Forensic Update

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Statement of purpose

Forensic Update is a publication of the British Psychological Society's Division of Forensic Psychology (DFP). Its aims are to:

- communicate current information on professional and practice matters to practitioners and researchers;
- publish current and topical research and reviews in forensic psychology and related areas in concise and easily readable form;
- act as a forum for discussion and debate on a broad range of practical, professional and ethical issues within criminal and civil justice systems;
- act as a forum for dissemination of knowledge from other branches of the criminal and civil justice system, executive and legislature;
- act as a forum for discussions with a broad range of other criminal and civil justice professionals and agencies.

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Welcome to the second issue of *Forensic Update* of 2014. You will recall that in issue 113 the competition for the MSc dissertation with most utility for forensic psychological practice, as voted for by you as readers, was opened. We would like to extend congratulations to Naomi Rose for her winning paper entitled ‘Extended induction: Investigating the value of peer-led programmes in prison (an evaluation of the Trust programme at HMP/YOI E)’. Entry for the fourth annual MSc competition will open with the next issue of *Forensic Update*.

As always, we begin this issue with ‘Notes from the Chair’. In his final notes as Chair of the Division of Forensic Psychology (DFP), Ian Gargan reflects on the developments of the DFP over the past two years and offers a message of hope for the continued development of forensic psychology. Thereafter, we have two collections of themed papers; the first on working with women offenders, and the second on routes to qualification as a forensic psychologist.

In the context of national moves towards individualised, gender-specific approaches to working with women offenders, this collection of papers represents practice- and evidence-based recommendations for working with women offenders from a breadth of theoretical and practice perspectives. Emma Fisher reflects on her experiences of working with adolescent complainants of rape and sexual assault and presents examples of how psychological theory can inform an understanding of the experience and management of two cases of young girls presenting to the police. Sarah Passmore, Samantha Woodhouse and Susan Cooper present an overview of the prevalence of crime perpetrated by women, research into violence risk among women and make recommendations for risk assessment. Susan Cooper and Alison Hodgson discuss issues relevant to the assessment and treatment of women offenders who perpetrate intrafamilial offences, with reference to the challenges of working with factitious disorder by proxy. Annette McKeown explores the prevalence of intimate same-sex relationships between female offenders in custody and discusses implications for risk management and intervention. Psychologically-informed practice is emphasised in the paper by Sue Devine, Grahame Greener, Karen Laws and Beverley Phillippo, who present a reflective piece on managing the duality of the discipline-therapy role of a prison officer, with examples of their practice in working with women prisoners and with reference to the value of the Primrose Service. Progressing to interventions, Michelle Carr, Alison Hodgson, Samantha Woodhouse and Marc Kerry describe and reflect on the integration of the gender responsive Trauma Recovery and Empowerment Model into the development of a dedicated trauma pathway for women prisoners. Katie Gilchrist applies a Cognitive Analytic Therapy formulation to a case study of a woman in a medium secure unit and describes the development of a relationally-informed care plan and strategies for collaborative team working. Finally, Claire Thompson evaluates the effectiveness of a short-term, DBT-informed group targeting emotion regulation and distress tolerance among borderline personality disordered women in a low secure service.

Navigating the early stages of a career in forensic psychology can be confusing and different routes to qualification as a forensic psychologist will suit different people. Furthermore, developments in routes to training can be unfamiliar to long-estab-
lished psychologists. The collection of papers in this issue aims to map out the journey of working towards qualification as a forensic psychologist, from multiple perspectives and including information on the British Psychological Society Stages 1 and 2, Doctoral routes to qualification and the Health and Care Professions Council routes. Dee Anand – Chair of the DFP Training Committee – sets the context for the mapping of BPS Stages 1 and 2 and this is followed by an introduction to the papers in the training routes section by Roisin Hall, Chair of the Forensic Psychology Qualification Board. Contributions follow from Sarah Disspain (Forensic Psychologist in Training), Dean Fido (PhD student), John Hodge (Registrar and Chief Supervisor), Julie Harrower (Chief Assessor) and Cerys Miles (Supervisor).

Finally, Debbie McQueirns presents the ‘Book Reviews’ section and offers intriguing enticement to budding book reviewers!

As always, please feel free to contact the Editors with comments on published articles or with suggestions for Forensic Update.

Emily Glorney & Rachel Worthington
Notes from the Chair
Ian Gargan

The Division of Forensic Psychology (DFP) continues to grow in strength and influence. The work of forensic psychologists is promoted by universities, valued by government and sustains treatment within the community, prisons and hospitals with efficacy.

Year in year, despite cutbacks in public spending, the voice of forensic psychology is being heard. Increasingly the Houses of Parliament search for consultation and liaison from us to guide their creation of policy. Communication with government and stakeholders is growing through earnest colleagues and the work of the British Psychological Society (BPS) policy team.

Universities continue research and the number of doctorate placements is growing.

Contact from other forensic psychology experts in various countries is trickling through the Division.

Strength of presence is increasing with other specialists in psychology, such as our clinical, health, counselling and organisational colleagues.

It has been my pleasure to witness this growth first hand over the past two years as a facilitator of a terrific team on the DFP committee representing all the Division’s members.

Our presence within the BPS has also been evident and the support from the Leicester office as well as the Board of Trustees has been nothing short of superb. Efforts are continually afoot from the BPS to harness the collective strength of 50,000+ members to offer assessment, treatment and education in forensic psychology through shared forums with our psychology colleagues among other specialties.

Moreover, the past two years demonstrated the power of ‘THE’, and any, individual to contribute as well as effect change. Growing the presence of Forensic Update, talking with government offices, leading clinical colleagues to enter dialogue with forensic psychology and battling to maintain the quality of qualifications and training has been forged by strong individuals who offer so much. We and I am very thankful and, personally, impressed by their ability to effect change.

Thank you, Dee Anand, for your continued support and I speak on behalf of all the DFP membership when we welcome you to the position of Chair. I hope you also witness such progress and humanism. Dee will become Chair at our annual conference in June in Glasgow. I encourage you all to attend if you can (and if you can garner some money from your organisation!) to contribute to the learning, AGM, and intellectual discussion.

Your annual conference is so important in making louder the forensic voice nationally.

Thank you all for the support in what has been an honour and privilege to serve the membership to promote forensic psychology in learning, practice and, I trust, continued development. The future is a bright sunrise and a collective responsibility.

‘So hope for a great sea-change
On the far side of revenge.
Believe that further shore
Is reachable from here.
Believe in miracles
And cures and healing wells.’
Seamus Heaney

Ian Gargan
Attachment and development considerations when working therapeutically with adolescents who have experienced sexual trauma

Emma Fisher

The aim of this paper is to use my personal experience of working with victims of sexual trauma and link it with the theories of therapeutic work with children. This will enable me to better understand how to work with adolescents on a therapeutic level in my role as a person centred counsellor. I will be looking at various theorists, such as Freud, Winnicott and Bowlby and the more recent model from SACCs; specialists in residential therapeutic treatments for children who have suffered severe abuse.

My experience of working with sexual trauma has come from my work at the Lancashire SAFE Centre, which is the Sexual Assault Forensic Examination Centre for Lancashire and Cumbria. As a crisis worker I work directly with the complainants of rape and sexual assault a few hours after the incident has happened. This has allowed me to see how trauma can affect a person. We see men, women and children of all ages, however, the majority are young people. Last year we saw 462 cases which were a mixture of ages. From this number 47 per cent were under the age of 18 and 53 per cent of those were classed as adolescents, between the ages 11 to 17 years. (E. Fisher, SAFE Centre, 15 July 2013)

The definition of an adolescent from The Oxford Dictionary is ‘(of a young person) in the process of developing from a child into an adult’ (The Oxford Dictionary, 2013). There is no clear beginning or end to adolescence but it tends to be whilst the young person is going through puberty.

Although no one is to blame for being the victim of a sexual assault there are some factors which can increase the likelihood. These include alcohol, drugs, and risk taking behaviours such as being out alone at night. Adolescents can fall prey to all of these; however, there are other factors specific to young people which can increase their vulnerability. These include being under children’s social services, family dysfunctions and a poor social economic standing (Rymaszewska & Philpot, 2006). The following statistics give emphasis to these factors. Looking at the adolescents who attended the SAFE Centre last year, 35 per cent were from a separated family, 27 per cent had consumed alcohol prior to the assault, 24 per cent had pre-existing mental health issues such as self-harm and anger management, 10 per cent were ‘looked after children’ in the social care system and four per cent had attended the SAFE Centre before. (E. Fisher, SAFE Centre, 15 July 2013)

Working with adolescents who have been through a traumatic event has shown me how differently each one will react. To show an example of this I will describe two 13-year-old girls who were the victim of rape by an adult male and attended the SAFE Centre for forensic examination with the police. It is important to mention here that these characters are not based on any one individual.
but on my collective experiences of being a crisis worker at the SAFE Centre for seven years.

Client one presents as confident. She is not interested in answering questions and is more bothered about having a cigarette. She is accompanied by a social worker who has brought her from the children’s home she resides at. Her mother is made aware of the allegation as she holds full parental consent but refused to attend and will give consent over the phone. During the initial meeting and history taking she is restless and makes jokes with the social worker. This is not her first sexual experience or the first time she has drunk alcohol.

Client two presents as quiet and withdrawn. She does not make eye contact or speak to anyone other than her mother and father who have accompanied her. She has brought a change of clothes and a blanket which is apparently her comforter. During the initial meeting and history taking her mother answers most of the questions. It is understood this is her first sexual experience and the first time she has drunk alcohol to excess.

These two teenagers are set to show how children the same age can be completely different in terms of their understanding, maturity, level of puberty and self development. They are both offered the same service at the SAFE Centre and have to answer the same questions, however, their responses and apprehension can be poles apart. This illustrates the multifaceted approach required to work with them therapeutically.

According to Freud and his psychodynamic theory back in the 1880s, from the day we are born our lives are a battle to meet our urgent innate needs. We gradually learn these needs cannot always be met so we develop coping strategies (Beckett, 2002). As we move into adult life, taking these strategies with us, we may experience difficulties coping with circumstances such as rejection, loss and love. This is because the strategies formed have been maladaptive. Freud also believed that psychological problems in adulthood were born from suppressed phantasies of one’s desires in childhood.

John Bowlby, a psychoanalyst in the 1950s, believed the external influences on a child had a more tangible effect on their development than Freud’s internal phantasies. He studied the relationship between mothers and babies in humans as well as mammals and found there was a deep connection between the mother and child. When this connection was broken by separation, for example, the child would become distressed. This created the idea of the secure base and attachment behaviours.

Together with Mary Ainsworth, a developmental psychologist, Bowlby categorised attachment behaviours into five types: secure; anxious-avoidant; anxious-ambivalent; disorganised; and non-attached (Beckett, 2002). Looking at our clients from the SAFE Centre, we can suggest the type of attachment behaviours they may convey.

Client one has an anxious-avoidant strategy. She does not seem distressed at the knowledge that her mother is not coming and can seem ambivalent to the carer. She may seek attachments with others but will show little distinction in how she acts with her carers and strangers. If she has grown up in a chaotic household she may have had many care givers. She will be ambivalent as to who gives her the love and attention as long as she gets it.

This may have lead to her risk taking behaviour and increased vulnerability to perpetrators such as the male who raped her. Anxious attachments in childhood have been linked with substance misuse, eating disorders, early sexual activity and high-risk sexual behaviour in adolescents (Geldard & Geldard, 2004).

Client two seems to have a secure attachment strategy. Her parents have both come to her rescue and provided comfort. She may present as immature compared to Client one, however, this is likely due to her secure upbringing. She will not have experienced as much trauma or dysfunction as
Client one and has, therefore, been protected from accelerated maturation.

It is important that her parents allow her to try new situations to increase her independence whilst continuing a consistent level of parental control. Client two may have been acting more like an adult whilst out drinking with friends but is more likely to revert to being a child at any sign of danger (Geldard & Geldard, 2004).

The attachment strategies of these clients is an important consideration when working therapeutically with them. An anxious-avoidant strategy may present challenges such as difficulties in developing a therapeutic relationship. The client may have issues in trusting and so may have a robust defence system. The relationship between the client and counsellor will be an important indicator of the client’s attachment strategy. Transference of the client’s feelings or attitudes towards their carer or the perpetrator may be experienced. The counsellor will need to be aware of their own countertransference to prevent reinforcing the client’s earlier negative experiences (Rymaszewska & Philpot, 2006). The therapeutic relationship can be used as an example of a healthy relationship and an altered attachment experience for the client (Purnell, 2004).

Client two may find it easier to create a therapeutic relationship as she will have experienced unconditional positive regard from her parents. This is not to say that therapy will be easier for client one. Client two has still been the victim of a rape which will undoubtedly have an effect on her confidence and her sense of self.

Adolescents are in the process of transforming from child to adult. Lesley Day, the Head of the Specialist Personality Disorder Service at Cassel Hospital in London, describes it as ‘a time fraught with different and transient emotions and states of mind, offering a particular kind of freedom to have new ideas and explore one’s identity’ (Day, 2003, p.9).

The development of one’s self or identity is an essential part of maturation. Object relations theory is another expansion of Freudian thinking. The theory states that to achieve a sense of self and other, one must have experienced a secure relationship with their primary care giver. The care giver becoming the ‘other’ and, therefore, distinguishes the child as a separate self (Beckett, 2002).

Winnicott placed emphasis on the parent-infant relationship in the emotional development of the child. He suggested that if the basic needs of the child are met dependably, the carer is ‘mirroring’ the child. Having these needs mirrored allows the child to develop their ‘true self’ (Winnicott, 1984).

So it seems that like attachment strategies, the early development of a child’s sense of self is also an important consideration. A child’s ability to cope with changes in their internal world such as emotions and their external world such as family dynamics is based on their experiences in early childhood.

There are also biological considerations in terms of an adolescent’s development and their reaction to trauma. Zoe Loderick is a psychotherapist who specialises in the treatment of trauma. Her work describes the part of the brain called the amygdala, which is the part that filters through stimuli in the search for any threats. If a threat is established, the part of the brain called the hypothalamus is immediately stimulated to respond. This response is known as the ‘fight or flight’. Loderick goes on to explain that if these responses are damaged by lack of success, it will be more likely that the person will become traumatised and possibly the repeat victim of trauma (Loderick, 2010).

In the case of client one, she has become passive to sexual advances from males. She may have learnt that to stay and fight or to try to run are both futile tasks. This may have led to her being programmed to allow the assault and not to use her active responses. With this perhaps being the first major
trauma. Client two has faced, her defences will hopefully not be too damaged. Through counselling there is hope she will find adaptive ways of coping to prevent these feelings becoming long-term sequelae (Varma, 1992).

After looking at the theoretical considerations for working with adolescents who have experienced sexual trauma, I will now look at the most advantageous conditions for therapy. Carl Rogers, the father of person-centred therapy, believed there are six necessary and sufficient conditions to initiate constructive personality change (Rogers, 1959). These include the counsellor feeling empathy, congruence and unconditional positive regard for the client. To offer a safe and caring space is important to any client but especially for adolescents, and those that have experienced trauma.

Winnicott believed that a ‘holding environment’ was essential to counselling. This ‘holding environment’ can be created by providing a nurturing and unconditional space where the client feels secure, this is to simulate the feeling of a child being held in his mother’s arms (Winnicott, 1984).

This environment can be strengthened by creating boundaries within the session. Counselling sessions naturally have boundaries of time, place and confidentiality which are very important in retaining the consistency of the session and, therefore, the relationship. With children and adolescents it is important to recognise that they may not want to communicate verbally. They may prefer to play with toys, craft materials or doodle on a piece of paper. Interjections and questions from the therapist should be kept to a minimum so they can experience the ‘not knowing’ and indecision of the play or picture along with the child. This is an example of creating a holding atmosphere for the child to relax in (Rymaszewska & Philpot, 2006).

It is significant to mention at this point the legal and ethical side to the boundaries. As a crisis worker in the NHS I am bound by policies and procedures in regards to safeguarding and child protection. The Children Act 1989, however, does not say we have a general obligation to disclose all suspicion of abuse; therefore, as a counsellor I do not have to report child abuse, if I believe the disclosure to be immediately detrimental to the child’s safety. Ethically I typically come from a consequential ethical approach where I weigh up the potential outcomes before I make a decision. I also include the client in the process wherever possible. I believe the adolescent should have a clear understanding of the boundaries to confidentiality in the therapy and be able to negotiate if they wish. This is the only way trust can be created.

During the SAFE Centre procedure we are very clear on our boundaries of confidentiality and the client’s own autonomy. We require parental consent to examine a child under 16, however, we will not proceed if the child themselves tells us to stop. The parents and the police often want the child to be examined for evidence but we give the autonomy back to child with the strong message, that no one has the right to do anything to you that you do not want to happen.

It seems vital to mention at this point these boundaries relate to the therapist as well. It is paramount that therapists we are aware of and retain their own limitations. Vicarious trauma can be a common result of working with sexual trauma and is where the therapist can experience the same level of trauma as the client by transference. Pistorious (2006) interviewed (as cited in Nen et al., 2006) female therapists who worked with sexually abused children and found that working with victims had an impact on therapists, personally and professionally. It is essential therapists and professionals have regular supervision to reduce the potential of vicarious traumatisisation.

A more recent approach to working with traumatised children has been the development of SACCs, the Sexual Abuse Child Consultancy Service, in 1987 by Madge Bray and Mary Walsh. Their wealth of experience...
working in this field has helped them to devise structured therapeutic interventions in residential care and family placements. There are three integrated strands to their work; therapy, life story work and therapeutic parenting. The therapy entails much of what has been talked of above and allows the child to carefully explore their inner world. The life story work helps the child to answer questions about their past such as What? Why? and When? Together with a worker the child collects evidence such as photos to help them understand their history. Finally therapeutic parenting provides a secure base for the child in their day to day life. This experience will hopefully help fill in the gaps in the child development enabling them to feel differently about themselves and the world around them. The SACCS integrated model works with ‘Openness, not secrecy; communication, not avoidance; and predictability, not inconsistency’ (Rymaszewska & Philpot, 2006, p.19).

There are a number of different approaches and considerations when working therapeutically with adolescents. The two clients presented have shown how each adolescent will have had a different life experience and it is this experience which can unlock the path to positive steps in development. It is very important for a therapist to have an understanding of attachment strategy, transference and human development. I believe it is up to the client to choose the best approach for them, whether it is psychodynamic, person-centred or an integrated model. The importance for me is that adolescents have access to express themselves in safety. A multi-agency approach provides the safety net the adolescent will need to be able to explore their inner and outer worlds. Therefore, I believe it is paramount to maintain clear boundaries and open channels of communication with the client and all associated carers and agencies.

In this environment the child will hopefully be able to explore their learned behaviours to reach a healthier and more stable state of being.

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References

Bibliography
Assessing risk in female offenders: A review of the HCR–20 and the FAM
Sarah Passmore, Samantha Woodhouse & Susan Cooper

In a prison system largely designed for men there is a need to recognise the issues that women encounter and how they link to their risk. Women represent around five per cent of the total prison population (Home Office, 2013) and although the overall number of female prisoners appear to be reducing (Home Office, 2013), it is important to note that the number of females committing violent offences has risen by 6.2 per cent since 2007 (Home Office, 2011). This paper will explore female pathways in to crime, whilst considering the benefits of a more gender specific approach to risk assessments, in particular the Female Additional Manual (FAM).

Pathways into crime have undergone extensive research interest, highlighting what leads an individual into crime (Bloom, Owen & Covington, 2003; Corston, 2007). Whilst it is important to acknowledge that men and women do commit the same offences, it is beneficial to explore how pathways and motives may differ between the sexes. In doing so, this may highlight female specific needs which can inform a more gender sensitive approach to predicting future violence.

Female pathways into offending differ to those of males (Corston, 2007). Research indicates that women experience more traumatic childhoods, including violence in the family home (Rosseger et al., 2009). Around 50 per cent of women in prison have reported experiencing domestic violence, compared with a quarter of men (Corston, 2007). Additionally, one in three women have reported suffering sexual abuse, compared to one in 10 men (Corston, 2007).

Experiences of abuse have been linked to an increased risk of committing violent offences, and although this link exists for men, research suggests that this link is more evident for women (de Vogel et al., 2012). Subsequently, victimisation can be a major cause in future criminal activity, drug use and relationship difficulties. As quoted in Baroness Corston’s report, ‘A vicious circle of victimisation and criminal activity develops, creating a toxic lifestyle that is extremely difficult to escape’ (Corston, 2007). Interestingly, histories of trauma and abuse are associated with a higher prevalence of substance misuse (de Vogel et al., 2012). It could be considered that women may use substances in an attempt to reduce or suppress negative affect and memories of abuse (Briere, 2002; Swadi, 2000). Drug offences make up around 21 per cent of all offences committed by females, making it the second most common offence in 2007. It has been reported that women are often first introduced to illicit substances by partners, who can then encourage the women into sex work as a means to fund their addictions (Bloom, Owen & Covington, 2003; Scott & Dedel, 2006).

It is important to note that women’s involvement in crime often occurs through their relationships with family, friends and intimate partners (Bloom, Owen & Covington, 2003). The characteristics of violence committed by women are different to men (de Vogel, 2011). For example, violence perpetrated by a woman is often more subtle and can occur in the context of relationships, families and child abuse (Monahan et al., 2001). Research indicates
that women perpetrate a similar level of intimate partner violence to that of men (Dutton, Nicholls & Spidel, 2005). It is noteworthy, however, that women have different motives for intimate partner violence than men, including jealousy and self-defence (Kruttschnitt & Carbone-Lopez, 2006) and women can use violence towards their partner as a reaction to ongoing violence by the male (Allen, Swan & Raghavan, 2009).

