

**DClinPsy Portfolio**

**Volume 1**

**Exploring psychologists' attachment style, compassion fatigue and satisfaction, and use of self-care within forensic settings.**

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## Abstract

**Background:** Attachment styles involve perceptions of the self and others and influence how individuals relate to other people. Insecure attachment styles have been strongly associated with the life experiences, criminal behaviour and mental health presentations common to patients in forensic settings. Therefore, challenging interactions associated with patients' insecure attachment styles and contact with traumatising material are considered common for psychologists working within these settings. However, previous research has also indicated that a significant number of psychologists may also have insecure attachment styles. Forensic settings have been associated with stress and burnout amongst health care professionals. However, no previous research has explored how psychologists' attachment styles may impact their levels of compassion fatigue and compassion satisfaction or influence their self-care in this setting.

**Aims:** This is an exploratory study which addresses a gap in the literature. It aims to explore the attachment styles and prevalence of compassion fatigue (burnout and secondary traumatic stress) and compassion satisfaction amongst psychologists in forensic settings. It will also qualitatively explore how psychologists manage negative feelings that arise in relation to their work and their use of self-care strategies in a range of situations. Finally, it will explore differences in the self-care strategies used by psychologists with different attachment styles.

**Methodology:** An online survey was used to gather data from 66 psychologists currently working in forensic settings in the United Kingdom. Quantitative measures of attachment style, compassion satisfaction and compassion fatigue were combined with qualitative questions regarding psychologists' self-care strategies. This provided data which was analysed using a mixed methodology, including correlational statistical analysis and qualitative content analysis. Attachment style groups were identified from the quantitative data and qualitative content analysis was applied to explore group similarities and differences in psychologists' self-care strategies.

**Results:** The results indicated that participating psychologists had a range of attachment styles. Compassion fatigue was not found to be as prevalent as suggested by previous research. Positive correlations were found between attachment related anxiety and burnout, and attachment related avoidance and burnout. Compassion satisfaction was found to be common within the present sample. A negative correlation was found between attachment related avoidance and compassion satisfaction. Similarities and differences in psychologists' self-care were highlighted between different attachment style groups.

**Implications:** A potential vulnerability was identified for psychologists with insecure attachment styles, in relation to burnout and reduced compassion satisfaction. Furthermore, there appeared to be a lack of knowledge and understanding of attachment theory and how this applies to clinical work. Therefore, a key implication is the development of training for psychologists in relation to this

topic. Use of multiple self-care strategies was common and self-care was perceived as important to clinical practice by the majority of the present sample. However, a training need for skills to be taught early in the psychologists' career and a need for self-care to be more widely supported at an organisational level regardless of stage of career was identified. The study concludes with a review of methodological considerations and the limitations these may present to the current findings.

## **Introduction**

### **Overview**

Attachment styles describe how individuals relate to others and involve perceptions of the self and others (Bartholomew & Horowitz, 1991). Previous research suggests that many patients in forensic settings will have an insecure attachment style (Pearlman & Courtois, 2005). Furthermore, psychologists' interactions with patients with challenging behaviour and traumatising material are common within these settings (Elliott & Daley, 2013) and these interactions are likely to activate the psychologist's attachment system (Roisman et al, 2007). Previous research also estimates that approximately half of all psychologists have an insecure attachment style (Rizq & Target, 2010). However, no previous research has explored how psychologists' attachment style may impact their levels of compassion fatigue and compassion satisfaction or influence their self-care. Therefore, the rationale for this study is to generate novel research regarding psychologists' attachment styles and how these may be associated with their levels of compassion satisfaction and compassion fatigue and self-care behaviours within the forensic setting.

This research is a mixed methods study, using quantitative analysis of self-report measures of attachment style (Bartholomew & Horowitz, 1991; Fraley, Waller & Brennan, 2000) and compassion fatigue (Stamm, 2012), as well as thematic content analysis (Berg & Lune, 2013; Graneheim & Lundman, 2003) to qualitatively explore the attachment style (Bowlby, 1977) and self-care strategies (Beauchamp & Childress, 2001) of Clinical and Forensic Psychologists currently working in Forensic settings in the UK. One aspect of this study is an exploration of the topic of attachment. As such, there is vast amount of literature available and a full review of its entirety is beyond the scope of this project. Therefore, this introduction first orients the reader to attachment theory, as it is relevant to this project, including recent changes in the understanding and measure of individual attachment style. It will then review the challenges faced within the forensic environment and why the psychologist's attachment style may be particularly relevant within this setting. Finally it will consider the topic of psychologist self-care. This will be followed by a discussion of the clinical relevance of this research and the research questions which this study will aim to answer.

### **Literature review strategy**

A thorough literature search was completed using the online databases: Web of Science, PubMed and PsychNet. A number of search terms were used, including combinations of the following: psychologist, therapist, clinician, self, care, attachment, style, forensic, secure, coping, strategies, compassion, fatigue, burnout. This search generated a vast amount of literature, particularly related to the topic of attachment. Therefore, this was scrutinised for studies that specifically addressed



issues relevant to the current research and demonstrated an overlap between variables. There was no previous research found to respond directly to the questions outlined by this study.

This introduction will review a basic understanding of attachment style research, including the measure of attachment style and how therapist attachment style has been explored in previous literature. It will not provide a complete review of the theory and application of attachment research. For a comprehensive review please see *The Handbook of Attachment* (Cassidy & Shaver, 2008).

## **Attachment theory**

Bowlby (1977) suggested that an attachment system was developed to maintain proximity of young children to their caregivers when in stressful or threatening conditions. Ainsworth, Blehar, Waters, and Wall (1978) developed this theory, reporting that the attachment system provides a constant sense of security which supports the child's exploration of the world beyond the caregiver attachment. Therefore the early attachment relationships are a foundation for the child's sense of self and sense of security with others.

The way attachment style is measured and categorised has developed since the initial work of Bowlby and Ainsworth, with a movement away from the three category model (secure, anxious-resistant and avoidant) towards viewing attachment along two continuous dimensions: attachment related anxiety and avoidance (Brennan, Clark & Shaver, 1998). This development will be reviewed in more detail in the following section. However, here it is relevant to note that attachment related anxiety is founded on self-doubt and concerns that attachment figures will not be available at times of need. Whereas, attachment related avoidance is based in an individual's distrust of attachment figures' goodwill, causing them to maintain behavioural and emotional independence and distance from others (Mikulincer, Shaver & Berant, 2013). This can be conceptualised as a four category model of attachment (Bartholomew & Horowitz, 1991), whereby individuals can be classified based on a combination of the two dimensions. These categories have been described as follows: Secure (low anxiety, low avoidance); Preoccupied (low avoidance, high anxiety); Fearful (high avoidance, high anxiety); and Dismissing (high avoidance, low anxiety).

Research has also explored the impact of individual attachment style on adult functioning, including how romantic attachments in adulthood may correspond to the attachment styles displayed within early caregiver relationships (Fraley & Shaver, 2000). Fonagy and Target (1996) also suggest that the quality of early attachments index the individual's ability to consider the self and others as psychological beings, and to contain and regulate their own feelings and respond to others' psychological states. Attachment insecurity has also been found to have a profound and severe impact on neuro-physiological development, somatic regulation, psychosexual development, and identity formation (Schoore, 2003a).

Roisman et al (2007) highlight the difference between the social and developmental perspectives on how attachment style is revealed in interpersonal behaviour. For example, the social perspective prioritises a diathesis-stress model, in which working models of attachment are triggered under conditions of stress or threat. Conversely, the developmental perspective typically suggests that attachment security may be a general interpersonal asset, rather than just being elicited when the individual is under threat. Throughout the literature, researchers highlight the contradictory

conclusions drawn, even from the same results (Roisman et al, 2007; Baldwin & Fehr, 1995), indicating the biases in interpretation based on the social or developmental perspective of the reviewer.

Therefore, Mikulincer et al (2013) proposed that an individual's degree of attachment anxiety and avoidance reflects both their sense of general attachment security *and* the ways they deal with stress and threats. These authors reinforce the viewpoint that individuals who are generally secure (scoring low on both anxiety and avoidance dimensions) hold positive mental representations of themselves and others and tend to use constructive and effective affect-regulation strategies. In contrast, those who have attachment avoidance may experience 'deactivating' of their attachment system, which may result in a detached or dismissive response to threats, frustrations, rejections and losses. Furthermore, those who have attachment anxiety may experience 'hyperactivating' of their attachment system, which may result in emotional elaboration in response to these stimuli.

## **Measuring attachment style**

Since the research of Bowlby and Ainsworth, there have been a variety of different ways of categorising and measuring attachment style suggested within the literature. These range from categorical models, which aim to establish people into clearly defined categories of attachment style (Hazen & Shaver, 1987), to more linear or dimensional models, which view attachment style as a continuum (Fraley et al, 2000). Previous research has considered the benefits of each of these approaches to understanding an individual's attachment style (Griffin & Bartholomew, 1994).

A number of measures of attachment style have been created, which access different aspects of an individual's perspective of their own attachment style. For example, some focus on their childhood attachments (George, Kaplan, & Main, 1985), whereas others focus on adult attachment relationships (Hazen & Shaver, 1987). Since there are many different measures of attachment style, each prioritising different elements of the attachment system, there is considerable criticism for the validity of these measures.

Roisman et al (2007) provide an empirical rapprochement comparing Adult Attachment Interview (AAI; George, Kaplan, & Main, 1996) research with research using self-reporting of attachment style. These authors highlight the divide between the social and developmental perspectives of attachment style and attempt to provide an objective account of the literature from both perspectives. They suggest that measures have been designed to tap different aspects of attachment security. For example, the AAI aims to tap 'unconscious' underlying psychological processes through the analysis of coherent narratives of childhood experiences, whereas self-report measures tend to target conscious appraisals of current relationships. These authors advise against a search for the ultimate method of measuring attachment style. However, Roisman et al (2007) emphasise that attachment style dimensions, assessed by linear self-report measures, are associated with adults' appraisal of the emotional tone of their relationships. According to those authors, this is in contrast to the developmental security assessed by the AAI, which is only partially related to current relational functioning.

Several authors have offered considerable reviews of the vast literature in this area, in an attempt to highlight the constructs and dimensions contributing to the challenge of measuring attachment style (Ravitz, Maunder, Hunter, Sthankiya, & Lancee, 2009). Roisman et al (2007) also reviews the

convergence and divergence of measures of attachment style. Both of these reviews consider the impact of the psychological, social and developmental perspectives taken when measuring attachment.

Ravitz et al's (2009) twenty-five year review of attachment measures, considers the appropriate use of different measures under different research or clinical circumstances. These authors indicate that all instruments developed to measure attachment style differentiate subtypes of insecure attachment from patterns of secure attachment. They also debate the state versus trait issues around attachment style. They suggest that, attachment behaviours are not always on display, but rather they are activated by triggers such as danger, threat or isolation. The in depth analysis of the array of attachment instruments available highlighted that the attachment interviews demonstrated good reliability and validity and were preferable to use over any self-report questionnaires. The authors highlight the debate about the 'unconscious' aspects of attachment related defences and how interviews such as the AAI aim to measure these specifically. Conversely, questionnaires such as The Relationships Questionnaire (RQ; Bartholomew & Horowitz, 1991) tend to measure conscious appraisals of individuals' thoughts and feelings in close relationships. The authors do however suggest that some questionnaire measures of attachment do also have good reliability and validity, including the RQ. Furthermore these authors recommend the use of dimensional measures of attachment as these appear to account for variability between individuals and have increased statistical power in research.

However, Ravitz et al's (2009) research can be criticised for its narrowed focus on psychosomatic research. This may limit the generalizability of the findings to research involving attachment style in other areas of the field. The authors also point out that although this is a thorough review of the literature there are developments in the field of attachment and measurement of attachment which may not have been included due to the rapid expansion and recent developments within the field.

Baldwin and Fehr (1995) discussed the instability of attachment ratings. This study reviewed the use of a single item attachment repeated measure and noted that individual's self-rating of their attachment style was changeable. This was particularly true for participants who reported themselves to have an anxious-ambivalent style of attachment, the majority of whom changed their style, even over a one-week period. The authors debate whether inconsistencies in self-report over time have methodological or conceptual implications. They question whether the instruments being used to measure attachment style are sensitive enough to incorporate individual differences within each category. As a consequence, these authors tentatively recommended that researchers in this field use measures which may be more sensitive to individual differences, such as linear scale measures rather than individual item assessments.

One criticism of this perspective is that when single-item measures and continuous scale measures are completed at the same time, they can indicate good correspondence. Therefore, Baldwin and Fehr (1995) also debate whether the concept of attachment theory requires further development to include natural shifts in attachment style over time. However, their review of previous literature suggests that there is very minimal correlation between the length of time between measurements and the degree of change in attachment style self-report. Similarly, (Hazen & Shaver, 1994b) consider the changeability of attachment self-report over time. These researchers noted that attachment theory does propose a significant amount of continuity. However, Baldwin and Fehr

(1995) also question whether the type of relationship invokes a different style of attachment. These authors suggest that the measures used to assess attachment style should correspond with the relationship being assessed. For example, if the research query is in relation to child-parent attachment then more static categorical measures should be used. Whereas, if an attachment within an adult romantic relationship is being assessed, there are more suitable linear dimensional measures available.

Rizq and Target (2010) highlight an important benefit to the use of contemporary dimensional models of attachment theory. They argue that categorical measures previously considered attachment status as a stable personal characteristic and therefore were potentially pathologising. However, dimensional measures indicate the spectrum of attachment styles and are more responsive to how emotion has been regulated, the experiences the individual has allowed into consciousness and how they make meaning of their primary relationships.

### **Patient attachment style in a forensic setting**

Mikulincer and Shaver (2013) reasoned that if one's key attachments have not been reliably available or supportive, that it is more difficult to attain relational security. The authors suggest that this can cause doubt about the individual's lovability and can cause worries about others' intentions resulting in the individual finding affect-regulation strategies characterised by anxiety and avoidance, rather than by healthy proximity seeking. This is highly relevant to forensic settings, where the patient group has higher rates of post-traumatic stress disorder and physical, sexual and emotional abuse in childhood and early adolescence than the general population (Garieballa et al, 2006), which may have resulted in increased insecurity within significant attachment relationships.

Furthermore, Garieballa et al (2006) draw a correlational conclusion that childhood victimisation may lead to trauma-spectrum disorders and later criminal behaviour. However, this study is based on a German and Sudanese forensic population, so may be criticised for the lack of causality and generalizability. In their defence, the authors suggest that cultural differences are minimal, despite the common assumption of notable cultural differences in psychopathological symptoms.

Pearlman and Courtois (2005) highlight that individuals who have experienced severe cumulative interpersonal violence, neglect or abuse, particularly in childhood and perpetrated by caregivers or attachment figures, experience alterations in all their relations with others. This may result in impediments in the individual's ability to create relational security and stability and develop healthy relationships later in life. Instead, the authors suggest that individuals may develop a pattern of relationships fraught with chaos and instability, and are likely to incur additional abuse, victimisation and loss as a consequence. In addition, the authors suggest that these individuals will not have learned to regulate their affect states, creating a sense of desperation. They are more likely to use dissociation or psychological defences, and when under emotional stress will use self-soothing and containment behaviours that are paradoxically unhelpful or self-destructive, such as self-injury, eating disorders, suicidality, substance abuse, risky sexual behaviour, aggression against others and re-victimisation.

Throughout the literature, attachment insecurities are identified within different forensic sub-groups. For example, Keinlen, Birmingham, Solberg, O'Regan, and Melroy (1997) showed that 63% of criminal stalkers had experienced a change or loss of primary caregiver during childhood and that

traumatic abuse occurred in 55% of cases studied. Preoccupied attachment styles have been linked to potential for violence (Pollock & Percy, 1999). Rosenstein and Horowitz (1996) reported that insecure attachment patterns are an underlying factor for a number of psychopathological states. In Ogilvie, Newman, Todd, and Peck's (2014) meta-analysis of attachment and violent offending literature, the results suggest that insecure attachment was strongly associated with all types of criminality, including sexual offending, violent offending, non-violent offending and domestic violence, even in the absence of psychopathology.

Shilkret (2005) suggested that attachment styles represent a pattern of interaction that have been adapted in response to parental and primary caregiving relationships. However, this pattern of interaction can also influence how the individual interacts with others in the world around them. In particular, this author discusses the generalizability of this attachment from the parent-child dynamic to other authority figures. Therefore, Shilkret proposes that it is reasonable to assume that patients will demonstrate their attachment styles within the therapeutic relationship.

## **Patient-Therapist attachment**

There is a wealth of literature in which therapist attachment style has been studied in relation to therapeutic alliance and therapy outcome. It is not within the scope of this project to review this literature in detail. Rather, the salient points regarding how the therapist-patient relationship has been considered within the context of an attachment bond will be outlined.

Mikulincer and Shaver's (2013) review of the relevant literature highlights how the patient-therapist relationship can be viewed as an attachment bond. Further, that the secure base provided by the therapist can facilitate healthy emotion regulation, relational security and exploration of therapeutic possibilities that can contribute to mental health. This is a continuation of Bowlby's (1988) suggestion that the revision of insecure attachment experiences that have accumulated throughout a patient's life can provide a key method for establishing therapeutic change. Bowlby regarded the extent to which these insecurities are identified, clarified, questioned, revised and transformed into more secure representations of attachment as associated to efficacious therapy.

Similarly, Schore (2003b) indicated that attachment styles can be strengthened and even changed over time from insecure and disorganised to secure, via explicit attention and response to interpersonal and attachment issues in psychotherapy. Schore suggests that this process should occur in parallel to the development of a secure therapeutic attachment as it would be ineffective to wait for a secure therapeutic attachment to develop first.

Mallinckrodt (2010) suggests that the development of a weak bond into a strong attachment bond that conveys felt security and acts as a safe haven for exploration is the primary effort of therapy. However, the author also highlights that the psychotherapeutic relationship does not always involve an attachment bond. Similarly, Winnicott (1969) argued that there is a difference between the therapist's role as a secure attachment base and their role as an effective emotional 'container'. Moreover, Winnicott argued that the therapist can maintain their role as a safe 'container' despite the relative lack of attachment bond. The concept of the therapist as an emotional container links to Bion's (1962) model of the parent as a 'container' for the child's 'uncontainable fears'. This theory suggests that the child projects fears into the caregiver who then modifies them so that the infant may introject them in a 'detoxified' form. According to Winnicott, the therapist's role in accepting

and modifying projected fears mirrors that of the parent. However, Winnicott noted that not every psychotherapy relationship will create an attachment bond. The author highlighted the uniqueness of the therapeutic relationship and stated that the attachment bond formed with one patient will not be comparable to the therapist's other therapeutic attachments. Furthermore, each therapeutic attachment will differ in terms of the pace at which the attachment is formed and the degree of security within the attachment.

In addition, Cordess (2004) suggests that the patient's attachment style can be used as a predictor of their capacity to form a therapeutic bond. This is substantiated by research that suggests patients with a secure general attachment will be more able to establish a secure attachment with their therapist, achieve greater depth of experience within sessions and experience increased sense of safety (Malinckrodt, Porter, & Kivlighan, 2005).

A growing number of studies have explored the links between client's adult attachment and working alliance, raising questions about whether there is a significant difference between the concepts of alliance and attachment within the therapeutic relationship. Malinckrodt et al (2005) noted that problems in clients' generalised adult attachment patterns are associated with poor working alliance. They argue that these concepts overlap in that both embody trust, mutual respect, emotional alignment between therapist and client, sensitivity, understanding, emotional availability and feeling hopeful and comforted. However, that there are significant differences in that attachment involves encouragement to explore frightening events in therapy, and accounts for a unique proportion of variance in how the individual relates to others, session depth and smoothness. This study could be criticised for considering four to eight therapy sessions as enough time to develop an attachment relationship, as opinions vary on the length of time required to establish an attachment. However, that variances in attachment and alliance were seen within this period could suggest that these results could be magnified in longer-term therapy cases. However, it is also of note that the generalizability of these results may be limited by sample size and lack of ethnic diversity within the sample.

There is growing research investigating the role of the therapist's own attachment style within the patient-therapist relationship. Of particular relevance to the present study is the exploration of how therapist attachment style may influence therapist self-care differences and how these differences may alter therapist behaviour within therapy. Limitations in the literature search in relation to the issue of therapist attachment style will be described below. The issue of psychologist self-care will be discussed in more detail later in this Introduction.

## **Therapist attachment style in a forensic setting**

Much of the previous literature in the area of therapist attachment style focuses on therapeutic outcomes and exploring the concept of matching complementary attachment styles to improve outcome. Within the current literature search, no research has been found to explore psychologist attachment style and self-care. There is also limited research which focuses on professionals' attachment styles within forensic settings specifically and this research often focuses on disciplines other than psychology. Therefore, the following review of therapist attachment style will largely be drawn from non-forensic environments and experiences of other disciplines. Cautious conclusions must be made regarding the significance of this data within this setting, based on the available

literature and the above discussion highlighting the key attachment challenges faced by patients within this setting.

Mikulincer et al (2013) emphasise the importance of the therapist's ability to provide a secure attachment base. These authors suggest that a secure therapist should find it easier to occupy the role of security provider and create a good therapeutic alliance. In contrast, an insecure therapist may be more likely to exacerbate problematic processes in the attachment relationship. Therefore, it is possible that the importance of increasing awareness of psychologist's attachment style is particularly relevant within the forensic setting, as the therapeutic relationship is likely to be impacted by the patient's disorganised attachment style, trauma in the patient's history, their ongoing difficulty with emotional dysregulation including threats of violence, as well as the nature of distressing forensic material that may trigger attachment responses in the therapist. These issues undoubtedly arise within non-forensic therapeutic settings, but according to the literature reviewed above may be more common within this patient group.

Fonagy, Target, Gergely, Allen, and Bateman (2003) further emphasise that the therapist's ability to mentalise and respond to the thoughts and feelings of the patient, whilst managing their own psychological state, is dependent on the quality and status of their own early attachment relationships. These authors also argue that the secure attachment status of the therapist is preferential, as personal experiences of abuse, trauma and neglect in childhood may disrupt the development of mentalisation. Furthermore, that the defensive inhibition of mentalising capacities may also exclude awareness of hostile mental states and intentions in others.

The research in this field clearly favours the provision of a secure attachment base by the therapist. However, Slade's (2000) observations plainly refute any notion that growing research in this area will exclude therapists who bring with them insight and empathy from personal experiences of attachment interference or breakdown. Slade states that many therapists will have suffered significant losses and abandonment, and will be in different states of recovery, repair and reconciliation. The author highlights that the way in which the therapist's attachment states are triggered will vary. Furthermore, that this will be influenced by the dynamic interaction between the attachment organisations of both patient and therapist.

Rizq and Target (2008a, 2008b) completed an interpretive phenomenological analysis of nine counselling psychologist's descriptions of their experiences in personal therapy. This research highlighted that the participants placed importance on their early attachment experiences when considering the development of their reflective capacity. Later, in Rizq and Target's (2010) research, the authors emphasise how attachment states of mind and reflective function in both therapist and patient may impact on the therapeutic relationship and play an important part in therapeutic process and progress. The results of this research also suggest that half of the counselling psychologists in the sample had insecure states of mind with respect to attachment. They explain that many of their participants referred to being driven by difficulties in their own early experiences, to heal themselves and to support others. The small sample size used in this study may limit generalizability to the profession. However, it is important to note that individuals entering caring professions, such as psychology, will bring with them a vast wealth of different life experiences, and therefore will have varying attachment styles.

## The cost of caring

Recent research has addressed the need to clarify the terminology used to report the different ways that work related stress can impact on therapists. Boscarino, Adams, and Figley (2010) summarise the differences between the stress related consequences of therapeutic work outlined in the literature. They define vicarious trauma as a component of compassion fatigue. According to Boscarino et al (2010) it is a risk factor to those who are exposed to significant numbers of traumatised individuals and who have an empathic orientation to their patients. It is experienced as a re-experiencing of the patient's traumatic event, a wish to avoid the patient and reminders of the patient's trauma and persistent arousal from knowledge of the patient's traumatic experiences. They also identify burnout as a component of compassion fatigue. Burnout is defined by Boscarino et al (2010) as a response to prolonged exposure to demanding interpersonal situations, causing a reduced sense of personal accomplishment, emotional exhaustion and depersonalisation. Compassion fatigue is therefore a term used to incorporate both vicarious trauma and burnout, but may involve additional components that are yet to be identified within the research. Compassion fatigue is defined by Boscarino et al (2010) as a reduced capacity or interest in being empathic that results from knowing about a traumatising event experienced by another person. According to Figley (2002) compassion fatigue can result in mistakes, misjudgements and blatant clinical errors.

