A DISCOURSE ANALYSIS OF CLINICAL PSYCHOLOGISTS' TALK ABOUT PSYCHOPATHY IN FORENSIC SETTINGS

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A thesis submitted in partial fulfilment of the requirements of

The University of East London for

the Degree of Doctor in Clinical Psychology

AUGUST 2016

Word count: 30223

ACKNOWLEDGEMENTS

I am indebted to the whole Clinical Psychology staff team at UEL for the challenges and rewards this training programme has provided, and especially to Claire Higgins and Trishna Patel for their support over the last three years.

Thanks to David von Brandt, Nikki Wood and Lara Frumkin for their advice and assistance in the early stages of this research. Thanks to Maria Castro-Romero for her suggestions and comments on drafts of this research, and for her encouragement during the write-up. Thanks to the participants who kindly gave their time in taking part.

I dedicate this research to my Mum and Dad, for getting me to this point in my life and for having no doubts in me; to Joey and Aoife, for keeping me grounded; and to Sam, for being a constant source of support and reassurance throughout this process.

ABSTRACT

Background: Psychopathy is a controversial psychological construct with a contentious history. Ambiguity regarding its pathology persists, coincident with long-standing critique of the construct. Contemporary research indicates ontological confusion, limitations with assessment practices, and the presence of a negative bias towards individuals identified as psychopathic; the implications of this raise serious ethical concerns. Despite this, the psychopathy construct is used within forensic settings to understand the psychology of forensic service users; in particular, clinical psychologists hold status as a professional group able to understand, assess for, and confer the presence of, psychopathy. In addition to the aforementioned limitations, there is also a lack of research into the accounts of clinical psychologists working in forensic settings.

Aims: To examine how clinical psychologists discursively construct psychopathy, including an investigation of the discourses and subjectivities produced and utilised in their talk, and the implications for action resultant from these.

Method: Eight one-to-one semi-structured interviews were conducted with clinical psychologists currently working in forensic mental health contexts (low, medium and high secure). Foucauldian Discourse Analysis was used to analyse the data.

Results: (1) Persons with psychopathy were constructed as problematised individuals. Constructions arose from four overarching discursive sites: dangerous, challenging, manipulative, and psychologically deficient. ‘At risk’ and ‘trauma’ discourses were utilised to explain the aetiology of psychopathy. ‘Intuition’ talk was employed by participants as a marker of the presence of psychopathy. (2) The psychopathy construct was identified as contested and problematic. To manage this, a variety of subject positions were taken up; three overarching subjectivities were identified: pragmatist, subversive, and expert/specialist. (3) Accounts pointed to a psychological imperative for psychopathy. Central to this was the promotion of three core psychology technologies: formulation, supervision, and reflective practice. These were constructed as solutions to the ‘problem’ of psychopathy in different ways. Clinical and research implications are discussed in light of the analysis.

CONTENTS

1 CHAPTER ONE: INTRODUCTION AND LITERATURE REVIEW

1.1 Introduction

This chapter will provide a rationale for exploring the accounts of clinical psychologists working directly with those with a label of psychopathy[1] in forensic mental health settings. I will first outline how my interest in this area emerged, followed by a summary of contemporary scientific and diagnostic understandings of psychopathy. I will then chart the emergence and development of the construct, from late Eighteenth century to present. I will examine issues pertaining to the practice of psychopathy and will then provide an overview of the main research drives to date, highlighting limitations and ambiguities. Lastly, I will outline the small body of research which examines professionals' accounts from a critical frame and which implies the need for alternative approaches to research and practice in the area of psychopathy.

The literature search strategy adopted for this study involved searches of psychology, medicine and science-based academic electronic databases (PsycInfo, PsyArticles, Science Direct, ProQuest, PubMed), general databases (Web of Knowledge, Sage), and Google Scholar for relevant articles and book chapters. Initial search terms were a combination of the following:

1. (professional) or (forensic) or (clinical) or (psychologist) AND
2. (account) or (talk) or (construction) or (perception) or (attitude) AND
3. (psychopathy) or (psychopathic) or (antisocial[2]) AND
4. (discourse) or (discursive) or (analysis)

Following extensive abstract scanning, the most relevant and recent literature was selected and comprehensively analysed. Additional relevant references within these texts were also sourced and subjected to the same process of analysis.

[1] Psychopathy is a socially produced construct; inverted commas are implied on all uses of the terms psychopathy, psychopath and psychopathic.
[2] Within several academic databases, the term psychopathy was subsumed by the term antisocial personality disorder due to recurrent overlap in the literature base.

1.1.1 Background to the Research

Several years ago, during my first week of working at an NHS secure forensic hospital, I was told that a long-term service user on the ward was a diagnosed psychopath, and was advised that he had a tendency to cause trouble so should 'be careful' around him. This was my first experience of the word in a clinical context and I recall that it took me by surprise; I remember feeling shocked and excited and, then, more afraid of the man in question. I later learnt that some time ago, a psychopathy assessment, the Psychopathy Checklist-Revised (PCL-R; Hare, 2003), had been conducted and through this process the man had been confirmed to have met the threshold which identified him as psychopathic. A year or so later, I observed and contributed to discussions regarding a particular service user and his ability to engage with the hospital's therapeutic programme. During these discussions, the word 'psychopath' was used, although at this point the man had not been formally assigned this label. A psychopathy assessment, the PCL-R, was later conducted and through this process he was confirmed to have met the threshold which identified him as psychopathic. I found myself reflecting on previously held discussions and comments about these men; their treatability, how they were experienced by others, the unique difficulties they posed to ward staff, and the overwhelming sense of hopelessness regarding their outcomes. I thought about these in relation to 'layman' depictions of the psychopath and also wondered about my own responses to the word, and to these men. It struck me that much was taking place in these interactions and I was moved to investigate this further.

1.1.2 The Forensic Mental Health Context

Admission to UK forensic mental health services is a likely outcome for individuals who present with serious offending behaviours and who are considered to be a high risk to themselves or others, in the context of a severe and enduring mental health diagnosis. Specifically, three levels of secure care- low, medium and high- reflect the nature and degree of offending and risk, as well as the gravity of an individual's mental health difficulties. Within forensic mental health contexts, the category of psychopathy is widely applied as a means of understanding service user behaviours

and in order to support decision-making regarding care and discharge; the PCL-R is the assessment tool typically used to do this (Cooke, Michie, Hart & Clark, 2004).

Traditionally, UK mental health legislation has sought a distinction between personality disordered and mentally ill offenders, however research indicates problems with this delineation, pointing to comorbidity within the forensic psychiatric population (Blackburn, Logan, Donnelly, & Renwick, 2003). Service users detained in secure hospital environments under the Mental Health Act (Department of Health, 2007b) are considered to pose a serious danger to the public (Rutherford & Duggan, 2008; The Sainsbury Centre for Mental Health, 2007). Individuals who have committed crimes and have a diagnosed mental health difficulty are constructed as falling between the categories of 'ill' and 'bad'; thus, a tension occurs as to whether they should be punished for their crimes or treated for their mental health difficulties (Peay, 2002). Care and treatment are a priority for forensic mental health services, typically through a multi-disciplinary care model (The Sainsbury Centre for Mental Health, 2007). Simultaneously, services are designed to ensure secure detention of those admitted, by restricting movement and freedom of choice. The effect of this is to join medical language of 'care' and 'treatment' with criminological and custodial practices of control, so shifting the meaning behind these concepts (Richman & Mason, 1992). As Parker, Georgaca, Harper, McLaughlin, and Stowell-Smith (1995) note, tensions arise in this construction when individuals have finished their 'treatment' but remain under legal restriction or are considered too dangerous for discharge.

Multiple studies indicate that stigma, prejudice and discrimination are a routine feature of forensic services, particularly for service users with a label of psychopathy. Studies have shown that staff experience an 'empathy-deficit' towards forensic service users, moderated by the nature of their crime and diagnosis (Bogojevic, Zigmund, Ziravac, & Pavic, 2013) and hold negative views towards those with personality disorder diagnoses (James & Cowman, 2007; Lewis & Appleby, 1988). More specifically, studies investigating forensic staffs' perceptions of individuals identified as psychopathic indicate that they are experienced negatively compared to other forensic service users, with a tendency towards 'therapeutic pessimism' (Salekin, 2002), a trend for 'management' work rather than 'therapeutic' work

(Bowen & Mason, 2012; Mason, Hall, Caulfied, & Melling, 2010; Mason, Caulfield, Hall, & Melling, 2010), and that the label increases clinicians' perception of risk and future criminality (Rockett, Murrie, & Boccaccini, 2007; Sörman et al., 2014). A related concern regarding staff burnout is also present across the literature (Crawford, Adedeji, Price, & Rutter, 2010; Moore, 2012).

1.2 What Do We Mean by 'Psychopathy'?

1.2.1 Psychopathy as a Concept

The Ministry of Justice (2011b, p. 4) defines psychopathy as a "particularly severe form of antisocial personality disorder" and states that it is an important personality disorder-type within offender services due to its relationship with high levels of re-offending, violence and failure to comply with treatment. Despite this imperative, an absence of clarity with regards to the conceptualisation of psychopathy persists (Kirkman, 2008; Lilienfeld & Andrews, 1996; Lilienfeld & Arkowitz, 2007). Multiple definitions of the construct are used which are, at times, contradictory and only partially overlapping (Skeem, Poythress, Edens, Lilienfeld, & Cale, 2003). Additionally, the status of psychopathy has shifted often, as has its symptomatology (Walters, 2013). Therefore, it is not reasonable to assume that clinicians and academics share a common understanding of this psychological construct.

Most mainstream literature into psychopathy has particular descriptive qualities in common. These are a lack of empathy, and a 'cold', callous personality, as well as behavioural features of impulsivity, antisociality, criminality and a failure to act 'morally' (e.g. Berg et al., 2015; Farrington, Ullrich, & Salekin, 2010; Schaich Borg et al., 2013). Notably, some proponents of psychopathy argue that the construct should be operationalised according to personality elements alone (Blackburn, 1998; Cooke, Michie, et al., 2004). Though beyond the remit of this research, some contributors to the field argue that psychopathy is an adaptive response to the pressures of modern social life, suggesting that an absence of conscience or moral scruple does not preclude pro-sociality (Galang, 2010; Holmes, 1991)[3]. It is possible

[3] Given the forensic-specific context of this thesis, this small body of literature has been omitted from the literature review.

that a bias towards research participants from prison and forensic settings has, for a long time, prevented elaboration of these ideas (Mullins-Sweatt, Glover, Derefinko, Miller, & Widiger, 2010; Widom & Newman, 1985).

1.2.2 Psychopathy as a Classification

In the UK, psychopathy has historically been a legal rather than a clinical category (Holmes, 1991). The term is not formally used within the most recent American Psychiatric Association's Diagnostic and Statistical Manual of mental disorders (DSM-V; American Psychiatric Association, 2013) or the World Health Organisation's International Classification of Diseases (ICD-10; World Health Organisation, 1992), nor is it recognised as a clinical diagnosis by any psychiatric or psychological organisation (Moss & Prins, 2006). Despite this, psychopathy holds status as a long-standing, even archetypal personality disorder construct (Crego & Widiger, 2014). A prevailing assumption is of the presence of an underlying 'essence' to psychopathy, an essential causal difference (impairment); the nosological task is, therefore, to capture this essence through the use of appropriate diagnostic criteria (Parker, 2002; Zachar & Kendler, 2007). Likewise, a long-standing endeavour to identify the presence of psychopathy across prison and forensic populations persists (Widiger & Lynam, 1998). Attempts at this task can be seen from the first DSM publication (American Psychiatric Association, 1952), which included a classification of 'sociopathic personality disturbance', characterised by callous and hedonistic behaviours, a lack of responsibility, and including presentations previously conceptualised as 'constitutional psychopathic state' and 'psychopathic personality' (American Psychiatric Association, 1952, p. 38).

Within both the DSM and ICD diagnostic systems, the closest diagnostic equivalent to psychopathy is considered to be antisocial personality disorder (APD), with which it is believed to share key symptomatology, such as lack of empathy/ inadequate conscience development, incapacity for mutually intimate relationships, callousness and impulsivity (American Psychiatric Association, 2013; World Health Organisation, 1992). Despite broader critiques of the DSM, including concerns regarding the potential for inappropriate application of stigmatising medical labels, it continues to be the primary, internationally-used classification system of mental health difficulties

across clinical settings and research contexts (British Psychological Society, 2011b). Accordingly, this research draws on a DSM-type classification of psychopathy and related concepts. For instance, the most recent advent of DSM-V signalled proposals to change the term 'antisocial' to 'antisocial/psychopathic', suggesting continued motivation to shift the APD diagnosis toward a psychopathy construction (Trull & Widiger, 2013). A lack of reliability and validity lead to the withdrawal of the proposed change (Widiger, 2011; Zimmerman, 2012), though not without contention (Lynam & Vachon, 2012). National Institute for Health and Clinical Excellence (NICE, 2010) estimates that approximately 10 percent of individuals with APD meet the criteria for a label of psychopathy, as measured by the PCL-R. However, the issue of whether or not APD and psychopathy are diagnostic equivalents remains unresolved and a heated debate persists as to the validity and usefulness of this concept conflation (Coid & Ullrich, 2010; Hare, Hart, & Harpur, 1991; Hare, 1996; Skeem, Polaschek, Patrick, & Lilienfeld, 2011). Irrespective, since its third edition (DSM-III; American Psychiatric Association, 1980), the DSM has gained legitimacy as a result of its use of empirical positivist research to validate diagnostic categories. Thus, through APD, the technology[4] of the DSM produces a researchable category which maps onto a biopsychosocial model of pathology and enables the study of antisociality and deviance in ways that the intangible category psychopath cannot (Pickersgill, 2013).

1.2.3 Psychopathy within this Research

In the broadest sense, psychopathy is conceptualised as a constellation of traits and behaviours (Buzina, 2012). Beyond this, there are many well-documented disagreements regarding what constitutes psychopathy (Miller & Lynam, 2012; Scott, 2014; Skeem et al., 2003). There are also several related terms which may or may not be implicated. This study does not seek to offer a definition of psychopathy; such an action would stand in opposition to its epistemology, research questions and methodology. However, in the interests of providing some boundaries of understanding, I have elected to exclude the terms 'Machiavellianism', 'dissocial personality disorder' and 'sociopathy'. While I acknowledge that there are inherent problems with selective terminological inclusion criteria, these terms are not typically

[4] 'Technology' here is used in the Foucauldian sense, meaning 'technologies of power', which are mechanisms by which particular power/knowledge arrangements are maintained (Foucault, 1988b).

utilised within UK forensic or clinical populations and had minimal purchase in the literature.

The appropriateness of including or excluding APD is less clear given ongoing debate regarding its relatedness to psychopathy (see section 1.2.2). While there are obvious limitations with conflating the terms psychopathy and APD, this issue is by no means close to resolution in the field of psychopathy research, nor is it within the aims or remit of this thesis to attempt to clarify this conceptual dilemma. As such, research reviewed for this study was careful to include literature which applied the term APD synonymously with psychopathy (e.g. Pickersgill, 2014; Reid, 2001).

1.3 A Brief History of Psychopathy: A Critical Perspective

In order to locate this research and to make explicit the contemporary meanings and connotations of the term psychopathy, a historical examination of its origins and development is necessary. Moreover, a disambiguation of the term is an essential task given the folkloric status of psychopathy (Cohen, 2002), and the oft acknowledged tendency to rely on mythology and anecdote in place of accuracy (Berrios, 1999; 1996; Hamilton, 2008). Of note, although the major proponents and their ideas are outlined here, more extensive histories can be found elsewhere, for example, Jones (2016) provides an extended analysis and historical account, while Arrigo and Shipley (2001) include a useful table on the historical contexts of psychopathy.

1.3.1 The Sociocultural Climate and the Rise of Psychiatric Expertise

Biopolitical societies, such that govern human life via regulation of the body, began to take shape in the Seventeenth century (Oksala, 2013). The origins of psychopathy as a formal clinical construct cannot be traced beyond the early 1800s (Henderson, 1939; Werlinder, 1978). At the time of the Enlightenment across the Western world, ‘reason’ became highly valued, while ‘unreasonable’ (deviant) behaviour was increasingly sectioned off from wider society via social practices such as lunatic asylums (Foucault, 1988a). Furthermore, pressing philosophical debate relating to the nature of humanity and individual agency, and seismic shifts in societal and

cultural structures brought on by global capital and rising secularity, coincided to produce huge societal anxiety (McKeon, 1985). Within this climate, the profession of psychiatry was establishing itself; concerns about criminality, social deviance and preoccupations regarding the boundary between madness and sanity, provided the ground for psychiatry to take up a professional position with public authority and expertise on diseases of the mind or intellect (Scull, 1979, 1993). As Szasz (1978, p. xvii) described: “[W]ith the decline of religion and the growth of science in the Eighteenth century, the cure of (sinful) souls, which had been an integral part of Christian religions, was recast as the cure of (sick) minds, and became an integral part of medicine”.

Thus by the end of the Nineteenth century, criminals, the mentally ill, the disabled and the poor had become the targets of psychiatric ‘individualisation programmes’ (Rose, 1999). Within this frame, notions of moral insanity, antisocial personality and psychopathy were made possible, leading to the growth and intersectioning of the criminal justice system and health and welfare services (Jones, 2016).

1.3.2 The Beginnings of the Construct of Psychopathy

Physician Benjamin Rush was the first figure to break with theological explanations of criminality by advancing scientific criminological thought (Rafter, 2004). Rush (1839, p. 1) posited the presence of a ‘moral faculty’ which, he argued, was the “capacity in the human mind of distinguishing and choosing good and evil”. As Werlinder (1978) notes, Rush’s work was significant because it sought to redefine insanity as a mental disease and in so doing, shifted criminality away from the remit of the clergy and into the purview of psychiatry, thus marking the beginnings of a medicalisation of offending behaviours.

Although a source of contestation (Berrios, 1999; Horley, 2013a), the widely held assertion is that aliéniste Phillippe Pinel offered ideas which would lay the foundations for contemporary understandings of psychopathy. Drawing on three case studies from his work, Pinel (1806, p. 150) proposed the presence of “manie sans delire” (mania without delusion) to refer to individuals presenting without apparent thought disorder but some perceived psychological disturbance. He

described the phenomenon as a “perversion of the active faculties, marked by abstract and sanguinary fury, with a blind propensity to acts of violence” (p. 156). What is not so widely acknowledged is that only one of Pinel’s three cases describes an individual who might be understood as psychopathic by anything like today’s understanding of the construct (Whitlock, 1982). As Arrigo and Shipley (2001) highlight, Pinel’s explanation was largely morally neutral, and thus stands in contrast to later definitions, which demonstrate more pejorative characterisations. As a consequence of the advancement of Pinel’s theory, psychiatrists were increasingly seen as authoritative experts on issues relating to criminal psychiatry paving the way for them to take on the role of expert-witness in criminal justice proceedings (Goldstein, 1998). As Foucault (1991) and others (Medina & McCranie, 2011) have posited, this positioning was an essential component of psychiatry’s claim to power and points to the intersectioning of law, medicine and morality; where psychopathy is located.

1.3.3 Early Nosologies of Character Disorder

In the context of the development of positivism in the late Nineteenth century and psychiatry’s quest to establish itself as a scientific endeavour alongside other, well-established forms of medicine, efforts were made to predict and codify human behaviour into disease categories using the methods of the natural sciences (Rapley, Moncrieff, & Dillon, 2011). Through this process, psychiatrists (and later psychologists) could ‘scientifically’ delineate the boundaries of social deviance and morality (Sarbin & Mancuso, 1970) leading to social condemnation of individuals via medical categorisation (Arrigo & Shipley, 2001). Central to this endeavour was the concept of ‘norms’, acquired by medicine shortly after 1800 (Hacking, 1996). Early attempts in this process signal the point at which previously disjointed ideas relating to inferiority, amorality and antisocial or harmful behaviour were merged (Millon, Simonsen, & Birket-Smith, 1998).

The term ‘moral insanity’, put forward by physician James Cowles Prichard, is regarded as the first nosological definition akin to contemporary understandings of psychopathy (Augstein, 1996). The term is also sometimes regarded as one of the earliest depictions of contemporary notions of ‘personality disorder’, due to its

foregrounding of an individual's character as a site of disorder (Elliott & Gillett, 1992). Psychiatrist Julius Koch included a cluster of disorders termed 'psychopathic inferiorities' in his extensive and systematised categorisation of mental disorders (Jones, 2016), while psychiatric nosologist Emil Kraepelin outlined sub-sets of 'psychopathic personalities' which, he proposed, were the consequence of a faulty or defective constitution, present from birth and persisting throughout the life course (Crocq, 2013). Later editions of Kraepelin's work included the sub-type 'born criminal'; professional criminals were believed to derive from this sub-type of the overarching disorder (Horley, 2013a). By defining deviant behaviour as a medical problem, the medical profession (in this case psychiatry) is mandated to provide treatment (Medina & McCranie, 2011). Kraepelin's categories of disordered personality types have had a lasting impact on the development and understanding of the notion of personality and its classification across mental health systems (Bentall, 2003; 2006).

1.3.4 The Birth of the Modern Psychopath

Psychiatrist Hervey Cleckley's seminal text *The Mask of Sanity* (1941) detailed several dozen case studies as the basis for identification of 21 characteristics of psychopathy. Across later editions spanning several decades, he refined the number of characteristics to 16. Table one outlines these characteristics from Cleckley's final publication of the work:

Table One: Cleckley's Clinical Profile of the Psychopath

1. Superficial charm and good "intelligence"
2. Absence of delusions and other signs of irrational thinking
3. Absence of "nervousness" or psychoneurotic manifestations
4. Unreliability
5. Untruthfulness and insincerity
6. Lack of remorse or shame
7. Inadequately motivated antisocial behaviour
8. Poor judgment and failure to learn by experience
9. Pathologic egocentricity and incapacity for love
10. General poverty in major affective reactions

11. Specific loss of insight
12. Unresponsiveness in general interpersonal relations
13. Fantastic and uninviting behaviour with drink and sometimes without
14. Suicide rarely carried out
15. Sex life impersonal, trivial, and poorly integrated
16. Failure to follow any life plan

Taken from Cleckley (1988)

Until this point, theories of psychopathy had been predominantly biological. Although Cleckley's work did not offer any substantial theory as to the causation of psychopathy (Werlinder, 1978), it served to shift the paradigm of psychopathy towards a psychological conceptualisation (Jones, 2016). Around the same time, psychoanalysis emerged as a primary psychological approach, which located the aetiology of pathology and corresponding behaviours in an individual's childhood psychosexual development, and away from collective, societal responsibility (Ramon, 1986). This theoretical influence is apparent in Cleckley's language, for example he describes psychopaths as incapable of "object love" (1988, p. 361) and as being "fragmented" persons (p. 367). Moreover, Cleckley's work reveals particular concern with regard to sexual behaviour, focussing more explication on this characteristic than others (Jones, 2016). In earlier editions of the work, the female case studies he presents are notable for their sexual promiscuity rather than antisocial behaviour, and are portrayed more as moral, rather than legal, offenders (Horley, 2013a). As behaviour considered sexually promiscuous shifts according to time, culture and gender (Le Moncheck, 1997) it cannot be said to reflect a fixed truth about what it means to have a 'psychopathic personality'. Notably, this stands in contradiction to the notion that the psy-disciplines are seeking value-neutral knowledge (Danziger, 1990).

The clinical profile outlined by Cleckley is the basis of contemporary understandings of psychopathy (Arrigo & Shipley, 2001). Most notably, the Psychopathy Checklist, developed by psychologist Robert Hare in the 1970s, is a modernisation and operationalisation of Cleckley's clinical profile (Patrick, Hicks, Krueger, & Lang, 2005). The updated version, the PCL-R (Hare, 2003), is the most widely used psychopathy assessment tool. It was developed for research purposes, however,

many textbooks (and clinicians) recognise it as a diagnostic tool (e.g. Molinari, 2015). It has since been adapted for multiple populations and settings; the Psychopathy Checklist-Screening Version (Hare, Cox, & Hare, 1995) and the Psychopathy Checklist-Youth Version (Forth, Kosson, & Hare, 2014). Hare conceptualises psychopaths as “intraspecies predators” (1998, p. 196) whose behaviours are “the result of choice, freely exercised” (1999, p. 25). Table two outlines the features of Hare's (2003) two-factor model. Individuals are marked on a scale of 0 to 2 according to the presence of each feature. The process comprises a clinical interview with the person under assessment and evaluation of extensive clinical documentation. In the UK, a score of 25 or above on the PCL-R means that the individual under assessment demonstrates characteristics or behaviours synonymous with psychopathic personality on the upper end of the spectrum of those demonstrated by the population as a whole, resulting in a label of psychopathy (Craissati, 2004).

Table Two: Features of Psychopathy According to PCL-R

Factor 1	Factor 2	Other items
Facet 1: Interpersonal 1. Glibness/ superficial charm 2. Grandiose sense of self-worth 3. Pathological lying 4. Cunning/ manipulative	Facet 3: Lifestyle 1. Need for stimulation/ proneness to boredom 2. Parasitic lifestyle 3. Lack of realistic, long-term goals 4. Impulsivity 5. Irresponsibility	6. Many short-term marital relationships 7. Promiscuous sexual behaviour
Facet 2: Affective 1. Lack of remorse or guilt 2. Emotionally shallow 3. Callous/ lack of empathy	Facet 4: Antisocial 1. Poor behavioural controls 2. Early behavioural problems 3. Juvenile delinquency	

4. Failure to accept responsibility for own actions	4. Revocation of conditional release *5.* Criminal versatility	

Taken from Hare (2003)

1.4 The Assessment of Psychopathy

As noted earlier, the PCL-R is the primary psychometric measure used in prison and forensic settings to establish the presence of psychopathy. It is regarded as an effective measure of risk and is commonly used to inform risk assessments (Hemphill & Hare, 2004; Loving, 2002; Russell et al., 2013), though this practice is not without detractors (Gendreau, Goggin, & Smith, 2002).

