

**An Examination of the Emotional Labour of Nurses Working in
Prison**

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Abstract

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Mann (2004:208) identifies three components of emotional labour: 'The faking of emotion that is not felt and/or the hiding of emotion that is felt, and the performance of emotion management in order to meet expectations within a work environment.' Nurses working in prison in England and Wales have a dual role; that of both carer and custodian. This thesis examines the emotional labour of nurses working in adult prisons who undertake a dual role in both caring and custody.

A qualitative, reflexive methodology was adopted with a postmodern philosophical foundation. Phase one of the study involved semi-structured interviews with nine qualified nurses from three adult prisons: two male establishments and one female. In phase two of the study, two of these nine nurses entered into a supervisory relationship with the researcher. Monthly clinical supervision sessions were held with both nurses over six months.

Findings from this study suggest that the nurse working in prison experiences emotional labour as a consequence of four key relationships: the relationship with the prisoner patient, the relationship with officer colleagues, and the relationship with the Institution; the fourth relationship centres on the contradictory discourses the nurse engages with internally, and is referred to as the 'intra-nurse' relationship. This relationship involves on-going internal dialogue between the two selves of the nurse: the professional self and the emotional 'feeling' self. In order to manage the emotion work inherent in prison work, it is suggested that the development of emotional intelligence through clinical supervision and reflective practice is of significant benefit to both health care and discipline staff.

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A Personal Reflection

I have worked in and around prison health care settings since I qualified as a nurse in 1995. I can pinpoint my journey into post-registration academia with some accuracy as I remember the event that questioned my perspective on nursing in prison with surprising clarity.

I obtained my degree in the summer of 1995 and my first post as a qualified nurse was in a prison. I chose prison as I had undertaken a very enjoyable placement in the setting during my training. I had been working in prison health care for six months, diligently learning the procedures and processes within which prison life revolves for both prisoner and staff, whilst coming to terms with my newly qualified status. This was a time punctuated with extreme stress and utter excitement. I felt as though I needed time to consolidate my training and become confident in my new role, so any thoughts of traditional study were far from my mind. My tutors had advised me that the first thing I needed to do when I qualified was to obtain a recognised post-registration qualification, which would enable me to mentor students. As the prison had no students, this priority was soon forgotten. I never stopped to think why they had no students.

Having been schooled in a positivist tradition, questioning authority was not in my nature; after all, I was only 24 and newly qualified so I assumed I knew nothing of any significance. I spent six months learning my new job and gaining in confidence, when I began to question exactly what I was doing. Incidents occurred in which I participated according to the prison procedure. I started to think, how exactly was I 'caring' when the system in which I was working only seemed to care about keeping prisoners secure? I sought out one of the health care managers with whom I had developed a good relationship and whom I instinctively felt was 'like me'. He appeared to have struck a balance between caring for his prisoner patients and yet was able to slip in and out of a disciplinary role with apparent ease. He took time to listen

to my concerns and anxieties as I struggled with the dissonance between my carer role, my custodial role and my own values about caring for people. Once I was aware of this inner struggle, I began to notice the way in which other staff worked and how some of them dealt with this issue. My sense was that many of my colleagues could not see the issue as I did. I then began to question myself – was I being too sensitive? Was I too 'soft' to work here? Was I imagining this problem; after all, the majority of my colleagues appeared to be managing? I turned the problem back on myself. The tension I experienced must be as a result of my own shortcomings.

A few weeks later, whilst locking up the psychiatric landing for the lunch break, I encountered a prisoner patient who had received some upsetting news from home. I cannot remember who he was, what the news was or indeed why he was an inpatient, but what I do remember more clearly than anything is the feeling of horror, anger and disbelief I experienced in having to lock him up when my caring instinct dictated that I should spend some time with him. I spoke to the nurse in charge and asked if I could leave him unlocked in order to do this, but my request was denied. 'It's patrol state, Liz. He has to be banged up.' As far as they were concerned, he was in a dormitory, would be frequently watched during lunchtime in case he tried to harm himself and, therefore, all would be well. I should stop worrying and go and have my lunch. Of course, all was well in terms of the prisoner patient's safety, but all was not well for me considering that I was unable to act in the patient's best interest – something I held as important and recognised as central to my practice.

This was the turning point for me. I began to scrutinise the Code of Professional Conduct, which led me to consider the nature of nursing in prison in terms of what exactly nurses were doing in this environment and quite what constituted care. This was the catalyst for my Master's degree study where I examined nurses' experiences of working in a male prison. I completed this study whilst continuing to work full time. After completing my

Master's, I began to consider my career options. I enjoyed working with prisoner patients and fitted comfortably into the culture of camaraderie at the prison. However, a move into management and then into teaching and practice development seemed an obvious option. By the time I reached academia, my thinking had moved on significantly and I was struck by the way in which nurses in prison not only had to deal with caring whilst being a custodian, but also had to care for prisoner patients who hated them and the system, and whom it was possible the nurses loathed too. I reflected on my own experiences. Quite how did I care for prisoner patients I could not stand? Although an extreme example, I happened upon a debate published in the Nursing Times in which two nurses were asked the question: could you nurse Saddam Hussein? This started me thinking.

I had indeed nursed some unpleasant people whilst at the prison and many of my friends and family asked me how I managed to look after them. I could never really answer it clearly. 'Oh, I don't think about what they have done' or 'they aren't doing the crime when I'm nursing them so it's OK'. But was it? Was it really? Did their offence have an impact on the way I viewed them? Did it mean I cared any less or provided insufficient care? Was that bad? Or indeed, was it inevitable? Should I have been tougher? Or, were my colleagues and I just doing our best in a difficult situation? I decided, then, that the way forward with my studies was to examine this further.

Preface

According to Phillips & Jorgensen (2002:vii), the preface 'suggests how the text has been produced and how it is to be consumed'. They continue to explain that 'the preface navigates the text between the individual and the collective'. It is my intention in this preface to provide the reader with a broader understanding of the context within which I write, both personally and philosophically, rather than to suggest how the text should be consumed. In order to achieve this with some clarity, my work has been created using a reflexive approach and, therefore, the reader is party to my thought processes as far as I can articulate them and their relationship to my study throughout.

I have been inspired by Tracy (2004) to adopt a distinctive approach to writing. Tracy (2004) utilises a different number of stars separating the text to signify a move between different theoretical positions, discussion of her methodology or to 'denote a jump from another facet of the same rhetorical space' (Tracy 2004:511). I intend to use this approach to denote a jump from the literature under discussion to my own reflections on its meaning. My 'jumps' between theory and reflection will be highlighted by the use of italics.

Thesis Design

My life has been shaped by continued exposure to structure and order; hence, it is an approach with which I feel safe and comfortable. However, there is something about adherence to structure which I feel can hinder progress and development. Not to question structure and the order of things, in some instances, means that nothing will move forward as adherence to dominant discourses only serves to support and perpetuate them. Although historically I have found questioning problematic, I have begun to realise that, as a PhD student, I am now in a position to do just that. Indeed, the

more I consider it, the more I feel it is in some way my responsibility to question. If one examines the development of theories and approaches to research in nursing, it is clear that, although there are many authors, only some are influential in changing practice. Not only have they developed new ways of thinking, but, more importantly, they have had the courage and confidence to publish and defend them. Finding this confidence and courage within myself has been difficult, given my propensity to assume others are correct. In addition, my own professional culture in the prison setting does not lend itself to speaking freely and with confidence, given the necessity for secrecy for the sake of security.

I had an expectation of what a PhD thesis should look like, i.e. introduction, literature review, methodology, etc. However, given the methodological approach I have adopted in this study, this academic rigidity is not appropriate. Even though I usually warm to such structure and instruction, I suggest that such an approach is unsuitable for this work, given its reflexive nature. The tension between my natural instinct and creative appropriateness for this study has been difficult for me to manage, illustrating perfectly the emotional labour of engaging with postgraduate research at this level.

According to Freshwater & Rolfe (2001:533), 'Reflexive research is characterised by ongoing self-critique and self-appraisal.' This approach is not just methodological; it is also used in both describing and monitoring methodology. To promote on-going reflection and self-appraisal, I will be writing in the first person and reflecting on literature and philosophical understanding in terms of my own experiences as both a prison nurse and nurse researcher, recognising the many discourses that have influenced me, the participants, and the culture within which we are practising – that of prison and academia.

I am about to make a bold statement about the philosophical underpinnings of this study; however, I have some reservations, as I am cautious not to direct the reader into a particular way of reading or thinking about my thesis. It is important to me that the reader of this thesis reads it in the way in which they want to. Directing is not something I believe in, but the very fact that I am writing this paragraph in order to inform the reader about the philosophical underpinning of this work does suggest a contradiction in terms of being directive about being non-directive. I do not believe that my position in this thesis is any more important or powerful than others who have gone before me or indeed who will come after me. I also recognise that the text I write here will be read by others who will unconsciously deconstruct and reconstruct it to make sense of it for themselves. However, given the reflexive nature of my work, it is important that the reader is given the opportunity to understand and possibly reflect on the philosophical perspective I have adopted.

This study is situated within the postmodern paradigm.

Having read copious material regarding this tradition, one thing is clear: it is most definitely not. Nevertheless, through gaining a better understanding of the postmodern perspective over time, I can see that to provide a clear definition of the term would be wholly inappropriate, given its underlying tenets. However, I am sure about the way in which I regard people. I have strong beliefs about the importance of individuality and respect, and I also have an intuitive perspective that individuals construct their own realities, which, to understand as the individual understands and experiences them, is impossible.

This thesis has been written with some semblance of order however, a more traditional approach to data analysis has been discarded. The postmodern paradigm from which I am writing suggests that dominant discourses shape understanding and knowledge. I recognise that my own personal

understanding of this study will be influenced not only by my experiences as a nurse working in prison but also by my personal values and beliefs which, in turn have been shaped by many external factors; most notably my upbringing as the daughter of a nurse and a prison officer, and additionally my secondary education in a catholic boarding school, itself an institution.

In addition to these influences, I suggest that the dominant discourses prevailing on three levels will also impact on my understanding and appreciation of my work, namely political/social discourses, institutional discourses at both local prison and university levels and, finally, the dominant discourses with which I engage by way of my development as a researcher and through my PhD journey via supervision and external sources such as attendance at conferences and training events. Therefore, the analysis present in this thesis is not limited to the analysis of the participants' voices. Although important, they are only a part of the many discourses that have shaped this work and, as such, the acknowledgment of dominant discourses is present throughout this study, including those in the thesis itself.

In keeping with the postmodern, reflexive nature of this study, I invite and encourage the reader to engage with me in challenging, questioning, confronting and deconstructing this work. I do not suggest that the conclusions in this thesis are true for all prison nurses. However, I do assert that they are true for the nurses who were involved in this study at the time they worked with me. The traditional acceptance of research reports as authoritative and superior needs to be confronted, as I believe it is only through challenge and reflection that a changed perspective and improved practice is possible.

I am very aware that by finally publishing this thesis, I have surrendered control of how you, the reader, will understand and make sense of my work. Although the reflective nature of it allows you to follow my own thinking throughout, I suggest that you will read it, deconstruct it and reconstruct it in

order to make your own sense of it. It is through this deconstruction and reconstruction that I hope new perspectives and perhaps new practices may emerge.

As Michel Foucault suggested at the beginning of a lecture series, 'I would be very pleased if at the end of each lecture you would voice some criticisms and objections so that, insofar as possible and assuming my mind is not yet too rigid, I might gradually adapt to your questions and thus at the end of these five lectures we might have done some work together, or possibly made some progress' (Foucault in Faubion 2002:1).

Chapter One: The Philosophical Picture

Given the reflexive nature of this thesis, I have chosen to relate my thoughts about the total confusion I initially experienced concerning the development of my understanding of postmodernist philosophy. What follows is a reflection on the way in which I have approached this journey to a better understanding.

As a child, my room would descend into chaos quite slowly, without me being aware of it. Consequently, I would reach a point where I would eventually notice the mess and spend a day with my mother sorting it out. Her approach was to empty everything onto my bed, clean the furniture and replace everything back tidily whilst discarding clutter. The aim of this approach was to ensure it was completed by the end of the day so that my bed was clear for me to sleep. Looking back on this, I now adopt this approach to anything confusing or messy. In essence, I find it best to throw everything into more chaos and methodically work through it, whilst cleaning and discarding the unnecessary. It is this approach I have taken with arriving at my understanding of philosophy. As is clear from the way this chapter is arranged, I bring the reader through my journey from confusion and chaos to a clearer understanding. I relate this journey to the experience of cleaning my room. I am aware that, since beginning this study, I have gradually descended into chaos without realising it, given my propensity to read and absorb other people's 'truths'. It is only in trying to describe my understanding of the philosophical basis of this thesis in writing, that I realise my 'philosophical room' is messy and has reached the point where I need to clean it and sort through what I feel is unnecessary. However, having been engrossed in the writings of Abrahamson & Freedman (2006), I am led to question my approach to managing 'mess', and indeed my need to manage it, as they assert that a degree of messy thinking is indeed useful as structured, organised thinking can limit creativity. Charmaz (2004:981)

advises qualitative researchers to 'treat bewilderment as a sign that you are entering the phenomenon'.

Whilst I appreciate that chaos and confusion is uncomfortable for many, I urge the reader to accompany me on this journey in order to understand more fully how I arrive at the conclusions I make.

Philosophical Confusion

I need to make it clear at this point that I feel there is confusion in the literature pertaining to postmodernism. According to Hawker (1998:96), confusion is defined as 'bemusement, bewilderment, discomfiture, mystification, perplexity, puzzlement, chaos, disarray, disorder, jumble, mess, muddle, shambles, turmoil'. For me, this confusion is as a result of the competing and sometimes contradictory explanations of the concept of postmodernism. In addition to the prevailing discourses with which I have engaged, I have also been operating within my own tensions concerning 'what' and 'who' to believe which, coupled with my discomfort of disorder (intrinsic to confusion), has resulted in difficulty for me. During my journey through this literature, I have discovered that authors are confusing postmodernism with post-structuralism. According to Cheek (2000), some writers have used the terms synonymously, which further adds to the ambiguity and confusion. I intend to spend some time reflecting on my own understanding of the terms in order to ensure that the reader of this thesis appreciates precisely which way I am thinking about the world. I have chosen to examine the work of two key authors who have written about postmodernism/post-structuralism from a health care perspective, in an attempt to elicit the differences between postmodernism and post-structuralism.

Rolfe (2006a) provides a clear picture of the underpinning notions present in both post-structuralism and postmodernism. According to Rolfe (2006a),

post-structuralist thinkers adopt a questioning approach to taken-for-granted assumptions about what is true; they reject the notion that there are underlying structures linking the phenomena of human life which can be predicted by determinable laws; and accept that there is an objective world 'out there' but that there is no one single independent truth which can describe it. In addition, for the post-structuralist thinker it is not so much the issue of truth that is central, but access to it. There is concern within the post-structuralist position that, even if the truth 'out there' is uncovered, we will not know we have uncovered it. Rolfe (2006a:9) states: 'The truth might well be out there, and our research study might well have uncovered it, but the ironist would argue that we can never really know whether we have uncovered the truth or not.'

Rolfe continues to describe the underpinning tenets of postmodern thinking as similar to those of the post-structuralist; however, the key difference appears to be the rejection and questioning of the objective world 'out there'. Postmodern thinkers 'claim that reality is constructed separately by each individual' (Rolfe 2006a:8), and therefore reject any belief that there is indeed a world out there which can be known.

Cheek (2000) suggests that there are many similarities between postmodern and post-structural thinking. However, her explanation concludes that they differ in focus and emphasis. Indeed, Cheek continues to suggest that the two traditions are impossible to separate and cites Best & Kellner (1991) who argue that post-structuralism forms part of 'the matrix of postmodern theory'. It is suggested by Cheek that there is a difference in the analyses employed by postmodernists and post-structuralists. Postmodern analyses 'tend to be wider in scope and...focus on aspects of culture, society and history' (Cheek 2000:40). She continues to suggest that post-structuralists tend to concentrate on analyses of literary and cultural texts, where text is referred to as meaning any representation of reality. Cheek continues to discuss the use of discourse analysis as part of the post-structuralist perspective.

Further discussions through supervision have led me to understand that, for the postmodernist, truth is contextual and relative. There is no 'one' truth. Rather, there are many. Truth is lost as soon as you think you have uncovered it, as it is contextual to that moment in time and within that context. The post-structuralist takes into account the way in which structures (social, institutional, personal, etc.) give an illusion of the truth; therefore, post-structuralists concern themselves with deconstructing those structures that perpetuate the belief that there is a truth.

Given the literature I have examined concerning the concepts of postmodernism and post-structuralism, and their application to nursing research, I chose to consider whether these positions are 'truths' or metanarratives in themselves.

This is where I begin to experience the elation of momentary understanding of the concepts, but then feel as though I have lost my grip of them when I read that discourse analysis is the domain of the post-structuralists. I compare this to the idea that truth is gone once you think you have it. I align myself with what Rolfe (2006a) has suggested is the postmodernist tradition. I do not believe that there is a 'reality out there' and concur that we cannot know it in any case (as it is suggested post-structuralists would imagine), but I genuinely believe that reality is constructed on an individual level and that to know this individual reality as the individual knows it is impossible. However, I still feel that the use of a discourse analysis to examine the emotional labour of prison nurses is the most appropriate approach, despite it being positioned within the post-structuralist position.

The very act of studying the available and accessible literature concerning postmodernism and post-structuralism is, I believe, worthy of examination in its own right. Literature accessible to me is limited. I am not referring to literature to which I have physical access, but literature to which I have

mental access. Much of the literature is confusing, contradictory and just plain complicated, making it difficult to grasp. This position not only leads me to reflect on my own abilities as an academic to understand complex theory, but also compels me to reflect on the nature of academic literature and its usefulness in transforming and developing knowledge if it is inaccessible. In addition, I am now in a space where I am confused about my own underpinning philosophy. Am I postmodern or am I post-structural? What does this say about me – that I crave solid ground and labels which in turn will allow me to produce a thesis grounded in solid fact that can be assessed according to traditional protocol? Alternatively, am I just reinforcing the academic expectation of solid theoretical understanding? Just by admitting to confusion, am I highlighting weakness as an academic or demonstrating strength and confidence in owning up to a position which others before and after me may also inhabit but have been or will be too oppressed by traditional academic expectation to admit to? Then again, why am I subscribing and adhering to traditional academic expectations grounded in a positivist tradition to which I have an intuitive aversion when studies concerning people are concerned. Conversely, why do I perceive an expectation that solid, theoretical, explicit understanding of complex concepts is a prerequisite for this work, given the dynamic and transformational capacity of qualitative research? One might suggest that a reflection on my perceived expectations by others is in order here. Perhaps these perceived expectations are inaccurate and grounded in my own personal understanding of academic expectations through traditional representations. This in turn is founded on the effect of the dominant discourses of present day academia in both prison health and health care in general, in which the positivist empirical tradition (and its associated approaches) are afforded more importance and seen as more 'true'. Indeed, many of the conferences I have attended throughout the course of this study are populated by traditional, positivist research and researchers. This, I suggest, serves to perpetuate this dominant discourse which, for many, is

accepted as the best way to approach research and has therefore become their 'truth', both on an individual and institutional level.

Further examination of other authors in the field of postmodern research, both inside and outside of the nursing arena, has provided me with a structure in order to assist in building understanding. Although I am aware that this 'structure' is illusionary and, in fact, that there is no structure, it has provided me with a way of organising my thinking at this moment in time.

