his mind to such an experience and stay with it long enough to make any sense of it. It was so difficult to bear and his discomfort was such that his instinct was almost to flee the room. Ms 4's torture of him had a sexualised feel and the perverse suggestion of role-reversal had an echo in Mr C's transference to me (also a woman younger than him) in a later supervision session:

> *Mr C from 30/10/02:*
>
> *Mr C asked me for some feedback relating to one of our mutual patients. I commented that I could see that he wanted/needed feedback and that I would give it at the risk of reversing our roles or effectively "hijacking" his supervision. "I would love to supervise you" he commented.*

His comment had a sexualised quality, and the requested feedback related to a situation in which I could be perceived as (unusually) vulnerable, resonating, again, with Mr C's description of the qualities he had found so attractive in Dr. X. In a further symmetry, he uses the word *"guru"* to describe himself: a word he has previously used to describe Dr X to me.

Formulation

In this example it is possible to see real difficulty in understanding the primary task of a therapist in the high secure forensic setting and the potency of countertransference that puts almost physical pressure on Mr C, undermining his capacity to think. The example shows how material that is initially intolerable at the level of conscious thought, can enable thinking about the unthinkable – in this case the possibility of a 'paedophile part' of Mr C that would make possible his attraction to Ms 4. Clearly, Ms 4 uses a 'child-like' part of herself to seduce those around her and then make them her victims. In this example, through her initial apparent compliance, she seduced Mr C into feeling like "a guru" – like Dr X whose child-like presentation he finds so attractive. In an enactment resonant with her Index Offence, she prevents him seeing and hearing what is there, concealing her hostility by projecting it into him and making it hard for him to think. He is tempted out of his safe therapeutic space and comes close to a dangerous role play based on a denial of the reality of their roles within their relationship that puts him at risk. The process of supervision enables him to symbolise sufficiently to make these links explicitly, to think previously intolerable thoughts and see what had been obscure.

The final vignette links with this in that it elaborates the potential physical impact of these processes. Using material from work with DC B, it demonstrates a correlation between increasingly disturbing material and the breakdown of a practitioner's defences and health and his withdrawal from work, considering the role of the professional consultations and his approach to them in this context.

Good morning Worm your honour
The Crown will plainly show
The prisoner who now stands before you
Was caught red-handed showing… feelings
Showing feelings of an almost human nature
Shame on him
This will not do. (Waters 1979)

Vignette 8 - DC B: *'The Impact'*

The experience of clinical supervision was highly variable amongst ward nursing staff. Some had arrangements for supervision that they valued, but it was our impression that supervision was arranged on a personal, ad hoc basis, rather than systematically organised. Ward staff commonly thought that the stress of working with a highly disturbed patient group, untrained, and with little formal supervision, was largely unrecognised. (DoH 1999a: 4.2.19)

Working with severely personality disordered individuals is difficult and stressful. It is emotionally draining and can be physically dangerous. Staff need to feel that they are well-trained and that they have support available, not least to talk through issues and to give a different perspective on a problem. This is a key way of preventing emotional manipulation by personality disordered patients who are adept at undermining staff and systems.

…We also heard that nursing supervision was piecemeal and that there was little monitoring of its value and effectiveness. Adequate support for individual nurses, in terms of training education and clinical supervision, was, and is, lacking. (DoH 1999a: 4.7.12-13)

We also call attention to the need for a structured system of clinical supervision to support the practice and personal needs of staff. (DoH: 4.7.17)

***'The Impact'* - analysis**

This vignette, most of which has derived from my final meeting with DC B, provides a summary of the process of my consultations with him and the progressive breakdown of his defences leading to his physical and psychological illness and withdrawal from his work. The material can be seen in the records of my last three consultation sessions with DC B in which he is able to identify and articulate the impact of his work on him in a way that makes it appear that something damaging has 'got into' him in an absolutely concrete way, attacking his capacity to think and to symbolise, and resulting in his withdrawal from me, and from his work through a physical – potentially fatal – illness.

This links in theme with the last vignette in that the content foregrounds DC B's approach to professional consultations – coming from an organisation with no structural process comparable to clinical supervision, but where the provision of work-based 'counselling' appeared to potentially pathologise feeling states that:

a) could be considered to be inevitable and be understood and
b) could be usefully harnessed in the service of the primary task.

Things "getting on top" of DC B

The extract below shows the first explicit link made by DC B between his work and his experiences of emotion. I have written in detail elsewhere about the first paragraph – forming part of the vignette '*The Neglected Baby'*. For the purposes of this discussion I use the sequence to illustrate the beginning of the process of DC B's defences breaking down leading to his absence from work. It had been six weeks since we had last met:

DC B from 26/07/05:

He said that it had been a "really strange" few weeks. He thought that things had "been getting on top" of him – then he had been ill for 2 weeks – he had been to a barbeque & got food poisoning followed by an infection - and then he had had a week's pre-booked leave. He spoke of the nature of our work, saying that he felt "relatively comfortable" talking to sex offenders but that there were other aspects of the work that were more difficult. One of his colleagues had told him about a

job she was working on. It was a case of neglect of a young baby. The child had been so badly neglected that it had resorted to eating its own faeces. DC B had found this very difficult to deal with. Again he said that things seemed to have got on top of him a little…

…He said that a strange thing had happened... He was, as he had said, very used to the nature of this work. However, all of a sudden, as he was driving to Court, "the enormity of it all suddenly hit me". He said that he had become preoccupied with the impact that this hearing could have on the lives of this family – that this woman was now likely to lose her children for good. He had found this experience quite anxiety-raising.

This is DC B's first overt reference to his awareness of work *"getting on top of him"*, and he also refers to an experience of physical illness – though he doesn't explicitly link the two. My understanding of the relationship between his experience at work and his physical illness is considered in detail in *'The Neglected Baby'* in which I explore the impact on him of taking in something that he cannot think about: that is literally indigestible and makes him ill – like a metaphor for his experience of his work. This vignette is attached as an appendix.

The second paragraph highlights a kind of 'epiphany' moment of insight, when he becomes suddenly aware of the reality of his work and its impact on the people concerned. He twice identifies that things have been *"strange"* and he speaks of being *"very used"* to the nature of his work: these words imply a level at which he is conditioned or desensitised – i.e. that his work is not thought about. He also notes his awareness that the experience of realising *"the enormity"* is *"quite anxiety-raising"*.

The following three consultation sessions were cancelled and we did not meet again for approaching five months. The next extracts come from our penultimate meeting. Again, DC B seems to be overtly aware of his emotional responses to his work and to the flow of these processes between his professional and personal worlds:

DC B from 06/12/05:

He had been speaking to a female colleague in their office when something she said (either he didn't tell me or, as I write this up, I cannot recall what it was that she said) made him "blub", tears streaming down his face. "You bitch", he said to her...

He then moved very swiftly on saying "and then I got a job that really did make me cry"...

...DC B had then gone home. He was sitting with his young son... "not usually a very demonstrative child". His son had suddenly flung his arms around him and DC B had found himself moved to tears. He had excused himself from his son saying he would go and get him a drink. He then went outside until he could compose himself. He said that he didn't want to have to explain to his son why he was crying.

Although he moves the material on, DC B links his crying with the content that follows with the phrase *"and then I got a job that really did make me cry"*. In the second paragraph, as he appears to be moved by his son's unusual demonstration of physical affection, DC B again finds himself crying, this time described in more neutral terms. He does not say that he does not want his son to see him crying, he says *"that he didn't want to have to explain to his son why he was crying"*. This has a different inference, indicative of his instinct to protect his son from the 'damage' that knowledge about his work could cause. This infers that, in his conscious mind, he knows and could articulate why he is crying: however, I am not confident that this is entirely the case.

He goes on to describe his contribution to an investigation in which he has interviewed the young adolescent victim of an alleged sexual assault at a Scout camp:

DC B from 06/12/05:

DC B had been interviewing the victim – a 14-yr-old boy... He had interviewed him once and the boy had found it so very difficult and painful. He just couldn't talk about what had happened. Couldn't say the words. DC B had thought "this

has to stop". He knew that the Sgt was very keen to get a good statement and charge the man with the more serious offence, but DC B thought that it was really not worth the distress and impact on this child that could/would have a lasting damaging effect. However, forensic evidence had come through and the Sgt had asked that the boy be interviewed again… In an effort to make it as easy as possible for the child, they had asked him what would be the easiest and most comfortable way for him. Was it difficult to speak to a man? Would he find it easier to be interviewed by a woman? The child had asked for DC B specifically.

… DC B said that after the interview, as they had parted, the boy had said "I hope I never see you again". It was a powerful moment in our interview.

Here it is evident that DC B does not want to cause further discomfort to this child who was previously literally unable to talk about what had happened to him. Then he takes his thinking in this respect further, saying that he was concerned that the experience of the interview *"could/would have a lasting damaging effect"* on this child. This raises something concrete about the potentially and **literally** damaging effect of the impact of words that I believe is linked to the fact that he *"didn't want to have to explain to his son why he was crying"* – i.e. for fear of causing him actual harm: that there is a **concrete** link between words and experience. This child has asked for DC B to conduct the second interview, suggesting that DC B has demonstrated to him a level of resilience: i.e. that the child can see that he has survived their first encounter without being irrevocably damaged by what was said.

The last two sentences in that sequence are interesting: *"DC B said that after the interview, as they had parted, the boy had said 'I hope I never see you again'. It was a powerful moment in our interview."* At face value, this sounds rather rejecting. However, if these words are coupled with an idea that there is something concrete about the link between words and experience, I suggest that there may be a real way in which this child has 'given' DC B something of his experience that DC B can take away and hold for him that, accordingly, he will never need to experience again. My noting that it *"was a powerful moment in our interview"* reflects the emotional complexity of the process – it felt as if we re-lived the moment. It was evident that DC B was moved and on the brink of tears as we fell silent for a few moments. The flow of the material is interesting as it moves immediately to DC B feeling he had *"had enough and couldn't*

take any more" implying that there is some link between these aspects of the material in his mind:

> *DC B from 06/12/05:*
>
> *DC B said that after the interview, as they had parted, the boy had said "I hope I never see you again". It was a powerful moment in our interview.*
>
> *DC B then said he felt he'd had enough and couldn't take any more. He laughed as he said it but said that he thought if he "had to hear one more thing about someone's willy or someone's bum….." He had to get away from it for a bit. "So I went off on my mountain bike. Actually no. I went surfing for a couple of days."*

DC B clearly recognises this as a turning point. Something about the quality of this last investigation leaves him feeling that he had *"had enough", "couldn't take any more"*: he cannot take any more **in**. Although he uses humour as a type of denial, he identifies the sexually abusive aspect of his work as what has become intolerable. His recognition of the need and value of taking a break from work, and the use of physical exercise in this way is potentially protective; however, although he does not know it now, this is the beginning of his long-term withdrawal from work and he will go on to describe how the protective function of exercise came to be dysfunctional and used perversely by him.

DC B's moment of epiphany

Following this, I learned that he had been absent from work for some time following diagnosis of a potentially life-threatening illness. Although he had not formally withdrawn from the process of the research, I did not see him for eighteen months and wanted to meet him again to re-establish his consent to participate – and to effect a proper ending to our work. I now reproduce a lengthy extract from the record of that meeting because it provides a useful summary of DC B's narrative understanding of the process of what happened to him, the nature of his relationship to his work and something of his experience of the professional consultations:

DC B from 22/05/07:

...He told me that he had had pericarditis – "inflammation of the membrane around the heart"... ...he didn't really know why he had suffered this particular illness but was aware that it could be caused by stress…

He said that it had been a strange year. He spoke of how much he had initially enjoyed the post in the child protection team... working with Sgt O. Then... as he was sitting in court, he suddenly thought to himself: "I just don't want to hear these things any more". He had returned to work following his illness on light duties and had eventually transferred to his current position which is as an Intelligence Officer.

...It was a case involving a young girl with Down's Syndrome who had been abused by her stepfather with her mother colluding… ...the video interviews... had been very distressing ... DC B and Sgt O had watched them together and been powerfully moved… ...the video evidence had been particularly harrowing…

...He returned to the subject of his need to get away from the Child Protection Team... he had become aware of the extent to which it was affecting his home life. He was even becoming fearful for and over-protective of his children… He had felt such a powerful sense of needing to get away from the Child Protection Team... He asked me if I remembered about the case of the Moroccan boy who had been accused of raping a baby. I did remember. A comment made by one of his colleagues had made him cry…

He said that he was bound to wonder whether his physical illness had been related to his experiences at work. He had been so desperate to get away from it. Now it was much easier not to have to deal with the people… He has been researching… much more neutral facts… Just facts. Then he could hand it over to someone else.

...he indicated that he had just begun to feel completely invaded by the work. He talked of a time when a colleague confided that she was being abused by her partner and he just "didn't want to hear it". And of another occasion on which,

on needing to take a statement from a victim, he couldn't do it. He had to get her to write it down and read it to him whist he typed it into a laptop computer. This, he said, was because if all he was doing was typing what was read to him, it was easier not to think about it – it felt as if the material was having less contact with his mind.

I said that it sounded as if he had begun to feel as if in some very concrete way he was being damaged by the work that we do and he agreed… We also spoke of the impact of having a potentially life-threatening illness and the way that can change things...

He said that he felt as if he had completely lost the balance in his life. "That's the word", he said "balance". As an example he said that he had always liked to keep fit but that this had been developing into an exercise in seeing how hard he could push himself. There was a compulsive quality to it as if he was using physical exercise to "get something out of his system"… He had gone to counselling himself after the illness. He had been through the Occupational Health process and regained his physical fitness and had told them that whilst his physical self had recovered, he thought that there was clearly an emotional aspect to how things had been. He asked to be referred to a counsellor and she had been really helpful in him regaining a sense of balance…

Early in the sequence, DC B highlights the physical illness he has experienced and it is clear that it is important to him: he makes a link between *"this particular illness"* and *"stress"* and notes his experience at court - his 'moment of epiphany' - as he thinks about something with which he has previously not properly engaged. In this session, DC B seems much more explicit in his understanding of the relationship between his professional and personal worlds. Having wondered about why he *"suffered this particular illness"* he can now make two speculative links: to stress and to his desire to leave the child protection team. I think his words indicate that there is something about the nature of the processes inherent in his work that he has found concretely damaging. He speaks explicitly about an experience of his work 'invading' him and of very overt ways in which he had come to avoid the material of his work having contact with his mind. He comments that, in his new role, the concreteness of researching facts feels safer to him than the messier process that inevitably involved forming some kind of

relationship with both victims and perpetrators: facts are concrete and 'standalone', can be 'handed over' to someone else, existing outside of him never to be internalised.

