

Striking a Balance; the Contribution of Forensic Psychotherapy to Imprisoned Women and their Environment

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ABSTRACT

In the UK forensic psychotherapy, with its roots in psychoanalytic thinking and practice, has developed mainly within the National Health System. Consequently its application and potential contribution to the treatment and care of imprisoned women is an under-investigated area. This paper describes characteristics of the population of women in prison, the extent of their health and social care needs and sets this against societal representations of women offenders. Dynamic psychotherapy in women's prisons must maintain an awareness of the women's issues and the social life of the prison. Drawing on work in the 2 largest women's prisons in the UK we focus on the contribution forensic psychotherapy, as one component of the health care service, can make to the care of these women and to their environment. We describe how the external world of the criminal justice system and prison environment and the internal world of the women can interact, either resonating with or habituating to each other. We propose that, when working to help imprisoned women understand their minds and the actions that flow from their psychic states, the forensic psychotherapist needs to strike a balance between helping patients integrate split off mental states and experiences that are traumatic while ensuring that these experiences do not overwhelm the mind of the patient, staff and institution. Copyright © 2015 John Wiley & Sons, Ltd.

Key words: women offenders, prison health care, forensic psychotherapy, psychodynamic psychotherapy, psychological interventions in prison

THE IMPORTANCE OF CARE IN PRISON

Population Issues

Worldwide, women comprise a significant minority of offenders in custodial conditions, between two and nine percent of the total prison population (Putkonen & Taylor, 2014) however their rates of imprisonment are rising faster than those of men (Walmsley, 2012).

In England and Wales, rates of imprisonment are high compared to other old European Union (EU) countries (Walmsley, 2003). The female prison population is currently c. 3941 versus 81,572 men (The Howard League for Penal Reform, 2014). These women are spread across 12 prisons currently and planned changes will reduce the number of sites further, relocating women to metropolitan areas of the country (Robinson, 2013). The number of women received into prison was 10,137 between July 2011 and June 2012 (Offender Management Statistics, 2013), per annum far more than the daily population; women both carry into prison their recent external life and depart with prison experiences, all within brief time frames. Women prisoners have complex family structures, many have dependent children; imprisonment long term or short term is disruptive of the care of children in a way that is different from male prisoners (Ministry of Justice, 2012).

Patterns of offending in women are different from men and this is reflected in the criminological characteristics of the prison population. In essence, women are less likely to commit serious violence and, if they do, this will be against people they know well and with whom they would be considered to have significant relationships i.e. partners, children (Flynn, Abel, While, Mehta, & Shaw, 2011). In 2005, women committed only six percent of murders, 1.5 percent of attempted murders, 16 percent of manslaughters and seven percent of woundings (Home Office, 2006). More recent figures show a broadly consistent figure across a decade where women account for c. 1 in 10 of all homicide convictions (Smith, Osborne, Lau, & Britton, 2012). The number of women either found guilty of sexual offences or imprisoned for them has been consistently small when compared with men, for example, in 2005 women were responsible for only 1.3 percent of sexual crime (Home Office, 2006), a figure that acquires greater importance when set in the context of poor detection and conviction rates for serious sexual violence against women (see Houston, 2009; Ministry of Justice, Home Office, & the Office for National Statistics [ONS], 2013). In the United States women and girls accounted for 26.2 percent of all arrests in 2012. However the trend in arrests over the previous 10 years showed a 2.9 percent increase in offences for this group, mainly accounted for by offences such as robbery, theft, property crime and driving under the influence (Federal Bureau of Investigation [FBI], 2012).

Health Problems in Women Prisoners

One of the challenges for health care in prisons generally and for dynamic psychotherapy in particular is the fact that periods of detention are mainly short; regardless of whether women are on remand or sentenced. Fewer than 500

women a year receive sentences longer than four years (Offender Management Statistics, 2013), a figure that is jurisdiction specific. Other countries, notably the United States, imprison women for longer periods of time (Subramanian & Shames, 2013; International Centre for Prison Studies, 2008) creating the quite different therapeutic challenges of hopelessness in an increasingly brutal prison system (Haney, 2008).