Studies have shown that providing care to patients who have experienced trauma can be stressful as well as rewarding (Ohaeri, 2003). Figley (1995) highlighted that formal therapeutic interventions with individuals who have suffered trauma can be particularly stressful for therapists. This research indicates that many therapists working with this patient group show signs of psychological distress as a direct result of these interactions.

Similarly, Schauben and Frazier's (1995) study indicated that psychologists reported vicarious trauma and psychological problems more frequently when working with patients who had experienced sexual violence. However, the generalizability of this study to all psychologists is questionable as the participants were all female. In Wee and Myers' (2002) research, in which counsellors working with traumatised patients were assessed for symptoms of trauma, they found that 44.1% of participants reached clinical trauma caseness. Furthermore, approximately three quarters of the group studied were presenting as being at moderate to extremely high risk for compassion fatigue and burnout.

It is important to note, that not all forensic patients will have experienced trauma, and not all therapeutic work within forensic settings will involve interventions specifically relating to traumatic experiences. However, research suggests that even in the profession outside of forensic settings compassion fatigue and burnout can be problematic. Figley (2002a) notes that effective working with those who are suffering in general, requires empathy and emotional energy to maintain a therapeutic alliance, deliver effective services and remain empathic. The author suggests that being compassionate and empathic can come at a personal cost to the therapist, in addition to the energy required to provide these services.

Elliott and Daley (2013) acknowledge that forensic settings are stressful, dangerous and emotionally demanding environments. These authors argue that although there is little evidence to suggest that there is an increased risk of violence within forensic settings, the risk of extremely aggressive and disturbed behaviours is higher. Their review of the literature suggests that health care professionals



working in forensic settings may be at increased risk of compassion fatigue. This may be due to increased exposure to the disturbing social issues, extreme challenging behaviours, severe personality disorders and enduring mental health problems experienced by patients within these settings. This study found that over a third of forensic healthcare professionals scored above clinical cut-off for experiences of psychological distress and had high levels of burnout. Over a quarter of participants had high levels of depersonalisation that are linked to detrimental implications for patient outcome. These results indicate a serious gap in relation to forensic health care professionals' own mental health needs and well-being. However, this study is limited by the small number of participants and as a profession psychologists formed only 6.7% of participants.

Figley (2002) also highlighted the link between attachment and compassion fatigue. Figley discussed the similarities and differences between compassion fatigue and 'countertransference'. 'Countertransference' is a psychodynamic term used to describe an emotional reaction to a patient that, unlike compassion fatigue, is unrelated to therapists' empathy, or the trauma or suffering of the patient. However, it can be argued that there are similarities within the processes experienced by the therapist, including an over-identification with the patient and seeing oneself in the patient. Figley described 'countertransference' as chronic attachment associated with family of origin relationships, and highlights that these are more related to the therapist's personal factors than the patient's. However, this raises questions about the personal attachment factors that may contribute to therapists' experiences of compassion fatigue. Moreover, whether there are attachment styles which may respond more effectively to coping with these stressors. For example, whether therapists with a Secure attachment style, who experience low attachment related anxiety and avoidance, have a positive view of the self and others (Bartholomew & Horowitz, 1991) and are more able to mentalise other's psychological distress (Fonagy et al, 2003), are more resilient to the impact of compassion fatigue.

Boscarino et al (2010) suggest that professionals exposed to similar stressors will not share the same response to those stressors. They highlighted that vulnerability to the negative consequences of care-providing occupations is increased within historically disadvantaged groups, those with a history of psychological trauma and those without social support. This is supported by Kassam-Adams (1999) whose study of psychotherapists indicated that a personal history of trauma is related to poorer psychological well-being within this profession. Boscarino et al (2010) conclude that the characteristics, such as the desire to care for others or personally challenging life experiences, that attract people into the caring professions, are the factors that may make them vulnerable to compassion fatigue. It is therefore important to consider how psychologists manage these challenges and personal vulnerabilities in order to continue effective practice.

## **Psychologist self-care**

Bercier and Maynard (2014) completed a literature review of over 4000 citations and 159 full text reports to examine the effects of indicated interventions to reduce symptoms of compassion fatigue experienced by mental health workers. These authors found that not a single study met inclusion criteria for this review. They concluded that there is significant evidence of the negative psychological effects of working with people who have experienced trauma. However, there is no rigorous evidence to inform how to intervene most effectively with mental health workers who

experience compassion fatigue. The study concludes that there is a serious gap in this research and a need to advance efforts in evaluating the practices currently being used.

Whilst research in this area is yet to outline efficacious interventions for professionals experiencing compassion fatigue, there are studies emerging suggesting actions that can be effective for individuals in the prevention and management of compassion fatigue. These include: developing a sense of mastery at work (Pearlin, 1989), establishing co-worker support (Boscarino et al, 2010), increasing resiliency skills, development of care-giving skills, use of conflict resolution and self-care strategies (Gentry, Baranowsky & Dunning, 2002).

The term self-care has been summarised by Beauchamp and Childress (2001) as the therapist's provision of adequate attention to their own psychological and physical well-being, to ensure that they remain effective in their work. Shapiro, Brown, and Biegel (2007) highlight the role qualitative research has played in providing insight into the self-care of therapists. From their review of the literature, these authors emphasise self-awareness, self-regulation, and balancing of self and others' interests as key foundations to self-care that are essential to successful therapy with patients. Figley (2002) advocates psycho-education around compassion fatigue, therapy combining desensitisation with exposure and relaxation, and development of a support system for the individual that is external to their role as therapist. This author also emphasises the importance of speaking openly about the struggles faced by psychotherapists associated with compassion fatigue, and the importance of the development of stress management and self-soothing techniques.

The research of Norcross (2000), and later Norcross and Guy (2007) summarises decades of explorative research into psychotherapist self-care. This culminates in the suggestion of twelve key strategies of self-care (Norcross & Barnett, 2008). These authors highlight the lack of empirical evidence of efficacy for suggested self-care strategies within this body of research. Therefore, they recommend that self-care strategies or principles should be offered rather than specific techniques. Also, that psychologists should adapt broad strategies to suit their own situation and preferences. Furthermore, that knowledge of a variety of self-care strategies is more important than one particular self-care skill. The twelve self-care strategies suggested include: valuing the person of the psychotherapist, refocusing on the rewards of the profession, recognising the hazards of the profession, minding the body, nurturing relationships, setting boundaries, restructuring cognitions, sustaining healthy escapes, creating a flourishing environment, undergoing personal therapy, cultivating spirituality and mission, and fostering creativity and growth.

Sandhu, Rose, Rostill-Brookes, and Thrift (2012) suggest that therapists in forensic settings who have empathy for their own experience are more able to have empathy for their patients. Furthermore, therapists who struggle to 'contain' their emotional experiences, avoid or deny them are likely to use the same strategies in dealing with patients' emotional experiences in therapy. These authors emphasise the problematic emotional and attachment challenges faced by therapists in forensic settings and advocate the importance of clinical supervision in relation to these issues, with particular focus on process issues, for the benefit of the clinician self-care, the patient and wider society.

Wise, Hersh, and Gibson (2012) state that it is time for psychologists to take an honest, compassionate and unflinching look at the role of self-care in professional psychology. These authors argue that self-care is an ethical imperative as it relates to competence. Similarly, Veron

and Saias (2013) highlight the ethical implication of psychological distress management by clinical psychologists. As these authors found that the majority of psychologists studied reported an avoidant style of coping, with a preferred strategy of reducing workload to manage distress. This strategy was chosen above problem focused strategies, such as supervision or talking to colleagues. However, this research was completed with only French clinical psychologists, therefore should be generalised beyond this population with caution.

## **Rationale and clinical relevance**

The rationale for this study is exploring the under-researched topic of psychologist attachment style and self-care, in order to support the mental health, well-being and longevity of psychologists working in forensic settings with this challenging patient group. There is no previous research that focuses specifically on the issue of psychologist attachment style and self-care within the forensic setting.

The results of this study could be of benefit to psychologists throughout their career. However, the insights and experience shared may be of particular use to psychologists who are early in their career, in training programmes or who may be concerned about the impact of working within the forensic setting on their personal well-being. Though the results may not be directly generalizable to individuals from different disciplines, the suggestions for self-care generated via this research may be informative to other disciplines when thinking about their own self-care within the forensic setting, and may support psychologists to share and promote self-awareness and self-care strategies within multi-disciplinary teams.

## **Aims and hypothesis**

The major aim of the present study is to address a gap in the literature by exploring psychologist attachment style and use of self-care within forensic settings. Subsumed under the main research aim are the following questions which will be addressed within the discussion section.

- 1) Exploring the range of attachment styles amongst psychologists in forensic settings.
- 2) Is compassion fatigue prevalent amongst psychologists in forensic settings?
- 3) Is attachment style associated with compassion fatigue?
- 4) How prevalent is compassion satisfaction amongst psychologists in forensic settings?
- 5) Is attachment style associated with compassion satisfaction?
- 6) Further demographic analyses.
- 7) Exploring psychologists' views of the relevance of attachment style to clinical practice.
- 8) Exploring qualitative experiences of managing negative feelings that arise in relation to client work.
  - i) During therapy sessions.
  - ii) Outside of therapy sessions.
- 9) Exploring qualitative self-care strategies utilised by psychologists in forensic settings within a range of situations.
  - i) In their direct therapeutic work.
  - ii) During the workday.
  - iii) Outside of work.

- 10) Exploring qualitative similarities and differences in experiences of managing negative feelings that arise in relation to client work between different attachment styles.
  - i) During therapy sessions.
  - ii) Outside of therapy sessions.
- 11) Exploring qualitative similarities and differences in self-care strategies utilised by psychologists in forensic settings within a range of situations between different attachment styles.
  - i) In their direct therapeutic work.
  - ii) During the workday.
  - iii) Outside of work.
- 12) Exploring psychologists' views of the relevance of self-care to clinical practice.

## **Method**

In this section the study design will be outlined. The reasons for utilising a mixed methods approach will be discussed. Following this, the questionnaire design and participant recruitment processes will be outlined along with the ethical implications of this study. The process of data analysis will also be outlined, including the rationale for the method of qualitative content analysis applied.

### **Study design**

A web-based survey was used to study the relationships between the study variables: attachment style, compassion fatigue and compassion satisfaction. It also incorporated an explorative qualitative element to investigate psychologist self-care. Where possible, the study variables were investigated using established self-report measures. However, due to there being no suitable measure available to study psychologist self-care, this aspect of the survey used open qualitative questions. The design of the study was therefore non-experimental, correlational and explorative. The Qualtrics web-based survey provided a secure, low-cost, and minimal time costing format that was easily accessible to psychologists around the UK. It also enabled a specific population to be sampled (for more information please see the participant recruitment section below). A justification for the use of a mixed methods approach will be presented below.

### **Why adopt a mixed methods approach?**

De Waal (2001) described mixed methods research as involving induction, deduction and abduction. That is the discovery of patterns, the testing of theories and the uncovering of a best set of explanations for understanding the results. Johnson and Onwuegbuzie (2004) define mixed methods research as the combination of quantitative and qualitative research techniques, methods, approaches, concepts or language within a single study. These authors argue that mixed methods research is not a replacement for either qualitative or quantitative designs, but rather it is a third paradigm that draws from the strengths and minimises the weaknesses of both approaches.

This combination of methodologies is often referred to as 'triangulation' (Hussein, 2009). According to Hussein (2009), the combination of multiple methods and theories using the triangulation method can increase the depth of understanding of the phenomenon under investigation. The author describes using triangulation for confirmation purposes, such as to investigate the reliability of two separate measures exploring the same phenomenon, and for completeness purposes, such as capturing a more complete, holistic and contextual portrayal of the units being studied. Hussein reported this method as particularly beneficial in adding deeper understanding to less explored or unexplored research problems.

Previously, the quality of mixed methods research has been questioned, and it has been argued that methodologists have been late to recognise this paradigm and provide an adequate process model (Johnson & Onwuegbuzie, 2004). However, more recently researchers have attempted to bridge the gap between qualitative and quantitative approaches, promoting a shared responsibility to attain accountability and research quality. Pluye, Gagnon, Griffiths, and Johnson-Lafleur (2009) suggested a scoring system to appraise the quality of mixed methods research. These authors note three crucial elements in the quality criteria as follows: justification of the mixed methods design,

combination of qualitative and quantitative data collection and analysis techniques, and integration of qualitative and quantitative data and results. Therefore, to attain quality and rigour within the present study, and as per Pluye et al's (2009) criteria, a justification of the mixed methods design will be provided here, followed by an outline of the data collection and analyses techniques used, and an explanation of the integration of qualitative and quantitative data and results.

### ***Justification for mixed methodology***

The review of previous literature highlighted some key studies that have produced novel information in relation to the under-researched topic of psychologist self-care. However, the only measure that has been developed to explore this subject is Mahoney's (1997) Previous Year Self-Care Patterns 10-item subscale. It was not deemed beneficial to use this measure within the present study due to the limited information it provides regarding the self-care activities employed. Rather a priority of this study was to explore the qualitative views of psychologists in regard to their self-care strategies, and develop a richer understanding of the activities psychologists consider supportive of their own self-care.

A further aim of the study was to investigate attachment style and levels of compassion satisfaction and fatigue amongst psychologist working in forensic settings. Much of the recent attachment style literature has been based on quantifying attachment styles and exploring this paradigm as a continuum (Fraley et al, 2000). Griffin and Bartholomew (1994) also promote the advantages of using multiple indicators in assessing this construct. Therefore, to capture the required data within the present study a quantitative approach was also called for.

Linking the findings from both quantitative and qualitative data provided a significant challenge, and this method contributes its own limitations, which will be explored further within the discussion section. However, both quantitative and qualitative data were necessarily integrated in the present study to facilitate richer understanding of the phenomenon explored and allow the data to be explored from multiple and varying perspectives. The main aim of which was to further the field of attachment style and self-care of psychologists. For more information regarding the process of analysis please see the data analysis section below.

### **Questionnaire design**

The survey consisted of a brief demographic questionnaire at the beginning of the survey. Following this three standardised self-report questionnaires were administered. Two of these provided a measure of attachment style. One was a categorical measure the other a continuous measure. Two separate measures of attachment were used based on the recommendations of Griffin and Bartholomew (1994). These authors highlight the advantages of using multiple measures of attachment to ascertain the reliability of the results. The remaining standardised measure investigated compassion fatigue and satisfaction. A further eight open qualitative questions were asked. Each element of the questionnaire will be described in more detail below. A complete copy of the survey is included in Appendix 1.

## Demographics

At the beginning of the survey participants were asked to complete a brief demographic questionnaire that was developed for this study. This included questions about age, gender, ethnicity and cultural background, job role and length of experience. These demographic differences have previously been reported to account for variability in stress and coping in forensic healthcare professionals (Elliott & Daley, 2013). Participants who were pre-qualification (Assistant Psychologists and Trainee Psychologists) were asked further questions about the length of time they had spent in their placement and the quality of their therapeutic experience; for example, whether they had facilitated individual therapy or therapeutic groups.

## Relationships Questionnaire (RQ; Bartholomew & Horowitz, 1991)

The RQ provided a categorical measure of current attachment style. This is based on a four-category model of attachment style. It has taken the three category model developed by Hazen and Shaver (1987), that included Secure, Anxious/Ambivalent and Avoidant styles and was originally developed from Ainsworth's (1978) developmental attachment theory, and reworded the descriptions of the attachments styles to develop a more complete theory of current adult attachment (Fraley & Shaver, 2000). The authors presented findings that suggested that attachment styles can be divided based on their positive or negative views of the self and others (Figure 1). This established four distinct attachment styles: Secure, Fearful, Dismissing and Preoccupied. Bartholomew and Horowitz (1991) argued that these categories differed from the attachment constructs used by developmental psychologists. This argument was supported by Fraley and Shaver (2000), who agreed that as attachment theory has developed the divergence between traditional developmental perspectives of attachment and current adult attachment has become increasingly apparent. Similarly, Roisman et al (2007) reported that comparison of the assessments used to examine the constructs of childhood and adult attachment has demonstrated that the measures are not interchangeable.

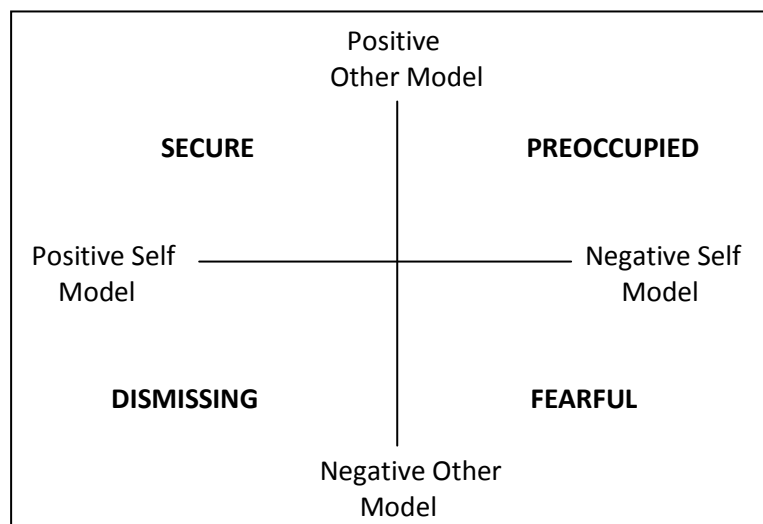


Figure 1: Four category model of attachment, from Griffin and Bartholomew (1994).

In the development of this measure, the authors completed multiple studies exploring attachment style. These compared self-reports of self-concept, sociability and interpersonal problems with the judgments of close friends, and compared results from the RQ with Adult Attachment Interviews, measures of friendship, self-esteem, self-acceptance, sociability and interpersonal problems. This measure reconciles categorical and dimensional models of attachment style, and despite measuring the construct of current adult attachment, does correspond to the attachment anxiety and avoidance dimensions outlined by Ainsworth et al (1978) that are also central to the Experiences in Close Relationships Questionnaire (see below). These authors suggested that there were some clear distinctions between attachment style groups. However, differences within categories were not ignored and the authors highlighted a mix of tendencies across time and within and across relationships. Some of the key similarities and differences are outlined as follows:

*Secure:*

- Low avoidance, low anxiety.
- Positive views of self and others.
- Tendency to demonstrate high warmth, balance of control in friendships, high level of involvement in romantic relationships and be sociable.

*Preoccupied:*

- Low avoidance, high anxiety.
- Negative model of the self, positive views of others.
- Tendency to blame themselves for perceived rejections, be self-doubting, make energetic attempts to achieve support and love, show high elaboration and self-disclosure, demonstrate emotional expressiveness, crying, reliance on others, caregiving, warmth, low balance of control in relationships and be sociable.

*Fearful:*

- High avoidance, high anxiety.
- Negative model of the self and others.
- Tendency to be avoidant of close relationships, be self-doubting, perceive others as not available in times of need, show social insecurity and passivity. Tendency to try not to seek others for support, deny vulnerability and attempt to keep attachment system down-regulated to avoid need for others. Tendency to show low self-disclosure, low intimacy, low level of romantic involvement, reliance on others but low use of others as a secure base. Tendency to assume a subservient role in relationships.

*Dismissing:*

- High avoidance, low anxiety.
- Negative model of others, positive views of the self.
- Tendency to be avoidant of close relationships and downplay the importance of others who are perceived as rejecting. Higher self-esteem and self-confidence, low emotional expressiveness, low crying, low warmth, low caregiving, low self-disclosure, low intimacy, low reliance on others, low use of others as secure base. Tendency to show behavioural and emotional independence and distance from others. Tendency to try not to seek others for



support, deny vulnerability and attempt to keep attachment system down-regulated to avoid need for others.

The RQ measure is a forced-choice instrument in which the four categories of attachment are briefly described and respondents are required to select which applies to them most. They are then required to rate how much each category applies to them using a seven point Likert scale. Bartholomew and Horowitz (1991) report impressive Cronbach's alpha values ranging from .87 to .95. Test-re-test data suggest the RQ classifications have moderate stability over a period of 8 months (Scharfe & Bartholomew, 1994) and Kirkpatrick and Hazen (1994) reported that 70% of their sample reported the same RQ attachment style over a four year period.

***Experiences in Close Relationships Adult Attachment Questionnaire Revised (ECR; Fraley et al, 2000)***

The ECR provided a continuous measure of current attachment related anxiety and avoidance. This is a 36-item scale that is further revised from the Experiences in Close Relationships Scale (ECRS; Brennan et al, 1998). The ECRS and ECR corroborate with the two main dimensions of attachment identified by Ainsworth et al (1978). The measure was constructed from all other attachment style measures, by completing a factor analysis on all the available items and selecting 36 with the highest absolute value correlations with one of the two dimensions: anxiety or avoidance (Mikulincer & Shaver, 2007). Half of the items correspond to attachment related avoidance the other half correspond to attachment related anxiety. Figure 2 illustrates how the four category model of attachment style correlates to these two dimensions.

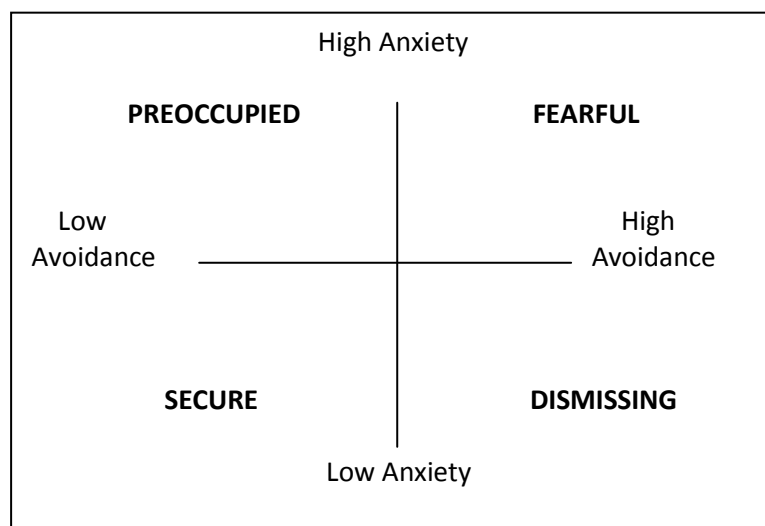


Figure 2: Attachment style categories differentiated using the ECR anxiety and avoidance dimensions.

The items are answered using a seven point Likert scale to report whether the participant strongly agrees or strongly disagrees with each statement. A number of items are reversed. Participants are made aware that they should consider their experiences in intimate relationships within their

responses, and that they should report generally rather than focus on one current relationship. To score this measure each subscale is summed and averaged for each individual providing a final score for each dimension. The ECR demonstrates very good test-re-test coefficients, usually ranging between .50 and .75, and it has high reliability, having been used in hundreds of studies and always having alpha coefficients near or above .90 (Mikulincer & Shaver, 2007).

### ***Professional Quality of Life Scale (PROQOL; Stamm, 2012)***

The PROQOL provided a measure of compassion fatigue and compassion satisfaction that are specific to working within a therapeutic role with individuals who have experienced traumatic events. According to the author, compassion fatigue can be demonstrated by the two components of burnout and secondary traumatic stress. Burnout is described as hopelessness and difficulties in working effectively that can be associated with a high workload or non-supportive environment. Secondary traumatic stress shares some similarities to vicarious trauma, and is described as a residual stress associated to working with people who have experienced traumatic events.

Compassion satisfaction is described as the pleasure derived from helping others at work. The PROQOL is the most commonly used measure to demonstrate the positive and negative effects of working with people who have experienced traumatic events. It was developed from the Compassion Fatigue Self Test (Figley, 1995) and has been translated in multiple languages and used worldwide in hundreds of studies. It demonstrates good reliability with alpha coefficients of .88 for the compassion satisfaction subscale, .75 for the burnout subscale and .81 for the secondary traumatic stress subscale.