Postmodernist Thought

According to Mautner (2000), postmodernism can mean many different things. The term is used in architecture, in contemporary culture and the arts and in philosophy; hence, Mautner (2000) and Alvesson (2002) both highlight the need for clarity of meaning in any writings claiming to use a postmodern perspective. However, Rodgers (2005:131), in attempting to provide a definition, asserts that 'this is a nearly impossible task because the very essence of postmodernism would seem to eschew a single definition'. Burnard (1999) suggests that, because postmodernism is against systems building and the development of grand theories, definition is problematic. He continues to suggest that postmodernism positively avoids definition, as to define it would be to 'force it to commit itself, to state itself positively' (Burnard 1999:241). Rodgers (2005) suggests that, although there is no single definition that can convey intent and meaning, there is one basic tenet of postmodernism which 'characterises the domain of the ideology' (Rodgers 2005:133). She provides the statement 'the center does not hold' as what she terms 'the rallying cry of postmodernists'. Although this is viewed as one aspect of postmodern thinking, Alvesson (2002:35) highlights others such as the centrality of discourse; fragmented identities; the critique of the idea of representation; the loss of foundations and master narratives; and the knowledge power connection as the central themes underpinning postmodern thinking.

I have chosen to use Alvesson's (2002) description of postmodernism because it is described in a way that I find attractive, given that he has utilised discreet headings to facilitate explanation, which I appreciate appeals to my love of structure. Placing the key tenets of postmodernism under discreet headings allows me to methodically examine each aspect as it relates to my work whilst leaving me secure in the knowledge that I have addressed each key area. I acknowledge that, by utilising the work of Alvesson in this fashion, I have aligned myself with his perspectives on postmodernism and have accepted them as my reality.

The Centrality of Discourse

Alvesson (2002:48) refers to discourse as: 'Language use anchored in an institutional context, expressing a fairly structured understanding or a line of reasoning with active, productive effects on the phenomenon it claims to understand "neutrally".' He continues to suggest that discourses not only structure the world but also structure the person's subjectivity and provide them with a place in the world and a social identity. Rodgers (2005:134) suggests that discourse is not limited to language but rather that it goes beyond it, as a statement is not merely words, but 'an interaction between the speaker and the listener'.

An appreciation of the importance of discourse in understanding phenomena is central to this study. The discourses of the nurses involved in my study provide this thesis with an insight into how prison nursing 'is' in the prison setting for these nurses, and provides it with an awareness of where the nurse is placed within the context of the prison. An examination of the emotional labour of the prison nurse is only possible if the nature of the discourse within which the nurse is placed is made explicit.

Fragmented Identities

According to Alvesson (2002:50), 'Postmodernism rejects the notion of the autonomous, self-determining individual with a secure unitary identity as the centre of the social universe...Generally the human subject is viewed as an effect of, or at least strongly constrained by and constituted within, discourse.' It is my belief that all people are individuals with their own views, thoughts and feelings that shape their identity which leads me to resonate with the notion of fragmented identities. Indeed, when thinking about this belief from a postmodern perspective, this goes one stage further in suggesting that people are a result of being involved in and constructing their own discourse and it is in these discourses that the feelings, views and thoughts of people are articulated.

In examining this stance from a Foucauldian perspective, I see the use of analysing and examining discourses as a means of looking at the way in which the use of power affects the situation in which prison nurses find themselves. Underpinning this idea, I suggest that the values, thoughts and beliefs inherent in the nurse may be shaped as a result of previous and present power relations. Francis (2000:22) states that the understanding of power embedded in discourse 'helps to explain the ways in which an individual's power position appears to shift depending on the interactive environment'.

Upon reflecting on this idea in my own life I can see that the discourse with which I engage in is very different depending on where I am. For example, discourse with my friends is different to that with my colleagues, which again is different to that I experienced as a nurse working in a prison. In turn, these are not only shaped by my own beliefs and values (themselves shaped by discourses in, for example, a catholic school and as a female) but also by the issue and influence of power in each of these arenas.

The Critique of the Idea of Representation

Postmodern philosophers question the idea of representation, i.e. the ability to represent objects using language. It is suggested that a general objective reality is elusive because objects can only be defined in terms of the object for the person to whom the object is significant. For example, my experiences of prison and hence my ability to describe it as an objective reality is flawed because to propose a general perception of 'prison' would be wrong – it is only my perception as it pertains to me that I am describing. That of an ex-prisoner would be very different. Therefore, the meaning of prison will be different to all those who have experienced it in whatever form (shaped and influenced by power and discourse) and therefore the meaning will never be final. It will always be 'incomplete and indeterminate' (Alvesson 2002:53).

The idea of representation and its meaning in a postmodernist study means that the notion of emotional labour and the narratives of those nurses involved in the study may only be pertinent to those nurses, at that time, in that context. This does not mean to say that what we learn from them will be useless information; far from it. I feel that the data enable and support further study of emotional labour in prisons and, indeed, can help inform the training and development of both new and existing staff in this setting. As Alvesson & Skoldberg (2000:5) suggest, 'The study of suitable (well-thought out) excerpts from this reality can provide an important basis for a generation of knowledge that opens up rather than closes, and furnishes opportunities for understanding, rather than establishing "truths".'

The Loss of Foundations and Master Narratives

Alvesson (2002) suggests that the postmodern school of thought rejects grand/master narratives and proposes that there is not one single truth but that there are many truths, developed and sanctioned from within the context that they are generated. A practical example of this can be seen in Ceci

(2004). In his foundational work, 'The Postmodern Condition: A Report on Knowledge', Lyotard (1984:xxiv) asserts that 'postmodernism is incredulity towards metanarratives'. In rejecting the metanarrative, or one truth, Lyotard offers the view that discourses of learning are 'taken up not from the point of view of their immediate truth value, but in terms of the value they acquire by virtue of occupying a certain place in the itinerary of Spirit or Life – or if preferred, a certain position in the Encyclopaedia recounted by speculative discourse' (Lyotard 1984:35). In essence, placing certain discourses in higher regard than others leads to an automatic acceptance that they must be 'the truth'. The work of Lyotard has been enlightening for me in conducting this study in terms of questioning my own perspectives on truth. However, I have also considered my reaction to Lyotard's seminal work and questioned whether Lyotard himself is suggesting a metanarrative.

According to Kermode & Brown (1996:376), 'The major appeal of postmodernism for nurses is the rejection of scientific objectivity and the celebration of valuing differing discourses.' Although Kermode & Brown present a critique concerning the use of postmodernism in nursing, reading their paper was somewhat of an enlightening moment for me. I began to question the 'truthfulness' of what I was reading and began to understand, through supervision, that this paper was just the ideas of two other academics and, as such, using the knowledge I now have, I feel that it is permissible for me to decide if they have something to say. Reflecting on my thoughts concerning what is right and what is true, I have considered the academic process and the way in which it has affected my perspective on 'truth'.

Having been schooled in a convent, we were encouraged not to question what we were being taught. I have a background where, traditionally, I tend to believe what I read. I always felt that if it was published it must somehow be 'right' and 'true'. Having reflected on this in some depth, I came to the conclusion that, during each stage of my academic life, certainties about what others have deemed to be true have been removed, stage by stage. I have developed my thoughts concerning 'truth' and 'certainty' into the following table.

Academic Stage	Level of Certainty	Facts/Knowledge
GCSE/O Level	Absolute certainty. Learn facts, take exams	Very black & white
A Level	Mostly certain although some concepts from GCSE are said to be not as definite as you believed them to be and are developed further Still learn facts and take exams	Mostly black & white
Degree	Some certainty but encouragement to engage in critical thinking Still learn facts and take exams	Becoming grey
Master's	Again, some certainty but more critical thinking Learn facts but discuss critically in exam and/or dissertation	Becoming paler grey
PhD	No certainty, free to question everything and propose own ideas as 'true' Decide what facts to learn and retain as pertinent to own research Examined through discussion More about developing confidence and ability to defend own ideas about what is 'true'	A blank sheet

Table 1: The Academic Ladder of Dominant Discourse

This academic ladder of dominant discourses leads me to consider that it is as though one is somehow given a higher degree of permission to question accepted truths depending on which rung of the ladder one is positioned. To support this, the mode of assessment for each stage gradually releases the need for written, more traditional examination methods of assessment, ultimately replacing it with peer review. From a Foucauldian perspective, it

would appear that the network of power relations operating within academia affect the way in which the student is regarded and situated by the discourse as they ascend this 'ladder', allowing the agency necessary for a more autonomous approach to the goal of academic achievement.

I have given some consideration to including this table in my work, as I am aware that its structure demonstrates a huge contradiction, given the underpinning philosophy I am working with. However, it is important to highlight the dominant hierarchical discourse present in academia, as it provides an understanding of the influences that have shaped my work to date. In addition, further consideration of the wider picture, that of permission to question, leads me to consider the extent to which one is allowed to question in society at large. In the context of this study, it highlights to me, the way in which one's position in society equates to the acceptability of questioning. In the prison world, hierarchies are important in ensuring the smooth operation of the system. However, these hierarchies also position inhabitants of that system and I am led to consider the position of prisoners in the prison system and the resultant inflexibility they have to question, given their position in the organisation.

The Knowledge Power Connection

In attempting to gain knowledge concerning the emotional labour of prison nurses, there are issues around power that need to be considered in terms of both the knowledge sought and the methodology employed. Undertaking a study in the prison setting raises many issues about power that, when viewed from a postmodernist perspective, encourage the need for discussion pertaining to what power means, how it is conveyed and its effect on the emotional labour and practice of nurses in the prison setting. This is examined at all levels in my study through discourse analysis and is considered in terms of the nurse, the prison officer, the prisoner patient and the researcher.

From a Foucauldian perspective where power is viewed through discourse, there are many levels that need addressing. There are power relations evident at all levels within the prison setting which affect an individual's understanding of their world, e.g. the nurse and the institution; the nurse and the multidisciplinary team; the multidisciplinary team and the institution; the nurse and the prisoner patient; between the nursing staff themselves; and the relationship between the researched and the researcher. Indeed, the impact of the sovereign power of the Prison Service on my study is been evident in the rigorous process of gaining access to the sites.

According to Manias & Street (2000), power has traditionally been viewed in terms of the 'juridico-discursive' model based on three assumptions: power is possessed; it flows from a centralised source from top to bottom; and it is primarily oppressive. However, from a Foucauldian perspective, power is not directly viewed in these terms as it can be constructive and does not necessarily flow from top to bottom. Foucault did not think that power is possessed as such but that it is exercised through the dominant discourses of social institutions (Manias & Street 2000). As such, Irving (2002:406) states that, 'Discourse is the medium for transmitting power/knowledge.' Alvesson (2002) cites Foucault (1977) who suggests that it is not the power that one possesses or acquires that is of interest but that these appearances of power are the outcome of more fundamental power relations, which can be seen through the discursive practices and dominant discourses surrounding people and institutions. Alvesson (2002:56) contends that the discursive formation is 'the combination of a set of linguistic distinctions, ways of reasoning and material practices that together organise social institutions and produce particular forms of subjects'. It is with this in mind that the analysis in my study addresses the spoken word not only through interview, but also through documentary evidence, data from clinical supervision sessions and reflections in my own reflective diary.

The idea that power is exercised through dominant discourses rather than being possessed is attractive to me in both the context of my study and upon reflection of my clinical practice in prison. When I return to my experiences in practice, I can clearly see that the dominant discourses of both the Prison Service and the prison culture within which I practised affected the power relations between my colleagues, my patients and myself.

Power and knowledge, according to Foucault, are inextricably linked because it is knowledge that underpins dominant discourses. As Manias & Street (2000:53) state, 'Knowledge reinforces and supports existing regimes of truth.' It is these regimes of truth within institutions that underpin the dominant discourse of the institution and subsequently how the institution and its population are controlled. Irving (2002:406) states that power and knowledge 'mutually condition each other so that, as ideas become accepted as knowledge or "truth", they can delimit the discussion of other possibilities'.

This resonates with two ideas central to both discourse analysis and Foucault's concept of power. Although they are not clearly linked, I feel it is important to mention them. Discourse analysis not only examines what is present, but also what is not present. For Foucault, power only exists because there is resistance to it. Within the postmodern tradition and discourse analysis, it feels as though one is always considering binary opposites and omissions – there is always a duality to thought that is not constrained by focussed, linear thinking which I suggest is embraced within positivist approaches to research.

There are clear links here with the notion of reflective practice in so much as it is the reflection on and in practice that challenges accepted knowledge and instigates changes in both practice and power relations amongst practitioners. The promotion of reflective practice through clinical supervision and qualitative interviewing alters power relations amongst practitioners and the institution within which they practice. As Blackburn so eloquently states,

'Reflection enables us to step back, to see our perspective on a situation as perhaps distorted or blind, at the very least to see if there is argument for preferring our ways, or whether it is just subjective' (Blackburn 2006:11). Although this perspective highlights the transformatory power of reflection, I suggest that this is something that those who practice in an oppressive institution or who are less than confident in their own positions may find difficult.

In his examination of power in psychiatry, Roberts (2005) highlights Foucault's work on disciplinary power, which is termed governmentality. The concept of governmentality has been used in the literature to examine nursing as a health profession (Holmes & Gastaldo 2002) and in understanding the position of nursing in the correctional forensic psychiatric setting (Holmes 2002; 2005). Irving (2002:406) defines governmentality as 'the way in which the conduct of government operates through the establishment of the moral obligation to self-govern'. She compares this to the notion of sovereign power in which obedience is based on 'fear of the consequences of disobedience' (Irving 2002:406). However, Holmes and Gastaldo (2002) suggest that the notion of governmentality can be viewed as a tripartite, complex system of power relations between sovereign power, disciplinary power and government, where sovereign power is exercised through repression and domination; disciplinary power through surveillance, punishment and rewards; and government power, which is rooted in the dominant discourse of moral obligation to self-govern. This complex power relation needs to be unravelled when examining the notion of emotional labour of prison nurses as they encounter all three forms of power in their daily practice, which affects their internal feelings, their practice, their relationship with patients and other members of the multidisciplinary team, and their position within the institution and the systems in which they work.

Figure 1 illustrates the knowledge power connection as viewed from a Foucauldian perspective and demonstrates my understanding of the link.

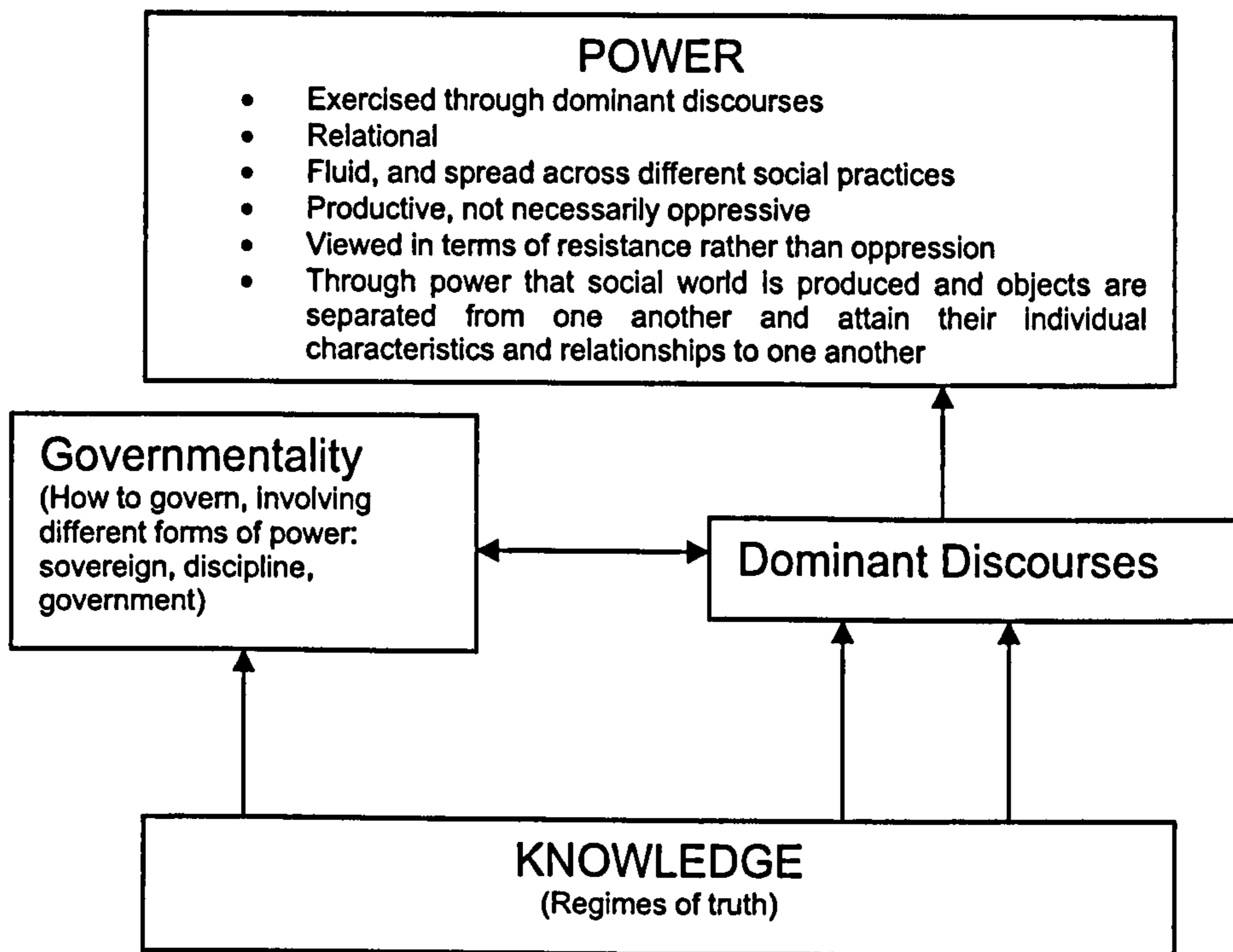


Figure 1: The Knowledge Power Connection

As this diagram shows, from a Foucauldian perspective, knowledge underpins the dominant discourses through which power is applied. Therefore, it is important to be aware of the way in which knowledge is developed, given its key role in underpinning dominant discourse.

Postmodernism is not without its critics. Paley (2004:112) states of postmodernism that it 'merely opposes modernist values, preferring subjectivity to objectivity, feeling to rationality and multiple realities to truth'. Kermode & Brown (1996:383) suggest that 'because postmodern constructions of knowledge are necessarily local, contextual and readily contestable, their social significance is miniscule and here lies the heart of the postmodernist hoax.' However, this suggests that Kermode and Brown (1996) focus on the need for generalisation as the basis and rationale for research and development. Postmodern approaches do not seek to provide

generalisations and I suggest that Kermode and Brown have misunderstood the focus of the aim of postmodern thinking. Instead, postmodern approaches espouse the importance of thinking about reality in a reflexive way rather than taking for granted what we are told is real and true. Postmodern thought encourages questioning of dominant discourses which, rather than seeking to find truth, looks for better understanding and a new perspective. Cheek (2000:20) suggests that postmodern thought 'highlights the constructed nature of what have often become "truths" and taken-for-granted aspects of our reality'.

Stajduhar et al. (2001) suggest that full engagement with the postmodern paradigm, where multiple realities and subjective truths prevail, 'detract from our disciplines' collective thrust towards knowledge that makes meaning and can be credibly applied within a practice domain' (Stajduhar et al. 2001:79). In their paper, they call for the identification and use of a 'middle ground' where the tensions between postmodernist thought and positivist approaches to knowledge, research and education can co-exist, which, they suggest, will enable the recognition of both approaches as valuable to the development of nursing. They fear that engagement with the postmodern paradigm will render all knowledge previously accepted as true, to be worthless. They suggest that a more critical gaze at both postmodernist and positivist methods of research will enable researchers to appreciate the benefits of both. Although I fully understand their position, and to some extent concur that blind acceptance of a new paradigm at the expense of what went before it is inappropriate, I suggest that nurse researchers need to have a good understanding of both approaches and should be able to reflect on the appropriateness of the different paradigms to the situation in which they find themselves. Clearly, there are objective truths obtainable through scientific methods if one is examining the physiological functioning of the heart, for example. However, when one is concerned with the exploration of human feeling, a positivist scientific approach is, in my view, inappropriate.