'Professional consultation': supervision by another name

I would like to consider what DC B's experience of this series of consultations might have been. Throughout the process there was some evidence of a capacity to hold me in mind between sessions:

DC B from 22/05/07:

He said that he often thought about the things that I had said about interviews and the helpful suggestions I had made that were useful in enabling him to think in the room. Just that morning, he had been talking to a colleague about a difficult interview and he had remembered and used something I had said to help him think about it.

However, overall DC B appeared to struggle to make good use of the consultations. This may have reflected his absence of a pre-existing model for a useful reflective process within a professional relationship and may have been different had we established a regular and more frequent pattern of meeting. This was mirrored in my regular preoccupations with the extent to which I was being helpful to him (or not) and difficulties concentrating, thinking and remembering. The frequency with which I note this establishes these references as evidence of uncertainty in the transference:

DC B from 15/04/05:

DC B said that he didn't want to talk about the foster carer any more – it was all organised and it was a case that seemed unlikely to go anywhere anyway. I wondered was he experiencing me as unhelpful?

DC B from 26/04/05:

This week I felt that I was finding it difficult to be helpful... I can't remember the details of this and wish I could.

DC B from 17/06/05:

I was also conscious of finding it difficult to concentrate. My mind had wandered at this stage.

…I was still conscious of finding it difficult to listen and, indeed, now I'm finding it difficult to remember.

…I am struggling to remember the latter part of the consultation. I am aware of a moment around half way through when I looked at my watch and was concerned that he might run out of material before the end. I was aware that I was feeling a bit unhelpful

When asked, DC B expressed a view that reflective time was helpful although he was unable to specify how. I tried to engage him in some exploration of what the **experience** of the consultations had felt like for him. He found this difficult to conceptualise and was unable to move beyond a description of the positive value to him of the work – saying a number of times that he had found it *"helpful"* and *"useful"*. Below, although he again finds it harder to say how, he does affirm his capacity to hold me in mind when I am not there, linking my 'helpfulness' with some capacity to think under pressure:

DC B from 22/05/07:

…I asked him if he could tell me something about what the experience of the consultations had been like for him. Immediately he said that he had found them enormously helpful – stressing this point about how helpful it had been. He said that he often thought about the things that I had said about interviews and the helpful suggestions I had made that were useful in enabling him to think in the room. Just that morning, he had been talking to a colleague about a difficult interview and he had remembered and used something I had said to help him think about it. It had, he said, been incredibly useful… saying again how he had found it really helpful.

Formulation

Over time, DC B seems to have had a really concrete experience of his work invading him and ultimately making him ill. There appears to be something very toxic in the unconscious dynamics that cannot be thought about, symbolised or known, that is potentially dangerous: his reflections to me explicitly linked his work and his potentially fatal illness in his mind. His organisation cannot manage thinking about these things and thus the only way to escape is to withdraw through illness – physical and/or psychological.

I am to some extent left wondering whether and how the consultations were really helpful to him. It has been suggested to me that they may have provided a level of reflexivity sufficient to make avoidant defences unsuccessful, bringing painful realities into conscious thought and his breakdown and withdrawal from this area of work more possible:

DC B from 22/05/07:

... He said that he wanted me to know that, at that time, he had withdrawn from everything. He wanted me to know that it was not just from me – nothing to do with me. I said that I couldn't help wondering whether engaging with a process of enabling thinking about the difficult aspects of work had at times seemed hard in that context.

His final comments to me, whilst a surface attempt to reassure me that he had not sought to separate himself from my input, and some kind of 'protective' reassurance that there was no implied rejection, clearly link me in the flow of the material with the breakdown of his defences and his withdrawal from his work.

> **The pervasiveness of these attitudes was heavily reinforced by the staff estates which provided something close to a *cordon sanitaire* around the hospitals, sealing them off from their surroundings. Large numbers of staff, and not only nurses, lived in the hospital houses, with other staff as neighbours, and used the hospital social club and sporting facilities as a principal source of recreation and leisure. Whole families, spread over generations, could work at the hospital with connections by marriage reinforcing the bonds. In 1992 an enrolled nurse retired who had worked at Broadmoor Hospital (apart from war service) since he joined as a 14-year-old 'doctor's boy' in 1940. He was the third generation of his family to work in the hospital and when his son joined the staff in the mid-70s – making it four generations – there were 13 relatives of his working in the hospital. Add the informal networks and connections in such communities and you begin to appreciate the sheer pressure to conform to the prevailing pattern of behaviour. (Kaye & Franey 1998: 41)**

Chapter 5: Findings

Child A visited Lawrence Ward literally hundreds of times. How could such a thing happen? One needs to understand the historical background. We heard from various sources that Lawrence Ward was regarded by patients and staff alike as a bit different: a ward where patients were trusted, where there were very few incidents, a ward which largely ran itself. It had relatively low staffing levels, levels which surprised nurses like Ms Edge coming from higher dependency wards. It was the ward to which official visitors were taken, a "flagship" ward. The now notorious garden was featured in a national gardening magazine. As Mr Moran, who was Ward Manager from October 1993 to June 1994, put it in the context of searching:

> "Lawrence Ward was a highly trusted and highly privileged set of individuals. It was like no other ward in the Hospital."

> "…You aspired to go to Lawrence Ward, you earned the right to go on Lawrence Ward, because it was operated on low staffing. They have wine and cheese parties. It was a slow insidious process that the invasiveness of such things as searching ceased."

Mr Moran agreed with the suggestion of Dr Strickland and Dr Crispin's Counsel that the relaxed regime of Lawrence Ward was well-known throughout the Hospital. Both staff and patients believed Lawrence Ward was different from other wards in the Hospital. (DoH 1999a: 3.12.1)

There is no reason to doubt that Mr Hemming indulged in unsuitable play with Child A over a period of time, quite possibly years. That a child could be exposed in this manner is disgraceful. The fact that her father approved is contemptible and is not in our view an acceptable justification for the failure to act on the part of the Hospital and Lawrence Ward staff. Some nurses did indeed express their concern but they were ignored by their senior colleagues, one of whom at least believed it was in Mr Hemming's therapeutic interest for the relationship to continue. The paramountcy of the child's interests, as demanded by the Children Act 1989, was clearly not in the minds of the PCT.

> More than anything else this episode captures the sense in which the PDU at Ashworth Hospital had degenerated and the depths to which professional standards and attitudes had dropped. What is so startling is that they did not realize how blunted their professional vision and judgement had become, and how conditioned they were to accept the unacceptable. This is a vivid example of how destructive of professional standards such large, closed, static and complacent institutions can be.
>
> We ourselves have pondered as we listened to days and days of such evidence whether we had become case-hardened to the horrors of what happened at Ashworth and the risks to which Child A was exposed. In reviewing what we have written we are not convinced that we have fully captured the awfulness of it all. (DoH 1999a: 3.23.42-44)

How could such things happen?

The above extracts, better than any others, summarise the 'raison d'etre' for this research project. The phrases "how could such a thing happen?" and "what is so startling is that they did not realize how blunted their professional vision and judgement had become, and how conditioned they were to accept the unacceptable" absolutely evoke the essence of my interest in the phenomenon of 'ordinary decent professionals' swerved off-course and nudged into behaving in extraordinary ways without insight. The descriptions of Lawrence Ward "which largely ran itself", having "wine and cheese parties", illustrate a particular kind of madness in the milieu, a topsy-turvy world in which the reality of the need for a securely boundaried environment in which roles were clearly defined in order to contain these dangerous patients was systematically denied over time. The quality of this denial is almost psychotic in its distance from reality and the notion that "it was in Mr Hemming's therapeutic interest for the relationship to continue" borders on delusional.

However, in my own experience, such extraordinary events are not unique to Ashworth Hospital, albeit usually less extreme.

The Fallon Report is a reasonable account of the emergence of a series of critical incidents in high security that effectively 'benchmarks' contributory factors. The observation of similar factors in my fieldwork data has enabled a higher level of understanding, illuminating unconscious dynamic processes of the kind described in the literature in relation to perversion, linking professional performance with the interpersonal clinical relationships and **showing** the ways in which working with people

in perverse states of mind can render the most competent of professionals unable to maintain coherent thought sufficiently independently to be an effective container.

The Fallon Report gave a detailed account of critical events, a comprehensive review of clinical and legislative approaches to managing patients with diagnoses of personality disorder and made structural and procedural recommendations for policy, legislation and service redesign. However there was a notable gap in the report's discourse: it did not begin to address in any depth the nature or significance of the relationships between the incarcerated patients and staff, what might be below the surface of the known facts, and what greater dimensions of understanding about why critical incidents emerged might be gained by linking these different levels of thought.

In places there were good understandings and cogent descriptions of the nature and needs of the specific population of patients subject to detention in the Personality Disorder Unit. Similarly, there is clear recognition of the impact of 'conditioning' on the staff – the 'embodied professionals', many of whom had more lengthy and established associations to the institution than the patients. However, it was not possible to identify areas in the report where links between the unconscious dynamics arising from the nature of the patients' psychopathologies, the clinical task and dysfunctions in the operational systems of the organisation were made meaningfully explicit. The passage below represents the closest example and may be considered to represent 'in a nutshell' what it is that I have hope to demonstrate happening although this thinking was not pursued:

> Dr Obholzer… invited us to pay regard to what he regarded as the "toxic emotional processes" in Special Hospitals:
>
> > "we are dealing with the most disturbed individuals in society, incarcerated with each other for a very long period of time, working with staff groups who are also there for a very long period of time and there is a corrosive effect on the staff group unless in fact management is aware of this, unless all the staff groups are in touch with this". (DoH 1999a: 4.4.23)

Crucially, the report appeared to usefully acknowledge the particular difficulties in providing care to certain kinds of patient that could result in a separating out of what should be the integrated, although apparently paradoxical, components of the primary task. However, the report does not really engage with the psychosocial relationships

underpinning the systems and processes of such organisations in order to understand how or why such splitting and other anti-task phenomena might occur. The solutions to the apparent failures in boundaries in Ashworth Hospital appeared to be the establishment of ever-more rigid boundaries, "complex managerial and professional mechanisms" (DoH 1999a: 2.8.22), that proved counter-productive and appeared to substitute for real understandings. Accordingly, it appears as if, like the parallel systems of supervision I have described, the problems and solutions described in the Fallon Report worked in parallel and did not interact and the "toxic emotional processes" and unconscious relationships between the patients, the staff and the operational systems within the organisation were not thought about or understood. Fallon makes no links and does not show how things go wrong: the report does not make explicit the evidence of such processes unfolding nor illuminate why apparently sensible people sometimes do foolish things.

My work makes these links visible and explicit.

After a detailed reading, it was possible to extract examples from the report that illustrate and indicate the following emerging themes:

- Authority – how it is held or not and how it is recognised and experienced.
- Security versus therapy (also central control versus local freedom and prison versus hospital) – role of the institution/primary task issues.
- Topsy-turvy – indications of role confusion – particularly between patients and staff – role reversals, distortions of reality.
- Boundaries and containment.
- Mafia mentality ('mafia gangs' – Steiner 1993).
- Reality/attacks on reality (and denials of reality).
- Splitting (and projective identification).
- Truth versus deception (overlap with denial).
- Personality disordered patients.
- Roles and tasks (indications of apparent confusion in this respect).
- Thinking/knowing and not-knowing/attacks on thinking.

These themes link the operational dysfunctions within the organisation with dynamic and clinical features described in the extant theoretical literature in relation to

perversion. The report illustrates the eruption of a series of critical incidents in the wake of a failure of boundaries, containment and the capacity to hold and maintain commensurate authority in appropriate roles. However this is not made explicit with any level of depth.

Detailed analysis of the records of my consultations with Ms A and DC B confirmed that the same themes could be observed in the live material. Notably, the most dominant emergent themes were those of boundaries and containment, knowing and not-knowing/attacks on reality, authority, roles and tasks, truth and deception – all of which are demonstrated in the theoretical literature as being central to understandings of perversion and interpersonal relationships with people in perverse and antisocial states of mind. Some examples were strikingly resonant with the Fallon Report:

> Patient B told us... he had reservations about some of the group work offered**.** For example, an anger management group he attended was led by a psychologist who was known to have had a fight with another psychologist in the hospital car park. This rather undermined the therapeutic value of the group... He saw nurses as more security guards than therapists... (DoH 1999a: 1.25.10)

Ms A from 29/11/04:

> *We have done a little work around patients – she told me of a very difficult experience facilitating an anger management group after which (in the evening) she had her "first ever as an adult" experience of a physical fight with someone – "and I started it".*

I have found two ways of understanding the material collected during the fieldwork:

1. As three case studies of professional practitioners, their approaches to their tasks and potential to maintain roles grounded in reality - as represented by their differing capacities to engage with a process of supervision in a helpful way and the overarching narratives that appeared to characterise each.

2. As a series of vignettes depicting face-to-face encounters between practitioners and patients/offenders. These can be held as evidence illustrating unconscious

processes that result in pressure on thinking of the kind that I had wanted to capture.

These two ways of understanding inter-relate: the vignettes providing the 'micro' examples that underpin the overarching narratives indicative of the differing ways each participant was able to use a consultative process in support of their primary tasks. Clearly it is Ms A and Mr C's material that represents the best evidence in relation to clinical settings: however, DC B's data provides an interesting insight into just how difficult it is for non-clinically trained professionals to get to grips with this kind of material and these sorts of psychological complexities and dynamics.

The overarching narratives

The central epistemological challenge of this research was the difficulty in identifying and finding evidence of dynamic processes that cannot be seen. The unconscious is 'seen' as a reflection in another person, whether it is understood and illuminated by a well-chosen interpretation or not understood, triggering an enactment. I searched for this evidence in the forum of supervision where I supposed the experiences of conscious and unconscious processes should converge and be available to be thought about. The overarching narratives in relation to the three participants suggested the following understandings:

Ms A: and her team appeared almost entirely engaged in defensive behaviours that served to minimise their opportunities for engagement with clinical work with patients. They were configured as if their primary task was to receive clinical supervision. There were pervading themes of competitiveness and rivalry – between Ms A and her team, Ms A and I and myself and her other clinical supervisor. This resulted in a perverse enactment in which roles were blurred, differences denied and linking that should have been supported was avoided. Ms A presented so little clinical material that she prevented supervision from being a usefully containing space in which to think about these challenging patients. She found it impossible to confidently take up appropriate authority in a leadership role that enabled her to establish structural and interpersonal boundaries within which to effectively manage her team in the operation of the primary task: the failure to do ordinary, sensible things was manifest.