The PROQOL is a 30-item measure which requires participants to state how frequently each statement occurs within their current work situation, using a 5 point Likert scale ranging from Never to Very Often. Each subscale is scored separately and a number of items are reverse scored. The scores for each subscale are summed and can be converted to t-scores. Subscale scores can be used to show whether individuals reach cut-off scores for Low, Average or High levels of compassion satisfaction, burnout and secondary traumatic stress.

### ***Qualitative questions***

Explorative qualitative questions were asked to give the opportunity for participants to provide elaborated responses on their use of self-care strategies in a range of situations, including within therapy sessions, during the workday and outside of work. For example, "What do you do within your direct therapeutic work that supports your own self-care (i.e. helps you to manage the impact of challenging therapeutic relationships)?" Participants were also asked to describe their attachment style and provide their views on the relevance of self-care and their attachment style to their clinical practice. For example, "Do you regard your personal attachment style as relevant within your therapeutic relationships? Please explain why". Finally, they were asked to describe how they manage negative feelings that may arise towards their clients in therapy sessions and outside of therapy sessions. For example, "During therapy sessions, how do you manage negative feelings that may arise towards your clients in the moment?". To view the complete questionnaire please see Appendix 1.

## Participant recruitment

Participants were Clinical and Forensic Psychologists currently working in forensic settings in the UK. A Pearson's  $r$  calculation was completed to estimate the minimum number of participants required to achieve a moderate effect size for the quantitative analysis (Figure 3). This calculation suggested that to reach a moderate effect size of .30 ( $r$ ) a minimum 65 participants was required (Cohen, 1992). Due to time limitations the survey was closed once this criterion was reached.

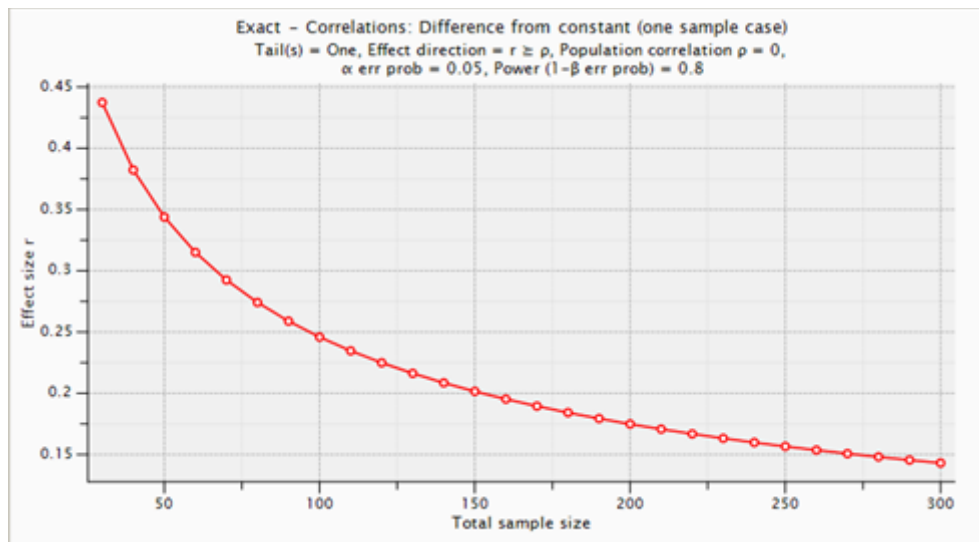


Figure 3: Graph to demonstrate effect size using a Pearson's  $r$  calculation.

Purposive and opportunity sampling was used to recruit participants. The researchers' contacts within forensic services were directly emailed a link to the survey. The survey was also advertised via the British Psychological Society forensic psychology departmental website, of which the project research supervisor was a member.

All participants were offered the opportunity to opt-in to a £100 prize draw as an incentive for taking part. This incentive was offered due to the prediction that recruiting participants from a pool of professionals with significant demands on their time may be problematic. Furthermore, it was an attempt to encourage a representative sample, by increasing the likelihood that participants who were experiencing stress and fatigue may take part. The prize draw was completed once the survey was closed. Each participant that opted to take part was allocated a number and one number was selected at random. The prize draw was officiated by an independent qualified Clinical Psychologist and Assistant Psychologist who had not taken part in the study. The winning number was verified and the winners' email address was used to send a £100 voucher of their choosing.

### ***Inclusion and exclusion criteria***

Participants were Clinical and Forensic Psychologists currently working in forensic settings in the UK. Though the training route for each discipline is somewhat different, it was hypothesised that the opportunity to develop therapeutic attachments and the need to use self-care was similar for Psychologists within both Clinical and Forensic roles in the forensic setting. Assistant Psychologists

and Trainee Clinical and Forensic Psychologists were also included in this study if they met criteria for having the opportunity to develop therapeutic relationships within their work. All Trainee and Assistant Psychologists that participated met this criterion and had worked in a forensic setting in the UK for a minimum of one year and had facilitated both individual and group therapy within forensic settings. The rationale for including Psychologists from both Clinical and Forensic backgrounds, as well as Trainee and Assistant Psychologists was primarily to maximise the available pool of participants.

## **Ethical issues**

### ***Informed consent***

Participants that opted to open the survey were provided with an information sheet outlining the key details of the study (Please see Appendix 1). This included information on the purpose, method and confidentiality. Participants were also made aware of the voluntary nature of the study and their right to withdraw their participation at any time. Participants were also provided with the researchers' contact details and were made aware that they could contact the researchers with any queries or concerns. Furthermore, the project's University of Hertfordshire School of Psychology Ethics Committee Registration Protocol Number was also included for the participants' reference (for ethics clearance documents please see Appendix 2). Prior to entering the survey participants were required to provide their consent to take part.

### ***Confidentiality***

Participants were informed that identifying information (email addresses) would remain confidential and would be used only for the purposes outlined within the participant information sheet. That is, to permit inclusion in the participant prize draw and for participants to receive a summary of the research project if they chose. To maintain anonymity, identifying information was kept separately from the survey dataset in a secure location within the primary researcher's home. In accordance with University of Hertfordshire good practice guidelines all identifying data will be securely destroyed after the completion of the training course. All other data related to this research will be securely destroyed after five years.

### ***Potential distress***

The chance of potential distress caused by participation in this research study was minimal. Participants were all psychologists currently working in forensic settings in the UK, who are required to have access to supervision by British Psychological Society standards and are trained to deal with distressing information in relation to their work. However, participants were informed that they could contact the researchers at any time should any queries or concerns arise (for participant information sheet please see Appendix 1). The researchers were prepared to signpost participants to appropriate support services or further information regarding the research project or topics contained within. However, no queries or concerns were raised.

## Participant demographics

Participants were 66 psychologists currently working within forensic settings in the UK. This section will review the demographic data collected regarding participant, age, gender, job role, length of experience and ethnic and cultural background.

Table 1: Frequency counts and percentages of different job types within the sample.

	Frequency	Percent
Clinical	44	67
Forensic	16	24
Assistant	2	3
Trainee Clinical	1	2
Trainee Forensic	3	5
Total	66	100

Table 1 indicates that over two thirds of the sample were Clinical Psychologists and approximately a quarter of the sample were Forensic Psychologists. The remaining participants were pre-qualification psychologists, including Trainee Forensic Psychologists, Trainee Clinical Psychologists and Assistant Psychologists.

Table 2: Frequency counts and percentages to show years post-qualification or pre-qualification.

	Frequency	Percent
< 5	19	29
5-9	13	20
10-19	13	20
20-29	12	18
> 30	3	5
Pre-Qualification	6	9
Total	66	100

Table 2 shows the range of different experience levels within the sample. The sample included participants from pre-qualification to over thirty years post qualification, with the majority of the sample falling within the post qualification to 29 years of experience range.

Table 3: Frequency counts and percentages for participant gender.

	Frequency	Percent
Male	16	24
Female	50	76
Total	66	100

Table 3 shows that the sample was predominantly female and only approximately a quarter of the sample were male.

Table 4: Frequency counts and percentages to show participant age.

	Frequency	Percent
18-25	1	2
26-35	26	39
36-45	20	30
46-55	13	20
56-65	6	9
Total	66	100

Table 4 shows that the majority of the sample were aged 26-35. Just under a third of the sample were aged 36-45, and a fifth of the sample were aged 46-55, with fewest participants falling within the 18-25 and 56-65 age ranges.

Table 5: Frequency counts and percentages to show participant ethnicity and cultural background.

	Frequency	Percent
White British	50	76
White Non-Specified	3	5
Non- Specified British	9	14
Other	3	5
Other British	1	2
Total	66	100

Table 5 indicates that the sample was predominantly White British. The remaining participants, including non-specified ethnicity British, White non-specified country of origin, Other country of origin non-specified ethnicity and Other ethnicity British country of origin, made up just over a quarter of the sample in total.

## **Data analysis**

The Results section presents an exploration in to the attachment style, levels of compassion fatigue and satisfaction and use of self-care amongst psychologists working in forensic settings in the UK. A mixed methodology has been applied within the analysis process in order to explore these areas effectively, and highlight any associations between the variables. Where statistical analyses have been completed in isolation from qualitative analyses, these are explained within the Results section. However, to fulfil the standards of mixed methods research outlined by Pluye et al (2009) an outline of the qualitative data analyses techniques used, and an explanation of the integration of qualitative and quantitative data and results will be provided below.

Two models of qualitative content analysis have been applied within this study. The first was the method outlined by Berg and Lune (2013). This method was used to analyse the qualitative data for questions completed by the whole sample. The second method used was outlined by Graneheim and Lundman (2004). This method was applied to compare specific 'cases' within the sample. Each of these methods will be described below.

### ***Berg and Lune's (2013) model of qualitative content analysis***

This model was applied to all the qualitative data provided by the whole sample. The authors describe striving for a blend of quantitative and qualitative analysis within this approach. They state that a purely quantitative content analysis can be reductionist, whilst combining this approach within a qualitative content analysis can provide a richer understanding of the content with additional means for identifying, organizing, indexing and retrieving data. The method calls for all relevant aspects of the data to be retained and for exact wording to be used as much as possible, and within the context it was implied. A combination of both manifest and latent content can be considered within the analysis. This provides opportunity to count surface structure and consider deeper structural meaning if required. However, there must be evidence for latent meanings. The authors highlight the importance of rigid and consistent application of the model. It is also recommended that researchers should incorporate independent corroborative techniques, such as agreement between independent coders, and they should offer excerpts from relevant statements and codes used within the write-up of the results to increase transparency of process and findings.

A primarily inductive approach was used, whereby the analysis involved an immersion in the data to extrapolate themes. However, literature about therapist self-care and attachment style provided some theoretical perspective during analysis. Therefore, it could be argued that a mixed inductive and deductive process was applied, as supported by Boyatzis (1998). Meaning units were identified within the text and coded. These were then grouped via use of coding frames and finally sorted into themes where appropriate, similarly to Strauss's (1987) axial coding technique. Berg and Lune (2013) suggest that the theme is the most useful unit to count. Therefore, for each participant response the coded meaning units were grouped by theme and then the singular inclusion in each theme was counted. This provided a meaningful quantification by theme. On certain questions it was possible to group participants according to theme, as responses fitted clearly into one theme only. It has been clearly reported within the Results section where this grouping was possible.

### ***Graneheim and Lundman's (2004) model of qualitative content analysis***

An essential aspect of this study was the integration of quantitative attachment style data with qualitative self-reports regarding self-care. This was achieved by selecting 'extreme cases' for each attachment style category and analysing the qualitative self-reports within these groups for themes.

Fraley et al (2000) highlights that variation in attachment is best modelled with dimensions rather than categories. The author suggests that there is no correct method to assign individuals to categories because there are no real types. However, Fraley et al suggest a model, which uses the interaction between the two continuous variables of avoidance and anxiety on the ECR, to identify 'cases' that best represent each category of attachment style. According to Fraley et al's framework, individuals who score low anxiety and low avoidance can be categorised as Secure attachment style, individuals with low anxiety and high avoidance are Dismissing, individuals with high avoidance and high anxiety are Fearful and individuals with high anxiety and low avoidance are Preoccupied. The selection of attachment style cases from quantitative data from the ECR measure is outlined further in the Results section.

Due to the limited sample size within each attachment style group outlined by Fraley et al's model, the qualitative content analysis model outlined by Graneheim and Lundman model was deemed appropriate. This model does not incorporate a quantification of content based on theme. Rather a primarily inductive approach was used to identify meaning units within the data for each group. This was considered alongside theory on the coping mechanisms and views on the self and other highlighted in the attachment theory research. This mixed inductive and deductive approach provided key information for what Graneheim and Lundman refer to as condensation, or shortening the text whilst preserving the core. Coding was then completed, which these authors describe as identifying tools which allow the data to be thought of in new and different ways. These codes were then categorised based on shared commonality, as per Krippendorff (1980), providing internally homogenous and externally heterogeneous groups from which themes were generated. These authors highlight that themes may link underlying meanings together within categories or cut across categories.

### ***Meeting quality standards in qualitative analysis***

In addition to Pluye et al's (2009) recommendations, Johnson and Onwuegbuzie (2004) state that it is essential for qualitative research to incorporate strategies that increase rigour. These authors recommended use of independent coder checking and recognition of value stances. They also suggested that researchers provide transparency by giving an adequate rationale for the interpretations of their data and making the analyses available for public inspection, so that the reader is able to decide whether the claims made are trustworthy and defensible. Therefore, meaning units, coding and themes for each analysis have been provided within the Results section.

Within the present study the final coding schemes provided by the qualitative content analyses were presented to a qualified Psychologist for verification and the opportunity to make alternative suggestions to the coding scheme. The codes were also applied to the text on two occasions over a two week time period (Joffe & Yardley, 2004). Inter-rater reliability was estimated by using an



independent coder to code 25% of the qualitative data. The agreement between the coders was greater than 90%, suggesting a high inter-rater reliability.

## Results

This section presents the results of an exploration in to the attachment style, levels of compassion fatigue and satisfaction and use of self-care amongst psychologists working in forensic settings in the UK. As previously discussed, in order to explore these issues more comprehensively, whilst highlighting associations between these variables, a mixed methodology has been applied. This section will present the quantitative analyses, followed by the results of a qualitative content analysis and finally the results of an integrative qualitative and quantitative approach. Each research question will be outlined below with clear reference to the method used to extrapolate the findings. However, for further detail on the processes of analysis used please refer to the Methods section. Limitations to the methodological processes used will be considered further in the Discussion section.

### Exploring the range of attachment styles amongst psychologists in forensic settings.

Table 6 provides data pertaining to the qualitative self-reports provided by the participants in regards to their attachment style. The qualitative descriptives used by participants to categorise their attachment style varied considerably, indicating that this sample do not refer to a single model of attachment, but rather draw their conclusions about their own attachment style from a variety of sources. For the purposes of analysis these have been grouped according to Bartholomew and Horowitz's (1991) four category model. However, this method is limited due to the range of constructs used by participants to describe their attachment style not being interchangeable with the current model of adult attachment used within this study (Roisman et al, 2007). For more detail of how participants were allocated to each category please see Appendix 3.

Table 6: Frequency counts and percentages of qualitative self-categorisation of attachment style.

	Frequency	Percent
Secure	56	85
Fearful	4	6
Preoccupied	0	0
Dismissing	3	4.5
Unsure	3	4.5
Total	66	100

Using the Relationship Questionnaire (RQ; Bartholomew & Horowitz, 1991) and Experiences in Close Relationships - Revised Adult Attachment Questionnaire (ECR; Fraley et al, 2000) there were six quantitative variables used in the main analyses to explore attachment style. These were the four categorical groups identified by the RQ: Secure, Fearful, Preoccupied and Dismissing, and the continuous attachment anxiety and attachment avoidance scales from the ECR. Descriptive statistics for these variables are shown below.

Table 7 provides data from the Relationships Questionnaire (RQ; Bartholomew & Horowitz, 1991). This measure categorises participant’s attachment style using the four category model outlined above, based on self-report ratings of their view of themselves and of others. The small group sizes for the Fearful and Preoccupied attachment style categories limit further statistical analysis. However, due to their theoretical distinctions and because a primary aim of the present study was to explore attachment style group similarities and differences, it was not deemed valid to combine these groups. The limitations of this decision will be reviewed further within the Discussion section.

Table 7: Frequency counts and percentages of attachment style measured by the Relationships Questionnaire.

	Frequency	Percent
Secure	44	67
Fearful	4	6
Preoccupied	5	8
Dismissing	13	20
Total	66	100

The contrasting results in the self-categorisation data (Table 6) and measured attachment style data (Table 7) above also suggest that there is some discrepancy between qualitative self-reports and categorical measures of attachment style, with the greatest differences being a tendency to over-report a Secure attachment style and under-report a Dismissing attachment style in qualitative self-reports.

Table 8: Frequency counts of attachment style measured by the Relationships Questionnaire for different job roles.

	Secure		Fearful		Preoccupied		Dismissing		Total	
	N	Percent	N	Percent	N	Percent	N	Percent	N	Percent
Clinical	30	68	4	9	2	4	8	18	44	100
Forensic	12	75	0	0	1	6	3	19	16	100
Assistant	0	0	0	0	1	50	1	50	2	100
Trainee Clinical	1	100	0	0	0	0	0	0	1	100
Trainee Forensic	1	33	0	0	1	33	1	33	3	100
Total	44	67	4	6	5	8	13	20	66	100

Table 8 shows the variance in attachment styles, as indicated by the RQ, between different job role groups. Generalisations must be made with caution due to limited participant numbers, particularly in the pre-qualification groups. However, this table suggests that the distribution of different attachment styles is similar between Clinical and Forensic Psychologists within this sample, with a ratio of approximately 3:1 more Secure than Dismissing attachment styles within these groups. The increased frequency of Fearful attachment style in Clinical Psychologists in comparison to Forensic Psychologists is one possible difference within the current sample.

The Experiences in Close Relationships-Revised Adult Attachment Questionnaire (ECR; Fraley et al, 2000) scores participants on two continuous scales: Anxiety and Avoidance. Descriptive statistics for the ECR can be viewed in Table 9. These results highlight the modestly positively skewed distribution within the sample. Inspection of the dataset reveals that skewness is not caused by erroneous scores, but is an indication of low reports of anxiety and avoidance within the sample.

Table 9: Descriptive analyses of ECR anxiety and avoidance subscales.

	N	Minimum	Maximum	Mean	Std.	Skewness	Kurtosis		
					Deviation			Std. Error	Std. Error
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic
ECR anxiety	66	1.17	4.83	2.40	.89	.910	.295	.338	.582
ECR avoidance	66	1.00	4.56	2.23	.78	.860	.295	.338	.582

Due to the skewed distribution within the sample and small group sizes highlighted above, all follow-up analyses were completed using non-parametric statistics

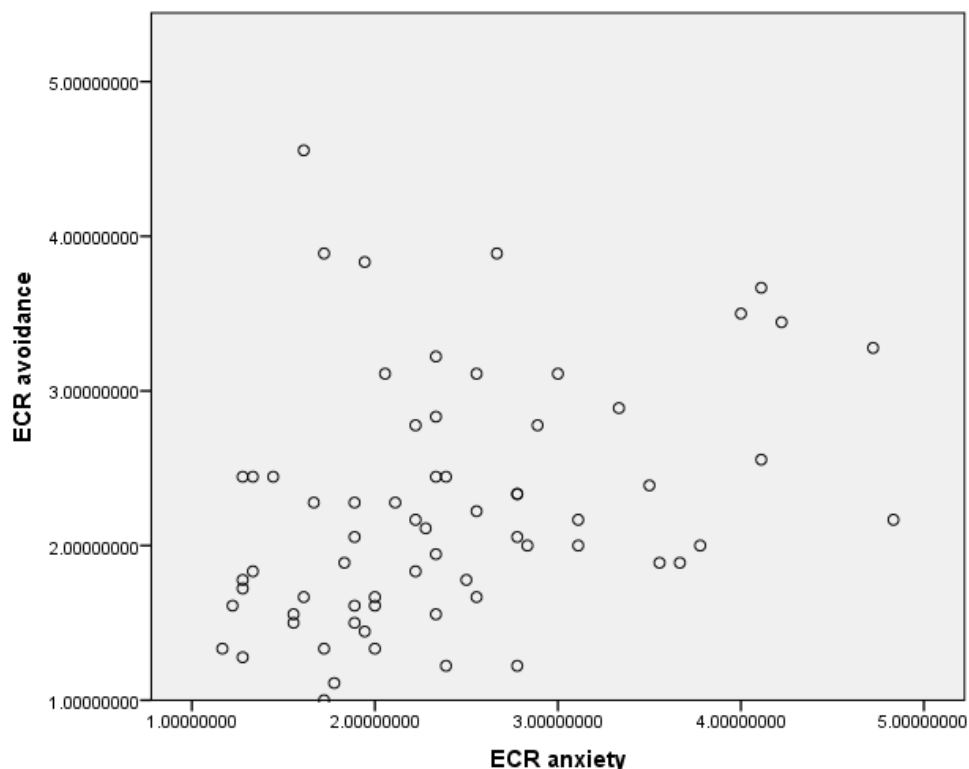


Figure 4: Scatterplot to illustrate correlation between the anxiety and avoidance subscales of the ECR.

Figure 4 illustrates the correlation between the anxiety and avoidance subscales of the ECR for the sample as a whole. This scatterplot also highlights the modest positive skewness of distribution in

the sample, with the majority of participants scoring low avoidance and low anxiety. A Spearman's Rank Order Correlation analysis was completed to further describe the distribution of attachment related anxiety and avoidance within the present sample. This indicated that there was a medium strength (Cohen, 1988) positive correlation which was significant between ECR anxiety and avoidance ( $r_s(66) = .391, p=0.001$ ).

Descriptive analyses were also completed to explore whether attachment groups, as indicated by the RQ, differed in their means/medians between the two measures of attachment related anxiety and avoidance indicated by the ECR. Figures 5 and 6 illustrate the distribution of ECR anxiety and avoidance scores for the four attachment style groups identified by the RQ.

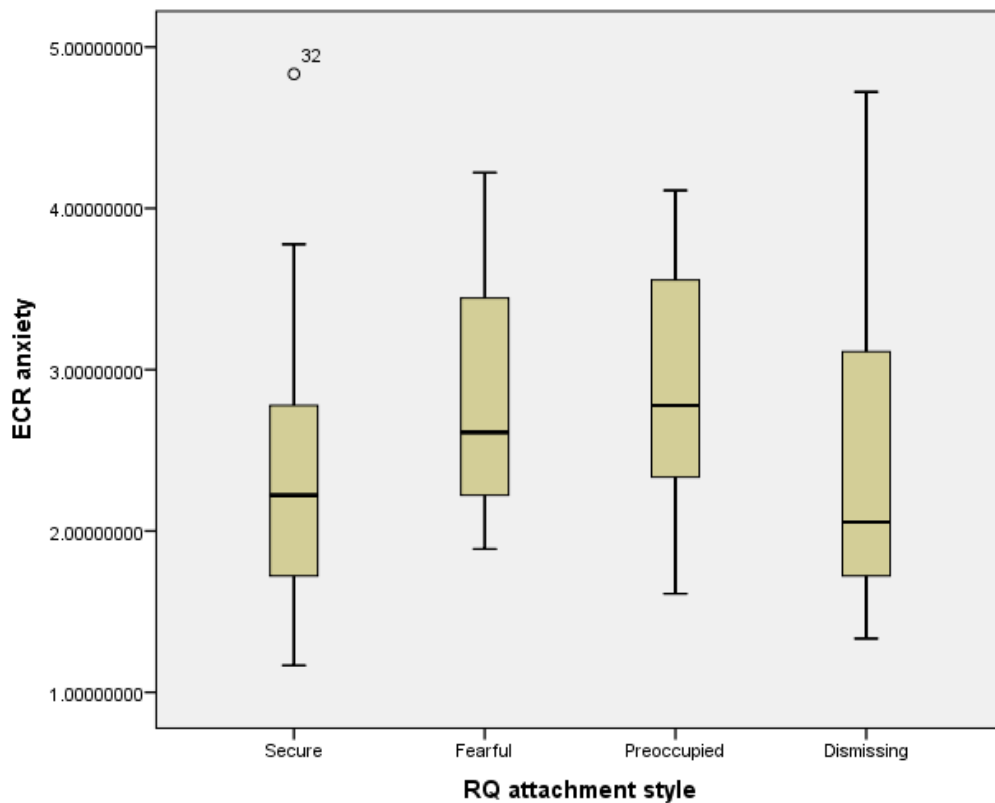


Figure 5: Boxplot to compare ECR anxiety between attachment style groups as categorised by the RQ.