Rigour

Rigour is an area of research practice that has provoked much debate within the qualitative research paradigm. In order to examine the concept and its application and meaning to this study, I have again attempted to gather as much information as necessary in order to allow me to methodically work through the discourse, thus repeating my approach to managing confusion. I feel that my 'rigour' room is messy.

I reject the 'traditional' view of rigour that Tobin & Begley (2004) refer to as the trinity of validity, reliability and generalisability. The traditional positivist paradigm accepts these concepts as central to methodological rigour but, given the context of my study, they are inappropriate. Freshwater & Maslin-Prothero (2005:643) define validity as: 'The quality of being well grounded on fact, or established on sound principles, and thoroughly applicable to a case or circumstances.' They define reliability in the context of research as: 'The likelihood of producing the same research findings using the same research conditions over a period of time or with different researchers' (Freshwater & Maslin-Prothero 2005:514). However, taken more broadly, rigour can be viewed as the means by which integrity and competence is established within research. Tobin & Begley (2004:390) assert that it is 'a way of demonstrating the legitimacy of the research process'.

The difficulty of applying traditional positivist ideas of rigour in qualitative research is highlighted by Koch & Harrington (1998), and in postmodern nursing research by Stajduhar et al. (2001). In order to assess validity and reliability in qualitative research, researchers have taken to using the parallel criteria proposed by Lincoln & Guba (1985): those of credibility (internal validity), transferability (external validity) and dependability (reliability). Confirmability is also used a part of the criteria and is only achieved when credibility, transferability and dependability issues have been addressed.

Although these criteria are useful, I suggest that thinking has advanced over the last 20 years and, although possibly helpful to the novice qualitative researcher, these now traditional measures of rigour in qualitative research serve to constrain creative thought and support a dominant discourse where it is a requirement to have stringent structures through which the researcher must justify their actions.

For example, Slevin & Sines (2000) in their paper concerning enhancing truthfulness, consistency and transferability in qualitative research draw on doctoral work that utilised a variety of approaches to address rigour. I propose that there are two issues that need to be examined. Firstly, I feel that there is somewhat of a need for qualitative researchers to believe that they must align themselves with a very structured way of justifying their actions. I question whether this is helpful in taking qualitative research away from being the poor relation to more traditional scientific research. I suggest that this approach only serves to support the dominant discourse of scientific research and does nothing to set it apart and value its own discourse. Secondly, I feel there is a focus in this paper for research to be transferable; something that I propose is inappropriate. They state that, 'It was concluded in the original doctoral thesis that the findings were truthful, consistent and that they were transferable to the total population studied and to current and future periods in time' (Slevin & Sines 2000:95). I question the extent to which research findings from this study can be viewed as transferable given the personal, political, cultural and contextual factors that affect people and their behaviour.

Transferability, as proposed by Lincoln & Guba (1985), refers to the generalisability of the enquiry. However, this is a concept with which I have difficulty given the postmodern view taken in my study that there is no one true meaning and individual subjective meaning is central. Although transferability of findings is seen as one of the main reasons for undertaking research, the postmodern underpinnings of this study mean that this is not so

in this work. The need for equal importance of all voices and the recognition of individuality overrides the obsession of the traditional quest of research to provide generalisable findings. Rather, this study is concerned with hearing all views and providing the reader with the opportunity and freedom to consider for themselves the relevance and applicability of findings to their own situation. As Freshwater & Rolfe (2001:532) state, 'Validity does not lie in the application of objective criteria by researchers and academics, but is rather a matter for the reflective users of the research.'

Tobin & Begley (2004) suggest that Slevin & Sines are aiming to ensure that their findings represent reality. However, given the theoretical position of the postmodern tradition in the context of my study, I question the need to demonstrate an accurate representation of reality because there is no 'one' reality to represent.

Rolfe & Gardner (2005:303) assert that, 'When we bring several persons together as people, when we consider a group of people collectively, something is lost at the expense of being able to make generalisations, and that something is *difference*.' In order to view the person, and make nursing, as Rolfe & Gardner suggest, a 'science of the unique' rather than a science, research methods and methodologies need to be reconsidered to reflect this. They continue to suggest that 'ongoing reflective/reflexive cycles of action and evaluation' (Rolfe & Gardner 2005:304) are the most appropriate approaches to develop practice and to add to nursing knowledge. This is not to say that positivist, scientific approaches to nursing research do not have a place in the development of knowledge relevant to nursing; however, I suggest that research that lends itself to a positivist approach tends to be medical/pharmaceutical, which, whilst related to nursing as a discipline, is distinctly different.

In assessing the rigour of research, it has been suggested that this is the means by which integrity and competence are established and a way of

demonstrating legitimacy. Traditional ways of addressing these issues examined the validity and reliability of the study or, put simply, the likelihood of producing the same research findings using the same research conditions over a period of time with different researchers, and by assessing the extent to which the study is well grounded in fact or established on sound principles. In my study, the concepts of validity and reliability or credibility, transferability and dependability are addressed through the reflexive approach to the study. Jasper (2005:256) suggests that, 'Reflective writing provides transparency of process, as well as the subjective role of the researcher and how issues relating to this have been addressed, for those assessing the study, enabling them to judge the value of the findings for themselves.'

Koch & Harrington (1998:882) endorse the use of a reflexive approach to research in which 'the research product can be given shape by the politics of location and positioning'. They promote the reflexive nature of a study in allowing the readers to travel easily through the paper, and consequently enable them to decide for themselves whether the text is believable or plausible. They feel that the notion of believability and plausibility are in themselves the main concepts that can address rigour in a qualitative study.

In order to place the difficulty of applying traditional measures of rigour to reflexive qualitative research, I chose to draw on statements made by Linda Finlay in her discussion of the challenge of reflexivity in research. She asserts that, as qualitative researchers engaged in contemporary practice, 'We recognise that research is co-constituted, a joint product of the participants, researcher and their relationship. We understand that meanings are negotiated within particular social contexts so that another researcher will unfold a different story' (Finlay 2002:212).

In his paper, Rolfe (2002) considers the notion of 'recognition' as an important concept in determining the truthfulness of qualitative research. He states that, 'An appeal to truth is therefore an appeal to authenticity, which in

turn is an appeal to recognition. Thus, a statement is considered to be true not when it is supported by scientific research (or indeed any other form of rational argument), but when it “rings true”, that is, when it resonates with our own experiences’ (Rolfe 2002:91). I assert that researcher involvement made explicit in reflexive research serves to support the truthfulness of a qualitative study in that the degree of recognition by others will be increased as they appreciate and understand the researcher’s position, who in turn, has fully appreciated and understood theirs. This could lead to accusations of bias in research from the more traditional scientific community, which they suggest leads to subjective research findings and does not meet the objectivity criteria for robust, rigorous research. However, this study is situated within a postmodern paradigm and it is not my intention to provide an objective view. Indeed, Mantzoukas (2005:279) suggests that reflexive studies are indeed only valid ‘if the researcher’s bias is fully incorporated and becomes transparent throughout the study’.

Tobin & Begley (2004) suggest that ‘goodness’ is one application of rigour suggested by some authors. It is suggested that goodness is presented as a concept which is ‘a means of locating situatedness, trustworthiness and authenticity’ (Tobin & Begley 2004:391). They suggest that goodness is not so much a construct to evaluate rigour, but more an approach that is embedded within a study. It denotes an approach to research that has clear and ethical processes throughout. Arminio & Hultgren (2002) cited by Tobin & Begley (2004) propose six areas through which goodness is demonstrated: foundation, approach, collection of data, representation of voice, the area of meaning making, and in the implications for professional practice. Although this structure is helpful in assessing the areas of a study in which goodness must be demonstrated to show integrity and competence, I fear that reliance on this model will cause researchers to move away from a deeper and fuller understanding of their actions and the effects of them on research.

Those from a more traditional, scientific position may suggest that a reflexive approach to research will in itself have implications for objectivity and rigour. I have closely examined a paper written by criminologist Alison Liebling (see Liebling 2001) in which she discusses the nature of prison research and issues with allegiances in order to view a different perspective on researcher involvement in research. Liebling's paper highlights for me some interesting and pertinent points concerning undertaking research within the Prison Service and, as such, I feel it deserves some detailed consideration in the context of my own study.

'Allegiances' and a Reflexive Philosophy

Ethical and philosophical issues abound when conducting research in the field of prison health. Naturally, there are ethical issues concerning utilising prisoners and prison staff as participants. However, in my study, considerations concerning my own position as a nurse with a background in prison health care and the effect this could have on the research process and outcomes are addressed throughout. In her paper concerning theory, practices and allegiances in prison research, Liebling (2001) asks pertinent questions around the problem of taking sides in prison research. I have studied Liebling's paper in detail because I feel that I could be viewed as 'taking sides' as I am a prison nurse researching prison nurses.

Liebling (2001:472) states that 'it is impossible to be neutral' and continues to suggest that political and personal philosophies contaminate research. Interestingly, however, although she suggests that there are contaminants in research by way of the researcher's own issues, she asks the question as to whether they distort the research. I do not feel that they contaminate or distort the research. I suggest that personal philosophies and experience can be viewed as adding to the research. My experiences as a prison nurse have informed and added to this study. Indeed, my input has served as another source of data.

In her writings about sympathising with the research subject, Liebling speaks of her own experiences in which she states, 'There is a link between openness, warmth, "devotion" to the task, the capacity to be sympathetic and the depth at which the research process operates. The more affective the research, in terms of shared feelings and experiences, the better the fieldwork gets done on the whole' (Liebling 2001:475). Although she is specifically referring to issues surrounding ethnographic research, I feel some resonance with this study. My position in the research has had an effect on the methodology and underpinning philosophy of this study. From my own experience of undertaking research with prison nurses in the past, I am prone to sympathising and empathising with them. This has proved to be a great source of emotional labour for me as the researcher.

I feel that it is impossible for the researcher who is undertaking inductive social research to maintain a truly objective view and remain apart from the research process in order to minimise or prevent any contamination. Indeed, I do not even see the involvement of the researcher in this type of research as negative. However, there are some schools of thought where the distancing of the researcher from the research to promote a more objective view is supported. As Hek et al. (2002:42) state, 'Whatever data collection methods are used, a great effort must be made by the researcher not to influence the collection of data.' When using phenomenology to understand a phenomenon, it is suggested that the researcher should 'bracket' their own views and assumptions about the phenomena being studied, thereby enabling researchers to study subjective meaning objectively (Smith 1997:31). I suggest that this is impossible, especially when the researcher is passionate and knowledgeable about their field of study. In addition, the perceived need to bracket feelings and prevent the researcher from having an input into the research is very much in the tradition of the positivist, empirical school. Indeed, in my Master's research (Walsh 1998) where I adopted a traditional phenomenological perspective, the bracketing of my

own personal feelings and knowledge proved to be stressful and, on reflection, inhibited the research to some extent because it was difficult to create a connection with the participants. I feel it is especially important to gain a connection with prison nurses as they are working in an environment where suspicion and mistrust are commonplace (Freshwater et al. 2002). I suggest that by developing a connection with prison nurses and ensuring they knew I identified with their professional situation helped foster a sense of trust between us, thereby affording the nurses an opportunity to talk freely and openly in an atmosphere of shared understanding.

In her paper, Liebling (2001) discusses the importance of how prison-related data are handled and the influence of the 'system' as a major influence on research. In one sense, the system has already influenced my own research to some extent through the application I submitted to the Prison Service to gain approval for this study. I have also had to ensure that all papers and conference presentations for publication are copied to the appropriate Prison Service department. Liebling relates her own research as an example of how the prison system exercised potential influence on data analysis and findings, especially in terms of politics and funding.

Liebling also discusses the issue of sympathising with research subjects when research is undertaken in prison. She discusses not only the issue and effects of sympathising with prisoners as research subjects (subordinates), but also with those who hold the power: the prison staff (superordinates). Although Liebling refers to prison officers as those with the power, this can be translated to refer to the prison nurse who also uses power in this environment.

She also suggests that the allegiances made during the research process make researchers want to be sensitive and diplomatic. However, she questions how this affects the research. I feel this issue is important in my study, as I have already adopted some degree of allegiance to the Prison

Service (as an employee) and to prison nurses as a professional group by the nature of my professional history. I suggest that my allegiances to prison nurses as a professional group have influenced me significantly, both in my approach to data collection and in the design of my study. My desire to improve the position of prison nurses both within the Prison Service and the wider nursing community influenced my decision to undertake this study. I feel that the professional standing of prison nurses within the nursing community must be improved through the undertaking, promotion and dissemination of research. I feel that nurses working in prisons also need professional support, which I endorse both in this study and in my work as a researcher, through clinical supervision. Therefore, I feel I need to be cognisant of quite how much these issues impact on my research. Both the impact of my own allegiances and the power and politics inherent within HM Prison Service are addressed through the use of a reflexive underpinning philosophy.

From examination of the literature pertaining to rigour in qualitative research, I suggest that reflexivity in both approach and methodology allows researchers to embrace research methods and philosophies congruent with the study of human beings and their behaviour, without resorting to the need for the use of measures of scientific objectivity to justify their work.

Although I have spent time reviewing and digesting the literature pertaining to the rigour of research, I feel that I need to conclude this section with an overview of my own perspective. The benefits of this are two fold. Firstly, it enables me to clarify my thinking and secondly, it provides you, the reader, with a clear view of this thinking, which I suggest is crucial in encouraging you to decide for yourself how my study meets any measures of rigour, however you wish to examine them.

I suggest that rigour is viewed as the way in which integrity, legitimacy and competence is established within research. It concerns the overall quality of

research. The concepts of reliability, validity and generalisability, traditionally used to measure the rigour of quantitative studies, are inappropriate concepts with which to judge the integrity and competence of this study because it cannot be replicated and the findings cannot be generalised. The now traditional parallel 'qualitative' concepts of rigour such as credibility, transferability and dependability are also inappropriate because the credibility of the researcher will be viewed differently by different readers, the findings are not transferable and, again, the study will not provide the same findings if replicated because the findings are contextual. This leaves me with an opportunity to examine what I think rigour really means in the context of my study. The underlying postmodern approach to my work and, indeed, my own intuitive feelings prevent me from dictating how to assess the way in which integrity, legitimacy and competence are established in this study. As such, I have chosen to provide the reader with my own thoughts on how I feel these issues could be addressed in this thesis.

The key terms that resonated initially for me, highlighted by the literature in assessing the legitimacy, competence and integrity of this study, were: 'recognition' (Rolfe 2002), 'goodness' (Tobin & Begley 2004) and 'plausibility' (Koch & Harrington 1998). However, upon reflection, this led me to feel constrained and as though I was being told how to address the rigour of my study. I felt as though this would prevent me from seeing my study as a bigger picture within its own context and, indeed, stifle my own intellectual development as a researcher. Being given criteria or guidelines by which to examine research quality does, I feel, prevent the reader (and researcher) from appraising the research using their own creativity, intelligence and ability. This also suggests that to embrace a particular way of assessing rigour assumes some 'truth' in the method of assessment. For example, adopting one particular suggestion over another in some way privileges it and suggests that it has more authority than other, perhaps more appropriate approaches. As Rolfe (2006b:304) states: 'Each study is individual and unique, and the task of producing frameworks and predetermined criteria for

assessing the quality of research studies is futile.' I suggest that if the reader and researcher are both equipped with a good understanding of the purpose of rigour and its application to research, then they will be able to make quality judgments about research accordingly.

To offer the reader of this thesis insight into the thought processes with which I have engaged in making decisions about my methodology and philosophical approach, I have adopted a reflexive approach to writing. I feel that this insight will be sufficient to allow the reader to come to their own conclusions about the quality of my study, be they using goodness, plausibility, recognition or indeed any other criteria by which they would like to judge my work for legitimacy, competence and integrity. In considering my work in terms of both traditional and more contemporary measures of rigour, I have concluded that a truly reflexive, honest and ethical approach to both conducting and reporting the research assists in addressing all issues of rigour.

This does, however, lead to the question of how the researcher assesses their own reflexiveness. Although I have responsibility for appraising the quality of my work, the assessment of quality is also in the hands of the reader, and it is the reader who will ultimately judge the degree to which the reflexivity of the researcher is demonstrated. I suggest that, throughout this work, reflection on my thinking, work and research processes has been automatic as I aim to provide the reader with all the information possible to enable them to accompany me on my journey and appreciate how and why I have chosen to follow this particular route. My degree of reflexivity in this thesis has been intuitive and it is for the reader to decide if they have been given enough insight to enable them to appreciate my journey.

Reflexivity

Reflexivity and the postmodern school of thought are closely linked; see Alvesson & Skoldberg (2000). Cheek (2000:20) suggests that postmodern thought 'is enabling as it encourages us to think about reality in a reflexive way'. She continues to suggest that reflexivity uncovers complex agendas hidden in both our own writing and practice. In taking this concept forward, Lincoln & Guba (2000) suggest that reflexivity in research forces the researcher to come to terms with the research project as well as with the many selves of the researcher. They cite Reinharz (1997) who suggests that we not only bring ourselves to the research but that we are also created within the research. I suggest that the use of a reflexive approach to research not only creates the researcher, as suggested by Reinharz, but also transforms the researcher.

Freshwater & Rolfe (2001) acknowledge the relationship of reflexivity to postmodern thought but introduce 'its cousin, intertextuality, which is a central concept of postmodernism that offers the means to challenge and resist the limits of a particular system of thought' (Freshwater & Rolfe 2001:531). They continue by highlighting that with intertextuality it is not possible to write and act in isolation. Every act has meaning only in relation to other texts and practices. They suggest that reflexive research practice not only encompasses reflection on self as researcher (and the resultant effects on the research) but also includes reflection on writing and practice in relation to other writing and practice, whilst being mindful that all texts are 'fabrications of the truth (which is not to say they are untrue, only that truth is a social construct) and as such are subject to deconstructive rewriting and rereading' (Freshwater & Rolfe 2001:531).

Finlay & Gough (2003:3) define reflexivity in research as being 'where researchers turn a critical gaze towards themselves'. Freshwater & Rolfe (2001) cite three types of reflexivity: a reflection on the process of reflection; a reflection that goes further to consider the social and political context in

which practice takes place; and a practical reflection in which practice is reflected on and modified as it is happening. In this study, I suggest that all three types of reflexivity are evident on both methodological and theoretical levels.

My desire to place the practitioner and their experience as central to the study leads me to include my own experiences and myself as a practitioner. Ideas of the practitioner as researcher is supported in the literature (see Stevenson 1996; Freshwater & Rolfe 2001; Carolan 2003; Allen 2004). Indeed, the postmodern paradigm within which this study is situated compels me to include my own experiences and consideration of my own position within the study because the impact I have on my work must be transparent in order for recognition of dominant discourses affecting the study to be clear and for the reader to follow my thoughts and decisions regarding the methodology and analysis of data.

Finlay (2002) provides researchers with 'maps' aimed at supporting various approaches to reflexivity. In this paper, she makes one assumption with which I take issue: 'In short, researchers no longer question the need for reflexivity: the question is how to do it' (Finlay 2002:212). Reflecting on my own journey through research and witnessing the dominant discourses prevalent within the wider nursing research community, I have only experienced a minority of researchers who truly believe there is a need for reflexivity in research. In my experience, the majority see it as a threat to objectivity and thus something that should be avoided. Indeed, Rolfe & Gardner (2005) highlight the opposition faced by more creative, reflexive qualitative researchers, sometimes from within the qualitative research community.