The other challenge for health care is the very high rates of physical and mental disorders in women reported internationally (Fazel & Baillargeon, 2011; Teplin, Abram, & McClelland, 1996) and in England and Wales (Singleton, Meltzer, Gatward, Coid, & Deasy, 1998; Plugge, Douglas, & Fitzpatrick, 2006). Many women prisoners will have complex and interrelated health problems. High rates of infectious disease and long-term conditions are complicated by poor access to care outside prison (Social Exclusion Unit, 2002). At the point of incarceration women will present with clearly interrelated problems some of which require urgent attention, e.g. acute withdrawal from alcohol and drugs of dependence and Hepatitis B and C. Psychiatric disorders are common. Robust studies are not as recent as is desirable but they give a sense of the scale of the population's difficulties. Teplin *et al.* (1996) reported rates of all psychiatric disorders, except schizophrenia, as higher than in the community. Singleton *et al.* (1998) reported higher rates of psychosis (14 percent) in both remanded and sentenced women than in either equivalent men or compared to rates for men and women in the community. The same study reported that approximately two in five women prisoners had alcohol problems and almost half were drug dependent. The Ministry of Justice (2013) reported high and similar rates of drug and alcohol use in male and female prisoners with women using more class A drugs, e.g. cocaine and heroin.

Singleton *et al.* (1998) found 50 percent of women had personality disorder. In women a diagnosis of personality disorder in prison has been associated with fire setting, self-harm and childhood abuse (Gorsuch, 1998; Coid, Wilkins, & Coid, 1999). Jenkins *et al.* (2005) report higher rates of suicidality in UK women prisoners compared with their male counterparts, with two in five women having made a suicide attempt at some point. Hassan *et al.*'s (2011) findings point towards continuing distress in women prisoners during the course of imprisonment. In the United States Chapman, Specht, and Cellucci (2005) linked suicide attempts to hopelessness, borderline personality disorder and a family history of suicide. Black *et al.* (2007) found that 54.5 percent of women prisoners in the United States met DSM-IV diagnostic criteria for borderline personality disorder, (American Psychiatric Association, 2000) more than twice that for men.

Social Problems in Women Prisoners

The degree and complexity of health problems must be seen in the context of both adverse early life experience in women who enter the criminal justices system and

poor educational and employment levels, whereby the limits created by trauma and neglect and lack of appropriate parenting permanently affect their life chances.

Consistent findings over time and across jurisdictions highlight high rates of childhood and adult victimization, sexual and physical, often linked with involvement in sex work, experience of the state care system as children, poor educational achievement and a lack of formal employment (McClellan, Farabee, & Crouch, 1997; Home Office, 1997; Peugh & Belenko, 1999; Plugge *et al.*, 2006, Home Office, 2007; Ministry of Justice, 2012). Peugh and Belenko (1999) report figures that women prisoners' rates of sexual and/or physical abuse were seven times that of equivalent men. This links with Teplin *et al.*'s (1996) finding of high rates of post-traumatic stress disorder (PTSD) in women in prison.

Half of women prisoners in the UK have dependent children less than 18 years old and half will live alone with their children pre-imprisonment. Disruption to the children's home circumstances and financial strain are two consequences of imprisonment for women (Ministry of Justice, 2012).

The criminological literature can fail to distinguish between social correlates and causes of crime. It is evident that the backgrounds of women offenders are characterized by a range of experiences that plausibly predispose someone to social deviance and potentially lawbreaking, even if there is doubt about the statistical significance of individual factors that are, in many cases, of long duration and contemporaneous, e.g. periods in the care system and school exclusion. It is also the case that women offenders are at a higher risk of many of these adverse childhood experiences than men. High rates of re-offending also suggest that maintenance of criminality should be considered as well as its origins. Social science can seem a blunt instrument for teasing out understanding of these complex interrelationships and both its findings and their inconclusive quality may appear banal. However, the difficulty of separating factors that impinge on social success and psychological well-being is of considerable conceptual importance and gender specific understandings of the interconnected role of substance misuse, sex work, and experience of violence are apparent in policy and academic literature (McClellan *et al.*, 1997).