Major mental illness has been found to be more prevalent in women than in men, and it is estimated that approximately 80 per cent of women in custody are found to have a mental health problem (Corston, 2007). Mental illnesses which are mainly or solely prevalent in females include post natal depression, postnatal psychosis and Fabricated or Induced Illness (also known as Munchausen by Proxy Syndrome) have been found to have a link to violence, especially towards children. It is important to note that although Fabricated or Induced Illness is evident in males, in most cases the perpetrator is the mother (Motz, 2001). Women are often the primary carers for their children and are at a higher risk of experiencing postnatal depression if they have a lack of social support, have experienced abuse, have low self-esteem or have experienced previous mental health difficulties (Mind, 2013). As previously discussed, a large percentage of women in prison have experienced abuse and enter prison with diagnosable mental health problems, potentially putting them more at risk of developing postnatal depression in the future.

**Risk assessments**

In order to explore gender and risk of violence, it is important to consider the benefits of using a gender specific risk assessment. The prediction of violent behaviour has been subject to considerable clinical and research interest over the last three decades, and has seen several controversial debates regarding the actuarial vs. clinical approach to the inter-rater reliability and predicted validity of these methods (Monahan & Steadman, 1994; Mossman, 1994; Webster et al., 1997).

The development of the Structured Professional Judgment approach (SPJ) by Webster et al. (1997) is widely used when assessing risk of violent behaviour. It is important to note that until recently there was no violent risk assessments developed specifically for the use with female offenders. Buss (1961, cited in Bjorkqvist, 1994) stated ‘women are so seldom aggressive, that female aggression is not worth the trouble to study’. Aggression was, according to his view at that time, typically a male occurrence (Bjorkqvist, 1994), and research indicates that ‘being male is one of the best predictors of violent and criminal behaviour’ (de Vogel, 2012). In addition, women historically committed fewer violent offences then men; although, as noted, violence perpetrated by women appears to have increased (Home Office, 2011). It has been reported that women experience aggression differently to men (Dittmann, 2003) and use more indirect aggression such as gossiping, spreading rumours, or other ways of damaging a person’s sense of self (deVogel, 2012). Men present more physical violence then women (Bjorkqvist, 1991); however, it is important to not underestimate a woman’s risk of committing physical violence. Men have been seen to be aggressive outside of the relationship, whereas women are more prone to aggression inside a relationship and within families (Monahan et al., 2001), again highlighting gender differences in the experience and perpetration of aggression and violence.

The HCR-20 was developed by Webster et al. (1997) and it set to achieve a comprehensive way to assess to risk of violent behaviour and the first using the SPJ approach (Guy, 2008). The HCR-20 consists of 20 items across three domains including Historical, Clinical and Risk Management, which also can be seen as past, present and future (Table 1). It was created to be used with specific populations including forensic and psychiatric individuals and refers to a specific definition of violence throughout
Table 1: Historical, Clinical and Risk Management–20 items  
(Webster, Douglas, Eaves & Hart, 1997).

<table>
<thead>
<tr>
<th>Historical (past)</th>
<th>Clinical (present)</th>
<th>Risk Management (future)</th>
</tr>
</thead>
<tbody>
<tr>
<td>H1: Previous violence</td>
<td>C1: Lack of insight</td>
<td>R1: Plans lack feasibility</td>
</tr>
<tr>
<td>H2: Age of first violent incident</td>
<td>C2: Negative attitudes</td>
<td>R2: Exposure to Destabilises</td>
</tr>
<tr>
<td>H3: Relationship instability</td>
<td>C3: Active symptoms of major mental illness</td>
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<td>H4: Employment problems</td>
<td>C4: Impulsivity</td>
<td>R4: Non-compliance with remediation attempts</td>
</tr>
<tr>
<td>H5: Substance misuse problems</td>
<td>C5: Unresponsive to treatment</td>
<td>R5: Stress</td>
</tr>
<tr>
<td>H6: Major mental illness</td>
<td></td>
<td></td>
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<tr>
<td>H7: Psychopathy</td>
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<td></td>
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<tr>
<td>H8: Early maladjustment</td>
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<td></td>
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<tr>
<td>H9: Personality disorder</td>
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<tr>
<td>H10: Prior supervision failure</td>
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the manual. ‘Violence is defined as ‘actual, attempted, or threatened harm to a person or person’’ (Webster et al., 1997, p.24). The reliability and validity of the HCR-20 has been of great interest to researchers around the world. Many researchers have focused on the use of the HCR-20 with male offenders as it has been highly validated as a good predictor of violent behaviour (Douglas & Weir, 2003; Gray, Taylor & Snowden, 2008) and a well known instrument used when assessing risk of violence. There have been concerns with the use of this instrument with female offenders in regards to the predicted accuracy of the tool (de Vogal & de Ruiter, 2005).

As previously noted, it can be argued that females offend for different reasons from those of men. It is important to note that although some items are similar in the HCR-20 for males and females such as mental illness and psychopathy, additional guidelines may be needed for women (Blanchette, 1997; Harer & Langan, 2001). It is important to capture factors that may increase the risk of violence that are exclusive to or more prevalent in women, including postnatal depression, fabricated or induced illness (previously Munchausen by Proxy Syndrome) and prostitution.

Debates and research into the factors that influence women into committing crimes have been long over due and the introduction of the Female Additional Manual (FAM) is a recent development into violent risk assessments for females. The FAM was based on the HCR-20 and developed by de Vogel, de Vries Robbe, van Kalmthout and Place (2011). Although it has been found that there are many risk factors attributable to females and males in the HCR-20, they felt that additional items and guidelines were needed to work in partnership with the HCR-20 to develop a more gender specific approach to assessing female’s risk of violent behaviour.

Discussion

The research into female risk assessment is a recent development and an important issue to understand and acknowledge. It has been seen that the number of crimes, specifically of a violent nature, have increased (Home Office, 2013), and research in to the differences between male and female violence continues. In order to approach female risk more specifically, the Female Additional Manual incorporates additional items and guidelines to assist in the assessment of
Table 2: Female Additional Manual items
(de Vogel, de Vries Robbe, van Kalmthout & Place, 2011)

<table>
<thead>
<tr>
<th>Historical (past)</th>
<th>Clinical (present)</th>
<th>Risk Management (future)</th>
</tr>
</thead>
<tbody>
<tr>
<td>H6: Major mental illness (additional guidelines)</td>
<td>Specific risk factors for women</td>
<td>Specific risk factors for women</td>
</tr>
<tr>
<td>H7: Psychopathy (additional guidelines)</td>
<td>C6: Covert/manipulative behaviour</td>
<td>R6: Problematic child care responsibility</td>
</tr>
<tr>
<td>H8: Early Maladjustment (additional guidelines)</td>
<td>C7: Low self-esteem</td>
<td>R7: Problematic intimate relationship</td>
</tr>
<tr>
<td>H8a: Problematic circumstances during childhood</td>
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<td></td>
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<tr>
<td>H8b: Problematic behaviour during childhood</td>
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<td>H9: Personality disorder (additional guidelines)</td>
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<td>H10: Prior supervision failure (additional guidelines)</td>
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<td></td>
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<tr>
<td>Specific risk factors for women</td>
<td></td>
<td></td>
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<tr>
<td>H11: Prostitution</td>
<td></td>
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<tr>
<td>H12: Parenting difficulties</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H13: Pregnancy at young age</td>
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<td></td>
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<tr>
<td>H14: Suicidality/Self-harm</td>
<td></td>
<td></td>
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<tr>
<td>H15: Victimisation after childhood</td>
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</table>

Violent risk in females by using a more gender specific approach. However, it is important to acknowledge the recent development of the HCR-20 version three (HCR-20\(^3\)), which incorporates a wider, more comprehensive variety of risk factors. Additionally, the HCR-20\(^3\) allows the clinician to think more psychologically about the individual by including opportunity to formulate the person's risk, and plan for likely scenarios in which violence may occur.

The revision of the HCR-20\(^3\) is recommended for use on both men and women, and in a recent study, gender was not considered to be predictive of future violence (Douglas & Strub, 2013). This would suggest that the sole use of the HCR-20\(^3\) would be sufficient when assessing women’s risk of violence. Many of the additional guidelines and items included in the FAM are now highlighted within the HCR-20\(^3\), for example, there is now a more extensive description of mental health difficulties, and victimisation following childhood is now covered. That said, the FAM continues to provide specific items that could be overlooked when scoring the HCR-20\(^3\), including prostitution, parenting difficulties, low self-esteem and pregnancy at a young age, which highlights the need to use each in conjunction with the other.

Increased numbers of violent offences committed by women have highlighted the need for risk assessments to capture a diverse range of risk factors, in order to ensure risk of future violence is not underestimated. It is important to understand the importance of female pathways into crime and how they
differ in terms of prevalence, characteristics and motives to their male counterparts, in order to accurately predict risk. By using traditional risk assessment such as the HCR-20 alone, clinicians may underestimate a female’s level of risk by excluding female specific items. The FAM has only recently been developed and, therefore, further research and clarification into the validity of these items is required.

It would be beneficial to expand upon findings used to develop the FAM in order to develop our knowledge of female specific risk factors. As research on the FAM has focused specifically on forensic psychiatric females in the Van der Hoeven Kliniek, it would be valuable to widen this further and use a variety of populations, including age groups and nationalities, in order to assess predictive validity. As noted within the FAM manual, as the majority of risk items are historical, it would be beneficial to explore more recent and future risk items that could be affected by treatment and interventions. Additionally, it would appear that more research is needed around specific items, particularly in relation to prostitution and how this is linked with violence in women. Following this, we may develop more insight and understanding in to why women commit violence and how we can effectively predict and manage this within our services.

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References


Working with Women Offenders

Assessment and treatment with women who have committed offences within the family
Susan Cooper & Alison Hodgson

Over recent years there has been a greater recognition of gender differences in the pathways to offending and the specific needs of female offenders (e.g. Belknap, 2001). Female offenders often have a history of trauma and abuse; domestic violence; and current mental health issues including personality disorder, substance misuse and self-harming behaviour (Bloom, Owen & Covington, 2003; Corston, 2007). Such factors can be relevant when trying to understand their offending behaviour (Blanchette & Brown, 2006; Chesney-Lind, 1997). In response to these needs, the Corston report Review of Women with Particular Vulnerabilities in the Criminal Justice System (Home Office, 2007) highlighted the need for a holistic, individualised, ‘women-centred’ approach to working with women. More recently, the need for gender specific approaches is as outlined in the NOMS document, A distinct approach: A guide to working with women offenders (NOMS, 2012).

This paper will focus on a distinct group of women offenders, those who have committed an offence against a person in the family, including violence against a partner and offences related to the physical and sexual abuse of children. It is widely accepted that women are victims of domestic abuse; research indicates over half the women in prison report being a victim of domestic violence (Norman & Barron, 2011), but over recent years research has started to reveal the extent to which women are perpetrators as well as victims. Some studies indicate levels of domestic violence perpetrated by females were comparable or in excess of those perpetrated by men (e.g. Archer, 2000, 2002; Bookwala, 2002; Dutton, 2006; George, 1999). Research also indicates that women perpetrate physical aggression against children in the home; Cawson et al. (2000) found in a sample of young adults reporting violence in home that the mother is more frequently reported as responsible (49 per cent) compared to the father (40 per cent). Similarly, women are also becoming identified as perpetrators of sexual offences. Data indicates four to five per cent of all sexual abuse is committed by females (Cortoni & Hanson, 2005), although it is likely that this is an underestimate of the actual figure; there are many reasons victims might not report this type of abuse including the victim’s dependence on the mother as a caretaker and the stigma associated with this type of abuse.

The Criminal Justice System and Family Courts often require guidance from psychologists in relation to this group of women offenders, such as the risk factors associated with re-offending; the relationship between intrafamilial offending and general offending; and the likelihood of re-offending. The assessments provided by psychologists can assist with decision making, such as sentencing, suitability for release from prison and whether a mother can have contact with or care for her children. It is, therefore, important that psychologists take a valid and reliable approach to assessment and treatment with this group to ensure sound decision making. In this paper
some of the issues relevant to assessment and interventions will be considered.

Assessment and formulation
Generally within forensic practice there has been a move toward standardised, structured risk assessment tools (Khroya, Weaver & Maden, 2009). There has, however, been some controversy in the past about using standardised tools with women if they have not been developed specifically for this population (de Vogel et al., 2012). More recently there has been a drive currently to address this with gender sensitive risk assessment tools such as the Female Additional Manual. Additional guidelines to the HCR-20 for assessing risk for violence in women (de Vogel et al., 2012). Many standard risk assessment tools have limited focus on early life experiences, but for women who have harmed their children, this area is extremely important when trying to formulate an understanding of risk. It is recognised that early attachments form the templates for adult attachments and attachment theory is useful in understanding both normal and abnormal care eliciting behaviours (Bowlby 1988); early childhood experiences with parents can consciously and unconsciously influence care behaviours (Adshhead & Bluglass, 2001). This type of exploration of early life can help contextualise and make sense of a woman’s offending behaviour and therefore make it more likely she will engage in further assessment and intervention work.

One of the issues with using structured risk assessment tools with women who perpetrate offences within the family is that recognised risk factors do not always apply in the same way as they do with other groups of offenders. For example, failure to comply with professionals is a recognised risk factor; yet a woman with Factitious Disorder by Proxy (FDBP), a condition in which a person deliberately produces, feigns or exaggerates symptoms in a person in their care (often a child), might seemingly comply with professionals and perversely thrive on this contact, attending all appointments offered, but this might actually be a feature of high risk behaviour rather than an indication of a reduction in risk. For such reasons it is important not to rely on published risk assessment tools that are not designed specifically for this population when making assessments of risk.

Offence paralleling behaviours (OPBs) can be useful indicators of risk, particularly in the absence of reliable risk assessment tools. OPB is defined by Jones (2004) as ‘any form of offence related behavioural (or fantasised behaviour) pattern that emerges at any point before or after an offence. It does not have to result in an offence; it simply needs to resemble, in some significant respect, the sequence of behaviours leading up to the offence’ (p.38). Using OPBs allows behaviour to be explored in a sequential way to allow us to work with a broader range of processes that are helpful in risk assessment. For example, one of the features of FDBP is the compulsive nature of the offending behaviour; even when the parent is aware that professionals have become suspicious, the abusive behaviour often continues (Lasher & Seridan, 2004). Thus, when the opportunity to offend against a child is removed as the parent is placed in a secure setting, she may engage in offence paralleling behaviour such as encouraging other prisoners to self-harm and then appearing to take on a caring role. Similarly, women who have perpetrated abuse within the home can be skilled at conning and manipulating professionals, convincing others they are a caring parent when beneath this façade they are actually perpetrating abuse; such offenders might continue to relate to professionals in this way, trying to present in a positive light.

The complex needs of this group of women offenders should be considered and incorporated into the assessment and formulation. With this population, there are often underlying personality disorder problems with issues of abuse, abandonment and neglect evident in their own childhood. For example, Matthews, Matthews and Speltz
(1989) found women who abuse children are likely to have experienced severe childhood trauma and sexual abuse, their adult relationships frequently unhealthy or abusive; and they have low self-esteem, anger and distorted thinking. Attention to the motivations for offending is clearly important. For example, survival is highlighted by Bloom, Owen and Covington (2003) as a common pathway into offending for women. Women sometimes engage in intra-familial offending with a male co-defendant, often a partner. In a study including a cross-national sample of 227 women arrested for a sexual offence, approximately half acted with another person (Vandiver, 2006). This raises questions about this group of women’s motivations to offend, the extent to which they are influenced by a male offending partner and why they might offend only within the context of a relationship, although it is important not to become influenced by stereotyped views of women as passive victims who are coerced by men.

Formulation is an essential part of the assessment process and used for guiding treatment strategies and interventions. The process of formulation involves working towards a psychological explanation of an individual’s problems that can inform treatment. Although it is accepted that formulation is a hypothesis or series of hypotheses about an individual, the work should be grounded in psychological research and theory related to this client group (such as, Adshead & Brooke, 2001; Gannon & Cortoni, 2010; Saradjian & Hanks, 1996) and, importantly, clinical experience of working with this group of women. As mentioned, important areas to cover include early life experiences, beliefs about children, relationship with others, and stressors and coping mechanisms. Formulation of sexual offending needs to take into account the offender’s experiences of sex and also her experiences of sexual abuse in their own childhood (Saradjian & Hanks, 1996).

**Treatment**

As with assessment and formulation, treatment should be gender sensitive and take into account the specific needs of female offenders. For example, it might be necessary to address abuse history and associated trauma. Helping women cope with their trauma in a more adaptive way will not only reduce subjective distress, but also reduce risk of re-offending by targeting maladaptive and/or criminogenic coping strategies.

Women who offend in the family can be resistant to psychological work, like many other types of offenders. A dominant construction of motherhood is the idealised mother in which women are constructed as selfless, nurturing and subsuming their own needs to care for their children (Phoenix, Woollett & Lloyd, 1991). The idealisation of motherhood can deny the negative or difficult aspects of mothering and can be experienced as oppressive to women whose experiences differ from the ideal. Thus for women who have not only failed to meet the ideal standard of motherhood, but have behaved in a way that is antithesis of this ideal, to actively harm their child, can lead to overwhelming feeling of shame, self-loathing and failure. These feelings can be a barrier to engagement. Women who have harmed a child might struggle to disclose such abuse and might even deny responsibility for the offences altogether. Developing the motivation to explore these issues is likely to take time and highlights the need to attend to the therapeutic process. Attention to the therapeutic process and relationship is important. For example, Ashfield, Brotherston and Eldridge (2010) also suggest directness, establishing openness, flexibility and appropriate use of self-disclosure can help develop the therapeutic alliance with females who have sexually offended against children. It is also important clinicians attend to their own emotional response to individual women and use this to inform therapy; strong feelings of anger, disgust, and rage can be invoked and need to be processed within a dynamic framework; it is also important to
be aware of the potential for the therapeutic relationship to repeat previous relationship dynamics.

One particular problem for treatment of FDBP is that women often do not present for therapy as they insist reported physical symptoms are genuine. Rather than focus on trying to explore the offences, which can further entrench the offender’s denial, therapy might focus on unresolved traumatic stress and psychological distress in response to their own previous childhood illness or loss, which are common in FDBP (Main & Hesse, 1990). The initial formulation process will be vital to appropriately inform therapy.

The notion that female offenders are both victims and perpetrators of harm has important implications for treatment. Treatment programmes are often designed in such a way that victims and perpetrators are treated as if two distinct groups. Programmes for perpetrators of violence are often designed for male offenders and seem to focus on the offender taking responsibility for the offence and empathising with the victim, which can be difficult when there are complicated victim/perpetrator issues, especially in cases of domestic violence where a woman has offended against an abusive partner. Likewise, it might be difficult to fully understand a women’s harmful behaviour towards her child without first understanding her own experience of abuse. We would suggest that interventions for this group of women offenders should attend to offender’s experiences as a victim of aggression as well as a perpetrator.

Conclusions
Assessments and interventions with women who commit offences against members of their family should be gender sensitive. It is important that clinicians are able to identify relevant risk factors using appropriate psychological guides and underlying psychological theory and then formulate an understanding of risk; this might include relevant issues such as attachments and relationships, prior trauma, personality disorder and mental health problems. Offence-paralleling behaviours can be useful proxy markers to inform assessments of risk. Treatment interventions need to be able to respond to the complex needs of this client group and go beyond traditional offending behaviour programmes. The therapeutic dynamics can be complex and need to be attended to if any work is going to be effective; it is also important to approach this group of women with sensitivity and empathy as these women are often struggling with intense feelings of shame and failure.

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Working with Women Offenders

Intimate relationships between female prisoners: Fact or fiction?
Annette McKeown

This paper explores the prevalence of intimate same-sex relationships between female offenders in custody. In the female prison estate, this phenomenon is often discussed but has rarely been studied. The prevalence of relationships between female offenders in custody in the UK is generally unknown and this paper seeks to develop the evidence-base in this under-researched area. In this study, female prisoners (N=92) completed a questionnaire exploring their relationship status; gender of partner; prison relationships; length of current relationship; number of previous relationships and previous relationships with prisoners. Results indicated that of those currently in a relationship, 27 per cent were in a relationship with another female prisoner and eight per cent were in a relationship with a female in the community. Some of the implications of relationships between female offenders are examined including complex risk management issues, duty of care, as well as the function of these relationships.

In the general community, there are varying figures indicating the prevalence of same-sex female relationships although a recent survey of 420,000 respondents from the UK found that approximately 1.5 per cent of respondents described themselves as gay, lesbian or bisexual (Office for National Statistics, 2011). If these estimates are representative of the prison population, similar estimates should exist although there is notable lack of literature on the subject. What is noteworthy, however, is that there is much anecdotal knowledge that same-sex relationships are quite overtly present in female prison establishments (Bennett, 2000). What is less clear is the prevalence and nature of such relationships and whether these relationships are underpinned by sexual preference or more linked to availability of partners. Management of some of the challenges associated with same-sex relationships in custody is also an area that warrants further discussion.

In the US, there has been some research exploring the prevalence of same-sex female relationships in custody. There have been estimates of prevalence which have varied between 25 per cent and 60 per cent (Forsyth, Evans & Foster, 2002; Owen, 1998). There has also been discussion about the difference between women who would define themselves as ‘gay’ in terms of their general sexual preference as opposed to those who have only engaged in same-sex relationships in custody (Bennett, 2000).

Theoretical considerations
A number of theories have also been used to attempt to understand these relationships. Deprivation theory (Sykes, 1958) suggests, in the case of women who have engaged in same-sex relationships only in custody, these relationships may be used as a temporary substitute to male relationships. There is also literature suggesting women may become involved in intimate relationships due to loneliness and in an attempt to help them manage distance from loved ones (Devlin, 1998). Sexual fluidity theory (Diamond, 2008) focuses less on this behaviour as a substitution to male relationships. It focuses on how gender preferences can become fluid in custody, and that contextual factors can result in some women discovering attractions towards other women. It could be argued, however, if the above theories
explained both male and female intimate relationships in custody similar patterns of intimate relationships would be observed in male prison establishments. Anecdotal evidence and preliminary research findings would suggest lower levels of intimate relationships in male prison establishments. For example, research findings suggest between 1.6 per cent and 3.4 per cent of a random sample of male prisoners indicated they had sex with another prisoner in custody (Strang et al., 1998). Therefore, it may be worth considering gender-sensitive explanations of intimate relationships.