As expected the Secure and Dismissing groups appear to score lower on ECR anxiety. Figure 5 shows an outlier in the Secure group. Further investigation suggests that this outlier is not an erroneous score. The 5% Trimmed Mean is very similar to the mean for the Secure group (2.20 and 2.25). Therefore, this case has been retained within the data file.

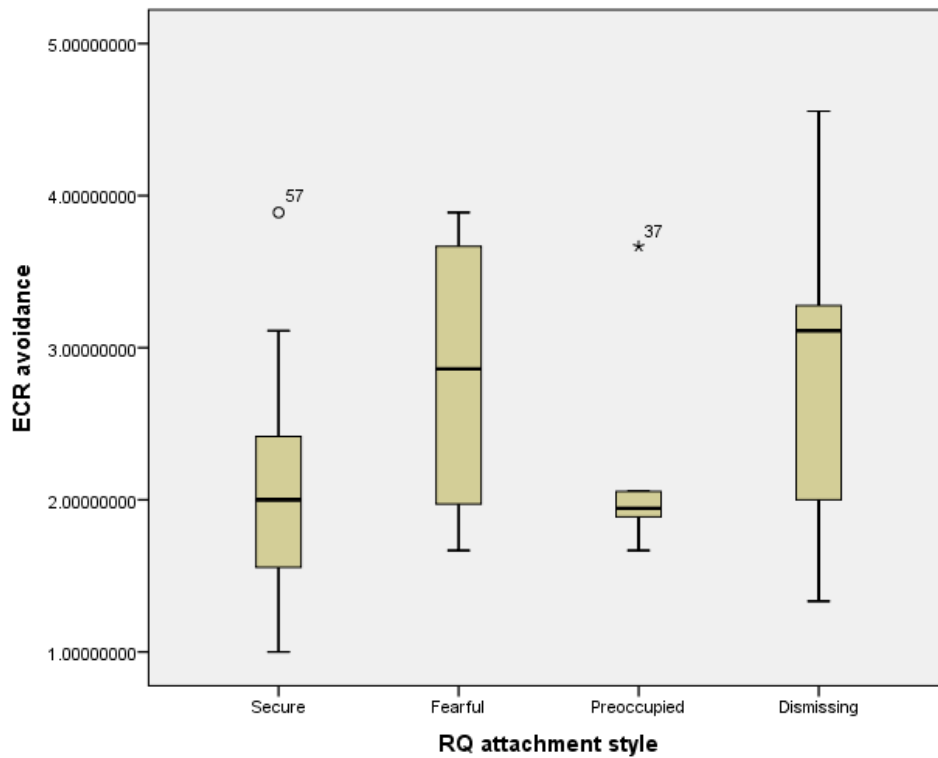


Figure 6: Boxplot to compare ECR avoidance between attachment style groups as categorised by the RQ.

Also, as expected the Secure and Preoccupied groups score lower on ECR avoidance. Figure 6 shows an outlier in the Secure group and an extreme outlier in the Preoccupied group. These outliers are also not erroneous scores. The 5% Trimmed Mean is very similar to the mean for the Preoccupied group (2.19 and 2.24) and for the Secure group (1.98 and 2.01). Therefore, these cases have all been retained within the data file.

Table 10: Descriptive statistics for ECR anxiety and avoidance subscales for each RQ attachment style group.

	RQ outcome									
	Secure		Fearful		Preoccupied		Dismissing		Total	
	ECR avoidance	ECR anxiety	ECR avoidance	ECR anxiety	ECR avoidance	ECR anxiety	ECR avoidance	ECR anxiety	ECR avoidance	ECR anxiety
N	44	44	4	4	5	5	13	13	66	66
Minimum	1.00	1.17	1.67	1.89	1.67	1.61	1.33	1.33	1.00	1.17
Maximum	3.89	4.83	3.89	4.22	3.67	4.11	4.56	4.72	4.56	4.83
Mean	2.01	2.26	2.82	2.83	2.24	2.88	2.79	2.55	2.23	2.40
Std. Deviation	.60	.79	1.03	.99	.81	.99	.94	1.09	.78	.89
Median	2.00	2.22	2.86	2.61	1.94	2.78	3.11	2.06	2.08	2.25
Skewness	.683	.975	-.138	1.253	2.061	-.003	.145	.964	.860	.910
Kurtosis	.850	1.341	-3.526	2.351	4.427	-1.149	-.618	-.366	.338	.338

Table 10 provides further descriptives for the present sample. The Kruskal-Wallis Test was applied to compare ECR anxiety and avoidance between RQ attachment style groups. These analyses indicated that there were no statistically significant differences between RQ attachment style groups for anxiety ( $p=.330$ ), but there was a significant difference in ECR avoidance across RQ attachment style groups ( $p=.031$ ). This suggests that within the present sample attachment related anxiety was consistently low between attachment groups. However, there was increased distribution of attachment related avoidance within the sample.

A Mann-Whitney U test was completed to test for significant ECR avoidance and anxiety differences between the attachment style groups. As explained above, the small group sizes for the Fearful, Preoccupied and Dismissing groups limited this analysis. Therefore, each of the three 'insecure' attachment groups: Fearful, Preoccupied and Dismissing, were compared with the Secure group for each ECR subscale. This analysis indicated that there were no significant differences between the Secure and Fearful groups for attachment related anxiety ( $p=.204$ ) or avoidance ( $p=.108$ ). There were no significant differences between the Secure and Preoccupied groups for attachment related anxiety ( $p=.146$ ) or avoidance ( $p=.679$ ). Finally, there was no significant difference between the Secure and Dismissing groups for attachment related anxiety ( $p=.524$ ). However, there was a significant difference between the Secure and Dismissing groups for attachment related avoidance ( $U=142, z=-2.741, p=.006$ ).

### **Is compassion fatigue prevalent amongst psychologists in forensic settings?**

The Professional Quality of Life Scale Version 5 (PROQOL) measures two key components of compassion fatigue: burnout and secondary traumatic stress (trauma), using two separate subscales. Cut-off scores are used to categorise participants as Low (<22), Moderate (23-41) or High (>41) on each subscale (Stamm, 2010).

Table 11: Frequency counts and percentages of burnout measured by the PROQOL.

	Frequency	Percent
Low	40	61
Moderate	26	39
High	0	0
Total	66	100

Table 11 shows that once cut-off scores were applied the majority of the sample reported low levels of burnout.

Table 12: Frequency counts and percentages of trauma measured by the PROQOL.

	Frequency	Percent
Low	62	94
Moderate	4	6
High	0	0
Total	66	100

Table 12 shows that the majority of the present sample scored low levels of secondary traumatic stress.

These results indicate that the present sample reported low to moderate levels of compassion fatigue overall. No participants reported high levels of burnout or trauma, or compassion fatigue overall. Descriptive statistics for the sample are provided in Table 13 below.



Table 13: Descriptive statistics for PROQOL burnout and trauma.

	N	Minimum	Maximum	Mean	Std. Deviation	Skewness	Kurtosis	
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Std. Error	Std. Error
PROQOL burnout	66	13	33	21.39	4.180	.317	.295	.036
PROQOL trauma	66	11	32	16.50	3.966	1.374	.295	3.040

Table 13 indicates a modestly positively skewed distribution for PROQOL burnout, and a highly positively skewed distribution for PROQOL trauma. This is reflective of the low levels of burnout and trauma reported within the present sample.

### Is attachment style associated with compassion fatigue?

Boxplots comparing the distribution of scores from the PROQOL burnout and trauma subscales with the categorical attachment style groups identified by the RQ, can be found in Figure 7 and Figure 8.

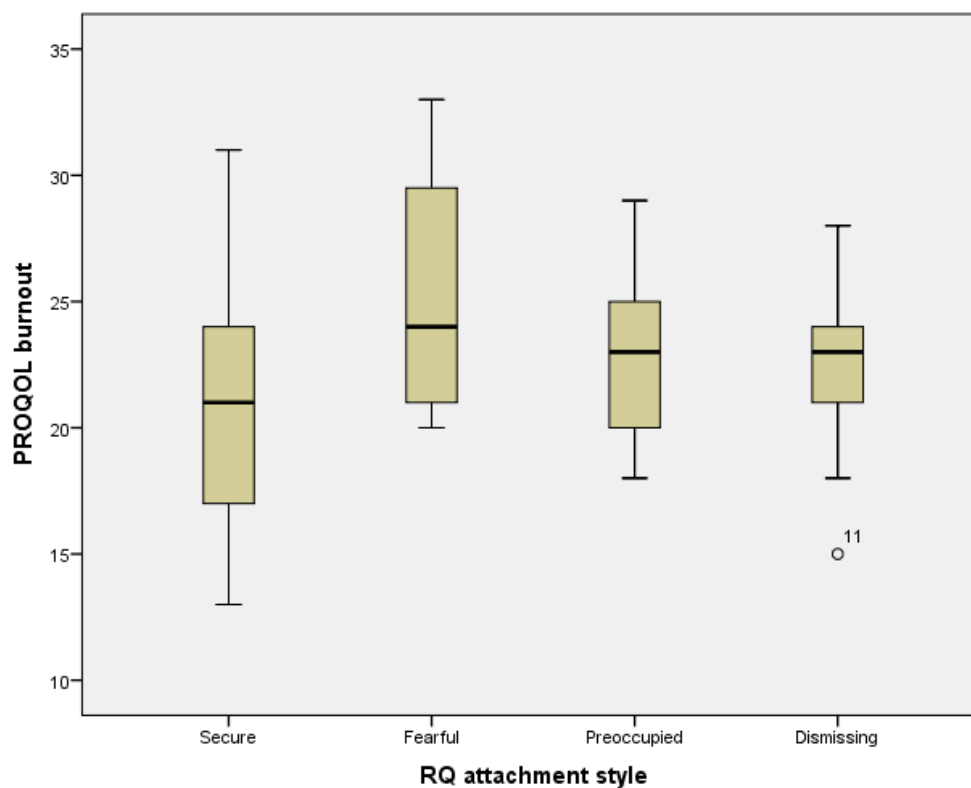


Figure 7: Boxplot to compare PROQOL burnout between attachment style groups as categorised by the RQ.

Figure 7 illustrates the increased occurrence of burnout within the Fearful group and decreased occurrence of burnout within the Secure group. There is one outlier identified within the Dismissing group. Further investigation suggests that there is discrepancy between the ECR and RQ scales regarding the categorisation of this participant. It is questionable whether the individual may be better categorised within the Secure group, due to low anxiety and low avoidance scores as measured by the ECR. However, further descriptive analysis of the RQ data indicates that the 5% Trimmed Mean is very similar to the mean for the Dismissing group (22.48 and 22.38). Therefore, this case has been retained within the data file.

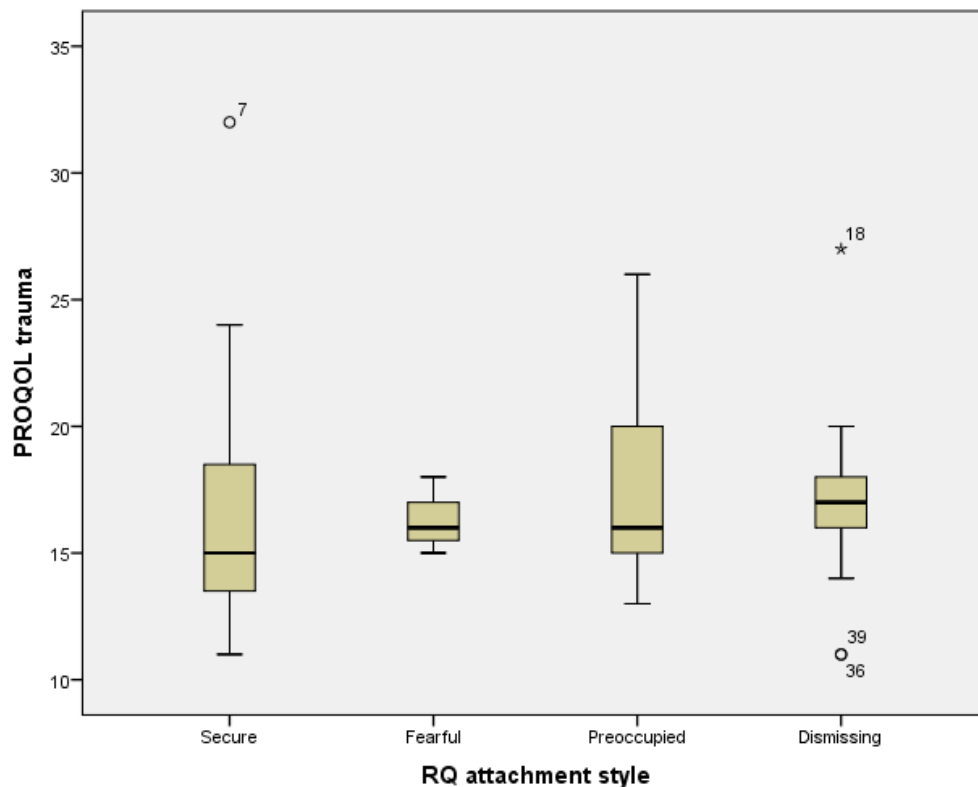


Figure 8: Boxplot to compare PROQOL trauma between attachment style groups as categorised by the RQ.

Figure 8 illustrates that there appear to be limited differences in distribution of PROQOL trauma between attachment groups within this sample. There is a decreased occurrence of trauma within the Secure group and increased occurrence of trauma within the Dismissing group overall. There are four outliers identified, one within the Secure group and three within the Dismissing group; one of which is reported as an extreme outlier. Further investigation suggests that the outlier in the Secure group is not an erroneous score and that this participant is also categorised as low anxiety and avoidance by the ECR. The 5% Trimmed Mean is very similar to the mean for the Secure group (15.84 and 16.18). Therefore, this case has been retained within the data file. The extreme outlier within the Dismissing group has low anxiety and low avoidance scores as measured by the ECR, suggesting that this participant’s categorisation within the Dismissing group may be questionable. Of the two remaining outliers in this group, one scores low anxiety and low avoidance on the ECR, and so the participant’s categorisation within the Dismissing group may be questionable, the other

scores low anxiety and high avoidance on the ECR, which is conducive of a Dismissing attachment style. The 5% Trimmed Mean is very similar to the mean for the Dismissing group (16.86 and 17.08). Therefore, these cases have all been retained within the data file.

Tables 14 and 15 provide descriptive statistics for each of the RQ attachment style groups on both compassion fatigue subscales of the PROQOL.

Table 14: Descriptive analyses of PROQOL burnout for each RQ attachment style group.

RQ outcome	N	Minimum	Maximum	Mean	Std. Deviation	Median	Skewness	Kurtosis
Secure	44	13	31	20.57	4.049	21.00	.334	-.165
Fearful	4	20	33	25.25	5.737	24.00	1.013	.280
Preoccupied	5	18	29	23.00	4.301	23.00	.377	-.630
Dismissing	13	15	28	22.38	3.453	23.00	-.543	.653
Total	66	13	33	21.39	4.180	21.00	.317	.036

Table 15: Descriptive analyses of PROQOL trauma for each RQ attachment style group.

RQ outcome	N	Minimum	Maximum	Mean	Std. Deviation	Median	Skewness	Kurtosis
Secure	44	11	32	16.18	4.019	15.00	1.628	4.272
Fearful	4	15	18	16.25	1.258	16.00	1.129	2.227
Preoccupied	5	13	26	18.00	5.148	16.00	1.100	.604
Dismissing	13	11	27	17.08	4.051	17.00	.787	2.525
Total	66	11	32	16.50	3.966	16.00	1.374	3.040

The Kruskal-Wallis Test was applied to compare PROQOL burnout between RQ attachment style groups and to compare PROQOL trauma between RQ attachment style groups. These analyses indicated that there were no statistically significant differences between RQ attachment style groups for either burnout ( $p=.150$ ) or trauma ( $p=.634$ ) subscales.

Analyses were also completed to explore compassion fatigue in relation to attachment style anxiety and avoidance as measured by the ECR. Figures 9 and 10 illustrate the distribution of PROQOL burnout within the sample when correlated with ECR anxiety and avoidance respectively.

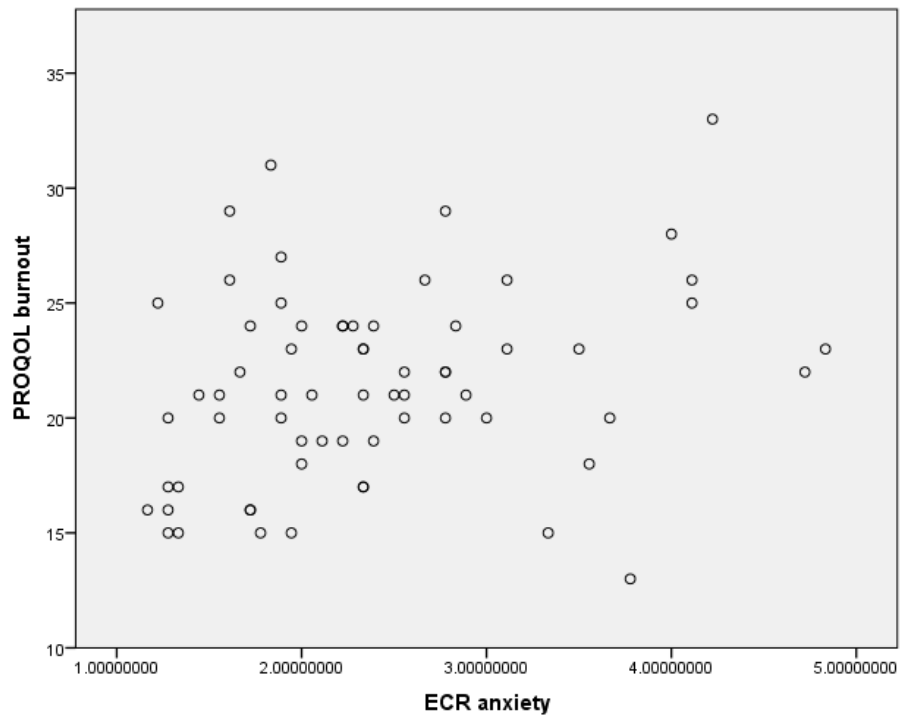


Figure 9: Scatterplot to illustrate correlation between the PROQOL burnout and ECR anxiety.

Figure 9 illustrates the correlation between PROQOL burnout and ECR anxiety for the sample as a whole. This scatterplot also highlights the modest positive skewness of distribution in the sample, with the majority of participants scoring low burnout and low anxiety. A Spearman's Rank Order Correlation analysis was completed to calculate the strength of the relationship between attachment related anxiety and burnout within the present sample. This indicated that there was a small (Cohen, 1988) positive correlation between the two variables ECR anxiety and PROQOL burnout ( $r_s = .27$ ,  $n=66$ ,  $p=.028$ ).

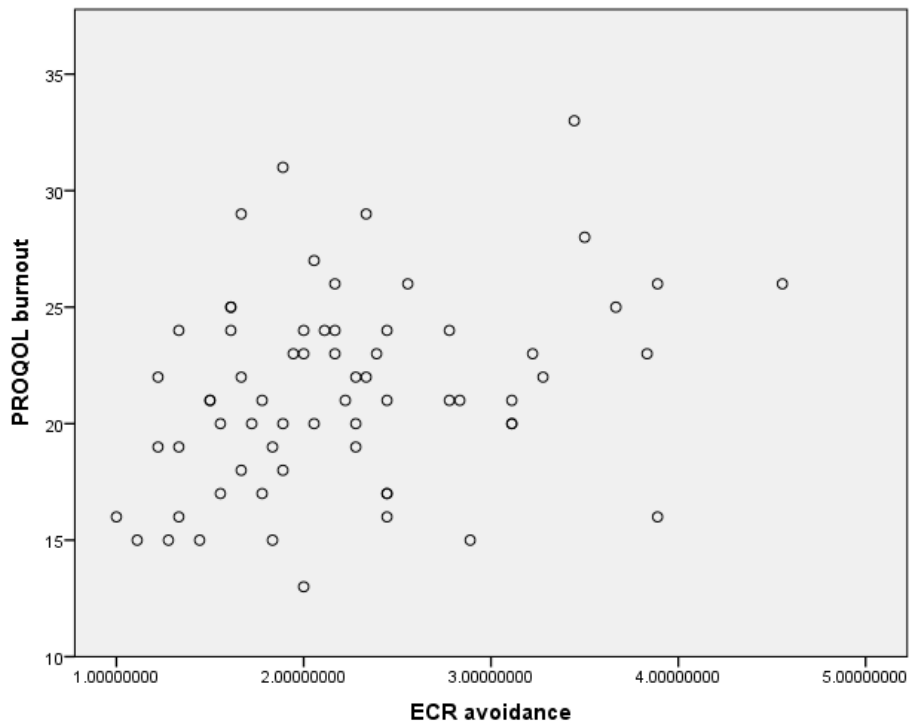


Figure 10: Scatterplot to illustrate correlation between the PROQOL burnout and ECR avoidance.

Figure 10 illustrates the correlation between PROQOL burnout and ECR avoidance for the sample as a whole. This scatterplot also highlights the modest positive skewness of distribution in the sample, with the majority of participants scoring low burnout and low avoidance. A Spearman’s Rank Order Correlation analysis was completed to calculate the strength of the relationship between attachment related avoidance and burnout within the present sample. This indicated that there was a moderate (Cohen, 1988) positive correlation between the two variables ECR avoidance and PROQOL burnout ( $r_s = .31, n=66, p=.012$ ).

Figures 11 and 12 illustrate the distribution PROQOL trauma within the sample when correlated with ECR anxiety and avoidance respectively.

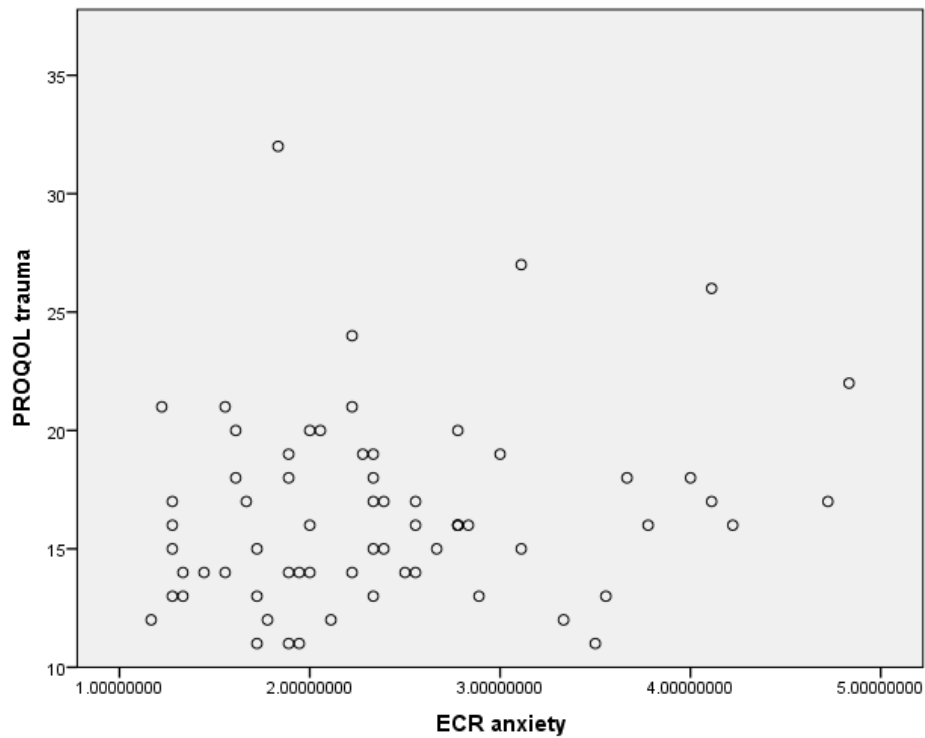


Figure 11: Scatterplot to illustrate correlation between the PROQOL trauma and ECR anxiety.

Figure 11 illustrates the correlation between PROQOL trauma and ECR anxiety for the sample as a whole. A Spearman's Rank Order Correlation analysis was completed to calculate the strength of the relationship between attachment related anxiety and trauma within the present sample. This indicated that there was a no statistically significant relationship identified between PROQOL trauma and ECR anxiety ( $p=.176$ ).