While the majority of studies into psychopathy continue to utilise the PCL-R as its measure of the presence of the construct (e.g. Morrissey, Mooney, Hogue, Lindsay, & Taylor, 2007; Walters, Ermer, Knight, & Kiehl, 2015), the literature also reveals a growing body of research which problematises the PCL-R as a meaningful, valid or reliable measure of psychopathy. Skeem & Cooke (2010) critique the PCL-R as having a monopoly of the field and suggest that the construct of psychopathy has become conflated with the PCL-R measure; this can be understood as an example of theory-laden observation (Kuhn, 1970). This is also significant because without any external validation of the construct (the gold standard for psychometric measures) a circularly issue arises: an individual qualifies for psychopathy through a high PCL-R score, and their high PCL-R score is evidence of the presence of psychopathy (Boyle, 2002; Pilgrim, 2001), thus a double bind ensues (Bateson, Jackson, Haley, & Weakland, 1956; Gibney, 2006). There are added concerns that forensic assessors may be vulnerable to a ‘partisan allegiance’ affecting the reliability and consistency of the PCL-R during court proceedings (Murrie, Boccaccini, Johnson, & Janke, 2008). Also, due to its lack of normal distribution, the PCL-R has been described as unreliable, particularly in relation to scores at the upper end of the scale, meaning that individual case estimates are likely to be inaccurate (Cooke & Michie, 2009).

Given this, alternative assessment tools have emerged, such as the Psychopathic Personality Inventory (PPI; Lilienfeld & Andrews, 1996) and the Comprehensive Assessment of Psychopathic Personality (CAPP; Cooke, Hart, & Michie, 2004). These measures and their underlying models profess to conceptualise and assess psychopathy in novel ways. Irrespective, recent research points to major limitations

of a range of psychopathy assessment tools (Singh, Grann, & Fazel, 2011). The implications of this raise serious ethical concerns when one considers that those assessed for, and classified with, psychopathy are subject to harsher criminal sentencing in Europe (Pham & Saloppé, 2013) and more likely to be sentenced to the death penalty in the USA (Blais & Forth, 2014; Edens, Davis, Fernandez Smith, & Guy, 2012). A high PCL-R score has also been found to be the strongest predictor of whether an individual is recommended for release from high security settings (Manguno-Mire, Thompson, Bertman-Pate, Burnett, & Thompson, 2007).

1.5 Sociodemographic Differences of Psychopathy

Thus far, research into sociodemographic differences such as race and gender are comparatively minimal. In line with positivist traditions of the broader literature base, research which seeks to investigate these differences takes as its starting point that psychopathy is a real-but-unobservable fact. In this context, several studies have produced mixed findings, indicating reliability and validity issues when the psychopathy construct is applied to women (Brinkley, Diamond, Magaletta, & Heigel, 2008; Salekin, Rogers, & Sewell, 1997; Vitale, Smith, Brinkley, & Newman, 2002) and individuals with Black and Minority Ethnic (BME) identities (Kosson, Smith, & Newman, 1990; Sullivan, Abramowitz, Lopez, & Kosson, 2006; Toldson, 2002).

Extensive research now exists indicating that BME groups are disproportionately represented across mental health contexts; individuals with BME identities are more likely to be in receipt of a mental health diagnosis and more likely to be admitted to a mental health hospital (Keating, 2009). Within the criminal justice system individuals with BME identities are heavily overrepresented as users and underrepresented as bearers of positions of responsibility (Blumstein, 2009). In addition, studies have indicated the presence of a negative bias in evaluating BME individuals (Garb, 1997; Iwamasa, Larrabee, & Merritt, 2000). Given this, it is interesting to note that Black men admitted to forensic psychiatric hospitals or secure units are significantly less likely to receive a label of psychopathy, or of personality disorder generally (Coid, Kahtan, Gault, & Jarman, 2000; Cope & Ndegwa, 1990; Shubsachs, Huws, Close, Larkin, & Falvey, 1995). With few exceptions, this issue remains under researched,

however there is some suggestion that seemingly disproportionate statistics may mask a continued negative bias towards BME individuals (Toldson, 2002). Additionally, an analysis of the discourses of black and white men with a label of psychopathy revealed differing models of subjectivity according to speakers' race identity (Stowell-Smith & McKeown, 1999), suggesting that subject positions based on race potentially impact on what psychiatric labels are possible for an individual to be assigned and take up.

In general terms, it is understood that levels of psychopathy are much higher in men than women (Cale & Lilienfeld, 2002). Research into gender differences focusses on the ways in which the construct converges and diverges along a gender axis, thus attempting to identify essentialised differences between men and women. For instance, psychopathy in women has been associated with relational, rather than overt, aggression (Marsee, Silverthorn, & Frick, 2005), higher rates of promiscuity and sexual misbehaviour (Robins, 1966; Salekin, Rogers, & Sewell, 1997), later age of onset and less aggression (Silverthorn & Frick, 1999). Since the Eighteenth century, the criminal justice system has focused on male offenders rather than female offenders (Shoemaker, 2001) and theories of faulty biology or masculinisation have developed as explanations for female crime (for an extensive critique see Cooper, 2011). In the arena of disordered personalities, women are far more likely to be assigned other diagnostic labels such as borderline personality disorder or, historically, hysterical personality (Bjorklund, 2006).

Differences in psychopathy assessment profiles have also been noted cross-culturally; this is significant given that the majority of research samples to date are derived from North American offenders and psychiatric service users (Hare et al., 2000). In the UK, a score of 25 or above on the PCL-R means that the individual under assessment demonstrates characteristics or behaviours synonymous with psychopathic personality on the upper end of the spectrum of those demonstrated by the population as a whole (Craissati, 2004). By contrast, in the USA, the cut-off score for what constitutes psychopathy is 30. Some research suggests that the same levels of apparent psychopathy traits produce lower scores on a PCL-R assessment in the UK compared to North American populations, highlighting a need for caution when interpreting scores and making clinical decisions (Cooke, Michie, Hart, & Clark,

2005). Nonetheless, this is indicative of the socially contingent nature of psychological assessment processes whereby the same person might obtain a different assessment outcome depending on where they are assessed.

1.6 Contemporary Psychopathy Research

The main thrust of psychiatric research into psychopathy has been primarily biomedical, based on positivist traditions seeking evidence for cause-effect relationships according to isolated variables, such as impulsivity, empathy, violence, instrumental criminality, callous-unemotional traits and moral judgement. These variables are considered observable indicators of the presence of psychopathy. Such research priorities follow a long history within psychiatric science of attempting to locate biological correlates of pathology which might inform (typically pharmacological) interventions (Moncrieff & Crawford, 2001). Other research priorities are examination of assessment tools (see section 1.4) and investigation of the concept of psychopathy in legal contexts. In a variety of ways, mainstream research into psychopathy attempts to theorise a relationship between an 'abnormal' personality, mind or self and a proclivity for extreme anti-social behaviours (Coid, 1993), thus pointing to the body as the site of psychopathology (Pickersgill, 2009). The majority of this research is based on adult male offenders or forensic psychiatric service users. There is also a small body of research from a relativist epistemological position, focussing on discursive investigations of the construct, either of the accounts of invested individuals or of relevant psychiatric text. The following three sections will briefly describe and critically appraise the main findings of relevant research, so as to familiarise the reader with some of the assumptions, debates and disagreements in relation to the notion of psychopathy.

1.6.1 The Neuroscientific Investigation of Psychopathy

Compared to neuroscientific research into other psychiatric diagnoses (e.g. depression and schizophrenia), neuroscientific investigation into psychopathy is in its infancy. To date, this research has drawn several preliminary theories implicating: the amygdala (Blair, Mitchell, & Blair, 2005); the orbitofrontal cortex (Blair, 2003); serotonin neurotransmitters (Dolan & Anderson, 2003); the hippocampus and its role

in fear conditioning (Laakso et al., 2001); and the prefrontal-tempero-limbic circuit (Weber, Habel, Amunts, & Schneider, 2008). Significantly, contemporary neuroscientific research does not appear simply deterministic, often acknowledging 'environmental factors' as having at least some stake in the accounts of psychopathy (e.g. Blair, Mitchell, & Blair, 2005). Instead, individuals are constructed as 'vulnerable to', or at 'genetic risk of', developing a disordered personality and their environment becomes a moderating force for the manifestation of traits (Rose, 2007). For example, neurobiological investigation has been undertaken to examine how genes affecting psychopathology might be moderated by early life experiences in the case of antisociality (Caspi et al., 2002; Frazzetto et al., 2007; Kumari et al., 2014) and psychopathy (Sadeh, Javdani, & Verona, 2013). Such research legitimises and reinforces emerging interest in the investigation and identification of controversial juvenile or 'fledgling' psychopathy (Lynam, Derefinko, Caspi, Loeber, & Stouthmaer-Loeber, 2007; Lynam, 2002; Skeem & Petrila, 2004), despite the possibility that traits used in the assessment of adult psychopathy (e.g. egocentricity, impulsivity, irresponsibility) may be normative and transient in juveniles (Seagrave & Grisso, 2002). Generally speaking, though, neuroscience literature appears less concerned with formal investigation of possible aetiological factors of psychopathy; examination of the ways in which it is biologically and behaviourally expressed takes precedence (Pickersgill, 2009). Thus, neurobiological research seeks to tell us *what* but not *why*, offering a description but not a theory of causation (Pilgrim, 2001).

A recent popular theory of psychopathy is the presence of a neurobiological inability for empathy, an affect considered to be traceable in the brain and experienced pre-consciously (Baron-Cohen, 2011; Rameson, Morelli, & Lieberman, 2012; Soderstrom, 2003). The notion of an absence of empathy maps onto longstanding conceptualisations of psychopathy (see section 1.3). This application of neuropsychological 'norms' has the effect of construing the psychopath as a "pathological other" who is not fully human (Bollmer, 2014, p. 299). In this way, the neuroscientific literature contributes to the wider construction of a new 'kind' of person (Hacking, 1995; 2006), one who is affectively deficient. This kind-making is made plain in Baron-Cohen's (2011) recent pop psychology text *Zero Degrees of Empathy*, which collects together and examines other instances of empathy deficiency (those with diagnoses of autism, borderline or narcissistic personality

disorder). The neuroscientific drive of psychopathy research appears to be steering biological determinism into complex and sophisticated ground, where research into brain structures, neurotransmitters and affect implicated in types of pathology are prioritised far beyond psychosocial investigation (Pickersgill, 2009), leading to the reconstitution of psychopathy as a totalised identity construction (Angelides, 2005).

Research which utilises modern imaging techniques (e.g. functional magnetic resonance imaging, fMRI) has contemporary cultural significance and also holds authority within the scientific and clinical communities (Beaulieu, 2002; Joyce, 2008). The ideas advanced through such research are subsumed by, and impact on, clinical discourse and practice. Following a review of the most recent scientific literature of psychopathy, Fowles (2011, p. 94) has argued that reification of the construct of psychopathy disinclines professionals from thinking in terms of complex interacting factors by wrongly implying the possibility of locating the term psychopath "somewhere inside the brain".

1.6.2 Psychopathy and Aversive Childhood Experiences

It is widely accepted that adverse childhood experiences such as victimisation, family dysfunction and maltreatment are implicated as risk factors for future psychopathology (McLaughlin et al., 2010), future offending (Maxfield & Widom, 1996) and a combination of the two (Laajasalo & Häkkänen, 2004; Matejkowski, Cullen, & Solomon, 2008). According to the PCL-R, a key indicator of psychopathy is the presence of conduct disorder-type behaviours in childhood and adolescence. The literature indicated a trend towards investigation of the presence of adverse childhood experiences in the context of psychopathy (see Farrington et al., 2010 for a summary of the available research into environmental influences and psychopathy). Some studies attempted this via a neurobiological framework (see section 1.6.1), more commonly, investigations have been undertaken into the attachment styles and childhood histories of those with a label of psychopathy. Associations were found for a family constellation of rejecting father/ emotionally warm, idealised mother (Frodi, Dernevik, Sepa, Philipson, & Bragesjö, 2001), unresolved loss and trauma (Nørbech, Crittenden, & Hartmann, 2013), poor parenting (Molinuevo, Pardo, González, & Torrubia, 2014; Salekin & Lochman,

2008), object relations deficits (Brody & Rosenfeld, 2002), familial adversity (Giovagnoli, Ducro, Pham, & Woitchik, 2013) and adverse childhood traumatic experiences, especially for females (Weizmann-Henelius et al., 2010). Other research indicated that child abuse was predictive of high PCL-R scores in adulthood, irrespective of gender and race (Weiler & Widom, 1996).

By implication, these studies hypothesise a degree of relational interaction as contributing to the manifestation of psychopathic traits. By positioning psychopathy in this way, a psychological basis for antisocial and undesirable behaviours is made available; however, by implicating individual care-receiving experiences in the pathway of the disorder (what might be described as the 'meso-level'), explanations involving wider macro-level factors are avoided (Ramon, 1986). The knowledge produced through this research is correspondent with a biopsychosocial imperative and contributes to a prevailing discourse that adult psychopaths developed as such due to underlying vulnerabilities, in interaction with early environment, including impaired attachment experiences. In turn, this points to particular interventive practices, as the disordered person is constructed as a site for rehabilitation (Foucault, 1991). Thus, interventions which focus on 'relationship' as an avenue for change are made possible, as are broader political practices, such as the development of governmental policy[5] and research[6], the propagation of a Therapeutic Community model across forensic and personality disorder services, and the development of highly controversial governmental initiatives of public order, i.e. the 'Dangerous and Severe Personality Disorder' initiative (Cordess, 2002; Duggan, 2011; Glen, 2005; Ministry of Justice, 2011a).

1.6.3 Psychopathy in the Court Room

As discussed (section 1.2) psychopathy has status as a legal term; clinical and legal elements of psychopathy discourse have long been integrated (Parker et al., 1995). Psychiatry, and latterly psychology, has established its place within courtrooms, prisons and parole boards since the 1880s, taking on a privileged position to define criminals and their culpability (Garton, 2001). Psychopathy has become a legal

[5] E.g. *Personality Disorder: No Longer a Diagnosis of Exclusion* (NIMHE, 2003)
[6] E.g. *Intervening to Prevent Antisocial Personality Disorder: A Scoping Review. Home Office Research* (Moran & Hagell, 2001)

synonym of ‘evil’; its application in courtroom settings ensures continuity of the law’s principles of logic and reason by maintaining a scientific frame of reference and by establishing the necessity of expert explanation from psychiatrists and psychologists (Ruffles, 2004).

The judicial implications resulting from the use of the term psychopath are considerable, and the application of prescriptive outcomes by courts following such expert opinion has been raised as cause for concern (Scott, 2014). Given this, it is perhaps unsurprising that non-professionals’ understandings of psychopathy, and the potential effects of these on legal processes, has been a focus of the literature. Research has indicated that the psychopathy label, when applied to individuals on trial, has a prejudicial impact based on perceptions of dangerousness far outweighing its probabilistic value (Bersoff, 2002; Cunningham & Reidy, 1998; Edens, Petrila, & Buffington-Vollum, 2001). Studies examining the perceptions of jurypersons found that the label impacted negatively on sentencing outcome (Smith, Edens, Clark, & Rulseh, 2014), that laypersons were significantly more likely to support a death sentence when the defendant was indicated to be psychopathic (Cox, Clark, Edens, Smith, & Magyar, 2013; Edens et al., 2012), and that defendants with psychopathy were experienced as less credible (Blais & Forth, 2014). Some studies reported a mediating effect based on gender, with men less likely than women to support indefinite imprisonment of individuals identified as sexually offending psychopaths (Guy & Edens, 2003; 2006). In the context of juvenile probation services, the term psychopathy was also found to have stigmatising effects (Murrie, Cornell, & McCoy, 2005) and, even when the category was not directly used but implied, participants showed increased support for the death sentence and decreased support for treatment while in prison (Edens, Guy, & Fernandez, 2003).

Multiple studies into the effects of labelling in various contexts have pointed to stigma and dehumanisation as likely outcomes. The negative effects of terms such as ‘the mentally ill’ on therapeutic stance (Granello & Gibbs, 2016) and the harmful impact of media reports linking mental illness with violence and danger (Bilić & Georgaca, 2007; Sieff, 2003) are such examples. Individuals are constructed as less-than-human, legitimising social responses such as disgust and fear, as well as enabling social practices of segregation, surveillance, punishment and abuse

(Hacking, 2004). These studies indicate that language has the power to cast particular attributes about objects and people in a prominent light (Holmes & Wolff, 2011), more than this, it has a constitutive power (Davies, 2000). In addition, labels applied to individuals by state institutions have particularly powerful effects, leading to internalised stigma (Goffman, 1963; McPhail, 2013). Internalised stigma of mental illness has considerable consequences, such as: maladaptive behaviours and impeded recovery (Livingston & Boyd, 2010); social exclusion (Sayce, 1998); and socially sanctioned economic penalties (Funk, 2004). Related to this, 'lay theories' are central to the reproduction of stigma (Link & Phelan, 2001) and are imbricated in professional/clinical understandings (Manuti & Mininni, 2010). As Rafter (2004) suggests, psychopathy is a metaphor for the outsider and other, and its elusiveness enables a correspondent social conviction in its existence.

1.7 Previous Investigations of Professional Accounts

Formal examinations of professionals' accounts are increasingly abundant; many of these are in the form of Doctoral theses and cover a wide range of psychological and psychiatric phenomena. In contrast, few attempts have been made to explore the accounts of professionals working with those labelled as psychopathic; some exceptions, which do so from a realist perspective, have been discussed (see section 1.1.2). There are also a small number of studies exploring professionals' accounts from a critical stance; four of these were considered directly relevant and serve as a 'springboard' for the present research.

1.7.1 Accounts of Professional/Expert Text and Talk

Through Foucauldian discursive analysis of psychiatric descriptions of psychopathy, Federman et al. (2009) illuminated the interplay of psychiatric power and the construction of the psychopath. More specifically, the authors elucidated a lack of epistemological debate as coexisting with prevailing discourses about psychopathy, which construct 'truth' despite a lack of evidence. They attributed this to the prevailing post-positivist paradigm of the scientific domain. The authors argue that psychopathy stands as a reference point across contexts for extreme mental and

criminal disorder which is co-produced and reinforced via public, political and scientific media. This analysis suggests that psychiatry has the capacity to function as a form of social control, whereby socially transgressive behaviour is understood in diagnostic terms, and that the insistent and uncertain nature of these terms enables their reproduction and reinforcement. It also demonstrates an underlying assumption within forensic psychiatry and psychology that mental disorder, at least in some cases, leads to a propensity for criminal behaviour. This legitimises the conceptualisation of criminality in medicalised terms and justifyies the role of expert witnesses and preventative treatment programmes (Anckarsäter, Radovic, Svennerlind, Höglund, & Radovic, 2009).

Hamilton (2008) examined several contemporary accounts of psychopathy from the writings of Robert Hare and Paul Babiak, two major proponents in the field of psychopathy research. Hamilton's analysis uncovered a "seepage" (p. 223) from scientific and medicalised constructions of psychopathy into mythical discourse, and a tendency for the 'facts' about psychopathy to be located in fiction. An uncertainty with regards to the scientific construct is exposed and the various ways in which psychopathy exists between science and imaginative fiction are delineated. This study highlights that, while authoritative 'expert' text seeks to establish psychopathy as a scientific fact, the concept itself is best detected 'out there', and as having a mystical or fantastic quality. The findings of the analysis also relate to Foucault's (1991, p. 222) observations of a shift in focus from crime to criminal, whereby preoccupations centre on "the danger potentially inherent in the individual", so moving away from the need for an observable transgressive act to punish.

In combination, Federman et al's (2009) and Hamilton's (2008) analyses demonstrate the blurriness of fact and fantasy in scientific discourse when delineating psychopathy and positioning the psychopath. They may also indicate the presence of an overlap between 'professional' and 'lay' understandings of psychopathy; such findings undermine claims of empirical objectivity. A tendency within scientific journals to refer to the Biblical story of Cain and Abel as "evidence" of the long-standing presence of psychopathy is a pertinent example of this fictionalisation (e.g. Kiehl & Hoffman, 2011).

Richman, Mercer, and Mason (1999) examined forensic psychiatric nurses' talk about deviant behaviour; the authors identified an intertwining of clinical, criminological and everyday discourse. Most significantly, the analysis revealed the presence of an overarching "taxonomic order of evil" (p. 300), whereby deviancy was attributed to an inherent evil in individuals identified as psychopathic. This stood in contrast to talk about individuals identified as psychotic, who were positioned as innocent via their madness, but denied ownership of action and thought. The authors concluded that the availability of a discourse of evil for those seen as psychopathic enabled the production of a dichotomy of good and evil, with notions of rationality and free-will utilised by participants to evidence this. This research may highlight the availability of a grand discourse of 'disease' versus 'deviance' for psychiatric professionals working directly with those with a label of psychopathy. Moreover, this study emphasises the socially constructed nature of deviance by evidencing that the deviant label can be removed, or minimised, depending on the presence of other labels (e.g. 'mad') (Gray, 2011). However, for those with psychopathy the deviant label has permanence, meaning that rehabilitative or reparative efforts are, by implication, impossible. Significantly, Szasz's (1974) earlier ideas regarding the simultaneous disowning of responsibility for, and enabling the social control of, 'problem' people are pertinent here; there is an accepted belief that psychopathic individuals deserve the most severe forms of social control because they possess characteristics considered to be the most abhorrent. This justifies the use of stigmatising labels ('psychopath', 'evil', 'deviant'), in order to alleviate any damage they cause.

Through analysis of interviews with 'elite' neuroscientists, Pickersgill (2009) examined ways in which experts discursively constructed APD and psychopathy. The analysis uncovered discourses of 'biology' and 'environment' which were employed by participants to explain the development of antisociality. More specifically, notions of 'risk' were embedded in participants' talk, which had the effect of producing non-deterministic accounts of APD and psychopathy. Additionally, out of talk about 'successful psychopaths', some ambivalence with regard to pathology and its location emerged. Here, as in other studies, Pickersgill emphasises a wider context out of which these discourses are possible; a rising focus on the notion of 'dysfunctional personalities' within UK mental health policy and practice (Pickersgill,

2010, 2012, 2014) and an underlying uncertainty with regards to their scientific categorisation (Pickersgill, 2011a, 2011b), evinces an interface between law and health with capacity to shape pathology.

Read together, Richman et al's (1999) and Pickersgill's (2009) findings are contraindicative of the apparent shift towards a language of 'destigmatising personality disorder' and its status as a treatable condition (Pilgrim & Rogers, 2005). Rather, these studies demonstrate the complexity of experts' talk and its powerful, constitutive effects, such as the construction of personality disorder treatment (whether preventative or curative) as both a therapeutic necessity and a professional ethical duty.

1.8 Summary and Rationale for Current Research

The history of the construct psychopathy reveals a powerful and long-standing discourse: some people are 'born bad'. A realist perspective on the psychological or (neuro)biological characteristics of individuals has been preferred across the mainstream literature to date. As Jones (2016) argues, such a focus inevitably produces only a thin understanding of a phenomenon which exists in psychological, social, physical and cultural realms of human life. Given the prevailing research paradigm and the history of the construct, such research foci is understandable (Godfrey-Smith, 2000); if psychopathy is understood to be a real-but-unobservable fact, the longstanding drive to identify its constituent parts makes sense. However, despite prolific research, no common pathology of psychopathy has been identified and researchers continue to debate the core features of the construct (Scott, Lilienfeld et al., 2012; Miller & Lynam, 2012).

Since the anti-psychiatry movement, individualised, biomedical investigation has been criticised for being a mechanism through which culturally troublesome behaviour is redefined according to pathological conditions of somatic origin, enabling treatment and control from medical authorities (Szasz, 1974). However, unlike research in other areas of mental health (e.g. Boyle, 2002), this shift in thinking in relation to psychopathy is in its infancy, perhaps pointing to the

pervasiveness of the belief that some people are pathologically ‘bad’. Thus far, the social component of psychopathy has been poorly investigated, especially with regard to how psychopathy is constructed discursively and how this contributes to the way individuals with the label are understood. This gap is problematic as clinicians and academics recognise that personality disorder diagnoses, including psychopathy, offer flawed or limited explanations for complex phenomena (Black, 1999; Bornstein, 2011; Pilgrim, 2001). Research should therefore seek to widen the clinical frame via sociological inquiry, moving away from a focus on randomised controlled trial (RCT) investigations, which centre on an individualised diagnostic concept (Pilgrim, 2001).

A body of research which closely explores the clinical significance and implications of the psychopathy construct from a critical perspective was identified in the literature; four of these studies were directly relevant to the present study and were briefly outlined. Noting these exceptions, scientific attempts to investigate the accounts of professionals on the subject of psychopathy are rare. Moreover, there do not appear to have been any investigations into the accounts of *clinical psychologists* working with individuals with psychopathy to date. This is significant given that the psychology profession holds status as a key professional group with the skills to assess for, and confer the presence of, psychopathy.

