



Promoting Professional Resilience

Jo Clarke

He is quick, thinking in clear images;
I am slow, thinking in broken images.

He becomes dull, trusting to his clear images;
I become sharp, mistrusting my broken images.

Trusting his images, he assumes their
relevance;
Mistrusting my images, I question their
relevance.

Assuming their relevance, he assumes the fact;
Questioning their relevance, I question the fact.

When the fact fails him, he questions his senses;
When the fact fails me, I approve my senses.

He continues quick and dull in his clear
images;
I continue slow and sharp in my broken
images-

He in a new confusion of his understanding;
I in a new understanding of my confusion.
(In *Broken Images* Robert Graves 1914–1946)

Introduction

Some occupations are unique with respect to which members risk exposure to traumatic events. Paton and Violanti (1996) describe these as ‘critical occupations’, a term coined to encapsulate the critical role played by such individuals in protecting communities, as well as the fact that ‘in the course of acting in this capacity, these professionals can encounter traumatic events which may, under certain circumstances, exert critical impact on their psychological well-being’ (Paton and Violanti, 1996: vii). Emergency service personnel and disaster responders are two clear examples where front-line workers face acute risk owing to the nature of their work. Body recovery after natural disasters, removal of victims from vehicle crashes, attending scenes of terrorist activity can all be readily identified as situations likely to challenge any individual’s psychological equilibrium.

However, more recently it has been recognised that some jobs involve considerably more *chronic* exposure to potential psychological risk, and although different from the demands of emergency work, should also be included under the umbrella term ‘critical occupation’. Working in child protection is one such area. The potential for almost daily encounters with child victims of abuse, damaged families, hostile abusers, interrogative and blaming media, not to mention the complexities of inter-agency working can at times conspire to impact on the well-being of even the most hardy individuals.

Drawing up an inclusive list of non-emergency ‘critical occupations’ would be a considerable challenge, but therapists working with perpetrators of sexual abuse, and prison and probation staff managing incarcerated and community-based offenders would be other indisputable examples. Much of the work presented here is based on the author’s research and experience in these two areas, and as such, regular reference is made to the associated literature.

The purpose of this chapter is to present an organisational strategy that has been designed specifically to enhance the well-being of staff working with the most difficult, disruptive and damaged prisoners held in High Security prison discrete units. The chapter starts by considering the concept of ‘risk’ in non-emergency critical occupations, particularly in relation to well-being, psychological harm, resilience and post-traumatic growth. The development of the strategy is explained, including the rationale for the five key domains. Case examples of different interventions in action are then provided. Although designed specifically for HM Prison Service staff, it becomes clear that the principles underpinning the strategy’s construction are equally applicable to staff working in any occupation where chronic exposure to potentially traumatic events is high.

The chapter concludes with a discussion around implementation of elements of the strategy across diverse organisations.



Risk in non-emergency critical occupations

The word 'risk' has become so overused in modern vocabulary as to have almost lost its significance. For example, the terms risk assessment, risk management, risk reduction and risk aversion are terms so regularly incorporated into organisational parlance, that people seldom seem to question anymore, 'risk of what?' However, it is argued that without explication, any efforts to reduce risk are at best ad hoc and at worst potentially damaging.

In the context of critical occupations there are a number of areas where the concept of risk requires specific consideration. The first, and the one on which the premise of critical occupations is based, is risk of exposure to events that are potentially traumatic. DSM IV (American Psychiatric Association, 1994) defines a traumatic event as one that is outside of the range of usual human experience and that would be markedly distressing to almost anyone. Examples given of such events include threat to life or physical integrity, sudden destruction of one's home, or seeing another person who has recently been or is being seriously injured or killed. Clearly, front line emergency responders face such events frequently. And so do social service and criminal justice professionals. Working with victims of abuse or being threatened with assault by someone already known to be capable of murder can be daily occurrences, not in the context of an emergency callout, but as part of the daily work routine. Indeed, studies comparing emergency responders with social services personnel, found the latter group reported higher levels of traumatic symptoms despite similar levels of exposure to traumatic stimuli (Paton, Cacioppe and Smith, 1992; Paton and du Preez, 1993).

However, if the event itself caused traumatic symptoms, the shelf-life of members of critical occupations would be dramatically short. So what other risks should be considered? Paton and Violanti (1996) refer to the 'potential' for an event to be traumatic, suggesting that a second area of risk is that of traumatic *responding* by an individual worker. As will be discussed later in the chapter, just because risk of exposure is high, it does not follow that distress is inevitable. The level of risk of such a response is embedded not just in events, but also in complex psychological and demographic individual differences. Age,

gender, length of service, previous trauma history and family history are all examples of factors associated with risk of stressful responding (e.g. Burke, 2007; Clarke, 2004; Clarke and Roger, 2007; Ellerby, 1998; McFarlane, 1987).

Thirdly, organisational practices evidenced to affect risk also require attention. Conclusions from research undertaken with emergency professions suggest that organisational variables represent stronger predictors of post-trauma outcomes than the incidents themselves (Dunning, 2003; Gist and Woodall, 2000; Hart, Wearing and Headey, Paton et al., 2000; Paton et al., 2003; Paton, Violanti and Smith, 2003; Paton, 2006). For example, organisations characterised by high levels of bureaucracy, internal conflicts regarding responsibility, persistent use of established procedures (even in novel situations), and a strong motivation to protect the organisation from blame or criticism, have all been found to increase the risk of poor post-trauma outcome (Alexander and Wells, 1991; Gist and Woodall, 2000; Paton, 1997). Conversely, positive organisational practices, such as adoption of autonomous response systems, consultative leadership styles, training to develop adaptive capacity, and tolerance of procedural flexibility, can all enhance the likelihood of positive outcomes (Dunning, 2003; Gist and Woodall, 2000; Hart et al., 1994; Paton, 1994).