Research highlights that relationships and attachments to others have particular importance for women in comparison to men (e.g. Covington, 2007). Relational theory (Hartling, 2009; Miller, 1988) emphasises the importance women place on feeling empathically understood and emotionally close to significant others. Intimate relationships in custody may thus provide a sense of attachment and emotional closeness for women. It has also been suggested that supportive social relationships are often fundamental components of women’s coping mechanism to deal with stress (Taylor & Master, 2011).

**Risk management issues**

Intimate sexual relationships between female prisoners present a number of challenges in custody. There can be jealousy present between female prisoners and this can result in difficulties including aggression and self-harm (Bennett, 2000). This can also create discipline issues including instigation of procedures to manage these behaviours including adjudication measures and ACCT (Assessment, Care in Custody, Teamwork) plans which are used for prisoners at risk of self-harm and/or suicide. When relationships break down this can also present environmental difficulties as women in relationships may be located on the same prison wing. It may be argued that breakdowns in relationships represent every day life. When these relationships potentially involve women with a history of violence, self-harm, and emotional difficulties this presents a somewhat greater challenge, however. The case study below is a fictional representation based on clinical experience. It seeks to capture some of the complexities that same-sex relationships can present in custody.

**Case Study 1: Rachel**

Rachel

Rachel is a 24-year-old woman and has a history of trauma in the form of sexual abuse as a child and domestic violence in her adult relationships. She has an index offence related to violence towards her female partner.

Since her reception into custody, Rachel has formed a number of different female relationships with other prisoners. Many of these relationships have been short-lived. Rachel had planned to marry at least two of these partners, and legally changed her surname to match one of these partners. Rachel is no longer in a relationship with any partner she planned to marry, or who she took a name of.

Rachel often self-harms when a relationship breaks down and she had received adjudications for being violent towards partners. She is aware her intimate relationships are a problem for her but seems to repeatedly become involved in similar relationships.

This case study highlights intimate relationships between prisoners clearly present an array of challenges to staff in terms of management. Although sexual relationships between prisoners are prohibited, anecdotal evidence suggests such relationships still continue. An influential document, *Guidance on the Management of Issues arising out of Relationships between Women in the Women’s Custodial Estate* (NOMS Women’s Team, 2010) outlined a number of these challenges and
strategies of dealing with these relationships in custody. In this document staff are encouraged to be aware of potential coercive and abusive relationships. These more abusive characteristics may be more prevalent in psychopathic and personality disordered prisoners. This document also encourages staff to be particularly aware of potentially vulnerable women in custody as relationships of this nature can be particularly harmful. For example, concerns have been noted that disabled prisoners can become involved in intimate relationships with other prisoners who then act as their carers despite have no training to undertake such a role. The potential of vulnerability in the case of the both parties cannot be ruled out. The importance of female prisoners wearing appropriate clothing has also been highlighted as a potential issue and dress codes were suggested. Strategies to manage overt expressions of affection were also outlined in this document.

Increasing understanding of the prevalence of relationships between female prisoners in custody is likely to help inform risk management strategies. There is little knowledge, for example, about the prevalence of the use of sex as a commodity to pay for substances or to obtain material goods. This is particularly important when considering the management of some of the potentially more complex implications of this behaviour. The potential of sexually transmitted diseases also present an important consideration. Understanding the prevalence of relationships between female prisoners in custody would provide greater knowledge of the potential prevalence of some of these challenges.

Method

Participants

All female prisoners in a female prison establishment were invited to participate in a broader study which explored violence in relationships. This study also explored the prevalence of relationships in custody. Female prisoners were informed their participation would be completely voluntary and anonymous. Of the 336 female prisoners in the establishment, 92 prisoners consented to participate. Of the 92 prisoners, 55 per cent were convicted of a violent offence and 45 per cent convicted of a non-violent offence.

Measures

Demographic Questionnaire

This self-report questionnaire was devised by the researcher and consisted of items including: age; index offence; relationship status; relationship gender; prison relationships; length of current relationship; number of previous relationships and previous relationships with prisoners.

Results

Ninety female prisoners provided information about their relationship status and 67 per cent indicated they were currently in a relationship (N=60). Of those currently in a relationship, 65 per cent (N=39) reported being in a relationship with a male and 35 per cent (N=21) reported being in a relationship with a female. As outlined in Figure 1, of the 21 women, five women indicated they were in a relationship with a woman in the community; 16 women indicated they were in a relationship with another female prisoner. Thirty women indicated they were in a relationship with a male in the community; nine women indicated they were in relationship with a male prisoner.

Of those who responded regarding previous relationships, 38 per cent (N=33) of respondents indicated they had previous relationships with female prisoners whilst in custody. As outlined in Figure 2, most of these women reported having between two and five previous relationships with female prisoners.

Discussion

This study provides preliminary indications of the prevalence of relationships between female prisoners in a custodial environment. Approximately one-third of female prisoners currently in a relationship reported their relationship was with another female
Annette McKeown

Figure 1: Percentage of women in relationships according to gender and location of partner.

Figure 2: Number of previous relationships with females in custody.
Intimate relationships between female prisoners: Fact or fiction?

prisoner. Over one-third of the overall sample also indicated having previous relationships with female prisoners. Future research would be useful to examine this further to consider the function of intimate relationships in custody and whether they merely link to sexual orientation. Given the relatively high prevalence it seems likely that female prisoners attribute positive characteristics to these relationships. It would be useful to explore further these positive attributes further and whether these relationships can be protective factors as anecdotal evidence tends to focus on the potential negative consequences of relationships in custody.

Consideration of potential risk management issues seem warranted, however, given observations in the literature of the risk of violence between female prisoners in intimate relationships (Bennett, 2000). It is perhaps noteworthy that approximately half of the sample was imprisoned for offences of violence. It is clear that violent women being in a relationship with each other may become a risky situation for both women involved, other prisoners, and staff if conflict arises. The potential of domestic violence within this context is also possibility and staff vigilance for this becomes imperative. This is particularly important given community findings that gay women (29 per cent) and bisexual women (49 per cent) experience higher levels of domestic violence than heterosexual women (Bureau of Justice Statistics, 2010). There is also the potential of offence-parallelising behaviour within a relationship context with a number of women incarcerated for offences of violence towards partners (Hamel, 2012).

There is also a noteworthy gap in treatment interventions for female offenders as there are no existing interventions focussed primarily on promoting healthy relationships. It is clear that some focus must be placed on same-sex relationships in such interventions, as well as consideration of maladaptive cycles in relationships and how these may parallel in custody. Psycho-education into healthy relationships also seems imperative as female offenders’ experiences are often characterised by patterns of unhelpful relationships throughout their lives.

Additional research is required with both male and female prisoners to explore the prevalence of intimate relationships in custody across the prison estate. Further research is also needed exploring the dynamics within these relationships including prevalence of violence, controlling behaviour, bullying, psychological aggression and whether indeed in some cases whether these relationships may be of a supportive nature. Recent research has found over 57 per cent of a female prisoner sample reported they had physically assaulted their partner in their most recent relationships in the past year (McKeown, in press). This clearly has implications for the management of such behaviour. Further assisting staff with strategies to deal with behaviour in this context would be beneficial as staff have been noted to present with uncertainty on how to deal with these issues (Bennett, 2000). Exploration of the function of relationships in prison is also an area which warrants further consideration.

There are a number of limitations to this study including the sample size and that it is focussed solely on one female prison establishment. Further areas could be explored as previously noted including comparing male and female establishments, sexual orientation of prison populations, characteristics and functions of relationships in custody amongst many other domains.

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References


Working with Women Offenders

Balancing the therapy role with the prison officer role

Sue Devine, Grahame Greener, Karen Laws & Beverley Phillippo

This is the view of four individuals who all decided upon the same career in HM Prison Service but for very different and varied reasons. Why you may ask? Let us give you some insight into the reasons why we joined the Prison Service. For some of us we wanted what we thought would be a job for life with financial security for our families. For others we have partners who have been employed in the Police and Prison Service for many years. A thought we all had in common was ‘If I could make a difference to one person then I have done a good job’.

We all had different thoughts and opinions on what skills we initially thought would be needed for the role of a prison officer. These ranged from opening and locking doors, helping prisoners to understand what had led them to offend, and rehabilitate them to reduce the risk of reoffending in the future.

As the Prison Service Statement of Purpose states: ‘Her Majesty’s Prison Service serves the public by keeping in custody those committed by the courts. Our Duty is to look after them with humanity and help them lead law-abiding and useful lives in custody and after release.’

We also thought the role involved being firm but fair, giving instructions, and listening and supporting prisoners with their concerns and worries. Further skills we thought we would need included having a patient and empathetic manner but also being aware of how dangerous and dishonest some prisoners could be in order to get their needs met. Working with women prisoners, we would all agree it was very difficult to be able to manage the time some prisoners needed with the day-to-day running of the prison regime.

Joining the Primrose Programme

With over 50 years’ prison experience between us and after spending many years on residential wings and the physical education department we decided it was time to change direction. We wanted to do something different, a new challenge. After experiencing ‘landing life’ and witnessing first-hand the problems that some women had, we started to ask ourselves questions such as, ‘Are we doing enough?’ and ‘Do we understand what these women need?’. Looking after a wing full of prisoners with limited staff can be very time consuming. Also, making sure the prison regime runs smoothly gives little opportunity and time to listen to women and to be responsive to their individual needs. We were all surprised to learn that there are a lot of people with mental health issues and personality disorders in prison who need specialist care and support. This is something at the very beginning of our careers we would never have thought about. At the beginning we thought surely people who are sent to prison have done something very bad therefore they should be punished. This raised various questions. What if some people have a personality disorder that affects their ability
to deal with situations or manage their emotions in a negative sometimes destructive way? We wondered what we could do to help. We thought surely more can be done. There must be more than opening and locking doors.

A new integrated pilot programme was up and running; The Primrose Service, located at HMP/YOI Low Newton, which was specifically designed for women who had severe personality disorders. We thought this could be the answer to some of our questions regarding what we could do and how we could help. We saw the Primrose Service offering a new opportunity for a multi-disciplinary team to work with women to address a range of individual needs not just focus on one specific area. We thought being involved in the Primrose Service would help us to understand the women better. We thought we could have the opportunity to help them practice skills in real life situations.

Like any person starting a new job we were filled with a mixture of excitement and anxiety. How would we fit into a programme running psychological interventions and treatments? How would we mix with doctors, psychiatrists and psychologists? People who were knowledgeable about mental health? People who had numerous qualifications and letters after their names? We also had not considered the number of acronyms that were used. More importantly, what they meant in full and when they were used. An example of a typical conversation may possibly go like this:

‘As discussed at the MDT, Miss X has now completed her SCID and HCR-20. We will soon be starting the PCL-R. She still engages in the Officer Led Programme’

Then, there were each woman’s traits, ‘Histrionic, Obsessive Compulsive, Schizoid, Schizotypal’. What was IPDE or a HCR-20 we wondered? The list was endless but we were willing to learn.

We have been able to learn this new knowledge and the role of the Primrose Prison Officer is seen as vital. We have developed an Officer Led Programme (OLP), facilitated Prim-role Play, which is psychodrama sessions, and facilitated Mobile Team Challenge (MTC). We also co-facilitate on treatment programmes including Life Minus Violence Enhanced (LMV-E™), Motivation and Engagement, Dialectical Behaviour Therapy Skills Training Groups, TREM (Trauma Recovery Empowerment) and individual offence-focussed Work.

Learning and supervision
To understand the ‘jargon’ we have group supervision and individual supervision with clinicians. Supervision was a new experience for us and we have embraced this over time. At the beginning we did not understand the purpose of supervision but through experience we all learnt about how valuable it is for our role and personal development. We learnt about personality disorders and considered whether any of the traits were linked to any of the women in the service. Other supervision sessions spent time looking at assessment tools and the aims of treatment programmes. Being released to attend training also had a positive effect on our development, as did working together to help each other. Understanding psychological language is a large part of our daily routine and like learning any other skill becomes easier as time progresses. More importantly, we can now link this terminology to the female offenders, which in turn makes us, as officers understand them and the role we have on the Primrose Programme better.

Balancing the therapy role and the discipline role
When working on the Primrose Programme, balancing the therapy role with the disci-

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1 MDT refers to Multi-Disciplinary Team Meeting; SCID refers to Structured Clinical Interview for DSM-IV; HCR-20 refers to the Historical, Clinical and Risk Management structured assessment of violence risk; PCL-R refers to the Psychopathy Checklist – Revised.
Pline role has proven both challenging and rewarding. One minute we may find ourselves in a treatment session being empathic and offering support listening to a prisoner disclosing traumatic childhood memories. Ten minutes later we may find ourselves restraining the same prisoner to keep them safe in order to stop them from harming themselves. To the prisoner this could be very confusing and feel like one minute we are trying to help them, the next minute we are fighting with them. We cope with this through always being aware of our dual role in the service.

We have learnt a lot about our own behaviour and the impact and impression that this can have upon others. Prison culture historically dictates discipline staff use ‘prison banter’ day-to-day, in different ways, for different reasons. For example, previously when enforcing prison rules we may have used humour in a sarcastic way without realising. We never really understood how this may be looked upon from a therapeutic perspective. Our views have altered. Since facilitating programmes such as Life Minus Violence – Enhanced® we have realised some of the ‘banter’ we have previously used, for example, could be deemed sarcastic which is a form of aggression. This was never our intention, we thought it was just the way prison works and most prisoners responded well. We are not saying do not use banter any more but we are just more aware of when and how we use it. It is our aim as facilitators to encourage participants on the courses to live pro-social lives without aggression and violence.

At times throughout our careers we have all raised our voices when dealing with difficult situations and conflicts. We have felt angry and frustrated thinking to ourselves ‘How dare they speak to us like that’. Previously we did not know or understand transference and the effects that others’ emotions can have. We now understand this more. Difficulties balancing the prison officer role and the therapeutic role can include volatile situations when control and restraint techniques are used as a last resort to de-escalate. This can be particularly challenging if you are undertaking a therapeutic role with the same person involved in the incident. Being aware of both roles and considering the effect this can have on everybody is vital.

At times it may be necessary to strip search a prisoner. They may become angry and aggressive in response to this and make threats to harm themselves or a member of staff. Their aggressive behaviour may link to their own past experiences of abuse and the only way that they think they can resolve the situation is to act in this manner. It could also be related to their personality disorder. As prison officers we would all agree aggressive behaviour is not acceptable. As Primrose officers working on the programme we look at underlying reasons for their behaviour. This is not always understood by our colleagues for a range of different reasons, the biggest being they simply do not have the time or have had the training we have. Our training has helped us value the importance of making time to reflect and encourage other staff to do so.

Healthy mind healthy body
Balancing the therapy and discipline role is also important for physical education officers. In the Primrose Service we understand the importance of physical education in improving the women’s overall well-being. When the decision was made to introduce the role of a facilitator who was also trained as a Physical Education Officer, this was an ideal opportunity to promote the importance of overall well-being to women with complex needs. The variety of exercise helps the individual to improve self-esteem and motivation by helping them to set and achieve personal targets. We have noticed that physical exercise has also helped the women to improve group cohesion and their coping skills. This gives opportunities to practice communication skills to interact, tolerate and accept others which help to prepare them for future group treatment programmes. The science of any physical
activity will tell you that endorphins in the brain give us an uplifted feeling of well-being and this helps to stabilise our mood. Therefore, this can help the women get through the different phases of the Primrose Programme keeping them stable while they may be going through a difficult time.

Coping with challenges
Pro-social modelling is a vital part of the work we do with prisoners. Our awareness and insight have increased and we now understand the reactions we may have given in the past are not only promoting aggression but behaving inappropriately to the person we are may be working with. We are by no means perfect and at times still feel angry and frustrated, but our insight into how we behave and manage this has changed thankfully for the better. Insight into why someone behaves the way they do, does not excuse behaviour but it does explain a lot of things. It is possible to promote pro-social behaviour through modelling positive behaviour ourselves.

At times working therapeutically with a prisoner can lead to them pushing boundaries or trying to ‘split’ staff. This could be over familiarity or asking to work with certain staff because they are the only person they can talk to. It is vital we are aware of this and be honest with them explaining what is and is not acceptable. This can sometimes have a negative effect as the prisoner may feel they are being rejected, controlled or criticised. This could link to past experiences when they have been rejected, abused or controlled as a child. It can be challenging but also important that reassurance is given in an empathic manner whilst maintaining professional boundaries.

Prior to working in the prison service we had never come across self-harm. Women in prison talked about ‘cutting up’. We were not familiar with this terminology but quickly learned the language of the women and began to understand this was their way of communicating with us. Why would someone want to deliberately hurt themselves? We had no concept as to the reasoning behind this act. Experience and training has taught us that the individual will normally self-harm when they are in a state of heightened emotions and inner turmoil. We also realised that self-harm can in some cases help make them feel more in control and less tense – possibly a ‘quick fix’ for feeling bad or helping them to connect with reality and not their bad memories. It is important to listen to the individual without being critical or judgemental and try to understand their feelings. There have been occasions when we have felt frustrated as some individuals, by their own admission, have used self-harm as a means to get their needs met. In these particular situations we learned the importance of understanding why the women may have self-harmed, being mindful and remaining professional in our approach.

Thoughts for the future
Based on our experience there are a number of important thoughts for the future we would recommend. These include the importance of having debriefs after sessions, attending supervision, and developing further staff training and awareness in areas such as mental health, personality disorder and therapeutic skills for staff across the prison estate. Having the opportunity to become involved in treatment gave us a completely different perspective, making us wonder why only limited mental health training is offered in our initial training. As prison officers we are trained in a specific way, however, there is a need to be open to thinking about and understanding situations in a very different way. We feel we have gained from the introduction to a therapeutic environment the ability and insight to recognise that not all prisoners, never mind officers, understand what it is like to have mental health issues or learning difficulties. ‘Our New Way’ is the new modern approach in the prison service, and we believe would benefit from prison officers receiving more mental health and psychological training to equip them for the challenges they face today.
In conclusion, we feel as prison officers it is possible to balance the discipline role with the therapeutic role. In our opinion, each role complements the other in our day-to-day work. This has enabled us to promote the Primrose Programme and encourage understanding of what the programme is trying to achieve to the broader prison. Balancing the therapeutic role with the prisoner officer role is possible. Change is possible. Embrace it.

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Working with Women Offenders

Reflections of a trauma intervention with women in prison
Michelle Carr, Alison Hodgson, Samantha Woodhouse & Marc Kerry

Introduction to the Specialist Women’s Personality Disorder Service, part of the Personality Disorder Offender Strategy

This service has been specifically developed to address the needs of women prisoners with severe personality disorder in England and Wales. The women’s service offers intensive assessment and treatment to help participants reduce the impact of personality disorder and reduce the risk of re-offending. Thus the treatment offered is designed to address criminogenic needs in order to reduce risk. The importance of addressing any additional non-criminogenic and/or mental health needs is recognised, especially if these needs interfere with the ultimate goal of reducing risk.

It is also imperative that the treatment offered by this specialist women’s service can meet the varying needs of a relatively small group of women. The treatment model adopts a focused approach to address the components of the participant’s personality functioning and risk factors associated with offending, including cognitions, emotional responding, and interpersonal and social functioning. The treatment model is guided by Livesley (2012), who suggests ‘a framework of combining eclectic treatment methods and delivering them in a co-ordinated way’. The treatment model is also gender sensitive and responsive, taking into account the specific needs of female offenders, for example, that abuse history and associated trauma should be addressed when working with women offenders (Bland, 1999) and consideration given to gender differences in offending behaviour, as women can often present with unique treatment needs.

The typical, for want of a better word, woman that accesses the service presents with some form of abuse and or history of trauma. Many of the women use dysfunctional strategies for dealing with this trauma including self-harm and substance misuse, and it is also possible that these dysfunctional ways of coping have led to them being in contact with the Criminal Justice System (CJS). It is highlighted that access to opportunities to deal with the effects of abuse is crucial in maximising a woman’s ability to avoid future involvement in crime (Blud, 2007; Cortson, 2007; Norman & Barron, 2011).

Interventions for trauma
There has been much debate about how to tackle the issues and complexities of trauma. The Cognitive-Behavioural Therapy (CBT) model has received a great deal of attention in the trauma literature. This model posits that irrational beliefs and negative feelings develop from experiencing traumatic events. Treatments using the cognitive-behavioural model include several different treatments, such as cognitive processing, exposure procedures and anxiety management training (Fo & Rothbaum, 1998). Cognitive processing involves exploration and challenging negative perceptions and beliefs about self, others and the environment (Blud, 2007). According to Pennebaker and
Campbell (2000), writing about an upsetting event can aid reduction of psychological distress. Schema-focussed therapy (Young, 1994) is also used to treat trauma and focuses on dysfunctional beliefs or maladaptive schemas. It has been suggested that maladaptive schemas are linked to extensive trauma histories (Blud, 2007). Dialectical Behaviour Therapy (DBT; Linehan, 1993) combines other techniques, including cognitive, behavioural, interpersonal and experiential techniques. DBT also uses practices of mindfulness, emotional regulation and distress tolerance. It is well documented that DBT has shown effectiveness for treating Borderline Personality Disorder (Linehan, 1993; Palmer, 2002). In terms of exposure approaches, the aim is to diminish traumatic memories by confronting the thoughts, feelings and memories of the feared situation. Some research supports the efficacy of exposure techniques (Foa & Meadows, 1997; Foa & Rothbaum, 1998), however, it has been suggested that some traumatic events are too upsetting to process using exposure techniques (Briere & Scott, 2006). Eye Movement Desensitisation Reprocessing (EMDR) involves the individual focussing on visual images, negative beliefs, bodily sensations and emotions associated with a traumatic event, whilst the patient visually tracks the therapist’s finger as it moves back and forth (Blud, 2007). Research into the effectiveness of EMDR has yielded mixed results. Another psychological approach to treating trauma is the psychodynamic approach.