Representations of Women and their Crimes

The literature on the real experiences and actual levels of criminality of women can seem at odds with representations in the media. It can be argued that the small number of women who commit serious crime have a higher chance than an equivalent man of becoming a household name. The UK media regularly award considerable coverage to women who kill or sexually abuse children, obscuring the usually minor nature of most female offending. Phrases like "baby-faced killer", "evil mother" are liberally scattered in the tabloid press. In

tandem with the denigration there is often a prior idealized representation (Morris & Carter, 2009) perhaps contributing to the strength of the swiftly following denigration. The very rare cases of women involved in the death of strangers or stranger children, e.g. Rosemary West or Myra Hindley, will be part of public discourse, their names and faces re-entering the media for years after imprisonment. The much larger number of men, whose actions were similar, disappear into obscurity.

Such cases have both a public representation in the external world but also a semi-public representation in the environment of the prison. Women who have harmed children will need protection in prison, as well as psychodynamic help. They embody the horror and sadness of such crimes, precisely because the victims are usually their own children. Such violence and killing is against the expectations of motherhood and of gender role more generally (Motz, 2001; Welldon, 1988). This is a challenge not only to the humanity of their fellow inmates but also to that of prison staff, both discipline and health care. The emotional state of the women concerned and the nature of these crimes can be profoundly distressing and take a great toll on staff if truly understood. To protect ourselves we can minimize their crimes. This invitation may arise, in part, from the splitting and projective process at play in the internal world of the woman herself, as will be illustrated in clinical vignettes, but may also come from within ourselves; such a defense may gain hold in the societal microcosm of the prison.

Health Service Systems in Women's Prisons: Integrated Psychotherapy?

The complex and interdependent health and social care needs of women outlined earlier has been historically poorly addressed by health services (HM Inspectorate of Prisons, 2005; Covington, 1998; Ford, Chang, Levine, & Zhang, 2013). It is only recently that health services in women's prisons have been seen as at all satisfactory (Care Quality Commission, 2013). Part of the improvement in the UK stems from a greater role of the National Health Service (NHS) in designing and delivering comprehensive care targeting both physical health (including sexual health) and mental health; supported by increased funding for services in the last decade. It is significant that psychological services have been seen to be of particular importance in women's prisons and there is a current debate about how best to use the insights derived from psychology and psychotherapy (Department of Health/National Offender Management Service, 2011; Bartlett *et al.*, 2015). Without doubt the patterns of morbidity in women offenders, with their high rates of enduring interpersonal problems and maladaptive coping strategies, suggest that psychological and psychotherapy services should constitute a significant component of the health care spend. It is for forensic psychotherapy, with its unique skills, to delineate the size and

character of its contribution for individual women and the wider prison system (Bartlett, 2011).

THE PSYCHODYNAMIC WORK OF FORENSIC PSYCHOTHERAPY IN PRISONS

Forensic Psychotherapy in Prisons; an Embryonic Development

In the UK forensic psychotherapy has developed mainly within the shelter of the NHS as opposed to the prison system and refers to the application of psychodynamic principles and treatment in the service of understanding and managing the forensic patient (Welldon, 1994; McGauley & Humphrey, 2003). The application of psychoanalytic and psychodynamic thinking and treatment in prisons remained sparse, with notable exceptions (Hinshelwood, 1993; Hobson, Shine, & Roberts, 2000), although this work was with male prisoners. It was not that the psychoanalytic understanding of women offenders languished. It was just that the careful assessment and treatment of these women often took place in the community or in forensic health care settings. Clinicians and authors have greatly extended psychoanalytic thinking providing a model of female perversion (Welldon, 1988, 1994) and the psychoanalytic mechanisms underlying women's crimes of violence towards their partners or their children (Welldon, 1996; Motz, 2001).