Finally, the extent to which risk levels might be compounded by events removed from the work context, but significant to the individual, also needs to be understood if risk potential is to be comprehensively managed. For example, in a study of prison and community-based sex offender treatment providers, respondents who had experienced a non-work related adverse event in the previous six months, also reported significantly higher levels of dissatisfaction with their organisations (Clarke, 2004). Such events included illness, relationship breakdown, house moves and so on. Although similar research failed to find an impact of traumatic life events 12 to 24 months after the event (Creamer et al., 1990) recent occurrence does appear to impact negatively on well-being.

An approach to managing risk incorporating these areas can underpin the development of a comprehensive strategy to enhance well-being for staff in critical occupations.



Psychological well-being and resilience in critical occupations

Until recently, research into the psychological impact of traumatic events, whether in an occupational or personal context, has focused almost exclusively on the potential for deleterious outcome. In a review of the literature concerned with the impact on treatment providers of working therapeutically with sex offenders (Clarke, 2004) not one study prior to 2000 considered positive aspects of the work. Because of the invidious nature of sexual violence against children and adults and the consequent exposure of therapists to detailed accounts of sexual abuse, the pervasive acceptance of detrimental effects is perhaps not surprising. This has been reflected in the nature of the psychometric instruments and surveys employed to assess impact. Measures of burnout (e.g. Maslach Burnout Inventory, Maslach and Jackson, 1986), vicarious trauma (Traumatic Stress Institute Belief Scale – Revision L, Pearlman, 1996) secondary traumatic stress and compassion fatigue (Compassion Fatigue Self-Test, Figley, 1995) prevail. Consequently, it should be expected that symptoms indicative of trauma, including intrusive imagery, avoidance, cognitive disturbance, mood changes and disruption of core beliefs, have been identified. In a similar review of the trauma literature, Stamm (1997: 5) concluded, ‘the great controversy about helping-induced trauma is not, can it happen, but what shall we call it?’

It is somewhat surprising then that consistently across studies, from the UK to North America and Canada, prevalence of symptoms has been moderately low, ranging between 20 per cent and 25 per cent (Ellerby, 1998; Farrenkopf, 1992; Jackson, Holzman, Barnard and Paradis, 1997; Rich, 1997; Turner, 1992). The reliability of these figures is also brought into question by the retrospective, snapshot research methodology by which they were derived. Failure to incorporate longitudinal components into impact research means no conclusions can be drawn about why some people are affected and not others, how long symptoms persist, what the long term prognosis is or whether or not deleterious outcome is caused directly by work-related exposure to trauma.

The cost of the focus on measurement of psychological harm has also meant that another consistently occurring statistic has, until recently, been overlooked; that which reflects that

anywhere between 75 per cent and 96 per cent of treatment providers experience their work as immensely satisfying and rewarding (Edmunds, 1997; Ellerby, 1998; Kadambi, 2001; Kadambi and Truscott, 2003; Myers, 1995; Rich, 1997; Turner, 1992). In the critical occupations literature generally, there is a growing body of evidence that positive outcomes are not only possible, but that they often outweigh the negatives (Gist and Woodall, 2000; North et al., 2002; Paton, Violanti and Smith, 2003; Tedeschi and Calhoun, 2003). Being able to exercise professional skills to achieve highly meaningful outcomes, a strong sense of personal and professional development, a sense of control over significant adverse events, protection of the public and connection to colleagues have all been cited as enhancing well-being (Kadambi and Truscott, 2001; Paton, 2006).

In an organisational context the term ‘well-being’ refers to establishing the right conditions for generating high levels of employee engagement. It emphasises the social and psychological dimensions of the workplace, workforce and the work people do, and is related to both physical and mental health. An engaged workforce is identified by high levels of resilience, characterised in turn by the ability to bounce back from negative emotional experiences despite threats to the individual, flexible adaptation to the changing demands of stressful experiences and high positive emotionality (Block and Kremen, 1996; Lazarus, 1993; Masten, 2001). This is illustrated by staff who are competent, autonomous, understand the difference they can make to their work place and have personal values and beliefs that fit the needs of the role they undertake. Consequently, an engaged and resilient workforce is one that has low rates of turnover, low levels of sick absence and high levels of performance. The development and maintenance of such should arguably then be the number one priority for both individuals and organisations in the critical occupations business.

A model of well-being

The number and complexity of factors implicated in risk to individual well-being outlined at the start of this chapter, highlights the need for a structured, systematic and integrated approach to their identification and management. The Model of Dynamic Adaptation (MDA) (Figure 9.1)