The psychodynamic approach focuses on cognitive distortions, but instead of replacing them with more helpful thoughts it seeks to interpret the meaning and the reason that it arose (Blud, 2007). The evidence for psychodynamic treatment of trauma is mixed and is limited by methodological weaknesses (Roth & Fonagy, 2005). Cognitive Analytical Therapy (CAT) is also used to treat trauma and is informed by cognitive and psychodynamic approaches. In short, CAT is an individually delivered therapy which emphasises the collaborative relationship between the therapist and patient. CAT focuses on helping the client understand their maladaptive behaviours, including the patterns and origins of the behaviours so that alternative strategies can be learnt. The evidence for the effectiveness of CAT is also mixed, however, it is increasingly used.

For women with very complex backgrounds and multiple problems, classic trauma therapies are not advocated. Furthermore, research has advocated a more present focussed approach based on psycho-education, coping skills and anxiety management when working with women who have experienced prolonged and severe trauma (Blud, 2007). Several authors have pointed out that exploration of past traumatic material is not always appropriate (Adshead 2000; Briere & Scott, 2006; Bryant & Harvey, 2000) and present focussed treatments, such as psycho-education and those aimed at developing coping skills as a safer and more effective option (Najavitis, 2002). Additionally, during the early stages of recovery, highly structured groups can facilitate feelings of safety, predictability and group therapy has been used in the treatment of survivors of abuse, and trauma. Furthermore, traumatised individuals have also been shown to benefit from group treatment as it can reduce feelings of stigma, isolation, and shame. Whilst allowing opportunities for observation, learning, modelling, and sharing of new coping skills (Zlotnick et al., 1997).

The full Trauma Recovery and Empowerment Model (TREM) programme was initially developed by Maxine Harris and the Community Connections Trauma Work Group (1998). TREM is a group intervention designed to address the enduring cognitive, emotional and interpersonal problems that have developed as a result of suffering sexual and/or physical abuse. TREM uses a cognitive-behavioural approach that has psycho-educational elements and teaches coping skills. The TREM programme consists of 33 group sessions. One group session a week is facilitated and this is broken down into four
modules. The first module called Empowerment encompasses 12 sessions of basic education of skills in self-regulation, boundary maintenance, and communication. Sessions also include discussions around how to look after yourself, how to develop positive pro-social healthy relationships and ultimately to increase the woman’s level of hope for a future which is not characterised by abuse. The second module is called Trauma Recovery and again it is based on psycho educational skills around physical and sexual abuse and how current behaviours are linked to this past abuse. It also provides the women with an opportunity to rediscover and reconnect with repressed memories, feelings and views. Additionally, it allows space to develop and appreciate the steps needed to solve problems and difficult situations safely.

The third module, Advanced Trauma Recovery, is a more in-depth exploration of trauma with opportunities to continue to develop more helpful ways of communicating and being assertive with others with the aim of allowing the woman to keep herself safe and in control of the situation. Finally the fourth module, Closing Rituals, consists of three sessions which are designed to give the programme a definite ending. This aspect of the programme is especially important as often women do not have good experiences of endings, which may have been aborted prematurely or particularly painful. It also gives the group time to evaluate and assess their progress and what changes they will make following the programme.

As far as the team were aware the TREM programme had not yet been piloted in any environment within England or Wales. This programme had been widely evaluated in community settings within the US and preliminary results are positive. A multisite project has been reported which ran for five years (1998–2003) in a community setting in the US. Findings demonstrated that participants within the exposed to the integrated trauma intervention reported significantly less mental health symptoms and trauma symptoms at 12-month follow-up (Morrissey et al., 2005). Other studies have also shown a reduction in trauma symptoms using the Trauma Symptom Scale when comparing the TREM group to treatment as usual at 12-month follow-up (Amaro et al., 2007; Fallot, McHugo & Harris, 2005; Toussaint et al., 2007). Furthermore, Fallot et al. (2011) conducted a quasi-experimental study with 251 women which measured the integration of the addition of the TREM programme compared with trauma services as normal. Outcomes were resoundingly positive in that there were changes in trauma recovery skills which were positively associated with engagement in the additional TREM programme. What’s more, the women who engaged with the TREM programme reported significantly greater reduction in the severity of their alcohol and drug use, anxiety symptoms and current stressful events. Additionally, they showed increased levels of perceived personal safety. Furthermore, previous literature advocates the use of CBT for the treatment of trauma (Blud, 2007) and this has been further advocated by the National Institute for Clinical Excellence (NICE Quick Reference Guide, March, 2005). In addition, the psycho-educational element of TREM is supportive of the present day approach. Thus due to the positive supportive findings and in line with published guidelines for the treatment of trauma and specifically PTSD it was decided that the service would integrate the gender responsive TREM programme into the beginning of the dedicated trauma pathway.

**Integration into the treatment model and facilitation of TREM**

Nine women from the specialist women’s service were approached and given a TREM awareness session as part of a service user meeting. Three women were excluded from this as they were already accessing DBT which also forms part of the trauma pathway. Of the nine women who received the awareness, six women self-selected to take part in a pre-group assessment with the potential to
move onto module one of the group programme. All participants who self-selected were chosen to continue on to module one of the TREM intervention, five of the individuals experienced the module in a group format. One individual was offered the TREM sessions on an individual basis, this had been care planned for the individual in question as there were concerns about her IQ level and presentation in a group setting.

All nine women who were approached have a diagnosis of one or more personality disorders and this has been formulated as linked to their risk of reoffending. Additionally, some of the women have high scores on the PCL-R which has been linked to difficulties in therapeutic groups and forensic environments (Hare, 2003).

Consent was obtained from all participants prior to the programme. It was sought within the week following the awareness and self-selection session. The individuals were asked to read and sign a consent form, complete four psychometric assessments, [Coping Styles Questionnaire (CSQ; Roger, Jarvis & Najarian, 1993), Trauma Symptom Inventory (TSI-2; Briere, 2011), Culture Free Self-Esteem Inventory (CFSEI-2; Battle, 1992), Social Problem-Solving Inventory (SPSI-R; D’Zurilla, Nezu & Maydeu-Olivares, 2002)], and take part in a short semi-structured interview.

When facilitating the group in a prison environment there were a number of factors which had to remain at the forefront including safety, security and the prison regime. It is worth considering that confidentiality is difficult to maintain when conducting group-work in prisons and, therefore, some group members are less likely to share experiences and engage. Other factors include operational prison staff not subscribing to the effectiveness of group therapy. It is for the aforementioned reasons that there is a school of thought that custodial settings are not suited for specialist trauma treatment.

Following completion of the group the same psychometrics and a similar semi-structured interview was completed with each individual. An interview guided approach was employed, as it is a widely used format for qualitative interviewing allowing flexibility whilst maintaining structure, boundaries and consistency. In this approach the interviewer has an outline of the topics or issues to be covered, but is free to vary the wording or order of the questions and can probe when necessary (Patton, 1990). These were completed in order to capture any shifts which may have been triggered by engagement in the TREM module.

Qualitative results from Module One

The women who engaged with the programme and the facilitators noted a number of these benefits following conclusion of the module and some of these are highlighted:

‘Yeah it taught me to have more self-esteem about my body image and how to pick a partner. I compared this time to last time and I want more this time.’

Member 4

‘Yes it helped me understand a little more that trauma can be the littlest thing.’

Member 2

It is important to note that often for the women engaging with the Women’s service, being a woman has not always been a positive experience and has, at times, been scary, degrading and humiliating. Therefore, this opening module allows the women a forum to explore themselves as a woman and the associated feelings, in a safe, nurturing space. Within this space the women were exposed to constructive feminist perspectives and ideologies built on a foundation of positive psychology. Research has shown that not only can positive emotions and narratives increase physical health; they can also greatly improve psychological health. Some of the positivity which was shared has been captured in the dialogue with the women on follow-up:

References

[Provide references here]
‘Value and respecting myself more.’
Member 5
‘It taught me to have more self-esteem about my body image.’
Member 4

Based on these fundamentals the members of the group were asked what they hoped to achieve; some members stated that they hoped they would learn and build upon essential skills such as communication, whilst others hoped to grow and develop personally. On follow up it is positive to note that these aims appear to have been achieved;

‘Able to say no, I feel more confident.’
Member 2
‘Yeah I don’t get dragged in to other peoples thinking; regardless of their influence I am not swayed.’
Member 4
‘I am who I am, I’m accepting myself.’
Member 5

Reflections following a brief trauma group intervention (TREM)
A number of ideas have been suggested as to why and how therapeutic groups can facilitate such positive outcomes. For many groups, including that of TREM, the therapeutic relationship is suggested as a catalyst, it begins with the facilitator taking an active role within the group to maintain boundaries, make sense of difficult emotions and experiences through the narrative form and validate experiences where necessary. Throughout the group there was a significant ease to which the information flowed. This may have been due to the milieu which was put in place initially by the facilitators and maintained throughout the module by all. The positives of this are captured in the following quotes:

‘It was really relaxed, not forced and not intense. We were able to have a laugh, you didn’t feel pressured; speak when you want to speak.’
Member 4

‘I was allowed to go at my own pace and the facilitators were softly spoken and also being told that everyone was welcome to stay until the end even if they didn’t want to speak was helpful.’
Member 2
‘There was trust in the group which made me speak out, the group helped build trust.’
Member 2

Additionally, there are vast amounts of research surrounding the importance of the relational component for women and this is felt to be even more important within a therapeutic group in a prison setting. As women in the prison system often have unhealthy, illusory or unequal relationships with spouses, partners, friends and family members. For that reason, it is important to model healthy relationships, among both staff and participants, providing a safe place and a container for healing. In addition it is noted that it is crucial to create an environment in which the women can experience consistent, reliable and mutual relationships with the facilitators and each other (Covington & Beckett, 1988). Just as was hoped in the manual, connections were certainly made (Fallot & Harris, 2002). This was demonstrated in the verbal feedback from operational staff, clinical staff and women in the group. Some of the factors which may have triggered these new connections appear to have been captured in the following quotes:

‘It felt good being in a group.’
Member 3
‘There was trust in the group which made me speak out, the group helped build trust.’
Member 2
‘There was a nice bond which was also practiced on the wing.’
Member 6

This is promising as this can be a difficult element to nurture especially in a prison environment. Helpfully, the manual allowed for mediating factors against the barriers which can be faced within a prison environment. To mediate against some of the common difficulties for women in prison of a number of adaptations are suggested in the appendix of the manual. These were extremely helpful and were well received by
the women. It also emphasised the gender responsiveness of the intervention.

The team had to think extensively about responsiveness prior to implementation as one of the women deemed suitable for the module has diagnosed learning difficulties and a high level of suggestibility. Due to this her treatment has mostly been facilitated on an individual basis and this was also recommended for module one of TREM. Due to this it could be questioned whether this woman experienced as much benefit as those who experienced the module in a group setting which assists with peer support and development of new connections.

Additional benefits of a supportive group setting, wherein members are able to narrate their stories, include the process of desensitisation to the trauma, as well as a ‘communalisation’ (Pennebaker & Seagal, 1999; Tedeschi & Calhoun, 1995). This connection between two or more human beings reduces feelings of isolation and allows the individual to create structure and meaning to a trauma, which also aids the processing element of the event. The effects of allowing an individual to form a narrative around their own personal trauma, has been shown within diverse groups of people and in a variety of settings. The group of women engaged with the first module of TREM were diverse. The women varied in age from 26 to 62, they had significantly different life experiences, relationship history and education. Notably the individuals had been engaged with the specialist service for different lengths of time, ranging from a number of weeks to five years. This would hopefully not be the case in future as the women would be offered the empowerment module on entering the service so the difficulties associated with lengths of engagement would not have such a profound impact and be less of a confounding factor. The impact of this factor is highlighted by the following example in which, one group member had only recently completed the assessment and treatment needs analysis stage, whereas two group members were nearing the end of their treatment. Although there are many positive elements to this, it was found that having women at different stages of treatment meant that they had either limited or more developed coping skills to assist in managing themselves in a group environment. For example, the newer group member was very vocal, struggled to contain her emotions and opinions within the group, and would often control group discussions. Difficulties become apparent when trying to manage this without being dismissive or invalidating to the survivor.

Due to the nature of the group, discussions about traumatic experiences were inevitable and were not discouraged. It was felt that by discouraging the women to discuss the trauma and difficult life experiences they had experienced this would only serve to reinforce the negative response which had been previously received about their experiences. However, this did cause some difficulties as some of the women found disclosures difficult to hear and deal with. There was also an incident of broken confidentiality in which some of the women entered another group intervention and began to discuss details from a previous TREM session. Upon reflection this incident led to engagement difficulties in that the group members became reluctant to share experiences. It had also affected another group intervention and this was unhelpful for the group and unfortunate for the individuals involved. Overall, it was found that the women did feel comfortable enough to open up and share experiences in the group environment; this is highlighted in the following quotes:

‘I’m usually in my own little self, so to get something out of me was a miracle. I tend to be a bit shy and untrustworthy and more comfortable with myself.’
Member 3

‘It was really relaxed, not forced and not intense. We were able to have a laugh, you didn’t feel pressured; speak when you want to speak.’
Member 4
This incident emphasised the importance of boundaries and containment for the women, from the use of a mutually signed contract to experienced facilitators who were able to manage and contain distressing narrative. It was also important for facilitators to reiterate the importance of a positive mental attitude throughout all discussions. The benefits of including positive emotional content in disclosures have been reported (Pennebaker & Francis, 1996). This finding was supported by qualitative findings from the TREM group and is highlighted in the following quotes:

‘Because I talked about my childhood it allowed me to let some of it go.’
Member 1

‘I have come through a lot of trauma; I now have the skills to cope with future trauma.’
Member 4

**Conclusion**

It has been highlighted that a woman’s experience of trauma can be linked to future offending; therefore, it is imperative that women are provided with an opportunity to cope with the effects of traumatic experiences in a more positive way. By delivering the first module of TREM, the specialist women’s service hoped to empower participants and provide a supportive environment in which they could learn. The Empowerment module offered the participants a short-term therapeutic intervention based on psycho-education, which hoped to provide them with more knowledge about themselves as women.

Research highlights the link between traumatic life experiences and the later onset of personality disorder (Livesley, 2003). More specifically, individuals diagnosed with BPD can present with difficulty in developing and maintaining trustful relationships, developing a positive self-image and managing interpersonal relationships (*DSM-IV*, 2001). It is noteworthy that following TREM, some of the participants reported a positive shift in terms of trust and a greater understanding about factors which can affect the trust we have for someone. The participants were able to link education about the biological aspects of being a woman and how this had contributed to a rise in their self-esteem. Furthermore, it is positive to note that the participants reported gaining a better understanding of what a safe relationship involved, and reported having more stable boundaries following completion of module one. The findings support previous research, that it is not always appropriate to explore traumatic experiences in detail (Adshede, 2000; Briere & Scott, 2006; Bryant & Harvey, 2000), and that focusing on educating and developing coping skills can be more beneficial. It is also valuable to have further research findings that support the use of TREM with women and also for the purpose of treatment with women in a secure environment in the UK.

**Recommendations and future directions**

It is positive that the participants were able to provide feedback regarding the first TREM module. An important recommendation involved the participants having the option of a catch-up session, in which they could review the material covered, in order to reinforce it. The specialist women’s service will continue to offer the initial empowerment module to all of the women entering the service, and are planning on implementing the full TREM programme to those women who have more complex trauma difficulties and would benefit from a more in-depth exploration of their life.

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References


Working with Women Offenders

‘Using CAT’ as opposed to ‘Doing CAT’: Adapting cognitive analytic therapy for use within a forensic patient setting
Katie Gilchrist

Within this paper I intend to outline an adapted model of Cognitive Analytic Therapy (CAT) whereby CAT is used as a reflective practice for frontline staff, instead of the more traditional one-to-one therapeutic approach. The aim of implementing this way of working was to enhance relational awareness and to develop greater insight and understanding of ward-based interactions, day-to-day dynamics and critical incidents (Marshall, Freshwater & Potter, 2013).

CAT has been a useful tool in working with offenders as it can help the offender to identify their own reciprocal role procedures and thus, have a say in risk management (Shannon, 2009). Reciprocal role procedures within CAT are highlighting the past patterns of relating, and the effect these patterns are having on our relationships, our work and the way we are with ourselves. For example, in childhood you may have learnt the only way to stop being picked on by others is to become tough and intimidating, resulting in the other person feeling intimidated and afraid. These procedures help to form an understanding of the world we live in and can lead individuals to strive for these roles in future interactions. Case studies of the use of CAT with a forensic population have indicated that having an understanding of an individual’s procedures can help to formulate the motivations and nature of offending behaviour (Pollock, Stowell-Smith & Gopfert, 2006). Using the previous example, if the individual who becomes tough and intimidating towards others then also uses physical violence to ensure that they remain in the more powerful dominant role, the motivation for doing so may be due to a fear of being vulnerable. Therefore, reducing the likelihood of offending may involve focusing upon the individual’s self-confidence and image, as well as traditional offending programmes like problem solving and anger management.

CAT, typically, involves working alongside the client in a side-by-side manner. However, this is not always possible. Potter (1999) looked at ‘using’ CAT as opposed to ‘doing’ CAT and asked ‘Can people in other therapies use CAT to inform or aid their own model of practice?’ ‘Can CAT be used with only an introductory grasp of its principles and methodology?’ (p.2).

My first awareness of CAT occurred when I began working as a nursing assistant in a forensic mental health setting. I enjoyed working alongside patients, however, struggled to fully understand some of the behaviours displayed within the ward setting. I attended a two-day CAT skills awareness course and felt that the concepts of CAT gave me a framework for making sense of patient behaviour in terms of understanding how we can learn responses in childhood and the impact of these on our adult behaviour.

As I was a nursing assistant on a female medium secure admissions ward, I did not have the professional qualification required for the traditional CAT skills course. Yet I was part of a ‘frontline’ team that acquired a high percentage of patient contact on a daily basis. It is plausible that nursing staff could
benefit from the development of additional therapeutic skills using a relational model like CAT. Marshall et al. (2013) created a tier modelled adaptation of the skills course and describe the aim as the development of skills based on CAT but with care and treatment by staff as the main focus and vehicle for change. Marshall et al. (2013) make the distinction between ‘using’ CAT and ‘doing’ CAT, with the focus being on ‘using’ CAT. Within this article I will demonstrate how you can ‘use’ CAT on an inpatient ward with a female offender pseudo named Isobel.

A case example of ‘Using CAT’
Isobel was in her 40s and had a long history of involvement with mental health services. Case history identified that Isobel lost her brother when she was a teenager, she was bullied at school and that she was aggressive toward others and property. Isobel began to have increasing obsessive thoughts about harming others and contacted services for assistance. However, when no immediate response occurred, she set fire to her flat and was charged with arson. Isobel had made little progress despite intense pharmacological treatment, psychological intervention and close nursing on the ward. She was perceived to be ‘stuck’ and there was concern over her care pathway. I wondered if applying CAT to her presentation would enable a greater insight into her behaviours and open an area for progression.

Isobel’s presentation at the beginning of the skills course was that she was fearful of and unwilling to progress, as she was seeking constant reassurance around her medical diagnosis for fear that if she did not have it then her identity would not remain and she could not stay in hospital where she feels safe. She was assessed for individual psychological therapy; however, she would become distressed within sessions, as well as presenting as highly anxious. Therefore, it was agreed by the clinical team that she would benefit from a more consultation-based approach.

Acknowledging Isobel’s zone of proximal development (Vygotsky, 1978), in terms of what she could achieve independently in comparison to what she could achieve with support from others, it was agreed that I would work alongside staff, in consultation, using CAT as a framework to understand some of the difficulties experienced by them and Isobel. By implementing CAT in this way, Isobel would be given care without having to further exacerbate her distress through one-to-one work.

Implementing the Adapted Cognitive Analytic Model
1. Mapping the moment with staff
Ryle and Kerr (2002) describe CAT as a social model of the self and suggest that reciprocal roles created in childhood can be seen in current behaviour and interactions with others. Using this theory, I explored the interactions staff entered into with Isobel. I began to map these interactions, as demonstrated in Figure 1. CAT posits that there is a ‘third rule’ and behaviour expressed is influenced by the individual themselves, staff and the environment. Mapping moments on the ward with the staff team, I began to create a ‘here and now’ map of an incident they recalled where Isobel was asking staff members the same question constantly regarding a possible move to a new ward. I asked staff to think about their responses and how this may have made Isobel feel. The first reciprocal role was ‘silencing, protecting, reassuring → safe, reassured, secure’. I asked how the above interaction with Isobel made them feel and the reciprocal role ‘constant questions, seeking reassurance → tired, fed up, worn out’ was formed. Mapping alongside staff indicated that they were tired of Isobel’s presentation and I was concerned that this could affect Isobel’s behaviour and her stay on the ward. To investigate this further, I created an ‘action’ map looking at action, impact and response (Ryle & Kerr, 2002). This indicated the procedural sequences that we observed Isobel entering in to and it was identified
Figure 1.

**IDEAL PLACE**

- Reassuring
- Mothering
- Protecting
- Safe
- Protected
- Dependent
- Mothered

- Either do for her
- Or do yourself

- Constantly ask for help
- Or ignore

**DREADED PLACE**

- Neglecting
- Rejecting
- Uncaring
- Uncared for
- Unsafe
- Alone

- Confusion
- Unclear
- Overwhelmed
- Angry

**EXIT POINTS**

- A New Way of Interacting:
  - "Let's do tasks together"

**Overbearing**

- Bullying
- Pressuring
- Nagging
- Smothered
- Overwhelmed
- Frustrated
- Rebellious
- Angry

**Pull staff in**

- Screams in day area

**Can't be ignored**

- Beliefs unsupported

**Doing for her**

**Overarching CAT Map**

This was shared with the MDT and nursing team.
that staff felt they were adopting ‘encouraging’ and ‘prompting’ roles in their interactions. However, mapping allowed me to think therapeutically about Isobel and I recognised that she could instead feel ‘pushed’ and ‘rejected’ by staff. This awareness created a shift within my maps and encouraged the team to reflect upon what Isobel’s perception may be of interactions on the ward.