Within the UK and North American prisons treatment programs for women have mainly drawn on cognitive behavioral principles and knowledge of criminogenic factors and focused on harm-reduction related to specific behaviors such as addictions and sexual offending (Najavits, Weiss, Shaw, & Muenz, 1998; Zlotnick, Najavits, Rohsenow, & Johnson, 2003; Zlotnick, Johnson, & Najavits, 2009; Sacks *et al.*, 2012). Arguably, two UK policy initiatives have unlocked some prison doors allowing the application of psychoanalytic thinking and psychodynamic treatment to cross over into women's prisons. In April 2003 prison health care became part of the NHS and funding transferred from the Home Office to the Department of Health and in 2007 Baroness Corston argued that equal outcomes for women required different approaches (Home Office, 2007). These changes paved the way for community mental health teams (CMHTs) to be based in prisons, where the prison is the community. In the two prisons we have drawn on to inform this paper these teams included psychoanalytic psychotherapists. If development thrives, a psychological therapies team can be established, offering a wide range of psychotherapies to the women, and working closely with their CMHT colleagues. Other prisons have used psychodynamic principles to develop therapeutic communities and psychologically informed and planned environments (PIPEs) within their establishments (Joseph & Benefield, 2012). These models offer an alternative approach to that of the visiting therapist, where the psychotherapist is "tacked on" to a traditional system (Hinshelwood, 1993), or to the whole institution approach, which is geared towards providing a specific and therefore narrower treatment approach aimed at particular offender group such as personality-disordered men such as in HMP Grendon.

The Patient, the Offence and its Traumatic Antecedents

A fundamental principle of forensic psychotherapy is that the offence has a meaning to the offender; a meaning that often contains unconscious elements (Cordess & Williams, 1996; McGauley, 1997) which, if not understood, may well be repeated (Freud, 1909). Consequently, as Blumenthal (2010) notes, the focus of a psychoanalytic approach with offenders is to keep in mind the actuality of the individual's offence within the therapeutic work. In forensic psychotherapy the offence is seen as having the equivalent status of a symptom which needs to be understood. Gaining such an understanding has particular challenges in the prison context as this symptom has often occurred in the recent past. In general women enter prison soon after their offence whereas the psychotherapist working in secure forensic hospital settings may only meet the patient several months or years after her offence when psychic defenses around the offence have reorganized.

For women who have been found guilty of serious offences such as murder, sexual offences, those involving interpersonal violence and offences against children, the temporal proximity of the offence traumatizes the mind generating acute psychological distress which can overwhelm the patient's mind with affect and sometimes evokes compensatory symptoms of disavowal and dissociation designed to immunize the mind. Women who have committed serious crimes are particularly vulnerable at two points; when the court finds them guilty and subsequently if the court imposes a long sentence. These are moments when the actuality of how others' see their offence can no longer so easily be split off and disavowed. Although it may seem counterintuitive to think of violent women as being traumatized by their own violence, the act of homicide has been shown to lead to symptoms of PTSD in forensic patients (Gray, Carman, MacCulloch, & Snowden, 2003; Evans & Mezey, 2007). Working to understand the offence is not possible in these circumstances and the forensic psychotherapist needs to focus on barometrically assessing the level of affect that these women can tolerate before they are overwhelmed or need to dissociate out of their experience and then trying to help them strengthened their capacity to modulate their affect so that it is less overwhelming.

The violent or perverse nature of their offences means that these women are almost always seen by the prison CMHT who take the patient's history. As well as the traumatizing nature of their offence these women have frequently been exposed to earlier traumatic experiences, often comprising physical and sexual abuse at the hands of attachment figures. However the majority of imprisoned women have not committed seriously violent or sexual offences but may be in prison for "another drug related robbery". Often we do not ask these women about their histories in the same detail and their early abuse and exposure to trauma can go unrecognized. However, such experiences may still fuel their often repetitive offending as their substance misuse may be an attempt to dissolve away trauma-associated affect.