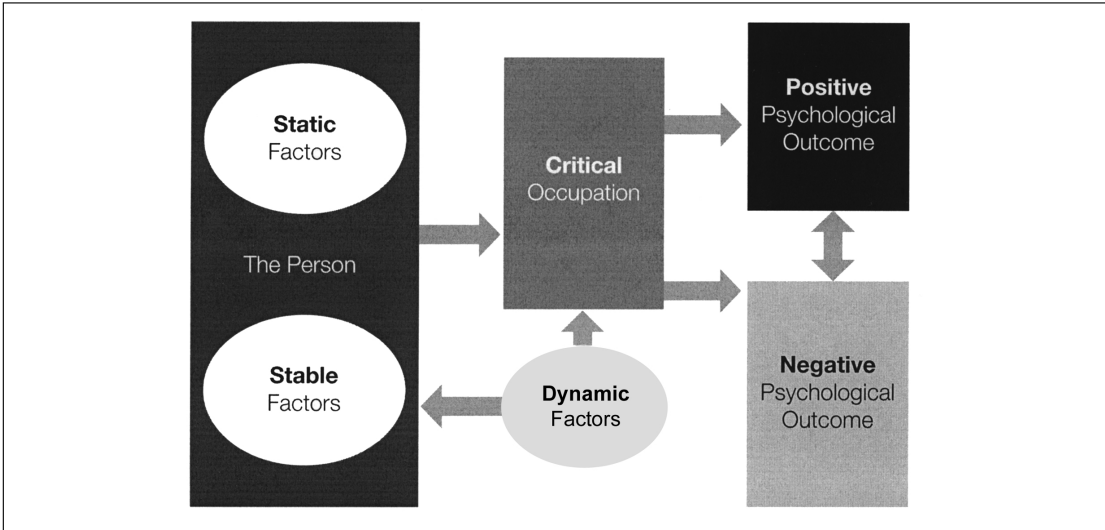


Figure 9.1 The model of dynamic adaptation

generated from research into the well-being of staff working therapeutically with sex offenders (Clarke and Roger, 2002; Clarke, 2004) provides a useful framework for this process. So named in an attempt to encapsulate the fluid risk status of an individual at any given time, it is based on the principles emanating from the risk prediction field (Grove and Meehl, 1996). In this, Here there is an emerging view that there are categories into which factors can be grouped that contribute to the prediction of risk (e.g. Hanson and Bussiere, 1998; Thornton, 2001). Although not yet empirically tested as a predictive model, a large number of variables incorporated in the MDA have been identified as significant, either in terms of heightening vulnerability to risk or increasing resilience to it. The organisation of variables in the way described allows for future development of the MDA as a reliable and valid risk prediction tool.

Variables are categorised according to the following definitions: *Static Factors* are any variables from an individual’s history that are either fixed or unchanging, or change in a highly predictable way. Age and gender are examples of these. *Stable Factors* are those that are potentially changeable but relatively stable. Under normal circumstances they would change only slowly, usually as a result of intervention or experience. Personality variables such as emotional sensitivity, coping styles and ability to take perspective are examples. *Dynamic factors* are those that can change rapidly, unpredictably and may well be outside the sphere of influence of the

individual. Examples might include winning the lottery, a spouse losing a job, a new colleague joining the team, or having an accident.

The Critical Occupation category incorporates all those variables relevant to the work that people and the work do. It includes risk of exposure to critical incidents, team cohesiveness, the physical environment in which the work takes place, policies and procedures, organisational support practices and so on.

The two outcome boxes refer to positive or negative psychological consequences, but are not mutually exclusive. As the figures from the sex offender treatment provider literature suggest, both rewarding and deleterious outcomes are possible simultaneously. The aim of any strategy to enhance well-being should be to tip the balance in favour of positive outcome for a majority of workers for a majority of the time.

The MDA is intended as a functional model for application to any critical occupation. However, identification of static, stable and dynamic variables, as well as rewards and cost of the work, needs to be specific to the occupation under consideration. Ideally, organisations will conduct their own longitudinal research, working with new, experienced and former practitioners, to establish the relative importance of the multitude of potential variables. The very nature of critical occupations though, means that some variables are likely to be common to all.

For example, within the static domain, age, gender, length of time in the role, family status



and previous history of trauma repeatedly emerge as significant to well-being (e.g. Clarke, 2004; Clarke and Roger, 2007; Clarke and Blythe, in preparation; Ellerby, 1998; McFarlane, 1987; Murphy, 1991). Within the stable category, dispositional optimism, emotional response style, coping strategies, perspective taking skills and empathy have all been identified as significant (e.g. Clarke, 2004; Clarke and Roger, 2007; Moran and Massam, 1997; Myers, 1995; Roger, Guarino and Olason, 2000). Dynamic factors, although little researched, include exposure to an event perceived to be traumatic within the previous six months, and quality of social support network post-event (Clarke, 2004; Pearlman and Saakvitne, 1995; Rich, 1997). Job and organisational characteristics include training, on-the-job support, preparedness and cultural issues (blame versus learning) (Alexander and Wells, 1991; Eisenberger et al., 2002; Gist and Woodall, 2000; Paton, 1997).

It is important to note that the extent to which a particular variable might influence either positive or negative outcome has not been elaborated upon here, and would need to be established in the context of other variables and the role to which it was being applied. For example, in a review of the literature on humour and coping in emergency work, Moran and Mossam (1997) concluded there is scope for some but not all humour to act as a positive coping strategy. Other variables may well be double edged swords. For example, high levels of emotional inhibition have been demonstrated to be detrimental to psychological and physical health (Roger, 2002). However, emotional expressiveness needs to take account of time and place. It is unlikely to be conducive to high performance or well-being in the face managing of a critical incident.

Understanding the rewards of working in a particular critical profession is also essential if well-being is to be enhanced. In a concept mapping exercise with sex offender treatment providers, Kadambi and Truscott (2003) identified seven key areas in which providers found reward and meaning in their work. These were labelled: protection of the public, socially meaningful curiosity, enjoyment of counselling, professional benefits, connection to colleagues, offender wellness and change and offending specific change. Knowing such specifics affords organisations the opportunity to maximise workers' development in these domains.

A strategy to enhance well-being of directorate of High Security Discrete Unit staff

HMPS Discrete Units

In 2005, HM Prison Service's Director of High Security (DHS) Prisons appointed a well-being advisor to consider the psychological support needs of staff working in DHS Discrete units (DUs). Discrete Units comprise Close Supervision Centres (CSCs) and segregation, special secure, detainee and protected witness units. All such units are self-contained within their parent establishment, in that they are run and managed by dedicated staff teams who in most instances have been especially selected for the role. A majority of DUs accommodate the most disruptive, dangerous and often damaged individuals in the prison system. These include men who have a history of institutional violence (that may include murder) who exhibit aggressive and unpredictable behaviour and who may well have a diagnosis of personality disorder. More recently, extremist prisoners charged with, or held on suspicion of, terrorist activity have presented a new and somewhat different psychological and emotional challenge to staff.

The types of challenges faced by staff on an almost daily basis include managing long-term prisoners with a history of serious hostage-taking (of both staff and other prisoners) and receiving constant personalised abuse from particular prisoners. The following incidents serve to illustrate other challenges: A previously quiet and reclusive prisoner mounting an unprovoked assault resulting in a member of staff being stabbed in the eye; a highly disturbed prisoner deliberately self-inflicting serious injury and excavating his own flesh to 'flick' at staff; prisoners uniting to go on 'dirty protest' whereby they urinated and defecated over their cells over a prolonged period of time.