2. Patient life history
Ryle and Kerr (2002) describe a reciprocal role procedure as a stable pattern of behaviour that originates in early internalised relationships which determine current patterns of relation with others and self. Using this theory I clarified if the reciprocal roles I identified for Isobel were suitable by looking at her history to see if a common reciprocal role internalised in childhood could be identified. Isobel’s experience of loss, bullying, aggression and her act of arson suggested to me that she had experienced rejection and separation as a child. Her offence of arson could be understood as a way of communicating her distress around feeling isolated and uncared for by others. By starting a fire, she was immediately recalled and placed back into hospital where she felt safe and supported.

Adding this to the map, I identified a link between Isobel feeling rejected and her constantly asking questions due to obsessive thoughts around her diagnosis of schizophrenia and anxiety, which she used as a way of identifying herself as a person. From her early experience of separation and anxiety Isobel could have developed a dependency on others to care for her and thus, created a strong mothering reciprocal role. It was highlighted by nursing staff that Isobel seemed dependent upon others, stating that she was incapable of doing anything independently and presenting as so anxious when asked to do so, that staff tended to respond by rescuing or mothering her. She may have created the belief that she feels safe and secure when cared for and that she needs to be in hospital for this to occur, due to the community feeling such an unsafe place, where she could be alone and ignored. Spending long periods of time in hospital being looked after due to mental ill health could have led to a fear of being alone or independent. This may have influenced her current coping strategies of needing reassurance, a wish to be mothered and a wish to remain in a safe, cared for environment. Whilst these reciprocal roles may have helped as a child, they were now leaving Isobel with an identity that was formed through her reliance on others; that to have independent thought or action could leave her isolated which was something to avoid at all costs. This may have created an over reliance on staff to tell her what to do.

3. Creating an over-arching map demonstrating key roles
I mapped many moments on the ward concerning Isobel’s interactions with staff and her environment and reading Isobel’s case history confirmed her reciprocal roles. Combining all of these, I created an over-arching map that demonstrated the key roles staff entered in to as demonstrated in Figure 1. The development of a sequential diagrammatic reformulation gave me a tool for attempting to understand Isobel’s behaviour without having to subject her to the anxiety and distress of doing CAT on a one-to-one basis. Whilst staff felt they were being consistent in their approach, the map highlighted subtle differences in the way they interacted with Isobel. The map identified that Isobel was dependent on staff and that at times staff responded in a reassuring way which we observed left her feeling cared for and mothered. However, this was not sustained as staff became frustrated with Isobel’s lack of progress and increasing dependency. This led staff to neglect or ignore Isobel’s dependency which may have left Isobel feeling rejected. Alternatively, staff reassured Isobel and tried to encourage her independence; however, when reflecting upon this, staff felt she may have perceived this as
attacking and smothering, feeling pushed to be independent when she did not feel ready. It was felt that Isobel did not recognise the positives of independent behaviour, only believing that she would return to the community where she would be alone. Isobel felt bullied, which led her to feeling angry and to attack staff who then felt like they were being bullied. This was, therefore, a key area to focus upon when looking at how we as a staff team could work with Isobel.

4. Recognition of key areas within reformulation
The exploration of reciprocal roles developed in childhood and the creation of an overarching map demonstrating key roles were invaluable in explaining Isobel’s behaviour. A written reformulation was created so that the team could clearly identify Isobel’s childhood influences, current coping strategies, roles they were being pulled into and areas for intervention. This narrative formulation created an area for intervention, as I was able to demonstrate subtle differences in staff approaches to Isobel’s behaviour. Staff had not recognised the impact of doing everything Isobel wished had on fellow team members who did not ‘mother’ her. Staff could now recognise when they were being pulled into a negative reciprocal role. They could identify how ‘mothering’ Isobel was unhelpful as it reduced her independence.

5. The creation of a ‘relationally informed’ care plan
From this, a ‘relationally informed’ care plan was devised and shown to Isobel’s multi-disciplinary team. This followed a trans-diagnostic approach, highlighting the dynamics affecting Isobel and considering her upbringing, interaction with staff and interaction with the ward environment. The care plan recognised Isobel’s zone of proximal development and stressed the importance of consistent staff responses that promoted independence in a supportive way. For example, instead of coming across as pushy when promoting independence, staff began to explain why they were encouraging Isobel to do things for herself. This enabled Isobel to better understand why staff were promoting her independence and develop more autonomy over her life and what she wants to achieve. Furthermore, adopting a relationally informed care plan altered staff practice on the ward as everyone could identify with Isobel’s behaviour. There was a non-blaming, non-mothering approach toward Isobel and this fostered Isobel’s independence.

Examining the CAT map allowed for exit points to be created. These were new ways of interacting; reciprocal roles not currently present on the diagram that could help Isobel’s presentation (see Figure 1). For example, staff were encouraged to work alongside Isobel in a ‘let’s do it together’ approach as illustrated in Figure 1. Staff began to reassure Isobel in times of anxiety and this empowered Isobel to complete little tasks in stages, for example, making her own drink of juice. Staff prompted Isobel to tend to tasks independently in a nurturing way, recognising that there may be areas she needed assistance with and supporting her in this. For example, Isobel would be prompted to change her bedding, a task she originally perceived she was unable to do. Staff would remain at the room door, encouraging and supporting Isobel through giving verbal instruction when needed and offering praise throughout. Isobel felt supported and helped in a safe way so began to make her bed independently. Isobel did not display any awareness of a change in her interactions with others, however, she began to present with more autonomous behaviour; eating meals, making her bed and tending to her personal hygiene independently. Her presentation improved positively and it was noted through staff reflective groups and weekly MDT meetings that there was a reduction in the frequency of Isobel’s obsessive questions around medication. Isobel’s ability to now utilise assisted leave into the community encouraged a move to a less intensive setting.
**Conclusion**
The construction of a sequential diagrammatic reformulation allowed for the creation of a relationally informed care plan and the development of exit points to improve Isobel’s current situation. The implementation of CAT provided a common language for understanding Isobel’s behaviour and this created a more psychologically informed environment. Mapping moments and developing reciprocal roles allowed the team to become attuned to Isobel’s behaviour and thus, better understand why she displayed the behaviour she did. The development of the sequential diagrammatic reformulation allowed the team to recognise the impact of Isobel’s upbringing on their own interactions with her. The development of exit points clearly demonstrated interactions that were more beneficial in helping Isobel to progress. CAT changed the culture of the ward as the team were now able to better understand patient behaviour. A non-blaming, non-judgemental approach was adopted as CAT allowed everyone to think trans-diagnostically and therapeutically.

There was a reduction in staff splits as everyone altered from mothering or pushing Isobel to working alongside Isobel. This created a stronger working environment as everyone adopted a consistent approach. Ultimately, the implementation of CAT principles allowed for all to fully grasp Isobel’s presentation, identify areas for improvement and to help Isobel move on to a less intensive setting. Whilst it is optimal to work alongside an individual in a side by side manner, I hope that I have demonstrated that ‘using’ CAT in an adapted form can change an individual’s behaviour and improve their current situation.

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**References**
Working with Women Offenders

Does adapted DBT have a place in forensic settings? The development of a DBT-informed emotion regulation group for female forensic personality disordered inpatients

Claire Thompson

This study explores the impact of a DBT-informed emotion regulation group upon female personality disordered inpatients detained within a forensic low secure psychiatric service. Emotion regulation is a core feature of borderline personality disorder, dialectical behaviour therapy having been developed on this premise.

Adapted sessions (20) were devised primarily from the DBT modules of emotion regulation and distress tolerance to meet the needs of both the inpatient setting and patient group. The group was run twice with eight patients in each group. Pre- and post-incident rates were used as an indication of potential treatment change in addition to measures of emotional control and altered states of capacity. Results indicated significant reduction in post-intervention rates of violence and self-harm, results from the psychometric data did not indicate such a degree of treatment change. Methodological limitations and implications for future practice are discussed.

Keywords: Female offender; DBT; BPD; dialectical behaviour therapy; female psychiatric service; borderline personality disorder.

FIGURES published by the Ministry of Justice in November 2013 reported 3956 women incarcerated in England and Wales, representing just under five per cent of the overall prison population. (Ministry of Justice, 2013). The female prison directorate currently appears to currently be in a state of flux, HMP Askham Grange and HMP East Sutton Park closing in 2014 with further imminent changes expected.

This is a concern for the potential impact on secure forensic mental health services when a significant number of female offenders with borderline personality disorder is well evidenced (Newhill et al., 2009; Sansome, 2009) and there is a noted lack of women only community mental health services (Ministry of Justice, 2013). The Corston Report (2013) also comments specifically on the disconnect between forensic and mental health services for female personality disordered offenders, especially those deemed to present a significant level of risk to others. Due to a lack of specialist services one option for female personality disordered offenders is to be admitted to independent hospitals providing secure health care services aiming to address both the risk and mental health needs of service users though this generally requires being sectioned under the Mental Health Act.

Borderline personality disorder and offending
The relationship between personality disorder and offending behaviour whilst complex and multi-faceted, is somewhat unsurprising given that a trait of antagonism or hostility is characteristic of a number of personality disorders within the Diagnostic
and Statistical Manual 5 (DSM-5). This relationship is supported by studies which have examined the prevalence of personality disorders amongst offenders which has consistently reported prevalence rates ranging from 10 to 15 per cent for primary clinical diagnoses of personality disorder (Anderson et al., 1996; Birmingham, Mason & Grubin, 1996; Duggan & Howard, 2009). In relation to borderline personality disorder the strong correlation with offending is not new, Coid in 1998 found that offenders with cluster B personality disorders (e.g. antisocial, borderline, histrionic) were 10 times more likely to have a criminal conviction and almost eight times more likely to have spent times in prison. A more recent but smaller scale study by Konstantinos et al. (2008) corroborated these results. This lead the authors to suggest that borderline personality disorder is strongly related to the manifestation of violent acts, predominantly thought due to the anger dyscontrol that is in both the DSM-5 and the International Classification of Diseases 10 (ICD-10) classification systems for BPD. Frequent, intense anger and aggressive outbursts are also included in both sets of criteria meaning borderline personality disorder has been found to be specifically correlated with violent acts (Duggan & Howard, 2009). The biosocial theory of BPD by Linehan (1993) proposes that this dysfunction of emotion results from biological irregularities combined with certain dysfunctional environments, as well as their interactions over time. Ultimately, this results in individuals that react quickly to perceived threats and have a low threshold in terms of their emotional reactions, such responses contributing to the increased likelihood of offending behaviour (Logan & Blackburn, 2009).

Researchers have also demonstrated links between BPD and the risk of reoffending (Nee & Farman, 2007) indicating a need to explore ‘what works’ with mentally disordered offenders, particularly female disordered offenders to reduce risk to the women themselves and to others. In July 2013, the Justice Select Committee published findings and recommendations in an attempt to ensure that the differing needs of females in the Criminal Justice System are both met and recognised. In response to this the Ministry of Justice commissioned a Review of the Women’s Custodial Estate in 2013. One of their key recommendation’s was the need to improve access to psychological interventions, namely learning from the Offender Personality Disorder Pathway with the potential for joint commissioning of services to meet both mental health and criminogenic need of the female prison population.

**Borderline personality disorder and DBT**

Within the DSM-5 (2013), BPD is defined as an amalgamation of behaviours that includes the following: efforts to avoid abandonment; a pattern of unstable and intense personal relationships; identity disturbance; markedly and persistently unstable self image or sense of self; impulsivity in at least two areas that are potentially self damaging (e.g. substance misuse, spending or eating behaviours); recurrent suicidal or self harm behaviour; affective instability; chronic feelings of emptiness; and inappropriateness, intense anger or difficulty controlling anger.

Dialectical Behaviour Therapy (DBT) was devised as a psychological intervention focused on addressing some of the symptoms or behavioural manifestations of BPD (Linehan et al., 1991). It aims to help participants develop skills in relation to four core areas of deficit within BPD: emotional regulation, interpersonal effectiveness, distress tolerance and mindfulness. These maladaptive patterns are considered to stem from the interaction between an individual who is emotionally vulnerable and an invalidating environment; or rather an environment that pushes, ignores or corrects behaviour independent of the actual validity of the behaviour. It is felt that by developing tolerance and coping techniques as well as encouraging cognitive and emotional change, DBT aims to address both emotional dysregula-
tion and the range of cognitive and emotional issues related to BPD. It combines standard cognitive behavioural techniques for emotional regulation and reality testing with concepts of mindful awareness, distress tolerance, and acceptance largely derived from Buddhist meditative practice.

All of these areas in combination have a main goal of achieving some measure of stability and cohesiveness in respect of emotions and mood, the dysregulation reported to be the underpinning of a proportion of violent and impulsive crime committed by female personality disordered offenders (Sansone & Sansone, 2009).

Enhanced DBT provides several formats of therapy. Skills training in a group to teach the skills and Enhanced one-to-one sessions to assist the client to apply these skills to their own life. The client is also provided with emergency telephone support for when they deem they are in crisis and their treatment team must attend weekly consult supervision to ensure best practice.

DBT has for a number of years been acknowledged as the psychological intervention of choice for BPD. It is a treatment option recommended by the National Institute for Health and Clinical Excellence (NICE) guidance (2009) for therapists working with female BPD suffers. However, only in recent years has DBT been considered potentially suitable in female forensic services (Nee & Farman, 2005; Van Den Bosch et al., 2012) as there are a number of factors that limit its usage in secure settings. The original modality of DBT devised in the 1990s focuses on a community setting, with one treatment goal being to maintain safety so as to assist clients to build community based lives that do not require hospital admissions (Dimeff, Monroe-DeVita & Paves, 2006). This, therefore, could be seen as potentially restricting its relevance to an inpatient environment, let alone a forensic one. The impression that an individual’s hospitalisation has prevented his or her suicide can paradoxically increase the likelihood of his or her future suicidal behaviours that prompt hospitalisation’ (Dimeff & Koerner, 2007, p.70). Contrastingly, an offender’s detention can allow for the carefully controlled management of a crisis, bring a new perspective to diagnosis and treatment and allow for a compassionate and clear understanding for the offender of their disorder.

These issues aside, forensic units present a number of practical challenges to the implementation of enhanced DBT. For example, an integral part of the programme is emergency telephone consultations between patient and therapist. For security and practicality reasons this may not sometimes be possible within a forensic inpatient service, restricting coaching of the skills. It is, however, acknowledged that is becoming increasingly used within forensic settings.

Some of the original skills techniques are also not instantly implementable within a secure environment, however, adaptations for offenders are becoming more common place. For example, self-soothing activities such as petting an animal or going for a walk on the shore of a lake may not be an option if Section 17 leave has not been granted, however cuddly toys, comforting textures and soothing pictures to aid the mastery of the varying skills can all be viable options.

The NICE guidance highlights that offenders should have the same access to health care as those not detained or imprisoned at first glance the judgement could be made that enhanced DBT within forensic settings would not be thought potentially feasible due to the reasons already detailed. In addition, the duration of a patient’s detention in forensic inpatients settings is becoming increasingly ruled by contextual factors such as the relevant section of the Mental Health Act and funding. Patients may not, therefore, be able to commit to or complete the full DBT programme, which in its entirety can take over a year.

In light of these restrictions of Enhanced DBT within forensic settings, a number of adaptations have been trialled and implemented within more challenging settings,
including secure psychiatric units and prison environments (Robins & Chapman, 2004). Despite all the aforementioned issues, the evidence still suggests that DBT may be an effective intervention with female offender populations within secure settings (Nee & Farman, 2005; Van Den Bosch et al., 2012). There are varying reasons for this; DBT addresses both short-term management and longer-term goals of overall behaviour change, social reintegration and consequential risk reduction. The bio-social theory used to explain the pathology of borderline personality disorder can also be related to the varying disorders that are often found in forensic facilities such as antisocial personality disorder and staff burnout which can occur in secure settings, and may be lessened by DBT (McCann, Ball & Ivanoff, 1996). Notwithstanding the small sample sizes, the results of these studies supported the positive effect of DBT upon BPD-related behaviours such as deliberate self-harm, aggression and mental illness related symptoms. The current study aims to examine the effectiveness of a DBT-informed programme within a women’s low secure service in the East Midlands of England.

Method

Participants
Sixteen patients aged between 21 and 54 (\(M_{age}=38.2, SD=5.8\)) from a female low secure psychiatric service were assessed as meeting the inclusion criteria for the group. The inclusion criteria was similar to that of the enhanced DBT programme in that all participants had a history of self-harm and demonstrated problems in at least one of the following areas; interpersonal relationships, emotional regulation, impulsivity and risky behaviours. Furthermore, all patients had a current diagnosis of Borderline Personality Disorder as outlined in the DSM-5, or Emotionally Unstable Personality Disorder as outlined in the ICD-10. In addition, all patients were required to demonstrate a level of willingness to change by agreeing to attend the course. Patient commitment was also assessed by willingness to engage in the 12-week psychological assessment process completed upon their admission. This includes clinical interviews and a battery of psychometric assessments, with recommendation for attendance at the group being made following a detailed formulation and as part of an individualised treatment pathway. Patient commitment was also continually assessed throughout the programme, with patients being informed that they would be excluded if they missed any three sessions in a 10-session module. Further exclusion criteria assessed prior to the commencement of the programme included active psychosis and a primary or secondary diagnosis of a learning disability.

Of the 16 women who commenced the DBT-informed group, 14 completed the full programme. One patient was excluded from the programme shortly after it commenced due to her unstable mental state, which significantly affected her ability to commit to the programme. A second participant left the programme after completing one module due to being transferred to another low secure unit nearer her home.

Assessment measures
A number of outcome measures were identified to assess the effectiveness of the group. Incident data for each patient was collected centrally by the hospital for a month prior to and a month post the intervention. As part of the requirements for the hospital reporting process these are already classified into categories, that is, violence or self-harm, therefore, this did not have to be done by the study author. In addition to incident data, self-report questionnaires were administered both pre- and post-intervention. The questionnaire felt most aligned to the treatment aims and, therefore, used as the psychometric measure of treatment change was the Inventory of Altered Self-Capacities (IASC). The IASC is a 63-item self-report measure of an individual’s psychological functioning in three important areas: Capacity to form and maintain meaningful
relationships, Capacity to maintain a stable sense of personal identity and self-awareness and Capacity to modulate and tolerate negative affect. The various scales of the IASC assess the following domains: Interpersonal Conflicts (IC), Idealisation – Disillusionment (ID), Abandonment Concerns (AC), Identity Impairment, Susceptibility to Influence (SI), Affect Dysregulation (AD) and Tension Reduction Activities (TRA). Descriptions of each of the scales are shown in Table 1.

**Intervention**

Due to the service not providing an Enhanced DBT programme, it was decided that it would be beneficial to provide an initial adapted DBT 10-session module, based predominately on DBT emotion recognition principles and basic skills. An additional 10-session module looking primarily at building emotional resilience through distress tolerance skills was then devised, also facilitating a session on mindfulness which within the Enhanced DBT programme is a module in its own right. The two modules, each containing 10 sessions (20 sessions overall) are shown in Table 2 (overleaf).

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**Table 1: Description of the Inventory of Altered Self Capacities (IASC) Scales.**

<table>
<thead>
<tr>
<th>Self-Capacities</th>
<th>Descriptions</th>
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<tbody>
<tr>
<td>Interpersonal Conflicts (IC)</td>
<td>Evaluates the extent to which the respondent endorses problems in his or her relationships with others and the tendency to be involved in chaotic, emotionally upsetting and sometimes short-lived relationships.</td>
</tr>
<tr>
<td>Idealisation–Disillusionment (ID)</td>
<td>Assesses the respondent’s tendency to dramatically change his or her opinions about significant others, generally from a very positive view to an equally negative one.</td>
</tr>
<tr>
<td>Abandonment Concerns (AC)</td>
<td>Evaluates the respondent’s overall sensitivity to perceived or actual abandonment by significant others and the tendency to expect and fear the termination of important relationships.</td>
</tr>
<tr>
<td>Identity Impairment (II)</td>
<td>Measures the extent to which the respondent has difficulty maintaining a coherent sense of identity and self-awareness across contexts.</td>
</tr>
<tr>
<td>Susceptibility to Influence (SI)</td>
<td>Assesses the respondent’s tendency to follow the directions of others without sufficient self-consideration, and to accept uncritically others’ statements or assertions.</td>
</tr>
<tr>
<td>Affect Dysregulation (AD)</td>
<td>Evaluates problems in affect regulation and control, including mood swings, problems in inhibiting the expression of anger, and inability to easily move out of dysphoric states without externalisation.</td>
</tr>
<tr>
<td>Tension Reduction Activities (TRA)</td>
<td>Evaluates the respondent’s tendency to react to painful internal states and effects with externalising behaviours that may distract, soothe, or otherwise reduce internal distress. May suggest a tendency to externalise when feeling frustrated, angered, maltreated, or otherwise internally stressed.</td>
</tr>
</tbody>
</table>
Table 2: Session plans for both modules.

<table>
<thead>
<tr>
<th>Module 1</th>
<th>Module 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. What is an emotion?</td>
<td>2. Distraction</td>
</tr>
<tr>
<td>4. Problems with emotions</td>
<td>4. Doing the opposite</td>
</tr>
<tr>
<td>5. Emotions, feelings, moods</td>
<td>5. Negative automatic thoughts</td>
</tr>
<tr>
<td>7. Recognising emotions</td>
<td>7. Shame</td>
</tr>
<tr>
<td>8. Naming emotions in others</td>
<td>8. Anger</td>
</tr>
<tr>
<td>10. Ending and evaluation</td>
<td>10. Ending and evaluation</td>
</tr>
</tbody>
</table>

The extended length of the modules enabled patients to consolidate key skills and concepts, and allowed a greater focus on the use of practical and relevant examples from patients themselves, to which they could apply the skills. The group occurred on a weekly basis for approximately one hour and was run by a Chartered Psychologist and a Forensic Psychologist in Training both of whom had received previous standardised DBT training.