DC B: presented as an archetypal 'ordinary decent' professional. There was ample evidence of him doing his best, being libidinous towards his work and struggling valiantly to maintain his psychological integrity under pressure. His material largely focused on face-to-face encounters with offenders. However, he was less psychologically available to me and found it hard to use the consultations to explore feelings and uncertainty but seemed to be hoping for direction. As time went on, it was possible to track the impact on him of the increasingly painful and disturbing material to which he was subjected. By half way through our meetings, he began to withdraw from me and to disengage with the process of the consultations: intervals between meetings became more frequent, characterised by cancellations until his contact with me lapsed completely. Eventually he succumbed to both physical and psychological ill-health, withdrawing permanently from the predominantly child protection work that had been his specialism. As with Ms A, the outcome was to effect a withdrawal from the direct, emotionally complex, and painful work with offenders. At times, boundaries were unclear and frequent comments in my research seminars suggested he approached the relationship as if it were a 'date'. Retrospectively I understand this better and can see that his withdrawal from me had parallels with the ending of an intimate relationship: I later learned that his marriage broke down.

Mr C: was retrospectively included as a counterpoint to Ms A and DC B. His material vividly illustrates the nature and potential danger of forensic work. Despite experience and clinical ability, he can be seen to be drawn into a potentially dangerous situation within a clinical encounter with a female patient. However, in contrast to Ms A and DC B, Mr C makes use of a reflective opportunity to link up thoughts that had previously been held separately in his mind and achieve an increased capacity to think about difficult things in a deeper way. He was enabled to reflect upon the countertransference within his relationship with this patient and think more deeply about what part of him might be available to link up with whatever part of her that was seeking re-enactment. Therefore, he could think with greater depth and clarity about the painful reality of how dangerous this woman might be and her risk to him.

These overarching narratives were enacted in the participants' respective approaches to the process of supervision. Ms A appeared to use the process perversely – in the service of defensive behaviour and anti-task activity; DC B's gradual withdrawal from me mirrored his withdrawal from his work and Mr C shows how unconscious processes,

that can influence the most experienced of clinicians and draw them into dangerous enactments, can be contained and understood – through supervision – in support of the primary organisational task.

The vignettes

'The Primary Task' shows the way in which Ms A's team of therapists appear to configure as if their primary task was to receive containment through supervision not offer it through their clinical contact with patients. Their behaviour is increasingly defensive and avoidant of meaningful contact with patients as their on-task activity declines. This withdrawal is accompanied by the absence of any outwardly-expressed fear of the patients, or engagement with their hostility and aggression. Aggression can be observed in descriptions of staff as hostile but it is never addressed in connection with prudential fear of the patients and their dangerousness. I believe this shows the displacement by projection of the patients' aggression that the primary task of this team should be seeking to contain – not enact. The withdrawal from the task is compounded by retreat into the protective structure of the organisation and by the adoption of a type of alternative: as if their primary task was to receive supervision.

The behaviour observed is extraordinary in its extent, persistence, pervasiveness and the resistance to solutions that would support the primary task. A complementary defence of denial of the role of a leader and the legitimacy of authority (see *'First Amongst Equals'*) further enables this collective defensive avoidance of the primary task. I understand this disengagement as a defence against the anxiety aroused by fear of the patients and projected hopelessness, coupled with an intrinsic difficulty in defining the organisational task in the high secure forensic setting.

'First Amongst Equals' shows the need for authority and the role of a leader denied. This is evident in Ms A's role within her team and links to *'The Primary Task'* in that the denial of leadership enables defensive, off-task activity to continue unchecked. Ms A's role is 'acting manager' – a hybrid clinical/manager post. The term undermines her position - evoking 'playing' at the role – implying a level of deception or fraudulence, 'playing a part', playing a role rather than holding it with legitimacy: there is interesting symmetry in her connection to acting.

The means of her selection to the role compounded the problem. Rather than the organisation engaging a process of assessing and sanctioning the most suitable candidate for the position, the team of creative therapists have been permitted to select their own leader through an unspecified but apparently *"very democratic process"* through which the possibility of healthy competition is denied. Although it might be suggested that this gave Ms A the team's sanction, in practice she sought their approval and found it harder to hold her authority and contain them. The breakdown of authority can be further observed in the relationship between this team and the wider organisation in which a number of factors contributed to a perception of them as being without potency and they were not supported in establishing appropriate operational boundaries and structures.

I suggest the creative therapists represent a kind of youthfulness/immaturity within the organisation, linked to the nature of their approach to the delivery of therapy and reflected in Ms A's persistently feeling 'child-like' and the team's boundary-testing, sometimes delinquent, behaviour. What can it mean to represent something child-like in an institution in which the primary task is the detention and treatment of dangerous offenders – many of whom have caused significant harm to children? It is reasonable to hypothesise that, in such an environment, what is enacted is an experience of the setting of appropriate boundaries and legitimate use of authority as inevitably abusive and coercive. Denial therefore defends against the anxiety this arouses. Such denial also undermines the possibility of a healthy, containing parental function for a leader and the capacity, through the use of authority, to set and maintain the boundaries necessary to safely deliver treatment and care – i.e. the primary task.

'The Ugandan Man' continues to demonstrate confusion between authority and abuse, showing the violence of unconscious projection moving around an interpersonal system in an almost concrete way. Through the exploration of this suspect's alleged violent behaviour towards a child, DC B has an experience of 'not knowing his own mind' that is near-psychotic in its intensity such that he is preoccupied by the experience. The Ugandan man presents a paradox to DC B: on the one hand, an emphatic insistence in his belief in moral values and respect; on the other, the possibility that he has used potentially fatal violence towards a child to instil such values.

The Ugandan man's difficulties with his children (an inability to tolerate their capacity for independent thought/behaviour) and their solution (violence as a means of control) can be seen enacted in the interview. He cannot tolerate a different perspective that reframes his actions as wrong, filling the interview with his rationalised description of his values and moral stance (although it is his actions not his beliefs that are under scrutiny). DC B, in a surprising moment, 'finds himself' agreeing with him. Beating DC B about the head and shoulders is not an option but, just as he has physically attacked his daughter's emerging independence, the Ugandan man unconsciously attacks DC B's capacity for independent thinking and in a denial of their separateness, his capacity for cruelty and sadism gets projected into DC B where it is held as his own. The unconscious process can clearly be seen in:

1. the number of times DC B oscillates between identifying with the Ugandan man and checking himself;
2. his preoccupation with the potency of this struggle;
3. the quality – the concreteness - of his agreement with the man.

The two halves of the paradox are so split in the encounter that DC B is completely preoccupied with his identification with the values promoted by the man and must keep reminding himself that he cannot support the violent means to this end. His confusion is evident and clearly demonstrates the attack on his capacity to think. The interview is a constant struggle for him to hold his own mind – a continual battle on the borderline between sanity and a type of madness. It is possible to see unconscious violence moving around the system through the mechanism of projection as the offender 'psychically assaults' DC B, in an enactment of his crime, using projection to control DC B's mind just as he has previously used violence to control his child's behaviour. DC B's capacity for independent thought is extremely compromised.

'The Foster Carer' similarly demonstrates pressure on thinking and the fabric of reality being compromised by unconscious defensive processes. As in *'The Ugandan Man'*, DC B notes disruption of his usual way of thinking and that his approach to this investigation is different. Despite the absence of supporting evidence, unusually he forms a particular view about this suspect, his vulnerability and his innocence. This is underpinned by his transference experience of him arising from similarities with his father. Throughout the process DC B feels as if he is persecuting this man and he is

preoccupied with concerns that his enquiries will damage him in some very real way. This initially makes it impossible for DC B to engage with the sexual content of the allegations. When he is eventually able to do so, the pivotal reality-testing moment for DC B is the suspect's markedly bizarre response to being asked if he had found the child victim attractive: *"no more than any other child"*.

On eventually being confronted with the suspect's overt hostility, DC B is astonished and again has a near psychotic experience of him being like literally two different people, so successfully has his hostility been split off and concealed. I believe DC B's experience of this man *"as if he had two different personalities"* is an indication of his capacity to unconsciously employ splitting when experiencing intolerable levels of anxiety. The evidence for this split and the previously apparently absent anger and hostility can be observed in four places:

1. The distortion of reality that allows DC B to perceive a 64-year-old man as *"elderly and frail"*.
2. DC B's persistent difficulty in engaging the man in the sexual context of the allegation and his concern that to do so will cause him real harm.
3. The foster carer's monosyllabic approach to the interview that enables him to control the process.
4. The assertion of his wife and solicitor that the man is suicidal, compounding the above.

The unconscious attack can be observed to swerve DC B off course, causing him to do something he would not normally do – i.e. decide the man's innocence before they had even spoken – and to deviate from his usual method of interviewing – allowing the man to control the process. Although DC B persists with the interview, reaching the pivotal moment when the nature of this man's relating to children becomes available for scrutiny, he continues to be unable to know his own mind in relation to this matter and the evidence for this is seen in the frequency of his references to this and his preoccupation with the 'strangeness' of his experience.

The theoretical literature (Klein 1946; Hyatt Williams 1998; Costello 2002) describes ways in which responsibility is replaced by persecutory anxiety when an individual exceeds their capacity to tolerate blame, and a mechanism by which persecutory anxiety

is aroused through the projection of destructive impulses into objects that are then experienced as external persecutory objects. Whilst this man continues to present as passive and frail, DC B consistently feels that his enquiries are hostile and dangerous. His eventual experience of the man's sudden, outwardly-expressed hostility suggests that this has been projected into him in the service of avoidance of the uncomfortable experience of getting near the truth – arousing severe persecutory anxiety in the man. Instead, the anxiety and persecutory feelings are experienced by DC B who is troubled by fear that his enquiries will hurt him – undermining his effectiveness in his task.

'The Police Officer' further illustrates the way in which projective processes can obscure the truth, preventing that which cannot be thought about or symbolised from being known. Although the victim clearly stated that his stepfather pushed him, a kind of perceptual 'fog' or 'smokescreen' is created in the interview that, despite the experience, skill and best efforts of the interviewing police officers, prevents them from exploring in minute detail the crux of the events in question and ensures that the actual truth about what happened remains obscure - as the 'moment of truth' is obscured by the 'psychological mist'. Again, hostility and aggression can be seen moving around the system and the characters concerned. It appears to arise from the suspect and his entourage who approach the encounter with overt hostility - 'upping the ante'. As in *'The Ugandan Man'*, confusion is generated from this pressure that prevents successful execution of DC B's task.

This is convincing evidence of projective processes, arising from a subject in a perverse state of mind, achieving the equally perverse aim of obscuring the truth. This colludes with defences against the persecutory anxiety arising from the possibility of being 'found out' and protects the suspect not only from detection but from experiencing potentially overwhelming feelings of guilt and responsibility and the likely internal and external world consequences.

Costello (2002) writes of the aetiology and phenomenology of so-called 'pale criminality' (Freud 1923: 52). Having a severely punitive superego, the 'pale criminal' externalises unconscious guilt and the criminal act then serves the twofold purpose of rationalising the guilt and resolving it through punishment. Costello described Klein's (1946) thinking about the role of projective processes in the relationship between guilt, the superego and emergent criminality and the externalisation of persecutory anxiety

that is then experienced as persecution. Using such theoretical perspectives, the failure of two experienced police officers to engage in a detailed analysis of what had happened to the Police Officer's stepson at the top of the stairs can be understood as a function of these defensive processes, not coincidence or oversight: the unconscious strategies are employed within the dynamic process of the interview in the service of keeping the truth obscured, protecting the Police Officer from experiencing persecutory anxiety, underpinned by feelings of guilt and responsibility aroused by the knowledge of events in the external world.

'Z and the Smell of Alcohol' underlines the difficulties highlighted in *'The Primary Task'* and *'First Amongst Equals'*. It depicts an extraordinary situation as Ms A is faced with a member of her team attending work whilst apparently under the influence of alcohol. There is something implicitly perverse about a member of staff using substances, changing reality and attending work in an altered state of mind – arguably presenting a clinical need in a reversal of roles. Ms A is observed to find it impossible to maintain her role and pursue her task as a manager - i.e. to engage Z in constructive discussions about his alcohol abuse, related performance deficits, the impact on the team and the associated risks. The opportunities she has to do this and the available supports are clear and her inability to engage with this reality, despite the evidence of her own senses, is extraordinary in its persistence. Again, hostility and aggression visibly move around the system and the entire team 'turn a blind eye' to their colleague's presentation and behaviour. Just as the 'moment of truth' is obscured for DC B in *'The Police Officer'*, so Ms A finds it impossible to 'take the bull by the horns' and challenge her staff member: the issue of his intoxication is continually sidestepped. The outcome is that she colludes with a denial of reality with the possibility of dangerous consequences.

Ms A's fears about the remainder of the team supporting Z, and her inability to engage with the reality of his substance misuse are indicative of her state of mind in relation to her role as a leader and holder of legitimate authority, similar to Steiner's (1993) description of so-called 'psychic retreats' - a perverse form of defence between the psychotic and neurotic in which the subject has a particular, compromised, relationship to reality. He described pathological splitting resulting in fragmentation of the ego and its projection into a constellation of part-objects that offered a type of fraudulent or perverse containment, sometimes configured into a kind of 'Mafia gang'. The perverse

aspect to the retreat feels very similar to Ms A's relentless inability, and that of those around her, to see and acknowledge in Z what was abundantly clear. Their persistent and collective failure to do so, even when presented with evidence in an unambiguous way, elevates this to evidence of an attack on reality and the capacity to think objectively in which the fabric of reality can be seen to break down. The sado-masochistic object relationships and the configuration of the 'Mafia gang' resonate with Ms A's apparently fearful relationship to the rest of her team and their relationships to each other – Z included. This relationship to the 'gang' undermines Ms A's capacity to maintain a boundaried role in which she can confidently and appropriately use authority that was also demonstrated in *'First Amongst Equals'*.

If the relationship to reality between manager and practitioner can be thus eroded, with the potential for dangerous consequences, it must be assumed the relationship to reality between staff and patients is equally fragile, resulting in vulnerability and the potential for critical incidents.

'Supervision: protective or perverse?' - 'Supervision used perversely' shows Ms A's approach to engaging with supervision, illustrating challenges to roles and boundaries from the outset and attacks on the potential for me to be helpful seen in her persistent talking and rivalrous themes. The example links to *'Z and the Smell of Alcohol'*, clearly showing the potential danger of a model of parallel processes of clinical and management supervision. When faced with the need to address performance issues in relation to her team, her decision to consult is ostensibly logical. However, Ms A acts in avoidance of the organisationally-sanctioned course of action clearly-defined by her manager. In conflict with that expectation, she chooses to consult her clinical supervisor rather than her line manager as directed. In doing so Ms A leaves herself vulnerable; her clinical supervisor has no accountability or responsibility for her work but gives advice that she follows although it directly contradicts the direction she has had from her manager. Her resulting inaction perpetuates a potentially dangerous situation compounding a collective denial of the reality of the danger. Her decision prevents me from being helpful and results in her acting outside of the legitimate organisational framework of governance and accountability. It is therefore a dangerous decision.