Reflection and reflective practice in research has been reported in the nursing literature (see Stevenson 1996; Fowler & Chevannes 1998; Graham 2000; Driscoll & The 2001; Allen 2004; Pfund et al. 2004 and Koch et al.

2005). It is interesting to note that, although the use of reflexive methods and reflection in nursing research is becoming more popular, there is a lack of such application to prison health research. One paper (Fox et al. 2001) stands out as adopting reflection in data collection but is firmly aligned with a positivist, empirical approach. Fox et al. (2001) report on significant event audit within the prison system, highlighting its use as a key tool of clinical governance within prison health care settings. They propose a definition of single event audit, citing Pringle et al. (1995), in which they state that single event audit occurs when 'individual cases in which there has been a significant occurrence (not necessarily involving an undesirable outcome for the patient) are analysed in a systematic and detailed way to ascertain what can be learnt about the quality of care and to indicate changes that might lead to future improvements' (Fox et al. 2001:124). Three prisons were involved in this study in which a multidisciplinary approach was adopted. Significant event audit meetings were observed and staff participated in semi-structured interviews. Overall, the authors found that significant event auditing had the potential to affect change in prison health care practice, although there were issues with staff attitudes to reflecting on practice through significant event auditing, ranging from enthusiastic to negative; a lack of understanding of the concept; lack of sustainability of proposed changes made as a result of the significant event audit; and attendance at the meetings proving problematic. Recommendations from this study included the need to revisit the terminology, the need to ensure adequate leadership and the need to promote significant event audit as a useful and worthwhile tool worthy of prioritisation.

Interestingly, though, Mauthner & Doucet (2003) suggest that, although reflexivity in research is useful, the deeper understanding of reflexivity within research and its implications for the study can only truly be appreciated through emotional and intellectual distance from the research. In their paper, it is clear that, although they adopted a reflexive approach to their work, it

was only through distancing themselves from it that they felt they truly understood the influences on their work.

This resonates with me in terms of the supervision I have received throughout this work. For a long time, I felt that I should have been writing, learning new concepts and applying them, or indeed engaging with practitioners. It took a crisis of confidence for me to understand the importance of stepping away from a project in order to see the bigger picture and to allow thoughts and ideas to develop, away from traditional study. It is this approach which, in the later stages of this work, I adopted. In addition to allowing me space and time to consider and reflect on my work, it also provided me with the distance necessary to reflect and see some of the influences on my work with more clarity. I could be accused of moving from a position of subjectivity to one of objectivity, which clearly contradicts my postmodern approach. However, I feel that it is through my use of reflexivity as both an approach and a methodology which enables this tension to be managed.

Discourse Analysis

Due to the underpinning postmodern approach to this study, I am cautious about applying a very structured approach to analysis. It is for this reason that I feel discourse analysis is appropriate. Cheek (2004:1145) states that 'discourse analysis is an approach rather than a method' and she continues to suggest that the nature of the discourse analysis is informed by the researcher's own underpinning philosophy. However, I suggest a contradiction. Discourse analysis is an approach rather than a method, which leads me to view it as a flexible, researcher-led approach to analysis, highly applicable to postmodern study. However, although there is flexibility, there will still be a degree of structure inherent in its use. This is inevitable, but it is the structure employed in order to conduct analysis that is left to the researcher to determine. In turn, this will be contextual and specific to the

researcher, influenced by dominant discourses and power relations. For me, this reinforces the importance of reflexivity in such studies in providing a clear map for the reader.

Papers using the ideas of French philosopher Michel Foucault as a means of analysing research data (see Holmes 2005; Holmes 2002; Irving 2002 and Bergschmidt 2004) and examining nursing/research issues (see Henderson 1994; Cheek & Porter 1997; Gastaldo & Holmes 1999; Manais & Street 2000; Sharkey 1999; Gilbert 2001; Gilbert 2005; Holmes 2001; Huntington & Gilmour 2001; Holmes & Gastaldo 2002; Ceci 2004; McKenna & Wellard 2005; Roberts 2005 and Winch 2005) have proved very informative in my choice of analysis; reading, considering and digesting the experiences of other researchers has provided me with an overview from which to consider my own study.

I have looked briefly at the work of Nietzsche in a paper concerning the implications of his ideas for the caring professions. I find some parallels here with my own philosophical stance. Nolan et al. (1998) state of Nietzsche that, 'He recognised that whatever was being said in philosophy, science or everyday life, it was context specific. He insisted on the diachronic or historically bound nature of language, and implied that science may only be short lived as a means of knowing about the world' (Nolan et al. 1998:252). It is the idea of research findings being context specific that makes me feel that a discourse analysis is the most appropriate method of analysis.

Discourse analysis as a method of analysis can be seen in a wide range of health care literature. Examples include dementia care (Adams 1998); nursing diagnosis (Powers 2002); community mental health (Cowan 2003); wound care (Hallett et al. 2000); ward rounds (Fox 1993); and nurse education (Kotecha 2002; McKenna & Wellard 2005).

In a paper concerning the use of discourse analysis in nursing scholarship, Buus (2005) suggests that there is confusion as to what is meant by 'discourse' and 'analysis of discourse'. In support of this, Alvesson & Karreman (2000:1125) also state that, 'Discourse is a popular term used in a variety of ways, easily leading to confusion.' Buus (2005:27) suggests that 'discourse is a congested concept'. This is, he suggests, due to the way in which the terms are conceptualised in different academic disciplines such as linguistics, literature theory, philosophy, social sciences and psychology. In an attempt to clarify the position I am working with, I have studied the work of Talja (1999); Alvesson & Karreman (2000); Ballinger & Payne (2000); Cheek (2004) and Stevenson (2004).

According to Ballinger and Payne (2000), there are two schools of discourse analysis: that which has as its focus the 'exploration and function of specific forms, phrases and turns of speech' and that which has as its focus 'analysis and deconstruction of dominant common sense views (discourses) of how the world/everyday life is' (Ballinger & Payne 2000:568). Cheek (2004) asserts that when discourse analysis is grounded in postmodern and post-structural understanding of the world, it is 'concerned with the way in which texts themselves have been constructed in terms of their social and historical "situatedness"' (Cheek 2004:1144). She continues to explain that 'texts not only represent and reflect a certain version of reality, they also play a part in the very construction and maintenance of that reality itself'. Cheek is clear to point out that texts are both constitutive of and constructed by their context.

Stevenson (2004) suggests that discourse analysis embodies two main approaches: Foucauldian and radical social constructionist. He proposes that social constructionist discourse analysts 'take the radical view that there is nothing beyond the text, and that there is no fixed external reality to represent in words' (Stevenson 2004:19). He also states that Foucauldian discourse analysis 'tends to divide texts (anything spoken, written or acted that can be read for symbolic meaning) into discourses. The discourses are

examined for how they position the speakers and how they reproduce relations of power' (Stevenson 2004:20). I believe these approaches to discourse analysis to be a subset of Ballinger & Payne's (2000) idea of discourse analysis having as its focus the deconstruction of dominant views.

Phillips & Jorgensen (2002) highlight three applications of discourse analysis in their book concerning theory and method. They suggest that there are three social constructionist methods and cite discourse theory, critical discourse analysis and discursive psychology. They suggest that all three approaches have roots in the ideas of Foucault. Phillips and Jorgensen assert that the basic underlying premise and starting point for discourse analysis is the understanding that our ways of talking (and hence interview data, documentary data, reflective diaries, etc.) do not neutrally affect our world, identities and social relations, but play an active role in creating and changing them.

According to Alvesson & Kärreman (2000), Foucault proposed two ways of investigating discourses; that of archaeology and genealogy, although Phillips & Jorgensen (2002) suggest that they overlap. Alvesson & Kärreman cite Davidson (1986) who asserts that, 'Archaeology attempts to isolate the level of discursive practices and formulate the rules of production and transformation for these practices. Genealogy, on the other hand, concentrates on the forces and relations of power connected to discursive practices' (Alvesson & Kärreman 2000:1128).

However, Scheurich & McKenzie (2005:850) explain these concepts further and assert that Foucault divided his work into three arenas of analysis; namely archaeology, genealogy and the care of self. They suggest that archaeology is the study of how *savoir* translates into *connaissance* in the formation of a discipline, where *savoir* refers to formal knowledge and informal, tacit knowledge including customs, practices, norms and institutional practice; whereas, *connaissance* refers to 'only formal bodies of

knowledge such as scientific books, philosophical theories and religious justifications' (Scheurich & McKenzie 2005:846). It is suggested that archaeology is interested in examining the way in which savoir leads to connaissance, or rather how an accepted body of knowledge is influenced by the institutional practices and tacit knowledge of a specific profession.

Phillips & Jorgensen (2002) suggest that Foucauldian archaeology is part of his discourse theory and examines the rules that determine what is meaningful and true at a particular moment in time. They suggest that Foucault's aim is 'to investigate the structure of different regimes of knowledge' (Phillips & Jorgensen 2002:13). They continue to describe what is commonly seen as the second era of Foucauldian analysis, genealogy, in which Foucault developed his theory of the knowledge/power connection. It is suggested that power provides the conditions for the social (Phillips & Jorgensen 2002:13). The example of 'crime' is given in their work of the way in which power is produced and is key in producing and separating objects in the world and hence individual characteristics and relationships to one another. Crime has its own institutions (prisons), particular subjects (criminals) and particular practices (resocialisation) and is bound up with a knowledge system, i.e. criminology. Given that Foucauldian thought suggests the inextricable link between discourse and power/knowledge, Phillips & Jorgensen (2002) highlight the effect this has on 'truth' and representation of reality. Foucault notes that it is impossible to gain access to universal truth as it is impossible to talk from a position outside of discourse. One will always be constructed and constrained by discourse. This leads Phillips & Jorgensen (2002:14) to assert that 'truth effects are created within discourses'. That is to say that, in a particular discourse, one truth in particular will be accepted as the dominant idea. When this occurs, other less dominant discourses are ignored and not considered. Discourse analysis looks not only for the dominant discourse (what is being said) but also at the less dominant discourses (what is not being said).

According to Scheurich & McKenzie (2005), genealogy focuses on power relations and their technologies. They suggest that Foucault emphasised the importance of undertaking genealogical study with four rules in mind: examine the production of power rather than its oppression; examine punitive methods as having a kind of quasi independent standing or importance (that is, see them not as actions of individuals but of something much larger); examine power as arising from a complex matrix or epistemological formation; and finally appreciate the effect of the 'new technologies of power' on the individual as a being rather than on the collective.

Cheek (2004:1142) suggests that Foucauldian discourse analysis identifies discourses as 'the scaffolds of discursive frameworks, which order reality in a certain way'. She suggests that discursive frameworks both 'enable and constrain the production of knowledge, in that they allow for certain ways of thinking about reality while excluding others'. She continues by citing Philip (1985) who provides the reader with examples of questions which the researcher might ask, such as what rules permit certain statements to be made, what rules order these statements, and what rules permit us to identify some statements as true and some as false.

Given the theoretical framework to which I am working in this thesis, the examination of prison nursing discourse in terms of linguistics, i.e. specific forms, phrases and turns of speech, is inappropriate. A more sociological approach is more relevant, hence it is the way in which, as Cheek suggests, texts are constructed in terms of the power relations, social situation and context with which I am concerned. Therefore, linguistic, conversational analysis has not been considered as an approach to analysis in this work.

Talja (1999), in her paper concerning the analysis of interview data, states that discourse analysis 'emphasises the role of language in the construction of social reality' (Talja 1999:460). She cites Frohman (1994:120) who provides a succinct description of Foucault influenced discourse analysis:

'Foucault influenced discourse analysis does not study the rules and conventions of mundane talk; rather it examines "serious speech acts", institutionalised talk or practices. This does not mean that the participants of the study should be institutionally privileged speakers. Instead, regardless of the roles and positions of the participants, talk is studied as an example of more general interpretative practices' (Frohman 1994:120, cited in Talja 1999:460).

The fact that Frohman should highlight that the participants' positions within the institution are not relevant resonates for me with the paper by Ceci (2004) where she discusses the nature of truth and knowledge, and highlights that knowledge is only perceived as truth if the community within which that knowledge is based agrees that it is true. Those in the community who make this decision tend to be those with power and, as such, their acceptance of knowledge as truth tends to be unquestioned.

Cheek (2004) highlights her research as an example of using a Foucauldian perspective on discourse analysis. She states that, 'Discourse consists of a set of common assumptions that sometimes, indeed often, may be so taken for granted as to be invisible or assumed' (Cheek 2004:1142). I feel there are important links to be made here with the notion of the expert practitioner as described by Benner (1984) in terms of the expert nurse's use of intuition, which they find difficult to articulate. The methodological difficulty of researching tacit knowledge has been highlighted in the literature (see Meerabeau 1992), but Rolfe (1997) suggests that by using the concept of abduction in discussing practice, and consideration of the concept of 'fuzzy' nursing, the expertise of nurses who claim to be unable to articulate their practice could in fact be verbalised. As Rolfe (1997:1074) states, 'The strength of this model is therefore not in its prescriptive ability but in its descriptive ability.' By collecting data from the reflections on practice of prison nurses, I suggest that the use of a discourse analysis helps reveal the nature of the tacit knowledge that expert nurses find difficult to explain, and

understanding of this tacit knowledge will further support reflection on the emotional labour of prison nurses.

Stevenson (2004:20) states that Foucauldian discourse analysis 'divides texts into discourses. The discourses are examined for how they position the speakers and how they reproduce relations of power'. In addition, he suggests that Foucauldian analysis is also concerned with 'how language uses us' because discursive practices position us in relations of power. There are also links here for me with Bourdieu's notion of capital, defined by Rhynas (2005:181) as 'the power of a person and can be exchanged or used in order to improve their position within the field'. Semiotic capital, the power viewed through linguistic meaning, is important to identify in the prison setting and is suitably achieved through discourse analysis.

Gilbert (2005) provides us with a clear and succinct description of his approach to Foucauldian discourse analysis through discussion of his work exploring trust and managerialism. He utilised discourse analysis to examine the concepts of trust and managerialism from two genres; those of academic literature and interviews. He explains that central to his discourse analysis is an examination of the way in which 'discourses work to produce new ways of governing and managing populations' (Gilbert 2005:456). Gilbert continues to explain the nature of his discourse analysis and its application. He asserts that there are two key ideas utilised in the analysis of his study: genre and interdiscursivity. Genre refers to the production, distribution and consumption of texts and interdiscursivity refers to the relationship between discursive and non-discursive practices. For Gilbert, the qualities of the text that attract attention in discourse analysis include the use of metaphors, rhetoric, orientation and constructions of 'other' in how discourse is used to situate and construct opposition. In his study, Gilbert utilised themes developed externally from the interview data, i.e. from the literature, in order to explore interview material.

Carabine (2001) provides a more detailed, operational description of undertaking Foucauldian genealogical analysis and illustrates this method of analysis using her own work concerning unmarried motherhood, 1830-1990. Interestingly, she notes an 11 stage guide to undertaking this type of analysis which, whilst attractive to me (given my comfort with structure), does appear to contradict previous literature suggesting that discourse analysis is not structured. She also suggests that there are key concepts that underpin this type of analysis. Most obvious is the need for the researcher to be mindful of the nature of discourse and its relation to power/knowledge.

Although Jean Carabine provides a clear and easily understandable approach which can be followed in the undertaking of genealogical discourse analysis, I am in two minds as to its usefulness for the novice discourse analyst. Firstly, I welcome the reassuring structure and advice which, as she links it to her own research, enables me to see the analysis in action. However, given the contradiction between previous literature which suggests discourse analysis is an approach rather than a method, I question to what extent Carabine's work will stifle my own creativity in the analysis of the discourse of prison nurses. Having reflected on her work and its relation to my own situation and research needs, I feel her guide is useful in providing a starting point for my analysis. However, I am cognisant of my desire to use my own intuition and inspiration in undertaking my analysis and, as such, will use her suggestion purely as a guide.

It is not only the transcribed interview data that are analysed using discourse analysis. Clinical supervision data, my own experiences, reflective diaries and documentary evidence are also addressed using this approach. In undertaking discourse analysis in this study, I have 'scrapbooked' my interviews and clinical supervision sessions. This has involved collecting data other than the interview data on the day of the interviews, such as newspapers, information on the setting and context within which the interaction took place. As the context occupies such a dominant theme in

terms of analysis, I feel that acknowledging information pertaining to the environment in which the interview/clinical supervision took place is vital. It is not only the immediate environment that is important, but also the world environment at the time because external events and current affairs also had an impact on both the participant and myself. As Cheek (2004:1145) states, 'Discourse analysis situates texts in their social, cultural, political, and historical context.' In order to recognise the social, cultural, political and historical context, further documentary data collection was important.

My perception of discourse analysis in the context of this study is that Foucauldian genealogical discourse analysis is appropriate because the setting in which the study is located is that of prison – itself an institution of power. In addition, the focus of the study is emotional labour; a concept which I feel, in the prison setting, is inextricably bound to issues of power relationships and control. Power relations operate at many levels within a prison: between officers and nurses, nurses and prisoner patients, nurses and nurses, management and nurses, etc. all of which have an impact on the emotional labour of the prison nurse.

In this thesis so far, I have attempted to provide the reader with an understanding of the philosophical underpinnings of the work, and an insight into my own thought processes and development, which has led me to this point in my studies. I have been almost 'grappling' with the postmodernist perspective, the theory of discourse analysis and their connection with my own personal perspective and their appropriateness to my study. I believe it is clear that discourse analysis is the most appropriate approach with which to analyse my data, and that postmodernism is the most appropriate philosophy. However, as I describe later in my findings pertaining to the prison nurse, there is somewhat of an inner contradiction, an inner struggle within, focussing on the tension between what 'should be' and 'what is'. The 'what should be' I deem to be the traditional academic discourse that I have developed with and been schooled in; the 'what is' is my own preferred way

of working. Promoting and working with my own personal ideal has been difficult and has taken a great deal of courage and confidence because I am not sure if it is acceptable. This inner struggle will be evident throughout my work. The first hurdle I faced was to accept that the dominant discourses in academia are just other people's perspectives, which are no more or less important than my own perspective.

Reflecting on the philosophy and associated analysis of my work, I have concluded that I want to trust my own intuition. So far in this thesis I have highlighted and discussed postmodernism, postmodernist philosophers and discourse analysis. It is at this point where I suggest that these works and papers have influenced my thinking immensely. However, I will now embark on the rest of this thesis with my new found confidence and will trust my intuition that although the work I present has been written with influence from others, ultimately it is based in my own thoughts about the best way to analyse and discuss the emotional labour of nurses working in prison. I considered that the use of genealogical discourse analysis would be the most appropriate route to follow. However, as Mills (2003:7) notes about the work of Foucault, 'We should draw on his work as a resource for thinking, without slavish adherence.'

Chapter Two: The Literature

Introduction

Prison health care has undergone major changes during the last three centuries, from the introduction of an organised health care service for prisoners to the relatively recent introduction of nurses in prisons to care for prisoners.

In any examination of nursing in a prison setting, it is important to establish a good understanding of the nature of the prison environment, its culture and the actual role of the nurse in practice. This chapter aims to provide the reader with an understanding of the development of the Prison Service, the development of health care services within it, the role of the nurse in prison, and recent policy developments affecting the provision of care to prisoners. Because the nurse working in this setting undertakes a dual role of carer and custodian, literature pertaining to both the role and subsequent professional issues of being a prison officer in a prison has also been examined as they can also be applied to the prison nurse. To this end, I will discuss prison culture in terms of the perceived impact on those working within it, in both the traditional roles of discipline officer and of nurse.