Examination of professionals’ talk has proved to be an insightful research endeavour in other mental health contexts (e.g. Harper, 1999); the accounts of clinical psychologists working with individuals with a label of psychopathy is likely to be similarly revealing and significant. Thus, this study aims to explore discourses within clinical and psychological constructions of psychopathy by examining clinical psychologists’ understandings, including how they construct this knowledge through speech acts, and the subjectivities that are produced by their constructions. It is likely that competing and contradictory positions will be taken up by the participants; an analysis of the functions and interests served by these positions may highlight social and clinical implications for psychology practice.

1.9 Research Questions

In light of the above literature review, by examining the discourses of those who use and apply a label of psychopathy in their professional lives, the following research questions will be addressed:

1. How are professional and wider socio-cultural contexts imbricated in how clinical psychologists construct psychopathy?
2. What discourses are produced through these constructions?
3. What are the implications of these constructions for clinical psychology practice within forensic settings?

2 CHAPTER TWO: RESEARCH METHOD

In this chapter, I will outline the epistemological and methodological positions adopted in this research, including its central characteristics and assumptions, followed by a brief summary of Foucauldian theoretical underpinnings informing the chosen approach to discourse analysis. I will then summarise the recruitment and interview procedures, as well as the ethical considerations involved in undertaking this research. I will summarise the analysis method and offer a rationale for its application to the data of the present research. Lastly, I will outline the reflexive considerations I sought to apply throughout the research process.

2.1 Epistemological Position

This research draws on a critical realist social constructionist framework (also described as 'moderate social constructionism') (Harper, 2011). Research in this tradition assumes that the types of reality available to us are co-constructed socially and through language, and differ according to place and time, which could be said to be epistemologically relativist. At the same time, this framework assumes the presence of underlying structures and mechanisms which produce phenomena that are constructed linguistically in particular ways, thus this position could be described as ontologically realist (Parker, 1992). A key assumption of this position is that, as individuals, we possess beliefs or claims about our world, based on the accumulation of lived experience and intricately tied up with socio-cultural contexts. The presence of social rules and standards determines which of these claims about reality are authorised as knowledge, meaning that certain claims have more social and cultural currency than others, as well as being more or less available to us. Central to the critical realist social constructionist argument, therefore, is the presence of an interacting and interactive process between individual and society, shaping available ways-of-being in the world, as well as what can be claimed as valid knowledge (Elder-Vass, 2012).

In relation to research, a critical realist social constructionist framework assumes the importance of contextualising talk and attending to the ways in which institutional and

material structures (extra-discursive factors) are manifested in individuals' lived experiences. An example of this in the context of the present research might be attending to the extra-discursive power of government policy and legislation in shaping forensic services and the 'necessities' which are upholding this, such as security procedures and the use of psychological assessment (Sims-Schouten, Riley, & Willig, 2007). In this way, a critical realist constructionist position recognises that by exploring relationships between discourse and practice, it is possible to locate talk within extra-discursive factors such as materiality, institutional power and embodiment (Iosifides, 2011).

A critical realist constructionist position differs from 'direct realism', which assumes that research data mirror reality and that through investigation, truth about the world can be uncovered. It also differs from a 'radical social constructionist' position, which assumes that discourse constructs reality and, therefore, research should focus solely on language as the only directly available source of information (Willig, 2008). Some researchers argue that the critical realist social constructionist position leads to selectively challenging knowledge claims, whereby analysis only partially problematises a phenomenon (Woolgar & Pawluch, 1985) and, more fundamentally, that it brings together two epistemologically incompatible positions (Speer, 2007). However, proponents of the position emphasise the political nature of research practice and argue that by moving beyond the text/talk under analysis, it is possible to engage with deeply socio-political and moral aspects of human life, thus adopting a more ethical research framework (Edley, 2001; Parker, 1998).

2.2 Methodological Position

There are two main traditions within discourse analysis; Discursive Psychology and Foucauldian Discourse Analysis (FDA) (Willig, 2008). The present research adopts the latter methodology; this was considered to correspond well with the epistemological position, with its starting point that available realities are not directly accessible and that interpretation and analysis should seek to move beyond language by locating talk within historical, political, cultural and social contexts (Harper, 2011). Moreover, by locating analysis within wider discursive practices with

a Foucauldian lens, explicit references to politics and power are enabled (Jager & Maier, 2009).

Some of the central assumptions of Foucauldian theory and research will now be outlined[7]. These ideas will be drawn upon in the analysis; although there is no single way to perform an FDA (see section 2.5.1), Foucault's works provide a range of ideas- a "tool box" -that a discursive researcher can draw upon (Foucault, 1974, p. 523).

2.2.1 Discourses and Subject Positions

Central to Foucauldian theory is the notion of discourse. Discourses can be understood as recurrent systems of statements that are used to talk about objects and events in the world, which make certain social practices and ways-of-being appear more reasonable than others (Parker, 1992). They indicate distinctive ways that a phenomenon can be talked about and point to existing limitations in self and other construction. In this way, discourses serve as 'building blocks' for entire institutions (e.g. medicine, law, science) (Edley, 2001). They point to operations of power and ways in which individuals are 'subjectified'; that is, the particular kinds of self it is possible to be (Foucault, 1982). This relates to the concepts of *positioning* or *subject positions* proposed by Harré and colleagues (Davies & Harré, 1990; Harré & Van Langenhove, 1999). Positioning offers an alternative to mainstream notions of identity and roles; through positioning, an individual's speech and action are located within particular social categories and this enables or disables particular self-constructs. For both a speaker and the subject of talk, subject positions are available based on the discourses within which they have been located, and the possible roles that a person may or may not claim for themselves arise from within these discourses (Willig, 2008).

Individuals are naturalised into particular discursive resources and practices, which are culturally and historically situated rules for the organisation of social knowledge, and which have implications for a person's subjective experience (Edley, 2001;

[7] Ideas and concepts discussed in this section are structured discreetly, however, readers should note that Foucault's works have aimed to illustrate that power, knowledge and subjectivities (as located in discourse) are interconnected (Rabinow, 1991).

Willig, 2008). For example, a clinical psychologist might talk about themselves as a 'scientist-practitioner'; this discursive practice demonstrates an available subject position which has particular effects in the construction of psychological phenomena, thus pointing to possibilities of action. Foucauldian discourse analysts would seek to examine whose interests are best served through different discursive formations (Foucault, 1980).

2.2.2 Knowledge and the Psy-Complex[8]

Knowledge, in the Foucauldian sense, has a productive role in shaping the world and what is knowable and possible within it (Arribas-Ayllon & Walkerdine, 2008). Foucauldian theory problematises the notion that there is a 'real' world whose 'true' nature can be uncovered, rather it assumes that there are multiple versions which are constructed through language and which have social, psychological and physical effects; therefore, available 'truths' construct and sustain certain forms of human social life (Burr, 1995) and shape the possibilities for action within an individual's cultural reference (Fairclough, 1995). For instance, of central concern to the present research is knowledges practiced by clinical psychologists, part of the constellation of professions prefixed by the term 'psy'.

Rose (1999, p. x) poses a series of questions in relation to the examination of knowledge which make plain the Foucauldian endeavour to produce a history of knowledge in the present and, in so doing, question present certainties: "Where do objects emerge? Which are the authorities who are able to pronounce upon them? Through what concepts and explanatory regimes are they specified? How do certain constructions acquire the status of truth?" It is the intention of Foucauldian research to answer these questions by investigating the techniques through which psy-professions generate, circulate and deploy particular knowledges in service of a particular version of reality; what might be termed 'regimes of truth' (Foucault, 1979). An example of this process of meaning production might be the use of psychometric assessment to legitimate conferring a diagnostic category (e.g. psychopathy) onto an individual. In this way, tools such as standardised questionnaires (e.g. the PCL-R),

[8] The term 'psy-complex' is attributable to Rose (1999) whose theories can be understood as conceptually Foucauldian.

categorisation systems (e.g. the DSM), and pharmacological and psychological interventions, can be seen as ‘technologies’ which produce knowledge or truth that becomes ‘common sense’ (Parker, 1997).

The psy-professions are also implicated in the production of binary divisions which enable forms of social regulation and control. Pertinent examples of binary divisions in the context of the present study are good/evil and mad/sane; truths about what constitutes these categories become part of the social fabric, turning surveillance practices, such as the “observations of others, supervision and recording of movements” (McIntosh, 2002, p. 72), as well as indefinite incarceration and indeterminate sentencing, into common-sense practice. In visible and explicit ways, technologies of surveillance are routine/integral/constituent in forensic contexts. However, surveillance can also be invisible; Bentham’s panopticon prison design, where prisoners internalise the disciplinary ‘gaze’, was theorised by Foucault (1991) as an example of such internal surveillance processes. Governmental policies about the management of problematic individuals (those with personality disorder, for example) are other examples of implicit surveillance.

2.2.3 Power

Following Foucauldian theory, “power and knowledge directly imply one another” and are inextricably linked (Foucault, 1991, p. 27). Moreover, power is not a ‘thing’ but is understood as existing between people, institutions and other intra-individual relationships. As such, power is not something that is owned by the State, and it can be seen to be operating at all levels of social relations, from the most proximal/micro to the most distal/macro (O’Farrell, 2005). Central in this regard are ‘technologies of the self’ and ‘technologies of power’ (Foucault, 1988b). These are practices and techniques by which individuals and institutions regulate and govern human conduct. These technologies orient towards an objectification of the body as a site of production and subjection (Rabinow, 1991), with the aim of making bodies ‘docile’ (Foucault, 1991). ‘Biopower’ is an example of a technology of power, whereby medical and political domains are linked through their use of the human body (McIntosh, 2002; Nilsson & Wallenstein, 2013; Peckover, 2002). This is of particular

relevance to the present study; the psychopath, as a deviant kind, is constructed *between* psychiatric and legal institutions.

With these ideas in mind, Foucauldian research is especially concerned with the networks, strategies and techniques by which knowledge is formed and decisions are accepted; what Foucault (1990, p. 102) described as “mechanisms of power”. Non-discursive practices are also implicated in this production process; they refer to the “institutions, political events, economic practices and processes” involved in the reproduction of power (Foucault, 1969, p. 162). This process of state sanctioned knowledge-production and dissemination, and enforcement of socially acceptable behaviours, as well as the corresponding production, dissemination and enforcement of *sanctionable* behaviours, is termed ‘governmentality’ (Foucault, 2007). At the same time, power has both a repressive and a productive capacity, and can fluctuate according to shifting alliances and dialogues (Parker, 1992). Thus, resistance in the form of counter-discourses (voicing alternative truths) are possible within talk. More than this, according to Foucault (1980), resistance is an essential component of the functioning of power, meaning that non-dominant discourse produces knowledge which undermines accepted truth claims and points to alternative positions and ways-of-being, thus making different social practices possible. An example of this is the *Hearing Voices Network*, which provides a powerful counterpoint to the prevailing knowledge that individuals who hear things others do not are unwell and need to be cured, typically through pharmacological interventions (Romme & Escher, 1993).

2.2.4 Rationale for Using FDA

In line with Hacking (2007; 2006), the psychopath has long been constructed as a human kind. More than this, the psychopath is an object through which multiple institutions intersect (medicine, psychology, law, government). The literature base reveals a shared belief in the construct across the ‘mainstream’ of these professions, but a concurrent and longstanding doubt is also revealed to run alongside this. Thus, there are tensions within the available discourses relating to psychopathy. By utilising a Foucauldian approach, it is possible to explore how the concept is understood, the ways in which language is used to construct these understandings,

the structural and material factors out of which these constructions are made possible and reinforcing, and the proximal and distal implications of this talk.

Limitations of FDA should be acknowledged; in seeking to comment on wider non-discursive, material practices and overtly moving away from consideration of the interactional context, FDA has been criticised as failing to attend to micro 'in text' issues and of imposing intellectual preoccupations onto practice (Schegloff, 1997). Moreover, the absence of a standardised methodological process means that Foucauldian researchers are at greater potential risk of analytic shortcomings when engaging with textual data (Antaki, Billig, & Edwards, 2004). Given this, I have sought to ground the analytical process in the methodological literature (Willig, 2008).

Other methodological approaches were considered. Most notably, a Discursive Psychology approach could be appropriately applied to the same dataset but would focus analytical attention on locally organised discursive practices, such as interpretive repertoires and rhetorical devices (Edwards & Potter, 1992). Through this methodological approach, micro-level interactions are attended to in order to understand how stake, accountability and interest are managed by participants, such as through patterns of speech which position accounts as natural or unproblematic (Edwards & Potter, 1992). An example of this is "category entitlement", which draws attention to a speaker's group membership for the purposes of legitimising a claim ("as a psychologist, I would say they seemed psychopathic"). However, this approach has been criticised for its failure to attend to macro-level socio-political power relations (Wetherell, 1998), which are central to the aims of this research. Significantly, through engagement with an additional layer of analysis and interpretation, beyond the speech acts of participants, discourse and practice are linked, with the consequential possibility of identifying alternative positions, leading to alternative social practices. This is of particular importance to the present research given that people identified as psychopathic are portrayed as 'other' and experience considerable social inequalities, demonstrated throughout Chapter One.

Moreover, this research is underpinned by an epistemological position which recognises that power/knowledge constellations of the psy-professions enable

certain things to be constructed as true via particular discursive constructions and related practices. It has been argued that psychopathy is one such construction, and that clinical psychology is a central figure in its reproduction. Thus, an FDA of the multiple ways clinical psychologists talk about and use the concept of psychopathy is an important endeavour. In interviewing only clinical psychologists this research seeks to attend to the continuities and discontinuities in how psychopathy is talked about by an invested and dominant professional group, and to attend to the dynamic constitution and reconstitution of manifold and contradictory discourse practices (Davies & Harré, 1990). This may also enable the identification of counter-discourses and an exploration of their alternative implications.

2.3 Procedure

2.3.1 Ethical Considerations

2.3.1.1 Ethical Approval

Ethical approval was sought and granted at School and University levels (Appendices A and B). The project was also registered and authorised on the Integrated Research Application System (IRAS) in order to obtain NHS Permission, due to recent changes to processes around recruiting NHS staff as research participants (Appendix C). Following this, three NHS Trust Research and Development (R&D) departments were contacted for ethical approval (Appendices D-F). No issues arose from these processes.

Of note, the original proposal outlined focus groups as the preferential data source. However, following informal consultation with senior clinical psychologists, interviews were identified as the preferred mode of data collection due to anticipated logistical difficulties in requiring potential participants to be available at a shared time. The proposal was amended accordingly and resubmitted for ethical approval, as above.

2.3.1.2 Participants' Rights

Informed consent was sought prior to conducting data collection (Appendix G). In concordance with the research method, it was not possible for participants to be aware of the information they might disclose prior to the interviews. Therefore, upon completion, participants were asked to reconfirm their initial consent to participation in order to truly ensure informed consent. Participants were informed of their right to withdraw from the research at any time. They were also advised that, should they wish for something discussed during the interview to be omitted from the transcription at a later date, this would be accommodated without issue. None of the participants have requested that the interview transcriptions be amended in any way.

All names, service locations, and other identifying information has been anonymised. All data were stored on an encrypted USB stick.

2.3.2 Recruitment

A purposeful sampling method was utilised, meaning that the sample for the research was targeted to meet the needs of the research questions. An information sheet (Appendix H) was sent to the psychology leads of forensic services within R&D approved Trusts, to be distributed to the staff. One service requested a presentation at a team meeting, which was facilitated.

The research inclusion criteria specified Health & Care Professions Council (HCPC) registered clinical psychologists currently working in forensic services and in contact with service users identified as psychopathic. No age, gender, ethnicity or religious restrictions were applied to recruitment. One participant was excluded from the research on the basis that they had never worked with anyone ascribed a label of psychopathy. All other individuals who expressed an interest in taking part met the inclusion criteria.

2.3.3 Participants

Eight participants were interviewed in total. Georgaca and Avdi (2012) recommend that a minimum of six participants be recruited for interview data in order to achieve theoretical saturation; this is the point at which enough data have been gathered to

allow for a repetitious and in-depth process of analysis, leading to a point at which no new data appear and all theoretical concepts are well developed (Morse, 2003).

Three participants were male, five were female. All participants were between the ages of 30 and 50 and identified as White British. Participants were working across low (3), medium (4) and high (1) secure NHS forensic services. Participants reported predominantly working in forensic settings since qualifying as clinical psychologists. Though no minimum time since qualification was stipulated, the most 'junior' clinical psychologist recruited had been working in forensic services for three years. Participants received their Doctoral Degrees from a variety of university institutions across the UK.

2.4 Data Collection

2.4.1 Interviews

Semi-structured interviews were the chosen mode of data collection. As noted in the original proposal, naturally occurring talk, such as that produced in focus groups, is considered to be the optimal data source for discursive research. This is because it is most likely to provide a context from which the construction of discourses can be examined through a conversational, 'natural' interaction amongst participants, whilst also providing a structure in which to contain discussions on contentious topics (Willig, 2008). However, focus groups were considered to be logistically problematic from a service management perspective, meaning that it was necessary to collect data via semi-structured interviews (see section 2.3.1.1). Significantly, adopting an individual interview method allowed for the collection of data from 'lone' respondents (i.e. no one else in their service expressed interest), meaning that the dataset represents a variety of clinical psychologists working across multiple settings and levels of security and, therefore, cannot be said to be 'service-specific'. Five interviews took place on NHS sites at the interviewees' place of work. Two interviews were held at private locations because participants were on annual or maternity leave at the time of the interviews. One interview was held at the University of East London.

A semi-structured interview guide (Appendix I) was developed in order to facilitate the interview process and to ensure a degree of uniformity in the topics covered during each interview. This was developed in reference to the literature and in collaboration with my Director of Studies. A pilot interview to test the efficacy of the interview guide was not possible due to difficulties with recruiting participants. However, due to the protracted recruitment process, earlier interviews were transcribed prior to later interviews taking place, meaning that a natural process of reflection and development in relation to the interview guide did occur. For instance, I became aware that the use of words such as 'difficult' and 'support' imply a problematic nature to psychopathy, which would potentially influence the direction of participants' talk. Consequently, at later interviews, I sought to adopt language used by the participants themselves, rather than offering particular descriptions unsolicited. Moreover, I recognise that an interviewer's questions are vital in the production of interviewees' accounts, and that my own subjectivities will have informed consequent talk (Baker, 1997). For instance, I am aware that my use of leading questions at times informed the content of the consequent conversation; this is a potential limitation of the study and, in order to ensure transparency, I have sought to be explicit about these dyadic features of discursive constructions throughout the written analysis. A reflective, conversational style was used throughout, in order to facilitate a comfortable space where rich data could be gathered (Smith, 2008). Broadly speaking, the interviewees were asked to talk about how they understood the concept of psychopathy, their experiences of working with this identified group, their thoughts on the impact of the label and related assessment processes on themselves, the individuals assigned the label, and the systems in which they practice.

2.4.2 Transcription

Eight participants produced a total of 435.7 minutes of data ($\bar{x}$ = 54.46; range = 48.18–65.86). Interviews were digitally recorded and then transcribed verbatim using a Jefferson-lite approach (Banister et al., 2011); see Appendix K for transcription conventions. I transcribed all data. This simple framework was considered most appropriate for the nature of the analysis, which focussed on broad discursive

practices rather than proximal speech features (e.g. gestures). Once transcribed, the full dataset amounted to 6360 lines of text typed on Microsoft Word.

2.5 Analysis

2.5.1 'Doing' Foucauldian Discourse Analysis

As Arribas-Ayllon and Walkerdine (2008) state, there is no 'right' way to 'do' FDA, no single set of techniques to be utilised by the researcher. Instead, there are a range of Foucauldian ideas which the researcher can apply to a discourse analysis depending on their research aims (see section 2.2). Moreover, the irony inherent in seeking to apply a rigid formula for 'doing' FDA must be acknowledged; this is anathema to Foucault's theses and his ideas about 'technologies of domination' are applicable here (Foucault, 1991). Several commentators have noted the artificiality of such distinct fault lines between the two traditions of discourse analysis, arguing that their respective analytical foci overlap (Potter & Wetherell, 1995; Willig, 2008). Nonetheless, as a novice researcher, I closely consulted guidelines for performing an FDA. One possible way of approaching FDA research is offered by Willig (2008). She outlines six stages to the process, though emphasises that these are non-linear:

- Stage one consists of identifying the 'discursive object' and the way it is being constructed within the text. Willig emphasises that attention should be paid to both implicit and explicit references, as well as what is not being said.

- Stage two consists of identification of discourses, which means locating the various constructions of the discursive object within wider discourse frameworks; for example, a biomedical discourse.

- Stage three consists of investigating the action orientation of the different discourses by exploring when and how they are utilised in the text. She recommends asking "What is gained from constructing the object in this particular way at this particular point in the text? What is its function and how does it relate to other constructions produced in the surrounding text?" (p.

116). The answers may point to ways in which a particular discourse justifies certain practices.

- Stage four consists of identifying available subject positions, which are the 'discursive locations' from which individuals can speak and act. Willig notes that subject positions implied by different discourses can either be taken up or resisted and both responses have implications.

- Stage five consists of consideration of opportunity for practice; that is, what actions (both productive and restrictive) follow from particular discourses.

- Stage six consists of exploring the relationship between discourses and subjectivities, thus considering what are the possible 'realities' given the available discourses and their arising subject positions.

Across multiple readings of the dataset, these features were investigated; discursive constructions (Appendix L) and subject positions (Appendix M), including possible practices and discourses, were identified and categorised. Holding in mind the research questions, further readings resulted in the identification of overarching constructions and subjectivities occurring across the dataset, into which initial themes were assimilated; these provided a data-driven structure for the analysis write-up. At all analytical stages, when engaging with the data, I used a pencil to mark the original transcripts; for auditing purposes, examples of annotated transcripts are reported in Appendices N-P. The final stage of the analysis involved transforming my note-form analysis into fully-formed text; this necessitated further clarification of analytical work and reengaging with the wider literature. This extensive process has meant that several layers of Foucauldian-informed analysis were conducted on the data, resulting in an empirically robust[9] analytical process.

[9] In the sense that the results of the present research aim to contribute to theory-building within the social sciences through a methodologically rigorous approach (Chouliaraki & Fairclough, 1998).

2.6 Reflexivity

As Parker (1994) highlights, different researchers necessarily interpret different results dependent on their context and the meanings they attribute and, therefore, the influence of the researcher can be felt at all levels of the research process. In this way, researcher bias is an inevitable feature of qualitative research (Parker, 1999). Thus, any qualitative analysis, including this one, is necessarily equivocal; even Foucault (1969) observed that his own analysis was deliberately limited. Reflexivity is an essential part of quality-evaluation in research (Fossey, Harvey, Mcdermott, & Davidson, 2002). Through the process of reflexivity a researcher can attempt to contextualise the 'regime of truth' they are constructing through their research (O'Farrell, 2005). Thus, from the beginning of this process, as well as at each of the research stages, I have sought to examine that which I am both drawn to and avoidant of when engaging with the data in order to remain alive to the limitations of the knowledge claims I make.

For instance, by adopting a critical stance towards the psychopathy construct, I am positioned and position myself in particular ways (Willig, 2009). I am aware that throughout the interview process I took up multiple contradictory positions, in order to probe and elaborate participants' accounts, and to make sense of what was being said. Simultaneously, I was conscious that the process of being interviewed could be experienced by interviewees as though their opinions and practices in relation to psychopathy were under scrutiny, leading to a modification in my questions and responses.

In addition, as a trainee clinical psychologist at the University of East London, I have been influenced by teaching which privileges a critical framework towards the practice of psychology and the knowledges produced by the wider profession; as such I aligned with a critical perspective towards the construct of psychopathy. At the same time, previous experiences of forensic services and familiarity with the practices therein have naturalised me to the various assumptions of a forensic context; the consequent ease with which I 'slipped' into reproducing prevailing knowledges about constructs like personality disorder and psychopathy was

therefore a potential source of tension within the present research. It is also possible that my preference for a critical stance towards mainstream clinical psychology practice, combined with previous experiences of working in forensic psychology settings, contributed to my decision to investigate clinical psychologists' talk about psychopathy. This potential bias was balanced by the fact that psychologists in forensic settings are the most likely professional group to conduct psychopathy assessments, rather than psychiatrists or nurses. Thus they hold an expert position in relation to the construct, making them a preferential research population for this study.

A reflexive review of other issues arising throughout the reflexivity process is offered later (see section 4.2).

3 CHAPTER THREE: ANALYSIS AND DISCUSSION

In this chapter I offer an analysis of interviews conducted with eight clinical psychologists working across secure forensic services. I will present an analysis of the discursive constructions of psychopathy, followed by an analysis of related professional subjectivities. An examination of available discourses, their implications and uses will occur throughout. Attention will then shift to an exploration of the practices and positions implied through this talk for clinical psychology and forensic services. Foucauldian theory will be utilised throughout the analysis in line with the research methodology and extracts will be used to evidence analytical work.

3.1 Theoretical Assumptions of the Analysis

Several related and interlinking themes were indicated across participants' talk, with variations arising via a number of culturally available discourses. While the analysis will at times refer to the frequency with which these types of talk occurred, it should be noted that this is of less importance within this form of analysis than examination of their availability and possible function. Additionally, theoretical underpinnings of this research recognise that analyses have a 'position' and, therefore, the present analysis offers one of a possible many readings of the data. As such, this research can be said to be culturally located and thus does not describe an irrefutable statement on clinical psychologists' constructions of psychopathy (Van Dijk, 2011). It should also be emphasised that the structure of this chapter implies a distinction across and between features of participants' talk; this is artificial given their co-occurrence across the dataset.

