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Developing support structures for healthcare professionals working within prison settings

Andrew Shepherd - Clinical Lecturer in Forensic Psychiatry,
University of Manchester
andrew.shepherd-2@manchester.ac.uk

Outline

1. Prisons as environments for clinical work
2. The nature of clinical work - theoretical perspectives
3. Experience of clinical practice
4. Supervisory needs and clinical practice
5. Implications - frameworks for moving forward

Miss P

Prisons as environments for clinical work

- Prisons, as institutions, represent sites of deliberate social marginalisation - the exclusion of the ‘unwanted’ from society as a whole
- Punishment within UK and European law is represented by ‘loss of time’ - but the environments in themselves can become ‘punishing.’
- Prisoners are often drawn from marginalised groups, with high prevalence of personal trauma, prior to their incarceration
- Rates of mental disorder within prison are high (Fazel 2002)
- Healthcare practitioners working within prison environments are charged with providing ‘equivalent’ care to that which could accessed in the community.

Nature of clinical work - theoretical perspectives

- Clinical work requires practitioners to directly ‘meet’ the distress of their patient - to ‘contain’ their experience (c.f Bion 1985)
- Distress may be expressed as a ‘symptom’ - a representation of distress, and perhaps effort at stabilisation, on the part of the patient.
- Symptoms are informed and interpreted in a fashion that is closely dependent on the institution in which the work takes place (e.g for psychosis - Mackie 2016)
- That is - symptoms are expressed within a psychosocial field (c.f Bourdieu 1969) and their expression will be determined by that same field (e.g prison as institution)
- Proposition: - *Clinical work involves the interpretation of symptoms, their containment, and translation to the patient in a form that can be processed*.

The experience of clinical work

- Process of symptom interpretation can be seen as example of ‘emotional labour’ - that is a form of ‘sense making’ or ‘biographical work.’
- This process involves at least two parties (focus on two in classical clinical encounter)
- Both parties engage in the act however
- Clinicians therefore also engage in this process
- In representing the ‘symptom’ clinicians may also experience a form of ‘projection’ (c.f containment) that is then modified / interpreted in light of their own experience (c.f transference / countertransference)
- Clinicians become incorporated into the experience and distress...

"...attachment is seen as being suspect from a boundary point of view, because it's just too difficult, because it means we might actually have emotions about people that we work with…"

"...*it's too discomforting, so I think that it's just at any number of levels, political and personal and intrapsychic, that there's massive resistance and massive anxiety about this whole area of work*…"

"*it's the nature of the job, isn't it? That you're going to take that stuff on board, that you're going to carry it with you…*"

"*You can manage if your home life is manageable, but if your work life and your home life are disrupted then…*"

Supervisory needs and clinical practice in prison settings

- Suggestion that idea of emotional labour, symptom formation and transference applies to all spheres of clinical practice (not simply mental health)
- Such projections within the prison environment may be particularly intense at times however
- There is a clear need for a means for clinicians to address these experiences in a safe, reflective, non-judgemental space
- Question arises - how can this be afforded in the face of service demands and restricted resource?
- How do we meet multi-agency needs in such settings?

Miss P

References

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