This vignette also illustrates the way in which a split between the two components of the primary task can be compounded by being held separately within the structural processes established for its management.

'Supervision: protective or perverse?' - 'Supervision used protectively' begins by clearly showing a projective process evident in Mr C's experience of countertransference. Then we see how his patient, Ms 4, effectively seduced Mr C into a dangerous position. From the hopelessness of her offence, she created the idealised false hope of her illusory initial compliance then coaxed Mr C out of his therapeutic space and into her environment in which she made the perverse suggestion of their role-reversal role-play as the beginning of her assault. When Mr C resisted and reinforced the reality of their correct and actual roles, Ms 4 tortured him in a way that was palpably horrific in his account to me. The protective process was underpinned by my own clinical supervision during which I was able to think about Ms 4's likely infantile experiences of psychic torture and her re-enactment of this in her relationships with others. I could conceptualise the danger should Mr C become caught in a psychotic transference within a relationship with someone so dangerous. The process of linking up Mr C's thoughts increased his capacity to be able to think about hitherto unthinkable things. He had an experience that two difficult, shocking things could come together in his mind and be shared with me without a catastrophic outcome. This created a more constructive space and established a greater possibility of us pursuing other challenges together. During this process he was enabled to think more deeply about what part of him might be available to link up with whatever part of Ms 4 that was seeking re-enactment. Therefore, Mr C could think with greater depth and clarity about just how dangerous this woman might be generally, and to him in particular.

'The Impact' demonstrates the presence of "toxic emotional processes" (DoH 1999a: 4.4.23) - something literally poisonous in the unconscious dynamics that cannot be thought about, symbolised or consciously known.

Over time, various aspects of the material indicated that DC B had a really concrete experience of his work invading him such that he retrospectively found it hard to separate this experience from the physical illness that he firmly believed could have been fatal. It was possible to chart his defensive behaviour alongside his withdrawal from the consultations and his increasing preoccupations with the unpleasantness of his

task. DC B's organisation had no structure within which to constructively think about such things other than a group 'counselling' process that seemed to serve a defensive function. Thus the only way to escape and process what 'gets into' staff is to withdraw through illness – physical, psychological or both.

Through DC B's material we can clearly see the way in which knowledge of the truth could be experienced as catastrophic. It has been suggested to me that the process of consultations during the research may have provided a level of reflexivity sufficient to undermine DC B's avoidant defences, rendering them ineffective, bringing painful realities into conscious thought and enabling his breakdown and withdrawal from this area of work. Ultimately, I find it difficult to know.

'The Neglected Baby' - attached as Appendix 5 – in the same way, demonstrates the impact on DC B of toxic processes, so unpalatable as to be impossible to symbolise. This is a specific example of the larger process that can be seen in *'The Impact'* to lead to the breakdown of his defences and his health.

'The Ambiguous Message' – attached as Appendix 6 – shows how Ms A's patient's projected inability to symbolise, loaded with uncertainty and confusion in relation to his experience of gender roles, reflected in his stereotypical descriptions, triggers a response from her in relation to her gender that is concretely wrong in external reality that she 'corrects' into a confused and *"ambiguous message"*. This clearly shows boundary disturbances enabling sexualised content of the clinical material to be uncontained and arouse anxiety. It is under the pressure of this anxiety, and the projected confusion of the patient who is unable to symbolise, that Ms A makes the almost psychotic assertion that she is a man – her 'correction' adding confusion ('ambiguity') not clarity and echoing her disclosure to me about her sexuality.

In all examples, I have explored the possible 'surface' explanations and I am confident that it is reasonable to conclude that there is a direct and defensive link between the observable phenomena and the psychopathologies of the patients. All are visible demonstrations of mechanisms associated with perverse states of mind and all have the net effect of ensuring that the offenders/patients are not fully, if at all, engaged in a thoughtful exploration of reality. In isolation, no single vignette can conclusively be held as evidence of pressure on thinking arising from the psychological proximity of

perverse states of mind. However, just as within each vignette the combination and intensity of factors gives substance to the interpretations I have offered, likewise it is the interplay between the vignettes and the availability of a number of examples that gives the consistency necessary to elevate the status of these findings from observation to evidence. I believe that the whole is greater than the sum of the parts, and that this interplay satisfies the requirements of the *Gestalt*.

> **The psychological realism that I am arguing for would also imply that any project to transform welfare would have to recognise our fear of difference and our need to distance ourselves from the mad, bad, dangerous, profane and dirty parts of our own subjectivity (split off and externalized in asylums, hostels, residential homes, sink estates and so on). (Hoggett 2000: 15)**

Chapter 6: Conclusion: "Thinking: that is the enemy." (Chasseguet-Smirgel 1985: 120)

I have shown that unconscious processes can be **seen** to put pressure on the most competent of professionals, which undermines their capacity to think and maintain a role in the pursuit of the primary task, with the outcome of obscuring the truth. In the settings I have studied, the potential outcomes of compromised clinical or professional performance may be highly dangerous. However, the essence of the study – the foregrounding of moments of compromise - is as universal as the anxiety that underlies the process and the selection of demonstrably 'ordinary decent' participants in the research underlines the applicability of the findings.

Supervision: clinical reflection or management tool?

There was much reference in the Fallon Report (DoH 1999a) to unwieldy management systems, confused arrangements for professional and managerial accountability and "considerable debate about the existence and position of the interface between professional and operational accountability" (DoH 1999a: 2.9.8). This was considered to be a key factor in professionals losing sight of their roles and duties, summarised in the extraordinary assertion of the Head of Social Work that his "…was an expertise in adult forensic mental health; no one ever indicated to him he had a responsibility for child protection issues as well" (DoH 1999a: 3.25.7).

Systems of clinical governance and professional self-regulation have developed a trend for clinical supervision to be delivered within discipline, but not always within the structure of direct line management. The model features two parallel processes of supervision – managerial and clinical: the former holds accountability, whilst the latter is reflective space. The outcome is to hold these two functions of supervision separately - effectively maintaining a split ("clearly distinguished and kept separate, wherever possible, from any line management or other responsibilities, duties or tasks" BPS 2008). According to Fallon: "complex interprofessional relationships are inevitable... It is possible to distinguish between professional accountability to a senior colleague and

managerial accountability to a manager in another discipline", whilst also recognising that "when arrangements like this are in play clarity is crucial" (DoH 1999a: 5.1.21). In their work on models of social work supervision, Hughes & Pengelly (1997) (citing Kadushin 1976 and Mattison 1981) consider processes such as peer supervision and consultancy that are split from managerial processes, highlighting the risk of blurred boundaries relating to responsibility and accountability, and of such processes "disintegrating into secretiveness, fragmentation and unsafe practice if the question of accountability is not confronted in the contract-setting" (1997: 56).

I suggest that, where the primary task being managed is a clinical process, then it is an important function of management that the quality as well as the quantity of clinical output is the subject of a reflective and accountable process. Splitting off this function into a separate process may have the advantage of 'protecting' a reflective space in which to achieve clinical sophistication and support professional self-regulation. However, unless responsibility is clear and a means of communication is available, the split and separation of these processes risks leaving vital information in relation to competence unavailable to the formal organisational processes of accountability and governance. A further hazard is a 'muddle' developing in relation to which material is the proper business of which domain of supervision. This supports the possibility of using the processes in a perverse way by:

1. enabling the material that arouses the most anxiety to be absent from the appropriate domain to which it belongs yet seemingly 'contained' in the inappropriate domain;
2. therefore limiting the capacity for the appropriate domain of supervision to be functional and helpful;
3. and not enabling the inappropriate domain to be helpful as inappropriate material is filling the space;
4. and the material arousing the most anxiety is falsely held to have been contained.

Accordingly the model carries significant risk.

Structure and process

There are two, not mutually incompatible, ways of thinking about the pressures I have demonstrated:

1. Projective processes arising from the specific patient group are exceptional and exceptionally potent because of the particularly concentrated population of patients in perverse states of mind. Therefore the staff's adoption of practices that defend against overwhelming anxieties aroused by the task will be severe and extreme.

2. The processes (projection and defences) are actually universal, resulting in fairly standard challenges and performance issues. The difference is that, because of the nature of the patient population and their capacities for dangerous behaviour, the potential consequences of the breakdown in the relationship to reality and authority are more extreme and severe. What are needed are ordinary but robust management systems for containing this.

Although the position I have taken in relation to understanding the organisation is closest to the first point, my actual management approach was more akin to the second. It appeared from the Fallon Report that the solution to the emergence of critical incidents or failures in containment was the establishment of ever more complex and rigid, yet paradoxically counterproductive, systems of management that "did not facilitate or support good patient care" (DoH 1999a: 5.1.21).

I have suggested in this thesis that the defensive behaviours observed can largely be understood as defending against the anxiety aroused by **fear**, whether it be the "prudential fear" (Cox 1996: 205) of the reality of the patients' violence/sexual violence and murderousness, or of identification with the patients' sadism and abusiveness and projected hopelessness – experienced as a kind of 'therapeutic nihilism'. In these kinds of settings, rigidly-held defences may be a necessary protection against consciously experiencing such fears. In simple terms, I have observed the need for frontline staff to distance themselves from knowing about the very distinctive, perverse, gratuitous violence committed by such patients in order to be able to set aside the anxiety aroused by the possibility that anyone – including themselves - might be capable of such acts

and manage the banalities of day-to-day institutional co-existence. Accordingly, the 'unspeakable' becomes the 'unthinkable'. This is confirmed in a study of positive therapeutic attitudes in nurses in DSPD services by Bowers (2002) who found that "the main way nurses had of dealing with the thoughts, preoccupations and emotions triggered by the index offence was by simply not thinking about it" (2002: 68). But when defences are persistently too fixed, they become problematic, undermining the performance of the primary task overall – and in crucial areas such as risk assessment. Supervision has a vital role to play in trying to ensure the movement between defensive and on-task behaviours, particularly through thoughtful consideration of processes arising within the relationship between patient and worker/therapist. If this capacity is not built in to the management supervision process, the danger is that the establishment of ever more prescriptive managerial structures merely compounds the rigidity of a framework to be opposed. Further, unable to reflect on the processes of their work and the negative affects aroused, professional engagement becomes perverse as staff are unable to contain these patients and instead enact their thoughtless and depriving early emotional experiences.

The Fallon Report described many instances of a lack of clarity in the status of policy and procedures at various levels of the organisation and the relative autonomy of the sub-systems within the whole. This is re-enacted in the wider policy context that reflects the symbolic task these hospitals hold as containers for social anxiety and fear. Surely what is required are sensible systems and processes that are grounded in the primary task and thoughtful about the actual needs and prognoses of the patients in terms of clinical treatment and the reduction of risk - i.e. organisational processes that are capable of withstanding the susceptibility of critical breakdowns in the relationship to reality and authority in the interests of protecting the public. In this respect, although I do believe that the nature of these particular patients and the underlying associated fears lends a particular potency to their projections and related anxieties, I also hold that such processes are universal and that therefore the findings of this research have relevance and applicability to other mental health and social work contexts.

Future thoughts

Dr Obholzer (DoH 1999a: 4.4.23) emphasised the need to understand the "toxic emotional processes" arising from the co-existence of 'embodied' patients and

professionals so pertinently illustrated in the Kaye and Franey (1998) quotation above. Whilst it is naïve to suggest that processes of public enquiry should delve deeper under the surface at the expense of concrete, measurable recommendations, I think it is reasonable that, rather than confine depth of clinical knowledge to 'clinical supervision', it might be important for managers to better understand the relationship between clinical processes and operational processes such as the pursuit of the primary task. I do not posit here that a psychodynamic paradigm provides an operational framework of 'solutions', rather that there are interesting questions to be asked about the qualities, knowledge and experience of managers in these contexts – and the level of sophistication that might be required to manage such intensely psychologically complex encounters. I hold that it is essential that managerial processes can explore and identify emerging enactments and that staff employed in this context are able to maintain a sufficient level of psychological maturity to bear challenges to their defences.

Similarly, I suggest reflection on the nature of leadership. Fallon described "clearly focused professional and managerial leadership... submerged in the treacle" (DoH 1999a: 2.8.22) and the absence of strong clinical leadership was a recurring theme. Specific study of styles of leadership in the context, and the parallels with leadership in other high-risk organisations and settings would be of great benefit.

Further reflection on the nature of the primary task in such settings would be helpful. Specifically ways of achieving integration of the two components of the primary task described by the Department of Health – security and therapy – within the context of the third component that I have suggested: the symbolic function of the high secure hospitals to contain monstrous, murderous and perverse impulses in phantasy and reality on behalf of society. Such reflection should be grounded in the reality that there are no certainties in either the efficacy of treatment or the reduction of risk – beyond the concrete presence of the wall. If the third component of the primary task is to contain social projections, the interplay between these institutions, their staff and patients, the community and society at large will always be complex. With thought, it may be possible for social policy to sanction approaches to such patients and their complexities without objectifying them as meriting only rigorous confinement and for professionals to practice reflexively rather than defensively, as if themselves experiencing a punitive detention subject to perverse projective processes.

The selection of a police officer as a participant was essentially in order to gain access to the processes of interest to me without any prior theorising or 'processing' by the clinician concerned. Within the scope of this project, I have not had the opportunity to fully explore the organisational issues in his context as I would have liked to do. The outcome of this process has raised interesting questions for me about the nature of management in the police service, the approach to staff support and their experience of fear and anxiety that would greatly benefit from further thoughtful research.

The process of this research mirrored my findings in that it has been a long struggle with uncertainty and of allowing myself the discomfort of being emotionally available to the dynamic experience in order to find something out – perhaps even something I would have preferred not to know. Thus I too needed to question how much knowledge I could bear of reality. I would hope to contribute further to the methodological literature in relation to this kind of qualitative research as a means of accessing the real experiences of professionals who are working in fear.