Results
Due to the limited sample size non-parametric tests (Wilcoxon signed rank tests) were used. The mean pre- and post-treatment scores across the differing domains of the IASC are displayed along with the mean pre- and post-incident data scores in Table 3. The results of the Wilcoxon signed rank tests indicate that there were expected changes across all domains of the IASC, as well as significant reductions in deliberate self-harm, aggression and overall incidents. Effect size analysis, using Cohen’s $d$ demonstrated either medium or large effect sizes.

Discussion
This study aimed to evaluate the effectiveness of a DBT-informed emotion recognition and regulation group facilitated at a women’s low secure psychiatric unit. The results indicated that there was a statistically significant difference in patient’s pre- and post-treatment scores on measures of deliberate self-harm, violence and overall incidents. Whilst the intervention may not be felt to target all these specific areas as directly as say anger management or self-harm management groups, the issue of emotion regulation and distress tolerance is felt to underpin strongly all three, and seen as evidence for a positive treatment change.

Pre- and post-psychometric scores also indicated a positive treatment change. Not surprisingly the two self-capacities related to affect control; Affect Dysregulation (AD) and Tension Reduction Activities (TRA) were noted to show the most significant positive changes. The usefulness of some of the other scales such as susceptibility to influence could be questioned as this is not a capacity targeted within this treatment.
Table 3: Mean pre- and post-treatment scores and incident rates (with Standard Deviations), significance levels and effect sizes.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Pre-group mean (SD) N=16</th>
<th>Post-group mean (SD) N=16</th>
<th>Sig</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpersonal Conflicts (IC)</td>
<td>22.6 (8.8)</td>
<td>16.2 (6.3)</td>
<td>0.010</td>
<td>0.38</td>
</tr>
<tr>
<td>Idealisation–Disillusionment (ID)</td>
<td>21.3 (9.1)</td>
<td>16.4 (6.4)</td>
<td>0.026</td>
<td>0.52</td>
</tr>
<tr>
<td>Abandonment Concerns (AC)</td>
<td>21.8 (10.9)</td>
<td>18.7 (8.2)</td>
<td>0.041</td>
<td>0.30</td>
</tr>
<tr>
<td>Identity Impairment (II)</td>
<td>22.9 (11.8)</td>
<td>19.1 (10.9)</td>
<td>0.037</td>
<td>0.28</td>
</tr>
<tr>
<td>Susceptibility to Influence (SI)</td>
<td>19.6 (10.0)</td>
<td>16.5 (5.8)</td>
<td>0.028</td>
<td>0.44</td>
</tr>
<tr>
<td>Affect Dysregulation (AD)</td>
<td>22.4 (11.0)</td>
<td>10.4 (3.8)</td>
<td>0.002</td>
<td>0.61</td>
</tr>
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<td>Tension Reduction Activities (TRA)</td>
<td>17.3 (8.2)</td>
<td>10.3 (2.6)</td>
<td>0.004</td>
<td>0.68</td>
</tr>
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<td>Deliberate Self-Harm (average per patient)</td>
<td>14.0</td>
<td>4.0</td>
<td>0.029</td>
<td>0.86</td>
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<tr>
<td>Violence (average per patient)</td>
<td>7.5</td>
<td>0.25</td>
<td>0.006</td>
<td>0.62</td>
</tr>
<tr>
<td>Total Incidents (for all 16 patients)</td>
<td>172</td>
<td>34</td>
<td>0.005</td>
<td>0.83</td>
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</table>

Despite the acknowledged methodological limitations of this study (including the small sample size), overall it is felt to highlight the potential for an adapted version of DBT within secure settings if the full enhanced programme is not viable due to financial or staffing restraints.

A number of factors suggest the need for caution when drawing conclusions from the results. These include variables such as engagement in previous treatment, most patients having engaged in some form of previous psychological therapy at differing hospitals. Whilst all 16 patients had recently been admitted into this specific unit, previous treatment could not be controlled for. Another factor was the variance in medication administered throughout the sample, with none of the 16 patients being medication free throughout the intervention. The sedation effect, for example, could potentially affect their ability to engage with the course material and consequential results. The small sample size is also recognised as a limitation of the study, as is the lack of a control group which would have allowed for more rigorous assertions from the results to have been made.

There were a number of environmental factors that also mean care needs to be taken in interpreting the results. The hospital setting itself may be a cause of instability, for example, dynamics on the ward and influence and role of nursing staff potentially impacting on a patient’s mood and incident rates. In relation to this latter variable in particular, the lack of adequate knowledge and training of nursing and other support staff on the unit is considered to be a limitation of the treatment that is likely to have impacted on the current study. If the full DBT programme were to be implemented this would be considered vital for assisting patients in generalising their skills as well as reinforcing skill usage on a daily basis.

The implementation of a DBT-informed programme within a low secure unit has served as an opportunity to conduct preliminary investigations into the potential effectiveness of the enhanced DBT programme for female forensic inpatients with a diagnosis of BPD. The positive results shown
within this study are important in relation to planning future treatment, adding weight to the argument that the potential therapeutic benefits of DBT within secure settings and forensic populations in general should not be overlooked. The fact enhanced DBT targets criminogenic needs such as poor problem solving, poor self-management, antisocial beliefs, anger and emotional dysregulation means there is scope for it to be used to target offending and ultimately reduce risk to both service users and the wider community.

References

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The Division of Forensic Psychology Training Committee (DFPTC) was tasked by the Partnership and Accreditation Committee with reviewing standards for both Stage 1 and Stage 2 training. Two working groups were established with Sarah Brown leading the Stage 1 standards review and Roisin Hall Stage 2, and DFPTC Chair Dee Anand overseeing both groups.

One outcome of the review was that the model of thinking that Stage 1 and Stage 2 are discrete enterprises came under scrutiny; a model presenting common themes that run through both Stage 1 and Stage 2 with differential emphases was deemed to be more appropriate. Across both Stage 1 and Stage 2 demonstration of a critical understanding of theories, knowledge and evidence (both current and emerging) is required, as well as core skills and capabilities, along with the application of ethics/standards, guidelines, legal contexts, and skills of evaluation and communication. This is outlined in a comprehensive model with a thematic approach that identifies the common themes that will inform the evidence required to demonstrate outcomes across the dimensions specified (see Figure 1).

Demonstrating ability across these themes at both a theoretical/academic level (Stage 1) and an applied/practice level (Stage 2) will assist in preserving the ‘gold standard’ of Chartership as a quality standard rather than a minimum requirement threshold as required for Health and Care Professions Council (HCPC) registration, and allow the British Psychological Society (BPS) to continue to make the case for Chartership as achieving this standard.

It should be noted that the BPS is the only body that offers a qualification in Stage 2 standards for forensic psychologists with the role of the HCPC primarily as a regulator. Stage 1 training programmes fulfil the important role of enabling graduates to fulfil the Standards of Proficiency outlined by the HCPC as representing the key concepts and bodies of knowledge that are relevant to the practice of forensic psychologists.

Practitioner psychologists (forensic psychologists) who are entrants to the HCPC Register must:

- understand the application of psychology in the legal system;
- understand the application and integration of a range of theoretical perspectives on socially and individually damaging behaviours, including psychological, social, and biological perspectives;
- understand theory and its application to the provision of psychological therapies that focus on offenders and victims of offences;
- understand effective assessment approaches with individuals presenting with individual and/or socially damaging behaviour;
- understand the application of consultation models to service-delivery and practice, including the role of leadership and group processes;
- understand the development of criminal and antisocial behaviour;
- understand the psychological interventions related to different client groups including victims of offences, offenders, litigants, appellants and individuals seeking arbitration and mediation.
The underpinning principles of the Stage 1 criteria is that students/trainees develop a range of transferrable skills that are relevant to forensic psychology practice and to a range of other areas/employment. The criteria have been developed with a problem-based learning approach in mind, such that students develop the appropriate skills and capabilities and ways of working such that they approach each task by reviewing the current knowledge/theoretical/evidence-base, identifying and developing the appropriate skills and capabilities and applying these within appropriate practice, ethical and legal frameworks. They then evaluate and reflect on this work and communicate it appropriately. These core skills at Stage 1 which transfer more transparently to Stage 2 include: assessment and formulation, intervention, legal and criminal justice context, client groups, forensic settings, advice and consultancy, development and training and of course the inclusion of research. Hence, rather than discriminating between skills and capabilities, the profile and understanding of ‘What is a forensic psychologist?’ and ‘What does a forensic psychologist do and where?’ is made clear.
from Stage 1 through to Stage 2. The central idea of this revision of standards was to make clear to the profession how we might best function and equip new entrants with the best tools, knowledge and ideas to operate with improved adaptability in a changing world. Fortunately, we were able to bring Programme Directors with us in this process and while the philosophy and standards were clarified with strong input from them and the DFPTC, it has been done in such a way as to require minimal changes within the core programmes being delivered and will roll out through the accreditation process with reference to the new standards.

This has been a challenging and extensive piece of work involving consultation with and participation of stakeholders. My thanks go out to all Programme Directors who have been involved in this process and the sterling and efficient work of all members of the DFPTC. It has been with a sense of achievement in the ongoing development of the profession that we have reached the stage where we were able to bring these recommendations to the Partnership and Accreditation Committee. Without the involvement of Roisin Hall and the Forensic Psychology Qualifications Board (FPQB) along with Lucy Horder and Susan Quinn at the BPS this would not have been possible. I am grateful to them for all of their input.

The challenge for us now is to ensure that Chartership retains its value and becomes increasingly transparent and streamlined with a clear focus on standards and professional development which would tie in with the revised standards for Stage 1 programmes. This is the beginning of the process, having effect at the beginning of the career of future forensic psychologists and ongoing development through the career pathway. I am convinced that a combination of the positive steps taken to this end, being steered by Roisin Hall and the FPQB and the work of the DFP will mean that the goal of retaining the value and merit of the Chartership qualification will be achieved in a reasonable timeframe.

**Dee Anand**
Chair – DFP Training Committee
Chair Elect – DFP
Becoming a Qualified Forensic Psychologist

Training routes in forensic psychology
Roisin Hall

At the DFP Strategy Day in December 2013 a working party was established to collate material on the different training routes available to those wishing to become registered or chartered as a practitioner psychologist. It is clear that there is a lot of interest in this matter amongst trainees, as well as those on the MSc courses and undergraduates, whilst key employers such as the prison services are keenly evaluating the relative merits of supporting training for Health and Care Professions Council (HCPC) registration vs. British Psychological Society (BPS) chartered status. The pieces you have in this edition of Forensic Update cover all the routes and more and, in my opinion, bring some much needed clarity. As well as information about what is available, contributors have written about the process from a reflective viewpoint and described their own experiences.

The DFP Training Committee has recently carried out a revision of the standards for accreditation for the academic courses and the resulting model, as seen in the piece by Dee Anand, Chair of the Training Committee, can be seen to provide a framework for the competencies required for both Stage 1, the MSc stage and Stage 2, the Doctorates and the Forensic Psychology Qualification.

It is fascinating to read the reflections from supervisors and trainees involved in the quite different routes. Sarah Disspain’s review of all the routes to registration and chartered status includes trainees’ views, whilst Cerys Miles gives a supervisor’s perspective and Dean Fido writes about entering forensic psychology through a PhD. Trainees are encouraged to follow up this information by logging on to the trainee forum, or by contacting one of the in-training representatives, Sarah Disspain and Sarah Senker, and by keeping a look out for DFP training events.

The BPS Qualification has gone through some major revisions over the years and there is still important work to be done to simplify and clarify this route and to ensure it is adequately resourced and supported. John Hodge’s paper highlights how the Qualification provides a form of apprenticeship training which maps onto the scientist practitioner concept of applied psychology. Julie Harrower’s paper discusses the assessment process and exemplifies the move to a more holistic approach.

The DFP has established a further working party to consider what the future employability prospects may be for those who wish to pursue a career in forensic psychology at a time when cutbacks may be limiting job opportunities. Given the number of training courses and the increase in interest, it may be prudent to explore what long-term opportunities there may be for employment as a forensic psychologist in the future.

Roisin Hall
Chair, Forensic Psychology Qualification Board
Becoming a Qualified Forensic Psychologist

How to become a Practitioner Forensic Psychologist
Sarah Disspain

With changes to the regulatory bodies and the introduction of different training routes, I thought it would be helpful to share some personal experiences of the training routes from trainees that are living them every day. I have also managed to get those responsible for the different routes to provide answers to some of the important questions potential trainees may be wondering about when deciding which route to undertake. These are collated in Table 1 below.

In 2009 the Health and Care Professions Council (HCPC) became the regulating body for Forensic Psychologists. In order to practice as a Forensic Psychologist you now need to be registered with the HCPC. This means you must meet and continue to meet the standards they set for the profession in order to demonstrate your ‘fitness to practice’. In order to register with the HCPC, you must successfully complete an approved programme. Completing an approved programme does not guarantee someone will become registered. Rather, it indicates that the person meets the HCPC’s professional standards and is eligible to apply for registration.

Prior to the introduction of the HCPC, the British Psychological Society (BPS) was the only regulatory body for qualified Forensic Psychologists. In order to become qualified you were required to be ‘chartered’ with the BPS. So what does being ‘chartered’ or ‘chartership’ mean? The Division of Forensic Psychology state that ‘Chartered Psychologist status is the benchmark of professional recognition for psychologists and reflects the highest standards of psychological knowledge and expertise. If a professional is chartered it is a mark of experience, competence and reputation for anyone looking to employ, consult or learn from a psychologist.’ One of the ways to achieve chartership is to undertake BPS accredited postgraduate qualifications and training.

Information about the different routes is provided in this article along with accounts by Forensic Psychologists in Training on the various routes in order to give you a first-hand insight into the experience below.
The BPS Qualification in Forensic Psychology (Stage 2)

This Qualification (Stage 2) involves a length of time spent in ‘supervised practice’ following the completion of an MSc (Stage 1). This means that, with support and guidance from one or more experienced colleagues, you can gain experience and develop your competence to work as a Forensic Psychologist within a real context. The training route requires candidates to submit portfolios of written evidence to demonstrate competency development in relation to four core roles. These core roles relate to: (i) Conducting applications and interventions; (ii) Research; (iii) Communicating with other professionals; and (iv) Training other professionals. Two exemplars (example pieces of work) for each core role are submitted along with supporting evidence of competency development. The supporting evidence includes a Practice Diary, detailing your reflections and learning on daily tasks and a Competence Logbook, detailing how you have developed and demonstrated your competence within each core role.

Usually Forensic Psychologists in Training undertake relevant work as part of their paid employment. However, trainees can also undertake this route independently. This requires more co-ordination on the part of the trainee but can provide further breadth of experience. Two trainees reflect on their experience below.

Reflections and experiences of the BPS Qualification in Forensic Psychology (Stage 2) route

As an HMPS Trainee: Contributed by Sarah Disspain (Forensic Psychologist in Training)

This training route is often considered to be labour and time intensive. Indeed, at times the route has felt painstaking and I have had times where I have questioned my ability to complete it. However, the rewards of the route for me have outweighed the negatives.

Whilst the route gives guidance on the process of becoming a Chartered and in turn Registered Practitioner Psychologist, the content of the training route is flexible, although is mainly dependant on your current employment or placement opportunities. At times I have experienced difficulty in accessing opportunities to undertake work related to particular competencies. However, it has also pushed me to think creatively, helped me to develop professional relationships with various Practitioner Psychologists and related disciplines and allowed me opportunities to develop the breadth of my practice. In turn I have had opportunities to work with a variety of populations in a variety of psychological roles, which has helped to shape me as a Practitioner Psychologist.

Submitting my portfolio of competence when it has been completed and deemed competent by my supervisor(s) has allowed me the time and opportunity to comprehensively develop the relevant competencies. The autonomy that you have over your learning can be empowering.

Finally the feedback process on your portfolio, which can again take some time, is something that has allowed me to develop my practice further. Having objective impartial feedback on my work has been an important part of my development. Whilst initially I have defended against my various negative emotional states in different ways when I have been required to resubmit additional work, when I have reviewed the feedback I have always found it useful in developing my practice.

In summary, whilst the route is extensive and challenging, the breadth and depth of experience I have achieved has helped ensure that I become a competent future Practitioner Psychologist. I believe having such an extensive training route is important when working within such an important field.
As an Independent Trainee: Contributed by Sarah Senker (Forensic Psychologist in Training)

I undertook an accredited Stage 1 MSc and then went on to start a PhD on the recovery of substance misusing offenders. I wanted the work I was doing during my PhD to be able to contribute to Stage 2 so put forward a case to the funders of my PhD to see if they would fund my enrolment on Stage 2 and my supervision costs. Upon approval, I sought a co-ordinating supervisor from the approved register and compiled the necessary documentation to enrol.

I am not attached to a workplace and am not in a traditional ‘trainee’ post within a forensic setting. That being said, doing Stage 2 with the BPS has permitted a level of flexibility and freedom in that I can source my own placement and training opportunities across a range of settings and cohorts. The Practice Diary can feel overwhelming at times but it is a useful way to reflect on the work being done. I recommend keeping it up-to-date and creating entries as soon as work has been completed. I have found the BPS to be entirely supportive whenever I have sought clarification on exemplars. I have been limited by the work I can undertake in addition to my PhD but Stage 2 does require much time, dedication and effort although the reward at the end is what keeps me going.

The Academic Practitioner Routes to Chartered Status or Registration

A more structured alternative is to work towards chartered status or registration with an academic institution. At present such courses are running at the University of Birmingham, University of Nottingham and Cardiff Metropolitan University.

The Doctorate in Forensic Psychology (University of Nottingham)

At the University of Nottingham there are two routes to a Doctorate which confers eligibility for chartered status or registration. Students may apply for the full Doctorate which is a three-year course where the first year is the equivalent of a Master’s degree. Or they may complete a Master’s elsewhere before applying to complete their training in Nottingham. In this case, candidates would apply for the two-year ‘top-up’ Doctorate.

Year 1 mainly consists of academic work where students work through a range of modules focussing on different aspects of forensic theory, practice and treatment. Students are required to attend all lectures, complete all module assignments as well as complete an individual applied research project (ARP) under supervision. Currently (as at 2013), there is a requirement for first year students to have completed at least one hundred days of a forensic placement under the supervision of a clinical or forensic psychologist in order to progress onto Year 2. If students do not have this experience, this observational placement must be completed during their first year. Years two and three primarily consist of placement and research. Trainees are required to work on placement across three different forensic settings and with three different forensic populations. Alongside the practical work, trainees are required to complete assignments which fulfill the core roles involved in becoming a forensic psychologist, as set out by the BPS. Finally, a Doctoral Research Thesis will be completed.
Reflections and experiences of the Doctorate in Forensic Psychology
(University of Nottingham) route

Contributed by Amy Tostevin (Forensic Psychologist in Training)

I have just completed the first year of the full three-year doctorate and will be beginning second year and placement in October 2013. When beginning the Doctorate, it is tempting to look forward to the placement years where you can really begin to train practically as a forensic psychologist. However, beginning with an academic and research year has meant that I now feel as though I have a strong theoretical base from which to begin the practical work. As with any form of training, I believe that practical work experience will be the most valuable in terms of helping someone to become a good psychologist. In years 2 and 3, I am hopeful that learning on the job alongside doing research will be the most valuable parts of the course, supported by the core theoretical information obtained during year one. The variety of highly qualified and distinguished lecturers, supervisors, guest speakers, etc., is what I feel has made this year so valuable; I can genuinely say that every topic we have been taught, I have enjoyed and found useful.

I have developed good relationships with my supervisor and lecturers which has really helped my confidence in this stage of training. Overall, I think there is a feeling of unity amongst my fellow trainees and the department as a whole. From what I have experienced so far, I would definitely recommend this course for people with a strong forensic interest in both clinical work and research.

The Doctorate in Forensic Psychology (University of Birmingham)

The three-year full-time programme at the University of Birmingham was the first of its kind to be accredited by the BPS. The course combines academic teaching, research and practice in order for the trainee to receive the Professional Doctorate (ForenPsyD). Trainees spend three days a week across each year in forensic placement lasting for a minimum of 120 days (40 weeks) that are across different settings and/or client groups. The university offer a range of placements (mainly in the West Midlands) that include inpatient settings, prisons, private practice and community settings. It is a requirement that the trainee’s practice is supervised whilst on placement for at least one hour per week by a qualified psychologist. A reflective Practice Diary, Supervision Log and professional case study is submitted each year to provide evidence of competency development upon which feedback is given. In addition, trainees attend the university one day per week for the first two years along with three sets of three-day teaching blocks across all three years and reflective practice groups. The aim is to provide the trainee with a knowledge base of therapeutic models, risk assessment tools, psychometrics and gain understanding of current literature and research relating to specific client groups. One day a week is for the trainees to conduct and write up research. All trainees are allocated an academic supervisor who is an experienced qualified psychologist within, or attached to, the university. Academic assignments are submitted across all years, providing an opportunity for development of academic knowledge and application of theory to practice. A substantial research project is conducted in Year 3 as part of the Doctoral Thesis.
Reflections and experiences of the Doctorate in Forensic Psychology (University of Birmingham) route

Contributed by Samantha Goswell (Final Year Doctorate Trainee)

I have found that the combination of academic teaching and supervised practice has enabled me to build my confidence and competence to work as a Forensic Psychologist. The range of placements has provided an opportunity to develop my knowledge and skills when working across different client groups and offence types. My placements included an adult male prison, a medium secure setting for adolescent males, and a community setting for children and adolescents. I consider that this allowed me to have a broader awareness of the role of a Forensic Psychologist in various environments in addition to enabling me to expand my skills of working within different psychological models.