3.2 Constructing the Psychopath[10]: A Uniquely Problematic Individual

Participants constructed individuals with psychopathy as problematic in a variety of ways. Talk arose from recurring variations of hegemonic discourses; 'at risk' and 'trauma' discourses were utilised across participants' discursive constructions, arising from overarching biomedical and biopsychosocial discourses to explain the

[10] To reemphasise, 'psychopath' is a conceptually problematic term; its use here intends to reflect the concept under construction between the interviewer and interviewee, as per the research questions.

aetiology of psychopathy. Additionally, a discourse of 'intuition' was used to describe ways in which psychopathy can be identified, sitting alongside descriptions of elusiveness ("slippery", "misunderstood"), so constructing psychopathy as a form of expert, specialist knowledge. Most frequently, constructions aligned with prevailing knowledges about psychopaths as 'bad', identifiable according to particular negative behaviours or characteristics. Participants' talk drew on language from the PCL-R and contemporary psychopathy research ("lack of empathy", "cold-callous", "manipulative"), thus biomedical, diagnostic and scientific discourses were prevalent across this discursive site.

Participants also produced an alternative construction, whereby individuals with psychopathy were constructed as psychologically damaged (i.e. 'mad'); this discursive construction was articulable via psychological concepts and theory arising from a biopsychosocial discourse. Constructions presented in this discursive site were the closest participants came to articulating a counter-discourse of psychopathy. From here, psychology-specific technologies (e.g. formulation) were positioned as mechanisms through which a richer, less stigmatised understanding would be possible. Thus, through this discursive construction, participants attempted to re-produce[11] (rather than reproduce) notions of psychopathy from within the structures of wider psy-complex power/knowledges.

Implicit across these discursive constructions was an assumption of behavioural 'norms', demonstrated via recurrent employment of comparison to other forensic service users and, at times, to the wider population. According to these parameters, a service user's behaviour was constituted as either a.) acceptable, b.) comprehensible given contextual factors, or c.) incomprehensible and deviant. In line with Hacking (2006), implicit (de)values were assigned to individuals with psychopathy according to the degree to which they deviated from these norming parameters.

[11] 'Re-produce' indicates a possible transforming process to these arrangements; 'reproduce' indicates pre-existing power/knowledge constellations (Moynihan, 2015; Shukaitis & Graeber, 2007).

Four overarching discursive constructions resonant with understandings of the label (e.g. Hare, 2003; Schimmenti et al., 2014) were identified across participants' accounts: dangerous, challenging, manipulative and psychologically damaged.

3.2.1 Dangerous

The psychopath was constructed as dangerous in a variety of ways: to more vulnerable service users; to staff, both physically and psychologically; to society at large. The prevailing sense was that psychopaths are responsible for a disproportionate amount of distress and difficulty in forensic settings, despite their rarity; this knowledge is in keeping with prevailing messages about psychopathy and aligns with wider extra-discursive practices, such as the Dangerous and Severe Personality Disorders governmental initiative (Duggan, 2011). In making sense of the psychopath as uniquely dangerous, this discursive construction is part of a framework which legitimises the need to incarcerate and contain. In the following extract, this sense of dangerousness is produced through multiple mechanisms: (1) emphasising that psychopathy is 'more than' APD; (2) emphasising that a person with psychopathy 'feels' different to all others; (3) articulating a need for 'intuition', implying that psychopathy is difficult to predict and foresee:

Extract 1 (Alistair: 150-172)

Kitty: so one of the things you were talking about earlier was, you were talking about APD as well as psychopathy, […][12] what's your sense of where psychopathy and APD merge? (.) or are they just the same thing?

Alistair: No they're not, I don't think they're the same thing. I think we've got lots of antisocial people here but not many psychopaths, if you wanna call it that, but it's a subset I think of APD. Erm (.) so you know if you look at the PCL assessment, half of it is basically antisocial PD you know, have they done all these things in the past that tick the box, (.) erm but then you've got that sort of feeling, I mean it's kind of a- it's a bit of intuition and experience I suppose, and working out who you

[12] Denotes text omitted for brevity. For transparency, omitted text is reported in Appendix Q.

> would score highly I think, but it's very much the sort of charismatic (.) <K: mm> you know lying, real sort of lack of empathy type of err type of people you know who are high PCL scorers, and antisocial (.) is maybe a bit more about erm I suppose both are to do with early circumstances but I think (.) you can put anyone into kind of really difficult situations and they might end up with antisocial PD, I think it takes (.) specific people to <K: mm> end up with sort of high PCL scores I think. (.) It's a small subset I'd say.

Alistair draws on a number of discourses in this construction of psychopathy; he takes up my question, including the diagnostic and psychiatric categories within it, to emphasise that APD and psychopathy are separate but related to one another, with APD constructed as comparatively commonplace across forensic settings. He legitimises this knowledge by calling upon the PCL-R as an objective diagnostic practice, so privileging associated biomedical assumptions of individualism and internal pathology. Thus, psychopathy is constructed as something rare but clinically identifiable.

Alistair draws on 'intuition' talk to exemplify psychopathy's distinctness. This was a common discursive mechanism across the dataset; its effect is to move possible constructions of the psychopath away from, or beyond, psychological assessment processes and nosological features, into a mythical, non-scientific space, whereby reliance on subjective, undefinable 'feelings' are legitimate means for the identification of psychopathy. Previous research into the mythologic tendency of professionals' accounts of psychopathy is resonant here (Hamilton, 2008). One possible consequence of this talk is that Alistair is positioned away from a status of scientist-practitioner, producing clinical experience and 'gut-feeling' as useful forms of knowledge. Clinical judgement (the scientification of intuition) is a legitimate psy-practice in assessment processes such as the PCL-R; Alistair's talk is locatable here. Instinct talk means that the subsequent construction of the psychopath as deceitfully charming- a 'classic' characterisation of the psychopath- does not require legitimation by objective means; as with all 'folk devils', the deviance of the psychopath is not located in the acts they commit, but in how they 'make' others feel (Cohen, 2002).

In accordance with mainstream research, the construct of empathy is identified as a central feature of psychopathy. Empathy is a concept within the purview of professional psychology and an example of a lay term which has been increasingly co-opted by the psy-professions as technical language (e.g. its inclusion on the PCL-R). By subsuming lay descriptions into professional terminology, asymmetric power relations are maintained and individuals with psychopathy are reproduced as sites for psychological attention and state intervention. The scientific value of diagnostic systems (DSM and PCL-R) are emphasised here in their ability to distinguish differing psychopathologies; in accordance with contemporary debates, psychopathy is constructed as a 'special' subset of APD (Coid & Ullrich, 2010; Skeem et al., 2011).

Alistair then emphasises different aspects of a biopsychosocial model to construct both APD and psychopathy as contrasting psychopathologies; while both are acknowledged as arising in part from "early circumstances", a (bio)psychosocial discourse constructs APD as a natural response by "anyone" in extreme circumstances, whereas a bio(psychosocial) discourse constructs individuals with psychopathy as having a predisposing vulnerability to developing the disorder. The practical implication of these constructions is that the behaviours of some individuals are difficult to comprehend without the use of the psychopathy label. Through such talk, the PCL-R and the psychopathy label are established as useful clinical tools for making sense of otherwise nonsensical behaviours, and for validating professionals' emotional responses. Most significantly, it is demonstrative of the self-fulfilling double-bind of psychopathy in action, previously noted in the theoretical literature (e.g. Pilgrim, 2001).

Alistair is then asked whether he thinks other professional groups would have a sense of the intuition ("flavour") for psychopathy. He responds:

Extract 2 (Alistair: 190-201)

(.) Not sure. I think its bandied about very easily the sort of label of psychopathy erm (.) errrrrrrrm no, I don't think there is that sort of real good sort of awareness. I think I think that the training helps er to give

> you that sense of what's antisocial and what's psychopathy <K: mhmm> erm but people get called psychopaths all the time when they're not, (LG) maybe because they're a child sex offender or something like that, but it's just because they've done something really nasty they think 'oh they must be a psychopath', but you know, not necessarily.

Others' responses are constructed as grounded in a 'lay' theory of psychopathy (Link & Phelan, 2001). This is offered as an implied explanation for why individuals with psychopathy are stigmatised, and is separated off from a more informed, clinical theory (McPhail, 2013). By emphasising that psychopathy is a term often misused and misapplied by others, clinical intuition is constituted as a form of technical knowledge which can be owned and used by a select few specialists (Federman et al., 2009). Thus, the construction of psychopathy as something dangerously illusive enables clinical psychology to position itself as having specialist knowledge and skills in the identification and use of the psychopathy label, as well as to train others in this 'awareness'. In this way, Alistair takes up an expert subjectivity (see section 3.3.3) and an effect of this is to make essential forms of practice which extend psychology's remit beyond the therapy room. By constructing psychopathy as something that is misused, confusing and requiring expertise, interventions such as shared team formulations and reflective practices become vital (see sections 3.4.1 and 3.4.2). Here, and across the dataset, a process of pastoral power is apparent whereby staff can be transformed into better practitioners through an increase in their ability to understand psychopathologies from a psychological perspective (Foucault, 1982).

Accounts of psychopathy retain a folkloric status and, as this extract demonstrates, professionals' talk is implicated in the proliferation of psychopathy's position as a long-standing moral panic (Cohen, 2002). This talk is not dissimilar to academics and researchers calling upon stories such as Cain and Abel as evidence for the ubiquitous existence of the psychopath cross-culturally and throughout history (e.g. Kiehl & Hoffman, 2011; Mackenzie, 2014). In constructing psychopathy in this way, its existence becomes common-sense and irrefutable.

3.2.2 Challenging

Participants constructed psychopathy as extremely challenging for staff teams to manage. Psychological language of 'splitting' and 'boundaries' was routinely called upon in this construction, suggesting that these terms have particular cultural valence within forensic contexts and pointing to a reification of metaphorical constructs (Lakoff & Johnson, 1997; Szasz, 1973). Several participants expressed ambivalence about the psychopathy concept; prior to the extract below, Evelyn described being "critical of the concept". Notably then, the 'challenging' construction is utilised by participants to manage this ambivalence; through it, the label is presented as necessary and helpful within forensic contexts. Thus, participants adopted a distal critical position towards psychopathy, by identifying problems at a theoretical level, and conjoined (or negated) this with a proximal realist position, by constructing psychopathy as a useful and meaningful concept for day-to-day working:

Extract 3 (Evelyn: 269-295)

Evelyn: There's probably only (.) a couple of people that I can think of really clearly where it's been a very very (.) predominant kind of (.) feature of their presentation or you know something that we've really (.) used as- by way of explanation for them.

Kitty: and what were those- what was what was that like? <E: erm> what happened?

Evelyn: (2) I think I think I quite enjoy working with people sometimes that are less (.) less psychotic in some ways and more (.) kind of (.) you know more of a personality presentation. I think you often have to think much more about the dynamics in the therapeutic relationship and as a psychologist you often feel like you have to- they're the people I use supervision more for, if that makes sense. Thinking about difficulties, you feel like boundaries are often pushed more erm (.) you know kind of often they're the people that (.) the team struggles more with like nursing staff and things, you might be thinking about how to work with

> them directly, and support (.) nursing staff from kind of barriers constantly being (.) pushed and maybe teams feel like they're being split and (.) you know people are told different things and you know kind of you know er (.) lying or telling fibs is a quite predominant feature and can be quite hard to manage in a team erm when people are sort of told different things and played in different ways (LG) and I think psychology can have a real use in that kind of like (.) you know, as sort of overall consultation and and sort of leadership role.

Evelyn begins by framing the additional challenge posed by the psychopath as an exciting alternative to other work, recruiting clinical language and mental illness/personality disorder distinctions into this construction. As in extract 1, psychopathy is constructed as a rare and unusual phenomenon, with the label used by staff as an explanation for an otherwise incomprehensible individual. Through this discursive construction high levels of supervision are framed as necessary, further reinforcing the construction of psychopathy as professionally challenging. Supervision constitutes a form of surveillance (a technology of power) whereby self-knowledge, insight and performance is monitored; Evelyn's active use of supervision indicates that surveillance practices are internalised and self-regulated (Foucault, 1988b). In this way, a process of docile-utility is operant, which serves to reproduce a neoliberal subjectivity, out of which Evelyn is individually responsible for the 'problem' of her emotional responses and self-insight (Gilbert, 2001). Thus, the supervisory relationship is a site for an economic transaction, through which emotions are regulated (professionalised) and productivity is maintained (Oksala, 2013).

Evelyn describes the nature of the challenge presented by individuals with psychopathy, utilising metaphors of boundaries and splitting; both are concepts within the particular purview of professional psychology, drawn from psychodynamic discourse (Bridges, 1999; Deacon, 2004; Yakeley & Adshead, 2013). As in extract 1, the challenge posed by the psychopath is described using technical knowledge, enabling a role for psychology in its explication and governance. Moreover, an effect of technical knowledge like this is to construe the object phenomenon as neutral and objective, a central ontological tenet of neoliberalism (Oksala, 2013). The effect of

this is to define psychopathy as a politically neutral truth, and psychology as a politically neutral truth-teller.

Evelyn describes ways in which the team “struggles” in relation to individuals identified as psychopathic; most notably, dishonesty and misinformation are central to this struggle, a description which aligns with wider available constructions of psychopathy in forensic settings and legitimises priorities of management rather than therapy strategies (Bowen & Mason, 2012; Mason, Caulfield, et al., 2010; Mason, Hall, et al., 2010; Parker et al., 1995). Structures of biopower imbedded in forensic psychiatric practices are apparent here; forensic institutions- a crossroads between medicine, government and law- render the containment of some individuals by other individuals essential. Behaviours constituted as challenging (e.g. “telling fibs”) are institutionally deviant and, therefore, they should be managed distally, through extra-discursive structures (i.e. secure facilities), and proximally, through consultation and leadership from knowledgeable psy-professionals. Thus, the constitutive and reinforcing relationship between a body (the psychopath), a collective (psy-professions) and institutions (medicine, government) is illustrated in the discursive construction of psychopathy as challenging (Lemke, 2013).

3.2.3 Manipulative

As in previous literature, another recurring construction of psychopathy across participants’ talk was an individual identifiable by their capacity to manipulate others (Blais & Forth, 2014; Richman et al., 1999); related terms used were deceitful, dishonest, scheming, slippery, duplicitous and devious. This construction is in keeping with dominant depictions throughout the wider literature, which signify the psychopath as deviant or ‘bad’ (e.g. Berg et al., 2015; Hare, 1999; Schaich Borg et al., 2013). The concept ‘manipulative’ is another lay term which has been appropriated by psy-professionals and imbued with a status of scientific, objective trait; its inclusion on the PCL-R is evidence of this process of language co-option:

Extract 4 (Fred: 474-507)

Kitty: I wondered er if you could say a little bit more about what are the particular difficulties of working with this client group?

Fred: I think er feeling as though you're being kind of manipulated, erm (2) sometimes erm (.) people can be quite skilled- but the thing the thing about kind of manipulation (.) is err I think it's quite unsettling, because whereas people with other personality disorders you can feel as though you're being manipulated, (.) it- you- it's more kind of easily understandable, and it's almost- you put it in the frame of (.) er the life that they've been through, so you can see the lens by which the person is in- interpreting you and trying to move in a in a certain kind of direction or- yeah. Whereas with kind of- with people er with psychopathy, it's almost like you don't know the the reason for which they're doing it in that way and sometimes it can just be in order to manipulate you, because that's one of their kind of their their strengths (.) so you don't necessarily see the kind of the reason why somebody's pushing or pulling you in a in a certain direction (2) erm (2) yeah er and well it's also I think gives you a <u>real</u> sense of feeling ill at ease erm and and unsafe, because you're not- it's it's almost like it's excavating the ground from beneath your feet, kind of thing. Erm with other people, you can more quickly get on to ground (.) where you're working on common goals together (.) er whereas the you know the ground kind of <u>shifts</u> er with people with psychopathy (.) erm yeah and very often because they don't they don't even view kind of what they're like as a problem in that way, or or as a negative and often <u>you</u> might not be all that certain (LG) about the- you know the collection of different traits that you're working with. If you're not clear about the concept, which lots of people aren't, then you find that you're either using the label in a very black and white way, which doesn't help you or you don't know that that much about it and you're slipping about all over the place, without having, you know, <u>anchor</u> points kind of for yourself (.) and you can't you can't use the other person as as as an anchor in a similar kind of way.

My question explicitly positions individuals with psychopathy as "difficult". Fred takes up this positioning with a construction underpinned by a diagnostic discourse; in

particular he draws on the language of the PCL-R (Hare, 2003). At the same time, Fred utilises intuition talk to describe “a feeling” of manipulation. As in extracts 1 and 3, the behaviours of, and emotional responses towards, individuals with psychopathy are constructed as incomprehensible. This is reinforced by a concurrent construction of other ‘kinds’ of service user, whose violence or damaging behaviours are comprehensible in the context of their diagnoses and histories (Hacking, 2007). Hence, a unique form of manipulation is assigned to the psychopath, one that is especially inexplicable and alarming. Language of “corruption of morals” is present here (Foucault, 1991, p. 77) out of which a ‘relational spectrum’ of deviancy is constructed, whereby the extent of an individual’s deviance is measurable according to the extent of professionals’ discomfort. Out of this construction, the label of psychopathy is positioned as a meaningful explanation for both an individual’s behaviours and a professional’s feelings. In so doing, a mutually reinforcing surveillance process is in action, requiring psy-professionals to engage in self-regulatory monitoring and formulation of their own internal emotional responses.

Throughout this extract, Fred employs an extended metaphor of being on unstable ground to describe the quality of his experience. Through this, the psychopath is constructed as disruptive and powerful with a corresponding subject position of vulnerability and professional instability. This construction necessitates introspection on the part of the clinical psychologist, a practice belonging to a cognitive psy-model; thus, evaluation of one’s internal states in-vivo becomes part of the sense-making process. The metaphor and comparative construction are simultaneously extended, serving to emphasise the unique challenge that individuals with psychopathy pose to the therapeutic endeavour, as compared to other service users. From this position, Fred establishes specialist knowledge about psychopathy as essential for preventing therapeutic uncertainty and misuse of the label through oversimplification. In this way, knowledge of psychopathy and self-knowledge are constructed as valuable safeguards, uniquely essential when working with psychopaths due to their manipulative nature. This is resonant with underlying messages in much the contemporary literature, which emphasise that identification and awareness of psychopathy are vital clinical assets in forensic systems (e.g. Hare et al., 2000; Loving, 2002). Thus, Fred conceptualises his experience of, and responses to, the psychopath in line with pre-existing psychological knowledges; his construction and

understanding both depend on and propagate available discourses relating to psychopathy (diagnostic/intuition) and to self-reflection (of cognitions and feelings). A theory-laden process of observation is therefore in action (Kuhn, 1970).

3.2.4 Psychologically Damaged

Individuals were constructed as vulnerable figures who are psychologically damaged, possibly not in control of, or responsible for, their actions. Various psychology theories were drawn on in this talk. A tension was present in the construction; participants drew on 'trauma' discourses (e.g. Dillon, Johnstone, & Longden, 2012; Patel, 2011) to explain subsequent psychological deficiency and also 'genetic vulnerability/ at risk' discourses (e.g. Laajasalo & Häkkänen, 2004) to evidence a predisposing deficiency. This construction is analogous with previous findings from professionals' accounts (Pickersgill, 2009) and with wider preoccupations in the literature (see section 1.6). Though both were present, the extent to which participants privileged one discourse over another varied:

Extract 5 (Clara: 102-120)

Kitty: erm so you talked about his sort of early childhood experiences (.) how much do you think or erm do you think that those play into psychopathy happening later, and if so, can you tell me a little bit about your understanding of that?

Clara: (3) I'm sort of- I suppose how we see psychopathy, I suppose the manifestation that ends up in a forensic unit <K: yes> erm I think (.) that that sort of erm uncontrollable desire to hurt or damage or or have power over other people in that way um (.) I think is necessarily a product of that. Its its an identification with the aggressor and it is certainly something to do with the violence and abuse and neglect that people have suffered at a younger age. I mean I I I don't know, I'd have to read more about it but I suppose my tacit assumption is that (.) if you have these traits and you had a a 'good enough' upbringing, I think you'd be able to to inhibit them and you know make them- 'just make

> an effort, pull yourself together (LG) no' [with irony] I think you'd be able to inhibit them, or perhaps channel them

Clara's construction is articulated as contextually contingent and thus applicable to a certain 'kind' of psychopath; one whose violence is both uncontrollable and a product of childhood trauma. In so doing, she outlines a cause-effect relationship between adverse early life events and psychopathy, specific to the context of forensic mental health. Previous research into the effects of childhood trauma on later presentations resonates here (e.g. Weiler & Widom, 1996; Weizmann-Henelius et al., 2010). Clara introduces psychological theory in order to make sense of this relationship; 'identification with the aggressor' is a psychodynamic concept (Freud, 1966) which constructs the psychopath as both victim and perpetrator by conceptualising them as interrelated and indivisible. A language of positivism is also implicit in seeking to establish identifiable causes for psychological phenomena. Through such talk, the psychopath becomes a complex figure who can be better understood via expert psy-knowledge. Simultaneously, a message of victimhood is emphasised; this talk makes available a position for clinical psychologists as both expert and defender, and resists dominant constructions of the psychopath as simplistically 'bad', a finding which may indicate a counterpoint to previous research into professionals' accounts of psychopathy (Richman et al., 1999).

Through an 'at risk' discourse, psychopathy is conceptualised as comprising predisposing traits which can be inhibited or activated by early life experiences. 'At risk' talk, as a discursive mechanism, moves explanations of psychopathy beyond simplistic reductionist accounts and into a moral social space, whereby early childhood experiences can either perpetuate or negate the onset of a disorder. This construction comes from a psychiatric discourse, the ontology of which presumes the body as the site of psychopathology (Rose, 2007), and also from a psychological discourse, drawing on the theories of the 'good enough' parent (Winnicott, 1971). Through this interaction of discourses, a relationship between psychiatric disorders and clinical psychology practice is established. This account manages contemporary critiques of clinical psychology (e.g. Smail, 1993) by introducing a socio-environmental dimension. At the same time, it reconstructs the psychopath as psychologically distressed; the psy-complex power/knowledge constellation (e.g.

distress/treatment) is thus reproduced and maintained. Previous research into professionals' accounts of psychopathy uncovered similar discursive processes (Pickersgill, 2009), although here the interjection of a psychology-specific discourse via the application of specific psychological theories makes explicit a manifesto for the use of psy-knowledge and practice, in order to address a somatically located psychopathology.

Clara elaborates:

Extract 6 (Clara: 130-144)

> […] psychopathy is a defence erm a defence against psychosis erm (.) and the fragmentation of the mind that that implies and also at the route of that is erm (.) a just a a terrible, terrible attachment disorder, a deeply disorganised attachment in the sense that (.) the child really hasn't been able to (.) establish any any sort of stable internal object, so everything's terribly frightening and awful and I think the people we see, you can see that, it coexists doesn't it and people move in and out of that; it's often people have attracted- and he[13] talks about this, people have attracted several different diagnoses throughout their lives, most commonly personality disorder, some kind of PCL-R assessment that indicates psychopathic traits and erm just psychosis or psychotic disorder erm and that coupled with sort of depression, anxiety and other things, but yeah. So psychopathy is the sort of cold-front, if you like, of the the the sort of terrible sequela of disorganised attachment.

A system of profession-specific knowledge is established, through which the psychopath can be understood via complex psychodynamic formulations. Again, an image of a psychologically deprived child is called upon to emphasise a sympathetic stance and also to legitimise a nuanced, non-reductive conceptualisation; co-occurring expert and subversive subjectivities are accomplished (see sections 3.3.2

[13] Clara is referring to Rob Hale, a psychopathy theorist whose work she draws on throughout her account.

and 3.3.3). The construction of psychopathy as a sad consequence of an adverse early life and some form of predisposing characteristic localises explanations of psychopathy at the level of care-giving and nurture experiences and is articulated as ultimate evidence for the authenticity of object relations and attachment theories (Ainsworth, 1969; Brody & Rosenfeld, 2002). Thus, psychopathy's status as archetypal personality disorder is reproduced (Crego & Widiger, 2014). This construction also neutralises the need to investigate wider, societal-level factors (Ramon, 1986) by relocating the 'badness' of psychopathy, as per lay-understandings, from the individual to the parent-child constellation. Thus, a focus on the perpetrators of abuses is avoided (Patel, 2011). Moreover, in locating a forensic-specific construction of the psychopath as damaged but comprehensible through particular psy-knowledges, and by drawing on an 'at risk' discourse, a legitimate claim can be made for state intervention in order to prevent future psychopathy; this claim is explicitly made elsewhere in the dataset and fits with contemporary research agendas related to the identification of juvenile or 'fledgling' psychopathy (e.g. Lynam, 2002; Skeem & Petrila, 2004).