In the late 1990s, as the development of CSCs was in progress, it was suggested that the single most difficult management issue confronting the Prison Service was creating secure and ordered conditions for long-term and difficult prisoners, while also establishing a realistic opportunity for them to progress, ultimately to less secure conditions (Morgan, 1997). Achieving such conditions without resorting to physical barriers, surveillance technology or regime deprivation was, and still is, considered to lie in the professional integrity of staff (King, 1985). The

skills needed to respond to the intensely demanding nature of the work are multiple, and over the past six years, considerable effort has been put into equipping DU staff with the professional competencies to fulfil their role. However, although an integral aspect of well-being (as will be discussed later), competence is only one of a multitude of elements that requires attention if a holistic solution is to be operationalised. As Liebling (1999: 161) highlighted: 'the question of how staff cope with the fluctuating possibility of abuse and violence, while maintaining a relationship with prisoners, has never been adequately addressed'.

Wilson (2001) highlighted that one of the core principles in setting up CSCs, in recognition of the demands placed on staff, was that routines and staffing arrangements should be organised to ensure effective staff support. This is particularly pertinent given the physical environment associated with most DUs. Although far removed from the austerity described above, DUs are necessarily managed with security and control as the highest priorities. For example, electronic doors operated externally prevent free entry or exit to staff, barred windows limit natural light, furnishing and decoration is kept to a minimum to reduce the potential for weapon construction, rest rooms for staff may be difficult to access (owing to electronic doors) or, if located centrally, overlooked by prisoners. The paradox then becomes clear that the very measures designed to increase physical safety may simultaneously have a negative impact on psychological well-being.

In an attempt to support staff, operating standards evolved which included a requirement for team members to receive individual sessions with a qualified psychologist. In addition to addressing well-being issues, sessions were intended to counteract regime 'drift' and the effects of attempted conditioning by prisoners. Some units also contracted-in Employee Assistance Programmes to provide access to external counselling.

Individual support sessions, while laudable in terms of responding to potential individual need, failed to encapsulate the wider spirit of Wilson's recommendations. Consequently, they came to represent the totality of the support infrastructure, whilst neglecting a multitude of other practices, strategies and techniques evidenced to enhance well-being. Furthermore, the inflexible nature of this approach met with considerable resistance. Specifically, the

mandatory requirement for attendance at individual support sessions resulted in staff perceiving that their ability to cope with high psychological demand was being undermined. This in itself resulted in distress, often exhibited as hostility, suspicion and outright anger, supporting empirical evidence that such an approach may result in greater severity and chronicity of symptoms (Bisson and Deahl, 1994; Carlier, Uchelen, van Lamberts and Gerson, 1998).

A second intuitive response designed to reduce the potential risk to staff was to limit the length of time individual officers stayed in DUs to two years. This was based on concerns surrounding capacity to cope and the potential for individuals to encounter numerous critical incidents in that time. Such a policy fails to account for individual differences in exposure, coping strategies, support networks or job satisfaction, the impact on teams of regular rotation or the financial implications of continually training new staff and inducting them to different ways of working, to name just a few. Further, there is a growing body of evidence to suggest that levels of distress may actually increase on leaving a critical occupation. For example, ex-sex offender treatment providers reported significantly higher levels of negative reactivity than practicing providers. Violanti (1996) points to the depressed, bored, tired and psychologically deadened state experienced by some police officers on leaving their role. He suggests it indicates a type of 'addiction to trauma', withdrawal, from which can be extremely difficult without intervention. Therefore, any decision to impose a maximum length of service in a critical occupation should also accommodate the potential costs to the organisation of relocating staff to less demanding roles, the potential requirement for ongoing support interventions and the personal cost to the individual of a possibly unwanted transfer.

Despite these efforts to address perceived needs of DU staff, it became evident they were not combating reported distress. Evidence for this was mostly anecdotal, although on one particular unit hard evidence was available in the form of high sick absence and turnover figures.*

*Sick absence among DU staff is generally lower than the Service population as a whole (Clarke and Blythe, in preparation). This might well attest the earlier observations regarding high levels of job satisfaction in COs, despite potential for distress, and cautions against over-reliance on sick absence figures as a measure of well-being.



Clarke and Lloyd (2004) in research intended to determine support preferences of DU staff, identified 35 separate items endorsed as beneficial to well-being. Using a critical item score methodology pioneered in earlier research (Clarke, McDougall and Harris, 2003) and the principles of factor analysis, the items were broadly categorised into two key areas; Operational Support and Personal Care/Emotional Well-Being. Items falling in the former group included 'A staff rotation plan that always leaves some experienced staff on the unit', 'Minimising the use of non-regular staff' and 'Senior managers acknowledging a job well done'. In the latter group 'Training in how to look after myself emotionally', 'Training in mental health issues' and 'Mandatory recovery time immediately after incidents and before debriefs or paperwork' were all considered supportive. Not only were many of the items far removed from previous organisational responses to minimising apparent distress, many of them were very straightforward to implement and far more in keeping with Wilson's (2002) original recommendation.

In an attempt to comprehensively address the support needs of DU staff, a long-term strategic approach has been adopted, incorporating many of the measures generated by staff in an effort to enhance well-being.

Strategy development and underpinning principles

The aim of any strategy is to help an organisation think through what it wants to achieve and how it will go about achieving it. Putting a strategy into practice and acting strategically ensures the organisation focuses on what needs to be done, is able to allocate resources accordingly and is not buffeted by events or distractions. The Strategy Survival Guide (2004) issued by the Cabinet Office, states that good public service strategies need to be; clear about objectives; informed by a rich understanding of causes, opportunities, trends, threats and possible futures; based on a realistic understanding of effectiveness; creative; adaptable; and, developed with, and communicated effectively to, all stakeholders. In developing the DU Well-Being strategy, a number of underpinning assumptions were made, including:

- Working in the Directorate of High Security DU is a critical occupation and presents unique psychological challenges to staff.
- Staff are in a constant process of adaptation to their work, influenced by a range of different factors.
- Allied to the point above, different staff have different needs at different times in relation to well-being.
- The Model of Dynamic Adaptation is an appropriate one on which to base an understanding of causes, threats and possible futures, given the points above.
- Pro-active, preventative strategies are more cost-effective than reactive, post-event strategies.
- The principles of evidence-based practice are highly relevant to interventions to enhance well-being. Intuitive interventions should only be implemented when theoretically supported and reinforced by thorough evaluation.