Postscript

> **If we look into the murky depths of the mirror of PD, we may eventually see a shadowy reflection of ourselves, of how we may behave when under stress and pressure; or we may see the tendencies we hold towards PD traits and the motifs from the symphony of PD that are echoed in our own lives. In learning, we may also have the chance to learn about ourselves, and discover what we have in common with those incarcerated in the High Security Hospitals. Then, perhaps, we may be prepared, if only in part, to be merciful to ourselves and to others. (Bowers 2002: 160)**

> In the latter half of the nineteenth century, so the story goes, a man escaped from detention in one of the Special Hospitals and successfully emigrated to Australia. Many years later, as an elderly man, he returned to the hospital and surrendered himself at the gate as an escapee. Such time had elapsed that the staff had changed, did not recognise the man, and initially disbelieved his story of escape. Retired colleagues were called upon to identify the former patient who was duly readmitted and eventually died whilst still detained. It is the only successfully completed escape (without recapture) in the history of that hospital. (Deacon 2004: 95)

I have referred to the way in which my changing role within the organisation reshaped my focus on different aspects of the research data and the continual tension I experienced managing the boundary around myself in the psycho-social field that made it hard to find a balance between necessary reflexivity and inappropriate self-disclosure. Through this process, my career developed in regular stages from social work management to my role as an operations manager within the high secure hospital that has largely been the focus of this study and I was eventually situated a step removed from clinical relationships and a step closer to the kinds of potentially coercive structural processes in place to manage risk. As I became more directly responsible for managing critical incidents and their outcomes, I was correspondingly more directive in my management style. Retrospectively, I can see that as my anxiety increased, so my need to establish systems and processes to keep people safe often overtook my availability for reflection – although the one consistent message given to me when I left the institution was that I had been able to make people feel safe.

I raise this as I have questioned whether and why what I have found is important. I have no doubt that I have shown a link between professional performance and interpersonal clinical processes. However, there is a perspective that suggests that if such phenomena defend against anxiety, there may be times at which such defences are necessary to the performance of tasks in settings in which such anxieties are rooted in

the reality of danger. Similarly, I cannot present findings with clear outcomes attached as my experience in the setting has been that there are no absolute safeguards that are completely protective against forces that mobilise the aspects within workers that are available to enactments. The Fallon Report succinctly and insightfully summarised this as the impact on the team's capacity to hold in mind the reality of what they heard about events at Ashworth Hospital, reframing the level of denial and attack on thought as a desensitising type of conditioning, raising the question of how much reality can we really bear to know:

> We ourselves have pondered as we listened to days and days of such evidence whether we had become case-hardened to the horrors of what happened at Ashworth and the risks to which Child A was exposed. In reviewing what we have written we are not convinced that we have fully captured the awfulness of it all. (DoH 1999a: 3.23.44)

Writing about the function of supervision in forensic settings, Cox (1996: 216) described the unsettling impact on therapists of contact with disturbing material, and the impact on their performance of anxiety or "foreboding" when "there is a matching resonance in terms of that which is, at best, disturbing, and, at worst, intolerable" (1996: 216). He suggested that it "is important that…the fundamental existential question is raised: 'What do you do when there is nothing you can do?'". I have not definitively answered that "fundamental existential question" and can only suggest that the activity of thinking and reflexivity is as important to managers working in psychologically complex settings as it is to clinicians as it is only by having the courage to see and engage with painful reality that we can acknowledge feelings such as hopelessness and fear and be creative agents of change.

As I finish writing this thesis, I have not worked in a forensic setting for over a year. Just like a process of public enquiry, I have therefore been able to approach my concluding thoughts not only with the privilege of hindsight, but having had the experience of 'readjusting' to working in the community where I now manage a portfolio of NHS mental health services. The transition to my current position outside of the boundary enabled me to more clearly see not only my own 'embodiment', but the insularity of an organisation containing society's projected fears. I had well-established roots in clinical social work and continue to apply a psychodynamic framework to a discipline of thinking as I develop as an operational manager of clinical services. Accordingly, I am increasingly confident that the processes I have illuminated are

indeed universal although the chosen setting provided a ‘concentrated’ field in which to study them.

In twenty years in social work, I have experienced shifting trends in policy that ever struggle on the boundary of the ‘least restrictive option’ and the social context continues to develop. It may be argued that 9:11 has altered the social focus of scapegoating to some extent; however the impact on social policy of competition, rivalry, division and fear arising from the deepening economic recession remains to be seen.

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Appendix 1: Participants' consent

Re: Consent to Participate in Research for Professional Doctorate in Social Work

"From perversion to policy: knowing and not-knowing in the emergence and management of critical incidents"

I confirm my consent to participate in the above research project.

I understand that this is doctoral research being conducted by Jude Deacon under the supervision of Andrew Cooper, Professor of Social Work, Tavistock and Portman NHS Trust and that the project will be undertaken within the requisite ethical framework.

I understand that aspects of the project are likely to be published and that confidentiality will be appropriately maintained.

The fieldwork for the project is likely to last approximately 6 months during which time I will receive clinical supervision from Jude Deacon, for one hour, every 2 weeks. There will be no financial charge for this supervision for the duration of the fieldwork.

This confirms my current consent to participation. I understand that I may withdraw from the project, at any time, without notice.

Signature:

Print name:

Date:

UNIVERSITY OF EAST LONDON - Consent to participate in a Doctoral research project

"From perversion to policy: knowing and not-knowing in the emergence and management of critical incidents"

I have read the information leaflet relating to the above programme of research in which I have been asked to participate and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researchers involved in the study will have access to the data. It has been explained to me what will happen to the data once the research has been completed.

I hereby fully and freely consent to participate in the study which has been fully explained to me.

Having given this consent I understand that I have the right to withdraw from the programme at any time without disadvantage to myself and without being obliged to give any reason.

Participant's name (BLOCK CAPITALS):

Participant's signature:

Researcher's name:

Researcher's signature:

Date:

UNIVERSITY OF EAST LONDON/TAVISTOCK CLINIC

Base for the research

The Tavistock Clinic
120 Belsize Lane
London
NW3 5BA

University Research Ethics Committee

If you have any queries regarding the conduct of the programme in which you are being asked to participate please contact the Secretary of the University Research Ethics Committee: Ms S Thorne, Administrative Officer for Research, Graduate School, University of East London, Romford Rd, Stratford, E15 4LZ, (telephone 0208 223 6274 e-mail s.r.c.thorne@uel.ac.uk)

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The research project will be conducted by Jude Deacon for the academic award of Professional Doctorate in Social Work.

Consent to participate in a research study

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in this study.

Project title

"From perversion to policy: knowing and not-knowing in the emergence and management of critical incidents."

Project description

The project has the general aim of achieving a greater understanding of the relationship between the experiences of individuals working clinically or professionally with dangerous people, the organisational dynamics that may contain or fail to contain dangerousness, and the impact of these dynamics on policy formation with particular reference to 'critical incidents'.

The project relies on a suggestion that there are powerful psychological processes that arise from the interpersonal relationship between the professional and the client group, that impact on professionals without them knowing. Such processes can undermine the practitioner's capacity to think clearly, and may influence their practice in a largely unseen way by 'nudging' them out of role and into actions that may be less than ideal and may lead to apparently inexplicable or unintended events and consequences. Accordingly, such processes may contribute to deficits in practice and eventual developments in policy.

It is assumed that such processes have the potential to affect all – even the most experienced professionals – and the organisational structures within which they operate. The aim of the project is to attempt to study these processes and show them happening.

Proposed participants are experienced practitioners who have been engaged with the researcher in a process of professional consultation or clinical supervision in which they have been invited to think about their experiences and processes of their work in a reflective way. Such meetings have been unstructured, without an agenda, with the practitioner offering the subject matter and content. These meetings have been recorded by the researcher in notes written from memory immediately afterwards. There has been no focused research question as such within these meetings – the aim being to look at the practitioners' descriptions of their work in their own way. The material therefore

reflects what it is that the practitioners have experienced as important about their working practice.

The aim of the project is to consider this material with a view to showing how psychological processes can impact on professionals and the institutional structures within which we work. This will be achieved by nothing more than an examination of the retrospective notes looking for evidence of psychological processes and using a theoretical framework to assist the process. This material will be used to support a similar process of scrutiny of the *Report of the committee of the inquiry into the Personality Disorder Unit, Ashworth Special Hospital* (DoH 1999a). This text is the report of the public enquiry into untoward events within the Personality Disorder Unit at Ashworth Hospital. Therefore it will be possible to study a documented untoward event in the context of day-to-day material provided by professionals working with a similar client group.

There is no other expectation of participants. It is important to note that this is essentially a theoretical study supported by some original data. It is not the practitioners themselves nor the quality of the practice that are the subject of the research, but the evidence of psychological processes flowing from one part of a system to another.

The material will be presented to the University of East London in a 40,000 word thesis to be examined for the academic award of Professional Doctorate in Social Work.

Confidentiality of the data

No data will be stored at any time that can identify the participants. The notes of meetings have been anonymised at the time of writing. Anonymised material may be shared in the researcher's supervision and with the Principal Investigator. Participants will not be identifiable.

Remuneration

There has and will be no payment to proposed participants.

Location

The data has been gathered at proposed participants' regular places of work. Data analysis will be supervised at the Tavistock Clinic as above.

Disclaimer

You are not obliged to take part in this study, and are free to withdraw at any time during the tests. Should you choose to withdraw from the programme you may do so without disadvantage to yourself and without any obligation to give a reason.

Appendix 2: DC B – Table of attendance

Date of meeting	Attended? Or cancelled? By whom?	Approx gap between meetings
08/02/05	Yes.	1st meeting.
21/02/05	Yes.	2 weeks.
08/03/05	No – no apologies sent. DC B on course but off sick. He has forgotten.	
30/03/05	Yes.	5 weeks.
15/04/05	Yes.	2 weeks.
26/04/05	Yes.	2 weeks.
10/05/05	No – DC B cancels on day.	
31/05/05	No – DC B cancels on day.	
17/06/05	Yes.	7 weeks.
28/06/05	No – DC B cancels by SMS on the previous day.	
26/07/05	Yes.	6 weeks.
23/08/05	No – cancelled by DC B.	
13/09/05	No – cancelled by me.	
20/09/05	No – cancelled by DC B.	
06/12/05	Yes.	Just under 5 months.
22/05/07	Yes.	18 months.

Appendix 3: DC B – Summary of sessions, themes & breakdown of defences

08/03/05		
None – does not attend for session.	• Ambivalence. • It's a date. I've been stood up. • Control. • Re-enactment. • He has not held me in mind – attack on thinking. • Attack on thinking (missing the session).	• Does not send his apologies – has apparently 'forgotten'. • Supposed to be on a course but was actually off sick.
30/03/05 – 5 weeks since last meeting.		
The Schoolteacher. The Foster Carer.	• It's a date. • Fairytale transformations. • Knowing and not-knowing. • The nature of the truth. • Homoerotic libidinous processes. • Re-enactments. • Boundaries. • Roles & identifications. • Countertransference. • Difficulty getting to the sexual content. • Truth/deception. • Being 'nudged' out of kilter – doing something he would not ordinarily do.	• Enjoys interviewing The Schoolteacher and clearly maintains capacity to detach and think despite efforts to 'wrong foot' him. • Does not enjoy the interview with The Foster Carer. Has been 'nudged' out of kilter. Finds himself wrong footed and doing something he would not ordinarily do.
15/04/05 – 2 weeks since last meeting.		
The Texting Woman. The Foster Carer. The Police Officer. The Abusive Family.	• Libidinous. Pervading sexual undertones. • Boundaries (session start time/texting woman). • Anxiety moving around the system. • What is B's experience of the relationships: his countertransference and the projections of those he interviews? He knows at times there is something strange going on in the interviews. • Defensiveness – preventing him asking the difficult questions. Truth/deception. • Model that to get at the truth could be fatally damaging. Aggression/destructiveness moving around the system. • Roles and tasks. E.g. split between Police and SSD. Him and the Police Officer. • Pressure on thinking. He doesn't know what to think. • Confusion. • My countertransference. • Feeling unhelpful. • His role/identification as a father. • Aggression moving around the system. • Use of authority.	• The Police Officer and The Foster Carer – two examples of being prevented from getting at the nitty gritty. • The Police Officer – we can see that he is nearly provoked into aggressive enactment but holds himself together.
26/04/05 – 2 weeks since last meeting		
The Foster Carer. The Schoolteacher. (The Ugandan Man.)	• Attacks on thinking – 'nodding off' in chair. • His countertransference – being bored with the schoolteacher's interview, nodding off. • My countertransference: difficult to be helpful. • Deception. Engaging with different realities. • Roles/split – Police/SSD. • Splitting. • His experience of the interviewees. • Aggression moving around the system – the caution. • My countertransference – feeling punitive towards the schoolteacher. As had B. • Truth. • Truth v evidence. • Authority.	• Some evidence of him being nudged into a punitive enactment with The Schoolteacher in delivering the caution. • **Enjoys** it.

10/05/05		
None – he does not attend the session.	• Boundaries. • Breaking down (car). • Attack on thinking (missing the session). • It's a date – I've been stood up. • Ambivalence.	• I disrupt the session time/date boundary. • B eventually cancels on the day – his car breaks down.
31/05/05		
None – he does not attend the session.	• Boundaries. • Attack on thinking (missing the session). • It's a date – I've been stood up. • Ambivalence.	• He cancels one hour before the consultation. • He tells me that he has been on a 2 week course in interviewing child victims.
17/06/05 – 7 weeks since last meeting.		
The Ugandan Man. Uncle L. The Search for the Truth.	• It's a date. • Fairytales – fantasy, reality, role play. • Victims/perpetrator splits. • Libidinous about work. Excited. • My countertransference – my mind wanders and I find it difficult to listen and remember. • Re-enactments – interviewing victims/grooming. • His relationships with interviewees. • The search for the truth. • Reality/things that change reality. • Attacks on thinking. • His countertransference. Struggling to have his own independent thoughts separate to the Ugandan man. • Confusion. Paradox. • Violence as a means of controlling object in external world. Projection as a means of controlling object in internal world. • Identification/difference. Interviewer/interviewee. • My countertransference – feeling unhelpful. • His capacity to hold me in mind. Thinking. • His identification with the role of a father. • Aggression moving around the system. • Struggling to maintain his defences – breaking down. • Authority	• He describes the course in interviewing victims and appears excited about work. • There is **clear** evidence of him being pushed out of kilter by the Ugandan Man. He has a very powerful experience of the force of this man's position.
28/06/05		
None – he does not attend the session.	• Boundaries. • Attack on thinking (missing the session). • Defensive avoidance – use of SMS rather than phone call. • It's a date and I'm stood up. • Ambivalence.	• He cancels the day before the consultation. • By SMS – does not even speak with me. • No alternative suggested.
26/07/05 – 6 weeks since last meeting.		
The Neglected Baby. The Woman who Couldn't Talk About it. The Texting Woman. Uncle L. The Abusive Family. The Impact.	• Things 'getting on top' of him. Breaking down. • Impact of his work. • My role as a transference object. • Roles in general and boundaries. • What can or can't be held in mind. • Protective factors – space/time to talk/think about work/how he is looked after. • Quantity of work overwhelming the capacity to reflect on the distressing quality of the nature of the work. Attack on thinking. • Something toxic poisoning him. What he hears is indigestible. Poisons him and makes him ill. Like the baby eating its own faeces. Re-enactment.	• **Things getting on top of B is the dominant theme of the session.** • Real sense of something getting in to him. • He has been ill. • He talks about the overwhelming volume of the work. • He talks about protective factors – sources of support. • He talks of being overwhelmed by the 'enormity' of what happens in his work and the enormity 'hitting' him. • He talks about anxiety being raised. • He expresses fears about his own children.