I consider that the level and quality of supervision within each placement was important for me in that it allowed for consistent opportunities to consider best practice, receive feedback and reflect on my work to further develop my competency. Whilst starting a new placement each year was anxiety-provoking, the length of time on placement and the placement structure allowed me to build positive and supportive relationships with colleagues and carry out longer-term assessment and treatment of clients. I have been able to work with, and learn from, colleagues from a variety of professional background as well as experienced Practitioner Psychologists.

The academic component has allowed me to enhance my knowledge of current literature, theory and research whilst being supported by the university’s highly experienced researchers and practitioners within a structured academic programme. Meeting with other trainees at the university on a weekly basis provided a strong sense of mutual support and the ‘reflective practice’ groups ensured that there are forums for sharing positive experiences and struggles relating to my practical and academic work. I have found that the academic elements of the course demanding at times, however, they have proved helpful in me developing and receiving feedback on my writing skills, in critically evaluating literature and research and in practising formal report writing. This part of the course requires a strong sense of self-motivation with a commitment to completing research and academic assignments outside of the hours outlined above.

The cost of the course is something for trainees to consider realistically in relation to taking this training route as this can add further pressure, particularly if trainees take on part-time employment in addition. For me, the benefits of this route far outweighed this aspect due to the supervised practice opportunities available and being part of the university has brought a sense of pride and accomplishment.

I feel the time limited structure of this route training has been beneficial in providing me with a definitive end point that I can work towards, which I found motivating. At times I have found the training overwhelming and challenging but I feel that this is necessary given the nature of the field I wish to practice in. Overall, I have found that the components of the Doctorate in Forensic Psychology Practice qualification has provided me with the skills required to work as a competent Forensic Psychologist.
Postgraduate Diploma in Practitioner Forensic Psychology  
(Cardiff Metropolitan University)
In line with the introduction of the HCPC registration requirements Cardiff Metropolitan University has also developed a practitioner training route. Successful completion enables graduates to apply for HCPC registration as a Practising Forensic Psychologist. It is also planned to offer a top-up Doctorate which would enable students to work towards eligibility for Chartered status. Students on this route acquire the knowledge, skills and experience necessary to be competent practitioners of forensic psychology through engagement in at least two years of practical learning (through placement/s with appropriate services). Students are required to evidence competency through completion of a portfolio comprising of a Practice Diary, a Supervision Log, a CPD Log and at least two case study examples (involving assessment, intervention, evaluation and recommendations with forensic service users).

Students are also required to submit reflective reports in four key areas of practice (Ethical and Professional Practice, Teaching and Training, Functional Assessment and Formulation, and Consultancy) and attend 10 workshops. These are intended to support students in developing knowledge and skills related to the areas of competency.

At completion of the training you are eligible to apply for Registration with the HCPC.

Reflections and experiences of the Postgraduate Diploma in Practitioner Forensic Psychology (Cardiff Metropolitan University) route  
*Contributed by Louise Herring (Forensic Psychologist In-Training)*
One of the main advantages of the practitioner programme is the flexibility of the route. The programme allows graduates to apply for Registration with the HCPC without completing the full Doctorate. However, those that want to gain further qualifications can choose to complete a ‘top-up’ Doctorate with the university. This was one of the main reasons I chose the programme, as it gave me the option to complete the Doctorate at a later date without impacting on my ability to practice independently. This has a number of advantages, including fitting in with my personal circumstances and allowing me to gain post-Registration experience before completing the Doctorate. Additionally, it helped to allay concerns I had about the potential impact of not having a Doctorate or Chartership on future career progression.

A further advantage of the course is the high level of supervision and feedback provided. Having regular meetings with my clinical (placement-based) and academic (university-based) supervisors ensured that I had the opportunity to discuss any practice issues, respond to feedback and that I was clear on how I could demonstrate competency from the outset. As someone who responds well to having regular and clear feedback, this has helped me to increase my confidence and competence.

Whilst specific competencies need to be evidenced, an advantage of the course is that students can decide how many of these are demonstrated. As I was already working as a Forensic Psychologist in Training involved in a number of different areas of practice, this meant that I rarely had to seek out specific pieces of work for the sake of submissions and could start evidencing competency from the outset. I found this a motivational way to complete training as it enabled me to see the progress I was making towards Registration from the beginning. However, it is important to note that this is from the perspective of
someone who already had experience of being a trainee, and this may be more difficult for people starting a new placement who may need to build a breadth of experience.

A further strength of the route is the balance between practical and academic work. Whilst it is a placement course, demonstrating competency has meant focusing on how my practice is driven by literature and research in the area, and ensuring that I am engaging in best practice. This was enhanced by the completion of workshops which encouraged the further development of clinical skills and the consideration of issues that may occur in practice. This has been beneficial as it has ensured that I critically evaluate and reflect on my practice, and understand the importance of CPD.

Whilst my experience of the course has been a positive one, it has been challenging. Completing the course has required commitment and sacrificing personal time to ensure that submissions are completed to a high standard within the deadlines. Whilst this is expected in many training routes, I needed to consider how to balance personal and work commitments. In addition, as the majority of the work is self-directed, the level of autonomy involved may not suit students who prefer high levels of guidance.

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**Table 1: Question and Answer Survey with those leading the different routes.**

**The BPS Qualification in Forensic Psychology (Stage 2)**

1. *Can you describe training route(s)?*

   The qualification is an independent route to full membership of the Division of Forensic Psychology (DFP). It is accredited by the HCPC and confers eligibility for BPS chartered status and HCPC registration. It is not a course but rather an extended period of supervised practice in a forensic psychology work setting. During this time, candidates submit evidence drawn from their work to demonstrate their competency on the four core or key roles expected of a practitioner forensic psychologist. Some 360 candidates are currently enrolled on this programme.

2. *What is expected of the trainees on the course in terms of work undertaken and submitted?*

   Candidates submit exemplar reports evidencing their work and competence in each of the four core roles: Conducting Applications and Interventions; Undertaking Research; Communicating with Other Professionals; and Training Other Professionals. They also submit Practice Diaries, detailing their reflections on their learning and a Competency Logbook covering each core role. Where a candidate is working as a trainee time to undertake training is usually allocated.

3. *How is it different from the other training routes offered?*

   The independent route is a form of apprenticeship training, learning ‘on the job’. The unique emphasis on supervised practice ensures that those who qualify have a lot of in depth experience of working in forensic psychology and, to quote several employers, ‘particularly able to hit the ground running’. The independent route requires a lot of the candidates and their supervisors, but gives them considerable flexibility and enables them to undertake the work whilst in employment.

4. *How long is the course for?*

   Candidates enrol for a minimum of two years, following an accredited MSc course. The current completion mean is five years which includes the MSc. The range is wide, with some candidates completing in two to three years, others taking very much longer, often with gaps in their enrolment due to maternity leave or moving jobs.
5. Can you do the course part-time and full-time?
The candidate and their co-ordinating supervisor design their Training Plan which is then
approved by the Chief Supervisor and subject to ongoing review. This enables individual flexibility
as to how the work is completed.

6. How much does it cost?
£4794 (BPS total average figure based on three-year enrolment, allowing for fees charged and an
element of resubmissions). This and any other training costs are normally covered by employers.

7. What are the requirements to apply?
Graduate membership of the BPS. A BPS-accredited MSc in Forensic Psychology.
An approved Co-ordinating Supervisor. Partial exemptions may be granted on the basis of
competence developed and demonstrated prior to enrolment on the Qualification.

8. What does it mean for those who complete the course successfully?
Eligibility to apply for
● HCPC registration.
● Full membership of the BPS Division of Forensic Psychology.
● Chartered membership status of the BPS.

Provided by Roisin Hall (Chair of the Forensic Psychology Qualification Board)

Professional (Practitioner) Doctorate in Forensic Psychology (University of
Nottingham) (full and ‘top-up’ programmes)

1. Can you describe training route(s)?
The full three-year programme is split into two parts – the Master’s component (Year 1) and the
doctorate component (Years 2 and 3). Year 1 comprises six theoretical modules, two research
methods modules and a research project. Years 2 and 3 are dedicated to supervised research and
practice in forensic settings, working directly with clients, conducting research and evaluation,
communicating psychological knowledge and training other professionals. Those already with a
relevant BPS-accredited Master’s in Forensic/Criminological/Investigative Psychology and work
experience are able to apply for the ‘top up’ programme which fast tracks trainees on to Years 2
and 3.

2. What is expected of the trainees on the course in terms of work undertaken and submitted?
The Master’s component in Year 1 is examined by continuous assessment of module assignments.
Each trainee is required to successfully complete the Stage 1 Master’s component to merit
standard (60 per cent +) before continuing onto the Doctorate. The Doctorate component is
examined by thesis and viva voce, focused on a specific topic area in forensic psychology.
In addition, the trainee submits a Practice Portfolio consisting of four placement reports with a
diary of client contact and a supervision log; a second practice case study on a topic not related
to the thesis; and a training report on the design, delivery and evaluation of a training workshop
made to professionals in other disciplines.

3. How is it different from the other training routes offered?
The programmes uniquely offers a one-year Master’s followed by two year’s practice and research
on placement anywhere in the British Isles. In relation to the ‘top-up’ programme it offers
trainees already holding a relevant Master’s the opportunity to undertake Stage 2 training in
Table 1: Question and Answer Survey with those leading the different routes (continued).

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. How long is the course for?</td>
<td>For the full programme, trainees will register for a minimum of three year's full-time (or six year's part-time or a combination). They can leave after one year (or two year's part-time) with the MSc in Criminological Psychology. For the ‘top-up’ programme trainees will register for a minimum of two year's full-time (or four year's part-time or a combination). A maximum of one year extension if necessary is available for both programmes.</td>
</tr>
<tr>
<td>5. Can you do the course part-time and full-time?</td>
<td>Yes; please see above.</td>
</tr>
<tr>
<td>6. How much does it cost?</td>
<td><strong>Home/EU Full-time:</strong> £7300 per annum (inclusive).</td>
</tr>
<tr>
<td></td>
<td><strong>Overseas Full-time:</strong> £16,110 per annum (inclusive).</td>
</tr>
<tr>
<td></td>
<td><strong>Home/EU Part-time:</strong> £4380 per annum (inclusive).</td>
</tr>
<tr>
<td></td>
<td><strong>Overseas Full-time:</strong> £9670 per annum (inclusive).</td>
</tr>
<tr>
<td>7. What are the requirements to apply?</td>
<td>Individuals with a first or upper second class honours degree (or an international equivalent) from a psychology programme (single or joint honours) accredited by the BPS and some relevant experience may apply for the full doctorate programme. In addition, to apply for the top-up programme, applicants would normally be expected to hold a Master's degree in forensic, criminological or investigative psychology or an international equivalent to Merit standard (60 per cent or above). Those applicants currently employed in a forensic setting are allowed to register full-time (or part-time) and use their employed setting for the placement work where possible.</td>
</tr>
<tr>
<td>8. What does it mean for those who complete the course successfully?</td>
<td>Successful trainees are conferred the title of ‘Dr’ after being awarded the D.Foren.Psy. The award leads to eligibility for registration with the HCPC and chartered membership with the BPS Division of Forensic Psychology. All trainees complete the programme with a minimum of one conference presentation and one publication.</td>
</tr>
</tbody>
</table>

Provided by Kevin Browne (Course Director)
Professional Doctorate in Forensic Psychology Practice (University of Birmingham)

1. Can you describe training route(s)?
The programme combines a number of theoretical and practical approaches and emphasises a developmental and domestic perspective to the study of offending behaviour and criminal activity.
The principal objective is to equip trainees in forensic psychology with research and practice skills based on recognised theory and evidence-based practice and to offer a sound understanding of criminal behaviour, its effects on victims and appropriate approaches to intervention with both offenders and victims.

2. What is expected of the trainees on the course in terms of work undertaken and submitted? Trainees attend placements, university, and are allocated time for research. For each academic taught module, trainees submit written assignments for and complete research work which goes towards their final year thesis. This is examined by viva voce. Trainees will receive appraisals with their placement supervisor and core competencies and standards of proficiency are assessed via case study reports, placement reports and practice diary. In order to progress to the next year, trainees must reach an average grade (e.g. B– from year 2 to 3) and have successfully passed their placement.

3. How is it different from the other training routes offered? The programme is an equivalent to Stage 1 and 2 of training as a Chartered Psychologist and is approved by the HCPC. As well as offering the Doctoral route, the programme includes victim focused workshops and teaching about a range of therapeutic models. The part-time Doctoral route is not commonly available but provides a good opportunity for individuals who are already employed and whose employers wish to retain them/assist their development. The full-time route benefits from our well-developed relationships and the good reputation the course has with our placement providers.

4. How long is the course for? It is available as a three-year full-time course or as a four-year part-time course for those currently employed in a forensic setting, where their employer allows them to work as a trainee forensic psychologist with a variety of client groups.

5. Can you do the course part-time and full-time? Yes; please see above.

6. How much does it cost? Three year’s full-time:
Home/EU: £7290 Overseas: £13,200
Trainees would normally require an additional £8000 per annum approximately for personal living expenses.
Four year’s part-time: Doctorate fee 2014/2015:
Year 1: £7290; Year 2: £7290; Year 3: £3645; Year 4: £3645

7. What are the requirements to apply? The entry requirements are a good honours degree in psychology (2.1 and above), which confers Graduate Basis for Chartership from the BPS, English language proficiency (Standard equivalent to IELTS level 7.0 with no element below 6.5), experience working with clients in a forensic
setting (for a minimum of six months) and personal maturity and stability to cope with the
demands of the academic and placement components of the course.

8. What does it mean for those who complete the course successfully?
Successful completion of both academic and practice training components of the Course confers
eligibility for BPS Chartered Psychology status and full membership of the Division of Forensic
Psychology. You will also be eligible to apply for registration with the HCPC as a Forensic
Psychologist, which is the statutory regulating body for psychology.

Provided by Catherine Hamilton-Giachritsis (Course Director) and Sue Hanson
(Course Administrator)

| Postgraduate Diploma in Practitioner Forensic Psychology |
| (Cardiff Metropolitan University) |
| 1. Can you describe training route(s)? |
We have focussed our programme on developing good, solid, clinical skills. The ethos behind the
programme was to develop good practitioners who were able to attend to the role of a forensic
psychologist, with the aim that after qualifying, people may come back to study to specialise in
an area with a top-up Doctorate with us. We also wanted to make the programme as accessible
as possible in terms of cost. Universities charge students based on the number of ‘credits’ each
person studies, so we made the course ‘cheaper’ by ensuring students only do the credits they
need to meet the competencies. So in short our programme is more focussed on the functional
assessment, intervention, evaluation and recommendations in forensic psychology practice.

2. What is expected of the trainees on the course in terms of work undertaken and submitted?
Students collate examples of competence in practice and produce a portfolio of evidence of the
work they have undertaken with service users. They also complete four reflective reports;
Formulation and Functional Assessment; Ethics and Professional Practice; Teaching and Training;
Consultancy. Students compile diaries of supervision and practice and complete the HCPC
Continuing Professional Development proforma, to prepare them for this once registered.

3. How is it different from the other training routes offered?
It tends to focus on core role 1, more than core roles 3 and 4, although these are assessed. Core
role 2 feeds in to the work students undertake, so our students are engaged in evidenced based
practice, they know what the literature says should be helpful with service users and they can
justify a course of assessment or treatment. We don’t expect students to engage in pure research
activities during their development as practitioners, they will already have completed the
academic and research elements by completing an MSc. We’d like to see good, proficient
practitioners, who come back to study for specialism in the form of a top-up Doctorate later.

4. How long is the course for?
Students have to complete a minimum of two year’s full-time work, but they may take longer to
demonstrate competencies. Students complete once they have demonstrated competencies, we
think this will take most people around two years, evidence to date suggests that four out of five
of people achieve this.
5. Can you do the course part-time and full-time?
Yes you can – part-time can take up to five years. Many people employed as trainee forensic psychologists use their job as their placement, so you don’t need to leave work to do the qualification.

6. How much does it cost?
£4700 currently, in total (not each year).

7. What are the requirements to apply?
BPS-accredited undergraduate and Postgraduate qualification in Forensic Psychology, or BPS Stage 1 of the Diploma in Forensic Psychology and extensive experience of applied forensic psychology practice.

8. What does it mean for those who complete the course successfully?
It means they are eligible to apply to the HCPC to practice as Forensic Psychologists in the UK. Our course is approved by the HCPC.

Provided by Nic Bowes (Programme Director)

There is also a new training programme which started in September 2013 at the University of Birmingham; the Doctorate in Forensic Clinical Psychology Practice. This four-year programme is unique course integrating forensic and clinical psychological practice at Doctoral level aimed at psychologists who wish to work in forensic and clinical settings. Please review the programme’s details on the University of Birmingham website for more information.

In conclusion, I wanted to draw all in-training members’ attention to the Trainee Forum. This is a forum which Stage 2 trainees can join to post questions and get advice and support with their training from other trainees. There are over 500 members, so there is a lot of experience and support on offer. All you need to do is send an email to dfp-trainees@lists.bps.org.uk and look out for responses. Alternatively contact Sarah Senker (DFP In-training representative) on ssenke@essex.ac.uk

Also please keep a look out for training events on the DFP website under ‘Events’. Training events focussed towards in-training members are free and there are lots of other relevant and interesting BPS training events that are accessible for a small fee.

Sarah Disspain
DFP in Training Representative
Becoming a Qualified Forensic Psychologist

Pursuing a PhD in Forensic Psychology

Dean Fido

Background to the training route

The PhD route is designed for students with a keen interest in contemporary issues facing forensic psychology and associated populations.

Unlike applied routes discussed within this article, the PhD option is a purely research-based approach. There are many routes for PhD candidate acceptance. Most important of these is the ability to formulate innovative, theory-driven research ideas, which have utility for application. Other prerequisites include a strong MSc or MRes degree in a related topic and evidence of well-written and presented research. Set PhD research placements are available, as are placements for researchers with independent research ideas.

Reflections/experiences of the training route

The PhD option is possibly the most obstacle-laden route for one wishing to become a practicing forensic psychologist. An individual taking up a PhD position will seek to become an expert in a distinct forensic issue via research-based investigation. Important to consider is that completion of a PhD does not grant permission to practice forensic psychology, it merely acts as a stepping-stone to the partition between lectureship, research, and forensic practice.

Unlike training avenues, the PhD route does not guarantee that you will interact with forensic populations. Sampling will predominantly depend on your overall research aims, funding, and supervision team. Supervision teams containing forensic psychologists with access to other institutions may act as gatekeepers for forensic samples, and will encourage their use. During a PhD, access to forensic samples will purely be research-based, foregoing the actual ‘working with’ offenders, which would be experienced in training routes. Whilst forensic issues can be researched in non-forensic samples (victims; aggression), allowing completion of one’s PhD, the lack of exposure to such populations may detriment the ability to obtain forensic-based work afterwards. For example, most trainee positions, and some taught courses, encourage at least six-month’s work experience with forensic samples prior to enrolment.

At the expense of forensic-base work experience, PhD completers will be able to boast a range of skills including large project planning, theory-driven research formulation, and mass dissemination. It is not uncommon for individuals enrolled on PhD courses to attend two or three academic conferences a year, where they will be able to disseminate their research to a wide, multi-disciplinary audience. Furthermore, as one’s PhD is essentially a series of inter-linked investigations, students are encouraged to forward these on for individual publication. It should be noted that trainees might also publish work, though their research opportunities are restricted to working hours, sample access, and the management of other duties.

Following the completion of a PhD, the most common directions are post-doctorate research and further specialisation in ones’ area of interest, or taking up a lectureship role. The under- and post-graduate teaching of forensic psychology, at some institutions, may require additional forensic-based work experience, and in some instances, chartership. If one wanted to transfer their research-
based skills from their PhD to another forensic training route (such as stage II training), then their PhD may enable them to submit evidence for partial exemption from core role II (research) and further contribute to BPS chartership. However, one would still be required to enrol as a trainee and complete the other three core roles. This will incur the associated costs as previously documented.

From a personal perspective as somebody who is coming to the end of their PhD, whilst I have been more than happy with my independent development both on a personal and academic level, the prospect of using this route as a means of entering the applied field of forensic psychology is daunting. Although my research makes me informed on key issues facing forensic psychology, I have foregone forensic work experience and the development of core competencies. Rightly so, these are important for BPS chartership status, and so transference to applied forensic psychology would require an unknown number of years of further training. As somebody now competent to teach various aspects of psychology at graduate level, neglecting an income for further years of training is a commitment that would need to be carefully considered.

In summary, the PhD route may be ideal for somebody who is interested in the investigation of certain issues surrounding forensic psychology and who has an interest in teaching and dissemination. On completion of a PhD, candidates can evidence a wealth of transferable skills, such as project planning, data analysis, and management, for other employment roles.

**Dean Fido**
PhD Doctoral Student,
Nottingham Trent University.
**What is the Qualification trying to achieve?**

Strangely, despite the plethora of documents and writing about the Qualification, little attention has been given as to what are its aims, other than BPS Chartership and, more recently, a basis of Registration for the Health and Care Professions Council. The output, in terms of the nature of forensic psychology and forensic psychologists has been largely neglected. Recently, Hodge (2013) has suggested that the competences and Core Roles required for the Qualification, map very well on to the role and requirements of Scientist Practitioners. This is consistent with a broader view that all psychology professions work within this general framework (Lane & Corrie, 2006)

The concept of Scientist Practitioner was initially developed by American clinical psychologists at a conference in Boulder, Colorado, in an attempt to develop their professional identity in 1949. This concept was quickly adopted by British clinical psychologists and has formed the basis of training in clinical psychology in this country. The essential elements of the Scientist Practitioner model are (Wikipedia):

- Delivering psychological assessment and psychological intervention procedures in accordance with scientifically-based protocols – [CR1]
- Accessing and integrating scientific findings to inform services – [MSc, CR2]
- Framing and testing hypotheses that inform decisions – [CR1, CR2]
- Building and maintaining effective teamwork with other professionals that supports the delivery of scientist-practitioner contributions – [CR1, CR3]
- Research-based training and support to other professions in the delivery of psychological services – [CR4]
- Contributing to practice-based research and development to improve the quality and effectiveness of the psychological aspects of service provision – [MSc, CR2]

As illustrated, these map closely with the competency development required by the Qualification. It is the research and developmental elements built into this model which clearly distinguish psychology practitioners from other professions.