Fundamental to the success of the strategy is flexible, dynamic and holistic application in which the individual and employer have complementary responsibilities for sustaining well-being. Flexible in that elements of the strategy can be applied to the need of each unit and every individual at different times; dynamic in that it can accommodate change in the light of feedback or in response to new research evidence; and holistic in that it encompasses the preparation of staff from the point of expressions of interest to join a critical occupation through to comprehensive planning and support for departure and beyond.

To help achieve this, wider organisational and governmental considerations needed to be incorporated. In particular, the Health and Safety Executive (HSE) management standards for reducing workplace stress, and the Department of Health principles for primary, secondary and tertiary prevention were consulted.

The six HSE management standards cover the primary sources of stress at work, considered to be:

- Demands – such as workload, work patterns and the work environment.
- Control – such as how much say the person has in the way they do their work.
- Support – such as the encouragement, sponsorship and resources provided by the organisation, line management and colleagues.



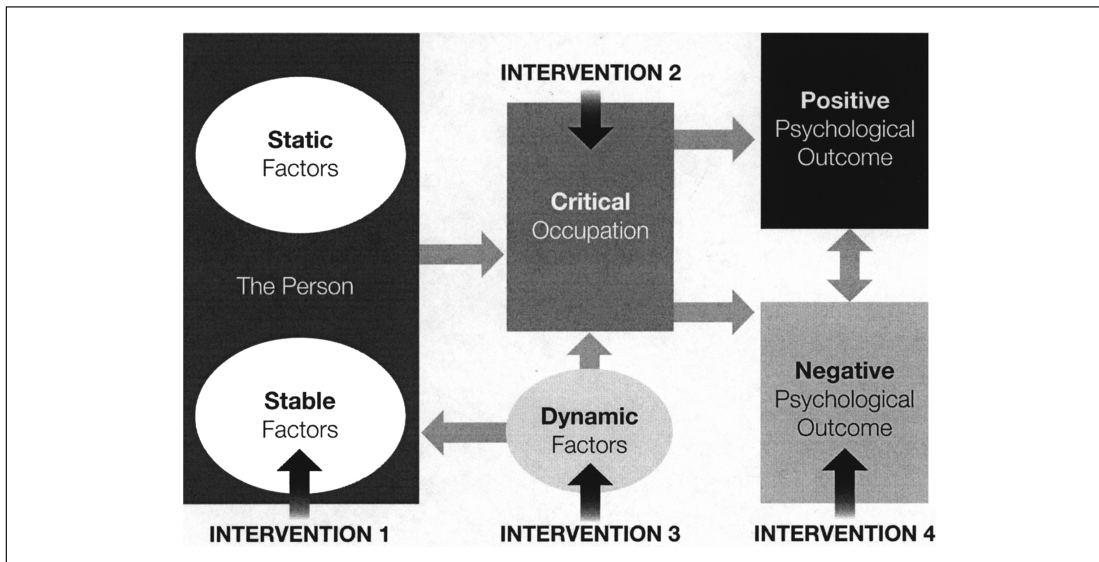


Figure 9.2 The model of dynamic adaptation with potential intervention points

- Relationships – such as promoting positive working to avoid conflict and dealing with unacceptable behaviour.
- Role – such as whether people understand their role within the organisation and whether the organisation ensures that they do not have conflicting roles.
- Change – such as how organisational change (large or small) is managed and communicated in the organisation.

Staff reporting positively about their working life in each of these domains is thought to reflect high levels of health, well-being and organisational performance. The DU Well-Being strategy is thus informed by these standards. However, the HSE acknowledges that while the organisation can take steps to reduce the potential for stressful responding, such emotional reactivity is largely a function of individual differences. Therefore, organisational measures for stress reduction need to be accompanied by protocols for addressing individual, psychological need.

To derive a framework for the strategy the organisation needs to first consider where it wants to be (its vision), and then how it might get there, through defining aims and short, medium and long-term objectives. By considering points on the MDA where intervention is possible, a coherent framework begins to emerge.

The points of intervention may be considered primary, secondary and tertiary in nature (DoH,

2007). In the context of the well-being model, primary intervention aims to promote good psychological health and requires action on its determinants to prevent dysfunctional outcomes; secondary intervention involves the early detection of dysfunctional outcome, followed by appropriate intervention; and tertiary intervention aims to reduce the impact of the dysfunctional outcome and promote quality of life through active rehabilitation.

Intervention One is concerned with the individual. It covers issues of selection, training and preparation of the individual to undertake a critical role. In addition to skills and competencies to do the job, self-care skills also need to be considered (psychological self-maintenance). The aim here is not necessarily to deselect staff who have yet to acquire the requisite skills, competencies or values to stay psychologically well and perform highly, but to generate a profile that enables the individual and organisation to work together to achieve such a position if potential is shown to do the job. Point One is thus considered a primary intervention.

Intervention Two concerns the job itself, and relates to the workplace, the work force and the work people do. Here, consideration needs to be given to the environment, organisational policies and procedures, on-the-job support, frequency of exposure to traumatic events, recognition of distress and so on. Essentially a primary intervention, elements of secondary intervention

would be applicable, if, for example, detrimental organisational practices were identified.

Opportunities to intervene at point Three are minimal. However, recognition and understanding of the impact that dynamic factors can have on well-being enables appropriate responses at both the individual and organisational level. Disclosure by a worker of difficult family circumstances, for example, can enable a manager to initiate different support options; understanding the impact on the team of a new manager can allow apposite preparation and so on. Intervention here would be an example of secondary prevention.