Although prisons have their own organisational culture, which inevitably affects the practice of those working in the environment, health care services within prisons also have their own organisational culture, which can be seen as separate from (although influenced by) the main prison culture. Therefore, I will also address the organisational culture within prison health care and the resultant nurse–patient relationship seen in the prison setting.

The Development of the Prison System

During the 17th century, criminals, vagrants, the destitute, the poor and the insane were segregated from society in jails, workhouses, houses of

correction and bridewells. Foucault refers to this period in his work as 'The Great Confinement' (Foucault 1971). However, the modern prison system in England has its roots in the 18th century when the mood of society changed and started to adopt the new philosophy sweeping Europe which became known as 'The Enlightenment', referred to by Sim (2002) as the intellectual, philosophical, cultural and scientific spirit.

During the 18th century, as social systems began to change in Europe, new forms of government and penal codes were adopted across the continent. There was a change in the forms of punishment and retribution used as society began to switch its ideas of acceptable and appropriate punishment. It was felt that there should be a scale of seriousness of crime and, as a consequence, punishment. Public, physical punishments such as those described by Foucault in 'Discipline & Punish' (Foucault 1991 [1977]) were no longer appropriate and the idea of imprisonment became more acceptable. It was now thought that punishment should be firm and certain but not brutal and prolonged. However, the philosophers of this era promoted the idea that punishment should be equal and that the only punishment that could be applied to all who required it was loss of liberty. It was also believed that prison could serve two functions: reformation and improvement of society. In prison, inmates would become more productive and prison would produce obedient, useful subjects.

Cousins & Hussain (1984) state that Foucault's seminal work 'Discipline and Punish' (Foucault 1991 [1977]) addresses the issue of how imprisonment came to be a frequent and obvious punishment when prior to the turn of the 19th century, prison had been of marginal importance in society. In addition to this issue, Foucault also examined the changing nature of punishment from public spectacle to private act behind prison walls. Foucault discusses the changes in the punishment of criminals in terms of a 'new modality' of power. State power was demonstrated in the way in which criminals were punished.

According to Sullivan (1996:449), Foucault devoted this whole publication to 'establishing that the prison was conceived to perform the latent social control function of discipline'. During The Confinement, punishments were brutal, public spectacles, e.g. public floggings and executions. As the country moved into the era known as The Enlightenment, the state exercised its power in the symbolic forms of punishment and in disciplining criminals in a different way. This different way is what is referred to as the 'new modality of power'. The new modality of power, demonstrated in one respect as punishment in private, was noted by Foucault to be aimed at the soul. It could be argued that power exercised in the form of punishment by the state was not only carried out in private behind prison walls but even more so as it was experienced in cells which were designed to segregate prisoners from one another. Indeed, Sullivan (1996) explains that the privacy of the punishment can be extrapolated even further to occurring in the soul of the individual. It is suggested that through repeated, silent punishment (solitary confinement), the state would eventually gain access to the soul of the prisoner and control it.

Foucault addresses the issue of the changes in penal practice not in terms of the law but in terms of the development of new ways of organising and managing individuals. Foucault's writings in this area are underpinned by the argument that prison and punishment of individuals is enveloped in a mechanism of power on a number of levels.

Eighteenth century prison reformers such as John Howard and Elizabeth Fry called for prisons to be healthy institutions and extolled the virtues of isolation and solitude, which they believed would remove the possibility of corruption between prisoners. They believed that confinement should be coupled with religious purpose. However, Forsythe (2004:760) states that, 'The purpose of restricting communication was to deprive the prisoner of the solaces and reinforcements of association and ensure that all communication was consistent with the purposes of discipline and reformation.' In 1865, The

Prisons Act amalgamated the traditional jail and house of correction into one institution, which became known as the prison.

Foucault (1991 [1977]) states that prison reform at this time was not about punishing less but punishing better. As has been mentioned, there was a shift from public punishment and humiliation to more productive, reformatory punishment. Change in the philosophy of punishment, whereby punishment was now directed at the soul whereas previously it had been directed at the body, influenced new techniques for controlling and observing prisoners. This is demonstrated in the designs of new prisons that were built. Two main designs were adopted in Britain. The radial design and the panopticon design. The panopticon design, developed by Jeremy Bentham in 1791, allowed for the promotion of solitude and non communication between inmates whilst ensuring optimum surveillance opportunities for guards. The radial design, where wings radiate from a central point, was the most popular design utilised in this era and can still be seen today in many prisons (Matthews 1999).

Panopticism is a central concept in the work of Foucault (1991 [1977]). He describes the links between disciplinary power and surveillance in terms of the architectural design and consequent effect of the observation of prisoners. Through the disciplinary apparatus of the panopticon, surveillance of prisoners was efficient in that disciplinary control occurred in two ways: by the actual surveillance of prisoners by a guard and, by the nature of the architecture, prisoners could not see the guard. Over time, this would lead to a second aspect of surveillance; that of surveillance of the self. By virtue of the architectural design of the prison, prisoners no longer knew if they were being watched or not, which led to assumptions that they were actually being watched. Assuming they were being watched, prisoners began to behave accordingly.

Underpinning these changes in controlling and observing prisoners was the idea that prisoners could be classified according to their crimes and therefore segregated appropriately, thus reducing the possibility of 'contamination' of one another. Although the prison reformers of the day wanted to see all prisoners placed into solitary confinement, discussion based on the model being used in America in the 1820s concluded that solitary living affected inmates' sanity. However, according to Forsythe (2004), there was much debate about the use of confinement and the practice did not cease until 1921 following developments in psychological theory emphasising the value of association and interaction for prisoners.

Medical personnel were introduced into prisons in the 1820s to care for the health of inmates. The first of the new prisons, Pentonville, was opened in 1842. This prison was designed for solitude and reflection and housed inmates with short sentences. Prisons became more military in style, with the introduction of militaristic practices and personnel. In addition to these staff, other professionals were introduced into the prison system including doctors.

However, it was soon discovered that the initial dual purpose of prison, to reform and punish, was not working as many prisoners were receiving short sentences in which there was not sufficient time to reform.

The use of imprisonment declined from the end of the 19th century to the beginning of the Second World War. It is thought that this decline in imprisonment was bound up with the changing nature of production in the country (Young 1999). In this new form of production line manufacture, the discipline of the worker was contained within the manufacturing process and, coupled with stability of employment and career prospects, crime and anti-social behaviour was reduced, thus reducing the prison population. Rusche & Kirchheimer (2003) in their book 'Punishment and Structure', maintain that systems of punishment are related to systems of production.

The economic climate had changed significantly in terms of manufacturing industries but there were also significant changes in welfare provision by the state. New agencies and institutions were created: social work, probation and juvenile reform/borstal. The use of prison declined because it was now viewed as a last resort for offenders. There was a sociological shift away from concentrating on the offence to concentrating on the offender. In 1907, the Probation Act encouraged the development of non-custodial penalties and in 1908 a separate system was invented for juveniles to be treated separately from adults.

The Development of Prison Health Care

The development of health care in prisons began following the 1774 Health of Prisoners Act, which stated that sick prisoners needed separate rooms and that each jail needed to have an experienced surgeon or apothecary. Prior to this 1774 Act, there was some medical provision for inmates, but until 1774 it had not been statutory. According to Stern (1987), the main purpose of this Act was to prevent the spread of typhus from the prison to the wider community. The prison reformer John Howard instigated this Act of Parliament. Howard believed that prison reform was not just about benevolence but also about discipline. He suggested that disease had a moral as well as a physical cause and that the prison system could address both causes. He also felt that health care provision for the incarcerated should not be better than that available in the community.

Throughout the 19th century, the philosophy of less eligibility for inmates underpinned the penal system. Therefore its workers were also influenced by this idea. Interestingly, the relationship between medicine and the incarcerated was more contradictory than the benevolent reformers realised. In society at this time it was felt that prisoners had less eligibility and fewer rights, and should therefore be treated differently to those outside prison. The notion of inequality in prison health was highlighted as recently as 1997

(Reed & Lyne 1997). This contradictory relationship of medicine being underpinned by benevolence but being involved in discipline in the prison setting would appear to be the beginning of the 'care custody debate', which still exists today and which I will discuss in more depth later.

From the outset, the general philosophy of the period was that illness and morality were linked and, as such, treatment of disease in prison was 'couched in discipline and morality' (Sim 1990:14). Therefore, the use of discipline was an important part of the prison health care worker's role. Indeed, even in the 21st century, criminality and health have been linked. It is suggested in the literature that if one accepts that criminal behaviour is unhealthy behaviour, the potential scope for health care need in prison is exponentially greater than in the wider community (Maeve & Vaughn 2001). In the late 1800s, it was decided that prison health care staff should be more robustly organised and, in addition to doctors, officers worked in prison hospitals and were required to undertake training and pass a course comprising technical training, first aid and nursing skills. The first textbook written for these staff was published in 1902 by Dr Smalley, the then medical inspector of prisons. Qualified nurses were not employed in prison until the 1980s (Norman & Parrish 2002).

The disciplinary role of the prison health care worker is highlighted by Sim (1990), who reports that medical rituals accompanied admission into prison. Sim cites Ignatief (1978) where he reports in the publication 'A Just Measure of Pain' that these rituals had a latent but explicit purpose of humiliation, e.g. the shaving of prisoners' heads to reduce the infestation of lice. It is reported that the forcing of prisoners by doctors and health care staff to have cold baths, the strapping down of the mentally ill and administration of electric shocks was part of the doctors' role in prison. The doctor in the prison setting was reported to have a great deal of power in terms of the punishment of prisoners. The governor of the prison was obliged to comply with the orders of the doctor. Doctors were required to live inside the prison and attend to

the sick and were not permitted to practice outside of the prison. Doctors were also responsible for decisions regarding changes in the level of discipline and in the diet of the inmate. In the early 1800s, prisoners rebelled against the poor diet, solitude and hard labour. As prisoners were disciplined regarding their behaviour, the doctor again had influence because it was the doctor who sanctioned the level of punishment to be given. Prisoners who had been labelled as 'difficult' or 'trouble makers' could be denied health care as the doctors held the power of health care provision.

When I began to practice as a nurse in a prison, I was newly qualified. Therefore, my only exposure to doctors had been as a student nurse in a large teaching hospital. It was clear to me during my training that doctors were very powerful, especially the consultants I had witnessed taking tea with ward sisters. My expectations of doctors in prison was, therefore, no different. However, I did feel that as a qualified practitioner I could question the doctors' decisions regarding prisoners in my care if I felt the need, as did many of my health care colleagues. What surprised me the most was the attitude of the rest of the staff in the prison, outside of health care, towards doctors. It appeared to me that what the doctor said was law. It felt as though nothing could happen to the prisoner without the agreement of the doctor. From the prisoner getting permission to wear his own shoes and getting an extra pillow to what type of employment the prisoner was to undertake all had to be sanctioned by the doctor. I could see that there may be some medical input into these decisions but was unclear as to why they could not be made by a nurse or health care officer. Fortunately this changed in 2003 when the procedures were updated and nurses and health care officers were given more autonomy (see Prison Service Instruction 47, www.hmprisonservice.gov.uk).

From 1865 until 1920, the role of the doctor in the prison setting developed substantially. According to Thomson (1925), the medical officer was the most important person in the prison next to the governor. He states, 'The Medical

Officer of the prison ought to be a good general practitioner, an expert in lunacy and in sanitation, a person of culture, insight, unfailing good temper, strong human sympathy, and yet have a keen eye for malingering and deception' (Thomson 1925:107). The 1865 Prisons Act saw the role of the doctor increase and for them to become known as the medical officer (MO). The 1877 Prison Act further increased the role of the MO and stated the necessity for physical examinations for all prisoners on reception into the prison. According to Fox (1934), every prisoner was kept away from other prisoners in the reception block of the prison until the MO had seen them. It is suggested that this was to enable the detection of disease, the assessment of their fitness for labour and 'physical training', and to establish their general medical condition.

The 1898 Prison Act then placed more emphasis on the role of the MO, as there was a shift in perception that the MO was the best placed professional to establish the causes of criminality and hence potential cures. According to Morris & Morris (1963:192), it was 'the advent of Lombroso and the Positivist School of Criminology invested the doctor with a new role, that of scientific investigator'.

MOs were now seen as being trained in psychiatry and began to play a greater role in the care of the mentally ill. In 1907, the Home Secretary decided that all mentally ill prisoners were to be put under the direct charge of the MO. By 1920, prison doctors were beginning to publish widely and began disseminating results at conferences. The feeling at the time was that the key skills required by the prison doctor were those of observation and surveillance.

In 1922, the publication of 'English Prisons Today' by the Prison System Enquiry Committee concluded that medical provision for the sick was inadequate in England's prisons. It was suggested that prison hospitals were being used for solitary confinement, that in some smaller prisons there was a

lack of treatment and questions began to be asked about the number of deaths in custody. The report also highlighted that prison doctors appeared to be diagnosing and treating mental illness based on little or no training and qualifications. This is an issue that has been raised as recently as 2001 in a Department of Health/HM Prison Service report which examined the core competencies required of prison doctors and their recruitment, retention and training. Many recommendations were made but one in particular states that, 'Every prisoner with a diagnosis of severe mental illness (acute psychosis) should be under the care or responsibility of a psychiatrist who is on the Specialist Register' (Department of Health & HM Prison Service 2001:24). 'English Prisons Today' also raised the question as to whether prisons were making prisoners mentally ill. In the 1940s, the Prison Medical Reform Council (PMRC) was established and aimed to promote the proper working of the Prison Medical Service. The council reported that it felt there was a culture in prison health care that assumed all prisoners were malingerers. It would appear that negative attitudes towards prisoners by prison staff were still in evidence as recently as 2004 (Tracy 2004; Walsh 1998; Cornelius 1992).

It was during the 1940s that the Reconstructionist ideology dominated the political thinking of the day. This ideology included the philosophy that the state could intervene in society through professionals, most notably in the lives of the criminal and deviant (Sim 1990). This ideology legitimised the power given to the medical profession in the prison setting. Prison doctors benefited greatly from this as their influence grew through presentations at conferences and publications. At the end of the Second World War, the Reconstructionist ideology remained the dominant philosophy of the day and prison doctors still retained considerable power. In male prisons, doctors were supported by hospital officers who were often recruited from the armed forces and from the staff of psychiatric hospitals. Female prisons, however, recruited qualified nurses and auxiliary nurses.

Between 1946 and 1948, the Prison Medical Service was rationalised and a post of Director of Prison Medical Services was established. The 1948 Criminal Justice Act began a new era in the treatment by society of its prisoners. This act allowed the courts to request medical reports prior to sentencing offenders and prison regimes became less harsh and brutal. The ideology of the day encouraged a more positive approach to prisoners and to train prisoners to become more effective members of society. The 1948 Act also introduced the mental health training of hospital officers and the appointment of psychiatric social workers.

In the early 1950s there was an increase in the national crime rate. Prisons became overcrowded and questions began to be raised about the appropriateness of the doctor's role in the discipline of the prison and the quality of care being provided to prisoners. This situation continued for the next decade with much criticism levelled at health care. In 1954, the Howard League for Penal Reform began to ask questions about prison doctors' qualifications and called for closer working with the relatively newly formed National Health Service (NHS). In 1961, there were calls made in 'The Lancet' for the amalgamation of prison medical services with the NHS. As the prison population had been rising and overcrowding became more common, unrest amongst the prison population began to spread. This unrest was demonstrated in the form of riots across the prison estate. It was expected that difficult prisoners would be dealt with through the use of medical power.

In 1962, the Prison Reform Council published proposals for improving prison health care and cited examples of poor practice, low standards and the negative, uncaring attitudes of staff. Following this report, an enquiry was launched to examine the general state of prisons, the lack of research on criminal rehabilitation, the inadequacy of prison doctors' qualifications and the involvement of prison doctors in discipline. This enquiry became known as the Gwynn Enquiry. In 1964, the findings from this enquiry were

published. One of the main recommendations to arise from this enquiry was that the Prison Medical Service should not be integrated into the NHS. It was recommended that the two systems should work in parallel, with prisoners accessing NHS treatment when the Prison Medical Service could not provide it. This report also recommended that prison doctors should be employed by the Prison Service but that there should be joint appointments with the NHS for psychiatrists. What can be seen from this report and the historical events that preceded it are that there are themes which keep emerging, such as the question of whether prison doctors' qualifications are suitable to meet the needs of the prison population, amalgamation with the NHS and questions regarding the standards of care provision in prison.

Between 1960 and 1980 the prison population continued to rise, with subsequent overcrowding and a resultant increase in the level of unrest amongst prisoners. More discipline and security was the solution proposed by the Prison Service. The Prison Medical Service began to examine the way in which prisoners' injuries were treated and how difficult prisoners were dealt with. It became clear during this time that the hospital officer was undertaking a nursing role but with inadequate training to do so. It was also discovered that medication was being used as a way of dealing with difficult prisoners.

In 1985, the House of Commons Social Services committee published a report concerning the Prison Medical Service. The report was intended as a guide for the improvement and development of the service. The report highlighted the inequality in care provision for prisoners compared with the NHS. It also commented on the poor living conditions in prison, the lack of in-cell sanitation, the lack of staff and the lack of medical staff speaking out about poor conditions. Again, there were calls for integration with the NHS. The Government responded to the 1985 report two years later and commenced a building and refurbishment programme to help alleviate

overcrowding and poor conditions. It was at this time that the recruitment of registered nurses who would train as hospital officers was initiated.

In 1990, a major disturbance at Strangeways Prison in Manchester was the catalyst for the Woolf Report (Woolf & Tumin 1991), which re-examined the possible causes and conditions that may have led to the disturbance. The report did not implicate the Prison Medical Service although it did mention that medical treatment was a cause of anxiety for prisoners who felt that medication was used inappropriately to deal with difficult prisoners. This had been highlighted 30 years previously. The report also mentioned that the Prison Medical Service was not providing care that was equitable with that provided by the NHS, as highlighted a few years earlier. Following scrutiny of the Prison Medical Service, it was decided that civilian nurses should be recruited into the Prison Service.

In 1992, the Prison Medical Service was replaced by the Health Care Service for Prisoners (HCSP) and was seen as a new beginning for prison health. Following repeated concerns about the standards of health care in prisons, the HCSP proposed 75% of the health care workforce in prisons should consist of qualified nurses. The remaining 25% would be hospital officers (Willmott 1997).

Throughout 1992–1995, the Chief Inspector of Prisons, Sir David Ramsbotham, published repeated inspection reports that highlighted poor standards of health care in prison. This culminated in 1996 when he published the seminal discussion document 'Patient or Prisoner' (HMIP 1996). Following the repeatedly poor inspection reports, Sir Ramsbotham was compelled to publish a discussion document to propose ways in which services could be improved and to question the poor standards of care. In this document, he recommended that the NHS take over responsibility for prison health care. This publication instigated a major restructuring in the organisation of prison health care at a national level in which a formal

partnership between the NHS and HCSP commenced. Since the establishment of this partnership, collaboration has developed further with more services being delivered by the NHS inside prison. In 2002, a statement by the Home Secretary and the Secretary of State for Health stated that funding responsibility for prison health services would be transferred from the Home Office to the Department of Health from April 2003. This was the first step in a five-year plan whereby NHS Primary Care Trusts would become responsible for the commissioning and provision of health care services to their prisoner populations.

Throughout the development of prison health care, there have been numerous calls for the incorporation of the HCSP into the NHS (Woolf & Tumin 1991; Smith 1984; HMIP 1996; Home Office/Department of Health & Social Security 1975; Smith 1992b). This is in addition to the various calls from medical and nursing professional bodies. Hughes (2000:60) highlights this issue and reports: 'That these discussions are not new reflects the historical roots of prison health care and highlights how the problems of the past can be perpetuated.'