Allen, Lemma, and Fonagy (2012) emphasize the impact of attachment trauma on the capacity for emotional regulation and mentalizing. Mentalization is the capacity to focus on mental states in oneself or in others and to understand self and other behavior as being determined by our internal mental states (Bateman & Fonagy, 2006). Their model of trauma stresses the dual liability that stems from traumatic childhood attachments which, not only stimulate extreme distress, but also impair the child's capacity to regulate emotional distress, partly through compromising the development of mentalizing. In the face of subsequent trauma mentalizing breaks down. The deficits in mentalizing that attachment trauma causes come to the fore in the individual's attachment relationships with her own children, where the sequela of earlier trauma can be re-enacted giving rise to her crime.

Clinical vignette

Miss A grew up in an underdeveloped country. Her mother left when she was three years old and she was brought up by her loving grandmother. Miss A later found out that her mother had left because of her husband's violence towards her. When Miss A was still a child her country was plunged into civil war and she saw the soldiers shoot her eldest sister. Miss A and her other siblings were sent to Europe to live with their father and stepmother. Her father's violence continued and he beat all the children as well as Miss A's stepmother, who soon left. This departure seemed to precipitate her father sexually abusing Miss A, who was not yet 12 years old. She tried numerous times to escape but only found a route out when she was old enough to marry. She quickly became pregnant but her marriage fell apart as she could not bear to have sex with her husband. She desperately wanted to keep her son so as not to repeat her own childhood experience of being mothered. Miss A was a young single mother with no support network. She became depressed and withdrawn and began to self medicate with alcohol. She described her feelings for her son as "all that she had" and became increasingly reliant on him for emotional support. When her son, not yet 12, began to be disruptive at school and was disobedient at home Miss A began to hit him. She was convicted of child cruelty.

Miss A's early sessions were characterized by non-mentalizing thinking; she would be overcome with anger at those who had removed her son from her, or dissolve into self critical distress when her thoughts approached what she had done. For several months she could not think about her own mind. The therapeutic priority was to help her reduce her arousal so that Miss A could take an alternative perspective on her behavior and her mind. Her therapist was active in working with Miss A to try and enhance her capacity to mentalize; focusing on elaborating and clarifying her affect states in relation to her interpersonal relationships, particularly her relationship with her son. Gradually the minutes during which Miss A could both tolerate her emotional states and begin to think about them increased. It became clear that her poor capacity to mentalize meant that she could not think about her son's mind and the mental states that lay behind his disobedient behavior. It also became clear to Miss A that she had been unable to envision how frightened her son had been of her. Miss A was released from prison and continued to see her therapist during this transition.

Miss A's childhood comprised both interfamilial physical and sexual trauma and the man made trauma of civil war which also violently erupted into her

family with the murder of her sister. Man-made traumas, compared to natural traumas such as earthquakes, cause the greater psychological distress in children (Kumar, 2009). These terrifying environments impinged on her capacity to mentalize and to regulate her distressing affects; possibly leaving her vulnerable to alcohol misuse. Her depression, anxiety, panic attacks and social isolation meant that she became overly dependent on her son. We understood his increasing resistance to fit in to how his mother wanted him to be as making Miss A, once again, feel powerless and vulnerable; in other words the subsequent traumatic stressor that precipitated a failure of her fragile capacity to mentalize. Her developmental experiences meant that when Miss A's capacity to mentalize collapsed primitive modes of thinking reappeared and her internal reality became her external one so that she was enacting the brutally strict, rigid and abusive regime of her childhood (Allen *et al.*, 2012). Her therapist tried to strengthen her capacity to mentalize; in essence to provide her with a pause button between feeling and action (Allen, 2001).