Intervention Four concerns action to be taken in the event of deleterious outcome, whether the result of a critical incident, other events related to organisational practices or individual circumstances. Generally tertiary in nature, responses might include referral to a mental health professional, adjustment of work demands, retraining and so on.

Table 1 illustrates the strategic framework for enhancing the well-being of staff working in DHS Discrete Units, derived from the MDA.

In addition to the central domains of preparation, practice and post-event recovery, the strategic framework incorporates two additional strands; evaluation and expert advice. Evidence-based practice is essential if the well-being of staff in critical occupations is to be enhanced. Even though empirical evidence for the efficacy of interventions in the non-emergency critical occupations is sparse, there is considerable evidence emerging from related fields that supports the testing of specific techniques in this context. Backed up by thorough evaluation, the intention is to develop an array of evidenced-based techniques for application in non-emergency settings. To this end, the advice of a number of experts in related fields has guided and will continue to guide the development and implementation of the strategy. The fields include critical occupations, stress and emotion, statistics and experimental design, supervision, and training methodology.

Implementation of the strategy

HM Prison Service's Directorate of High Security Well-being Strategy is in the early stages of implementation. The number and range of interventions mean that it will be a number of

years before all elements are in place, and even longer before empirical evidence of efficacy is available. The full version of the strategy includes justification and supporting empirical evidence for the inclusion of each element in the four central domains, and will not be elaborated upon here. However, to illustrate the strategy in action, three case examples are provided, in which two interventions from the Practice domain and one from Preparation 2: Training domain, are described.

Practice: Develop and implement a plan of Environmental Resilience

In 2005, concern was raised regarding the morale and subsequent performance of a staff team managing a small but highly disruptive group of prisoners held under conditions of close supervision. Reasons for the malaise were varied and plentiful, ranging from the implementation of new policies and procedures with little or no consultation, the long term placement of an extremely challenging prisoner, to a difficult team member perceived to be working beyond personal competencies and at high risk of being manipulated by prisoners. Many staff reported wanting to leave the unit, sick absence was high and when staff were on duty they spent as little time as possible interacting with prisoners. The consequence was that the prisoners became more disruptive and difficult to manage, perpetuating the disquiet. The development of environmental resilience with this team was considered by the author the most appropriate way to change the prevailing conditions.

Environmental Resilience (ER) essentially refers to how an organisation can develop people's resilience to deal with adversity (for a detailed description see, for example, Paton, Violanti and Smith, 2003). Two key components are how it can facilitate a capacity for adaptability prior to exposure and how it can support individuals to sustain resilience post-incident (Johnston and Paton, 2003). Central to the ER construct is the concept of empowerment. Empowerment 'enables' people to deal with environmental demands (Conger and Konungo, 1988), with empowered people having enhanced beliefs about their ability to achieve a desired level of performance, no matter what the hoped-for outcomes. An organisation can facilitate this capacity by focusing on what are

Table 9.1 Strategic framework: enhancing the psychological well-being of staff working in DHS Discrete Units

Vision In three years' time, the Directorate of High Security will have a comprehensive support infrastructure in place for Discrete Unit staff. It will consist of targeted selection and preparation of staff, evaluated interventions proven to enhance psychological resilience and reduce the risk of distress, and will be sufficiently flexible to accommodate the needs of a majority of staff.					
Aims					
1	2	3	4	5	6
Preparation: Selection of staff (1° prevention)	Preparation: Training of staff (1° prevention)	Practice: On-the-job support (1° and 2°)	Post-event recovery: (3° intervention)	Evaluation:	Expert advisory panel:
Objectives					
Identify core qualities and competencies for each type of Unit Review existing selection procedures Construct a user friendly selection protocol Identify relevant psychometrics Construct a qualitative element to assessment Evaluate protocol over 2 year period	Review existing training, ensuring needs are met Introduce 'top-up' training Develop simulation components to enhance preparation Introduce training in Self Maintenance Prepare staff for integration into established teams	Develop models of supervision Review the mandatory use of counselling Construct exit plan Develop and implement a programme of Environmental Resilience Identify and implement adaptive working practices Review optimum time in DUs Develop early distress warning system	Identify a range of evidence based interventions for post event recovery e.g. Trauma disclosure Review and enhance existing post-incident procedures Design integrated assessments for frequent incident exposure including elements of psychological growth	Psychological self-maintenance training Trauma disclosure Environmental Resilience Use of supervision Use of counselling	Establish a network of advisors with expertise in different elements of the strategy

considered the four cognitive components of empowerment; Competence, Meaningfulness, Choice and Impact.

Competence describes an individual's belief that they possess the skills and abilities necessary to perform the job. Clearly related to preparation in terms of training, it also incorporates more personal skills useful for looking after oneself. The more competent staff feel, the more productive and adaptable they are and the more effort they put into their work.

Meaningfulness refers to the 'fit' between the needs of the role and the values, beliefs and behaviours of the individual. This is likely to be reflected ultimately in how much an individual cares about their work (Thomas and Velthouse, 1990). Individuals who find their work meaningful are likely to perceive problems and demands as welcome challenges (Antonovsky, 1990). In the social services and criminal justice professions, meaningfulness is likely to be high, and reflected in the large proportion of workers who report their jobs to be highly satisfying and rewarding, despite the adversity faced.

Choice, according to Spreitzer (1997) refers to the extent to which an individual perceives their behaviour as self-determined. It is likely to be evident in an individual's predisposition to act positively under adverse conditions (Dunning, 1994). Choice for staff can be difficult to facilitate in a highly structured, necessarily disciplined environment, where strict application of rules is considered to enhance equity and fairness for prisoners. However, there are opportunities for managers to exercise discretion, thus allowing staff some freedom in how units are operated.

Impact refers to the extent to which an individual perceives they can influence strategy, administration or operating outcomes at work to make a difference. Spreitzer (1997) points out that where choice concerns control over oneself, impact concerns the notion of control over organisational outcomes.