3.3 Subjectivities within Contested Practice

Across the dataset, participants constructed psychopathy as having a contested and problematic status within forensic mental health contexts in a number of ways, echoing concerns raised in the literature; the concept was described as lacking clarity, and talk of service limitations enabled a questioning stance in relation to its usefulness (e.g. Lilienfeld & Andrews, 1996; Skeem et al., 2011; Walters, 2013). Additionally, misconceptions and misapplication of the label were highlighted, as were stigmatising and labelling effects, both from the public (e.g. Sieff, 2003) and within forensic services (e.g. Bogojevic et al., 2013). Within this professional context of contested practice, a variety of subject positions were taken up, that is, a location with a structure of rights and duties (Davies & Harré, 1990). These variously resisted and conceded to a discourse of biomedicalism, whilst concurrently drawing on alternative psychological discourse, which served to legitimise practices such as formulation and reflection. This oscillation between subject positions required participants to selectively acquiesce and resist dominant ideologies. For example, diagnostic accounts of psychopathy were conceded to as necessary for accessing

services, while their reductionist nature was emphasised, pointing to formulation practices. Thus, dual subjectivities of pragmatism and subversion co-existed, as did other, seemingly diametric arrangements. As such, this section examines participants' subjectivities, how they are formed via technologies of power and self and how they engage in self-regulatory practices (Foucault, 1988b). Practices made possible through these subjectivities were in service of a wider psy-project, i.e. proposing a biopsychosocial framework for understanding the psychopath (as an apparent alternative to a biomedical framework) and a simultaneous proposal for psychologising the workforce (see section 3.4). Therefore, available subjectivities both reproduced and re-produced power/knowledge constellations.

As discussed, participants constructed psychopathy as a clinically elusive concept ("slippery", "unclear", "misunderstood") revealing a degree of ontological uncertainty resonant with concerns raised in the critical literature (e.g. Gunn, 1998; Pickersgill, 2009b). When orienting to problems with psychopathy theory and practice, participants often emphasised personal beliefs, values and preferred ways of working as contrasted to wider institutional requirements, which were constructed as limited and limiting; as one participant stated "it's hard sometimes to be the best psychologist you can be all of the time" (Evelyn: 327-328). This self-positioning can be understood as a discursive mechanism through which practitioners sought to manage professional personae within a morally contested landscape (Harré & Van Langenhove, 1999). It is also interpretable as a small act of discursive resistance, whereby clinical psychologists problematise diagnostic regimes of truth.

A wider assumption of the 'untreatability' of psychopaths precluded a renegotiation of psychology's role, given that individualised talking therapies are traditionally seen as the central component of clinical psychology work. In positioning themselves as able to redeploy psychology skills in service of wider systems, the subjectivities that participants took up through their talk were in line with broader contemporary political aims to expand the reach of the profession beyond the therapy room, into positions of leadership and consultation (British Psychological Society, 2010; Lavender & Hope, 2007).

Subject positions co-occurring across the dataset have been categorised according to three overarching subjectivities: pragmatist, subversive, and expert/specialist.

3.3.1 Psychologist as Pragmatist

Often negotiated alongside testaments of higher-level critique, and co-occurring with discursive constructions of the psychopath as challenging, participants' talk produced a subjectivity of pragmatic practitioner. Through this subjectivity, the use of the psychopathy label was made reasonable and related assessment practices were legitimised as helpful explanatory devices:

Extract 7 (Beth: 218-242)

Kitty: So I wondered um if you had any thoughts about the theory behind 'the psychopath', based on your experiences, based on what you've read, based on your work with I suppose personality more broadly.

Beth: I guess, I mean (2) this is where I feel thinking of a diagnosis as your best guess working hypothesis to guide (.) what's gonna be useful is what I come back to again and again um (3) I don't know, I mean I'm kind of thinking about the checklist (.) I suppose the way I think of it is, (.) how realistic is it to expect someone to change and so it's more about (2) working with them to enable them to have the best life and to interact in the best possible way with everyone in their lives (.) he (2) there was some really, really complex stuff things going on with his family as well and he (.) sexually assaulted his daughter when she came in to visit him whilst he was on the ward, which was (.) just awful erm and I think that kind of shifted our expectations of, you know, if he was doing that during visiting time on a ward (.) we really, really kind of thought about how (.) it just felt impossible to think about giving him leave and certainly thinking in terms of discharge it was kind of (2) umm it just felt impossible and I think (.) that I suppose the theory with psychopathy you're- in terms of risk- you're really, really are likely to get, you know, high recidivism rates and I think again, just in realistic

> expectations and I hope that doesn't sound like we wrote him off, but I think it was probably more a kind of reality check on what he was gonna be able to manage (2)

In emphasising a pragmatic approach to diagnosis and simultaneously emphasising its fallibility, Beth contingently acquiesces with existing diagnostic power/knowledge constellations; there is a hidden tautology here resembling an 'it is what it is/ it's the best we have' approach to current practices. Beth aligns with and uses the dominant discourse to understand a clinical dilemma, but from a position of limited concession; she negotiates her relationship to diagnosis as one that is troublesome but necessary, emphasising her personal values in the process, thus legitimating its use in specific contexts. This reasoning is applied to diagnostic features of the PCL-R, producing a construction of individuals with psychopathy as psychologically deficient and incapable of change, mirroring a tendency for therapeutic pessimism noted in the literature (e.g. Salekin, 2002). Beth positions this as knowledge that is in the best interests of the service user by drawing on principles of collaboration and enablement, central to professional psychologists' public identity (Holmes, 2002). In this way, the therapeutic aim shifts from producing change to facilitating quality of life, conceptualised as a more realistic goal. Across the dataset, improved quality of life was asserted as a central aim of interventions with psychopathic individuals; given the frequency of this discursive mechanism across participants' accounts, it is perhaps significant that this shift in therapeutic focus does not explicitly arise in the wider literature. Here, restrictions imposed by both the diagnostic category and the forensic system are implicitly acknowledged; hence, possible therapeutic outcomes are renegotiated in accordance with extra-discursive restrictions. Beth articulates a concern that this is misinterpreted as hopelessness, suggesting anxiety in relation to this shift in the therapeutic endeavour and a degree of discomfort with the subjectivity she inhabits at this juncture.

A pragmatist subjectivity is emphasised by drawing on 'real life' examples; in the example Beth provides, offending behaviour (sexual assault) is discursively tied together with a 'risk' discourse and serves to make common-sense the need to consider public protection alongside an individual's care, demonstrative of tensions highlighted in the critical literature (e.g. Parker et al., 1995; Richman & Mason,

1992). The expectation that mental health professionals are responsible for ensuring public safety is a relatively recent phenomenon (Appelbaum, 1988), part of the move towards “the absolute protection of others” via control of the individual (Foucault, 1990, p. 144) . A complex relationship between, and layering of, medical and legal frameworks, in order to jointly conceptualise and manage the problem of psychopathy, it is implicit here (Medina & McCranie, 2011). Thus, an internally constituted theory of offending is established which constructs the psychopath as pathologically predisposed to offend (a medicalisation of offending) with a corresponding position as risk-manager made essential to the clinical psychologist, via their status as official mental health worker. In this way, a pragmatist subjectivity reproduces asymmetric power relations and makes essential extra-discursive practices at the macro-level, such as formalised, state sanctioned protocols for risk management (e.g. Department of Health, 2007a). As in extract 3, earlier research into forensic staffs’ tendency towards management rather than therapy work for individuals with psychopathy is resonant (e.g. Bowen & Mason, 2012).

3.3.2 Psychologist as Subversive

In various ways, participants positioned themselves as defenders, protectors, ethical and critical practitioners in relation to psychopathy thinking and practice. Subversive or critical subject positions were taken up by participants in relation to talk which problematised the psychopathy label on a variety of grounds: for being misunderstood by others; for being overused; for being established via an assessment which did not adequately account for a person’s strengths; or for the stigma resultant from its application. Several of these concerns mirror those raised in the literature (e.g. Link & Phelan, 2001; McPhail, 2013; Singh et al., 2011). Notably, a concern that the label leads to an absence of ‘strengths’ work appears to be a unique finding, not previously noted in the literature.

The subversive subjectivity can be understood as a form of stake management whereby participants sought to highlight their status as morally conscious psychologists by distancing themselves from problems with the construct (Woofitt, 2005). It was also a subjectivity from which participants critiqued current practice and proposed alternative modes of thinking, often drawing on humanist, person-centred

and strengths-based discourses to do so, thus reflecting a position for clinical psychologists as multi-modal practitioners (McFall, 2006). In the following extract, Danielle recounts a time in her professional life where personal principles of fairness and ethical practice compelled her to take subversive action:

Extract 8 (Danielle: 909-934)

Kitty: Do you ever engage in processes of reassessment?

Danielle: I have got a really interesting example (.) about this actually about somebody I worked with who had been (2) assessed er- it was a PCL-SV- assessed as being under the threshold for cut-off, but then she went through a really hostile period and was <u>really</u> really difficult to work with, this was before I joined the team, very dismissive and um <u>lack</u>ing in empathy towards other people and so on, and it was interesting that at that most difficult time, she was rerated and scored very highly erm and <u>then</u>, by then several years on she was about to be discharged and I <u>had</u> to re-evaluate it because actually she was back to where she was at the beginning, and I think there was something very much there about, when she was so difficult and challenging to work with, I think people just wanted answers or a simple explana- not a simple- you know, erm (.) a way to under<u>stand</u> this <K: mm> when actually I think there was a a a the a with this particular woman and it's you know, and I think she was <u>always</u> gonna do this, is at a time she feels most vulnerable, she becomes very <u>dom</u>inant and wants to be very powerful you know (.) and I felt like just- and again this is my bias, and it's a shame that people who were there at the time couldn't speak to this, cos there might've been a whole other reasons and I might just be reading between the lines incorrectly erm (.) but it felt that, again, just <u>doing</u> something like that just to kind of- is that really understanding what's going on? <u>If</u> it was done without a formulation, it might've been done with a formulation erm (2) yeah.

Danielle constructs the psychopath as simultaneously challenging and vulnerable, drawing on diagnostic features of psychopathy and a language of compassion to do so. In particular, she draws on the principles of reciprocal roles, a cognitive analytic principle which assumes that underlying psychological distress is manifested in counter-correspondent actions (e.g. vulnerability-domination). Through her construction, Danielle acquiesces to diagnostic/psychiatric discourses whilst simultaneously drawing on psychological concepts. This oscillation between dominant and alternative discourses serves to re-produce power/knowledges about psychopathy and legitimise an imperative to understand the psychopath as psychologically damaged (see section 3.2.4). Danielle evaluates past actions via a lens of specialist psy-knowledge; although aware that she is problematising the subjectivity inhabited by the team (pragmatist/non-critical), she expresses discomfort with the alternate subjectivity she inhabits (subversive/critical) and negotiates this by highlighting the legitimacy of colleagues' imagined disagreement. Thus, she caveats her evaluation by stressing that the PCL-SV (Hare et al., 1995) may have coincided with a formulation, which would negate her concerns. In this way, via a subversive subjectivity, formulation becomes an essential practice which reinforces earlier re-production of the power/knowledge constellation (psychopath/psychologically damaged).

Danielle draws on principles of individual responsibility to position herself as ethically compelled to reassess the individual being described. Implicit in this talk is a self-regulatory process which enables acts of resistance; from a subject position as ethical and moral practitioner identification of 'unfair' practices is possible, pointing to counter-practices which contravene scientific assumptions about psychopathy. i.e. that it is a stable construct (e.g. Blair, Peschardt, Budhani, Mitchell, & Pine, 2006). Thus, a subversive subjectivity enables counter-practices such as reassessment, which query existing disciplinary power/knowledge arrangements. Danielle is then asked about her motivation to reassess. She responds:

Extract 9 (Danielle: 945-952)

Because it just didn't feel fair <K: why not?> Thinking about- well thinking about the PCL-SV construct that it should be static and life-long (.) you know <K: ok> it just, she'd got better, she'd become more

trusting of professionals, you know. There were times where she could be quite- and again a a the ways that we rate it here is that we have like kind of like a a a matrix, I suppose, evidence for, evidence against, so I was able to balance and go back and look at the evidence for it against, you know.

In being called to justify a subversive act, Danielle draws on a scientist-practitioner discourse and so contextualises her subversion within a wider acquiescence of the dominant hegemony. Objective, "evidence" techniques are emphasised as part of the decision-making process; forms of knowledge production typically privileged by the psy-disciplines (Harper, 2004). Thus, the rhetoric of clinical psychology as an evidence-based, scientific discipline is reemphasised and its worth according to the delineated boundaries of the psy-complex is retained (Rose, 2009).

3.3.3 Psychologist as Expert/Specialist

Expert or specialist subjectivities were prevalent across the dataset in multiple forms, pointing to particular practices for clinical psychologists; demystifying psychopathy for non-psychologists, supporting challenged staff, and describing specialist, objective knowledge were some of the roles and actions arising from this subjectivity. Such actions resonate with critical commentary regarding psychology's (and psychiatry's) long-standing mandate to provide treatment for, and be experts on, deviant behaviour (e.g. Medina & McCranie, 2011; Sarbin & Mancuso, 1970), with a consequent effect of rendering psychological practices such as formulation and reflection essential (see section 3.4). Discourses underpinning this talk were both psychiatric and psychological; through these, a biopsychosocial framework for psychopathy was made possible (e.g. Paris, 1998) and an expert subjectivity enabled its status as legitimate knowledge:

Extract 10 (Gary: 310-350)

Kitty: And you mentioned a moment ago that psychopathy- […] it was helpful for the team as a sort of method of formulation? Are there any other ways that it feels like a useful (.) erm diagnosis or way of understanding someone, that you've experienced in your work?

Gary: yeah because it- just as with any good formulation, and sometimes diagnosis, that it can lend itself to (.) er (3) paradoxically perhaps, given the you know emotive label, it can lend itself to a erm (.) less pejorative understanding of (.) the behaviour and a more useful understanding of how to reduce its frequency and how to help the individual achieve some better quality of life.

Kitty: why paradoxically?

Gary: because the word psychopath comes with lots of emotional baggage (.) erm but in the context of a good clinical team, who are (.) trained to understand how to interpret that label, and how to (2) work with people with that label (.) erm like I say, it can improve the quality of their lives, and it can reduce the (.) extent to which they challenge services, hurt staff, hurt other patients and themselves.

Kitty: and that baggage, is that something- versus sort of how erm clinicians can interpret it, is that the sort of difference between the lay understanding psychopathy and our clinical understanding of psychopathy?

Gary: (2) erm (BR) is that (.) is that the difference? Yes it is, because if I was to give someone that label in a clinical context, I would ensure the team (.) surrounding them fully understood what it meant, and that might be a team whose only experience of the diagnosis has been associated with (.) films involving criminal characters (.) or erm (2) a lay sense developed through other media accounts of psychopathy, which are likely often to be misplaced.

Kitty: and how would you ensure that?

Gary: by describing its (2) core characteristics (.) by describing the erm evidence associated with (.) what we know about it's er inception and

> (.) erm development, what we know about the sort of infant (.) child adolescent correlates in diagnosis, you know just lending a sort of pathway understanding to its manifestation.

Gary highlights an available critique of the psychopathy label, that it is emotive and potentially pejorative; however, his reconstitution of the label as something that, through formulation, can actively reduce stigmatising effects re-positions psychopathy as potentially liberatory. Moreover, by citing improved quality of life as a possible outcome, the label is constructed as being in the best interests of the service user and the potential for harmful labelling effects are, therefore, acknowledged and neutralised. Gary's account aligns with a post-positivist tradition of establishing and targeting observable indicators of psychopathy and with priorities of the wider literature base (e.g. Coid, 1993); this corresponds with findings from earlier research into professionals' text (Federman et al., 2009). Thus, through an expert subjectivity, emerging concerns relating to potential iatrogenic harm are undermined (e.g. Granello & Gibbs, 2016). A 'risk' discourse is also implicit in this talk, with risk reduction and the therapeutic endeavour constructed synonymously. An economic discourse is apparent, demonstrative of the biopolitical imperative inherent in the organisation and reproduction of forensic psychiatric systems (Foucault, 2008); formulation is the arrangement by which both staff and service user can be most benefited according to multiple axes: Risk, management, safety and quality of life. This process is constructed in the context of service development, pointing to the potential for psychology to claim expertise in this regard, in line with contemporary moves beyond the therapy room and a drive for the profession to demonstrate its value (British Psychological Society, 2010; Newnes, 1996).

Gary elaborates this therapeutic endeavour further; the subjectivity he inhabits (expert), and the consequent action this enables (training staff to better understand), constructs a corresponding subjectivity for clinical staff, whereby they are transformed into a site for management and improvement. An 'insight' discourse is implicit here; professional psychology is positioned as able to conduct an 'assessment' of staffs' understanding of psychopathy according to prevailing diagnostic and scientific knowledges (e.g. Hare & Neumann, 2008). In so doing, a problematised subjectivity is proposed for non-psychology staff, who are constructed

as likely to be clouded by “misplaced” lay-understandings of psychopathy. An expert subjectivity, promulgated via specialist knowledge, thus transforms non-psychology staff into objects for insight assessment; a finding resonant with previous critical research (Gilbert, 2001). Common sense practices arising from this process are psychologising the workforce via shared formulations and reflective practice (see section 3.4). At the same time, Gary implies personal responsibility for the production of a psychologised workforce; principles of evidence-based practice, diagnostic features and developmental correlates are knowledges he must impart to less knowledgeable others. In this way, the professional capacities of the scientist-practitioner psychologist, founded upon the identification and treatment of specific variables, are similarly a site for assessment by others. Inhabiting an unproblematised expert subjectivity requires Gary to unquestioningly reproduce prevailing knowledges; in so doing, he too is made “docile and capable” (Foucault, 1991, p. 294).

3.4 Establishing a Psychological Imperative for Psychopathy Practice

The previous sections demonstrated ways in which participants constructed psychopathy as problematic; juxtaposing concerns were produced relating to both a problem individual (dangerous, challenging, manipulative, psychologically damaged), and a problem label requiring management via particular professional subjectivities (pragmatist, subversive, expert/specialist). Participants also problematised established diagnostic understandings and practices as reductionist and limited, utilising psychological language to propose alternatives to, or enrichment of, current understandings of psychopathy.

In considering the implications of these constructions for clinical psychology practice within forensic settings, participants’ talk produced an imperative for the use of psychology technologies such as reflective practice and supervision across the workforce, as modes of making sense of the (incomprehensible) psychopath, to increase empathy and reduce ‘burn-out’; a neoliberal psy-project whereby staff are objectified as sites for individualised intervention. Additionally, via formulation technologies, a ‘psychologically-minded’ construction of the individual with psychopathy was promoted, rendering visible their psychological deficiency and

damage; this construction was positioned as beneficial to staff in increasing their compassion, as well as to service users in recognition of their status as vulnerable mental health patient. Across participants' talk then were processes of pastoral power which transform subjectivities of staff, psychologist and service user (Foucault, 1982).

The remainder of the analysis and discussion will look in more detail at how this psychological imperative is negotiated and made possible through participants' speech acts relating to formulation, reflective practice and supervision; while this will be presented in two parts, these technologies can be said to work together in service of the overarching psy-project.

3.4.1 Formulation: Constructing a Psychological Status for Psychopathy

Psychological formulation was constructed by participants as a means to protect against diagnostic reductionism and the 'seeping in' of lay understandings of psychopathy; as in the wider literature, both actions were conceptualised as potentially stigmatising and problematic (e.g. Boyle, 2007; McPhail, 2013). Thus, aspects of the forensic system were positioned as simplistic or troublesome in relation to psychopathy. Psychology technologies (i.e. formulation) were proposed as a solution to this, professing to centralise a person's context and enrich otherwise reduced identities, so constructing a biopsychosocial framework for psychopathy (e.g. Paris, 1998). This is in line with wider professional assumptions, whereby formulation is considered to be an alternative to diagnosis (Carey & Pilgrim, 2010) and has status as an official psychology technology (Kinderman & Tai, 2009). The psychological theories participants drew on to achieve this were multi-modal (psychodynamic, schema, cognitive analytic, motivational interviewing, systemic). However, when participants talked about formulation, the extent to which they drew on notions of 'context' as an important aspect of psychological formulation varied across accounts; occasionally, participants constructed formulation as an alternative to diagnostic labelling. More often, formulation and 'contextualising' were identified as practices that could 'add to' the diagnostic label. At other times, the diagnostic label itself was constructed as a type of formulation.

In constructing a psychologised model of psychopathy, psychologists enriched and contextualised the object of the psychopath, and also reproduced him/her as a site for governance, control and treatment, including psychological treatment. This mirrors previous literature (e.g. Ramon, 1986), however, participants' talk also re-produced existing power/knowledge arrangements about psychopathy by positioning clinical psychology as a central stake-holder, via ownership of psychology-specific technologies. Participants typically negotiated this re-production from inside the structures of wider dominant discourses, thus reproducing hegemonic ideology. Through their talk, participants connected multiple, disparate discourses, so constructing the psychopath as a unique 'kind' of person, one who is both mad and bad (Hacking, 2006):

Extract 11 (Clara: 151-183)

Kitty: (.) and you mentioned there, right at the start, about sort of conflicting accounts of psychopathy and what it engenders and how it could be very difficult for staff members to work with people with that diagnosis erm (.). So how- what does psychology offer to that? Can it offer anything to that? You know, what's your understanding of that? Erm

Clara: in in um- I was gonna say with psychopathy- <u>actually</u> with erm in forensics in general I think that erm (.) probably the most <u>valuable</u> thing psychology has to offer is is consultation, reflective practice and group work with the staff (.) and that's certainly- erm when we started an LD forensic ward, that was our explicit goal was to create a staff team who had erm the same formulation, who all held erm a kind of simplified version of a formulation in mind at <u>all</u> times, which guided the care of the patient and that I think is is (.) better for the patient than a few one-to-one sessions with- (LG) and, so the work would be- I suppose the work with <u>this</u> man who was, you know (2) <u>very</u> difficult to help, to put it like that, I suppose the work I did with him was to gain a better understanding of of of his reality, his world view, his internal world and how that might have affected him and then work together as a staff team so- one of the things <u>we</u> did together, and this was this was

> planned with the team, erm we sort of wrote his autobiography in a way, erm it was difficult to do because as I said he's completely fragmented, erm but it was it was- we were able to pull out certain themes and at the end of that we were able to, I suppose, erm bring out certain things that he found valuable or important in his life um that lead to the practical work the ward OT erm and she just took some things and was able to work on them with him, and I suppose the aim was not only to improve his quality of life but also (.) to allow the the team as a whole to understand what a horrible time he'd had <K: mm> and to be able to see the boy (.) who had once been present I suppose, as naff as that sounds, the inner child (LG) [said ironically].

The questions I pose here both imply and enable the subsequent talk, in that they are underpinned by an assumption that psychology may be uniquely positioned to address 'staff difficulties'. Clara takes this up by describing several practices in the purview of clinical psychology; the status of consultation, reflective practice and team formulating (so-called 'indirect work') are elevated to "the most valuable" practices within a psychologist's repertoire. As in other extracts, this is concordant with a contemporary 'leadership initiative' and recent proposals that clinical psychologists are uniquely placed to support staff (Onyett, 2012). Previously noted by Rapley and Miller (2003), a simultaneous 'giving away' and retaining of psychology is made explicit here; via intervention from a psychologist, staff can acquire a "simplified version" of specialist knowledge. Moreover, through formulation technologies, a staff team can be created that 'does' care practice according to these psychological knowledges. Thus, staff teams are a conduit for the propagation of psychological discourses that produce particular ways of being with individuals identified as psychopathic (and all forensic service users). This resonates with recent interest in team-driven formulations as a practice by which an individual's life circumstances are centralised (Summers, 2006). A potential effect of this is to expand awareness of 'signs and symptoms' away from their diagnostic counterparts by reinterpreting them into understandable responses to distressing experiences (Johnstone, 2013).

Throughout this talk, multiple psychological languages and theories are drawn on, such as collaborative working, psychodynamic concepts and person-centred

principles. Clara takes up a subject position of expert and constructs psychological knowledge as at once specialist and accessible to others. The imperative for a psychologically informed understanding of the psychopath is reinforced through a discursive construction of the psychopath as very challenging and hard to help, echoing wider concerns relating to staff 'burn-out' (e.g. Ministry of Justice, 2011b; Oddie & Ousley, 2007). In so doing, the psychopath is established as the object of help and a corresponding position of 'helper' is made available to staff, with a caveat that psychology knowledges must be internalised in order to gain a "better understanding" of the psychopath-object, through which the worker can practice care "at all times". This talk exhibits a process of governmentality in action, whereby the psy-project (a psychologised workforce) makes staff teams into objects for improvement via psychological technologies (e.g. formulation), in turn making available a 'better helper' subject position.

As in extracts 7 and 10, the therapeutic endeavour is reconceptualised on behalf of the service user to a focus on "quality of life"; implicit in this talk is an acknowledgement that forensic environments may be challenging for service users, and also that 'higher' therapeutic goals (i.e. discharge) may not be possible, echoing a state of 'therapeutic pessimism' noted in the literature (Salekin, 2002). As such, a related therapeutic endeavour is proposed: to enable staff teams to become aware of a service user's vulnerability via specialised psychological knowledge. The underlying implication is that through this process staff will experience increased compassion towards individuals with psychopathy which will alleviate punitive treatment and stigma. Here, and elsewhere in the data, a default (problematised) position is constructed for staff as 'empathy-deficient' and 'unknowledgeable', reflecting concerns raised in the wider literature (Bogojevic et al., 2013; James & Cowman, 2007). Clara takes up a corresponding position as responsible for redressing this (via an expert subjectivity). Thus, pre-existing power/knowledges which enable clinical psychologists to inhabit positions of expertise regarding service users' feelings are re-produced to include expertise on the feelings of whole teams and systems.