26/07/05 (continued)		
	• His role/identification as a father. • Victim/perpetrator interviews. Splitting. • My countertransference feelings of being overwhelmed. • The task – is it about a search for the truth? Or is it about finding evidence? And are they the same? • The truth. • Thinking and not-thinking as a defence against anxiety. 'Getting used' to it. • Authority.	
23/08/05		
None – he does not attend the session.	• Boundaries. • Attack on thinking (missing the session). • It's a date – I've been stood up. • Ambivalence	• Session has been arranged at last session – 27/07/05. • Session cancelled by B.
13/09/05		
None session cancelled.	• Boundaries	• Session has been arranged at last session – 27/07/05. • Session cancelled by me – initially to attend data analysis day at Tavistock but I was also off sick.
20/09/05		
None – he does not attend the session.	• Boundaries. • Attack on thinking (missing the session). • It's a date – I've been stood up. • Ambivalence.	• Session has been arranged at last session – 27/07/05. • B cancels – is on a course.
06/12/05 – just under 5 months since last meeting.		
Uncle L. The Moroccan Boy. The Couple. The Scout Camp. The Impact.	• Truth v evidence. • Impact of the work – increasing sense of the capacity to damage. Even to talk about it can be damaging/abusive. Aggression moving around the system. • Breaking down. Needing to physically separate from work. • Impact of the work. 'Bitch'. • His identity/role both personal (father) and professional. • Denials of reality. • Attacks on thinking. • Managing feelings about the work – protective or containing factors. • Potency/libido: when is it legitimate and when is it perverse? • Splitting. • Roles and tasks. • Boundaries. • Crying. Unconscious links between his work and domestic life. Breaking down. Boundaries. • Being moved – the powerful moment in the interview. Impact of work. • Countertransference. • Authority.	• Again the impact of the work on B is a dominant theme in the session. • He has developed a level of cynicism – the child in the Uncle L vignette. • He talks about something he dreaded happening. • He cries in response to something said by a colleague – 'bitch'. • Then he gets a job 'that really did make me cry'. • He talks about watching video evidence with his Sgt and the way they have to stop at intervals because it is so distressing. • Talks about a sense of anger and outrage at the actions of the male half of The Couple. • Goes home to his own children and is moved to tears by the appropriate demonstration of affection of his son. • We are both moved – there is a powerful moment in the interview. • He feels he'd 'had enough' & 'couldn't take any more' – couldn't bear to hear any more. • He has to get away. Goes away. Surfing. • He is thoughtful about his professional identity – what kind of police officer is he? • Talks about protective factors again – to whom he can talk to get support. • Tells a story about a colleague whose partner asked her not to talk to him about the distressing aspects of her work.

22/05/07 – 18 months since last meeting.		
The Couple. The Impact. The Moroccan Boy.	• The impact of the work on him. Life-threatening illness. • The symmetry of his internal and external worlds being damaged. Breaking down. • My role as a transference object. He states he found me helpful in contrast to my previous countertransference experiences of being unhelpful. • Attacks on thinking. • Protective factors – 'counselling'. • Damage to him – aggression moving around the system. • Living with uncertainty. Knowing & not-knowing. Thinking. • Concrete v fluid. Defences against anxiety. • Boundaries. • 'Facts' as opposed to 'truth' or 'evidence'. • His countertransference experiences of the relationships with the suspects/interviewees. • His role/identity as a father	• He has lapsed contact with me and has not been returning my messages. • The impact of the work on B is the central theme of the session. • His defences have completely broken down. • He can identify a sudden moment in court when it struck him that he didn't 'want to hear these things any more'. • He has been physically ill and off sick with a potentially life-threatening condition that is also known to be associated with stress. • He recognised an emotional component. • He has had to stop working in the child protection team. • He recalls the sense of 'needing to get away' from the child protection team. • He reflects on the impact on his home and family life – his fears for and over-protectiveness of his children. • He refers to 2 female colleagues off sick with stress. • He identifies that his current post does not require him to engage with people. • He wonders whether there is a link between his physical illness and his experiences at work. • He talks about protective factors – who has been available to speak to him – staff support 'counselling' – not being successful. • Talks about things he just didn't want to hear and of the ways he had developed of ensuring he didn't hear. • Talks very explicitly of being damaged by his work. • 'Losing the balance' in his life. • Compulsive exercising to 'get something out of his system'. • Losing his capacity to enjoy anything. • Has been to Occupational Health. • Has been to 'counselling'. • Is in a position of 'not-knowing'

> **PD patients look the same, talk the same, and in many if not most situations act the same. Yet regularly and periodically they act in ways that demonstrate that they inhabit an entirely different psychological and social world, one where our normal rules for understanding and morally judging behaviour simply do not count. Unlike those who suffer from psychoses, they largely do not have strange beliefs, nor do they hallucinate, hear voices or become disorganised and agitated in their thoughts and actions. However, their view of society and of us is just as perverse, and just as different, if not as obviously evident or visible…**
>
> **… People with a personality disorder are different. They differ in the way that they think, feel, relate to others, and contain (or fail to contain) their impulses. (Bowers 2002: 1/4)**

Appendix 4: The nature of the patients

I have, in various places, written about the particular presentation, psychopathologies and challenges of the patients detained in high secure settings. Below, reproduced from the Fallon Report, it is possible to illustrate this without any breach of confidentiality:

> Mr Daggett was born in 1960. During the early 1980s he was convicted of a number of offences including indecent assault on girls, indecent exposure and driving offences. Several of these offences were committed after he absconded from the Edenfield Centre at Prestwich Hospital, where he had been admitted under section 3 of the Mental Health Act. He was originally detained in Ashworth Hospital in 1984 under a hospital order with restrictions. He was given the legal classification of psychopathic disorder. In July 1989 he commenced a period of trial leave at the Edenfield Centre, Prestwich Hospital, from which he absconded in September the same year. He gave himself up to police and was returned to Ashworth. In July 1990 he was given a Conditional Discharge by a Mental Health Review Tribunal (against the advice of both the Home Office and the SHSA). In December the same year he was charged with criminal damage at Skipton Magistrates Court. Despite the opposition of the Crown Prosecution Service he was granted bail; he hired a car which he drove through a shop window in Doncaster. He was duly returned to Ashworth. In 1992 he confessed to an assault on a twelve year old girl in Worcester in November 1990, during the time he was conditionally discharged. The same year his RMO, Dr Strickland, applied to the Home Office requesting permission for Mr Daggett to have trips out of the Hospital with a single escort. At the time of his absconsion on 25 September 1996 he was a patient on Lawrence Ward. On that day he was on a shopping trip to Liverpool escorted by a single escort, namely, Enrolled Nurse, Mr James Corrigan. He returned to the Hospital on 8 October. (DoH 1999a: 3.1.1)
>
> By far the most serious allegations concern the possible abuse of a little girl, Child A, who over a period of years was visiting two patients on Lawrence Ward, Mr Corrigan and Mr Hemming. We feel it is important for the readers of this Report to have some impression of what sort of men these

patients were. We reproduce the graphic words of Leading Counsel to the Inquiry, Mr John Royce QC, at Knutsford:

> "The first man, Mr Peter Hemming, had a very substantial history of paedophile activity with young girls. Back in 1972 he indecently assaulted a nine year old girl and then three days later he tricked a seven year old girl and a nine year old to go with him to a secluded place, where he forced the nine year old to perform oral sex. He was sent to prison. In 1975, he impersonated a police officer and in the process persuaded a 12 year old girl to allow him to search her physically, and he fondled her genitalia in the process. In 1977 he accosted an 11 year old girl in an alley. When she resisted, he banged her head against the wall. In 1978 he enticed a 11 year old boy into a building, he threatened him with a knife, forced him to strip, he committed acts of gross indecency with him, he then tied him up and kept him until the following morning, when he repeated those acts of gross indecency with that young boy. He was sentenced to six years' imprisonment, of which he served four. Five days after his release from that prison sentence, he stopped two young girls of about nine and ten. Again he pretended to be a policeman. He enticed them to an area where they were out of sight, he made them strip at knife-point, he used tape to bind and gag the younger girl. He then forced the older girl to have oral sex with him, he then started to strangle her until she lost consciousness. He then hit her head against a concrete step. When she had recovered to some extent, he bound her with tape, and stuffed a sock in her mouth. He then forced the younger girl to have oral sex with him and when the first girl managed to escape from this terrifying ordeal, he himself fled. He was convicted of indecent assault, actual bodily harm and attempted rape. It was that offence that led him to being given a hospital order unrestricted in time and that led to him coming to Ashworth Hospital.
>
> The other man, Paul Corrigan, had a severe, serious history of abduction and buggery of young boys, and served various sentences of imprisonment. But the offence which led him in due course to come to Ashworth is breathtaking in its awfulness. In November 1981, a 13 year old newspaper boy used to make his way across a park to deliver his newspapers. Corrigan had been released from prison early that year, but in November, he saw this lad and he hatched a plot. He plotted to kidnap him, to bind him with chains, to gag him and to cover his head with darkened goggles so that he could not see where he was going, and indeed that is what he did three weeks later with the help initially of another man. He chained him, put the goggles over his head, he forced him at knife-point back to his flat. At the flat, he was subjected, that boy, to a catalogue of torture, of sexual acts, and other activity which was so foul and degrading that it was all part of the humiliating and horrific ordeal that young man had to undergo at the hands of Paul Corrigan. Eventually he was taken out into the country, where Corrigan used the knife on that boy in a way that almost defies belief. He cut off or partially cut off his genitals; he inflicted about 100 wounds upon him,

> and finally he cut open his stomach and left him in a ditch to die. The body was found by three schoolboys the next day".

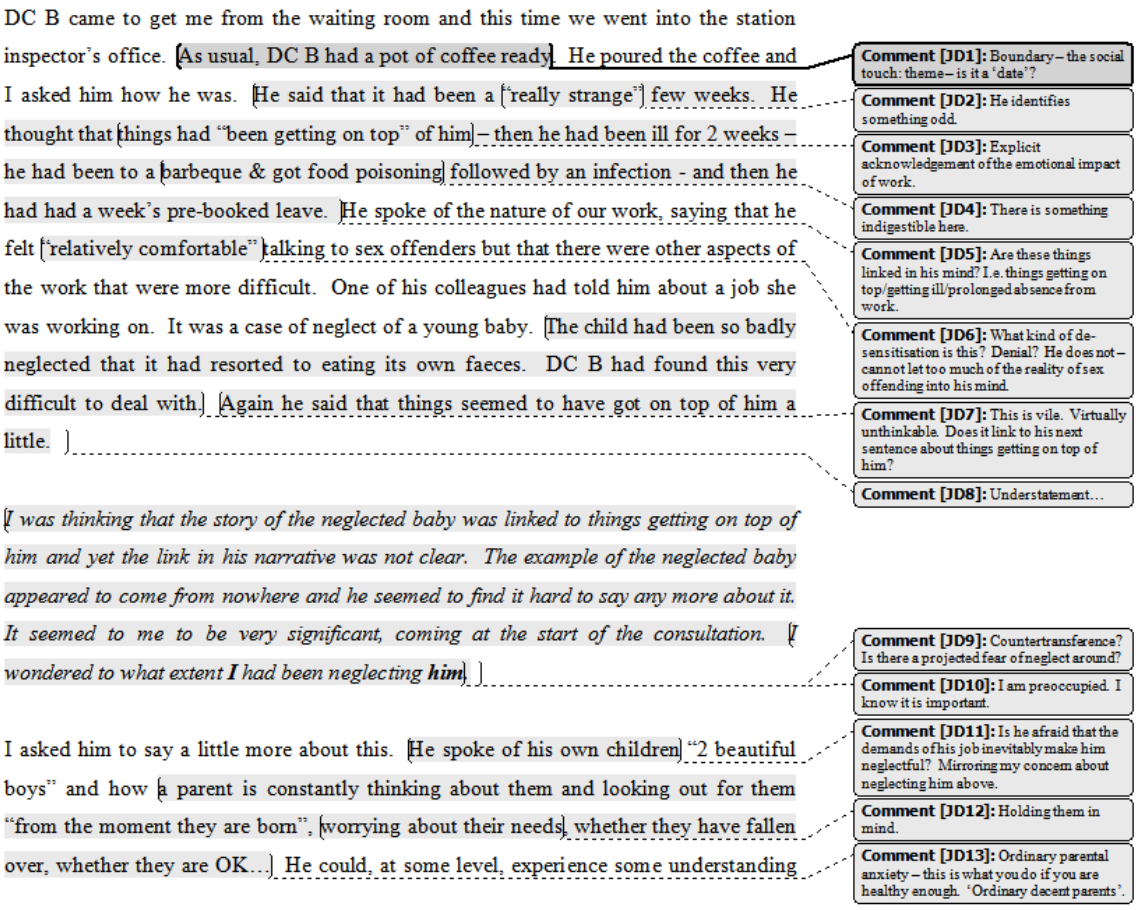
These crimes are sickening. It is against this backdrop that one must ask why this child was allowed to visit these men, frequently unsupervised, at all, let alone on any ward, but particularly on this ward housing patients with serious personality disorders, all of whom had serious criminal histories, including murder, rape and sexual assaults against children. (DoH 1999a: 3.11.2-3)

It is an indisputable fact that language fails to be a sufficiently capacious vehicle to describe ultimate experience. This is true whether it is that of religious ecstasy: 'silence heightens heaven'; or that of abject terror: 'I *was* tongue-tied and terrified'. It is logically and experientially impossible to say 'I *am* tongue-tied!' As T.S. Eliot (1957) reminds us: 'the poet is occupied with frontiers of consciousness beyond which words fail, though meanings still exist'. (Cox & Thielgaard 1997: 3, italics in original.)

Appendix 5: Methodology example - DC B: *'The Neglected Baby'*

Analysis stage 1

From 26th July 2005:



of people who had committed sexual offences – ["they have often had abusive experiences and histories themselves"], physical abuse could also somehow be rationalised in his mind. However, he found it impossible to understand how someone could fail to meet the needs of a baby. ["How could anyone do that?"]

He went on to talk about what sort of work he had been doing since we last met and he commented that he had mainly been interviewing victims.

Comment [JD14]: He has a model for understanding.

Comment [JD15]: Attack on thinking? Cannot let it into his mind.

Comment [JD16]: Reinforcing/emphasising his 'normalness'. And his struggle to understand. And a level of denial.