Johnston and Paton (2003) argue that identification of organisational conditions that cultivate powerlessness is the first step to developing an empowered workforce. Removal of those conditions, together with encouragement of self-reliance, leads to the experience of empowerment, resulting in behaviours characterised by initiative and perseverance.

Putting these principles into practice with the team described above required input with both the frontline staff and unit managers. With the

support of the prison's senior managers (essential to the perception of meaningful intervention), a five stage process was initiated in line with Johnston and Paton's recommendations. This included:

1. Focus groups with frontline staff to identify their perceptions of barriers to well-being and high performance.
2. Examination of which of these (if any) could be removed or changed.
3. Use of training in how to manage the demands of work that cannot be adjusted.
4. Consideration of best methods to support managers.
5. Consideration of new ways of working to encourage resilience.

Focus groups with frontline staff resulted in the identification of a range of issues that concerned team members. For example, officers expressed anxiety at not feeling confident to manage prisoners' mental health issues in the absence of a specialised mental health provider. The result was staff finishing their shift concerned they had at best, not dealt with the prisoner well, and at worst made things more problematic for their colleagues coming on duty. Clearly an issue of competence, staff had found this issue very difficult to voice outside the ER forum, partly for fear of being judged, but also simply because the question had not previously been asked. The matter was addressed through additional on-site training, and more frequently scheduled visits from the mental health nurse.

A second, less clear cut, issue was a perception that prisoners had their requests and applications expedited more efficiently than staff. One particular incident surrounded the purchase of a musical instrument for a particularly demanding prisoner that some staff felt was not deserved. They felt vexed that goods seemed to have been purchased quickly and without question. By comparison, when staff had asked for the installation of lockers for storage of their personal belongings, very little seemed to happen. The consequence was staff feeling angry, resentful and undervalued. The ER focus group not only allowed this issue to be aired, it also provided an opportunity for a number of different perspectives to be heard. It transpired that the prisoner's order had taken many months to be processed, but since it had arrived the prisoner had been far calmer and less demanding of staff.

The unit manager was also able to take up the matter of the lockers and agreed to keep the team regularly updated about progress.

A third and highly emotive issue for the team concerned the working environment. As highlighted earlier in this chapter, often the very measures put in place to enhance physical security can compromise emotional well-being. A centrally located general office with 360° views of the unit and lack of rest facilities meant no privacy for staff during the core day. With a minimum of four centrally operated electronic doors, entry and egress from the unit was also problematic. It is hard to imagine the demand placed on individuals of being permanently observed. Although it took time to address, adjustments were made as a consequence of the concerns raised. The central office windows were covered with one-way reflective sheets, allowing observation of prisoners but not prisoner observation of staff, and a small office, away from the central area but within the unit, was converted into a rest room.

These examples illustrate stages one to three of the process in action. Most actions were undertaken with minimal cost implications, which in any case were likely to have been disproportionately low compared with the increased well-being of the team.

Additional focus groups were held with the first-line managers, including one Principal Officer (PO) and four Senior Officers (SOs) and two psychologists having input to both prisoner and staff well-being. First-line managers are central to the development of ER in teams for a multitude of reasons. They act as role models to their team and provide feedback to staff (Johnston and Paton, 2003). They also have the authority to introduce ER related initiatives, such as structuring team briefings (affording opportunities for impact); setting progressively more challenging targets (developing competence); increasing variety of tasks (choice) and matching skills of staff to roles within the team (meaningfulness). They also need to have their own support needs met.

The managers identified additional issues that they perceived may have been hindering the development of resilience in the team, and amongst themselves. For example, with two SOs on duty, it was not always clear who was responsible for what. SO tasks could be broadly split into either operational or administrative in nature. New practice meant the roles were clearly

defined, the managers were clear about their responsibilities, and staff knew who to go to over what issue. The managers also discussed the need to enhance competence and choice by providing a supporting role to staff managing highly demanding prisoners, rather than the hands-on approach they had been adopting. It is easy for the often overwhelming operational demands on prison staff to overshadow the very solutions that can reduce or remove them. The opportunity, time and space afforded to the managers and staff by the ER process resulted in the implementation of a range of simple, straightforward and cost effective solutions that may not have otherwise been identified.

Eighteen months on from the initial intervention, the team hold ER meetings on a monthly basis. Although not yet empirically tested, morale in this well-functioning and integrated team is high. Visitors to the unit comment on the calm and ordered atmosphere and staff present as relaxed and competent in their roles.

Practice: Identify and implement adaptive working practices

Some high risk jobs involve undertaking repetitive and painstaking tasks that most of the time, do not demand high levels of emotional energy to perform well. They do, however, require vigilance and can at times become critical in nature. An example of one such job is that of monitoring the correspondence, both verbal and written, of prisoners subject to Safeguarding Children measures.

In 2006, new procedures were introduced to undertake this task, and, in one prison, a small team of ancillary grades was appointed to administer them. Despite the newness of the role, the then Director of High Security prisons raised concerns regarding the potential for the work to exert critical pressure on well-being. He asked for a review of that potential and for interventions to be considered that would reduce the risk of psychological harm to the team.

The prison concerned had 180 prisoners subject to the measures. The team was required to monitor communications and make an assessment about the nature and level of risk in relation to public protection. The gathered data may be used in a number of ways, including preventing a known sex offender gaining access



to children, foiling an escape attempt, or imposing conditions on a licence prior to release. Accordingly, team members are required to remain highly vigilant in the face of potentially emotionally upsetting material, in the knowledge that their assessment is likely to have a significant impact on public safety. It is a highly responsible and high profile role.

In order to establish the nature of the risk posed to psychological well-being, a focus group comprising representatives of the team and the team leader was held. This group identified the following challenges: anticipation of the content of material they may encounter – generally found to be worse than the content itself (issues of preparation); reading security files containing graphic offence information and occasionally photographs; managing strong emotional reactions to the content of phone calls monitored (compounded by wearing headphones which give the sensation of personal involvement in the conversation); the amount of time spent monitoring conversations, which could be for eight hour stretches; and singleton working, particularly at weekends, with no opportunity to debrief.