The Vicissitudes of the Legal and Prison Systems

Just as the patient can split off knowledge about who she is and what she has done in particular situations the legal system can work in synchrony to maintain this split. The circumstances around some offences, often those where a child has died in "suspicious circumstances", mean that a woman may be charged with the offence but released on bail and her day-to-day life continues as normal while complex forensic evidence is being collected. Court dates may be postponed while forensic psychiatric and forensic pathology reports are prepared. It may be a couple of years later that the woman is found to be guilty and sentenced to imprisonment. Frequently, these women's minds have split off their offence and this disavowal seems to have been lent extra weight by the length of time and the normality of their life between being charged and being convicted. Our clinical experience is that, at a fundamental level, this group of women maintain a position of innocence in their mind. Often their narratives contain justificatory statements for example "If I am guilty then why was I allowed to stay with my other children?"

It is important that any system which deprives people of their liberty has robust processes which, under certain circumstances, allow prisoners to appeal against their conviction and or the length of their sentence. However the process of appeal can present particular difficulties for the area of psychotherapeutic work that is aimed at understanding the offence and helping the patient integrate the often violent, split of aspects of herself that have been projected into the offence. At a conscious level the woman's legal advocates may advise her not to talk about her offence in psychotherapy for fear of compromising the appeal. At a less conscious level the appeal process supports that part of the patient's mind that maintains a position of her lack of agency in or responsibility

for her offence. At times therapy may be underway when a patient and her legal team decide to appeal, as in the following case vignette.

Clinical vignette

Miss B was a young woman who had committed a seriously violent, attack on a man that she had misidentified as a sex offender. She had been sentenced to several years in prison. Initially in therapy she presented as smiling and free of any distress or disturbance. However she did dream and brought this to her session. In her dream a close relative, who is about the same age as her and, in reality was present at the scene of Miss B's offence, has arrived at the reception of the same prison. A prison officer comes to Miss B's cell and says something along the lines that Miss B needs to go down to the reception and tell her relative what she has done. In her dream Miss B replies that she can't do this as a fight might break out between them and that her relative would be frightened of her if she knew what she had done. This session was soon after New Year, at a time that Miss B was waiting to hear whether her appeal had been granted. She told her therapist that the new year had started badly as she felt "bad" when she received a letter from her solicitor informing her that there was no news, as yet, regarding her appeal. Sometime later in the session she said, in a rather flat, emotionless way, that if she didn't get her appeal in the next six months she would kill herself.

We thought that Miss B had to dream about a violent, frightening situation as the actuality of her violence could not be represented in her conscious mind. In her dream she had insight into how frightening it would be to know about the violent aspects of herself, and how she feared that facing these might precipitate a violent explosive reaction. Miss B's dream provide her therapist with a portal to begin to talk to her about the violent and despairing aspects of herself which her conscious mind worked hard to keep split off. Although there is the reality of the conscious disappointment Miss B felt at receiving her letter, in a subtle way this was conveyed in her narrative as if it was her solicitor and his act of writing to her that had made Miss B feel bad; not the facts of her crime that she had been found guilty of nor the personal tragedy of being imprisoned for so long at a young age. In other words Miss B presented herself as being free of who she was and what she had done, except in her dream. The task for Miss B's therapist is to help her lessen the splits in her mind. However this requires finding a delicate balance so that, on the one hand, the patient's fragile defenses are not breached too quickly, which might precipitate a suicidal explosion, while on the other hand, the patient's aggressive and violent impulses are not minimized.

The Effect on Staff; Being Mindful of Enactments and Institutional Responses

The prison staff and the health care team were all aware of Miss B's suicidal risk and she was being carefully monitored. However working closely with women who have committed horrendous crimes, have experienced extreme neglect and abuse and who have highly disturbed internal worlds can be both distressing and disturbing for staff, both discipline and health care. In forensic institutions,