3.4.2 Supervision and Reflective Practice: Psychologising the Workforce

Other technologies central to the imperative put forward by these discourses were supervision and reflective practice, constructed as practices which enable staff to retain an emotional distance from their work and provide protection from psychological harm resultant from working with psychopaths. Supervision has status within professional psychology as a valuable tool for self-improvement (Holloway, 1995). It is also an institutionally regulated practice for monitoring best practice and staff competency (e.g. Care Quality Commission, 2013). Likewise, reflective practice has become a standardised practice across healthcare contexts, however, it is a broad terminology which can mean many things, and is used and understood differently within and between professional groups (Finlay, 2008). Therefore, in the context of this study, I was guided by participants' descriptions; these typically constructed reflective practice as a regular, dedicated meeting, separate from case management tasks, which could be utilised by all clinical staff to explore professional difficulties within a safe environment. Furthermore, participants identified that reflective practice was often, but not always, facilitated by a psychologist and that it usually consisted of some focus on, or examination of, the underlying psychological processes during interactions between staff and service users. The types of psychological theory and models informing these meetings varied. In line with current healthcare priorities, it was also conceptualised by participants as an antidote to poor client care, 'burn-out' and a 'lack of compassion' (Graham, 2000; Miller & Jack, 2008; Oddie & Ousley, 2007). Thus, participants aligned with broader cultural preoccupations of the healthcare sector, pointing to a (possibly unintended) political agenda underpinning this talk.

These practices can be understood as part of a wider 'talking is healing' rhetoric present within modern mental health services and, arguably, across wider sociocultural contexts (Harley, 1999). The psychologist, as a trained 'talking healer', is thus primed to take on the subject position of helper, with staff as the corresponding object of help. Indeed, clinical psychology professes commitment to reflection as a crucial component of therapeutic work (British Psychological Society, 2006). In this way, clinical psychologists are implicated in a process of pastoral power re-enactment, whereby they hold specialist knowledges in service of

transforming a psychologised workforce. Moreover, often implicit in participants' accounts was an alternative discourse, which could be described as a 'talking is improving' discourse; here, spaces for staff to deconstruct their emotional responses are ultimately underpinned by a service development agenda (e.g. Johns & Freshwater, 1999):

Extract 12 (Harriet: 79-123)

Harriet: Um (2) I think it's around a lot in working with teams, as well. There is- people I think- almost, people get elevated in mythological status sometimes. You know, you get a bit of the, this man's a psychopath, so there's a lot of anxiety created immediately before that person even arrives on the ward, and (.) how best to handle them, and (1) um (3) I think people can be a little bit less sympathetic, (.) a little bit less patient, with, (BR) with that individual, and (1) be immediately sort of, being quite defensive, I think. Not wanting, I'm not going to be the one that's sort of duped or whatever. I'm not going to let him get one over on me, and. Yes, I think that's around quite a bit, as well.

Kitty: Would you say there's a role for psychology um in (2), with, inside a team, to help manage some of that stuff, some of that anxiety? And some of that, um sort of like suspicion, it sounds like?

Harriet: Definitely. I think probably quite central. I think certainly that's how it's worked here, really. So you'd be part of the ward rounds, trying to offer sort of a psychological perspective on it, trying to help think about (1) what its function is, where it's come from (.) what it realistically means (BR) (1) day-to-day in sort of thinking about managing that individual. Sort of helping the, the team think about that's- particularly the nursing staff who have to manage people on a day-to-day basis. Much more difficult than, you know, the psychologist who comes on for an hour a week or whatever to see that person. (BR) Um (1), helping them think about boundaries, all that kind of stuff. Training we get involved with as part of the induction. And we can do sort of subsequent training for the ward if it is recognised as a need or

> required. Um we also have reflective practice, I think which is a key element there, so. <K: Oh, okay> We have uh weekly (2) reflective practice here, uh (1) which I think is great- I never worked somewhere you have weekly. Um so it's fantastic. We're able to facilitate that. Quite often, it's the psychologists or one of the, sort of, (.) psychological therapists that we have here that facilitate that. (BR) And so we also participate in that as well as facilitate it. Um so I think that's, yes, essential, really, to kind of help think about what gets evoked by these individuals, what is getting triggered is us, what's getting triggered in them, and, sort of, what the interaction is, the dynamics that are going on, (BR) (1) thinking of the way forwards. So there's that, that we (.) get involved with as well. And then (BR) I have before, sort of, worked with, maybe, primary nurses who've got a particularly difficult individual, trying to support them and offer some individual supervision or a space to think about (BR) (1) what's going on and, you know, how best to manage some of those complex interactions that can arise (cos) they can be some very tricky individuals, I think, to work with.

Here, as at other points in the dataset, staff are constructed as reductionist in their understandings of and responses to psychopathy; over-simplistic, 'lay understandings' are recruited into this construction and positioned as illegitimate and harmful forms of knowledge. In particular, Harriet foregrounds and problematises a tendency to 'mythologise' the psychopath figure, which resonates with wider research (Hamilton, 2008). At the same time, discursive constructions of the psychopath as challenging legitimise staffs' problematised responses. As in extract 11, my leading question as to whether psychology has a special role is taken up by Harriet; through our discursive interaction, a position is made available for clinical psychologists as critical-experts of staff *and* service users. However, by emphasising that ward staff have to "manage" these challenges on a daily basis, Harriet demonstrates awareness of a relational imbalance between psychologists and other staff, thus repositioning herself as sympathetic and non-blaming. She then 'joins with' the team and, in so doing, constructs herself as a 'self-reflexive practitioner' in need of reflection practices and so reinforcing professional priorities (British

Psychological Society, 2006). The language of education and growth is also utilised in this talk, suggesting that self-knowledge can be cultivated by others who hold the right expertise. In this way, self-knowledge becomes a legitimate object for intervention; “thinking about” what has been evoked and triggered, as well as “ways forwards”, become tools for this intervention, with clinical psychologists taking up a position as expert intervenors. Thus, a process of pastoral power is acted out, with the aim of transforming the workforce according to a ‘psychologising’ ideology.

As in extract 10, an ‘insight’ discourse is in operation in this talk, whereby staff become objects of evaluation and assessment by a more knowledgeable other. This interaction enables psy-practices that address insight through increasing self-knowledge. These practices are constructed as essential aspects of forensic working, in order to ‘protect’ oneself from psychological distress and to better understand and empathise with service users, thus reinforcing earlier problematised discursive constructions of the psychopath, and reinforcing previous research which suggests that personality disordered service users are the most disliked and emotionally challenging (e.g. James & Cowman, 2007; Lewis & Appleby, 1988). Psychological language is drawn on to describe the effects of self-reflection; psychodynamic ideas are implicit, including notions of transference and countertransference (e.g. Temple, 1996). At the same time, a reduction in pejorative and emotive responses is a therapeutic goal of these interventions. Thus, the subject undergoing self-reflective work is objectified according to these various principles, and a version of self is produced that is orientated to and through psychodynamic (psychological) knowledge, as well as in line with a positivist discourse which privileges rationality and neutrality as preferred modes of being. In this way, non-psychology staff are made the objects of a psychologising project which, on the surface, could be said to align with post-modern/liberatory principles of ‘giving away’ psychology (Miller, 1969). However, a tension is present within this talk in the form of a coinciding tacit assumption that self-knowledge requires continual replenishment, meaning a *limited* position is available to others as ‘psychologised non-psychologist’ and a corresponding *limiting* position to clinical psychologists as ‘psychologising psychologist’. Thus, a pendulum effect ultimately ensures stasis and a reproduction of existing power/knowledge structures, aligning with professional preoccupations of ‘psychologists as leaders’ (Onyett, 2012).

Also implicit in this account is a professionalisation of compassion coincident with wider contemporary concerns regarding healthcare practice (e.g. Department of Health, 2012). Previously a lay-term, compassion has been reconstituted by health and social care institutions into a quantifiable professional skill that is objectively evaluable across the workforce, and has been cited as an important factor in the various failings of the NHS (Bradshaw, 2009). This reification process re-produces compassion as a legitimate object for intervention and staff are subjectified accordingly. In this way, technologies of professional psychology such as reflective practice and supervision are part of wider surveillance practices for workforce regulation.

4 CHAPTER FOUR: DISCUSSION AND CRITICAL REVIEW

The aim of this chapter is to consider the main analytical findings in the context of the research aims and questions. I will begin by revisiting these aims and, with these in mind, I will summarise key findings from the analysis, situating this in the wider literature. I will then review the research in relation to findings from previous relevant studies outlined in chapter one, which are resonant in various ways. I will then critically evaluate the study according to 'credibility', 'transparency' and 'rigour' criteria, outlined by Spencer and Ritchie (2012); these are considered to be recurrent principles of robust qualitative research, irrespective of epistemological position (Spencer, Ritchie, Lewis, & Dillon, 2003).

4.1 Summary of Findings

To recap, the research questions for this research were:

1. How are professional and wider socio-cultural contexts imbricated in how clinical psychologists construct psychopathy?
2. What discourses are produced through these constructions?
3. What are the implications of these constructions for clinical psychology practice within forensic settings?

The first two questions were addressed via close examination of participants' accounts about their work with, and understandings of, psychopathy. Throughout, persons with psychopathy were constructed as problematised individuals in a variety of ways: dangerous, challenging, manipulative, psychologically damaged. Psychiatric and diagnostic discourses of classification and related traits were frequently drawn on in order to describe psychopathy, privileging associated biomedical assumptions of individualism and internal pathology. Reliance on psychology and psychiatry technologies (formulation and diagnostic labelling) in order to 'understand' and make sense of individuals was apparent. An 'at risk' discourse constructed individuals with psychopathy as having a pre-existing vulnerability to developing the disorder; this is resonant with findings from previous discursive literature (e.g. Pickersgill, 2009a)

suggesting the availability of this discourse for forensic practitioners, beyond the bounds of the present research. However, the 'at risk' discourse was also located alongside a 'trauma' discourse and rooted in a 'forensic specific' context, which constructed individuals with psychopathy in forensic mental health settings as victims of their early life experiences; this appears to relate to previous studies into the presence of a relational interaction as contributing to the manifestation of psychopathic traits (e.g. Brody & Rosenfeld, 2002; Giovagnoli et al., 2013; Weiler & Widom, 1996). More specifically, however, this is a novel finding for critically-informed discursive research into psychopathy and may indicate the presence of fine-grain distinctions within constructions of the psychopathy construct. Multiple psychological theories were utilised to legitimise this discourse. Additionally, 'intuition' talk occurred across participants' accounts. This straddled scientific (clinical judgement) and mythical (a "feeling" or "sense") discursive locations, further distinguishing individuals with psychopathy as both 'other' and otherworldly, as well as emphasising that the concept itself is elusive. Previous discursive research findings on the presence of an overlap between 'professional' and 'lay' understandings of psychopathy is resonant here (Federman et al., 2009; Hamilton, 2008), as well as legitimising concerns in the literature base regarding the use of expert opinion during court proceedings (Scott, 2014). Perhaps most significantly, this research finding serves to operationalise previous research into clinical limitations of the use of psychopathy as a psychological concept (McPhail, 2013).

Combined, this talk produced psychopathy and those so ascribed as simultaneously bad and mad, and located them in a unique moral and social space, implying a psychologically-informed psychiatric (or, indeed, a psychiatrically informed psychological) understanding for psychopathy; what has been described in the wider literature as a biopsychosocial model (Paris, 1996, 1998). These findings dovetail with the wider essentialist research agenda which prioritises investigation of a biological hypothesis for psychopathy and, increasingly, a neurobiological hypothesis (e.g. Baron-Cohen, 2011). Interest in psychosocial factors is positioned through this lens, with 'signs and symptoms' of psychopathy (i.e. behaviours and characteristics) understood as manifestations of some form of psychological damage. As other research has suggested, a biopsychosocial model can be understood as biomedicalism reimagined, in that it enables deficit discourses and depoliticises

distress (Pilgrim, 2002). Processes of medicalising deviance and reifying psychopathy were therefore operant in participants' accounts, making a culture of social control a legitimate reaction (practice). This is concordant with concerns raised by critical researchers (e.g. Cohen, 2002; Gunn, 1998).

The present research findings connect with that of the wider literature; as demonstrated in Chapter One, psychopathy has a status as a longstanding social and moral dilemma, with footholds in both lay and professional contexts. It is positioned as a form of disordered personality (mental illness), placing it within the purview of the psy-professions and so endorsing practices concordant with a biomedical/biopsychosocial paradigm (e.g. psychiatry and psychology). However, as with other so-called personality disorders, this position and related practices are morally contentious and ontologically uncertain (Pickersgill, 2009b; Pilgrim, 2001), meaning that practitioners' status as morally adequate is implicitly in question (Jayyusi, 1984; Manning, 2000). In line with this, participants oriented to dilemmas regarding psychopathy in forensic settings, thus constructing a problematised professional context. This meant that it was incumbent on those being interviewed to justify and legitimise their position, so as to manage their status as morally and professionally credible.

The analysis revealed that participants negotiated a contested professional context via particular subjectivities. These were: (1) a 'pragmatist' subjectivity which functioned to warrant the use of the label and related practices within an imperfect system; (2) a 'subversive' subjectivity which demonstrated disagreement with elements of psychopathy practice, either conceptually or through counter-practices; (3) an 'expert' subjectivity, through which psychopathy could be demystified via psychological knowledge, so solving potential problems with, or limitations of, the label. Across these subjectivities, a discourse of biomedicalism was variously resisted and reinforced, implying a tension underlying the ontological position of the clinical psychology profession, in that it seeks to frame itself as both a scientific and a socio-moral endeavour. Across their accounts, participants emphasised personal belief systems as contrasted to wider institutional requirements, which can be understood as another discursive mechanism through which participants sought to manage professional personae (Harré & Van Langenhove, 1999). That participants

grappled with these seemingly paradoxical enterprises throughout their accounts indicates that this predicament remains unresolved and is a source of tension for individual practitioners as they seek to align personal and professional preferred selves within a morally contested landscape. To date, the present study is the first to examine subjectivities available to professionals working with individuals identified as psychopathic. Thus, this analysis of the discursive processes underpinning clinical psychologists' professional positioning is an original contribution to the literature base and provides a meaningful platform for future research.

The third question was addressed via an examination of the material and social practices implicated by these constructions and related subjectivities, both for the clinical psychology profession and for those within its professional purview (Harper, 1999). These amounted to what can be described as a psychological imperative for psychopathy. Central to this was the promotion of three core psychology technologies; formulation, supervision and reflective practice. These practices were constructed as solutions to the 'problem' of psychopathy in different ways: formulation was presented as a vital means by which other professionals could become better informed about the 'disorder' away from stigmatising lay-understandings, leading to an improved, more objective practice. Within this, a tension across participants' accounts was apparent as to whether the term psychopathy was a formulation in and of itself, or whether the term needed to *be* formulated in order for it to be useful. This micro-level tension is perhaps reflective of broader ontological confusion noted in the wider literature (e.g. Skeem et al., 2003). Moreover, this distinction is important given recent critiques of psychiatric diagnostic systems as failing to attend to an entire dimension of distress experiences (Vanheule, 2012). Formulation was also constructed as a means by which a person's early life experiences could be contextualised in relation to current psychopathology, underpinned by a biopsychosocial discourse.

Supervision and reflective practice were also central to an underlying psychological imperative; participants indicated that clinical implications of these interventions were an increase in empathy and a protected position of emotionally removed safety for staff. Supervision and reflective practice have cultural valence in contemporary

healthcare contexts, thus the promulgation of these psychology-specific technologies aligns with wider socio-political anxieties. Implicit across this talk was the notion of ‘insight’ and the implication that, through these various practices, individual and team insight (including clinical psychologists’) could be targeted and increased. These findings connect with those of the wider literature; in particular, the presence of ‘therapeutic pessimism’ and ‘empathy deficiency’ towards those with a psychopathy label is reproduced here (Salekin, 2002; Bogojevic et al., 2013), suggesting that this may be a consistent and ongoing issue within psychopathy practice, and that these concepts may simultaneously reinforce, and be embedded within, available discursive constructions.

In summary, findings revealed a positioning of clinical psychology as a vital meaning-maker in an endeavour which proposes a limited re-production of social and material practices pertaining to psychopathy, seeking to shift current practices into a more ‘psychologically-conscious’ domain, without dismantling overarching dominant ideology (Edley, 2001). Whilst this can be interpreted as strategic compliance, small-scale change from within a system can facilitate incremental realignments in hegemonic discourses (Bracken & Thomas, 2010) thus enabling the possibility for alternative subjectivities for individuals labelled as psychopathic, and alternative ways-of-knowing for those who work with them. Thus, possible dominant discourses though which clinical psychologists discursively make sense of the psychopathy construct have been expounded, as have the subjectivities and praxis dilemmas for clinical psychologists in the forensic field.

4.2 Comparison with Other Research

The results of the present research echo Richman and colleagues' (1999) findings, in that both studies demonstrate the presence of an imbrication of ‘disease’ and ‘deviance’ discourses in participants’ constructions of psychopathy. Both studies also serve to highlight that although psychopathy is understood by clinical professionals via psychiatric language, their priority in terms of intervention is often at the level of management of the individual and protection of others. However, in contrast to Richman et al.’s findings, the results of the present research did not uncover discursive constructions of ‘evil’, rather, participants sought to depict individuals with

psychopathy as damaged as well as damaging. Given that Richman et al.'s study investigated accounts of psychiatric forensic nurses, this may indicate that different discursive constructions are more or less available across professional groups.

The findings of the present research were resonant with Hamilton's (2008) analysis of contemporary accounts of psychopathy. In particular, 'intuition' talk and the elusive nature of psychopathy revealed a mythologic tendency in professionals' accounts and demonstrated that psychopathy assessment processes were at least partially subjective. As studies into other contested phenomena have shown, social ('lay') representations are locatable at the centre of understandings of psychological and medical constructs (Manuti & Mininni, 2010). Thus, distinctions between clinical/professional knowledges and lay knowledges about psychopathy are overstated; popular and scientific conceptions of psychopathy are overlapping and reinforcing, rather than dichotomous (Garton, 2001). This is perhaps unsurprising when one considers that extreme morally and socially objectionable problems, which are unreceptive to medical treatments, are more likely to be conceptualised via psychiatric and psychological language and simultaneously imbued with moral overtones (Gunn, 1998). Combined, these studies demonstrate that accounts about psychopathy are located in an indeterminate space between scientific fact and fiction, thus suggesting a transparent exercising of socio-political control, constructed as neutral science. However, unlike Hamilton's analysis, accounts from the present research cannot be said to entirely ignore the absence of an objective, scientifically solid basis for psychopathy. Instead, participants attempted to negotiate this through professional subjectivities which enabled particular stances and practices in relation to its problematic status.

The results of Federman and colleagues' (2009) study uncovered a totalising psychiatric power, whereby individuals with psychopathy were depicted as unnatural, legitimising categorisation via diagnostic frameworks and emphasising a position as threat to social stability. In a similar way, discursive constructions in the present study implicitly demarcated outer limits for what is 'normal', with individuals and their behaviours frequently described as incomprehensible without the label, thus enabling norming processes to occur (Hacking, 1996). Findings from both studies demonstrate that professionals and academics use the psychopathy construct in an

attempt to explain and understand deviancy through categorisation. However, the effect of this is to produce a self-fulfilling double bind (Bateson et al., 1956; Gibney, 2006). In contrast to Federman et al., the accounts from the present research did not reproduce notions of psychopaths as ‘evil monsters’ and implied variations within the power/knowledge constellation between psychology and psychiatry; participants sought to foreground notions of psychological damage and related concepts, therefore constructing individuals with psychopathy as victims as well as perpetrators. In comparing these studies, nuance and disagreement within psy-complex knowledges is apparent, with clinical psychologists attempting to engage, to some extent, in thinking about the effects of environmental and social factors on individuals’ lives. As discussed, accounts rarely elaborated or ‘thickened’ this type of talk, suggesting a lack of availability of these constructions and related discourses for practitioners (Geertz, 1973). Academic expert texts emphasise that there is “no convincing evidence that psychopathy is the direct result of early environmental factors” (Hare, 1999, p. 170), thus the lack of thick descriptions of psychopathy in this vein is perhaps unsurprising.

Similar to Pickersgill's (2009a) study into the accounts of neuroscientist researchers, participants constructed psychopathy as a psychological deficiency, acknowledging early life experiences as factors in the manifestation of the disorder. As with Pickersgill’s findings, a sophisticated biomedical discourse underpinned this construction, drawing on an ‘at risk’ discourse with the effect of negotiating criticisms of reductionism. However, the interjection of psychology-specific language also produced a manifesto for the use of psychology-specific knowledge and practice in order to address a somatically located psychopathology. The present research has conceptualised this as a biopsychosocial discourse, which is in the particular purview of the clinical psychology discipline.

4.3 Credibility

According to Spencer & Ritchie (2012) research can claim credibility in its adherence to defensible and plausible arguments, based on the evidence generated. I have fulfilled this criterion in a number of ways: Firstly, I reflexively engaged with multiple works of Foucault over a three-year period. In doing this, I have attempted to ground

my research in an embedded awareness of Foucauldian theory and concept to produce a theory-driven analysis which fully attends to its methodological aims. Secondly, I have been a member of a peer-led four-person ‘analysis group’; membership to this group was based on chosen methodology (FDA). On a weekly basis, we each brought an anonymised transcript excerpt and would spend an hour separately analysing these, before coming together to share and justify our analytic work. At later stages of the write-up process, my ‘fully-formed’ analyses were scrutinised and questioned by the group. Thirdly, my supervisor provided feedback and critique on a draft of my analysis, ensuring that my analytical work was grounded in the data. Combined, these processes have ensured that the findings produced by this research are internally and theoretically coherent and persuasive (Willig, 2001).

4.4 Transparency and Rigour

Transparency and rigour are essential in order to contextualise qualitative research findings, and refer to a systematic and transparent process of collection, analysis and interpretation of data (Spencer et al., 2003). A clearly outlined rationale for the development of this research and the research questions was provided in chapter two. Furthermore, a detailed outline of analytical process was provided and limitations of this have been considered (see section 2.5). Initial themes and extracts of annotated data (Appendices L-N) provide an audit trail for the analytical process.

4.5 Reflexive Review

As discussed (see section 2.6) a reflexive dialogue which seeks to actively question one’s own knowledges is an essential component of quality-evaluation in research, and allows the researcher to consider ways in which their subjectivity and meaning-making has influenced the research process (Henwood & Parker, 1994; Willig, 2001). Therefore, in this section I will endeavour to interrogate the research epistemology and methodology and the process of data collection from a personal reflexive stance.

4.5.1 Epistemology and Methodology

A critical realist social constructionist epistemological position was adopted in this research. Criticisms of this approach and my rationale for its application have been discussed (see section 2.1). In line with this position, the analysis developed an account of ways in which extra-discursive factors influenced participants' discursive constructions of psychopathy (e.g. policy and practice guidelines) and informed possible subjectivities for clinical psychologists working with individuals with psychopathy (e.g. responsibility for public protection informing therapeutic aims). As such, the research has attempted to establish that language constructs knowledge and social realities, but that material boundaries impact what is available and prohibited (Willig, 2008).

However, at times I found it difficult to straddle social constructionist and critical realist positions simultaneously; in attempting to create a dialogue between them I may have undermined the central tenets of each. For instance, consideration of the lived reality for professionals and service users (e.g. restrictive service structures), as well as interactions experienced as distressing, difficult or destructive, compromised my ability to maintain a critical stance towards prevailing knowledges about psychopathy and, at times, deterred me from examining how psychopathy is socially constructed through talk. Likewise, criticisms that there are no formal organising principles by which to distinguish the discursive from the non-discursive are applicable (Sims-Schouten et al., 2007). When required by the analytical process to move beyond an investigation of extra-discursive features impacting on discursive constructions and subjectivities, in order to make inferences about the 'real world', the absence of a systematic method disinclined me from articulating analytical thought (Willig, 2008).

My own repertoire of 'common-sense' knowledges and related practices have been informed by several years of professional experience in forensic systems. Reflecting on the chosen epistemology, a preference for constructionist perspectives towards prevailing discourses and power structures may have, therefore, been tempered by my 'lived experiences' of forensic work and the discourses by which I have been subjectified. In hindsight, I wonder whether it felt safer to engage with the dataset

from a critical realist social constructionist stance, so as not to perturb my own regime of truth; in so doing, I may have avoided 'speaking truth to power' (Worley, 2009).

With regards to the methodology, I sought to ensure coherence and plausibility through the use of a systematic and thorough analytical process, however researcher bias should be acknowledged; for instance, during my reading I was especially interested in the ways in which psychologists explained psychopathy within their talk and the types of work that were implied as necessary by this. It is reasonable to surmise that another researcher may have been drawn to different elements of the data and thus arrived at conclusions alternative to those presented here.

4.5.2 Data Collection

Given the extreme nature of prevailing discursive constructions of psychopathy, when clinical psychologists were asked to talk about their work it is perhaps unsurprising that a dis-ease with underlying assumptions was expressed and negotiated throughout their accounts. However, the relationship between the interviewee and interviewer also bears consideration (Frith & Gleeson, 2012). For instance, it is possible that asking professionals to describe how and why they work in particular ways implies that the legitimacy of their practices are being called into question (Kovacova, 2013). Indeed, scepticism as to the motives of the researcher, and what might be 'uncovered' about current practices, were concerns articulated by those who declined to participate in the study. Related to this, my position as a trainee clinical psychologist from the University of East London, well-known for its critical and critiquing stance, may have led participants to feel a need to justify their stance and practices in relation to psychopathy. In attempting to negotiate this, I am aware that I often adopted a 'one-down' position in my interview style, such as prefixing my follow-up questions with statements like 'I don't know the answer to this, but…'. In turn, this may have influenced the subject positions that participants were able to take up, such as talking from an expert position.