It is not only the repeated calls for prison health care to be amalgamated with the NHS that were seen time and time again throughout the development of prison health care. Concerns regarding the inappropriate use of medication to manage difficult prisoners, poor conditions/standards of care and the appropriateness of the qualifications of both doctors and hospital officers have all been highlighted more than once. All are being addressed at a national level through the change in commissioning of services from the Prison Service to the Primary Care Trusts, the implementation of more robust standards, and better training and development opportunities for prison doctors. Hospital officers are also now being trained more effectively in line with occupational standards recognised externally to the Prison Service.

I can see that there are main issues regarding the development of prison health care that appear to come to the fore in cycles. Such issues include the amalgamation of prison health care with the NHS, the qualifications of doctors working with prisoners and the standards of care provision to prisoners. I am unsure as to whether attempts to address them have just failed in the past or whether they have just been ignored. I also wonder whether, if they have just simply been ignored, this was allowed because prisons are, by their very nature, hidden from the public view, or were the powers in charge unable to change the practices being undertaken. Fortunately, now the Department of Health is involved in prison health care through Primary Care Trust (PCT) commissioning of services and increased funding, standards and practices have to change and are definitely changing for the better because prison health care is no longer hidden.

Recent Policy Development

There have been major changes in prison health care in the last decade. The most radical of changes began with the previously mentioned publication from Her Majesty's Chief Inspector of Prisons, Sir David Ramsbotham. Following some poor inspections of prisons, Sir Ramsbotham published a discussion paper, which has proved to be the catalyst for changes in prison health care. In his discussion paper 'Patient or Prisoner' (HMIP 1996:i), Sir Ramsbotham aimed 'to consider health care arrangements in prisons in England and Wales with a view to ensuring prisoners are given access to the same range and quality of health care services as the general public receives from the National Health Service'. This report examined the concept of the prisoner as a patient and asked if the prisoner with health care needs was seen as a prisoner or as a patient and how their health care needs might best be met. Following the publication of this discussion paper, Sir Ramsbotham recommended that 'it is no longer sensible to maintain a health care service for prisoners separate from the NHS', (HMIP 1996:7). The discussion paper also stated that, 'There is an immediate need for the Home

Office and the Department of Health, together with the Prison Service and the National Health Service to agree a timetable for the NHS to assume responsibility for the commissioning and provision of health care and health promotion in prisons' (HMIP 1996:7).

Traditionally, prison health care was provided by the Prison Service through the Directorate of Health Care at the Prison Service. HM Prison Service itself is part of the Home Office. Following this discussion paper, a working party was established with representation from both the NHS Executive and HM Prison Service to examine the recommendations. The report of this working party was published in 1999 (NHS Executive & HM Prison Service 1999) and endorsed the aim of providing access to the same range and quality of health care for prisoners as is available in the NHS. However, at that time, they did not support the recommendation that responsibility for commissioning and provision of health care should become that of the NHS. Moreover, they recommended that a 'prison service partnership at all levels is the most practicable way of delivering equivalence of health care to prisoners', (NHS Executive & HM Prison Service 1999:42). As a consequence, a formal partnership was established between the Prison Service and the NHS, and the Prison Health Policy Unit and Task Force were created. The Prison Health Policy Unit replaced the old Directorate of Health Care and assumed responsibility for developing prison health policy, which would integrate and draw on existing NHS policy. The Task Force was established to support prisons and health authorities in the development of services, assessment of prisoner health care need and the changes identified in the prison health improvement programmes.

The working party report also considered the future organisation of prison health care and ways in which to improve provision. As part of this, health care staffing was examined as was the culture within which health care was being provided. In addressing issues of culture, the report mentioned that the health care culture was influenced by traditional attitudes, with an emphasis

on security and less on nursing practice and health improvement. In regard to this traditional culture, the report states that, 'newly recruited nurses often found it difficult to influence the culture that lacked clear lines of accountability to support them. These factors reduced job satisfaction and contributed to poor retention of nursing staff' (NHS Executive & HM Prison Service 1999:11).

During the same period, a large-scale research study was commissioned by the United Kingdom Central Council for Nursing and Midwifery (UKCC & University of Central Lancashire 1999) to scope the issues involved in the work of practitioners working in secure environments. This study made many recommendations and reached a number of conclusions concerning nursing in prison health care. One of the most significant was similar to that from the working party in that health care culture is influenced by traditional attitudes, emphasising security before nursing practice and health improvement. The report found that this was particularly evident where senior members of staff had been in post for several years and were not qualified nurses. This report also mentioned the lack of clinical supervision opportunities for nursing staff working in prison health care. It was felt that this was possibly due to practical problems and a lack of management support which created implementation difficulties.

Following the publication of 'Nursing in Secure Environments' (UKCC & University of Central Lancashire 1999) and public concern regarding health care in prison, the Prisons Minister and the Health Minister set up a working party to look at the development of nursing in prisons in England and Wales with specific reference to health care officers. The report published by the working party (NHS Executive & HM Prison Service 2000) provided recommendations for the training and induction of health care officers and new nurses and also for the development of health care managers in prisons. It was as a result of this report that health care officer training was revised and replaced with the NVQ in Custodial Health Care.

In September 2002, a statement was issued by the Home Secretary and the Secretary of State for Health stating that funding responsibility for prison health services would be transferred from the Home Office to the Department of Health from April 2003. The transfer of prison health to the NHS brings with it exciting developments for nursing staff currently working within prisons. It is expected that there will be more scope for the professional development of both prison health care staff and staff in the wider NHS as a result of these changes.

The Context of Prison Nursing

Currently, there is a prison population of 79,152 in England and Wales, both male and female (HM Prison Service 2007). It is estimated that over 1 million people per year are affected by imprisonment, be they in prison themselves or have a family member in prison. The health care needs of this population are similar to those in the community. However, it is suggested that 90% of the prison population have a diagnosable mental health problem (including personality disorder), a substance misuse problem or both, and 80% of prisoners smoke (NHS Executive & HM Prison Service 2001). In addition to the possible pre-existing health needs of prisoner patients, there are health needs created as a consequence of imprisonment. Examples of these include the lack of direct access to over-the-counter medications, restriction on family networks/support, overcrowding and limited opportunities for self-care. Overcrowding in prisons is currently high on both the political and media agendas as the prison population in England and Wales reaches capacity and police cells are commandeered to house prisoners. In addition to overcrowding affecting the care needs of prisoners, Vere-Jones (2007:5) highlights it as a problem for nurses working in prison because 'overstretched prison nurses cannot provide the therapeutic intervention that inmates require because of overcrowding'.

Prisoners are categorised into one of four categories when they are in prison. The categories range from D (lowest category and security risk) to A, which refers to the highest category. The category that a prisoner is placed into reflects the risk that prisoner poses to the security of the state if at large and the extent to which the prisoner's escape would pose a threat to the public and the police (McCausland & Parrish 2002). The category to which prisoners are assigned will often determine their geographical location in the prison system and the extent of the secure conditions in which the prisoner is located.

A multidisciplinary team comprising doctors, nurses, health care officers, physiotherapists, chiropodists, dentists, radiographers, specialist nurses, opticians, etc. provide health care services to prisoners. Interestingly, the multidisciplinary team in a prison comprises a far wider spectrum of professionals than in a primary care team in the outside world. For example, the nurse/health care officer in the prison setting may also liaise with probation officers, discipline (prison) officers, chaplains, psychologists, physical education staff and educational staff in caring for a prisoner.

Registered nurses and health care officers provide nursing care in prison. Health care officers can be viewed as 'specialist' prison officers. These specialist prison officers undertake a six-month training course provided by the Prison Service in basic health care and nursing. Some of these prison officers may also be registered nurses but some are not. In 2003, the traditional Prison Service health care officer training was replaced by an NVQ Level 3 in Custodial Health Care delivered in conjunction with external educational providers and, in 2006, a foundation degree was piloted.

It was when I undertook a placement as a student nurse that I was informed of the relatively recent introduction of nurses into prison health care. Until the 1980s, there were nurses employed in prisons but they were trained as health care officers. Therefore, they were prison officers with a nursing

qualification. Having spoken with many health care officers during this placement, it became obvious that the introduction of nurses into the prison setting had caused much animosity with existing prison staff. Some officers felt that nurses with minimal training in what is termed 'jail craft' were not skilled enough in the custodial/discipline side of the job and that it was inappropriate to allow nurses into prisons. Some even suggested to me that it was unsafe. This made me question the organisational culture of the prison system, which operated at the time in quite a militaristic way with definite staff inmate groups. It appeared to me that some officers felt that the nursing philosophy would encourage a softer approach to custody and that discipline would lessen in some way. The introduction of nurses into the workforce was a very difficult transition for many existing staff to deal with. Once I was working as a qualified practitioner in prison, it became clear to me that this was only an issue in some prisons and that many prisons had welcomed nurses into their workforce. This experience highlighted to me the hidden hierarchies and prison-specific discourse present in the prison setting.

The role of the nurse in a prison is varied and complex. Prisoners present a range of health problems, often spanning the spectrum of traditional nursing specialities. Hence, nurses working in prison need skills in mental health nursing, general nursing (both medical and surgical), primary care/practice nursing, learning disability nursing and children's nursing (for those nurses working with young offenders). This presents a professional challenge to practitioners, educationalist and researchers alike. Not only are nurses working in prison providing nursing care to the prison population but they also have a role similar to that of the prison officer in maintaining security and order. This demands skills and competencies in both nursing care and security.

On a practical level, the prison population can be viewed as a small community representative of the community outside prison. Prison staff can therefore expect to deal with chronic illness, mental illness, drug and alcohol

misuse, acute medical problems and trauma. In addition, nursing staff also provide health screening services for all prisoners entering the prison system and inpatient services for medical, surgical and psychiatric care. In addition to this, nurses and health care officers also provide well-man clinics, chronic disease management clinics and primary health care/practice nursing similar to that provided at a local GP surgery. The fact that nurses are practising in a 'concentrated' community inevitably means that involvement with prisoners as patients, seen on an almost daily basis over long periods of time in a setting which is often highly charged emotionally, is expected to have an impact on the level of emotion work undertaken by the nurse. However, this setting requires that boundaries and limits be placed on the traditional nurse–patient relationship, which in turn requires added emotional care from the nurse to ensure that the needs of the prisoner are met.

I trained as a general nurse. The health care needs of the prisoner population in the prison where I worked, a large adult male prison, obviously required my general nursing skills. However, there were additional skills I needed to acquire and develop: to effectively meet the needs of the establishment, I needed skills in security; to meet the needs of prisoners, I needed skills in mental health nursing, emergency nursing, learning disability nursing and skills in working with colleagues whose focus was discipline and security. I began to feel that a prison nurse had to be a 'jack of all trades' and it was this requirement to have a wide range of nursing skills that made me feel that prison nurses were different to nurses working in settings outside the prison walls. In addition to this, prison nurses need to practice in a secure environment and therefore act as part officer, part nurse. Although this in itself is fairly unique, it is the wide range of nursing skills needed that I feel makes a prison nurse different from other nurses. Caring for prisoners can be viewed as no different to caring for patients outside the prison, but I suggest that it is the underlying power that the nurse working in prison has (by virtue of carrying keys) and the emotional stress of caring for people who are deemed criminal and who are sometimes difficult and manipulative in a

situation that is highly emotionally charged that makes prison nursing different from nursing in the wider health community.

Care and Custody

I searched the databases CINAHL, MEDLINE, Academic Search Premier, Blackwell Synergy, British Nursing Index, Ingenta Connect and Psych INFO for literature concerning prisons and prison health care. The prison health care studies that I identified during this search originated mainly in the UK, Australia, America and Canada. There is a paucity of empirical literature in this area, hence, in addition to prison health care literature, the literature pertaining to nursing in a forensic setting was also examined. A comparison has been drawn with the forensic nursing literature, as there are similarities with that of prison nursing in so far as both nursing groups are working in a secure environment. It was also felt to be important that the literature concerning the role of the prison officer and the relationship between officer and prisoner be examined, as the discipline role of the nurse working in prison can be viewed as similar to that of the prison officer.

Prison Nurses/Correctional Nurses

As has already been identified, nurses working in prisons in England and Wales have a dual role; that of carer and custodian. Anecdotal literature suggests that this role and the prison environment pose unique problems and challenges to the nurse. Much of the published work concerning nurses working in the prison environment is anecdotal (Alexander-Rodriguez 1983; Day 1983; Holleran 1983; Dopson 1988; Reeder 1991; Dulfer 1992; Mason & Adam 1992; Burrow 1993; Stevens 1993; Wilmott 1994; Barr 1995; Burrows 1995; Peternej-Taylor & Johnson 1995; Willis 1995; Rodgers & Topping-Morris 1996; Wilmott 1996; Lyne 1997; McMillan 1997; Schafer 1997; Wilmott 1997; Reams et al. 1998; Norman & Parrish 1999a; Norman & Parrish 1999b; Smith 2000; Parrish 2002). Although empirical literature is limited, it supports much of what is discussed in the anecdotal reports.

A study commissioned by the UKCC (UKCC & University of Central Lancashire 1999) was the first major research study to examine nursing in a secure environment. The study utilised many data collection methods and was both qualitative and quantitative in its analysis. Data collection methods included the use of focus groups, interviews, questionnaires, audit and observation. As this study examined secure environments, the researchers utilised data from prisons, high security forensic psychiatric services and medium and low security psychiatric services. This study investigated, amongst other areas, the preparation of nurses working in secure environments. Evidence arising from the study demonstrates a lack of specific learning outcomes for pre-registration students undertaking placements in secure environments, an overall lack of availability of placements in secure environments, limited research activity by educational establishments concerning secure environments and a lack of effective preceptorship for newly qualified nurses working in secure environments. The study also examined post-registration preparation for nurses working in this type of setting and discovered that availability of continuing professional development opportunities was inconsistent in terms of support and investment for prison staff and highlighted the limited evidence to suggest whether or not any post-registration courses improve competence for working in secure environments. This study highlighted the poor implementation of induction in secure environments, although it is mentioned that there is a good understanding of what is necessary to induct nurses into the secure environment. It is suggested that effective induction could prevent some of the problems experienced by practitioners and could improve the tone and culture of the organisation.

Another British study commissioned by the RCN Prison Nurses Forum (Dale & Woods 2001) aimed to provide a comprehensive overview of the roles and boundaries of the practice of nurses working in prison. Following an extensive literature review, the study utilised observational case studies,

focus groups and consensus conferences for data collection. In addition to these data collection methods, re-analysis of the data presented in the UKCC & University of Central Lancashire (1999) report was also undertaken. This project highlighted the competencies required by nurses working in prisons whilst noting the different types of health care centres in which these nurses work. The difficulties experienced by prison nurses are also emphasised and are reported to be centred on the nature of the environment where the primary purpose is security not health care. Indeed, security often takes precedence over all other considerations including, at times, health care. Nurses included in this study also reported the nursing role in prisons as being more about breadth than depth, as nurses in prison are providing care from many nursing specialities including mental health, general nursing and primary care. Nurses in this study felt that the unique culture of the prison environment is not well suited to the traditional values of professional nursing practice, although it is not clear what these traditional values of nursing are.

Gulotta (1986) examined the factors influencing nursing practice and job satisfaction in a correctional hospital in America. Prison hospitals in America are referred to as correctional hospitals. Fifty registered nurses who had worked in the correctional setting for at least six months were studied using a survey methodology. Two questionnaires were administered to these nurses. Data were analysed using descriptive statistics that included frequencies, percentage and correlational measures. This study identified that, for the correctional health care setting studied, the nursing administration, hospital administration, nursing practice ability and nursing role, as defined on the questionnaire, were found to facilitate nursing practice. It was also discovered that the correctional administration was the least facilitating factor to nursing practice and had fewer correlations with job satisfaction than with any other variable. Nurses in this study felt that the goals of the correctional administration and the nursing service were in opposition. This implies that the goals of security and nursing are in conflict with one another, leading to a

care versus custody dilemma which is highlighted frequently in the anecdotal literature.

Gulotta also found high levels of job satisfaction in this group of nurses, which is felt to be due to the uniqueness of the setting. Gulotta recommended that there needs to be a balance between security constraints and inmates' health care needs. It is felt that this can be facilitated through good communication and co-operation between health care and correctional staff. Also recommended is a programme of health awareness for correctional staff to provide an insight into the operations of a health care setting.

Droes (1994) explored the nature and problems of nursing practice in a correctional setting in America. She employed a qualitative method and utilised participant observation, of which there was in excess of 100 hours, along with informal interviews and conversations. Three men's prisons were included and she interviewed 40 nursing staff. Data analysis was completed using a constant comparative method of analysis. Two broad questions guided the study, namely: what is the nature and what are the problems of nursing practice in a correctional setting? Two different groups of nursing staff participated in this study. Forty registered nurses who were employed in three prisons participated in informal interviews and conversations. Also included in this study were five nurses, all of whom had current or past experience in seven additional prison and jail settings, and who were personally known by the researcher. They were interviewed formally and at length outside the correctional setting. Droes discovered three important facets of nursing in a correctional setting. Firstly, the special world where nursing work occurs; secondly, the actual correctional nursing work; and finally, the correctional health care scenes – the interactions that occur among various individuals and groups, which influence correctional nursing practice.

In discussing what Drees refers to as 'the special world' where the nursing work occurs, Drees explained that the structural conditions of the correctional setting hold consequences for nursing care to inmates. Structural conditions are elaborated further in three areas: 1) the ever present security measures, 2) inadequate facilities, equipment and supplies and 3) insufficient staffing. Drees highlighted the ever-present security measures as the most profound influencing factor in the delivery of nursing care.

Drees found that the interactions between various individuals and groups within the correctional setting hold consequences for nursing practice. She discovered that custody's toleration of health care was most notable in the interactions between custody staff and health care staff. Drees continued to describe a continuum of toleration of health care staff by custody staff. At one end of the continuum, contentious toleration of health care occurred where 'custody staff accepted inmate health care grudgingly and viewed it as a distraction and interference with the performance of their own work' (Drees 1994:204). At the other end of this continuum, Drees describes considered toleration which 'denoted situations in which custody staff evaluated health care as not only benefiting inmates but also assisting in the performance of their own work' (Drees 1994:205). At the centre of this continuum, Drees mentions an acknowledged toleration in which 'custody staff...perceived correctional health care as meeting reasonable needs and as a routinised and accepted aspect of correctional work' (Drees 1994:205).

From the data, Drees concluded that the nurses had differing conceptions of nursing, although they fell into three broad categories. Some nurses had a limited conception of nursing in which they tended to focus on acute medical and surgical problems. Other nurses held an expanded conception in which they included the narrow, acute medical surgical nursing but also included a public health and social-psychological approach to health care problems. Drees also mentioned a third group of nurses holding a different conception of nursing, namely 'other directed' nurses. She stated that they 'held

conceptions of nursing that tended to reflect the prevailing views of influentials within the correctional health care scene' (Droes 1994:205).

Droes drew two main conclusions. Firstly that, in this study, custody staff exert significant influence on the correctional health care environment and secondly that nurses working in the correctional environment with increased levels of education and experience in public health are prepared to provide a broader scope of health care to inmates. Therefore, Droes concluded that the most favourable conditions for health care delivery in prisons occurred when there was a considered toleration by correctional officers and an expanded conception of nursing by nurses.

This study provides a valuable insight into the problems of nursing in a correctional setting. Although informal interviews were carried out in the course of data collection, there is no mention of the type of questions the nurses were asked by the researcher. This study was conducted in America and therefore it must be acknowledged that there may be cultural biases present in the findings. Droes noted that caution must be applied in generalising these results to other correctional settings due to the characteristics of the sites and the respondents. However, there are underlying themes in this study which are consistent with both empirical and anecdotal literature, both nationally and internationally.