**The development of the Qualification process**

The Qualification began as the BPS Diploma in Forensic Psychology and had two stages. Stage 1 was originally achieved by an in-house set of examinations together with the submission of a piece of postgraduate-level research; or alternatively by acquiring an MSc from an accredited postgraduate course. The Stage 1 in-house examination route closed two years ago, leaving the forensic MSc as effectively the entry-level qualification into Stage 2.

Stage 2 was developed by the BPS to address the absence of any clear professional training route for forensic psychologists and in the lack of any clear source of funding to encourage universities to develop training (e.g. similar to that of clinical psychologists which is funded by the NHS). Stage 2 was
conceived as a set of 20 competences, encapsulated within four Core Roles, which are meant to be developed and demonstrated during the course of the trainee’s work. It was originally intended that Stage 2 should be achieved within two to three years.

The 20 competences have stood the test of time, and are identical now to their original conception, although their descriptions are currently being brought up to date. They are also reflected in the key roles required for academic forensic psychology courses. However, how the competences were to be achieved was less clear, as was the means of their assessment. These matters have focused the attention of the Qualification Board (previously the Board of Examiners) over the past 10 years. This has largely been done through a series of (not always popular) amendments to the Candidate Handbook, which has also had to remain consistent with the overarching Regulations which govern all BPS postgraduate training and qualifications. This period of time has seen the introduction of reflection into Practice Diaries; the development of a set of assessment guidelines; the concept of a summary Exemplar Report; and the more recent introduction of Training Plans and Competence Logbooks. All of these introductions have not been easy for trainees (or indeed for their supervisors, who have had to learn to work within the new structures alongside their trainees).

It is important to understand that the BPS Stage 2 process is a form of apprenticeship training (Collins, 2005) – learning ‘on the job’. This is very different from an academic course. The advantages are – eventually – a very thorough acquisition of skills. The disadvantages lie in the lack of structure for learning normally provided by academic courses. If you wish to get through Stage 2 quickly, you, and your Supervisor, must create structures to promote your learning, using the tools provided by the Candidate Handbook, Training Plans, Exemplar Plans and Competency Logbooks.

Before you begin, you need to understand the nature of competency assessment. This requires that you must not only demonstrate the knowledge required by academic assessment, but over and above this demonstrate your skill in the use of that knowledge and associated processes. This requires the repetition, reflection and practice of each skill or competency, as will usually be evidenced in your Practice Diary and in the developing quality of your work output.

**How to get through Stage 2 quickly**

At the time of writing the average time to complete Stage 2 is 5.8 years. This, however, includes the many candidates who interrupt their training – for example, for maternity leave – plus a number who registered for both Stages 1 and 2. It is possible to complete Stage 2 in two to three years, and some candidates are now achieving this. The key to doing so is to get organised from the start and to recognise that all aspects of the work you do can help to develop and demonstrate competences.

The Training Plan is the first step to organising your training. The Training Plan is intended to provide focus to help you to develop and demonstrate a subset of the competences each three-month period and it is reviewed and renewed on a quarterly basis. To start with, the competences will most likely be those required by your current operational workload, and the initial competences in the Core Roles. *It is very important here not to focus just on one Core Role, but to make use of the opportunity provided by the Breadth of Experience Rule which allows you to use the same project or experience to demonstrate competences in two different Core Roles.*

An example of this could be that if you are demonstrating your skill in conducting risk assessment (or indeed interventions) in CR1, then the outputs of these assessments (or interventions) can be communicated in CR3 to evidence competences 3.2 (paper reports); 3.4 (oral presentations) and 3.5 (responding to queries). You can identify
similar links between these and other Core Roles to significantly reduce the overall work required to demonstrate the competences.

Your quarterly Training Plan can also help to focus your entries in your Practice Diary, by largely confining these to the competences in the current plan. Your Practice Diary should always be reflective (i.e. demonstrate your psychological thinking by explaining how you have used research and theory to determine your practice) and also contain the evidence of the repetition and practice needed to develop your skills.

Running alongside the Training Plans should be your Competency Logbooks, which should be taken to each three-monthly training review to enable your Supervisor to (briefly!) comment on your progress on each of the competences you are currently working on. As you demonstrate the competences to his or her satisfaction in each exemplar, you can support this view with a few selected Practice Diary references and other evidence and comments. This way your Competency Logbook will gradually fill as you demonstrate the different competences. Once a competency has been demonstrated, there is little real need to revisit it with further comments, unless you wish to add more and better evidence later for assessment purposes. This way the Competency Logbooks act as true logbooks and provide a record of your passage through the competences, and a developmental history to support your Exemplar Report. The gaps in the Competency Logbooks will also help you to develop your later Training Plans.

Exemplar Reports are meant to be (like apprenticeship pieces) the best examples of your work, to eventually be put forward for assessment. It is likely, therefore, that Exemplar Reports made in the earlier stages of your training will require amendment or even to be completely changed, as your practitioner skills develop. Always remember that if your current plans don’t allow you to demonstrate your best work, they should be changed.

When it comes to assessment, your Exemplar Report should pull all the evidence of your competence across the full Core Role together and make a business case for your competence in that Exemplar/Core Role. This is essentially a CR3 task and is not dissimilar to writing a risk assessment or end of intervention report.

In conclusion
Stage 2 of the Qualification in Forensic Psychology is capable of being achieved in a much shorter time than is currently the average. However, to do this requires both the trainee and Supervisor to make best use of the tools available to organise an optimal learning experience.

John Hodge
Registrar and Chief Supervisor

References
Wikipedia. The Scientist Practitioner Model.
Becoming a Qualified Forensic Psychologist

Assessment in the Forensic Qualification

Dr Julie Harrower

I TOOK ON THE POST of Chief Assessor for the BPS Forensic Qualification in April 2013, having taken part in the original establishment of this award many years ago. I have held various Board roles in the past, including Chief Examiner and Chair, and in relation to assessment I have many years experience as an academic in terms of setting assessment, and ensuring quality assurance in relation to the outcomes of those assessments.

The role of the Chief Assessor is to monitor the assessment process in order to ensure equity, fairness and transparency. There are clearly agreed procedures in relation to the assessment process for the Qualification with a number of quality checks en route from receipt of the candidate’s portfolio to the conclusion. Two Assessors separately assess each submission in relation to each of the four Core Roles. The Lead Assessor for each Core Role then considers their conclusions in order to produce a single agreed assessment decision. This can be Competence Demonstrated; or Conditional Pass which requires minor amendment and resubmission; or Competence Not Yet Demonstrated which requires a more detailed resubmission. Where there is any doubt or disagreement the candidate may be invited to a viva voce where two independent Assessors ask the candidate for clarification in relation to any omissions or unclear evidence in order to enable the candidate to demonstrate their competence. The assessment process refers to the time from when the assessors receive a candidate’s portfolio until the conclusion of the viva voce examination if this has been deemed necessary. During this process the Chief Assessor will provide advice/guidance to assessors on their decision-making, in particular whether or not to invite a candidate to viva voce, and identifying which units of competence need to be examined at viva voce. Assessors will, more often than not, be clear about their decisions in these areas, so the input of the Chief Assessor can simply be a reassurance that the appropriate decision has been made.

The Chief Assessor attends the viva voce and produces the notes of the meeting as well as the final report. As all viva voce examinations are recorded, the Chief Assessor will listen to the recordings of the viva voce examinations and will read the candidates’ portfolios, producing a report for both Assessors to consider and provide feedback before the final report is agreed. This facilitates discussions with the assessors about the assessment outcomes and other members of the Forensic Psychology Qualifications Board (FPQB) when the assessors’ recommendations about the assessment outcomes for candidates are being considered.

Less commonly, assessors will have difficulty making a decision (for example, when they are unsure if the work submitted by the candidate meets the standard required, or where there is disagreement among the assessors about the outcome of the assessment). In these cases the Chief Assessor will facilitate discussion and agreement between the assessors on an appropriate outcome for the candidate. Where agreement between assessors cannot be reached, the Chief Assessor will make a final decision (although this has never needed to happen in my experience).

The Chief Assessor will also provide training sessions for assessors as requested or required, and there is an annual Assessors Conference. These sessions are devised to ensure that assessors are kept updated about...
any changes to the Qualification and are an opportunity to discuss the benchmarks that are used in the assessment process to facilitate some consistency among assessors in terms of the application of standards and quality assurance.

The Chief Assessor is a member of the FPQB and contributes to the general business of the FPQB. This includes, for example, discussions about applications from people who wish to become assessors for the Qualification, about the organisation of *viva voce* examinations, about modifications to the Qualification, and about preparation of internal validation reports and external visits from organisations such as the Health and Care Professions Council.

Additionally, the Chief Assessor may contribute, in collaboration with the Registrar and Chief Supervisor, to external FPQB activities such as workshops or presentations to groups of students who are considering enrolling for the Qualification, or who have already enrolled on the Qualification. This allows us to provide an overview of the Qualification and to deal directly with any queries.

However, the Registrar, Chief Supervisor, or the Society’s Qualifications Officer deal with all queries from candidates and supervisors. In this way the process of supervision is completely separated from the process of assessment, which enables candidates to discuss issues with the Chief Supervisor/Registrar independently.

**Recent assessment themes**

The time taken to complete the Qualification is reducing and it is of note that the External Examiner has commented on a significant improvement in quality across performance on all four Core Roles in the last three years. However, the FPQB remains keen to address concerns that the assessment process for core role exemplars has become unduly complex. Accordingly there is a concerted effort underway to clarify what is required to demonstrate competence on the core roles, to ensure competencies are assessed on a more holistic basis and to provide more intelligible feedback.

The Chief Assessor runs an annual workshop for assessors at which the four Lead Assessors present evidence on the key themes and issues relating to their particular Core Role. Recent outcomes and actions have included:

- An ongoing project by the Lead Assessors to clarify the descriptors for the competencies required for each core role and what is needed to evidence competency.
- Improved consistency in feedback given to candidates.
- The drafting of a *Handbook* and further training opportunities for Assessors.
- Workshops on Core Role 2 for candidates, with consideration for further workshops for the other Core Roles.

The 2014 workshop identified further needs for:

- Training sessions for Assessors, to include standardisation exercises to improve consistency across assessors.
- A simplified set of processes.
- More feedback about the process from the candidates.

Specific points noted about candidate submissions are outlined below.

*Core Role 1: Conducting psychological applications and interventions*

**Strengths**

- An improved use of theory to underpin the assessments and interventions.
- Good choices of exemplar projects.
- Greater attention to ethical issues and to anonymity.
- Evidence of good practice in working with other professional colleagues.

**Weaknesses**

- Not providing enough evidence of the candidates’ own contribution from a forensic psychology perspective.
- Not providing enough signposting, or clear explanation of how the evidence provided clearly demonstrates the competency.
Further requirements

- More evidence of better planning and use of the relevant literature.
- Recognition that evaluation is an integral component of assessment and intervention work and must be factored into the initial planning.

Core Role 2: Research

This core role shows the highest variability in quality of submissions, but there has been a significant improvement, particularly in the use of the research report format.

Decider issues include:

- Is an organisational need met?
- Is there a critical literature review and does it justify the research question?
- Is the hypothesis or research question clearly stated?
- Is the method sufficiently well described to be understandable and replicable?
- Are reliable and valid measures used?
- Does the analysis follow the research report format?
- Is the dissemination appropriate for non-technical stakeholders as well as psychologists?
- Is the data collection ethical?

Core Role 3: Communicating psychological knowledge and advice to other professionals

- Candidate submissions have become much better organised.
- Clarification is required about the submission of supplementary evidence.
- More links should be made between literature and practice.
- Need for more demonstration of how the work contributes to policy.
- Need for more evaluation.
- Need to ensure that psychological evidence is provided.

Core Role 4: Training other professionals in psychological skills and knowledge

Good practice includes:

- More use of TNA methodology and report to explain, structure and plan the work, and including elements such as project risk assessment and the obtaining of agreement from others.
- Evidence-based aims and objectives, noting the significance to the wider work environment. Planning which considers relevant factors affecting the design of the training and its transferability.
- Demonstrate clearly how training was implemented, taking into account issues of resourcing.
- Planning and implementing appropriate assessment systems,
- Structured evaluation review and report, designed and reviewed with agreement of others and showing both strengths and areas for improvement.

Dr Julie Harrower
Chief Assessor
Becoming a Qualified Forensic Psychologist

The BPS Chartership vs. HCPC Training Route: A Supervisor’s perspective

Cerys Miles

I BECAME a qualified forensic psychologist via the BPS chartership route in 2008, at a time when very few trainees were successfully completing this qualification. I found the process challenging and at times demotivating, and experienced the common frustration of initially ‘failing’ Core Roles on the basis of what were unclear criteria and overly critical feedback. It was only through the support of my supervisor and colleagues who were going through the process alongside me that I remained focused and achieved my goal, albeit later than I had initially anticipated.

I went on to use my own experiences in my subsequent supervision of trainees through the BPS chartership route. I have found that the process seems to have slowly become clearer over time and I have been able to support my trainees accordingly. This has been reflected in the trainees I have supervised passing Core Roles on the first and second submissions at a much higher rate than was the case when I was a trainee, a trend I believe has been observed nationally.

Nevertheless, there continue to be challenges associated with supervising trainees on the BPS route towards chartership. One of these is the frustration relating to inconsistencies in the feedback provided by the assessors of submitted Core Roles. This is exacerbated by the ‘anonymous’ nature of the feedback and the lack of opportunity to discuss this with the assessors involved. It can feel as if you have no ‘say’ as a supervisor in terms of assessing the competence of trainees whose forensic psychological skills I observe on a daily basis. I have also found the timescales associated with having to wait for feedback from the BPS on a Core Role submission difficult to manage and this can lead to uncertainty and a loss of momentum when supporting a trainee in planning their on-going work for chartership.

As a supervisor of BPS trainees I have (for a fee) joined the Register of Applied Psychology Practice Supervisors (RAPPS). Whilst this is apparently intended to identify those with ‘special expertise’ as a supervisor, according to the BPS website, the register is open to all psychologists with chartered membership. This leads me to question the need for a separate RAPPS, when the BPS provides a ‘List of Chartered Members’ as well as a ‘Directory of Chartered Psychologists’ for those who wish to offer their services to the public.

More recently I have had the experience of supervising trainees through an HCPC practitioner programme route. It has taken me time to become accustomed to the differences between this and BPS chartership, for example, becoming familiar with the ‘standards of proficiency’ against which trainees are assessed, rather than the Core Role criteria. However, I have been well supported in developing my understanding of the programme requirements by the university where the programme is run, for example, through training and feedback events. The flexibility of the programme, particularly in terms of how standards of proficiency can be demonstrated, is especially helpful and far less restrictive than the distinct BPS Core Role model. I have also found the dual supervisor approach adopted on the programme on which trainees I supervise are enrolled (whereby each
The BPS Chartership vs. HCPC Training Route: A Supervisor’s perspective

When I first became involved in the supervision of HCPC trainees, concern was expressed amongst the profession that this would be seen as an ‘easy’ route towards qualification and thus produce registered forensic psychologists who were not of an equal standard to BPS chartered forensic psychologists. In my personal experience, this is absolutely not the case and I am confident that the trainees I have been involved in supervising, who have just finished the HCPC training process and achieved registration, will be excellent practitioners, indistinguishable from chartered forensic psychologists. Indeed, to access a place on an HCPC training programme in the first place, trainees undergo a rigorous assessment process, which provides a useful means of gauging suitability and readiness for the route. They also (like BPS chartered forensic psychologists) have the opportunity to follow up their qualification with a doctorate, an excellent means of achieving continued professional development post qualification. It is important to add that there is nothing ‘easy’ about the HCPC route. Both supervisors and trainees have to work hard to develop and demonstrate competency, and a considerable level of commitment is required. Rather, the HCPC route, in my experience as a supervisor on one of the available programmes, is a more clearly structured and supportive process for all involved.

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trainee is assigned both an academic and clinical supervisor) invaluable in providing support to trainees. Frequent supervision is closely linked to the submission of work throughout the programme, and timely feedback ensures that progress is maintained. In my experience the HCPC route is far more empowering for both supervisors and trainees, in that it is the supervisors (in close collaboration with the trainee) who ultimately assess whether the trainee meets the required standards of proficiency in order to register as a practitioner psychologist with the HCPC. While there is both an internal and external moderation process to supplement this, I feel that I have much more of a meaningful influence in terms of determining a trainee’s competence, when compared to supervising trainees on the BPS chartership route.

I have also found that trainees on the HCPC route are more easily able to maintain motivation and commitment to this programme compared to BPS trainees, who understandably can find the process disempowering. This appears to be linked to the clear requirements for qualification as well as the hands-on support provided to trainees by the affiliated university. HCPC trainees, for example, are provided (at least on the programme on which I have trainees registered) with compulsory workshops that specifically link in with the work required for the training programme (including reflective reports and case studies). While BPS trainees are able to attend national CPD events, these are often held in locations that are difficult for trainees to reach and/or are not necessarily clearly linked to Core Role criteria.
Book Reviews

Edited by Debbie McQueirns

For this issue we have just one review: Dr Nick Wakefield, Mersey Forensic Psychology Trust, looks at Teaching Clients to Use Mindfulness Skills by Christine Dunkley and Maggie Stanton.

Thank you to all those who have asked to review a book. Several readers are now with a book to review, hopefully in time for the next issue. I am in contact with various publishers and updating the books we have available for review so please do contact me by email for an updated list. I am also in the process of preparing guidelines for book reviewers in response to requests.

For the next few months those that take a book for review will get a complimentary book or two for your shelves – this is a book that is unlikely to get selected for review by Forensic Update readers but may be of interest.

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Teaching Clients to use Mindfulness Skills:
A Practical Guide
Christine Dunkley and Maggie Stanton
Routledge (2013)

Reviewed by Dr Nick Wakefield

Mindfulness as a concept, therapeutic approach and clinical tool has grown in recent years with many Clinical Psychology training programmes now providing Mindfulness experiential teaching to students. Teaching Clients to use Mindfulness Skills: A Practical Guide does exactly what it sets out to do, bringing together the authors’ wealth of clinical experience to offer the reader practical ideas and solutions for helping clients, and clinicians, to understand mindfulness techniques and how to use those techniques.

The book starts with a very brief overview of what mindfulness is, and though it is a little light on theory this can be excused as the book is not intended as a theoretical discussion of the subject and readers can immerse themselves in numerous other volumes if they are so inclined. Having said that, the chapter, and book as a whole, might have benefited from some directions for where to look for such immersions.
Each chapter offers step-by-step guidance on how to explore a range of mindfulness techniques in a systematic way. Whilst these steps are thorough they are in no way prescriptive, offering a variety of approaches to discuss and experience each technique. Of particular use are the ‘common client’ comments, some of which will no doubt be familiar to those of you who teach mindfulness already. Whilst the authors offer suggestions on how to address such comments this it is not prescriptive and it provides the reader with the opportunity to consider how they might address them with their particular client group. Throughout the chapters there are numerous case examples which help to bring the techniques to life, a type of experiential learning reflecting the mindfulness approach. These examples helped to bring to mind some of my own clients and apply the skills as I read. The key aims and stylistic approaches at the end of each chapter help to clarify the rationale for each technique and set the tone for transferring them into client sessions. The chapters build from basic to more complex skills in a natural developmental way culminating in case examples which help to bring the preceding chapters together. The only thing lacking form my perspective was some consideration of delivering such skills in group settings, with the focus very much on individual sessions.

Mindfulness can be applied with a range of clients in a variety of settings and can compliment other therapeutic approaches. This book can provide useful techniques to any psychological clinicians’ therapeutic repertoire. I have found a number of the techniques in this book useful in helping forensic clients with severe mental health problems and traumatic histories to develop mindfulness skills as part of their emotion regulation abilities. Any clinician, regardless of experience, would find this easy to read, easy to apply guide to mindfulness, helpful addition to develop and support their clinical skills.

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Research. Digested.

The British Psychological Society’s free Research Digest
Blog, email, Twitter and Facebook

www.researchdigest.org.uk/blog

‘Easy to access and free, and a mine of useful information for my work: what more could I want? I only wish I’d found this years ago!’
Dr Jennifer Wild, Consultant Clinical Psychologist & Senior Lecturer, Institute of Psychiatry

‘The selection of papers suits my eclectic mind perfectly, and the quality and clarity of the synopses is uniformly excellent.’
Professor Guy Claxton, University of Bristol
Forensic Update
Newsletter of the Division of Forensic Psychology

Guidelines for Contributors
We welcome contributions in various formats including: reviews, research (completed or in progress) and commentaries on any aspect of forensic psychology or related fields. It is usually possible to publish contributions more quickly than refereed journals. However, this will be somewhat dependent on the amount of material the Editorial Team receives. Articles will be edited by the Editorial Team. Forensic Update is published quarterly in January, April, July and October. Copy should be with the Editors at least three months prior to proposed publication date. The Editors cannot guarantee that a submission will appear in the following edition after it has been accepted. Please contact the Editors if you would like to discuss ideas for papers or guidance for submissions.

Audience: Please write your article at a level suitable for an intelligent reader with a basic knowledge of forensic psychology. Please try to avoid assuming detailed specialist knowledge. Please keep statistics to a minimum.

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Further guidance on presentation can be obtained from the Style Guide published by the British Psychological Society. It can be downloaded free of charge from the Society’s website.
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