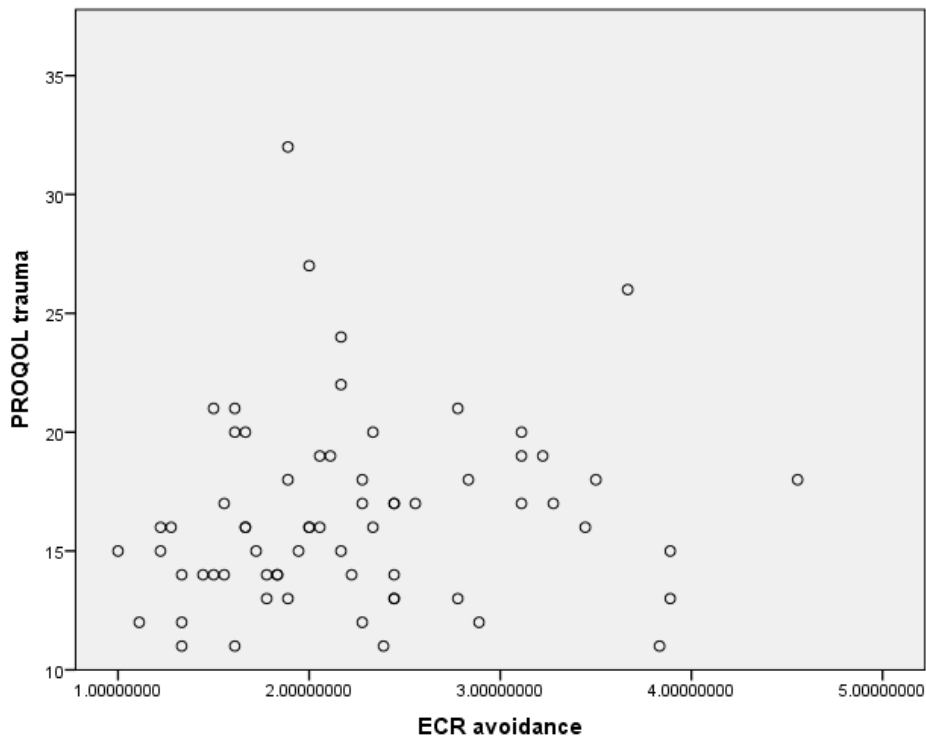


Figure 12: Scatterplot to illustrate correlation between the PROQOL burnout and ECR avoidance.

Figure 12 illustrates the correlation between PROQOL trauma and ECR avoidance for the sample as a whole. A Spearman’s Rank Order Correlation analysis was completed to calculate the strength of the relationship between attachment related avoidance and trauma within the present sample. This indicated that there was no statistically significant relationship identified between PROQOL trauma and ECR avoidance ( $p=.148$ ).

### How prevalent is compassion satisfaction amongst psychologists in forensic settings?

The Professional Quality of Life Scale Version 5 (PROQOL) compassion satisfaction subscale indicates how satisfied individuals are within their job, with particular reference to their role in helping others. Cut-off scores are used to categorise participants as having Low (<22), Moderate (23-41) or High (>41) compassion satisfaction.

Table 16: Frequency counts and percentages of compassion satisfaction as measured by the PROQOL.

	Frequency	Percent
Low	0	0
Moderate	41	62
High	25	38
Total	66	100

Table 16 shows that once cut-off scores were applied the majority of the sample scored moderate levels of compassion satisfaction. The remaining participants scored high levels of compassion satisfaction. No participants reported low compassion satisfaction.

### Is attachment style associated with compassion satisfaction?

A Boxplot comparing the distribution of scores from the PROQOL compassion satisfaction subscale with the categorical attachment style groups identified by the RQ, can be found in Figure 13. Figure 13 visually illustrates an apparent increased occurrence of compassion satisfaction within the Secure group and decreased occurrence of compassion satisfaction within the Dismissing group.

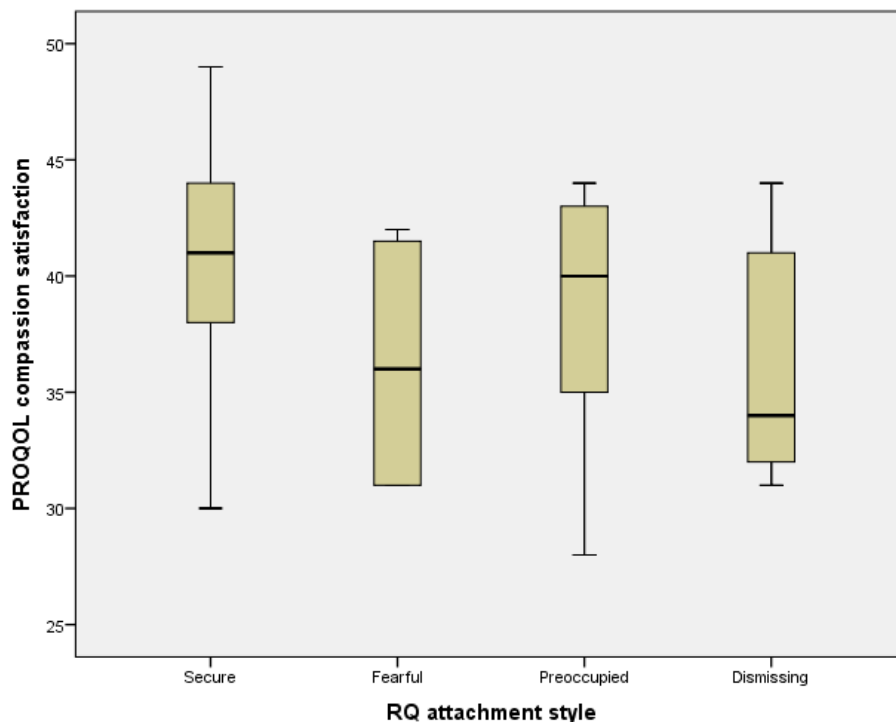


Figure 13: Boxplot to compare PROQOL compassion satisfaction between attachment style groups as categorised by the RQ.

Table 17: Descriptive statistics of PROQOL compassion satisfaction for each RQ attachment style group.

RQ outcome	N	Minimum	Maximum	Mean	Std. Deviation	Median	Skewness	Kurtosis
Secure	44	30	49	40.64	4.62	41.00	-.408	-.199
Fearful	4	31	42	36.25	6.08	36.00	.023	-5.865
Preoccupied	5	28	44	38.00	6.60	40.00	-.985	-.061
Dismissing	13	31	44	36.38	4.93	34.00	.380	-1.611
Total	66	28	49	39.33	5.16	40.50	-.339	-.753



The Kruskal-Wallis Test was applied to compare PROQOL compassion satisfaction between RQ attachment style groups. This analysis indicated that there were no statistically significant differences in compassion satisfaction between RQ attachment style groups ( $p=.067$ ).

Analyses were also completed to explore compassion satisfaction in relation to attachment style anxiety and avoidance as measured by the ECR.

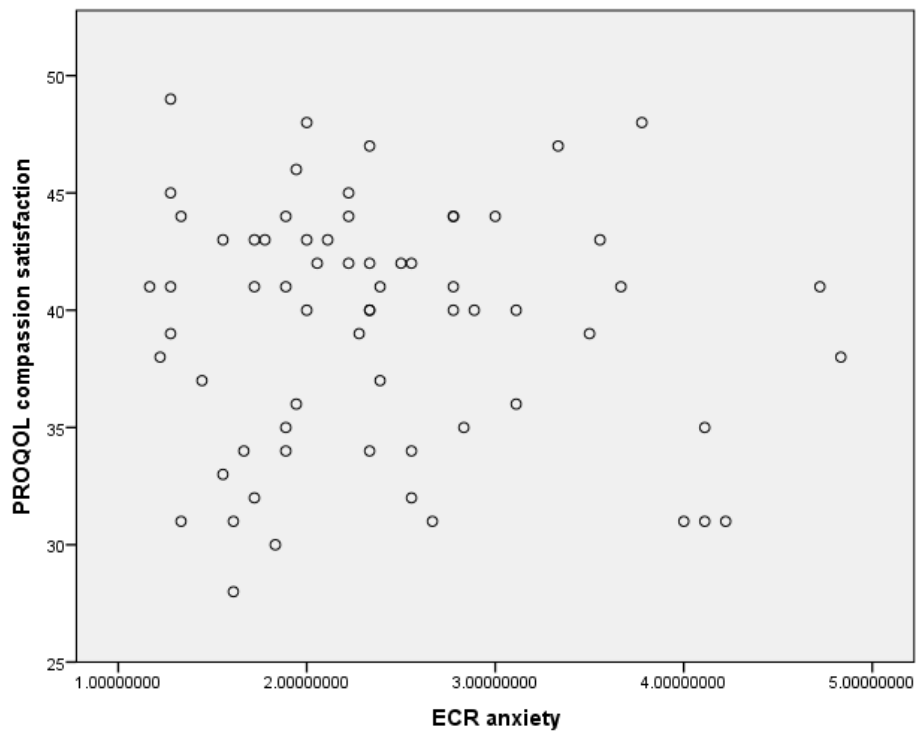


Figure 14: Scatterplot to show the relationship between ECR anxiety and PROQOL compassion satisfaction.

Figure 14 illustrates the distribution of PROQOL compassion satisfaction within the sample when correlated with ECR anxiety. A Spearman's Rank Order Correlation was used to calculate the strength of the relationship between ECR anxiety and PROQOL compassion satisfaction. There were no statistically significant relationships identified between PROQOL compassion satisfaction and ECR anxiety ( $p=.767$ ).

Figure 15 illustrates the distribution of PROQOL compassion satisfaction within the sample when correlated with ECR avoidance, illustrating a possible negative correlation.

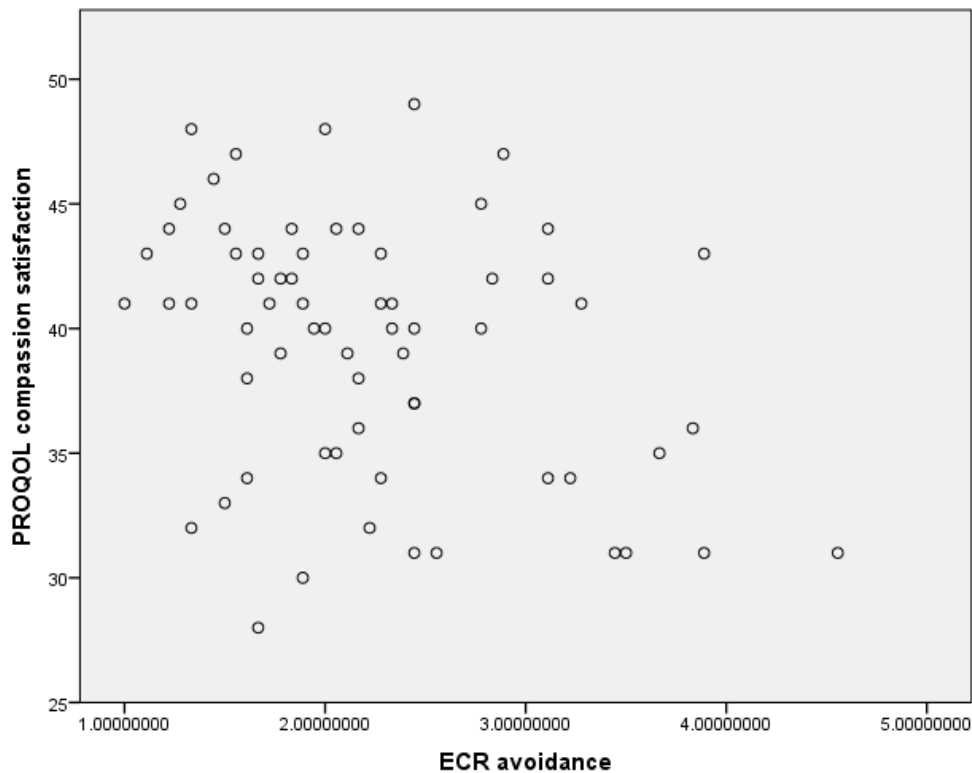


Figure 15: Scatterplot illustrating the relationship between ECR avoidance and PROQOL compassion satisfaction.

A Spearman's Rank Order Correlation was used to calculate the strength of the relationship between ECR avoidance and PROQOL compassion satisfaction. This analysis indicated that there was a moderate negative correlation between the two variables ECR avoidance and PROQOL compassion satisfaction ( $r_s = -.30$ ,  $n=66$ ,  $p=.013$ ). This result suggests that participants with lower attachment avoidance were more likely to report higher compassion satisfaction.

### Further demographic analyses.

The aim of this part of the analysis was to explore whether any group differences in PROQOL burnout, trauma and compassion satisfaction existed based on gender, age group, number of years post-qualification and job type (i.e. Clinical or Forensic Psychologist). As the majority of the group was White British no differences between cultural/ethnic groups were explored. A Mann-Whitney U Test was completed to compare the distribution of PROQOL trauma ( $p=.982$ ), burnout ( $p=.893$ ) and compassion satisfaction ( $p=.753$ ) across gender group. Kruskal Wallis analyses were completed to compare the differences in PROQOL trauma ( $p=.807$ ), burnout ( $p=.802$ ) and compassion satisfaction ( $p=.788$ ) between groups based on age group. Kruskal Wallis analyses were completed to compare the differences in PROQOL trauma ( $p=.999$ ), burnout ( $p=.567$ ) and compassion satisfaction ( $p=.370$ ) between groups based on number of years post-qualification. Kruskal Wallis analyses were also completed to compare the differences in PROQOL trauma ( $p=.886$ ), burnout ( $p=.821$ ) and compassion satisfaction ( $p=.578$ ) between groups based on job type. There were no statistically significant differences found between groups for any of these analyses.

## **Exploring psychologists' views of the relevance of attachment style to clinical practice.**

A content analysis was used to explore the views of psychologists, regarding the relevance of their attachment style to their clinical practice. The major themes and frequency counts can be viewed in Table 18 along with the codes used and example meaning units. For more information on the qualitative content analysis process please see the Methods section. In total, 58 participants responded to this qualitative question. Based on this analysis, it was possible to divide the participant responses into three distinct groups. The majority of the sample did consider that their attachment style was relevant to their clinical practice. A smaller proportion indicated that they had mixed views of the relevance of their attachment style and the least common response was that their attachment style was not relevant to their clinical practice.

Table 18: Codes, Themes and Frequency counts from qualitative content analysis of questionnaire content regarding relevance of attachment style to clinical practice.

<b>Theme:</b>	Yes, relevant	Mixed views of relevance	No, not relevant
<b>Frequency: (58 responses)</b>	48 (83%)	9 (15%)	1 (2%)
<b>Example meaning units:</b>	<p>“the more secure base you have the more secure your therapeutic relationships can be”</p> <p>“you are having a relationship whether you like it or not”</p> <p>“I end up using my attachment style in therapy which may not be what they need”</p>	<p>“it plays less of a role than in my personal relationships”</p> <p>“professional relationships are bound by somewhat different rules and limits”</p>	<p>“no as even if it were a different style, as a professional I would be able to remain objective”</p>
<b>Codes:</b>	<ul style="list-style-type: none"> <li>-security</li> <li>-boundaries</li> <li>-caring</li> <li>-emotional intimacy</li> <li>-quality of alliance</li> <li>-foundation</li> <li>-yes</li> <li>-difficulty developing relationships</li> <li>-relational knowledge</li> <li>-self regulation</li> <li>-emotional needs</li> </ul>	<ul style="list-style-type: none"> <li>-work and personal attachments are different</li> <li>-adjust your temperament</li> <li>-possibly</li> </ul>	<ul style="list-style-type: none"> <li>-no</li> <li>-remain objective regardless of style</li> </ul>

## Exploring qualitative experiences of managing negative feelings that arise in relation to client work.

A content analysis was used to explore how psychologists manage negative feelings that arise in relation to their client work. Table 19 indicates the qualitative experiences of psychologists in relation to how they manage negative feelings during therapy sessions. There were 66 responses to this qualitative question. Many participants provided multiple responses, and were included within multiple categories and themes. For more information on the qualitative content analysis process please see the Methods section. It appears from this analysis that a significant proportion of the sample contained their negative feelings in sessions, many reported sharing their experience with the patient and approximately a quarter of the sample reported using a self-protective action to cope with their emotional experience.

Table 19: Codes, Themes and Frequency counts from qualitative content analysis of questionnaire content regarding managing negative feelings during therapy sessions.

<b>Theme:</b>	Self-protective action	Contain	Share with patient
<b>Frequency: (66 responses)</b>	17 (26%)	51 (77%)	25 (38%)
<b>Example meaning units:</b>	“mindful breathing, acceptance, blocking”  “distancing myself emotionally from the situation”	“contain them and continue with the work in hand”  “listen and work through”	“share them [my feelings] with the client”  “express within the relationship as potential learning point”
<b>Codes:</b>	-mindful breathing -self regulation processes -self monitoring -acceptance -blocking -mindfulness -focus on positive -self-talk -self-awareness -prepare -depersonalise -distance myself -surfing the wave of emotion -pray	-do not express to patient -do the opposite (be overly nice) -note for supervision -containment -protect patient	-reflect on with patient -share with patient -interpret with patient -reflect back process -be authentic

Table 20 indicates the qualitative experiences of psychologists in relation to how they manage negative feelings outside of therapy sessions. There were 66 responses to this qualitative question. Many participants provided multiple responses, and were included within multiple categories and

themes. For more information on the qualitative content analysis process please see the Methods section. It appears from this analysis that a significant proportion of the sample reported using external support systems, almost half used independent problem solving, a fifth of the sample completed an unrelated activity, some used an internal cognitive coping strategy and a few reported that experiencing negative feelings outside of sessions was not applicable to them.

Table 20: Codes, Themes and Frequency counts from qualitative content analysis of questionnaire content regarding managing negative feelings outside of therapy sessions.

<b>Theme:</b>	External support	Internal cognitive coping strategy	Independent Problem solving	Unrelated Activity	Reported N/A
<b>Frequency: (66 responses)</b>	55 (83%)	10 (15%)	32 (48%)	13 (20%)	2 (3%)
<b>Example meaning units:</b>	“Use of peer supervision and informal debriefs with friends/colleagues”	“I accept my limitations and accept circumstances over which I have no influence”	“Reflect on their behaviour and consider what function it may have for them to help develop therapy in the future”	“Distraction – when I get in from work I have other commitments / demands that make it difficult to allow space for work worries”	“Not an issue”
<b>Codes:</b>	-supervision -peer supervision -talking to colleagues -discuss issue with partner/family -vent	-blocking -acceptance -mindfulness -objectivity -short exposure -grounding -humour -prayer about work	-formulation -refer to theory -independent reflection/ reflective logs -functional analysis -planning -CPD	-exercise -socialise/ friends/family -take breaks -relaxing activity -change task/distraction	-not applicable

### **Exploring qualitative self-care strategies utilised by psychologists in forensic settings within a range of situations.**

A content analysis was used to explore the self-care strategies used by psychologists in a range of situations, including: within their direct therapeutic work, during the workday, and outside of work. Table 21 indicates the qualitative experiences of psychologists in relation to the self-care strategies they use within their direct therapeutic work. There were 65 responses to this qualitative question. Many participants provided multiple responses, and were included within multiple categories and themes. For more information on the qualitative content analysis process please see the Methods section. It appears from this analysis that support seeking and management of the therapeutic relationship were priorities within this sample. Over a third of that sample reported using an internal coping strategy, with some reporting that organisation supported their self-care, and a small

number considered environmental security an important factor. The least common response was that participants made no conscious effort towards self-care within their direct therapeutic work.

Table 21: Codes, Themes and Frequency counts from qualitative content analysis of questionnaire content regarding use of self-care within direct therapeutic work.

<b>Theme:</b>	Support	Internal coping strategy	Organisation	Therapeutic relationship	Environmental security	No conscious self-care
<b>Frequency: (65 responses)</b>	34 (52%)	23 (35%)	14 (22%)	32 (49%)	4 (6%)	2 (3%)
<b>Example meaning units:</b>	“Debrief with colleagues”  “Work as part of an MDT”	“Adopt a position of acceptance with regards to the patient and myself”	“Having set therapy sessions/times and keeping these”	“Agree a set of ground rules for dealing with difficulties at the start”  “I explicitly name things within the therapeutic model/frame to address the challenging issues”	“request staff accompany me in sessions”  “Use alarms”	“Overall doesn’t affect me hugely”
<b>Codes:</b>	-supervision -team meeting -speak to colleagues -debrief	-reflection -detachment -acceptance - depersonalise -self awareness -grounding -anticipate difficulties -rehearsal	-space between sessions -work-life balance -plan appointments carefully -breaks -caseload -pace myself -work part time -take my time -short sessions -set appointment times	-discussion with patient -formulation -therapeutic goals -boundaries -be honest -containment -refer to therapeutic model -process notes -terminate session -positive regard	-personal alarm -prepare ward staff for risks -security procedures	-don’t know -doesn’t affect me

Table 22 indicates the qualitative experiences of psychologists in relation to the self-care strategies they use during the workday. There were 66 responses to this qualitative question. Many

participants provided multiple responses, and were included within multiple categories and themes. For more information on the qualitative content analysis process please see the Methods section. It appears from this analysis that support seeking was prioritised within this sample. Just less than a third of the sample reported using a non-work related activity to attend to their personal wellbeing, others reported using an internal coping style and considered workload management an important factor in their self-care during the workday.

Table 22: Codes, Themes and Frequency counts from qualitative content analysis of questionnaire content regarding use of self-care during the workday.

<b>Theme:</b>	Workload management	(Non-work related activity) Attending to personal wellbeing	Support	Internal coping style
<b>Frequency: 66 responses</b>	23 (17%)	42 (30%)	49 (35%)	25 (18%)
<b>Example meaning units:</b>	“not seeing people back to back”  “keeping busy can actually help at times”	“always have tea and food (chocolate etc) on hand!!”  “play a relaxing cd”	“Share openly difficult clinical/work situations with trusted colleagues”	“There is probably a degree of detachment which has developed over the years”  “Go easy on myself”
<b>Codes:</b>	-manage case load -leave work at work -breaks between sessions to write notes -week without client contact -appropriate working hours -structured day -keep busy -more difficult sessions not at end of day -balance workload with different tasks -updated timetable and to do list	-time out -mindfulness -eat -drink -sleep -play -exercise -walk -leave the ward/building -email partner -general chit chat -plan leave -self development -music	-contact with colleagues face to face/phone -organisational support -personal therapy -supervision -supervision groups -support others -emergency check ins with supervisor -team trained to understand trauma -debrief meetings	-reflect -detach -self compassion -be boundaried - -compartmentalise -cry -don't dwell/ -ruminate -intellectual preparation -humour



Table 23 indicates the qualitative experiences of psychologists in relation to the self-care strategies they use outside of work. There were 66 responses to this qualitative question. Many participants provided multiple responses, and were included within multiple categories and themes. For more information on the qualitative content analysis process please see the Methods section. It appears from this analysis that relationships and maintaining mental wellbeing were most frequently reported within the sample as methods of self-care used outside of work. Almost half of the sample reported using play activities, and many reported looking after their body. Fewer reported self-development activities as important to their self-care outside of work. Only a small proportion of the sample reported that this issue was not applicable to them and that they did not use self-care outside of work.

Table 23: Codes, Themes and Frequency counts from qualitative content analysis of questionnaire content regarding use of self-care outside of work.