Additionally, several of the participants were ex-colleagues; it is reasonable to assume that a pre-existing relationship impacted on the type of talk that was possible. For example, at times participants evoked my professional identity in order to legitimise a point. The following brief extract is an example of such talk: “and you know Kitty, you’ve worked with people, you […] know there are people who really, really struggle with the theory of mind” (Clara: 499-500). Had there not been a prior relationship between myself and Clara, she may not have drawn on assumed shared knowledge in this way, possibly resulting in a different type of talk. Likewise, had I not had a prior relationship with Clara, I may have felt more able to question the assumptions implicit in her talk at this point. Related to this, my use of the word ‘we’ at times during the interview process is worth reflecting on as it has multiple discursive effects: (1) it evokes my professional identity in line with those I am interviewing; (2) it removes me from personal responsibility, in that my stake as an individual in problematic concepts is downplayed; (3) it emphasises the presence of an institution to which clinicians, including myself, belong and are bound by, so justifying present practices through shared ownership.

Through the interview process I have become acutely aware of the use of taken-for-granted language, including my own, across mental health contexts, the most obvious being the use of the word ‘psychopath’. As the interviewer, I sought to remain aware of the potential impact of my choice of words (Baker, 1997); despite this, the interviews were physically and discursively situated in a forensic, psychiatric context. As such, psychiatric and diagnostic language was difficult to avoid and I am aware that at several points across the interview process I ‘acquiesced’ to the seeming necessity of this. A potential consequence of this is that assumptions inherent in these ways of talking were not fully explored. However, it is also possible to interpret this experience as an effect of extra-discursive practices impacting on what is possible to say, pointing to the power of psychiatric language in facilitating communication between professionals based on shared understandings.

5 CHAPTER FIVE: IMPLICATIONS OF FINDINGS

In chapters three and four, I presented an extensive analysis of interviews with eight clinical psychologists in conversation about psychopathy. In this chapter I will explore clinical implications of the research and arising recommendations, followed by in-depth consideration of the research findings and contributions, in the context of the wider literature.

5.1 Implications and Recommendations

The findings of this research point to important clinical and research implications in relation to psychopathy in forensic settings. Arising recommendations are aimed at mental health professionals working with those identified as psychopathic, those involved in service and policy development, and researchers investigating the field. The implications and recommendations discussed here are not exhaustive, rather the aim is to provide an illustration of current concerns and related possible future directions based on the research findings. It is my hope that by introducing these recommendations across professional and academic contexts, it will be possible to foster "subversive discursive practices and spaces for resistance" (Willig, 1999, p. 12) which will impact positively on the lives of those with a label of psychopathy.

5.1.1 Stigma and Labelling

Participants' recurrent articulation of psychopathy as a stigmatising label is suggestive of a form of structural discrimination (Link & Phelan, 2001). While participants attempted to address this through increasing others' knowledge and shared team formulations, the potential impacts of this stigma were not fully explored in their accounts. As McPhail (2013) emphasises, the psychopathy label can divert clinicians away from in-depth consideration of traumatic experiences and the effects of these on an individual. Several participants attempted to engage with this, however, their constructions were 'thin' in contrast to prevailing problematised constructions (Geertz, 1973). As well as negative responses from others on the basis of stigmatised identities (Bogojevic et al., 2013) research into stigma effects

has shown that stigmatised individuals negatively evaluate themselves, leading to maladaptive behaviours and impaired recovery (Livingston & Boyd, 2010). There is potential for psychological theory to be informative in this regard. For instance, Hatzenbuehler's (2009) psychological mediation framework of stigma provides a framework through which to illuminate the relationship between stigma and mental distress in order to inform clinical interventions. Clinicians might consider such tools to assist them in conceptualising the lived experiences of individuals with a label of psychopathy, providing a means by which the intra and interpersonal psychological processes implicated in stigma can be examined (McPhail, 2013).

Despite acknowledging the limitations of the label, participants repeatedly articulated that it would not be possible to do away with it because it stands in for an experience that mental health professionals find difficult to understand, and that labelling is a part of contemporary human life. This belief is echoed by commentators advocating in favour of diagnostic systems (e.g. Green, 2013). *If* labelling is an inevitable process, a potential solution might be to re-vision the label away from its controversial history. One possible alternative might be for clinicians to begin using the term ‘high risk, high need’ (McPhail, 2013). This term more appropriately reflects that individuals with psychopathy in forensic settings often require high levels of therapeutic input and care and moves away from the moral overtones and elusiveness of the psychopathy label, shedding its historical baggage in the process. While I acknowledge that this is an imperfect alternative in that it draws on other, problematic constructs such as ‘risk’, research has indicated that this conceptualisation engenders more positive outcomes for individuals (Wilson, Cortoni, & McWhinnie, 2009). Labelling theory is resonant here; it may be that the label psychopathy promotes deviant behaviour, while an alternative label makes different ways-of-being possible (Thoits, 2010).

5.1.2 Formulation

The findings demonstrated that formulation is used by clinical psychologists within forensic settings as a way to contextualise diagnostic descriptions of psychopathy and to centralise individuals’ negative life circumstances (Johnstone, 2013). This is in concordance with core competencies of the psychology profession, which sees

formulation as a means to provide a rich description of psychological distress (British Psychological Society, 2011a). However, the results also uncovered a reproduction of individualised diagnostic constructions of psychopathy repackaged as a form of formulation, likely to perpetuate labelling effects and associated stigma. Given this, clinical psychologists working with psychopathy might consider locating psychological formulations away from diagnostic labelling in order to 'thicken' alternative non-essentialist descriptions, which more comfortably align with the aims of the wider profession. This is vital if formulation is to continue to function as an 'antidote' to the narrow depictions offered by psychiatric diagnoses (Boyle, 2007). Thus, modes of formulation which offer distinct alternatives to a focus on traits and behaviours, and which are dynamic and transitive, should be promoted (Harper & Moss, 2003).

5.1.3 Reflexive Reflective Practice

The findings demonstrated the presence of an implicit agenda to promote reflective practices across the workforce. As noted, reflective practice was understood by participants to mean a safe space in which to examine and understand professional relational difficulties. However, reflective practice can also be defined as a space in which to "make sense of the *uncertainty* in our workplaces and […] to work competently and *ethically*" (Ghaye, 2000, p. 7 emphasis added). Given this, it is significant that the findings indicate an absence of discussions regarding the ontological uncertainties and ethical implications of psychopathy within forensic settings; due to its contested status, this should be seen as an essential component of reflective discussions. Likewise, the findings indicate that clinical psychologists are mostly unaware of the discursive mechanisms, constructions and subjectivities extant in their talk. Through examining these aspects in relation to psychopathy, professionals may become more aware of the effects of their speech acts and the taken-for-granted knowledges through which they practice, leading to more critical practices. Heenan (1998) suggests 'reflexive discourse practice' as a means by which this might be enabled, whereby the clinical focus is expanded in order to include consideration of wider professional discourses. Other possibilities for praxis might be shared team analysis of, and reflection on, the language used within formal documents, such as risk assessments and psychology reports. This may have the

effect of bringing an increased awareness to the constitutive power of language and to the professional positions inhabited, within an applied context. Irrespective, in fostering discursively and ethically-conscious conversations as part of reflective practices, clinicians may move away from (or beyond) totalising categories like psychopathy, instead seeking out nuanced frameworks for understanding the lives and presentations of those with whom they work. It may also mean that clinicians are empowered to use the psychopathy label in a knowledgeable way, remaining alive to its limitations and implications, as well as acknowledging their role in this process. Significantly, this recommendation sits within the boundaries imposed on forensic practitioners by extra-discursive practices and is therefore potentially actionable.

5.1.4 Policy and Service Development

The findings of this research indicate the presence of a complex relationship between medical and legal domains; a biolegal space (Foucault, 1988a). If, as its professional body suggests, clinical psychology has the capacity to apply its skills base to service and policy development agendas (British Psychological Society, 2010), it is important that this is taken as an opportunity to foster shifts in discourses at a systemic institutional level. Through this, it may be possible to develop alternative discursive spaces from which dominant psychiatric decontextualised constructions can be challenged (Boyle, 2011).

One possibility in this regard is that policy developers, and healthcare professionals advising them, emphasise ontological uncertainties related to psychopathy within policy and guidance documents. As Pickersgill (2009b) asserts, failing to do so risks reifying a controversial and stigmatising category. Policy has a key role in governing clinical practice, therefore discussion of practice guidance and its clinical and social implications should occur concurrently; to separate them is unethical. In coproducing these issues, clinicians will be better placed to make fully-informed decisions about their practice. While this may produce a quandary for clinicians to actively navigate in daily practice, such awareness-raising is essential in providing ethical healthcare to service users (Horley, 2013b).

Likewise, service practices should be evaluated in light of the absence of a clearly defined conceptual definition of psychopathy (Federman et al., 2009) and questioning whether it is appropriate to measure something that is not clearly defined in the literature, and which may not be useful. This may relate to extra-discursive practices within forensic systems, which can act as boundaries to the production of alternative ways of understanding people with this label. For example, the absence of any strengths-based clinical tools may reinforce problematised constructions; as one participant describing the PCL-R process expressed: "there's no strengths focussed stuff and you only really notice that when you sit down with someone […] and you start every session by apologising for the negative focus" (Evelyn: 476-478). It is possible that the development and introduction of an alternative, strengths-based measure for psychopathy, may enable different understandings of the phenomenon, or enrich the presently 'thin' alternative descriptions that are available to clinicians[14].

5.1.5 Possibilities for Future Research

Research can be considered contributory if it advances knowledge or understanding about policy, practice, theory or a particular substantive field (Spencer et al., 2003). Although the present research analysed data from a small number of clinical psychologists within a specific context, the findings provide insight into ways in which a particular discursive landscape pertaining to psychopathy is operant. Furthermore, in conjunction with the growing body of critically-informed research pertaining to the psychopathy classification (e.g. Parker et al., 1995; Pickersgill, 2009a, 2009b), there are grounds for generalisability (Myers, 2000). Further research to enable greater understanding of prevailing socio-cultural discourses and forms of knowledge about psychopathy, and the professional subjectivities that are produced in relation to these, is therefore essential (Harper, 1996). As Pilgrim (2001) emphasises, a shift away from narrow clinical foci in relation to personality disorders, towards an

[14]As previously noted in the literature review (see section 1.2.1), this concept reflects emerging research which proposes the presence of an adaptive element to psychopathy in the wider population. Likewise, it may also open up the possibility for clinicians to draw from other, non-forensic conceptualisations of psychopathy, as a constellation of adaptive/success-driven traits (e.g. Hare, 2007).

enlarged social framework of transdisciplinary knowledge and research needs to be fostered.

The discourses underpinning participants' accounts demonstrated the presence of a problematised identity for individuals with psychopathy; conversely, with the apparent exceptions of a study detailed by Parker et al., (1995) and Stowell-Smith & McKeown's (1999) analysis (see section 1.5), interviews with service users detained under the category of psychopathy have not been utilised as a source of research data. Research indicates that biomedical models and related psychiatric discourses transform service users' experiences and understandings of mental distress (Georgaca, 2013). Thus, future research might investigate how those with a label of psychopathy in forensic settings understand the label and the meanings they ascribe for themselves through an analysis of their talk. If the aim of psychological qualitative research is to provide a platform for "hearing the voices of the excluded" (Ashworth, 2003, p. 24) then research which seeks to explore the experiences and self-constructions of people with psychopathy is an essential endeavour.

Additionally, given apparent tensions between psychiatric and psychological discourses evident in the present research, and apparent differences with other professional groups demonstrated in the literature (e.g. Mason, Caulfield, et al., 2010; Richman et al., 1999), an investigation of the discourses available across professional groups may be an insightful investigation, enabling understanding of how different professional discourses and subjectivities are imbricated. Studies in other fields (e.g. Stevens & Harper, 2007) have identified that the availability of repertoires depends, to some extent, on professional membership; this may have implications for practice.

6 APPENDICES

6.1 APPENDIX A: UEL SCHOOL OF PSYCHOLOGY ETHICAL APPROVAL

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants
BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

SUPERVISOR: Lara Frumkin **REVIEWER:** Miles Thomas

STUDENT: Kitty Clark-McGhee

Title of proposed study: Exploring how clinical psychologists in a forensic setting construct psychopathy.
Course: Professional Doctorate in Clinical Psychology

DECISION (Delete as necessary)**:**

***APPROVED**

APPROVED: Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

Minor amendments required (for reviewer):

Major amendments required (for reviewer):

1

Confirmation of making the above minor amendments (for students):

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name (Typed name to act as signature):
Student number:

Date:

ASSESSMENT OF RISK TO RESEACHER (for reviewer)

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

[X] LOW

Reviewer comments in relation to researcher risk (if any):

You need to check local NHS ethical procedures if you are recruiting Psychologists from different areas as particpants.

Reviewer Miles Thomas

Date: 2/4/15

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee (moderator of School ethics approvals)

PLEASE NOTE:
*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, travel approval from UEL (not the School of Psychology) must be gained if a researcher intends to travel overseas to collect data, even if this involves the researcher

6.2 APPENDIX B: UEL RESEARCH ETHICS COMMITTEE APPROVAL

EXTERNAL AND STRATEGIC DEVELOPMENT SERVICES
uel.ac.uk/qa
Quality Assurance and Enhancement

04 December 2015

Dear Kitty

Project Title:	**Exploring how clinical psychologists in forensic settings construct psychopathy**
Principal Investigator:	**Kitty Clark-McGhee**
Researcher:	**Dr Lara Frumkin**
Reference Number:	**UREC 1516 19**

I am writing to confirm the outcome of your application to the University Research Ethics Committee (UREC), which was considered by UREC **on Wednesday 18th November 2015.**

The decision made by members of the Committee is **Approved**. The Committee's response is based on the protocol described in the application form and supporting documentation. Your study has received ethical approval from the date of this letter.

Please ensure that you submit a copy of your IRAS application form and R&D/HRA approval letter to the Research Ethics office (researchethics@uel.ac.uk) once received. This is in order for us to provide you with a letter of UREC consent and sponsorship on behalf of UEL for your study. You should adhere to the conditions specified in your R&D/HRA approval letter.

Should any significant adverse events or considerable changes occur in connection with this research project that may consequently alter relevant ethical considerations, this must be reported immediately to UREC. Subsequent to such changes an Ethical Amendment Form should be completed and submitted to UREC.

Approved Research Site

I am pleased to confirm that the approval of the proposed research applies to the following research site.

Research Site	Principal Investigator / Local Collaborator
Participants' workplaces	Dr Lara Frumkin

Approved Documents

Docklands Campus, University Way, London E16 2RD
Tel: +44 (0)20 8223 3322 Fax: +44 (0)20 8223 3394 MINICOM 020 8223 2853
Email: r.carter@uel.ac.uk

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
UREC application form	1.0	03 November 2015
Participant information sheet	1.0	03 November 2015
Consent form	1.0	03 November 2015
Interview topic guide	1.0	03 November 2015

Approval is given on the understanding that the UEL Code of Good Practice in Research is adhered to.

The University will periodically audit a random sample of applications for ethical approval, to ensure that the research study is conducted in compliance with the consent given by the ethics Committee and to the highest standards of rigour and integrity.

Please note, it is your responsibility to retain this letter for your records.

With the Committee's best wishes for the success of this project.

Yours sincerely,

Rosalind Eccles
University Research Ethics Committee (UREC)
UREC Servicing Officer
Email: researchethics@uel.ac.uk

6.3 APPENDIX C: CHANGES TO R&D APPROVAL PROCESSES

From: [redacted] [redacted]@nhs.net] [15]
Sent: 26 October 2015 10:18
To: Kitty Marie CLARK-MCGHEE
Subject: R&D Reviews Required for Research

Hello Kitty,

Thank you for calling Noclor this morning. As discussed, the HRA Approval process is the new system for obtaining NHS Permission (or R&D Approval) to conduct research in the NHS. This HRA Approval process commenced in August and is currently being implemented on a phased basis and will soon replace the conventional process for obtaining NHS Permissions (and will be called HRA Approval). Completing the IRAS document set will remain the method by which you obtain your HRA Approval/NHS Permission. When we spoke I advised you that while the HRA Approval process was still in the phasing-in period and it is up to you whether you apply for HRA Approval (via indicating 'HRA Approval' on Q4 of the IRAS R&D form) or remain with the current, standard process of applying for NHS Permission via R&D offices for the relevant research sites (via indicating 'NHS/HSC Research and Development offices' on Q4 of the IRAS R&D form). Having just reviewed the HRA guidance, it appears that for studies being completed solely in fulfilment of an educational qualification, until further notice, they are to continue to apply for NHS Permission as normal so, you are to select in your IRAS R&D form, under Q4. 'NHS/HSC Research and Development offices'. Apologies for the confusion here.

I hope the above helps. If you require any further clarification please do not hesitate to get back in touch.

Kind regards

[redacted]
Research Compliance Officer
Research & Development
noclor Research Support Service

[15] Redacted information to preserve anonymity of participating Trusts, services and participants.

6.4 APPENDIX D: X TRUST R&D COMMITTEE ETHICAL APPROVAL

Despite the changes to NHS staff recruitment (see Appendix C), each Trust's R&D department had differing degrees of rigour in their approval processes, hence, some of the approvals were granted in the form of a simple email response, while other Trusts required evidence of the IRAS document set and a formal peer review of the research proposal.

[TRUST HEADER]

[redacted]

Tel: [redacted]

17/11/2015

Dear Kitty Clark-McGhee

Re: Research proposal application to [redacted] dated: 20/10/2015
Exploring how clinical psychologists in forensic settings construct psychopathy

Thank you for your recent research proposal which was considered at the last [redacted] meeting.

The [redacted] committee has considered your project and I am pleased to inform you that the proposal was supported. [redacted] will forward your application to the Trust R&D Office for peer review.

Notice that [redacted] support **DOES NOT** mean R&D approval. In order to carry out research in the Trust you will need to obtain R&D approval. First you will need to go onto http://www.myresearchproject.org.uk/ and set up an IRAS account. (IRAS stands for Integrated Research Application System). Contact R&D office for further information.

Yours sincerely

Dr X [electronically signed]

Clinical Scientist
[redacted]

[redacted] NHS

NHS Trust

[redacted]

[redacted] R&D Office
Trust Headquarters
[redacted]

Tel: [redacted]
Fax:
Email: [redacted]

8 February 2016

Dear Ms Clark-McGhee

Letter of Access for Research

As an existing NHS employee you do not require an additional honorary research contract with this NHS organisation. We are satisfied that the research activities that you will undertake in this NHS organisation are commensurate with the activities you undertake for your employer. Your employer is fully responsible for ensuring such checks as are necessary have been carried out. Your employer has confirmed in writing to this NHS organisation that the necessary pre-engagement check are in place in accordance with the role you plan to carry out in this organisation. This letter confirms your right of access to conduct research through [redacted] for the purpose and on the terms and conditions set out below. This right of access commenced on **08/02/2016** and ends on **29/09/2016** unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal investigator for the research project has received a letter from us giving permission to conduct the project.

You are considered to be a legal visitor to [redacted] premises. You are not entitled to any form of payment or access to other benefits provided by this organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through [redacted] you will remain accountable to your employer [redacted] but you are required to follow the reasonable instructions of your nominated **research supervisor** in this NHS organisation or those given on her/his behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with [redacted] policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with [redacted] in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on [redacted] premises. Although you are not a contract holder, you must observe the same standards of care and propriety in

dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and the Trust prior to commencing your research role at the Trust.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice [redacted] and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

[redacted] will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately.
Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

If your circumstances change in relation to your health, criminal record, professional registration or suitability to work with adults or children, or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the NHS organisation that employs you through its normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely

[redacted]

[redacted]
Research Governance Officer

Letter of access appendix - List of projects

Study Title: Exploring how clinical psychologists in forensic settings construct psychopathy R&D reference: M30EW1504 REC reference:		
Study duration:	Start date: 09/02/2015	End date: 30/09/2016
Letter of access duration:	Start date: 09/02/2015	End date: 29/09/2016
If any information on this document is altered after the date of issue, this document will be deemed invalid.		

Trust Headquarters, [redacted]

Tel: [redacted].nhs.uk

6.5 APPENDIX E: X TRUST R&D COMMITTEE ETHICAL APPROVAL

From: [redacted] [redacted]@[redacted].nhs.uk]
Sent: 09 December 2015 14:57
To: [redacted]
Cc: Kitty Marie CLARK-MCGHEE
Subject: RE: RE: Ethical Approval - Project Review

I am happy to approve this project.

[redacted]

From: [redacted]
Sent: 29 October 2015 12:42
To: [redacted]
Cc: 'u[redacted]@uel.ac.uk'
Subject: RE: Ethical Approval - Project Review

Dear Clinical Director,

The above project was discussed at the Ethics Sub-Committee meeting on Thursday 29th October 2015. I write on behalf of the Committee to share with you the advice of the committee in considering the ethical dimensions of the project. Final approval will rest with you as Clinical Director.

Summary of Advice

Project 345: Exploring how clinical psychologists in forensic settings construct psychopathy (Kitty Clark-McGhee)

· No ethical concerns

We hope this advice is helpful to you in considering whether to approve this proposal. Members of the Ethics Sub-Committee would be happy to discuss this with you further.

With best wishes,

[redacted]
Quality Outcomes & Experience Analyst
[redacted] NHS Foundation Trust
Trust Headquarter, [redacted]
Tel: [redacted] Mob: [redacted]

6.6 APPENDIX F: X TRUST R&D COMMITTEE ETHICAL APPROVAL

From: [redacted] [redacted]@[redacted].nhs.uk]
Sent: 23 November 2015 15:22
To: Kitty Marie CLARK-MCGHEE
Subject: RE: non-research study R&D request

Kitty,

Duly noted, with thanks.

Regards,

[redacted]
Research & Development Manager

[redacted] Mental Health NHS Trust (Tuesdays and Thursdays)
[redacted] Hospital * Tel: [redacted] * Fax: [redacted]

[redacted]
Tel: [redacted] * Fax: [redacted]

_____
From: Kitty Marie CLARK-MCGHEE [u[redacted]@uel.ac.uk]
Sent: 20 November 2015 11:06
To: [redacted]
Subject: RE: non-research study R&D request

Dear [redacted],

In order to keep you updated, I am sending you a copy of the fully authorised IRAS R&D offices application and the SSI forms for [redacted] sites.

Also attached are the submitted supporting documents (participant letter, information sheet, consent form, semi-structured interview guide).

All the best,

Kitty

_____
From: Kitty Marie CLARK-MCGHEE
Sent: 15 October 2015 16:45
To: [redacted]
Subject: Re: non-research study R&D request

Dear [redacted],

Many thanks for this information. I am indeed in the process of an IRAS application so it sounds as though I should keep you updated as to the outcome of this.

All the best

Kitty

-------- Original message --------
From: "[redacted]"
Date:15/10/2015 14:38 (GMT+00:00)
To: Kitty Marie CLARK-MCGHEE
Subject: RE: non-research study R&D request

Kitty,

Thank you for your e-mail. If your study involves NHS staff only, it is exempt from Ethics review and it will be classed as a Cohort 1 study under the Health Research Authority's (HRA) new approval process as of 11 May 2015. This means that you can complete the secure online IRAS form (at https://www.myresearchproject.org.uk/Signin.aspx) by creating an account and then submitting directly to the HRA for review.

Cohort 1 studies no longer require local NHS permission from R&D Offices within participating sites, but there is a need for your university (as the sponsor) and this Trust (as the participating site) to assess local capacity and capability as part of a general feasibility review beforehand. If you proceed with your application, I would respectfully ask that you ensure this R&D Office is kept informed of any progress relating to approval of your study. Further information on the HRA approval process for this type of study can be found here: http://www.hra.nhs.uk/about-the-hra/our-plans-and-projects/assessment-approval/hra-approval-cohort-1/#HowToApply.

Please also note that HRA approval is undergoing phased implementation nationally and if your study does not meet the criteria for Cohort 1 studies, then it will need to go through IRAS and be submitted to this R&D Office for local NHS permission. I will be happy to assist you further, if this is indeed the case.

If you have any other questions in the meantime, please let me know.

Kind regards,

[redacted]
Research & Development Co-ordinator

[redacted] Mental Health NHS Trust (Tuesdays and Thursdays)
Research Office,[redacted]
[redacted]
Tel: [redacted]
Fax: [redacted]

6.7 APPENDIX G: CONSENT FORM

University of East London
School of Psychology, Stratford Campus, Water Lane, London E15 4LZ

UNIVERSITY OF EAST LONDON

Consent to Participate in a Programme Involving the Use of Human Participants.

EXPLORING CLINICAL PSYCHOLOGISTS UNDERSTANDINGS OF PSYCHOPATHY IN FORENSIC SETTINGS

I have the read the information leaflet relating to the above programme of research in which I have been asked to participate and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what it being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researchers involved in the study will have access to the data. It has been explained to me what will happen once the programme has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me and for the information obtained to be used in relevant research publications.

Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason.

Participant's Name (BLOCK CAPITALS)
……..

Participant's Signature
……..

Investigator's Name (BLOCK CAPITALS)
……..

Investigator's Signature
……..

Date: ……

6.8 APPENDIX H: INFORMATION SHEET

University of East London
School of Psychology, Stratford Campus, Water Lane, London E15 4LZ

PARTICIPANT INFORMATION LETTER

Consent to Participate in a Research Study

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in this study, which is being conducted as part of a doctoral degree in clinical psychology.

Project Title

Exploring Clinical Psychologists Understandings of Psychopathy in Forensic Settings

The Principal Investigator(s)

Kitty Clark-McGhee
Email: [redacted] Tel: [redacted]

Project Description

This study aims to explore how clinical psychologists understand psychopathy, what knowledge and experiences inform these understandings and how this might impact on clinical practice. Participants will be asked to discuss this topic during interviews, lasting 45-60 minutes. No hazards or risks are anticipated for potential participants.

Confidentiality of the Data

All names, service locations and other identifying information will be anonymised through coding procedures, which will be help securely and separately from transcribed data. Following completion, audio recordings will be deleted. Electronic copies of the anonymised transcripts will be kept securely for possible research publication at a later date.

Location

The interviews will be held in a private room at your place of work.

Disclaimer

You are not obliged to take part in this study, and are free to withdraw at any time during tests. Should you choose to withdraw from the programme you may do so without disadvantage to yourself and without any obligation to give a reason.

University Research Ethics Committee

If you have any queries regarding the conduct of the programme in which you are being asked to participate, please contact:

Catherine Fieulleteau, Research Integrity and Ethics Manager, Graduate School, EB 1.43 University of East London, Docklands Campus, London E16 2RD (Telephone: 020 8223 6683, Email: researchethics@uel.ac.uk).

Thank you in anticipation.

6.9 APPENDIX I: SEMI-STRUCTURED INTERVIEW GUIDE

SEMI-STRUCTURED INTERVIEW GUIDE

Topics will be negotiated with participants before and throughout the interview process.

Possible topics for discussion may include the following:

- Why did you decide to take part in this research project?
- Can you tell me about your work with clients with a psychopathy label?/ What is it like to work with people with this label?
- How do you prefer to work with people with psychopathy? What works best? Do these ways of working fit with the service/NHS requirements?
- How do you ensure that you remain reflective when working with people with a label of psychopathy? Are there times when this has been difficult?
- What contributed to your decision to work in forensic services? Was working with individuals with psychopathy part of this decision? Did the possibility of working with people with psychopathy appeal to you?
- What does the term psychopathy mean to you?
- What have been your personal experiences of working with people with psychopathy?
- Do you think that psychopathy is an important construct in forensic services? In what ways?
- Do you think that popular culture, and the media, contributes towards societal understandings of psychopathy?
- Have you worked with women with psychopathy? If so, how, if at all, is it different? Do you think it impacts on their experience and the treatment that is offered to them?
- What are some of the main issues you have experienced whilst working with individuals with psychopathy?
- What support do you think clinical psychologist's need when working with this client group? Is this different than in other professional settings, and if so, why?
- Is there anything else you would like to talk about?

6.10 APPENDIX J: RESEARCH TITLE CHANGE

A title change was requested and approved in order to more accurately reflect methodological intentions and analytical breadth of the study.

SCHOOL OF PSYCHOLOGY
uel.ac.uk/psychology
Acting Dean: Professor Rachel Mulvey, BA MA DCG PhD FICG FHEA

UEL University of East London

Date: 30/03/2016

Student number: u1031917

Dear Kitty,

Notification of a Change of Thesis Title:

I am pleased to inform you that the School Research Degree Sub-Committee has approved the change of thesis title. Both the old and new thesis titles are set out below:

Old thesis title: Exploring how Clinical Psychologists in Forensic settings construct Psychopathy.

New thesis title: A Discourse Analysis of Clinical Psychologists' talk about Psychopathy in Forensic settings.

Your registration period remains unchanged. Please contact me if you have any further queries with regards to this matter.

Yours sincerely,

Dr Kenneth Gannon
School Research Degrees Leader
Direct line: 020 8223 4576
Email: k.n.gannon@uel.ac.uk

Stratford Campus, Water Lane, Stratford, London E15 4LZ
Tel: +44 (0)20 8223 4561
Email: m.r.mulvey@uel.ac.uk

6.11 APPENDIX K: JEFFERSON-LITE TRANSCRIPTION CONVENTIONS

Transcription symbol	**Meaning**
(.)	Pause of less than 1 second
(2)	Pause of one second or more, with length (in seconds) denoted in brackets
(LG)	Laughter
(BR)	Intake of breath
-	Indicates a breakoff of utterance e.g. th-
text	Emphasis by speaker
(())	Inaudible speech
XXX	In place of any names to preserve anonymity
mhmm/ mmm/ erm	Phonetically transcribed sounds

6.12 APPENDIX L: INITIAL THEMES - DISCURSIVE CONSTRUCTIONS

Psychopathy as a feeling	An intuition/ a flavour/ a sense, psychopathy feels different to other service users, is threatening, mythical and non-scientific Praxis: clinical intuition legitimate practice
Psychopathy as horrifying	The things psychopaths have done are chilling/ unsettling/ terrible, others find it difficult to be with them, incomprehensive behaviours Praxis: reflective practice, supervision, support for teams
Psychopath as unlikeable	Annoying/ nasty/ hard to like, they can make staff cynical, cold Praxis: important for staff to reflect/ name their feelings/ have supervision
Psychopath as manipulative	Their actions are deceitful/ dishonest/ scheming, they are slippery and devious, they lie Praxis: important for staff to reflect/ have supervision, psychiatric/ diagnostic language
Psychopath as challenging/ trouble maker	Compromise therapeutic work on the ward, they are hard work/ difficult to manage, they disrupt dynamics/ push boundaries/ split teams, they can lead to burn-out Praxis: important for staff to have supervision, psychological language
Psychopath as dangerous	Risky/ high risk, high levels of recidivism, dangerous to vulnerable service users, dangerous to staff well-being, they are a public safety issue, management vs therapy, hopelessness Praxis: public protection, risk assessments, managing expectations (pessimism?)
Psychopath as self-focussed	Inherently selfish/ narcissistic, lacking empathy, driven to meet psychopathic needs, out of control, traditional therapeutic motivations do not work for them Praxis: novel ways of working?
Psychopathy as rare	It is an unusual, unique phenomenon, it is elusive, incomprehensible

Psychopath as vulnerable	They have been damaged, have complex needs, are helpless/ scared/ victims/ unwell, psychopathy is caused by a disturbed childhood, psychopaths are psychologically impaired/ deficient/ less resilient/ not in control Praxis: at-risk/ trauma discourse, psychological formulation essential/ team formulation/ awareness essential
Psychopathy as stigmatised label	The label is damaging, psychopaths are poorly served/ treated by others, psychopaths are victims of system, psychopaths are misunderstood/ difficult to understand Praxis: raising team's awareness is essential, 'insight' of staff in question, fighting injustice, raising awareness across teams

Across multiple readings, these discursive constructions were assimilated into four overarching constructions of psychopathy/ the psychopath: (1) dangerous (a feeling, horrifying, dangerous, rare); (2) challenging (unlikeable, challenging/ trouble-maker); (3) manipulative (manipulative, self-focussed); (4) psychologically damaged (vulnerable).

Of note, following subsequent re-readings of the data, 'psychopathy as stigmatised' was re-interpreted as a practice because it was identified as arising from, and discursively tied to, psy-practices of team formulation and reflective practice.

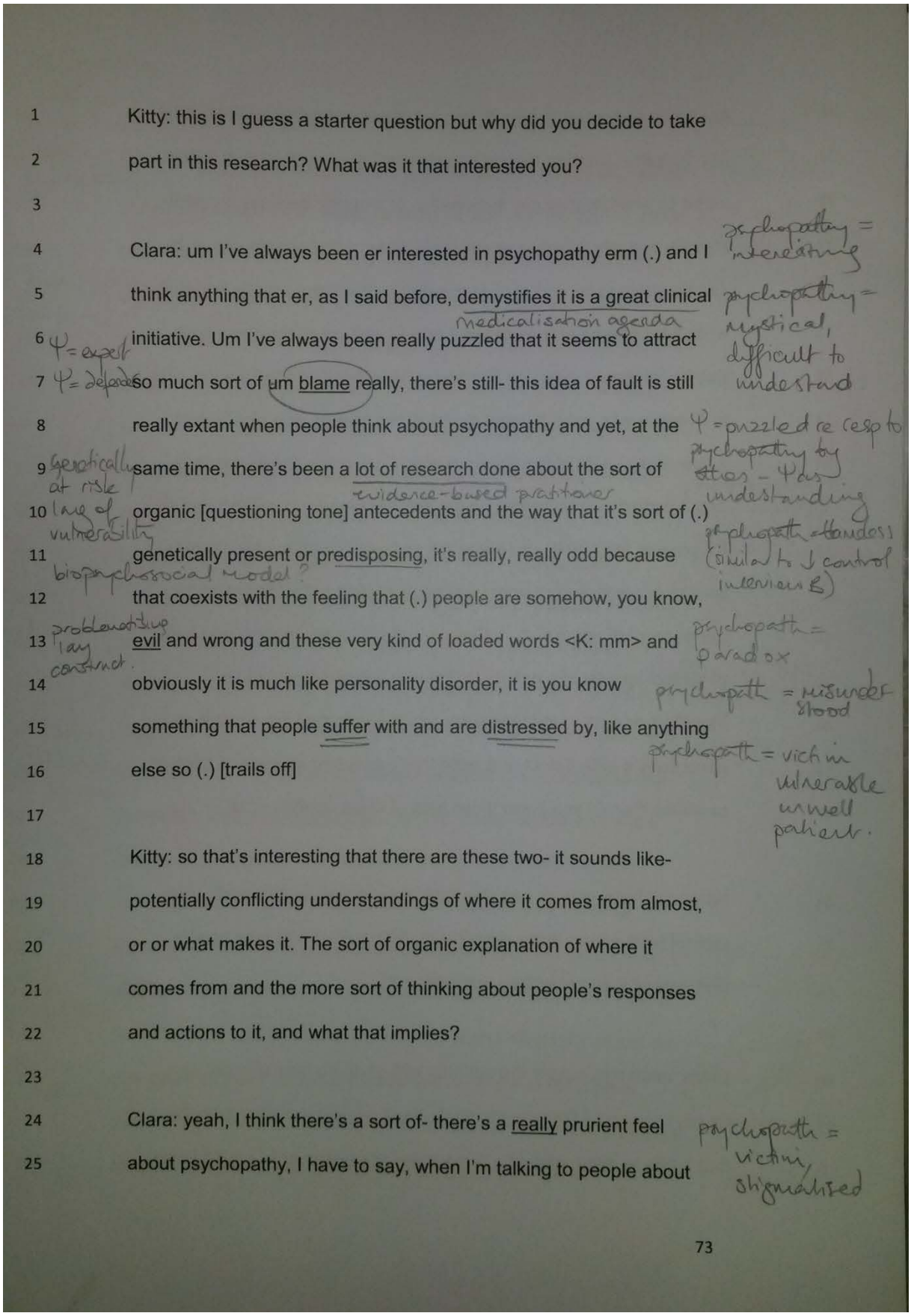
6.13 APPENDIX M: INITIAL THEMES – SUBJECT POSITIONS

Psychologist as expert	Specialist, responsible for psychopathy assessment, knowledgeable, expertise via experience, psychology is essential for psychopathy Praxis: specialist knowledge to offer to teams, scientist-practitioner, theory to practice linking
Psychologist as skilled	At working with complexity, working with teams (staff insight?), compassionate/ non-judgemental/ empathic, multi-skilled, reflective practitioner, leader
Psychologist as defender	Against injustice, against misuse of labels, against lack of knowledge, responsible for protecting service users, an advocate/ champion/ fighter, fighting against diagnosis, fighting for formulation, centralising trauma Praxis: biopsychosocial model, psychological formulation, promoting psychological thinking
Psychologist as sceptical	Suspicious of label, doubtful, questioning its usefulness
Psychologist as helping others	Demystifying psychopathy, imparting specialist knowledge/ facilitating learning, reducing stigma through objective knowledge (scientist-practitioner), bringing alternative perspective (non-medical) Praxis: Reflective practice, team formulations, introducing psychology to teams
Psychologist as subversive/ critical	Aware of power, aware of limitations of diagnosis, theory vs practice, rebelling against status-quo, anti-psychiatry Praxis: reassessment of PCL-R, talking about power with service user, thinking about limitations of label
Psychologist as objective	Rational, scientist-practitioner, dispassionate/ unaffected emotionally, able to use knowledge, aware of/ wise to psychopathy Praxis: assessment?
Psychologist as pragmatic	Realistic, limits to critical stance, aware of real-life challenges for ward staff, diagnosis best-worst option, the system as limiting, need to work within the system, time

	pressured/ limited by environment, labels helpful Praxis: label used to help teams understand
Psychologist as ethical	Concerned by ethical/ moral dilemmas, trying to do the right thing, individually responsible for actions, driven by fairness, thinking about consequences for individual Praxis: reassessment of PCL-R

Across multiple readings, these subject positions were assimilated into three overarching subjectivities available for participants: (1) pragmatist; (2) subversive (ethical, subversive/critical, sceptical, defender); (3) expert/specialist (skilled, helping people, objective)

6.14 APPENDIX N: EXAMPLE OF ANALYSED TRANSCRIPT 1



Kitty: this is I guess a starter question but why did you decide to take part in this research? What was it that interested you?

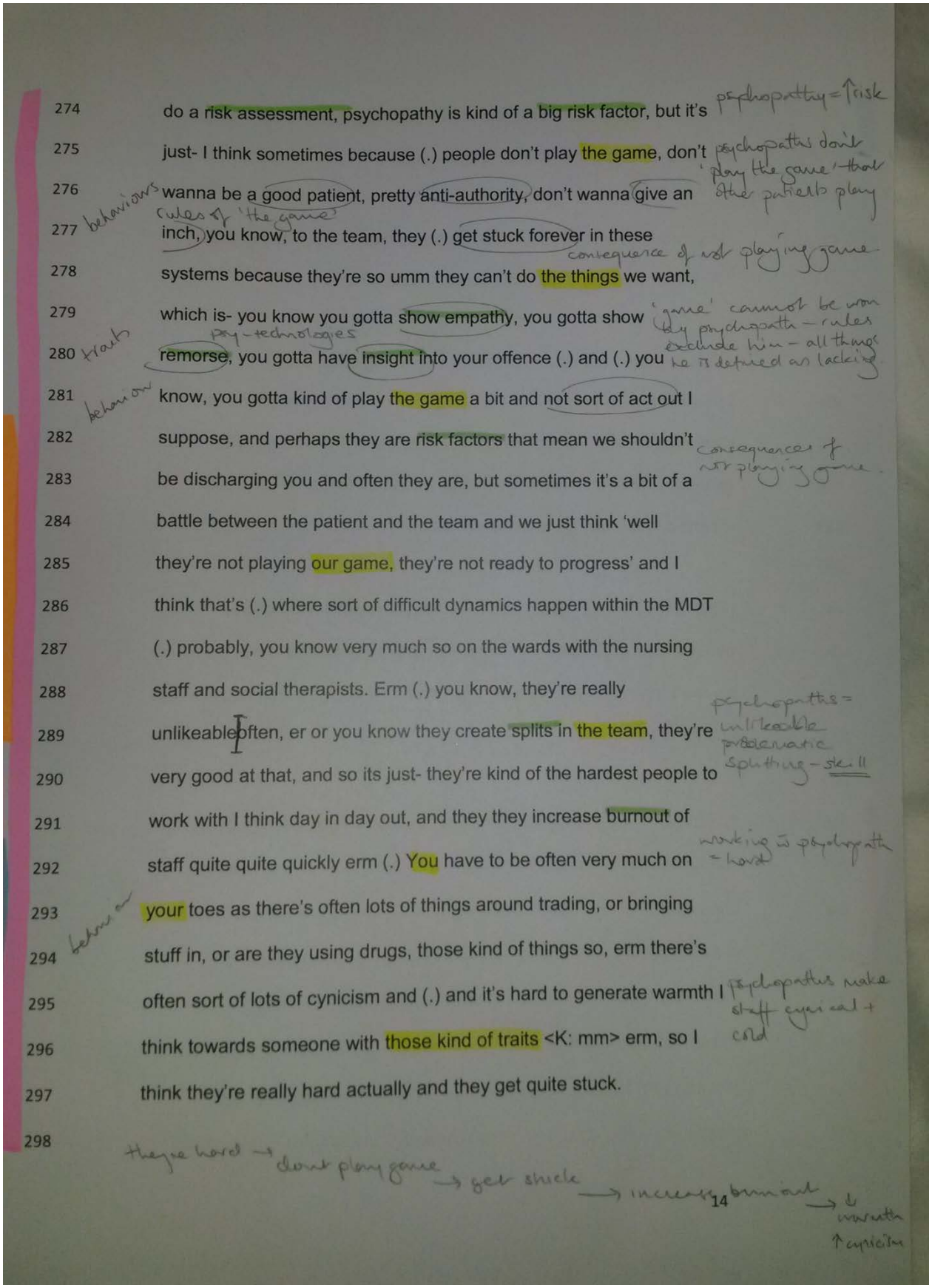
Clara: um I've always been er interested in psychopathy erm (.) and I think anything that er, as I said before, demystifies it is a great clinical initiative. Um I've always been really puzzled that it seems to attract so much sort of um blame really, there's still- this idea of fault is still really extant when people think about psychopathy and yet, at the same time, there's been a lot of research done about the sort of organic [questioning tone] antecedents and the way that it's sort of (.) genetically present or predisposing, it's really, really odd because that coexists with the feeling that (.) people are somehow, you know, evil and wrong and these very kind of loaded words <K: mm> and obviously it is much like personality disorder, it is you know something that people suffer with and are distressed by, like anything else so (.) [trails off]

Kitty: so that's interesting that there are these two- it sounds like- potentially conflicting understandings of where it comes from almost, or or what makes it. The sort of organic explanation of where it comes from and the more sort of thinking about people's responses and actions to it, and what that implies?

Clara: yeah, I think there's a sort of- there's a really prurient feel about psychopathy, I have to say, when I'm talking to people about

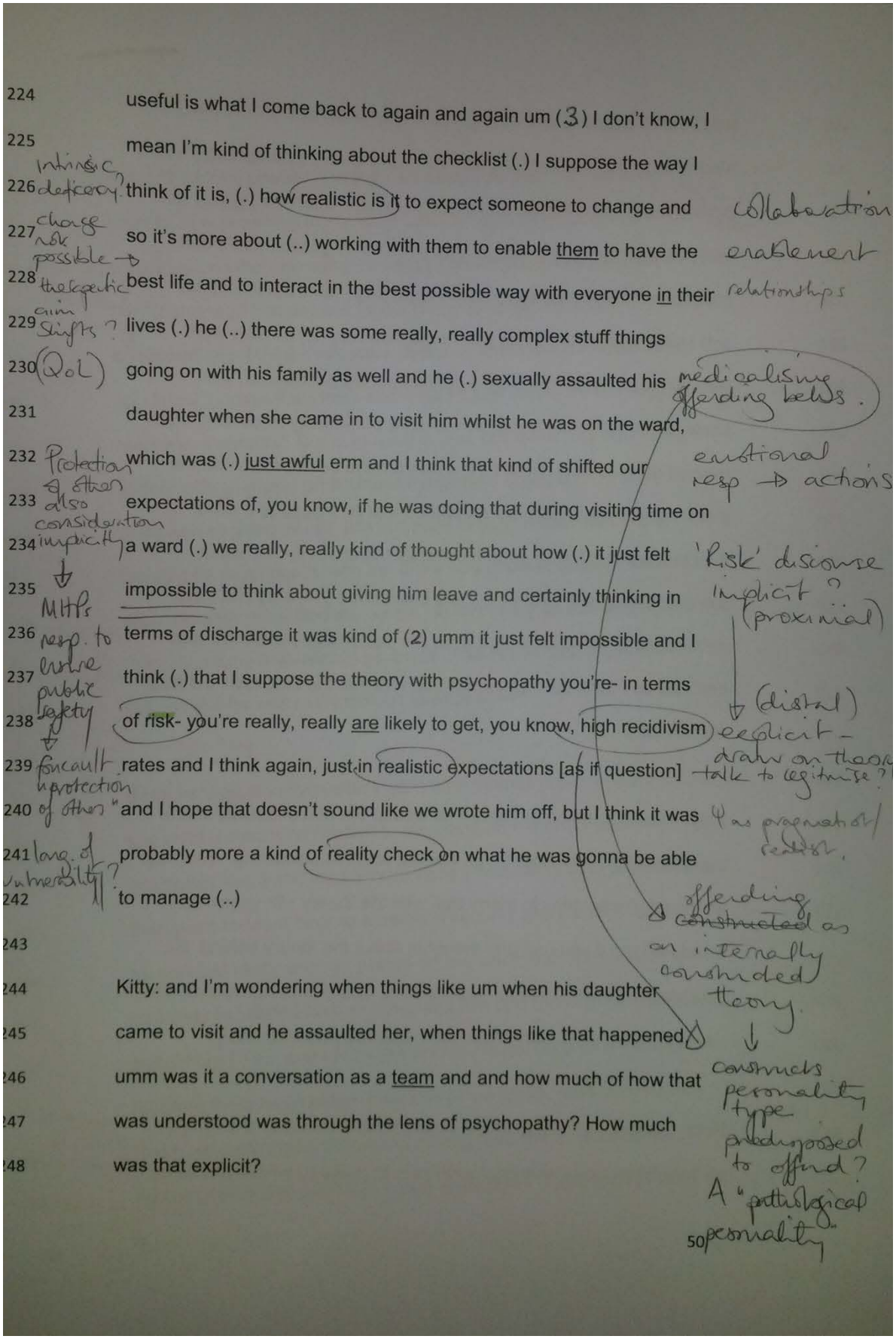
73

6.15 APPENDIX O: EXAMPLE OF ANALYSED TRANSCRIPT 2



274 do a risk assessment, psychopathy is kind of a big risk factor, but it's
275 just- I think sometimes because (.) people don't play the game, don't
276 wanna be a good patient, pretty anti-authority, don't wanna give an
277 inch, you know, to the team, they (.) get stuck forever in these
278 systems because they're so umm they can't do the things we want,
279 which is- you know you gotta show empathy, you gotta show
280 remorse, you gotta have insight into your offence (.) and (.) you
281 know, you gotta kind of play the game a bit and not sort of act out I
282 suppose, and perhaps they are risk factors that mean we shouldn't
283 be discharging you and often they are, but sometimes it's a bit of a
284 battle between the patient and the team and we just think 'well
285 they're not playing our game, they're not ready to progress' and I
286 think that's (.) where sort of difficult dynamics happen within the MDT
287 (.) probably, you know very much so on the wards with the nursing
288 staff and social therapists. Erm (.) you know, they're really
289 unlikeable often, er or you know they create splits in the team, they're
290 very good at that, and so its just- they're kind of the hardest people to
291 work with I think day in day out, and they they increase burnout of
292 staff quite quite quickly erm (.) You have to be often very much on
293 your toes as there's often lots of things around trading, or bringing
294 stuff in, or are they using drugs, those kind of things so, erm there's
295 often sort of lots of cynicism and (.) and it's hard to generate warmth I
296 think towards someone with those kind of traits <K: mm> erm, so I
297 think they're really hard actually and they get quite stuck.
298

6.16 APPENDIX P: EXAMPLE OF ANALYSED TRANSCRIPT 3



useful is what I come back to again and again um (3) I don't know, I
mean I'm kind of thinking about the checklist (.) I suppose the way I
think of it is, (.) how realistic is it to expect someone to change and
so it's more about (..) working with them to enable them to have the
best life and to interact in the best possible way with everyone in their
lives (.) he (..) there was some really, really complex stuff things
going on with his family as well and he (.) sexually assaulted his
daughter when she came in to visit him whilst he was on the ward,
which was (.) just awful erm and I think that kind of shifted our
expectations of, you know, if he was doing that during visiting time on
a ward (.) we really, really kind of thought about how (.) it just felt
impossible to think about giving him leave and certainly thinking in
terms of discharge it was kind of (2) umm it just felt impossible and I
think (.) that I suppose the theory with psychopathy you're- in terms
of risk- you're really, really are likely to get, you know, high recidivism
rates and I think again, just in realistic expectations [as if question]
and I hope that doesn't sound like we wrote him off, but I think it was
probably more a kind of reality check on what he was gonna be able
to manage (..)

Kitty: and I'm wondering when things like um when his daughter
came to visit and he assaulted her, when things like that happened
umm was it a conversation as a team and and how much of how that
was understood was through the lens of psychopathy? How much
was that explicit?

6.17 APPENDIX Q: TEXT OMITTED FROM TRANSCRIPTS

Extract 1 … and one of the things I'm really not clear– I don't know whether you have the answer to this, but …

Extract 6 … Rob Hale, I don't know if you've read Rob Hale's research, he's erm this month he's giving a talk but he was clinical director at the Tavistock <K: ok> and his theories about psychopathy I find very compelling to the point of, you know <K: did he write in the Guardian recently?> yeah um it's about how …

Extract 10 … for the woman who had the BPD diagnosis and an LD diagnosis, and then psychopathy…

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