the particular personal anxieties against which a psychological defense is mounted are often fear of helplessness and of losing control and fear of destruction or corruption (Adshead & McGauley, 2010). In women's prisons our observation is that this defense often takes the form of staff "forgetting" these women's offences and their violent behavior. At times this might be all too necessary so that front-line staff can continue to treat and care for women without becoming overwhelmed by knowledge of the suffering they have inflicted on others. By providing psychodynamic understanding through supervision, reflective practice, and consultation the forensic psychotherapist can help staff to manage these anxieties. If however "turning a blind eye" becomes the norm staff can unconsciously adopt an attitude of "pseudo-caring" manifest in an "activity of protection" evidenced by multiple meetings and referrals for several types of psychological therapy, excessive verbal re-assurances to the patient and special privileges. This occasionally happened in the system around Miss B. This pseudo-protective caring arises when the patient's offence is minimized in her mind and staff collude with what Sohn (personal communication) described as the patient's "delusion of normality". In such situations the woman fails to get authentic treatment as neither her violence nor her despair is taken seriously.

Clinical vignette

Miss C had been convicted several serious interpersonally violent offences directed at both strangers and associates. She was being seen for psychological treatment. Although staff consciously "knew" her crimes her therapist often observed officers laughing and joking with her; sometimes about her violence. Her therapist's experience was that both the patient and the staff viewed her treatment sessions as a "coffee time chat". Within the prison regime Miss C was very quickly granted responsible jobs and privileges. Miss C's dangerousness and risk appeared to be located outside of the minds of the staff and the walls of the prison.

These distortions cause damage on two levels. They damage the wider environment of the prison as they can lead to boundary violations and an escalation of risk if staff become seductively engaged in this "delusional" dynamic. We know that problems arise in prisons where staff are too anti-prisoner and officers over-use their power but problems also result if staff are too yielding or favorable towards prisoners (Crewe, Liebling, & Hulley, 2011). They also damage the sane part of Miss C's mind. If the social defense system of the prison supports the staff, who may be defending against the anxiety that Miss C's violence evokes, then the omnipotent "mad" part of Miss C's mind gains considerable ground (Hinshelwood, 1993; Menzies, 1959). Although many prisons adopt a behavioral approach of rotating all discipline staff to protect against boundary violations this may have a hidden cost of disrupting the continuity and care inherent in prisoner-staff relationships as staff behavior is the most important factor which determines the quality of prison life for inmates (Crewe *et al.*, 2011).

CONCLUSION

Although forensic psychotherapy is in its infancy within the prison system it is encouraging that in the UK prisons see the provision of psychological therapies as a legitimate part of their remit. We maintain that the work of the forensic psychotherapist involves striking several balances, all of which generate interesting questions, the answers to which will influence the developmental trajectory of the discipline over the next decade.

First, the forensic psychotherapist needs to find equipoise between focusing on the treatment of women and attending to the institutional fabric and processes which comprise their environment. Second, the forensic psychotherapist needs to keep in mind the legacy of dual liability and develop a clinical feel as to the location of the switch point beyond which the patient's capacity to mentalize about herself, her actions and her offence collapses. The forensic psychotherapist is well placed to anticipate and articulate links between the internal and external worlds of women and can therefore make a critical contribution to the understanding and management of risk.

Third, there is a balance to be struck as to how this finite resource is best used. Which women should the forensic psychotherapist treat and the allied question of where does forensic psychotherapy sit in relation to other psychological therapies? There are undoubtedly a group of high-risk imprisoned women with complex psychopathology and offending behavior who require sophisticated case formulations and risk assessments that would be well suited to the skills of the forensic psychotherapist. These women also need more than short-term protocol driven, psychological interventions to help them understand their difficulties and aggressive behavior. At present, if a psychological therapy service is available in the prison, there is a diversity of therapeutic pathways open to women. Often the choice of therapy is constrained by sentencing length. However, therapeutically we remain in the dark as to whether these routes lead to equiparity as therapeutic outcomes are poorly articulated even more poorly assessed. One pressing challenge for all professionals working with imprisoned women is how to improve their continuity of care and treatment "through the gate," as the therapeutic pathway so often ends at the gate. Resources "beyond the gate" are stretched and joined up working between agencies is difficult to achieve. This disjointed situation, combined with their chaotic internal worlds, leaves newly released women vulnerable; although Miss A continued to see her therapist post release she was only able to sustain this for a few months.

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