<b>Theme:</b>	Self-development	Relationships	Body	Play activities	Maintaining mental well-being	N/A
<b>Frequency: (66 responses)</b>	6 (9%)	40 (61%)	27 (41%)	32 (49%)	39 (59%)	2 (3%)
<b>Example meaning units:</b>	“Personal therapy at some points when feeling overloaded”	“Maintain relationships with friends and family members”	“good diet, sleep, not too much alcohol”	“take part in activities I enjoy”	“keeping home and work life separate”	“this does not impact [me] outside of work”
<b>Codes:</b>	-personal therapy -academic/intellectual endeavour -personal goals -cultural experiences	-partner/family/friends -social groups	-exercise -eating well -active -alcohol -yoga -bubble bath -rest -sleep	-hobbies -fun -relaxation -holidays -read books -watch film/ TV -music	-boundary work/home -switch off -perspective -don't dwell -view work as fulfilling -check for warning signs -challenge unhelpful thoughts -distraction -don't feel guilty -cry -reflection -acceptance -mindfulness -preparation -avoidance	N/A

## Exploring qualitative similarities and differences in self-care between different attachment styles.

The scatterplots in Figure 16 illustrate the correlation between the anxiety and avoidance subscales of the ECR for the sample as a whole, including reference lines representing norm mean scores for both subscales of this measure. Cases were selected that represent the most ‘extreme’ scores for each attachment style within the sample. Due to the skewed distribution of ECR anxiety and avoidance within the sample, with majority of cases falling into the Secure category and limited cases falling into the Preoccupied, Fearful and Dismissing categories, and the similarity between scores within the Secure and Fearful categories, case selection was limited to three cases for the Preoccupied and Dismissing groups and four cases for the Secure and Fearful groups. For more information on the selection of cases and qualitative content analysis process please see the Methods section and for an appraisal of the limitations of this methodology, including the impact of small group sizes on generalizability, please see the Discussion section.

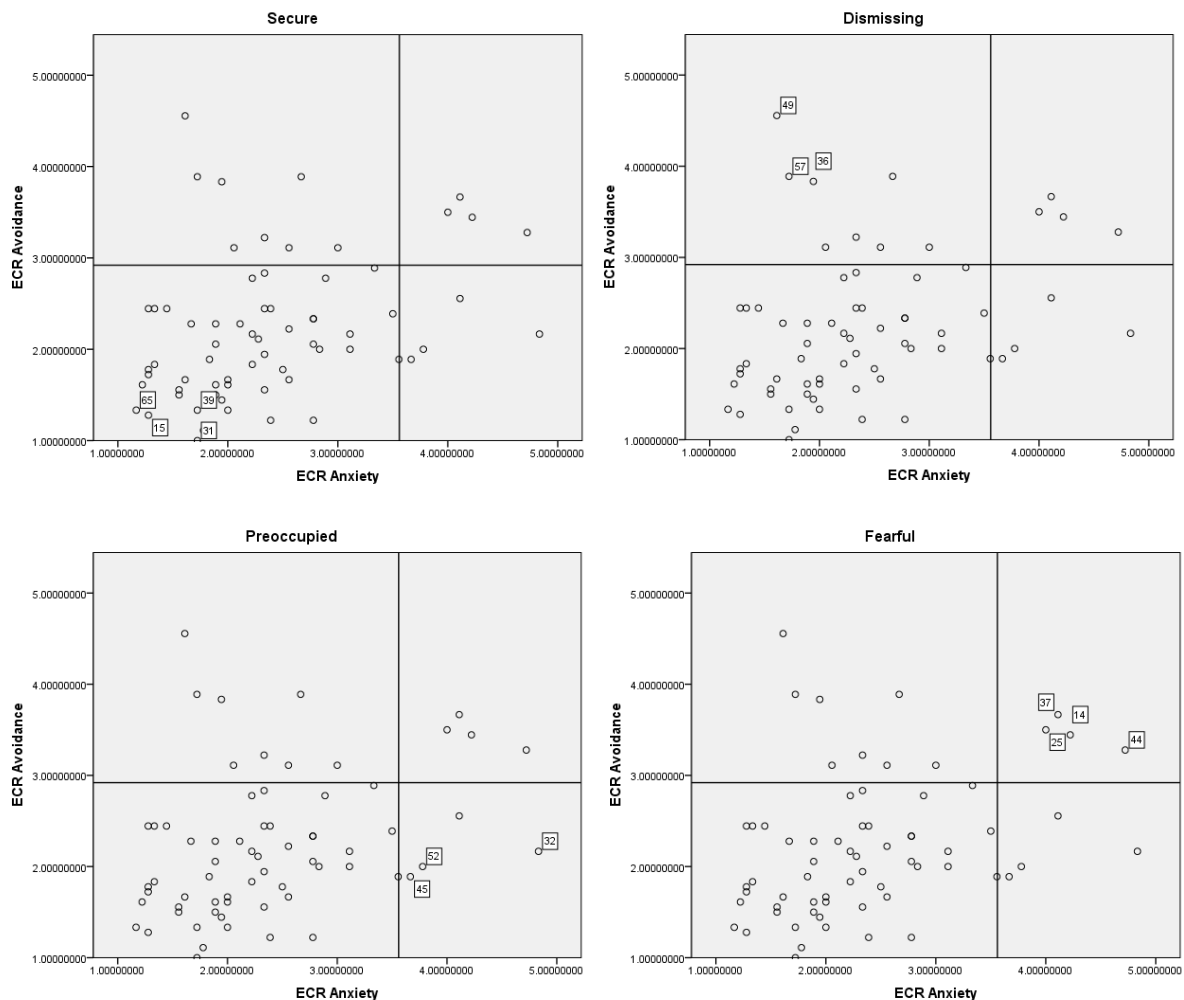


Figure 16: Scatterplots of ECR anxiety and avoidance subscales used to identify attachment style ‘cases’.

A qualitative content analysis was used to explore differences between how psychologists from each attachment style category manage negative feelings that arise in relation to their client work. Table 24 indicates the qualitative experiences of psychologists in relation to how they manage negative

feelings during therapy sessions. It appears from this analysis that there are differences in how negative feelings are managed during therapy sessions between attachment style categories. For example, the Secure and Preoccupied groups reported balancing mindful awareness of self with development of the patient (other), whilst the Fearful group reported focusing on adapting the self. The Dismissing group reported using mindful awareness and boundary management.

Table 24: Coding and Themes from qualitative content analysis of questionnaire content regarding managing negative feelings during therapy sessions for attachment style cases.

<b>Attachment style</b>	<b>Condensed meaning unit</b>	<b>Coding</b>	<b>Themes</b>
Secure	Notice, bracket Feedback feelings of fear	Mindful awareness, share	
	Notice, gently reflect with patient Put to one side	Mindful awareness, share	-Mindful awareness of self -Development of other
	Hold on to them without letting it interfere	Mindful awareness	
	Recognition, self-management skills	Self-awareness, self-management	
Fearful	Recognise and identify feeling, name feeling in interpretations	Recognise, share	
	Very aware of these, warning/monitoring system, self-monitoring, understanding	Vigilance, self-monitoring	-Focus on negative feelings -Adapting self
	Acknowledge them, remember them, think about them	Focus on negative feelings	
	Depends on client, empathise with them, challenge my thoughts, become assertive and direct	Adapting internal processes, adapting approach	
Preoccupied	Notice them, suspend judgement	Mindful awareness, adapt internal processes	
	Express it to client, help them understand why others respond to them this way	Share, development of other	-Mindful awareness -Adapting self -Development of other
	Hold it in my head, accepting how I feel	Mindful awareness, adapt internal processes	
Dismissing	Notice them, discuss immediately with patient	Notice, share	
	Recognise it, do not hang on to it, continue with plans	Mindful awareness, carry on	-Mindful awareness -Boundary management
	Reflect later without prejudice, be professional, listen and gather information	Mindful awareness, carry on	

Table 25 indicates the qualitative experiences of psychologists in relation to how they manage negative feelings outside of therapy sessions. It appears from this analysis that there are similarities in how negative feelings are managed outside of therapy sessions between attachment style categories, for example in the prioritisation of support seeking. However, there also appear to be differences in how the feelings are used to inform thinking about the self and other. For example, the Secure and Dismissing groups focus on understanding the other, and the Preoccupied groups focus on understanding both self and other. However, the Fearful group reported focus on emotional self-management, rather than using the feelings to inform understanding.

Table 25: Coding and Themes from qualitative content analysis of questionnaire content regarding managing negative feelings outside of therapy sessions for attachment style cases.

<b>Attachment style</b>	<b>Condensed meaning unit</b>	<b>Coding</b>	<b>Themes</b>
Secure	Supervision, partner, exercise	Support, exercise	-Support seeking -Physical self-care -Developing understanding of other
	Formulate, peers, partner	Formulate, support	
	Informal support peer/colleague, clinical supervision	Support	
	Personal reflection, peer discussions	Reflection, support	
Fearful	Peer reflective practice, clinical supervision	Support	-Support seeking -Focus on emotional self-management
	Examine them, supervision, vent, use humour, switch off to prevent rumination, move on to the next thing	Focus on feelings, internal defensive processes	
	Supervision, talk to colleagues	Support	
	Supervisor, peers, MDT, seek reassurance, check whether feelings are mine or clients	Support, focus on feelings	
Preoccupied	Personal reflection, Supervision, feelings are useful to inform future work and self-development	Reflection, support, self-development	-Support seeking -Reflection to inform understanding of self and other -Self-protection
	Supervision, reaction to less likeable part of patient, formulation	Support, formulation	
	Keep busy, reflect on why I was thinking about it, think about safety and security measures at home.	Distraction, reflection, self-protection	
Dismissing	Notice them, formulation, discuss with team, supervision	Awareness, Formulation, support	-Emotional self-management -Maintaining boundaries -Use feelings to inform understanding of other -Support seeking
	Reflection, asking why, supervision, using the feeling in future or making sure it doesn't affect therapy	Focus on feelings, support, contain	
	Client not personal friend, manage my emotional responses, professional, job not personal life, may take to supervision	Focus on boundaries, contain, support	

Table 26 indicates the qualitative experiences of psychologists in relation to their use of self-care in their direct therapeutic work. There was one non-response within the Secure group for this question, reducing the sample size to three for this group. It appears from this analysis that there are similarities in the approaches used to self-care within direct therapeutic work between attachment style categories. For example, all groups reported using support seeking and managing the therapeutic relationship. Differences were also noted, such as the Fearful group's focus on emotional self-management.

Table 26: Coding and Themes from qualitative content analysis of questionnaire content regarding self-care in direct therapeutic work for attachment style cases.

<b>Attachment style</b>	<b>Condensed meaning unit</b>	<b>Coding</b>	<b>Themes</b>
Secure	Maintain boundaries	Boundaries	
	Balance helping understanding and reducing challenging aspects, reflect on goals, boundaries	Manage patient experience, boundaries	-Manage therapeutic relationship -Mental preparation -Support seeking
	Prepare, plan, debrief, support		
	[No response]	Mental preparation, support	
Fearful	Workload, detachment	Workload management, detach	
	Self-awareness, supervision, reading	Support, develop understanding	-Workload management -Support seeking -Emotional self-management
	Take my time, accept rejection	Emotional self-management	
	Seek advice on managing feelings, supervision, challenge those feelings in therapeutic work	Emotional self-management, support	
Preoccupied	Boundaries, give feedback in session, respect, consideration and freedom of choice, terminate if not responding	Boundaries, manage therapeutic relationship	-Manage therapeutic relationship -Support seeking
	Terminate if needed, explain feelings to patient	Boundaries, manage therapeutic relationship	
	Open and honest in therapy without offending the patient, supervision	Manage therapeutic relationship, support	
Dismissing	Pay attention to my processes, address challenging issues with patient with focus on my feeling	Self-awareness, therapeutic relationship	-Support seeking
	Make it fun, interact informally with patients, remind myself of their history and trauma	Lighten emotional interactions, therapeutic relationship, empathy	-Self-awareness -Manage therapeutic relationship
	Supervision, reflect in the moment on my feelings, behaviour and responses	Support, focus on self	

Table 27 indicates the qualitative experiences of psychologists in relation to their use of self-care during the workday. It appears from this analysis that there are similarities in the approaches used to self-care during the workday between attachment style categories. For example, in the prioritisation of support seeking, use of mental coping strategies and attending to physical self-care.



Table 27: Coding and Themes from qualitative content analysis of questionnaire content regarding use of self-care during the work day for attachment style cases.

<b>Attachment style</b>	<b>Condensed meaning unit</b>	<b>Coding</b>	<b>Themes</b>
Secure	Colleague support, lunch breaks	Support, time out, physical	
	Compartmentalise it	Mental organisation	-Support seeking -Time out
	Exercise, do non-work related things, support	Physical, Time out, support	-Physical self-care -Mental coping strategies
	Take breaks, walk, talk to colleagues, supervision	Time out, physical, support	
Fearful	Support, supervision, breaks between sessions, reflect and write notes, short breaks	Support, time management, reflect, time out	
	Keep busy, reflecting, mindfulness, exercise	Time management, mental strategies, physical	-Time management -Support seeking -Mental coping strategies
	Eat, drink, talk, tell jokes, laugh	Physical, support, mental strategies	-Physical self-care
	Lunch break away from office, speak to peers, supervision, stick to working hours	Time out, physical, support, time management	
Preoccupied	Reflect on my feelings and discuss in supervision, support, healthy lifestyle, minimise impact of stress	Reflect, support with feelings, physical wellbeing	-Support with feelings -Attention to emotional impact of work
	Talk about emotional impact in supervision, safe supportive office environment, go easy on myself, reduce workload, positive self-talk, plan nice events	Support with feelings, attention to emotional impact of work workload management, mental strategies	-Physical self-care -Workload management -Mental coping strategies
	Support from colleagues, supervision, take time off when I'm not coping	Support, attention to emotional impact of work	
Dismissing	Keeping busy so there isn't time for dwelling, support, supervision and de-brief, tea, food, chocolate	Time management, prevent rumination, support, physical	-Mental coping strategies -Time management
	Breaks, talk to peers, laugh and joke, reflective diary, leave feelings and work and don't ruminate	Time management, support, mental, reflect, prevent rumination	-Support seeking -Physical self-care
	Reflective mindfulness if stressed, go for a short walk	Mindfulness, time out, physical	

Table 28 indicates the qualitative experiences of psychologists in relation to their use of self-care outside of work. It appears from this analysis that there are similarities in the approaches used to self-care outside of work between attachment style categories. For example, all groups report using detachment as a priority outside of work.

Table 28: Coding and Themes from qualitative content analysis of questionnaire content regarding use of self-care outside of work for attachment style cases.

Attachment style	Condensed meaning unit	Coding	Themes
Secure	Friendships, hobbies, interests, exercise, sleep hygiene	Social, interests, physical	
	Don't watch work related programmes	Detach	-Detach -Physical self-care
	Process information then switch off, go to bed early	Detach, physical wellbeing	-Other interests
	Don't dwell, exercise, busy active life, keep work life in perspective	Detach, physical wellbeing,	
Fearful	Don't discuss work at home	Detach	
	Cycling, gym, guitar, switch off, reading, tv, alcohol, mindfulness, talk to partner but benefits vary	Physical, interests, detach, mindfulness, support	-Detach -Mental strategies -Physical self-care
	Exercise, rest, reflection	Physical, reflection	-Other interests
	Try not to think about it, gym, switch off	Detach, physical	
Preoccupied	Social and leisure pursuits, challenge irrational/unhelpful thoughts, use distraction, self-soothing	Social, interests, mental, emotional management	-Social activities -Detach -Mental strategies
	Boundaries, don't take work home, adjust my plans after difficult day, relaxation, go out for dinner, time with partner	Detach, relax, activities, social	-Emotional management -Other interests
	Hide away and cry then move on, "not my stuff"	Cry, detach	
Dismissing	Detaching and switching off as I drive away, don't do much (watch tv/read) helps switch off, go to bed early	Detach, physical	
	Use self-care to unwind and relax	Relax activities	-Detach -Physical self-care
	Mindful activities to distract from role of professional/partner/parent	Detach	

### Exploring psychologists views of the relevance of self-care to clinical practice.

A content analysis was used to explore the views of psychologists, regarding the relevance of self-care to their clinical practice. 66 participants responded to this qualitative question. Many participants provided multiple responses, and were included within multiple categories and themes. The major themes and frequency counts can be viewed in Table 29 along with the codes used and

example meaning units. For more information on the qualitative content analysis process please see the Methods section. The majority of the sample considered self-care to be important to their clinical practice. Only a small proportion reported that they believed it was not relevant. Almost half described needing to apply effort to use self-care strategies and a similar proportion described learning self-care skills over time. In contrast over a third reported that self-care occurred naturally.

Table 29: Codes, Themes and Frequency counts from qualitative content analysis of questionnaire content regarding the relevance and practice of self-care by psychologists in forensic settings.

<b>Theme:</b>	Important	Not relevant	Occurs naturally	Requires effort	Learned skills
<b>Frequency: (66 responses)</b>	43 (65%)	1 (2%)	26 (39%)	31 (47%)	29 (44%)
<b>Example meaning units:</b>	"I think self-care is hugely important"	"No Don't tend to pay much attention to it"	"Tends to happen naturally"	"made a conscious effort to prioritise this"	"My self-care has been developed over my career"  "this is a skill I have learnt"
<b>Codes:</b>	-important -relevant	-not relevant	-naturally -spontaneous -habitual	-effort -conscious -focus -deliberate	-learned over years -experience -developed skills

## Discussion

The main aims of this study were to explore the attachment style, compassion fatigue, compassion satisfaction and use of self-care amongst psychologists working in forensic settings in the UK. The following discussion will review the findings and the implications of the results alongside the methodological limitations of the study. In keeping with the self-reflexivity required by qualitative approaches (Elo et al, 2014), I include a section on self-reflection and how researcher stance may have influenced this study. Areas for future research will also be discussed followed by a conclusion.

### Revisiting the research questions

#### *Exploring the range of attachment styles amongst psychologists in forensic settings.*

Bartholomew and Horowitz (1991) report distribution of attachment style classifications based on a four category model. This research suggested that within the general population percentages of each category range from 47-57% Secure, 18% Dismissing, 10-14% Preoccupied and 15-21% Fearful. In the present study, the results of the Relationship Questionnaire (RQ) suggest that there are slightly higher percentages of Secure (67%) and Dismissing (20%) attachment styles, and reduced numbers of Preoccupied (8%) and Fearful (6%) attachment styles. However, these results indicate that, similarly to the general population, psychologists contribute a range of experiences and relationship styles to their professional role. Similarly, research by Rizq and Target (2010), highlighted the presence of 'insecure' attachment styles amongst counselling psychologists. These authors argued that narcissistic injury sustained in early attachment relationships may be a factor in choosing to enter the profession, but may also impact on clinical work.

Of interest, was the difference in self-report of attachment style, in contrast to the categorisation provided by the RQ. Participants within the present study demonstrated a tendency to over-report a Secure attachment style (85%) and under-report a Dismissing (4.5%) attachment style in qualitative self-reports. Preoccupied (0%) and Fearful (6%) attachment styles were also under-reported. A further 4.5% of the sample reported that they were unsure how to describe their attachment style. This bias towards reporting a Secure attachment style may indicate a lack of understanding of attachment style literature. It may reflect a perception that a Secure attachment style is desirable when working as a psychologist. This may highlight a lack of opportunity to explore personal attachment style in psychological training or professional roles, and for psychologists to develop awareness of the benefits of varying attachment styles and how they can be optimally managed within the therapeutic context.

The two measures of attachment used within the present study: the Relationship Questionnaire (RQ; Bartholomew & Horowitz, 1991) and Experiences in Close Relationships Revised Adult Attachment Questionnaire (ECR; Fraley et al, 2000) demonstrated good reliability. As expected, those who were categorised as Secure and Dismissing on the RQ had lower anxiety on the ECR, and those who were categorised as Secure and Preoccupied showed lower avoidance on the ECR. ECR results were compared between RQ groups, demonstrating no significant difference in ECR anxiety between RQ attachment style groups, but a significant difference in ECR avoidance between groups was highlighted. This suggests that within the present sample attachment related anxiety was consistently low. However, there was a wider distribution of attachment related avoidance. These

results may highlight that attachment related anxiety is perceived as a less desirable trait for psychologists in this setting, or psychologists who have an anxious attachment style may be less likely to choose to work in this setting than those who have an avoidant style. Suggestions for further research that address this query will be discussed below.

### ***Is compassion fatigue prevalent amongst psychologists in forensic settings?***

Research regarding the nature of therapeutic work in a forensic setting (Figley, 2002), suggests that there is a personal cost for providing support in this challenging environment. However, in the current sample the majority of participants scored below average for burnout (94%) and secondary traumatic stress (61%), with the remaining participants scoring average levels of burnout (6%) and secondary traumatic stress (39%) as measured by the Professional Quality of Life Scale (PROQOL). These results suggest that compassion fatigue is not prevalent within the current sample.

These results are in contrast to the findings of Elliot and Daley (2013), who found that a third of the forensic health professionals within their sample scored above the threshold for psychiatric caseness with marked levels of psychological distress. In their study psychologists made 6.7% of the sample. Therefore, it is possible that the results of the present study reflect a significant difference in compassion satisfaction between disciplines.

Conversely, it is also possible that the present data is skewed due to the sampling procedure. Purposive and opportunity sampling was used with the offer of entering a prize draw to encourage those who may be short of time, or reluctant to engage due to stress. However, it is possible that this was not enough to generate a completely representative sample. It is likely that anyone who was experiencing burnout and secondary traumatic stress may perhaps be less inclined to take part in a survey about self-care. Recommendations for future research that address this issue will be discussed below.

### ***Is attachment style associated with compassion fatigue?***

The results of the present study suggest that there was a small positive correlation between ECR anxiety and burnout, as measured by the PROQOL. There was also a moderate positive correlation found between ECR avoidance and burnout. This suggests that those who score higher on avoidance and anxiety may be more prone to experiencing burnout at work. This indicates that all three insecure attachment styles are at increased risk of experiencing burnout when compared to those with a Secure attachment style. This finding supports the research of Mikulincer and Shaver (2007), which suggested that avoidant therapists may struggle to provide sensitive care and this may interfere with their ability to meet client needs, limiting their success and satisfaction in a therapeutic role, and therapists with an anxious attachment style may experience more distress within their work. These results may indicate that it is more important for psychologists with a non-secure attachment style to develop coping strategies that protect them from burnout in order to achieve longevity in this field. Furthermore, that services may need to increase sensitivity to therapists' needs and be made aware that these may vary depending on the therapist and their dominant attachment style.

### ***How prevalent is compassion satisfaction amongst psychologists in forensic settings?***

The present study suggests that psychologists in forensic settings are experiencing average levels of compassion satisfaction (62%). However, 38% of the sample scored above average compassion satisfaction. This result suggests that, not only are psychologists not struggling within this environment, they are actually thriving and gaining positive personal effects from working with this patient group. This finding is similar to Elliott and Daley's (2013) research demonstrating that a vast majority of forensic health care professionals in their sample reported high levels of satisfaction at work. Elliott and Daley found an association between perceived staff support and satisfaction. However, they also debated whether the professionals in their sample had accepted that stress was an integral part of working in the forensic environment and had developed coping strategies to manage this. Conversely, it is possible that in the present study the sample is skewed, as those who were not satisfied within their job may not have dedicated the time to completing the survey.

### ***Is attachment style associated with compassion satisfaction?***

The results of the present study suggest that those who reported higher anxiety on the ECR were significantly less likely to report compassion satisfaction. Due to the tendency for those with high attachment anxiety to have negative models of the self (Bartholomew & Horowitz, 1991) it is possible that these psychologists experience reduced self-compassion which may impact their enjoyment and satisfaction in relation to their work. This is in line with Wei et al (2011), who suggested that those with higher attachment anxiety are more likely to be self-critical, feel overwhelmed by their own distress and be unkind to themselves. Wei, Liao, Ku, and Shaffer's (2011) study also highlighted the positive association between self-compassion and personal well-being. Those authors stated that self-compassion also helps individuals to feel cared for, connected and emotionally calm. However, as with the present study, it is not possible to ascertain causal relationships from Wei et al's (2011) research.

This result may also link to research by Dinger, Starck, Sachsse, and Scauenburg, (2009), which found that anxiously attached therapists were more likely to create poorer working alliances with patients. According to their research, patients of anxiously attached therapists were also more likely to report a decline in alliance over the course of therapy. Therefore, difficulty generating working alliances with patients may also be a factor causing reduced compassion satisfaction amongst psychologists with an anxious attachment style. However, research by Tyrrell, Dozier, Taegue, and Fallot, (1999) indicated that more anxiously attached therapists actually demonstrated stronger alliances with avoidant patients, and discussed the importance of matching compatible therapist-patient attachment styles, highlighting that this theory requires further investigation.