In an Australian study, Doyle (1999) examined the factors influencing the practice of psychiatric nursing in an Australian prison. A qualitative methodology was adopted for this study in which 10 psychiatric nurses working in the prison setting were asked in a focus group to identify and explore issues of concern in their practice within the prison setting. Following the focus group, themes identified were explored further by the use of in-depth interviewing, using open-ended questions and non-directive language techniques. Twenty nurses were interviewed: the initial ten from the focus group plus another ten who had expressed an interest in the study.

Interviews were tape-recorded, transcribed and analysed using thematic textual analysis. Clusters of themes were identified and the emergent understandings were returned to the subjects for clarification and comment.

Doyle (1999) reported the following factors as influencing psychiatric nursing in the prison setting: challenging patients, threats to the personal survival of patients, the technology and artifice of confinement, conflicting values of Corrections and nursing staff, stigma by association and prisoner identification of the nurses within the prison administration. He concluded by summarising that psychiatric nurses working in the Australian prison system are practising in an environment where the philosophy and values of correction and criminal justice intrude on nursing practice goals and their outcomes. Doyle recommends ongoing further research in this setting to inform changes in prison-based practice. The findings from this study confirm what is highlighted in the anecdotal literature; that is, the intrusion of a correctional/prison philosophy on core nursing values causes professional difficulties for the prison/correctional nurse.

It is widely recognised both in the empirical and anecdotal literature that nursing in a prison presents the nurse with a range of challenges and frustrations that affect nursing practice. Much of this, it is thought, is the result of the dual caring and security role that the nurse undertakes in this setting. In addition to the dual role of carer and custodian, the nurse also has to practice within the culture of the prison setting. It is important to remember that the main function of a prison is security/rehabilitation and not health care (Norman & Parrish 2002).

Forensic Nursing

Due to the paucity of empirical literature concerning prison nursing, the literature pertaining to nurses working in forensic settings, i.e. nurses caring for mentally ill offenders in secure psychiatric settings, has also been

accessed. Forensic nursing is often referred to as a nursing speciality but, interestingly, the term forensic has broadened to encompass nurses who work with victims of sexual assault and nurses who work with coroners. Interestingly, Martin (2001) refutes the supposition that forensic nursing is a speciality as he feels that, on reviewing the literature, specialist skills and knowledge have not been documented. However, to ensure a valid comparison of the forensic literature with the prison literature, only the relevant work pertaining to forensic nurses working with mentally disordered offenders in secure environments has been examined.

In his thematic analysis of role tensions in forensic nursing, Mason (2002) mentions the 'prisonization' of secure psychiatric services. It is suggested that the increasing number of mentally ill offenders admitted to secure psychiatric services from prison has led to an emergence of different tensions and conflicts as patients move from the prison culture into the culture of the secure psychiatric setting. The tensions reported to be common for forensic nurses working in secure environments are said to be centred on the difficulty of maintaining a therapeutic service and operationalising security procedures. This is similar to what can be found in the literature pertaining to prison nursing. However, another area of difficulty for the forensic nurse is the management of feelings generated when caring for offenders convicted of heinous crimes (Hammer 2000). This particular tension is not particularly well documented in the prison nursing literature. However, in relation to the potential difficulties of nursing offenders as a group, it is mentioned by Evans (2000) in an anecdotal report that discusses correctional nurses' punitive attitudes towards offenders and hence the effect on the therapeutic relationship. Evans suggests that the older the nurse and the greater the years of correctional nursing experience, the greater the tendency to reflect a punishment and institutional orientation. It is suggested by Greenland (1988, cited by Evans 2000:11) that, 'Professionals readily absorb the prevailing ethos and values of penal institutions.'

Murphy & McVey (2003), in their paper concerning the challenge of forensic nursing and nursing patients with personality disorder, cite O'Brien & Fote (1997) who highlight that there is high intra-personal conflict for the nurse working with this group of patients as they experience a number of conflicting emotions. It is suggested that these conflicting emotions, such as empathy and anger, may be exacerbated when the client has committed a serious offence (Tennant & Hughes 1997).

Rask & Hallberg (2000), in a Swedish study that investigated forensic nurses' views of their area of responsibility, highlights the considerable apprehension felt by forensic nurses regarding their roles in both therapy and custody. Similar findings have also been found in the literature pertaining to prison nursing, (Droes 1994; Doyle 1999).

Foster & Onyeukwu (2003) examined the attitudes of forensic nurses to substance using service users. This study was conducted in the UK using the American substance abuse attitude survey with a sample of 63 multi-ethnic forensic psychiatric nurses working in a residential secure unit. Foster & Onyeukwu explored the attitudes of these staff and found that they exhibited sub optimal attitudes to their clients. Their findings indicated that sub optimal attitudes to the client group had an effect on the quality of the nurse–patient relationship and hence on the quality of care provided. They also suggest that this effect on the nurse–patient relationship can result in avoidance of the patient by the nurse and reluctance to refer on to other services. Foster & Onyeukwu also refer to the work of McKeown & Liebling (1995) who suggest that the prime focus for staff working with drug users in a residential setting have, as their focus, the prevention of drugs entering the ward. This, as Foster & Onyeukwu explain, is likely to bring nurses into conflict with their clients and promote a position that 'can easily become over controlling and adversarial' (Foster & Onyeukwu 2003:582).

Fisher (1995) examined the ethical issues encountered in psychiatric nursing practice with dangerous mentally ill patients. A comparison can be drawn between this study and the prison setting due to the nature of the client group. Although the study by Fisher (1995) was undertaken in two locked psychiatric wards in a large urban medical centre, the issues raised apply just as well to the prison setting. Fisher collected data by conducting semi-structured interviews with 18 members of nursing staff. A field design was employed and constant comparative analysis and dimensional analysis from the grounded theory method were utilised to analyse the data. The analysis of the data revealed three main ethical problems encountered by nursing staff whilst caring for dangerous mentally ill patients. These were: balancing support for patient autonomy with the need to maintain unit control, balancing the need for distancing with the desire to establish a therapeutic relationship and, finally, balancing the desire to 'do the right thing' with the need to get along with colleagues. These findings can serve to reinforce the anecdotal evidence already discussed concerning nursing in prison. It can be seen from Fisher's work that the main ethical issues experienced by the staff in her study were balancing care and custody and the impact of the organisational culture on practice, also reported by Drees (1994), Doyle (1999) and Gulotta (1986).

Holmes (2002), in his grounded theory study of forensic nurses in Canada, uses the Foucauldian perspective of power and governmentality when analysing the findings of his study. Foucault states that, 'Governmentality is the powerful web of power relations that links together three distinct forms of power: sovereignty, discipline and government' (Foucault 1991, cited in Holmes 2002). Holmes continues to highlight the notion of government, which includes punishment techniques, as an activity that aims to shape, mould or affect the conduct of an individual or group. This can be applied to both the staff of a prison and its inmates, thus affecting the way in which staff attitudes and behaviours are brought to bear on the inmate population.

According to Foucault (1991 [1977]), the governmentalisation of the state combines the use of different forms of power and is supported by a mechanism of security. Holmes refers to the 'apparatus of security' as the utilisation of diplomatic-military techniques, and relates police and pastoral power, to the caring of others. In describing and providing an understanding of nursing practice in a secure environment where nursing staff are both custodians and carers, he utilises the two forms of governmentality (police and pastoral power) in his analysis. He suggests that this is a useful model to use when examining nursing practice in this setting 'where the roles of agent of social control (police) and agent of care (pastoral power), through various power techniques, are assumed today by nurses' (Holmes 2002:86). In his study, Holmes refers to the context of detention in the study site (a correctional forensic mental health unit containing approximately 120 inmates) affecting the nursing care provided. This context includes the spatial organisation of detainment, the power relations between nurses and officers and the power relations between nurses and inmates. Holmes concludes from his qualitative study of 21 nurses and 3 correctional officers that nurses working in a secure setting such as that studied, constitute a strategic node in the web of power relations within the correctional forensic psychiatric setting and are therefore agents of governmentality. This study examined the role of the nurse in the correctional setting and used the theories of Foucault to analyse them. However, it only examined the role of the nurse and does not make reference to the role that governmentality by the state has on the attitudes and professional behaviours of the nurse working in this setting.

Godin (2000), in his paper concerning community psychiatric nurses and their use of power, discusses the closure of the asylums and the developing services in the community. He argues that, 'The developments in chemical, administrative and legal controls, once confined to the asylum, now operate over mental patients in the community' (Godin 2000:1396). He cites Etzioni's (1975) model of power in which it is mentioned that there are three sources

of power used to encourage compliance in an organisation: coercive, remunerative and normative. Coercive power promotes compliance with the organisation through the use of force or the threat of force. Godin likens this to the power in a prison where prisoners 'are usually negatively involved with the organisation in an alienated relationship' (Godin 2000:1400). He continues to explain that remunerative power uses economic assets to promote compliance, such as in factories. Normative power, he suggests, uses prestige, esteem and symbolic rewards.

In a separate paper (Holmes, 2001), the concept of panopticism is discussed in the context of surveillance techniques used in psychiatric hospitals. Holmes discusses panopticism in terms of managing psychiatric patients and being able to observe them easily. Ultimately, if thought to be permanently observed, the observed will eventually internalise the surveillance and take over the task of observing themselves (Monod 1997, cited in Holmes 2001). Although Holmes's paper concerns the effect of constant observation in psychiatric hospitals on patients and staff, it can be applied to the prison setting where initially the panoptican design was hailed as a utopia for managing and observing prisoners. According to Foucault (1991 [1977]), the panoptican induces self-surveillance, self-regulation and the internalisation of discipline. Although the panoptican design can no longer be seen in prison architecture, its principles are still very much in use in both prison and psychiatric hospitals.

Holmes suggests that continuous observation is a form of disciplinary power and discusses in his paper the issues that this use of observation and hence disciplinary power has on psychiatric nurses. It is suggested that prison nurses can also be seen to be using power through both observation and discipline in the prison environment whilst caring for prisoners. Holmes suggests that it is not only the patient who is affected by panopticism but also the nurse. Holmes asks if nursing practice itself is affected by the fact that the nurse may also perceive that they are being continuously watched by

their colleagues. Holmes also suggests that by relying on technology such as cameras and microphones to observe patients, the therapeutic relationship between nurse and patient may suffer as the human element of the relationship is reduced. Holmes warns that failure of nurses to go beyond shallow observation may put the nurse at risk of becoming an extension of the surveillance devices. It is suggested that by using surveillance to observe psychiatric patients, nurses will dehumanise caring.

Culture in Prison Health Care

According to Crawley (2004:8), organisational culture can be defined as 'the commonly shared beliefs, values and characteristic patterns of behaviour that exist within an organisation'. So, what are the commonly shared beliefs, values and characteristic patterns of behaviour in a prison health care setting?

Prisons, as in any institution, have dominant discourses and, in prison especially, there are very regimented structures. According to Horner (1999), doctors have a history of supporting oppressive regimes and, as can be seen from examining the history of the development of prison health care previously, they fully embraced their role in prison discipline. It is felt that this may still be the case (Horner 1999). Drees (1994) also mentions the philosophy of some correctional nurses in her study where she found that, although there was a clear caring and custody role, some nurses focussed on the custodial aspect of their work, which could be viewed as contrary to their role as nurses. Indeed, Meave & Vaughn (2001) also raise the issue of motivation in prison nurses, as prison health care could draw health care providers who are attracted to the idea of controlling and punishing prisoners.

Stoller (2003), in her discussion of accessing health care in women's prisons, uses the notions of time, place and space to deliver her analysis. It is her use

of the notion of prison as an anti-place in which she attempts to explain the apparent lack of empathy for prisoners by those who care for them: 'The architectural and regulatory construction of prison naturalises the prisoner as a depersonalised unit, teaching both the staff and the prisoner that this hyper-management and loss of agency is normal within the walls of this total institution' (Stoller 2003:2264). This is consistent with the work of Goffman (1968) in his seminal work 'Asylums' in which he speaks of the concept of the total institution.

Although the work of Goffman has been central to my earlier thinking concerning prisons as total institutions, I feel it is important to reflect on the notion that it is not just the physical construction of an institution that affects its inmates. Having worked in the reception area of a prison, where prisoners are received into the institution, it was clear that the architecture of the building supported a 'conveyor belt' approach to what I saw as dehumanising prisoners, e.g. first the prisoner was given a number at the front desk, then moved to the search area, proceeded to the shower area, which was followed by the delivery of prison clothing and an interview with the health care staff. However, it was not just the physical setting that promoted the dehumanisation. The staff operating within this system also effected this situation with their approach and attitude – equally products of the institution. Therefore, I suggest that it is not just the physical environment that causes dehumanisation, but the relationship of the staff to the prisoner, and indeed the relationships between prisoners.

Stoller (2003) also discussed the concept of 'nested' places and describes the clinic within the prison setting as a nested place to which access can only be gained by passing through the culture of the prison within which it is nested. Stoller states that the culture of the prison will inevitably have an effect on the nature of the clinic through the feelings, attitudes and beliefs that those travelling through the prison bring to the clinic.

It has been well documented that the culture within which prison nurses work has a great impact on their practice (Norman & Parrish 2002; Willcox 2002; Schafer 1997). In an anecdotal article, Stevens (1993) highlights the collision of cultures that nurses experience when practising in a secure environment. The following representation from Stevens (1993) illustrates the two main cultures prevalent in a prison where health care is not the primary focus. Although Stevens' comparison of cultures is helpful in highlighting the issues facing nurses, it must be remembered that this is just one perspective.

Element	Health Care	Prison
Values	Basic goodness	Evil is present
	All individuals are essentially the same	Criminal traits exist
Beliefs	Individuals who say they are sick should receive attention	Individuals who say they are sick are trying to get out of something
	People obey the rules	People break the rules
Norms	Respect the patient	Distrust the inmate
	Get the patients well and home	Get the individuals convicted and incarcerated
	Anger and hostility are acceptable behaviours when a person is ill. Assistance is offered, anger is redirected	Anger and hostility are not acceptable. Hostile inmates necessitate higher security
	Resisting treatment calls for counselling with restraints being the last resort	Resisting arrest is not tolerated and restraints are the first resort (handcuffs)
	Assumption of danger to self is minimal	Assumption of danger to self is ever present

Table 2: A Comparison of Cultures, adapted from Stevens (1983)

Stevens' representation highlights the exact issues underpinning nursing practice in prison that test nurses' professional values to the limit in undertaking their nursing role. I feel that it is the traditional nurse–patient relationship that exists in prison which sets prison nursing apart from the more traditional arenas of nursing. The context in which nurses are caring for their patients obviously has an impact on the care they provide due to the secure nature of the setting. However, in terms of the core of traditional nursing, it is the nurse–patient relationship that must be understood.

The Nurse–Patient Relationship

When examining the nature of the nurse–patient relationship in the prison setting, it became clear that this is an area that warrants research as little could be found. As I have mentioned previously, the empirical literature pertaining to prison nursing is limited so I have examined some of the literature concerning the nurse–patient relationship in the forensic nursing arena, as I believe this is the closest area with which to make comparisons. Firstly, it is important to review the literature concerning the nurse–patient relationship outside of the prison setting. This is important given that this is where student nurses are socialised into nursing and hence from where nurses develop their perceptions of effective nurse–patient relationships.

There is a wealth of literature pertaining to the nurse–patient relationship outside of the secure setting (Chapman 1980; Ramos 1992; Williams 2001; Lotzkar & Bottorff 2001; Gallant et al. 2002; Peternej-Taylor & Yonge 2003; Castledine 2004; Maatta 2006). I have observed that the literature referring to the nurse–patient relationship can broadly be divided into two areas: the development of the nurse–patient relationship and factors affecting the relationship. I have chosen to discuss them under these divisions.

Relationship Development

In his article stressing the importance of the nurse–patient relationship, Castledine (2004) cites Peplau (1988) who highlighted four phases of the nurse–patient relationship: orientation, identification, exploitation and resolution. Much of the empirical work I have examined concerning the nurse–patient relationship also identifies stages and levels of the nurse–patient relationship.

In an exploratory study examining the nurse–patient relationship through discussion of 67 critical incidents by 15 nurses in various health care specialities, Ramos (1992) identified three clear levels of nurse–patient

relationship: Level 1, the instrumental level; Level 2, the protective level with an emotional component; and Level 3, the reciprocal relationship with resolved control issues. Level 1 is described as common to all relationships and highlighted to be devoid of an emotional connection. Examples where this type of relationship was identified included four main situations: where the participants were strangers; when the patient was unconscious; when the nurse was only able to spend a minimum amount of time with the patient; and when instrumental needs were overwhelming (Ramos 1992:501). The outcome of this level of nurse–patient relationship was seen in this study to remain if the nurse was too busy to talk with the patient, or if the nurse and patient were incompatible. Ramos does not elaborate on what she means by incompatible.

The second level of the nurse–patient relationship is reported in this study to operate on a purely instrumental level. In a relationship of this type, nurses in this study reported ‘beginning levels of balanced emotional and cognitive connection with the patient’ (Ramos 1992:502). This is supported by the notion of a unilateral connection whereby the nurse retains control of the relationship. Ramos suggests that, at this level, the nurse involves themselves in the patients’ situation both cognitively and emotionally which leads to a purposeful interaction in terms of nursing care. However, it is reported that nurses’ actions at this level are based on their own values and wishes and that nurses operating within a relationship at this level assumed that the patients’ values and wishes corresponded with their own.

The third and highest level of relationship reported in this study concerns the reciprocal relationship with resolved control issues. At this level, the nurse and patient form a mutual relationship where ‘this more relaxed bond was described as “closer than what is needed for basic care”’ (Ramos 1992:503). This level was seen to include an emotional and cognitive identification with the patient, much like at Level 2. However, at Level 3, it was reported to be more intense and professionally rewarding. The author acknowledges that

working at this level requires the nurse to create some emotional distance in identifying and isolating feelings. The nurses in Ramos's study identified that the outcomes of working at Level 3 were overwhelmingly positive, resulting in an easier relationship and more satisfaction. Ramos (1992:504) suggests that the nurses in her study were somehow 'professionally energised' by having experienced Level 3 relationships.

Ramos reports that most nurse–patient relationships are built through these three stages. However, given the changing nature and commercialisation of health care, achieving Level 3 relationships with patients is becoming increasingly rarer as this type of relationship takes time to develop, and it is suggested that time is often restricted. Although this is not seen as impossible, institutional constraints make it harder. The fact that Level 3 relationships are becoming less frequent has manifested itself in decreasing job satisfaction and a 'yearning' to interact with patients and their families more. These nurses perceive the Level 3 relationship as that which is most beneficial to the patient in best meeting their needs.

Where Ramos (1992) highlighted the stages of the nurse–patient relationship in terms of its levels of bonding, Lotzkar & Bottorff (2001) used an exploratory case study approach to examine the development of the nurse–patient relationship over a fixed period. The authors employed observations of interactions in a cancer treatment unit that had previously been videotaped as part of a larger study. They report using a secondary ethological analysis of the videotaped data and state that, 'Ethology is the detailed study of naturally occurring behaviours and is characterised by an inductive phase and a deductive phase' (Lotzkar & Bottorff 2001:277). One videotaped nurse–patient dyad was selected for intense study as it demonstrated a good example of the development of a relationship. The interactions between this particular nurse and patient were recorded over a three day period. The analysis of this data highlighted 60 interactions. The data were analysed using qualitative ethological methods. A focus group of five expert cancer

care nurses was then convened to determine the extent to which the findings were both meaningful and applicable to nurses working in similar settings.