Comment [JD17]: He has previously mainly brought material from perpetrators to the consultations. Interesting split – victim/perpetrator.

Analysis stage 2

What do I notice?

1. A 'really strange' few weeks. Things had been 'getting on top of him'.
2. Then he went to a barbeque and got 'food poisoning' followed by an 'infection'. Two weeks off sick followed by a period of 1 week planned leave.
3. 'Relatively comfortable' with sex offenders. But other things 'more difficult'.
4. His colleague tells him about a case of neglect of a young baby who - had resorted to eating his own faeces.
5. DC B had found this very difficult to deal with. Again he said that things seemed to have got 'on top of him' a little.
6. I struggle to make explicit the link between the neglected baby and things 'getting on top of him'.
7. DC B then speaks of his own children.
8. He can understand/rationalise sexual & physical abuse but not neglect. He cannot understand.
9. My notion that there is a link between the unthinkable thing that he cannot understand and things getting on top of him.
10. He says that recently he has been mainly interviewing victims.

Why do I notice what I notice?

1. He can identify and articulate the pressure of his work and the negative impact on him. Also he is identifying that something is odd/'strange'.
2. He eats something and something toxic ('food poisoning') gets into him and infects him. Leading to a significant period away from work.

3. His next association appears to be to the type of work he has to deal with and the way in which some things are harder for him to think about than others.
4. His example of something difficult to deal with/think about is an account his colleague has told him about a badly neglected baby who had resorted to eating his own faeces. It is perhaps a uniquely unpleasant account. I.e. he hears something 'unpalatable'.
5. He is explicit that he found this 'difficult to deal with' and he repeats that things had 'been getting on top of him'. He hears something 'unpalatable' and he cannot digest it.
6. It is clear to me that the two things are connected – the neglected baby and things 'getting on top' of DC B – and I can sense it is important. But I struggle to make the link explicit – it seems to be a powerful association. I wonder what baby part of him is feeling neglected by me as we have not met for some time. I have not contained him or met any of his needs to debrief. Looking back, the flow of the material is interesting – he moves between the apparently indigestible material to 'things getting on top of him': here it **is** possible to make a link.
7. I explore it a little with him by asking him to clarify. He speaks of his own experience as a parent and a caregiver. Again the movement of the focus of his material is interesting. He moves from neglect to talking about his own children. Quick link in his mind. He describes the preoccupations of 'ordinary decent (healthy) parents'. Is there some level of unconscious fear/identification with the risk of neglect? A challenge to his role as a successful parent? Linked to the demands of his job? There seems to be a link also to the possibility of him fearing being a neglectful parent and my wondering if I have neglected him.
8. Somehow he can identify with the likely deprivation of the physically or sexually abusive parent. But he cannot relate in a 'surface' way to the failure to meet the basic care needs of a child that constitutes neglect and the implicit aggression expressed by default. He cannot understand. It is unthinkable.
9. This is like a 'micro-vignette' that mirrors or encapsulates the process of my work with him – i.e. that the discomfort of his work and the material to which he is exposed over time overwhelms him and makes him ill – eventually to the point of withdrawing from his job.
10. Previously, he has been mainly interviewing perpetrators. Is there anything significant in this particular shift in the focus of his work? Is there a different

level of identification with victims? What are the tensions/implications/experiences of working with both victims and perpetrators in this context? How can it be thought about? How can the potentially conflicting identifications be managed?

How do I interpret what I notice?

That there is something that DC B cannot understand that makes him ill.

B's colleague tells him about a neglected baby that resorted to eating its own faeces → B 'finds it difficult to deal with'/'cannot understand' this → B goes to a barbeque and eats something → he gets 'food poisoning' followed by 'an infection' → this results in time away from work.

B is told something he finds indigestible → it was about eating shit → he goes to a barbeque and eats → he is ill afterwards.

A link can be inferred between him getting food poisoning and the baby eating its own faeces. A baby eating its own faeces is unthinkable – thinking about it would make you sick. He is an ordinary bloke with no mechanism for thinking about things like this.

Analysis stage 3

This is a vignette that illustrates the physical impact on DC B of encountering something about which he literally has no appropriate frame of reference to think. When confronted with something so unpleasant as to be virtually unthinkable, he is unable to symbolise and a link can be made between the unthinkable event and his subsequent physical illness.

It is clear in this vignette that DC B's main preoccupation is with things *"getting on top of him"* as this is how he opens the meeting – with an explicit acknowledgment of something unusual and the impact of his work:

DC B from 26/07/05:

He said that it had been a "really strange" few weeks. He thought that things had "been getting on top" of him…

He goes on to explain that he has been absent from work for an extended period:

DC B from 26/07/05:

… he had been ill for 2 weeks – he had been to a barbeque & got food poisoning followed by an infection - and then he had had a week's pre-booked leave…

Initially this seems understandable: that he has experienced a bout of food poisoning followed by an infection whilst his immune system is presumably depressed. Then his pre-arranged leave means he is absent for a further week. However, the flow of the material is interesting as his next thought is:

DC B from 26/07/05:

He spoke of the nature of our work, saying that he felt "relatively comfortable" talking to sex offenders but that there were other aspects of the work that were more difficult.

This suggests that there is a link in his mind between his experience of the *"more difficult"* aspects of work and his absence. He then tells me explicitly about something he has found *"difficult to deal with"*:

DC B from 26/07/05:

One of his colleagues had told him about a job she was working on. It was a case of neglect of a young baby. The child had been so badly neglected that it had resorted to eating its own faeces. DC B had found this very difficult to deal with. Again he said that things seemed to have got on top of him a little.

The story told to him by his colleague is vile. It is virtually unthinkable. B goes on to repeat that *"things seemed to have got on top of him a little"*. It is reasonable, I think, to make the following inferences from the flow of the material:

1. Things *"getting on top of him"* – because it is his opening comment, is of greatest importance to him and at the front of his mind.
2. He links this to aspects of his work that he finds *"more difficult"*.
3. He then makes an explicit link with a particular example of something he has found *"difficult to deal with"*.
4. He then 'closes the circle by repeating, almost verbatim, his opening comment: *"Again he said that things seemed to have got on top of him a little"*. From which we can assume a link between the story of the neglected baby and his experience of things *"getting on top of him"* that is his main preoccupation today.

On being invited by me to say a little more about this, DC B's mind moves immediately to his own family, reflecting the concerns and capacity to hold children in mind of an 'ordinary decent parent':

DC B from 26/07/05:

He spoke of his own children "2 beautiful boys" and how a parent is constantly thinking about them and looking out for them "from the moment they are born", worrying about their needs, whether they have fallen over, whether they are OK…

Again, the flow of the material is interesting, leaving me wondering if he is linking neglect, the demands of his work and his own young family, in a fear of his own potential to be neglectful. This is supported by my countertransference experience of feeling neglectful:

DC B from 26/07/05:

I wondered to what extent I had been neglecting him.

It is further supported by the next sequence in which it is clear that he has some model of understanding to apply to the acts of physical and sexual abuse. It is specifically neglect that, in this context he has found so disturbing:

DC B from 26/07/05:

He could, at some level, experience some understanding of people who had committed sexual offences – "they have often had abusive experiences and histories themselves"; physical abuse could also somehow be rationalised in his mind. However, he found it impossible to understand how someone could fail to meet the needs of a baby. "How could anyone do that?"

His comment that he finds it *"impossible to understand"* suggests that it is difficult for him to think about. He cannot relate in a surface way to the failure to meet the basic care needs of a child that constitutes neglect and the implicit aggression expressed by default. He cannot understand. It is unthinkable. The final association of the flow of his material in this vignette is:

DC B from 26/07/05:

He went on to talk about what sort of work he had been doing since we last met and he commented that he had mainly been interviewing victims.

Previously, he has been mainly interviewing perpetrators. I would suggest again that it is possible to infer some significance in this particular shift in the focus of his work and the material above. There are clearly different tensions/implications/experiences of working with both victims and perpetrators in this context. Is there a different level of identification with victims? How can the potentially conflicting identifications be managed? There is no mechanism available for DC B, outside of this process with me, for him to think about such issues.

This, I would suggest, is a reasonable understanding of the material. However, I think that it is possible to give it greater depth. The story of the neglected baby, told to him by his colleague, gets 'taken in' by him in a way that is both concrete and literal. Once 'in', he cannot understand – i.e. he cannot think about it or 'digest' it. He gets food

poisoning – followed by an infection – as if in a very concrete way, what he has heard has not only made him sick but has been toxic to him – contaminating him first with illness then invading his system with infection. He implicitly but not explicitly makes the connection between this physical illness and his sense of things *"being strange"* and *"getting on top"* of him.

There is something that DC B cannot understand, think about or symbolise that makes him ill. I.e. a link can be inferred between him getting food poisoning and the baby eating its own faeces. A baby eating its own faeces is unthinkable: thinking about it would make you sick. He is an 'ordinary decent bloke' with no available mechanism for thinking about things like this.

We can trace this as a kind of illustration of the indigestibility of his experiences, using as closely as possible the language as recorded in the session as follows:

> [DC B] *thought that things had "been getting on top" of him → one of his colleagues had told him about... a case of neglect of a young baby. The child had been so badly neglected that it had resorted to eating its own faeces → DC B had found this very difficult to deal with → he had been to a barbeque & got food poisoning followed by an infection - and then he had had a week's pre-booked leave → again he said that things seemed to have got on top of him a little.*

I.e.: DC B is told something he finds indigestible → it was about eating shit → he goes to a barbeque and eats → he is ill afterwards.

He also seems reflective about his own capacities as a parent and I, at the same time, experience a preoccupation with the possibility that I have neglected him – either by not being available, or by a kind of failure to be sufficiently helpful – enacted in my struggle and eventual failure to make the links explicit to him. It is possible to hypothesise that there is a projective process at work – that I am experiencing the projection of DC B's potential to be neglectful, and enacting it in my inability to helpfully think in the room.

A parallel may be drawn with DC B's emerging experience of his work. I.e.: the job is shit. A mess of body fluids represented in the material he has to hear and 'take in' with which he has to work. This is like a 'micro-vignette' that mirrors or encapsulates the process of my work with him – i.e. that the discomfort of his work and the material to which he is exposed over time overwhelms him and makes him ill – eventually to the point of withdrawing from his job. In the longer-term (although he does not yet know it), he will be completely 'filled up' with material he cannot digest, he will experience a major (life-threatening) physical illness, have a lengthy absence from work and request transfer to a different kind of team. See *'The Impact*'.

I was astonished to hear a highly intelligent boy of ten remark after the sudden death of his father: 'I know father's dead, but what I can't understand is why he doesn't come home to supper'. (Freud 1900: 254)

Appendix 6: Methodology example - Ms A: *'The Ambiguous Message'*

Analysis stage 1

From 29/11/04:

…In particular, she told me that she was keen to explore the impact of the work on our personal lives in general especially the link between our work and sexuality. Ms A told me that she is gay. She blushed visibly in telling me, commenting that it wasn't easy to disclose although she knew that I would find it acceptable if she did so. *I, too felt some discomfort, although I think, in some part of my mind, I knew and was not surprised at her disclosure, although, perhaps unsettled by her apparent discomfort.* She spoke of a conversation with a colleague of ours, a male consultant psychotherapist (I would estimate as being in his mid 50s). He had asked her something like "what does your boyfriend think …?" "I don't have a boyfriend", she replied, feeling very uncomfortable, and as if she didn't know what to say. "That surprises me", he said. *It surprised me, too, I thought: I know him as an 'earthy' sort of man who, in lay terms, I would regard as very 'worldly', quite a sexual person, and not given to making assumptions…*

Comment [JD1]: Introduction of a sexual boundary.

Comment [JD2]: Cross-ref session 20/04/05.

Comment [JD3]: Very quick disclosure. Bringing her sexuality into the room. Content sexualised very quickly.

Comment [JD4]: Cross-ref session 18/05/05.

Comment [JD5]: Blushing – like a schoolgirl. Again sexual undertone.

Comment [JD6]: 'Disclosure' – the language of sexual abuse treatment.

Comment [JD7]: My discomfort – is it some of hers projected? Or a type of 'coyness' aroused by her sexualising the content? Clearly I am anxious.

To begin with we briefly acknowledged some boundary challenges – associations within the hospital, staff and patients – and Ms A's friendship with a very old friend of mine. She was keen to reassure me that she had always been aware of the differing nature of her relationship with that person and with me – had never discussed me with her. *I believed her, not least because the converse is true…*

Comment [JD8]: This session is all about boundary challenges. I know her. I have supervised her colleague. We have a mutual friend. We have shared supervision space. We went to the same university.

Comment [JD9]: Here, having introduced the problem of the boundary, she is assuring me that the nature of the relationships is different.

…Mr 1 reported "thoughts about women", but Ms A couldn't remember them *and there's something here I can't remember.* Then the fire alarm test started. *I became very conscious of Ms A's hearing difficulty – which is not always apparent – I felt a little self-conscious, in case I should inadvertently obscure my lips. The fire alarm test, though brief, is very distracting.* Mr 1 has a disconcerting manner – she demonstrates, he drops eye contact and looks at her body – she looks at me "it's making me feel

Comment [JD10]: Attack on thinking.

Comment [JD11]: It is a very intrusive interruption that makes it much harder for her to hear me.

Comment [JD12]: This was a very distracting moment. I found it very difficult to concentrate and felt extremely uncomfortable and yet below I have recorded that I thought I didn't.

uncomfortable doing it to you now" *(I check myself, ask myself 'do I feel uncomfortable?', but if so, I'm not aware)* – she wonders what he is thinking at those times, he seems to drift away. Ms A had asked Mr 1 to think of the roles of women/men & he apparently cannot do so. She has to amend the task a number of times before asking him to describe women/men. He seems even to struggle with this but finds a few words - men: "steel toe caps", "strong": women: "baby-carrier", "high heels", "stockings". At which point "in order to bring it into the room", Ms A said "And, of course I'm a man", quickly correcting herself, "…man/woman". "Man/woman. I gave a very ambiguous message" she said.

Comment [JD13]: Fetishised.

Comment [JD14]: Cross-ref sessions 21/02/05, 07/02/05, 24/01/05.

Comment [JD15]: Clearly, she had intended to say 'I'm a woman'. At one level this is a very mad/psychotic comment. However, it also links back to her earlier comments about her own sexuality and the impact of the work on sexuality. Is this a very concrete denial of gender? How is maleness and femaleness held in mind in this institution? **Denial of difference/reality. Sexualised.**

Analysis stage 2

What do I notice?