### ***Further demographic analyses.***

The present study found no significant results in relation to demographic analyses, for example differences in compassion satisfaction, compassion fatigue and attachment style, related to gender, age group, number of years post-qualification and job type (i.e. Clinical or Forensic Psychologist). This is in contrast to research by Elliott and Daley (2013), which found significant differences in psychological well-being and coping in relation to gender, age, length of employment and job role. There are a number of possible reasons why the present results did not highlight demographic differences. As previously discussed, it is possible that this reflects differences between professional

disciplines and their experience and management of work related stress. Elliott and Daley's sample was more diverse in terms of job role, incorporating forensic mental health care professionals from a range of disciplines. Their research also indicated a greater range of stress related scores. However, the results of the present study may also be due to methodological limitations. For example, the present sample size (n=66) was small in contrast to that used by Elliott and Daley (n=135). Methodological limitations of the present study will be discussed in more detail below.

### ***Exploring psychologists' views of the relevance of attachment style to clinical practice.***

The majority of the present sample (83%) reported that they viewed their attachment style as relevant to their clinical practice. Within this group, participants referred to both positive and negative implications of this. For example, many reported that their attachment style helped to provide security within therapeutic relationships. This is supportive of research by Fonagy and Target (1996), which indicated that an individual's ability to recognise and respond to others' psychological states is directly related to their own early attachment experiences. These authors argued that a secure attachment permits the development of mentalisation abilities. In contrast, some participants in the present study demonstrated awareness that their attachment style may hamper their therapeutic work and be incompatible with their patients' needs. This corresponds to research by Milkulincer et al (2013) which noted the incompatibility of certain insecure attachment styles when investigating the patient-therapist relationship. Pearlman and Courtois (2005) also note that for some patients a therapist's Secure attachment style may be perceived as threatening. It is not within the realm of the present study to infer about attachment style compatibility within the therapeutic relationship. However, the views of the majority of participants within the present sample appeared to correspond to research by Rizq and Target (2010), which reported that attachment states in both patient and therapist may impact on the therapeutic relationship, and process and progress in therapy.

A further 15% had mixed views about whether their attachment style was relevant. Many of this group reported that they perceived their working and personal attachments to be different. This belief is supported by research such as Baldwin and Fehr (1995). These researchers indicated that people can have many different forms of interpersonal relatedness, and argued that it is incorrect to speak of a person's single attachment style. This argument was based on questions about measurable differences in attachment style due to temporal instability and contextual variation of attachment styles from one relationship to another. However, further research has indicated that measures of attachment do demonstrate adequate reliability and face and discriminant validity, and emphasise the importance of matching the method of measurement to the attachment relationship under investigation (Ravitz et al, 2010). For example, Ravitz et al argue that it is appropriate to use a self-report measure when conscious attitudes and behaviours in current relationships are relevant to the research question – however, the Adult Attachment Interview (George et al, 1996) is more suited to identifying less overt aspects of attachment style. Despite the ongoing debate around variance in attachment style between relationships, researchers do appear to agree that therapist attachment style is relevant within the therapeutic relationship (Black, Hardy, Turpin, & Parry, 2005).

In contrary to research in this area, 2% of the sample believed that their attachment style was not relevant to their clinical practice. These results may indicate a gap in training regarding the significance of personal attachment style to clinical practice, particularly in relation to the



associations between psychologist attachment style, compassion fatigue and compassion satisfaction found in the present study and the associations between therapist attachment style and therapeutic outcome outlined by previous research.

***Exploring qualitative experiences of managing negative feelings that arise in relation to client work during therapy sessions.***

Previous research has indicated that with explicit attention and response to attachment issues and interpersonal reactions in therapy, attachment styles can be strengthened and changed over time (Schore, 2003). The difficulty of facilitating this process has been emphasised due to the need to compensate for the failures of other attachment figures (Dozier & Tyrrell, 1998). Moreover, Wilson and Lindy (1996) highlighted the personal challenges faced by therapists. These authors stated that no therapist is immune from spontaneous emotional responses, errors, or secondary traumatic stress when working with traumatic material, challenging relational processes or attachment disturbance.

The results of the present study are supportive of Wilson and Lindy's argument, as 100% of the sample reported experiencing negative feelings in relation to their clients during therapy sessions. These qualitative responses were analysed for differences in the strategies applied to manage these feelings. This explorative analysis indicated that psychologists within this sample often used multiple strategies. Due to the unique nature of therapeutic relationships (Winnicott, 1969) the application of these techniques will depend on the fluctuating needs of the patient and therapist. Therefore, the aim of this analysis was to identify the different strategies used rather than determine one single 'correct' strategy. The majority of the sample reported that they typically contained (77%) their own negative feelings that arise towards patients within sessions. 38% of the sample reported that they would share their experience with the patient and 26% reported using a self-protective action in the session. Self-protective actions reported included mindful breathing, self-regulation processes, self-monitoring, acceptance, blocking, mindfulness, positive self-talk, depersonalisation, surfing the wave of emotion and prayer.

Pearlman and Courtois (2005) outlined a relational treatment for patients who have experienced complex trauma, highlighting the benefits of maintaining firm, although not rigid, boundaries with patients in order to avoid attempts to make up for the fragmented or destructive attachment relationships they experienced in childhood. According to the authors, this involves therapist emotional availability and authenticity without over-disclosure or boundary violations. They also recommended that therapists maintain emotional equanimity and tolerance, and use awareness of their own emotional reactions as they work responsively to the patient's needs. They also describe the therapist's needs in terms of supportive strategies that aid their attachment awareness, affective attunement and competence to engage in relational repair in way that is suited to the unique therapeutic context.

***Exploring qualitative experiences of managing negative feelings that arise in relation to client work outside of therapy sessions.***

Just as negative feelings have been found to arise in relation to client work within sessions, it is also possible that these feelings can present outside of sessions. The results of the present study indicate that 97% of the sample did experience negative feelings in relation to client work outside of

sessions. Only 3% reported that this was not applicable for them. These findings are supportive of Figley's (2002) research, which suggested that the act of being compassionate and empathic extracts a cost under most circumstances. Figley theorised several contributing factors that can have a cumulative effect on increasing susceptibility to compassion fatigue in therapists. 'Empathic Response' is described as the effort to reduce the suffering of another through empathic understanding. In doing so, the therapist gains insight into the perspective of the client and may experience the emotions felt by the client. Similarly, 'Compassion Stress' is the residual emotional energy from an empathic response, combined with an on-going demand for action to relieve the suffering on the client. 'Traumatic Recollections' are memories of the therapist's experiences with the client that cause an emotional reaction. Each of these factors may be associated with experiencing negative feelings in relation to client work both during and outside of therapy sessions.

The majority of the sample that reported they did experience negative feelings outside of sessions also reported using multiple strategies to manage this experience. 83% of the sample reported using external support systems. This relates to Figley's research, which indicated that external support from colleagues, supervisors and social relationships unrelated to work were an important factor in reducing compassion fatigue. 48% used an independent problem solving strategy such as formulation, referring to theory and reflection on the case. These results may indicate that managing negative feelings and thinking about the client outside of session is considered a natural part of the process of therapy and can inform the therapeutic work. Furthermore, these results may indicate that the present sample view psychological formulation and supervision as suitable frameworks for developing understanding of these complex cases and processing the emotional consequences of this work. 20% of the sample reported completing an unrelated activity, such as exercise, socialising or distraction techniques. Figley's research also described the protective factor 'Disengagement', which was described as the ability of the therapist to distance themselves from the thoughts, feelings and sensations associated with therapy. The unrelated activities described by the present sample may be an indication of recognition for the need to 'disengage'. Figley considered disengagement as recognition on the part of the therapist of the importance of self-care. A further 15% reported using an internal cognitive coping strategy, such as mindfulness, acceptance, and objectivity to cope with negative feelings that arise in relation to client work outside of sessions. The results of a qualitative exploration of the self-care strategies used by psychologists in different situations will follow.

### ***Exploring qualitative self-care strategies utilised by psychologists in forensic settings within a range of situations.***

A qualitative content analysis was used in this study to present novel findings in relation to the different strategies applied by psychologists in their direct therapeutic work, during the workday and outside of work. Whilst a wealth of research has evolved in the area of therapist self-care, the quantitative measurement of this topic is limited to one self-report questionnaire developed by Mahoney (Previous Year Self-Care Patterns 10-item subscale; 1997). In Mahoney's study of psychotherapist's personal problems and self-care patterns, the author reports the limitations of the Previous Year Self-Care subscale. The brief nature of the questionnaire limits reports of self-care to a few specific activities, it also does not explore the therapist's use of self-care in different situations. Therefore, a qualitative approach to exploring self-care was applied in the current study, as this approach could provide richer information regarding the self-care strategies used and be more

sensitive to the differences in self-care used within direct therapeutic work, during the workday and outside of work.

Norcross and Barnett (2008) provided a review of their research and recommendations regarding therapist self-care. These authors highlighted the importance of self-care from an ethical perspective, reporting that activities of self-care are an ethical responsibility in order to effectively implement the psychological care of others. They argue that psychologists often view self-care positively, are aware of its benefits, and recommend it to their clients. However, the demands of this multi-tasking profession restrict the time available within the workday to utilise self-care and psychologists often inappropriately learn that taking time to nourish themselves is 'selfish'. Furthermore, the fatigue caused by this work can limit energy resources for self-care outside of work. However, the present findings suggest that self-care is seen as valuable within this sample and may also contribute to the finding that the majority of this sample show good compassion satisfaction, despite a stressful work context.

***Exploring qualitative self-care strategies utilised by psychologists in forensic settings in their direct therapeutic work.***

The majority of the present sample (97%) described using self-care within their direct therapeutic work. Only 3% of the present sample reported that they made no conscious effort towards self-care within their direct therapeutic work. However, it is possible that these participants are utilising strategies similar to those described below, without labelling this as self-care.

The present sample most frequently reported using support seeking (52%) as a self-care strategy in their direct therapeutic work. This included immediate debrief after therapeutic sessions, informal discussion with colleagues and more formal supervision sessions. This result is in line with the recommendation by Pearlman and Courtois (2005) for all therapists who are exposed to challenging traumatic material to have frequent supervision for this work.

49% of the sample also reported that management of the therapeutic relationship directly supported their own self-care. For example, agreeing therapeutic boundaries, terminating the session if required, having clear therapeutic goals, and discussing issues with the patient. Pearlman and Courtois also highlight that patients who have experienced trauma or who have insecure attachment styles are more likely to engage in risk-taking behaviour in sessions, have disjointed effect, experience re-victimisation and make attempts both conscious and 'unconscious' to prompt rejection from the therapist. They recommend using awareness of 'countertransference' responses to support patient understanding. However, the current results may suggest that management of the therapeutic relationship is also a perceived by participating psychologists as being supportive of their self-care.

35% of the sample reported using an internal coping strategy in their direct therapeutic work such as depersonalisation, acceptance, or anxiety management techniques. This indicates that psychologists are using active strategies within sessions to support their own self-care.

22% reported that personal organisation supported their self-care, for example arranging sessions at set times, managing the number of sessions in a day to allow for breaks, and having shorter session times if appropriate. Veron and Saias (2013) noted that of their sample of French psychologists the preferred self-care strategy was to 'lighten their schedules. However, in the analysis of the present data the theme 'organisation' more appropriately described the considered planning of session times.

Finally, 6% of the sample considered environmental security an important factor, such as using personal alarms and having additional staff accompaniment in sessions. In many forensic settings this is mandatory practice and may not have been a consideration for participants in relation to their personal self-care activities, however physical security is particularly relevant within this field.

***Exploring qualitative self-care strategies utilised by psychologists in forensic settings during the workday.***

100% of the sample reported using self-care strategies during the workday. Good compliance of this sample with self-care practice indicates the importance of this as an issue for this sample. Support seeking (35%) was prioritised within this sample in relation to self-care during the workday. This included planned and emergency supervision sessions, supervision groups and informal support from colleagues. Similarly, Veron and Saias (2013) reported that the preferred self-care strategies of a sample of French clinical psychologists involve seeking support from others, including speaking with colleagues and supervision. Pearlman and Courtois (2005) also emphasised the importance of frequent supervision that is trauma-sensitive, for all therapists at every level of experience. These researchers reported that the quality of the supervision relationship must be considered, as it needs to be safe and supportive enough to explore 'countertransference' responses without causing harm to the patient or therapist.

30% of the sample reported using a non-work related activity to attend to their personal wellbeing. This included eating and drinking, exercise, general conversation with colleagues, listening to music and leaving the building or ward area. A further 18% reported using an internal coping style such as compartmentalising, avoiding rumination, intellectual preparation and self-compassion. Finally, 17% considered workload management important in supporting their self-care during the workday. This included a combination of reducing workload when needed, but also in contrast keeping busy as a method of coping with emotional stress. It also included practical activities such as maintaining an up to date timetable and to do list and planning time in the day to write up notes.

It was apparent from the present sample that some essential self-care activities, such as eating and drinking, and work activities central to the role, such as therapeutic note and diary keeping, required intentional effort and protected time to ensure that they could be completed despite workload pressures. This indicates a need for forensic services in the United Kingdom to safeguard these protective strategies at a time when forensic healthcare professionals are under increasing pressure from excessive workloads (Coffey & Coleman, 2001).

***Exploring qualitative self-care strategies utilised by psychologists in forensic settings outside of work.***

97% of the present sample reported using self-care strategies outside of work. Only 3% of the sample reported that this issue was not applicable to them and that they did not use self-care outside of work.

The qualitative content analysis of self-care strategies used outside of work indicated that relationships (61%), such as spending time with family members and friends were viewed as an important factor in supporting self-care. Maintaining mental wellbeing (59%) using strategies such as detaching from work whilst at home, switching-off, using mindfulness and also viewing work as fulfilling were also frequently reported within the sample. 49% of the sample reported using play activities, such as hobbies, holidays and watching television as beneficial to their self-care outside of work. 41% also reported looking after their body, by using exercise, eating well, maintaining good sleep hygiene and using alcohol in moderation. A further 9% reported self-development activities, such as personal therapy, personal goals and cultural endeavours as important to their self-care outside of work.

This range of activities associated with being supportive of self-care by the present sample, reflects the significance of placing focus on broad strategies and having a multitude of skills, rather than focusing on one particular strategy (Norcross, 2000). Norcross and Barnett (2008) described twelve aspects of self-care. These were: valuing the person of the psychotherapist, refocusing on the rewards, recognising the hazards, minding the body, nurturing relationships, setting boundaries, restructuring cognitions, sustaining healthy escapes, creating a flourishing environment, undergoing personal therapy, cultivating spirituality and mission and fostering creativity and growth. It is apparent from the present qualitative content analysis that certain activities are preferred in all situations, such as support seeking. However, as recommended by Norcross and Barnett (2008), participants typically reported using an array of self-care strategies in different situations. Furthermore, all of Norcross and Barnett's suggestions were being utilised across the sample, apart from one aspect of the strategy 'creating a flourishing environment' that included enhancing workplace comfort and aesthetics. This may be related to the restrictions within the forensic environment prohibiting workplace personalisation, or that the present sample did not consider this a self-care activity. However, it may also highlight a need for services to pay attention to creating a safe, effective and comfortable working environment for the protective benefits of their staff.

***Exploring qualitative similarities and differences in experiences of managing negative feelings that arise in relation to client work between different attachment styles.***

The present study used a qualitative content analysis to explore the responses to negative feelings and self-care strategies employed by psychologists with different attachment styles. The attachment style groups included participants that had been identified as the most 'extreme' cases within the sample based on the results of the Experience in Close Relationships Questionnaire. However, the limitations of this process and small group sizes will be described in the methodological considerations section below.

***Exploring qualitative similarities and differences in experiences of managing negative feelings that arise in relation to client work between different attachment styles during therapy sessions.***

Mikulincer et al (2013), suggested that the therapist's attachment orientation can impact therapeutic processes. They suggest that a Secure therapist should find it easier to occupy the role of security provider than a therapist with an insecure attachment style, whose contributions to the therapeutic relationship may complicate therapeutic processes. However, the present study supports previous research (Rizq & Target, 2010) demonstrating that psychologists have varying attachment styles. Therefore, it is relevant to explore how psychologists' different attachment styles may influence therapeutic processes.

The debate regarding whether attachment style responses are activated when the individual is threatened or stressed, or whether attachment style is a general interpersonal asset continues (Roisman et al, 2007; Baldwin & Fehr, 1995). Therefore, the present study requested that participants consider occasions when they have experienced negative feelings in relation to their clients, as this may provide insight into their attachment related responses.

All four attachment categories reported having a mindful awareness or recognising these feelings as they arise. However, the Fearful group reported increased focus on their own negative feelings compared to the other attachment groups, including vigilance for their negative responses. This finding may be consistent with a higher report of attachment related anxiety within this group on the ECR. Furthermore, this may indicate an attempt to pre-empt attachment system activation so that the associated emotional responses can be 'down-regulated' (Bartholomew & Horowitz, 1991). This finding may indicate a need for self-care and support to be tailored for the needs of this attachment group. For example, including strategies that promote acceptance of negative experiences (Wise, Hersh & Gibson, 2012) such as mindfulness.

Both the Secure and Preoccupied groups reported using these feelings to develop the patient. Interestingly, according to Bartholomew and Horowitz (1991) both of these groups tended to have a positive model of others. Therefore, in the therapeutic relationship it is possible that the psychologists in the present sample notice their own negative response and interpret this as an opportunity to support the patient with correction of a maladaptive behaviour. In contrast the Fearful group, who Bartholomew and Horowitz report to have negative views of the self and other, reported using these feelings as a prompt to adapt themselves and their approach.

Finally, the Dismissing group tended to report using boundary management in response to their own negative feelings in sessions. This may reflect this group's negative model of others and positive model of the self (Bartholomew & Horowitz's, 1991). If so, this may indicate that the Dismissing group interpret their negative feelings as a response to the patient's attempts to cross therapeutic boundaries.

The small sample groups within the present study limit the generalizability of these findings. This issue will be discussed further in the methodological consideration section below.

However, the differences outlined between the attachment groups appear to be particularly apparent in direct therapeutic work contexts. Therefore, it may be beneficial for future research to focus on differential attachment activations and explore whether the current findings can be replicated using observational methods.

***Exploring qualitative similarities and differences in experiences of managing negative feelings that arise in relation to client work between different attachment styles outside of therapy sessions.***

Each of the four attachment style groups reported using support seeking outside to manage negative feelings that arise in relation to their clients outside of sessions. This is in contrast to the literature highlighting the differences in support seeking between different attachment styles (Bartholomew & Horowitz, 1991). For example Bartholomew and Horowitz argue that individuals with Fearful or Dismissing attachment styles have a negative view of others, which increases the tendency to prioritise self-reliance and not turning to others when in need. It is possible that the results of the present study indicate that psychologists develop adaptive coping strategies to overcome these tendencies. Furthermore, generic training currently prioritises the need for external support and this may over-ride individual attachment style tendencies. Alternatively, the 'extreme' attachment cases identified within the present sample may not meet Bartholomew and Horowitz's criteria. This will be discussed further in the methodological considerations section below.

***Exploring qualitative similarities and differences in self-care strategies utilised by psychologists in forensic settings within a range of situations between different attachment styles.***

A qualitative content analysis was also used to explore the reports of self-care used by psychologists in each of the four attachment style categories. The aim of using this approach was to highlight novel links between attachment style and preferred self-care strategies used.

***Exploring qualitative similarities and differences in self-care strategies utilised by psychologists with different attachment styles in their direct therapeutic work.***

All attachment style groups reported using support seeking and managing the therapeutic relationship to support their own self-care in their direct therapeutic work. This suggests that attachment style did not influence use of these strategies. However, one key difference was the tendency for the Fearful group to focus on emotional self-management. Similarly to above, these results may provide further evidence that individuals with a Fearful attachment style attempt to 'down-regulate' their attachment system to minimise need for support seeking (Bartholomew & Horowitz, 1991). It is possible that this is an adaptive method used by this group to manage the increased anxiety experienced. However, it is unclear whether the 'down-regulating' reported leads to avoidance of certain emotional experiences, reducing opportunities to seek support from others or alter the dynamics within their therapeutic relationships.

***Exploring qualitative similarities and differences in self-care strategies utilised by psychologists with different attachment styles during the workday.***

The results of the qualitative analysis indicated further homogeneity of themes in self-care identified between attachment style groups as being used during the work day. All four groups reported using support seeking, mental coping strategies and attending to their physical self-care. These results may suggest that differences between psychologists' coping styles are less apparent outside of situations, such as direct therapeutic work, where attachment system activation is more likely. It may also be evidence to suggest that psychologists develop adaptive self-care strategies to support them during their working day regardless of their attachment style.

***Exploring qualitative similarities and differences in self-care strategies utilised by psychologists with different attachment styles outside of work.***

Further homogeneity of themes was noted in relation to self-care used outside of work. All groups reported using detachment as a priority outside of work. This finding supports the research of Figley (2002) which described the protective factor 'Disengagement' as the ability of the therapist to distance themselves from the thoughts, feelings and sensations associated with therapy. It is apparent from this analysis that within the current sample this need for disengagement is recognised by psychologists regardless of attachment style.

***Exploring psychologists' views of the relevance of self-care to clinical practice.***

The results of the present study indicate that 98% of the sample reportedly used self-care strategies. Only 2% reported that they believed self-care was not relevant to their clinical practice. This is further indication that self-care is prioritised by the majority of the present sample. This may be further evidence that the self-selecting sample created a bias towards those who use self-care and generalizability issues will be discussed further in the methodological consideration section below.

Many participants elaborated on their experience of using self-care. 65% of the sample considered self-care to be important to their clinical practice. This is in agreement with research such as Norcross and Barnett (2008) which refers to the ethical imperative of self-care when providing psychological support for others.

47% described needing to apply effort to use self-care strategies. In contrast 39% of the sample reported that self-care occurred naturally. This divide in opinion within the sample may be indicative of a lack of training in the subject of self-care. Similarly, 44% of the sample described learning self-care skills over time throughout their career. Whilst learning through experience is to be expected, it may also highlight a trial and error approach to self-care at an individual level. This may mean that those early in their career are vulnerable to lack of experience in self-care. Furthermore, individuals who are unable to develop these skills independently may experience burnout or choose to leave the field of forensic psychology due to consistent exposure to disturbing social issues, challenging behaviours, severe and enduring mental health issues and personality disorders (Elliott & Daley, 2013). Therefore, the present study may highlight the need for self-care to be prioritised as a crucial developmental focus throughout psychology training and beyond.



## **Implications of the present study**

The clinical implications of the current study are presented below. These should be interpreted in combination with the methodological considerations of the study which will be presented in the following section.

Psychologists have varying attachment styles and degrees of attachment related anxiety and avoidance and approximately one third do not meet the criteria for a Secure attachment style categorisation. Previous literature has debated the benefits of securely attached therapists, associating a secure attachment with the ability to mentalise (Fonagy & Target, 1996). However, Pearlman and Courtois (2005) highlight that it cannot be assumed that patients with insecure attachment styles will respond positively to a Secure therapist. They argue that the therapist's reliability and consistency can paradoxically be threatening or incomprehensible rather than comforting to patients with insecure attachment styles. Moreover, Tyrrell et al (1999) noted that patient attachment styles may be complimented by different psychologist attachment styles. Therefore, though it was not in the scope of the present study to investigate patient experience and outcome, the present research can contribute to the debate highlighting individual differences between psychologists, including diversity and variation of attachment styles. Furthermore, this research does not support a preference towards a secure attachment style over insecure styles amongst psychologists. Rather, similarly to Rizq and Target (2010), this study highlights the potential advantages of improved understanding of attachment theory and attempts to highlight that this is less about 'boxing' individuals into categories and more about understanding how attachment style may guide psychologists' experiences and therapeutic processes.

Compassion fatigue was not found to be as prevalent as suggested by previous research. In contrast, compassion satisfaction was found to be common. These results suggest that there may be personal benefits to working within the forensic setting. Though this research does not dispute the challenges that are common within the forensic environment, it does suggest that the participating psychologists have developed suitable and effective ways of coping with these challenges. It may also suggest that psychologists are in a position to disseminate their knowledge and experience of these coping skills to professionals of other disciplines.