The team identified the following areas as particularly rewarding:

- Knowing that actions taken have a far reaching effect on public safety.
- New, novel and interesting work.
- Systematic gathering of information.
- Able to use initiative.
- Able to operate independently.
- Close knit team.
- Attendance at Safeguarding children meetings.
- Greater involvement in prison life.
- Potential to have a big impact.

The components of ER were already evident in the team (impact and meaning especially). The priority therefore was to develop healthy working practices to enhance the existing rewards of the work and reduce the risk of work content impacting negatively. To achieve this, the principles of 'Full Engagement' explicated by Loehr and Schwartz (2003) were consulted as complimentary to other practices evidenced to enhance well-being.

Loehr and Schwartz propose that 'performance, health and happiness are grounded in the skilful management of energy' (p. 5) resulting in greater empowerment and

productivity. Full engagement requires an individual to be physically energised, emotionally connected, mentally focused and spiritually aligned. It involves not just the expenditure, but also the recovery of energy in these domains. In a job involving the monitoring of high risk prisoners, being disengaged in any of the domains could have disastrous consequences. Therefore practices such as monitoring phone calls continuously for eight hours for example, needed addressing.

Four interventions were proposed. To aid the management of physical energy, regular formalised breaks were introduced. Five to 10 minutes in every 90 was recommended, with team members physically leaving their work stations for that period of time. Some team members additionally opted to undertake a lunchtime exercise programme to augment their physical energy. To assist with the renewal of emotional energy, formal debriefs were recommended to provide team members with an opportunity to off-load the issues at the end of each day. Voluntary sessions with a mental health professional were also offered on an 'as needed' basis. To help staff remain mentally engaged, a rotation system was recommended, whereby team members moved between the tasks needing to be undertaken.

In addition to the above, preparedness training was also advised. Training in psychological self-maintenance skills, emotion management and the nature of psychological distress can enable staff to feel equipped and empowered to manage their emotional reactivity as it arises, rather than feel overwhelmed or baffled by it.

A recent review of the monitoring team found a psychologically and physically healthy staff group, fully engaged with their work and thriving in the face of some considerable adversity.

Preparation 2: Training

Within the Preparation 2 domain of the strategy, training, a number of initiatives have been implemented that will be summarised here by way of illustration.

An evaluation of a related but separate strategy, to reduce violence in prisons (Fylan and Clarke, 2006), identified a deficiency in the existing training for staff working with challenging prisoners. Although staff indicated



they enjoyed and appreciated the training, they lacked confidence and competence to apply the new skills they had learned. Research findings from the disaster and emergency literature have identified a clear link between competence, well-being and resilience (e.g. Spreitzer et al., 1997), suggesting a priority need to address the apparent shortfall between training aims and outcome.

Two steps were taken. The first was to identify those skills based training modules considered critical, and develop them into more comprehensive packages. This aim was to provide more practice opportunities with a view to building confidence in the use of specific skills. The second step was to consider ways of making the training more engaging and relevant to the workplace. It was recognised by trainers and trainees alike that the abstract nature of the classroom is not conducive to engagement with skills that are likely to be needed in highly emotionally charged and volatile situations. For example, applying the skills of a motivational interview to encourage a prisoner to progress is far less challenging in the training room that it is in a cell with a prisoner refusing to go to work.

To address this problem an expert in the use of dramatic techniques was bought in to advise on developing the training modules. A variety of techniques have now been incorporated that encourage far greater interactive practice of skills in much more realistic settings.

In addition to enhancing existing training, additional training was established, focusing uniquely on the development of psychological self-maintenance skills. As most practitioners in high risk jobs would probably affirm, training in the skills to do ones job is often comprehensive, but in the skills to look after oneself, non-existent. The training of choice for incorporation into the well-being strategy is that devised by Roger (2002). Based on the principles of emotional detachment, and developed from a series of experimental studies on the role of emotional inhibition and rumination in prolonging physiological recovery from stress, the programme describes the behavioural and psychological process of stressful responding and the physical correlates. Attendees generate their own risk profile, through use of established psychometric instruments and then practice methods for managing risky elements and enhancing protective ones. An empirical evaluation of the programme when used with

police officers demonstrated significant increases in job satisfaction and reduced absenteeism (Roger and Hudson, 1995).

A number of research projects have been initiated in support the strategy's development, including the construction of an early distress warning system and exit support plans. The proof of efficacy will come from long-term evaluation of projects and the ongoing feedback of frontline staff and managers.

Well-being in critical occupations

Critical occupations are unique with respect to which members risk exposure to potentially traumatic events. However, what should be evident from the review provided here is that even if risk of exposure is high, risk of deleterious outcome for individual workers need not be. Indeed, contrary to previous assumptions regarding pathological outcome in the face of trauma, an increasing body of evidence is emerging supporting what has been described as post-traumatic growth (PTG) (Tedeschi and Calhoun, 2003). PTG is defined as 'significant beneficial changes in cognitive and emotional life beyond levels of adaptation, psychological functioning, or life awareness that occur in the aftermath of psychological traumas that challenge previously held assumptions about self, others and the future' (Paton, 2005: 226).

Understanding the processes and factors involved in both positive and negative outcomes for workers in critical occupations enables organisations and individuals to respond accordingly. Establishing and maintaining appropriate preparation, practice and post event recovery environments should ensure the risk of psychological harm is kept to a minimum and the opportunities for psychological growth substantially enhanced.

Clearly, organisations have a duty of care to their employees to generate working environments that are as safe as possible. Individuals also have a duty of care to themselves to ensure they avail themselves of all opportunities to stay psychological well in the work context. These complimentary responsibilities are likely to be most effectively executed in environments where there is a genuine desire to enhance performance and well-being through consultation and collaboration. Organisations that impose support

structures from the top down are unlikely to reap the benefits of their intentions. It should not be surprising that many of the interventions included in the DHS Well-being strategy, supported empirically in the relevant literature, were also recommended by frontline staff – testament to staff's wisdom, experience and intuition for what works in enhancing their well-being.

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