1. Her wanting to explore the impact of our work on personal lives/sexuality.
2. The comments made by the male psychotherapist.
3. The further acknowledgement of the challenges to boundaries between us.
4. There's something here I can't remember.
5. Patient has a disconcerting manner.
6. Discomfort in the room.
7. Mr 1's description of women and men.
8. Ms A's response.

Why do I notice what I notice?

1. Working across a boundary. It is likely to be uncomfortable territory. What does it mean to have her sexuality in the room and on the agenda?
2. I am surprised at his assumption, his apparent prejudice.
3. How difficult, I wonder, will it be for me to stay in role in working with her.
4. 2 things.
    a. It is unusual for me not to remember.
    b. It mirrors Ms A not remembering the pt's 'thoughts about women'.
5. He looks at her body.
6. Does this link to his disconcerting manner? As I read and re-read this, I keep thinking that what I have recorded is that she asks if it is making **me** feel

uncomfortable – her doing it to me. But actually, she is saying it makes **her** feel uncomfortable. I check myself to see if I am uncomfortable and conclude I'm not. However, in the re-reading of it, I am.

7. Very concrete, sexualised, fetishistic.
8. 3 things.
    a. She 'brings it into the room'.
    b. Man/woman.
    c. What I know about her sexuality.

How do I interpret what I notice?

Might I conclude that there is something more than a coincidence about her feelings about her sexuality, the pt's objectified views about gender and her words *"And, of course I'm a man"*, quickly correcting herself, *"…man/woman"*.

Analysis stage 3

This small vignette appears to neatly illustrate some aspects of the manifestations of boundary difficulties in this setting and the attendant impact on the relationship to reality. The extract is from a session that took place at the outset of our work together. Ms A stated, as one of her aims from clinical supervision, that she would appreciate the opportunity to explore the impact of forensic work our personal lives, specifically on our sexuality and our understandings of our sexuality. It is true that, whilst working with patients so many of who have committed sexual offences, there are apparently few opportunities for thinking about practitioners as sexual selves and the potential identifications and projections in the context. This may to some extent be a reflection of the difficulty of managing this particular boundary and the perhaps inevitable associated feelings of discomfort in exploring sexual matters. Ms A states this as an aim at the outset of the session from which I infer that thinking about her sexuality is of importance to her – in the front of her mind in this session.

In the extract, Ms A's description of her own sexuality appears to me to be a rather sudden disclosure, somewhat at odds with her assertion that it is hard to disclose, physiologically evidenced by her blush – that has a coy and sexualised feel:

Ms A from 29/11/04:

She blushed visibly in telling me, commenting that it wasn't easy to disclose although she knew that I would find it acceptable if she did so. I, too felt some discomfort, although I think, in some part of my mind, I knew and was not surprised at her disclosure, although, perhaps unsettled by her apparent discomfort.

It is an awkward moment in which her *"apparent discomfort"* is mirrored by my countertransference: feeling *"some discomfort"*. Her use of the word *"disclose"* further underlining the sexual context. I immediately question my assumptions and capacity for stereotyping in a rather self-conscious way that is echoed in her comments about our colleague assuming that she had a *"boyfriend"*. From the outset of the session therefore, it is possible to observe the potential breach of a personal/professional boundary, which arouses anxiety (evident in the shared *"discomfort"* – is it mine, or is it Ms A's projected into me?). This compromise of the boundary is further compounded by the reference to the male colleague who, in fact, at that time acted as clinical supervisor to us both. In another echo of the evident *"discomfort"* she describes *"feeling very uncomfortable"* as this colleague attributes to her a *"boyfriend"* in a mistaken assumption about her sexuality that then confuses the gender of her chosen partner leaving her feeling *"as if she didn't know what to say"*. When she says she does not have a boyfriend, his comment *"that surprises me"*, on the surface rests with the assumption that she is heterosexual and single, although could register surprise that she is gay.

The next sentence records a discussion between Ms A and myself in relation to an explicit acknowledgment of potentially skewed boundaries in relation to associations and relationships throughout the institution in which we had both worked for some years and also refers to further symmetry in the external world in that we had both attended the same university (although not at the same time) and have a mutual friend. In those two paragraphs we can see many references to the boundaries that represent the differences between people and the nature of relationships – sexuality, gender, role, personal/professional etc.:

Ms A from 29/11/04:

To begin with we briefly acknowledged some boundary challenges – associations within the hospital, staff and patients – and Ms A's friendship with a very old friend of mine. She was keen to reassure me that she had always been aware of the differing nature of her relationship with that person and with me – had never discussed me with her. I believed her, not least because the converse is true…

Ms A then goes on to describe a particular encounter she has had with Mr 1. As the fire alarm test sounds, I again note feeling *"self-conscious"* in the session, wondering if it is in relation to being sufficiently attendant to Ms A's hearing impairment but also echoing my *"discomfort"* arising in the first paragraph. Initially, Ms A stated that Mr 1 reported *"thoughts about women"* the specifics of which she could not recall. I, too, note that there is something I cannot remember. Interrupted by the fire alarm (that was so loud that it was hard to hear ourselves think) she goes on to highlight his *"disconcerting manner"* of dropping eye contact and looking at her body rather than her face, at which times he appears to disassociate, leaving her wondering what he is thinking about (in an echo of our inability to think). This she demonstrates rather than describes, saying that in doing so, by looking at me in that way, she feels uncomfortable:

Ms A from 29/11/04:

Mr 1 has a disconcerting manner – she demonstrates, he drops eye contact and looks at her body – she looks at me "it's making me feel uncomfortable doing it to you now" (I check myself, ask myself "do I feel uncomfortable?", but if so, I'm not aware) – she wonders what he is thinking at those times, he seems to drift away.

I have noted in the session that I was not aware of feeling uncomfortable however on reading and re-reading these notes, I do feel a distinct sense of discomfort. Her choice of words appears to transform her demonstration from something of her patient's behaviour that she is showing me to something that she is much more concretely doing to me as she says *"it's making me feel uncomfortable doing it to you now"*.

Ms A's wondering about her patient's thoughts as he looks at her body must, in some way link to his *"thoughts about women"* that she cannot remember. I think that it is reasonable to suggest that this link between his internal world and his victims in the external world is, particularly for a woman, difficult to make explicit and to think about. Similarly, her looking at me in a demonstration of his gaze over her body must be held in the context of her immediately preceding disclosure about her sexuality, giving the session a particular kind of sexual context. I would suggest that, in some part of her mind there was a link between his *"thoughts about women"* and herself as a woman in the room. Therefore, perhaps the unspoken question is 'what are his thoughts about her?' And what link might there be in her mind between this question – of her patient's thoughts about her sexuality and the question asked of her – explicitly about her sexuality – by her male colleague above.

Ms A then talks about asking her patient if he can describe some of the roles attributed to men and women. Mr 1 is unable to conceptualise this task – perhaps because of the relative abstraction of the concept of 'roles'. He eventually offers some very concrete, stereotypical and fetishised descriptors that he associates with the different genders:

Ms A from 29/11/04:

He seems even to struggle with this but finds a few words - men: "steel toe caps", "strong; women: "baby-carrier", "high heels", "stockings".

In order to make the link between these rather 2-dimensional and sexualised ways of thinking about men and women and the reality of their different genders in the therapy and in the room, Ms A presumably intends to say "and of course I'm a woman", however actually says *"**and of course I'm a man**"*, before somewhat unsuccessfully 'correcting' herself: *"man/woman"*; acknowledging to me: *"I gave a very ambiguous message"*.

This sequence seems to me to be a very interesting encapsulation of the extreme difficulties in appropriately managing and maintaining boundaries in this setting. This is evident in a surface reading of the material - in the early paragraphs in which Ms A and I explore our common associations in the external world of the institution and beyond. However, we can give it greater depth by thinking about the unconscious

process of the clinical encounter that she describes. Ms A opens by depicting a context in which she is interested in exploring the impact of the forensic institution on her sexuality; she offers this as a reason for her decision to change and her choice of new supervisor. This is not unreasonable – and could be considered open and insightful. However, the material quickly gets a little 'out of kilter' and the presence of anxiety is immediately evident:

1. Her description of her sexuality is rather sudden and has the air of someone 'blurting out' something. She articulates an assumption that I will accept the personal and sexual disclosure: *"she knew that I would find it acceptable if she did so"*.
2. Feelings of *"discomfort"* are explicitly registered by both Ms A and me.

The language of the session/session record reflects a sexual context:

1. *"…she was keen to explore the impact of the work on our personal lives in general especially the link between our work and sexuality"*.
2. *"Ms A told me that she is gay"*.
3. *"She blushed visibly…"*
4. *"…it wasn't easy to disclose…"*

The flow of the material is interesting as her next association is to an encounter with a male colleague who:

1. Makes a confused and mistaken assumption about her sexuality that is also a rather unboundaried comment.
2. Accordingly confuses the gender of Ms A's chosen partner.

Ms a then moves on to describe her encounter with a male patient and as soon as he is mentioned there are a number of references in the material to challenges to thinking/memory. This patient finds it impossible to think symbolically about the roles assigned to men and women but introduces some concrete, stereotypical descriptions. Those relating to women, in particular, are highly sexualised. He is known to have unspecified *"thoughts about women"* and to stare intrusively at her body, in an apparently disassociated way, at which times her anxiety is evident in her description of

this *"disconcerting manner"* and she wonders what he is thinking about. A compromised capacity for thoughtfulness, or attack on thinking, is represented by Ms A's inability to remember the nature of the patient's *"thoughts about women",* the material that I cannot remember, the fire alarm test that *"though brief, is very distracting"* (resonant with Ms A's hearing impairment, preventing us from hearing ourselves think) and the nature of the patient's thoughts at those times when he *"seems to drift away"*. Ms A then tells him, incorrectly, that she is a man, before trying to correct herself: *"man/woman"* and again, in an echo of her colleague above, gender is confused.

It is possible, using the language of the session write-ups, to track a context in which Ms A expresses a certain degree of curiosity about the relationship between her work and her sexuality. A thread of anxiety can be observed, uncontained by appropriate boundaries and with a context that is both sexual and confused. The introduction of Mr 1 into the session material appears to immediately trigger a reduced capacity for thinking. He has unnamed and unknown thoughts about women and a way of looking at their bodies that, in Ms A's description to me, takes on a physical feel, arousing further anxiety. He is unable to symbolise sufficiently to be able to articulate gender 'roles' but produces some extremely sexualised images of femaleness that appear to prompt Ms A into the extraordinary assertion that she is a man:

> [Ms A is] *keen to explore the impact of the work on our personal lives… especially the link between our work and sexuality → Ms A told me that she is gay → she blushed visibly → it wasn't easy to disclose → I, too felt some discomfort… perhaps unsettled by her apparent discomfort → a colleague of ours asked "what does your boyfriend think …?" → we briefly acknowledged some boundary challenges → Mr 1 reported "thoughts about women", but Ms A couldn't remember them and there's something here I can't remember → Mr 1 has a disconcerting manner → he drops eye contact and looks at her body → "it's making me feel uncomfortable doing it to you now" → she wonders what he is thinking at those times, he seems to drift away → Ms A had asked Mr 1 to think of the roles of women/men & he apparently cannot do so → men: "steel toe caps", "strong": women: "baby-carrier", "high heels", "stockings" → Ms A said "And, of course I'm a man" → "man/woman".*

Ms A's first clinical example of her work appears to illustrate how her patient's projected inability to symbolise, loaded with uncertainty and confusion in relation to his experience of gender roles, reflected in his concretely stereotypical descriptions, triggers a response from her, initially concrete and incorrect in external reality, that she 'corrects' into a confused and *"ambiguous message"*. The vignette highlights boundary disturbances that enable the sexualised content to be uncontained and arouse anxiety. It is under the pressure of this anxiety, and the projected confusion of the patient who is unable to symbolise, that Ms A makes the almost psychotic assertion that she is a man – her 'correction' merely adding confusion, not clarity.

Appendix 7: Glossary of terms and abbreviations

Absconding/absconsion:	An unauthorized absence from a Leave of Absence trip, i.e., the patient escapes whilst on an arranged visit outside the walls of the hospital.
ACPO:	Association of Chief Police Officers.
A/L:	Annual Leave.
ASPD:	Antisocial Personality Disorder.
BPD:	Borderline Personality Disorder.
BPS:	British Psychological Society.
Breakaway:	Training in techniques for deflecting physical assaults.
CHRE:	Council of Healthcare Regulatory Excellence.
CNM:	Clinical Nurse Manager – managing an in-patient ward.
COREC:	Central Office for Research Ethics Committee.
CPA:	Care Programme Approach – the national policy and practice framework for the delivery of mental health services.
CPD:	Continuing Professional Development.
CPS:	Crown Prosecution Service.
CTM:	Clinical Team Meeting – of the multi-disciplinary team.
DoH:	Department of Health.
DSPD:	Dangerous and Severe Personality Disorder.
Escape:	As distinct from absconsion, refers to a patient escaping from within the secure perimeter of the hospital.
GMC:	General Medical Council.
GP:	General (medical) Practitioner.
GSCC:	General Social Care Council.
Hospital Order:	Made under S.37 of the Mental Health Act (1983) is an alternative to a sentence. The convicted individual is detained in hospital for treatment. Generally the hospital order will be subject to a Restriction Direction under S.41 of the Act, giving the Home Secretary powers over various aspects of the convicted person's management.
HPC:	Health Professions Council.
HR:	Human Resources – administration of personnel.

ILPS:	Inner London Probation Service – now London Probation Area.
MDT:	Multi-disciplinary team.
MHRT:	Mental Health Review Tribunal – an independent body reviewing continuing compulsory detention & treatment under the Mental Health Act.
MSU:	Medium Secure Unit.
NFA:	No Further Action – a term used by the CPS on deciding not to proceed with a prosecution.
NHS:	National Health Service.
NMC:	Nursing & Midwifery Council.
NOMS:	National Offender Management Service.
PMVA:	Prevention & Management of Violence & Aggression: NHS approved techniques for the safe containment of violent incidents.
PCT:	Patient Care Team.
PCTM:	Patient Care Team Meeting.
PDU:	Personality Disorder Unit (Ashworth Hospital).
POA:	Prison Officers' Association.
Police Federation:	Police officers' staff association.
RCN:	Royal College of Nursing.
RMO:	Responsible Medical Officer (Mental Health Act 1983).
RSW:	Responsible Social Worker.
SD:	Service Director.
SM:	Service Manager.
SSI:	Social Services Inspectorate.
S/W:	Social work or social worker (see context).
TOIL:	Time Off in Lieu – i.e. of hours worked in excess of contractual hours.
Secure perimeter:	The physical boundary of the hospital: the wall.
SHSA:	Special Hospitals Services Authority: the Special Health Authority which ran the Special Hospitals 1989 - 1996.
UDI:	Unilateral Declaration of Independence.