The present study highlighted a potential vulnerability for psychologists with insecure attachment styles. This research suggests that these psychologists may perhaps be more likely to experience burnout. Furthermore, participating psychologists with anxious attachment styles were also less likely to experience compassion satisfaction. These results suggest that it is relevant for psychologists to have knowledge of their attachment style, using up-to-date measures, so that individuals who are more prone to burnout or less prone to compassion satisfaction can make informed decisions about their self-care and opportunities to seek enjoyment from their work. Furthermore, for services to be made aware of the variety of attachment styles amongst psychologists and for self-care and support provision to be adapted appropriately. Thus, training facilities as well as services thereafter may need to focus on developing personal insights around attachment styles and ways of working, with a view to supporting a variety of styles and approaches, in the interests of maximising both reflexive working and self-care. Similarly, White (1997) proposed that individual differences between therapists are often disqualified or displaced in the process of developing expert knowledge within the professional role. White (1997) argued that this may lead

to 'thin descriptions' of aspects of therapists' lives that may be beneficial to their therapeutic work and act as a protective factor against burnout. From a Narrative perspective, White suggests that 're-membering' practices may support therapists to explore and incorporate their significant historical and relational experiences and aspects of their personal identity into their work and lives more generally.

Furthermore, not all psychologists within the present study believed that their attachment styles were relevant to their clinical practice. Despite previous research regarding the impact of psychologist attachment style on the therapeutic relationship (Mikulincer et al, 2013) and the present study suggesting that insecure attachment styles may be more vulnerable to burnout, it is apparent that there is a lack of knowledge and understanding of attachment theory and how this applies to clinical work. Therefore, a key implication of the present study is the development of training for psychologists in relation to this topic.

This research highlighted that it is common for psychologists working in forensic settings to experience negative feelings as a consequence of their client work both during and outside of therapy sessions. This may highlight a need for psychologists to be aware of the strategies they can use to manage these feelings so that they don't cause longer term emotional disturbance. Within the present study, psychologists in forensic settings reported using a range of self-care strategies during their direct therapeutic work, during the work day and outside of work. Of primary importance was regular supervision and informal or formal peer support from colleagues when at work, and the maintenance of family or social relationships outside of work. However, as recommended by Norcross and Barnett (2008) the present sample reported benefiting from utilising multiple strategies that were appropriate to each situation and that supported self-care from a holistic perspective. As this sample reported low levels of compassion fatigue it may be beneficial for the theorising of Norcross and Barnett to be widely distributed amongst psychologists in forensic settings. Furthermore, the present study found that psychologists with different attachment styles did report differences in how they managed negative feelings during therapy sessions. Therefore, supervisory attention towards active therapeutic work may need to be particularly focused and sensitive, and perhaps form an integral part of what is covered during supervision. Moreover, the ethical imperative for psychologist self-care and understanding of attachment style for the improvement of psychologist experience and responsive psychological services for patients is supported.

Psychologists working in forensic settings did perceive self-care to be important to their clinical practice. However, how they developed and used self-care skills appeared to vary. This suggests that there is a training need for skills to be both taught and shared early in the psychologists' career. No significant differences in compassion fatigue were noted regardless of psychologist experience. Therefore, it may also be beneficial for self-care to be more widely supported at an organisational level, so that psychologists are being supported to benefit from implementing self-care strategies regardless of stage of career, as self-care is seen as an essential set of skills required throughout the lifespan of psychologists.

## Methodological considerations

Several methodological limitations have been highlighted throughout the present research. The key considerations, rather than a definitive list, are described in more detail below.

The sample size met Cohen's (1992) recommendation for a moderate effect size in relation to the quantitative measures used. However, in comparison to previous research (Elliott & Daley, 2013) the sample size was relatively small, and perhaps lacked demographic variety. The sample distribution was also skewed, in terms of attachment style security and levels of compassion fatigue. The limited distribution of participants within the insecure attachment categories also detrimentally impacted the statistical analysis, particularly between group comparisons. The decision was made that it was not valid to amalgamate the two smallest groups, Fearful (n=4) and Preoccupied (n=5), due to their theoretical distinction and the further limitations this would have incurred upon the interpretation of results. Non-parametric Mann-Whitney U and Kruskal-Wallis tests were completed to demonstrate the potential for group differences and to outline a possible methodological approach for future research. The results of the present study, though indicating the potential for interesting attachment style group differences, should be interpreted with caution due to these limited group sizes.

It is proposed that the sampling procedure may perhaps have been limited in its ability to accumulate a representative sample. It is possible that the opportunity to complete a questionnaire about attachment style would cause apprehension in individuals who are experiencing high attachment anxiety or avoidance. Similarly, it may not have been appealing for psychologists to complete a questionnaire on self-care if they were experiencing secondary traumatic stress, burnout or simply did not have time to dedicate to research due to experiencing high pressure at work or high workload. Incentivising participation with entry into a prize draw may also not have been enough to gain participation from those individuals.

The use of a mixed methodology was both a strength and a weakness in the present study. This research was largely explorative and the mixed methodology permitted investigation of quantitative measures of attachment style and compassion fatigue and satisfaction alongside qualitative self-reports of self-care. Whilst this methodology provided novel findings it is limited in its ability to establish causal relationships between variables. However, Morgan (2014) highlighted the benefits of using mixed methodology and the ability for research to justify this approach based on the increasing attempts to standardise and improve rigour in mixed methodology studies. However, Morgan also recommends using research methods that been mastered by the researchers, or working in teams to ensure that there is expertise in both quantitative and qualitative aspects of the research. Due to the requirement for the present research to demonstrate an individual achievement in part-submission for a doctoral qualification in clinical psychology it was not possible to work in a research team. However, expertise for both qualitative and quantitative methodology was sought from the project supervisor and clinical course team statistics and research methods expert.

The process of selecting 'extreme' cases of attachment style was based on the methodology of Fraley et al (2000). However, those authors also highlighted the limitations of categorising individuals based on attachment style (Roisman et al, 2007), as this reduces the precision of the measurement and lowers statistical power. Despite this warning those authors suggest that there are good and bad ways of making these categorisations and recommend that a preferred way of assigning individuals is by using the median scores of the sample to identify high and low attachment anxiety and avoidance. In this case, due to the skewed distribution towards low attachment anxiety and avoidance in the sample this would not have provided a reliable categorisation. Therefore, in the present study, the general population means were used to identify 'extreme' cases. This process identified that only a small selection of participants could be categorised in each of the insecure attachment styles. Furthermore, these cases were less 'extreme' in terms of their variation from the mean, than the cases identified as Secure, which demonstrated very low attachment anxiety and avoidance compared to the general population means.

It was also not possible from the present study to ascertain whether the psychologist's therapeutic relationships with patients involved an attachment bond (Mikulincer et al, 2013). Although, participating psychologists had practiced for over a year in the field and facilitated both individual and group therapy, the present study did not directly examine therapeutic relationships but self-reports around these and therefore cannot infer much about the nature of the actual therapeutic bonds obtained.

## **Self-reflections**

Researcher self-reflections on stance are regarded an important aspect in terms of quality assurance in qualitative studies (Pluye et al, 2009). Ownership over reflexive stance is also perceived as relevant to the research process by this author. Therefore, this section will identify the key issues faced by the researcher in relation to researcher stance. This is not to suggest that only these issues were impacted by researcher stance and it is likely that other influences to the research decision making process did occur. However, the purpose of this section is to demonstrate that the researcher remained conscious to these influences and attempted to limit the influences of personal beliefs on the study outcomes.

Early in the process of qualitative data analysis it became apparent that a purely inductive approach was not possible as the researcher's knowledge of theories was creating a deductive influence in the analysis. Therefore, it was decided that a mixed inductive and deductive approach would be used both to generate novel theory and compare and contrast the data to previous theories in this area, which due to the methodological limitations described above, have yet to be rigorously tested (Boyatzis, 1998).

The selection of a topic related to attachment theory also suggests an ideological preference for this perspective on behalf of the researcher. Therefore, care was taken, particularly in the analysis of between attachment style group data, to remain closely aligned to the data. The methodological quality assurance processes used also supported researcher neutrality and ensured that the approaches used were appropriate, rigorous and inter-rater reliability checked.

## **Areas for future research**

The limitations of the sampling procedure used within the present study have been highlighted. Therefore future research in this area may benefit from additional attempts to encourage wider demographic variance. Furthermore, it may be beneficial to target individuals who may be struggling with self-care or compassion fatigue. One possible approach would be to use a forced-entry screening and selection process rather than use a self-selecting sample. However, the ethical implications of this approach would need to be justified.

When reviewing the results of the present study it is relevant to consider the low levels of secondary traumatic stress and burnout reported by the sample. It is possible that the high levels of self-care qualitatively reported are associated with the low levels of compassion fatigue quantitatively reported. However, it is not possible to identify a causal relationship between self-care and low burnout and secondary traumatic stress within this study, due to the lack of appropriate quantitative measure of self-care and the cross-sectional nature of the study design. It is hoped that the present study could provide a basis for the development of a more detailed self-care measure. The development of a broader measure of self-care would allow the relationship between self-care and compassion fatigue to be effectively quantified in future.

## **Conclusion**

The present study explored the attachment style, compassion fatigue and satisfaction and self-care strategies used by psychologists currently working in forensic settings in the UK. This largely explorative research highlighted a number of findings including the low prevalence of compassion fatigue, high levels of compassion satisfaction and the variance in attachment styles within the sample. A recommendation for use of caution when interpreting the results of the present study was made due to a number of methodological limitations. However, clinical implications of the research were identified and recommendations were made regarding improved training in respect of personal attachment style and self-care when working as a psychologist in a forensic setting. Furthermore, potential was identified for these skills to be shared by psychologists with professionals from other disciplines working in the field. Finally, recommendations for further research included using the qualitative data within the present study to inform the development of a quantitative measure of professional self-care.

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## Appendices

### Appendix 1: Complete survey including, participant information, consent and debrief pages.

**Project Title: Exploring therapist attachment style and associated self-care of Psychologists in forensic settings.**

**If you agree to take part in this study, you will be asked to complete a brief survey about your own attachment style and the strategies of self-care you use in relation to your work (as a Clinical or Forensic Psychologist in a forensic setting).**

**It is expected that *this survey will take up to 20 minutes to complete.***

***Please note that any information you provide will remain both confidential and anonymous and will only be used for the purposes outlined here. Participation in the study is voluntary and you may withdraw your assistance without explanation at any time if you wish. By taking part in this survey you are consenting for the information you provide to be used for this research project.***

***As a thank you for your participation, you will be entered in to a prize draw for £100*** after the survey closing date. This prize will be randomly allocated and the winner will be informed via email. The survey responses you have provided will not be linked to the email address provided by you. All information provided in the survey is anonymous. Your email address will only be used to inform you if you are the winner of the prize draw, and if you choose, to send you a summary of the research outcomes.

I consent to participate in this research.

I do not consent. I would not like to participate in this study.

Thank you for your participation.

You may use the Researcher's email address below should any queries or concerns arise.

Researcher:

Sophia Collins, sophia.collins@hotmail.co.uk

Third year Trainee Clinical Psychologist from the University of Hertfordshire.

Supervisor:

Nick Wood, n.1.wood@herts.ac.uk

This study has been approved by the University of Hertfordshire School of Psychology Ethics Committee.

Registration Protocol Number: LMS/PG/UH/00124

**Please confirm that you are a Clinical or Forensic Psychologist, currently working in a forensic setting in the UK.**

- YES, I am a **CLINICAL** Psychologist currently working in a forensic setting in the UK.
- YES, I am a **FORENSIC** Psychologist currently working in a forensic setting in the UK.
- YES, I am a **Trainee CLINICAL Psychologist** currently working in a Forensic setting in the UK.
- YES, I am a **Trainee FORENSIC Psychologist** currently working within a Forensic setting in the UK.
- YES, I am an **Assistant Psychologist** currently working in a Forensic setting in the UK.
- NO, I am NOT a Clinical/Forensic Psychologist or an Assistant or Trainee Clinical/Forensic Psychologist currently working in a forensic setting in the UK.

**Have you developed therapeutic relationships in your work in a forensic setting? Please select all that apply to you.**

- YES, I have facilitated individual therapy
- YES, I have facilitated group therapy
- YES, I have provided psychological support to a patient over multiple meetings
- YES, I have provided social support to a patient over multiple meetings
- NO, I have not developed therapeutic relationships (I do not work therapeutically with a patient over multiple meetings)
- Other / I'm unsure (please describe)

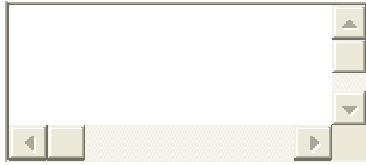
**What is your gender?**

- Male
- Female

**What is your age range?**

- 18-25
- 26-35
- 36-45
- 46-55
- 56-65
- 65+

**Please use the space below to describe your ethnicity and/or cultural background.**



**How much experience do you have working in a forensic setting?**

- 0-3 months
- 3-6 months
- 6 months- 1 year
- 1 - 3 years
- Over 3 years

**How many years post-qualification are you?**

- I am pre-qualification (Assistant or Trainee)
- Less than 5 years
- 5-10 years
- 10-20 years
- 20-30 years
- Over 30 years





**Style C**

I want to be completely emotionally intimate with others, but I often find that others are reluctant to get as close as I would like. I am uncomfortable being without close relationships, but I sometimes worry that others don't value me as much as I value them.

1	2	3	4	5	6	7
Disagree Strongly			Neutral/Mixed		Agree Strongly	

**Style D**

I am comfortable without close emotional relationships. It is very important to me to feel independent and self-sufficient, and I prefer not to depend on others or have others depend on me.

1	2	3	4	5	6	7
Disagree Strongly			Neutral/Mixed		Agree Strongly	

### The Experiences In Close Relationships Revised Questionnaire (Fraley et al, 2000)

The statements below concern how you feel in emotionally intimate relationships. We are interested in how you *generally* experience relationships, not just in what is happening in a current relationship. Respond to each statement by indicating how much you agree or disagree with the statement.

(strongly disagree 1 < 2 < 3 < 4 > 5 > 6 > 7 strongly agree)

29. It helps to turn to my romantic partner in times of need.

30. I tell my partner just about everything.

31. I talk things over with my partner.

24. I prefer not to be too close to romantic partners.

4. I worry that romantic partners won't care about me as much as I care about them.

18. My partner only seems to notice me when I'm angry.

19. I prefer not to show a partner how I feel deep down.

20. I feel comfortable sharing my private thoughts and feelings with my partner.

5. I often wish that my partner's feelings for me were as strong as my feelings for him or her.

32. I am nervous when partners get too close to me.

6. I worry a lot about my relationships.

7. When my partner is out of sight, I worry that he or she might become interested in someone else.

8. When I show my feelings for romantic partners, I'm afraid they will not feel the same about me.

15. I'm afraid that once a romantic partner gets to know me, he or she won't like who I really am.

16. It makes me mad that I don't get the affection and support I need from my partner.

17. I worry that I won't measure up to other people.

1. I'm afraid that I will lose my partner's love.
2. I often worry that my partner will not want to stay with me.
3. I often worry that my partner doesn't really love me.
9. I rarely worry about my partner leaving me.
10. My romantic partner makes me doubt myself.
11. I do not often worry about being abandoned.
21. I find it difficult to allow myself to depend on romantic partners.
22. I am very comfortable being close to romantic partners.
23. I don't feel comfortable opening up to romantic partners.
12. I find that my partner(s) don't want to get as close as I would like.
13. Sometimes romantic partners change their feelings about me for no apparent reason.
14. My desire to be very close sometimes scares people away.
25. I get uncomfortable when a romantic partner wants to be very close.
33. I feel comfortable depending on romantic partners.
34. I find it easy to depend on romantic partners.
35. It's easy for me to be affectionate with my partner.
36. My partner really understands me and my needs.
26. I find it relatively easy to get close to my partner.
27. It's not difficult for me to get close to my partner.
28. I usually discuss my problems and concerns with my partner.

### **The Professional Quality of Life Scale (Stamm, 2012)**

**When you work therapeutically with people you have direct contact with their lives. As you may have found, your compassion for those you help can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a Psychologist.**

**Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things *in the last 30 days*.**

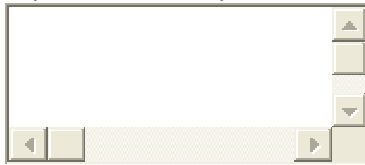
**1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often**

1. I am happy.
2. I am preoccupied with more than one person I work therapeutically with.
3. I get satisfaction from being able to work therapeutically with people.
4. I feel connected to others.
5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working therapeutically with those I help.
7. I find it difficult to separate my personal life from my life as a Psychologist.
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I work with therapeutically.
9. I think that I might have been affected by the traumatic stress of those I work with therapeutically.
10. I feel trapped by my job as a Psychologist.
11. Because of my therapeutic work, I have felt "on edge" about various things.
12. I like my work as a Psychologist
13. I feel depressed because of the traumatic experiences of the people I work with therapeutically.
14. I feel as though I am experiencing the trauma of someone I have worked with therapeutically.
15. I have beliefs that sustain me.
16. I am pleased with how I am able to keep up with psychological techniques and protocols.
17. I am the person I always wanted to be.

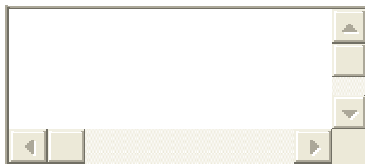
18. My work makes me feel satisfied.
19. I feel worn out because of my work as a Psychologist.
20. I have happy thoughts and feelings about those I work therapeutically with and how I could help them.
21. I feel overwhelmed because my case/work load seems endless.
22. I believe I can make a difference through my work.
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I work therapeutically with.
24. I am proud of what I can do to help.
25. As a result of my therapeutic work, I have intrusive, frightening thoughts.
26. I feel "bogged down" by the system.
27. I have thoughts that I am a "success" as a Psychologist.
28. I can't recall important parts of my work with trauma victims.
29. I am a very caring person.
30. I am happy that I chose to do this work.

What is your attachment style?

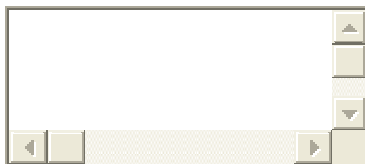
My attachment style is



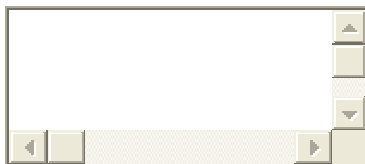
Do you regard your personal attachment style as relevant within your therapeutic relationships?  
Please explain why.



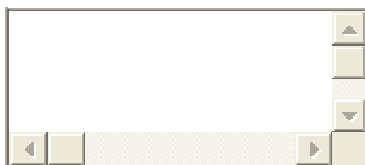
**During therapy sessions**, how do you manage negative feelings that may arise towards your clients in the moment?



**Outside of therapy sessions**, how do you manage negative feelings that may arise towards your clients?



What do you do **within your direct therapeutic work** that supports your own self-care (i.e. helps you to manage the impact of challenging therapeutic relationships)?



What do you do **within your general working day** that supports your own self-care (for example; that helps you to manage stress, fatigue, the impact of coping with potentially distressing information etc.)?

An empty rectangular text input box with a light beige background and a thin grey border. It features a vertical scrollbar on the right side and a horizontal scrollbar at the bottom.

How do you use self-care strategies **outside of work** to manage challenging or traumatising information that is disclosed to you as part of your work?

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Please describe how relevant self-care is to you in relation to your work as a Psychologist in a forensic setting (i.e. is it something you make a conscious effort to do, does it happen naturally, is it a skill you have learnt, do you consider it unimportant or irrelevant etc.)?

An empty rectangular text input box with a light beige background and a thin grey border. It features a vertical scrollbar on the right side and a horizontal scrollbar at the bottom.

## **DEBRIEF**

**Project Title: Exploring therapist attachment style and associated self-care of Psychologists in forensic settings.**

**Thank you for your participation in this study. The aims of this research are to explore Psychologists' view of their attachment style in the context of therapy and the therapeutic alliance in a forensic setting. It also aims to explore Psychologists' perspectives on self-care in relation to their attachment style.**

**As a thank you for your participation you will be included in a prize draw for £100. The winner will be randomly selected and informed via email after the survey closes.**

**The survey responses you have provided will not be linked to the email address provided by you. All information provided in the survey is anonymous. Your email address will only be used to inform you if you are the winner of the prize draw, and if you choose, to send you a summary of the research outcomes.**

**If you would like to be entered into this draw please provide your email address below.**

**Please state whether you would like the opportunity to receive a summary of the completed research project, which will incorporate the analysis of participants' reflections on self-care and may generate recommendations for self-care strategies, as well as further research ideas.**

- Yes, I would like to receive a summary of the final research project via email
- No thanks, I would not like to receive a summary of the final research project

If you have any further questions please contact the Researcher via the email address provided below.

**Thank you for participating in this study.**

**Researcher:**

Sophia Collins, sophia.collins@hotmail.co.uk

**Supervisor:**

Nick Wood, n.1.wood@herts.ac.uk



Appendix 2: Ethics Clearance

**UNIVERSITY OF HERTFORDSHIRE  
HEALTH AND HUMAN SCIENCES**

**M E M O R A N D U M**

**TO** Sophia Collins

**CC** Nick Wood

**FROM** Dr Richard Southern, Health and Human Sciences ECDA Chairman

**DATE** 19 August 2013

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Protocol number: LMS/PG/UH/00124

Title of study: Exploring therapist attachment style and associated self-care of Psychologists in forensic settings.

Your application for ethical approval has been accepted and approved by the ECDA for your school.

This approval is valid:

From: 19 August 2013

To: 31 December 2014

**Please note:**

**Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1. Should you amend any aspect of your research, or wish to apply for an extension to your study, you will need your supervisor's approval and must complete and submit form EC2. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1 may need to be completed prior to the study being undertaken.**

**UNIVERSITY OF HERTFORDSHIRE  
HEALTH & HUMAN SCIENCES  
ETHICS APPROVAL NOTIFICATION**

**TO** Sophia Collins  
CC Nick Wood

**FROM** Mr Fraser Heasman, Health and Human Sciences Vice Chairman  
**DATE** 15 May 2014

Protocol number: **aLMS/PG/UH/00124**

Title of study: Exploring therapist attachment style and associated self-care of Psychologists in forensic settings.

Your application to modify the existing protocol LMS/PG/UH/00124 as detailed below has been accepted and approved by the ECDA for your school.

Details of modification:

Participants to include psychologists in training and assistant psychologists working therapeutically in the forensic setting with supervision from a qualified psychologist.

No other changes. The support strategies outlined in the original application (Q12b, 15, 17) also apply to Assistant Psychologists and Trainee Clinical Psychologists. These participants will also have access to regular clinical supervision and the opportunity to seek support in relation to this research (including the issues of attachment style, therapeutic relationships and self-care) via their supervision or via contact with the researcher. They will also be prompted to towards seeking further support in the online debrief following survey completion. These participants will also be requested to confirm that they are currently working in a forensic setting with access to supervision prior to participation.

Reason for modification request:

To increase pool of participants and to broaden the 'voices' of survey responses to include people in training, who are often neglected or marginalised.

This approval is valid:

From: 15 May 2014

To: 31 December 2014

**Please note:**

**Any conditions relating to the original protocol approval remain and must be complied with. Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1 or as detailed in the EC2 request. Should you amend any further aspect of your research, or wish to apply for an extension to your study, you will need your supervisor's approval and must complete and submit a further EC2 request. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1 may need to be completed prior to the study being undertaken.**

**Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately. Failure to report adverse circumstance/s would be considered misconduct.**

**Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study. Students must include this Approval Notification with their submission.**

### Appendix 3: Attachment style group allocation based on qualitative self-reports .

Participants were allocated to attachment style groups, according to Bartholomew and Horowitz's (1991) four category model, based on their qualitative self-reports. It was apparent from the data that participants used varying constructs to describe their attachment styles. According to the literature, these constructs are not interchangeable (Roisman et al, 2007). However, participants have been allocated to the most appropriate group based on conceptual similarities in the constructs used. When participants provided more than one attachment style the primary style reported was accepted.

RQ Category	Qualitative Self-Report	Frequency	Percent
Secure	Secure	27	41
	Secure – anxious	18	27
	Secure – ambivalent	11	17
	<b>TOTAL: 56</b>	<b>85</b>	
Preoccupied		0	0
	<b>TOTAL: 0</b>	<b>0</b>	
Fearful	Anxious	2	3
	Anxious - ambivalent	1	1.5
	Ambivalent	1	1.5
	<b>TOTAL: 5</b>	<b>6</b>	
Dismissing	Dismissive - avoidant	3	4.5
	<b>TOTAL: 3</b>	<b>4.5</b>	
Unsure	Unsure	3	4.5
	<b>TOTAL: 3</b>	<b>4.5</b>	