Findings were reported in terms of behavioural clusters occurring on the part of both the patient and the nurse on each of the three days. Day one was reported to involve much work on both the part of the patient and nurse in getting to know one another and creating a foundation for the relationship. Also, demonstrations of the nurse's competence and negotiations concerning patient care and compliance can be seen. Day two highlighted a deepening relationship with the patient in terms of better understanding of the patient's position and sustaining the connection that had been established. The patient spent day two communicating physical distress and becoming more comfortable with the nurse. On day three, which was anticipated to be the last day the nurse would be working with the patient, many of the behaviours from day two were replicated. However, it was noted that the nurse took a more authoritative tone and approach with the patient. Both the nurse and patient were also reported to have prepared for the termination of their connection by maintaining a positive atmosphere, being open and honest about the nurse's whereabouts and discussing the conclusion of care.

An overarching observation made by the authors was the use of humour and social conversation throughout the interactions in order to provide the nurse with 'an opportunity to get to know the patient in a way that extended beyond his diagnosis' (Lotzkar & Bottorff 2001:291). They report that humour was also used to contribute to the softening of the relationship in terms of the patient's care, in resolving differences of opinion and in breaking the monotony of routine tasks. They also note that most of the observed interactions were 'dominated by issues and concerns related to immediate symptoms experienced by the patient' (Lotzkar & Bottorff 2001:291). Lotzkar & Bottorff suggest that a nurse's knowledge of interaction patterns within the nurse-patient relationship could help them better understand the complex

dynamics that occur within this relationship and may assist in making it more effective.

Factors Affecting the Nurse–Patient Relationship

Much of the literature concerning the nurse–patient relationship centres on areas other than its development. Intimacy in the nurse–patient relationship, social judgments, boundaries, empathy, the concept of partnership within the relationship, rights, responsibility and trust have all been identified.

Williams (2001) examined nurses' perceptions of intimacy within the nurse–patient relationship through the use of semi-structured interviews and diaries with 10 registered nurses. Using this qualitative approach, Williams explored four main areas: the nurses' understanding of the term intimacy, how nurses describe relationships that involve intimacy, what factors influence the level of intimacy in a positive and negative way and what nurses feel about intimacy within the nurse–patient relationship. In her 2001 paper, Williams discusses the nature of intimacy as perceived by these nurses and highlights the complexity and variety of their conceptions. The nurses in this study felt that disclosure and sharing of personal information between the nurse and the patient helped develop rapport, but the nature of the information shared differed between this sample. It is the level of disclosure that the sample reported to be significant. The level of disclosure ranged from exchanging superficial information to the sharing of 'deeply held secrets' (Williams 2001:191). Sharing personal experiences and instrumental touch were also seen as being intimate with patients. Some of the nurses in this study felt that intimacy was inappropriate in the nurse–patient relationship. These nurses viewed intimacy as characterised by closeness and emotional involvement, more applicable to personal, private relationships. This view of intimacy as inappropriate in the nurse–patient relationship relates to Menzies Lyth's (1988) work concerning the need to maintain an emotional distance as a defence against anxiety.

Maatta (2006) discusses Edith Stein's model of empathy in terms of managing the tension between closeness and distance within the nurse-patient relationship. In her review of the empathy literature, Maatta examines the work of Martin Buber who supports the view that empathy is something that cannot be achieved as a conscious act of will. She contrasts this by adding Carl Roger's belief that empathy 'is identical with dialogue and is the outcome of a cognitive act of listening' (Maatta 2006:3). The focus of Maatta's paper is the concept of empathy as advocated by Edith Stein, who offers an alternative opinion. Asserting that empathy is a lived experience, Stein suggests that one uses one's own memory to understand another's feelings by relating one's own experiences to those lived by another. As such, it is suggested that empathy is analogous to memory and imagination, which are experienced second hand. Therefore, it is advocated that we can recollect the feelings we experienced in a similar situation to those we relate to in another. However, we can never truly know what it feels like for the other person; only how we felt before and an estimation of how we might feel if we were the other person, based on our own prior experience. Using this concept, Stein suggests that there are three levels of empathy: we experience the other person as an object, we attempt to clarify and identify with their emotional state, and we release the feeling of affinity with another and enter into a period of self-recovery.

Maatta suggests that the first stage in Stein's three-stage model can be taught but that the second stage cannot. According to Maatta, the second stage of Stein's model is fundamental to managing the tension highlighted in the empathy literature between closeness and distance. As the second stage of the model is only temporary for the person empathising, it is suggested that a full understanding and acceptance of the temporary nature of this stage is beneficial. According to Maatta (2006:9), 'By referring to Stein's three levels, there is a way to go through the whole empathic process and retaining empathy without feeling submerged.' From my own experience and

reading I identify the second stage of this model to be closely related to emotional intelligence because the degree of self-awareness and ability to understand others' emotions is of paramount importance here. The concept of emotional intelligence is discussed in more depth later in this thesis.

Gallant et al. (2002) suggest that the nurse–patient relationship is viewed in today's nursing world as a partnership. However, they suggest that there is a lack of clarity as to what this entails or how it is achieved. Using concept analysis, Gallant et al. examine this concept in depth. They conclude that there are structural and procedural phenomena that are central to its development and include phases of the relationship and the roles and responsibilities of each party. In addition, they suggest that the process involved in a partnership encompasses power sharing and negotiation. As they state, 'The mere existence of the relationship does not by itself constitute a partnership' (Gallant et al. 2002:153). It is the recognition of partnership involving processes in the relationship that leads them to discuss the issue of 'power sharing' as a cornerstone of partnership. In addition, they suggest that it is negotiation within the relationship that allows for power sharing and ultimately decides the rights and responsibilities of each party within the relationship. Gallant et al. (2002) highlight the main benefit of partnership working within the nurse–patient relationship as empowerment of the patient. According to the authors, it is assumed in the nursing literature that effective partnership working within the nurse–patient relationship is professionally satisfying for the nurse.

Within the literature pertaining to the nurse–patient relationship, the issue of rights and responsibilities within the relationship is often referred to. Chapman (1980) discusses the rights and responsibilities of both parties, which is discussed in detail later. Peternelj-Taylor & Yonge (2003) discuss the nature of boundaries in the nurse–patient relationship in relation to the professional roles and responsibilities of the nurse. They suggest that, 'The ability to create and maintain treatment boundaries within the nurse-client

relationship is one of the most important competencies required by psychiatric mental health nurses' (Peternelj-Taylor & Yonge 2003:55). They acknowledge the complexity and difficulty of this competence and suggest that many factors, including familiarity, trust, 'the seductive pull of helping' and a lack of understanding of boundary theory, can threaten the nurse-patient relationship and lead to what they term 'boundary violations' (Peternelj-Taylor & Yonge 2003:55). They suggest that boundaries mark the parameters of the professional relationship.

Two stages are described in terms of boundary issues: boundary crossings where boundaries are transgressed temporarily with a return to the established limits of the relationship; and boundary violations, which are referred to as 'transgressions that are clearly harmful or exploitive' (Peternelj-Taylor & Yonge 2003:57). The authors discuss the notion of fiduciary responsibility in which the nurse takes responsibility in the relationship that is based on the trust of the patient that they will act in their best interests. This leads to the nurse-patient relationship being viewed as asymmetrical because the nurse assumes a position of power over the patient, where the patient places their trust in the nurse.

As I have mentioned through the work of Maatta, the notion of partnership is often aspired to in the nurse-patient relationship, which often brings with it an expectation of equality. This is in stark contrast to Peternelj-Taylor & Yonge (2003:57) who state, 'Regardless of whatever equalizing strategies might be used in practice, psychiatric mental health nurses simply cannot wish away their fiduciary responsibilities.'

The authors continue to highlight areas in which nurses must be alert to the possibility of boundary violations. Such areas include not being able to differentiate between the professional relationship and a social relationship; aiming to satisfy the personal needs of the nurse rather than the treatment needs of the patient; and the inappropriate sharing of personal information.

Strategies suggested by the authors to prevent boundary crossings and violations centre on the open acknowledgement of the potential for such events. They report that self-denial is commonplace when discussing boundary violations and that nurses are quick to embrace an 'us and them' scenario where it is felt that boundary violations only happen to others. They suggest that nurses are quick to judge other professionals at the expense of engaging in self-reflection and 'exploration of their own vulnerabilities' (Peternelj-Taylor & Yonge 2003:60). In addition to this lack of reflection, the authors highlight the insidious nature of boundary crossings and violations, which result in a lack of recognition by the nurse. The authors suggest that helpful strategies for addressing these problems involve self-monitoring, self-awareness, education and clinical supervision.

Peternelj-Taylor & Yonge (2003) discuss the responsibilities of the nurse in the nurse–patient relationship in terms of boundary crossing and boundary violation. In contrast to this, Olsen (1997) writes about the effect of patient responsibility on the nurse–patient relationship when the nurse views the patient as causing the clinical problem. Using a qualitative approach, Olsen interviewed 51 nurses using five clinical vignettes to examine the nurses' approaches to various hypothetical clinical situations. Three question sets were used to examine the responses: the initial emotional response to the patient; the effect of the patient history and information on the participant; and the patient's responsibility for their situation and its subsequent effect on the participant. Following qualitative content analysis of the participants' responses, Olsen concluded that many of the nurses 'believe that their sense of caring concern for patients, and thus the quality of their relationship with patients is influenced by the degree of responsibility they perceive the patient to have for the clinical situation' (Olsen 1997:521). Olsen observed that nurses sometimes purposely distinguished between those patients who they felt they would have a positive connection with and those whom they felt were responsible for their situation. However, they did sometimes go beyond blaming the patient and a more subtle approach was used whereby the

participants tried to formulate excuses for the behaviour in an attempt to achieve a positive perspective on the patient. Olsen suggests, though, that both approaches, i.e. mitigation and distancing, 'contain the ethically erroneous underlying assumption that patients with less responsibility deserve more care' (Olsen 1997:521). Olsen suggests that the act of mitigating serves to make the patient feel unable to discuss the real issues surrounding their behaviour, and it is suggested that when patients are unable to discuss feelings of guilt, shame and responsibility for their behaviour, these feelings will be exacerbated. In addition, the behaviour that led them to their clinical situation will not be addressed adequately.

Johnson & Webb (1995) draw on the seminal work by Stockwell (1983) and Kelly & May (1982) concerning the unpopular patient. However, Johnson & Webb (1995) suggest that the evaluative labels attached to patients are not as predictable as suggested by Stockwell and Kelly & May. They suggest that it is more social judgments by nurses towards patients that affect the nurse-patient relationship. In their qualitative study, they used participant observation 'to discover something of the moral climate in which nurses work on one medical ward' (Johnson & Webb 1995:466). Focussing on situations in which nurses were confronted with difficult moral choices, it became clear that some patients were judged by the nurses and categorised as popular or unpopular. Staff in this study demonstrated judgments about patients based on their perceived social worth. The authors note that these judgments are based on social constructs in relation to 'a complex web of powerful social influences', rather than traits that patients do, or do not, possess (Johnson & Webb 1995:471). This is in contrast to previous studies where it is suggested that nurses attach evaluative labels to patients according to personal biographical details.

I suggest that nurses working in prison may well be using the complex web of powerful social influences to locate the prisoner patient rather than the personal biographical details suggested elsewhere. This is in alignment with

findings in previous work (Walsh 1998) in which prison nurses sometimes felt that it was not the person who affected the relationship but the nature of their offence. Social judgments about offending behaviour rather than judgments about the prisoner patient's personal/biographical situation appear to be more important. Johnson & Webb (1995) continue to suggest that the labelling of patients by nurses causes intense guilt for the nurse, 'especially when they feel they are modelling lower standards than they would wish to maintain', but they conclude that, 'With better recognition of the emotionally charged nature of nursing work, we might begin to employ more constructive strategies for managing social relations in nursing' (Johnson & Webb 1995:474).

The Forensic Nurse–Patient Relationship

A study by Martin & Street (2003) attempted to examine the nurse–patient relationship in an acute forensic setting. By using interviews and examination of nursing records, Martin & Street note that the therapeutic relationship described by nurses was different to that documented in the patient records. They suggest that nurses in this study adopted a custodial orientation to their record keeping. Their documentation practices highlighted the commonality of recording snapshots that highlighted the nurses' perspectives of the patients. They also report that nurses' documentation was very impersonal and 'rendered invisible the nurse–patient interactions' (Martin & Street 2003:547). This impersonal nature resonates strongly with the seminal work of Menzies Lyth in the 1960s concerning the detachment of nurses as a defence mechanism against anxiety. Menzies Lyth's work is discussed in more detail later in this thesis.

Interestingly, the nature of forensic nursing implies the need for the nurse to work with the patients in addressing their offending behaviour. The nurses in this study reported 'a social awkwardness and constructed the relationship with patients as a fragile process that could be damaged by exploring

offence issues' (Martin & Street 2003:548). It is also reported that nurses in this study also felt that the nurses' thinking and approach could be tainted by considering the patient's offence. However, one participant reported that nurses 'could become judgmental and impose their moral and value standards on patients, Martin & Street 2003:548). Walsh (1998) found that nurses working in the prison setting often avoided thinking about the offence of their patient so as not to be judgmental. This, I suggest, is a coping mechanism when dealing with patients who have committed disturbing crimes.

In their discussion of the care custody tensions in forensic nursing, Martin & Street (2003) mention the nature of the term custodial as having two connotations. Firstly, there is the custodial role of nurses related to security practices. The second they suggest refers to the 'cultural approach to patient care that can be considered as incompatible with therapeutic care' (Martin & Street 2003:548). They contend that care and custody can coexist but are unclear as to the extent to which the forensic nurses in this study practice in a therapeutic as opposed to a custodial manner.

In their study of forensic nurses' objectivity and discursive practices, Mercer et al. (2000) interviewed 30 staff working in a high secure hospital. Interviews were conducted on an individual basis and were centred on the discussion of six brief case scenarios, based on actual forensic patients. Participants were asked for their general impressions and theoretical perspectives on the cases, to put forward suggestions for a plan of care, and to discuss their thoughts on the likely outcome and prognosis.

The authors found that the concept of evil persists amongst forensic nursing narratives. Evil was applied to those cases where the behaviour was seen to be calculated, rational, planned and/or repeated. Evil was deemed to be beyond the reach of the therapeutic intervention. The nurses viewed the intentionality behind the criminal act as mediated by intelligence and choice.

Mercer et al. (2000) suggest that the concept of free will was linked by the nurses to the 'absence of moral bounds and restraint' (Mercer et al. 2000:199). The nurses in this study did demonstrate some distinctions concerning their labelling. If the attribution of mental illness prevented the patient from being labelled as evil, 'personality disorder was seen to signify a propensity for evil' (Mercer et al. 2000:20). Where the case studies contained clues to mental illness, the nurses felt that this offered some vindication for offences. This is congruent with the findings of Olsen (1997) discussed earlier in terms of his suggestion that nurses often try to provide mitigation for behaviour in order to foster a positive connection.

Unfortunately, Mercer et al. do not continue to discuss the implications that these perspectives may have on the care and treatment of the secure hospital patient; rather, they report that this is the focus of their current work. One can only surmise how the care and treatment of this patient group may be affected by the feelings of the nurse.

Hellzen et al. (1999) examined carers' experiences of caring for patients acting in a disturbing manner. The setting for this study was a special unit for disturbed psychiatric patients and the authors utilised narrative interviews concerning one particular patient with 15 of the 19 nursing staff working in the unit. From analysis of the interviews, the authors concluded that carers in this setting experienced a sense of losing control and powerlessness when caring for this disturbed patient, which manifested itself in feelings of hopelessness and despondency leading to questions about their future. Participants also experienced a tension between their image of the patient as 'a nice person, a person for whom they felt compassion, and a "bastard" or a "devil" they hated' (Hellzen et al. 1999:658). They indicated that the patient was only viewed positively when he was passive, but their feelings of lack of control led them to feel subjugated. These feelings were reported to have been exacerbated by a sense of being forgotten by their nursing and medical colleagues in other parts of the hospital. Staff in this study stressed the

importance of talking about their feelings with their colleagues who shared in their experiences as they felt they needed 'a safety valve in order to endure the situation' (Hellzen et al. 1999:659). Adding to existing feelings of anguish, staff noted that the dissonance between the ideal care they wanted to provide and the effect of insults and humiliation of staff by the patient on the care they felt they actually provided, led them to become aware of 'the darker side of their own personality', leading to further despair. It is reported that the patient's 'dark' side raised a similar response in the carers, which they felt 'they did not recognise in themselves and which made them afraid of themselves' (Hellzen et al. 1999:659). This study highlights the plight of nurses trying to care for a patient who 'rewarded them with unfriendly, humiliating, violent and dangerous actions when they tried to maintain his dignity' (Hellzen et al. 1999:659). A prolonged exposure to this reaction to caring left the nurses with a sense of loneliness and of being misunderstood and ultimately an ambivalent view of the patient, resulting in the staff seeking support from one another. It was felt that this led the staff to 'focus on their own being instead of on the nursing care' (Hellzen 1999:659). The findings of this study can be related to the experiences of prison nurses caring for disturbed prisoners, both with psychiatric illness and without, as the authors describe the situation of caring for a patient who, unlike in a more typical nurse-patient relationship, does not want to be cared for.

This study has significant resonance for me in my own position working with prisoners. As I worked mainly with the non-mentally ill, I was rarely confronted with aggression and difficulty as a result of mental illness. However, I was confronted frequently with angry, aggressive men who did not appear to appreciate my colleagues' actions or mine, leading me to question quite why I was bothering to care. This experience, on an almost daily basis, led to strong bonds being made amongst the ward team which I can now see were our coping mechanism. Upon reflection, I feel that over time, for me, there was a shift in my focus from providing nursing care to

becoming preoccupied with my own being and ensuring my professional safety.

In her paper concerning individuals with dangerous and severe personality disorder (DSPD), Glen (2005) discusses the moral responsibility of the person with the disorder and the way in which psychiatric nurses work with this group in understanding the unpleasant things some of their clients do. She discusses the philosopher Kant and quotes his absolute insistence that 'human beings are solely responsible and accountable for what they do' (Glen 2005:99). Glen suggests that DSPD be regarded as a 'moral category, framed in terms of goodness, badness and other ethical concepts' (Glen 2005:99). It is this reframing of the DSPD label that Glen suggests will enable practitioners with an understanding of moral philosophy to be better able to deal with this client group. Interestingly, Glen discusses the concept of DSPD in terms of personality, emotional colour blindness and even madness and concludes that many come to the conclusion that those with DSPD are plain wicked. However, it is this confrontation of the term 'wicked' that leads psychiatric nurses to a new understanding of the concept of DSPD framed in moral philosophy. She espouses a pragmatic approach to dealing with clients labelled with DSPD. Although Glen's paper does not suggest any specific solution to dealing with the personality disordered patient, links can be made from her paper to those patients in the prison population. By this, I do not mean solely those with DSPD but also other prisoner patients who may exhibit similar behaviour. For example, Bowers et al. (2000:12) cite Noak 1995 who suggests that, 'The main threat to the nurse-patient relationship comes from the manipulative, rule breaking, boundary pushing behaviour of personality disordered patients.' I suggest that this behaviour is not specific to patients with personality disorder.

Although this section of the thesis is concerned with the nurse-patient relationship in the forensic setting, there are many parallels that can be drawn with the prison health care setting, not least the fact that both

environments are predominately locked environments. In a study of 20 registered nurses and 20 mental health care assistants working on seven Swedish psychiatric wards, all of which had locked entrance doors, Haglund et al. (2006) examined the staff perception of the effect on both staff and patients by asking for their thoughts on the advantages and disadvantages of locked doors in psychiatry. Although the setting for this study examines having locked doors to psychiatric wards, I feel it is important to reflect on the findings of this study to consider how the locked environment of the prison may impact on both staff and prisoner patients with regard to the nurse-patient relationship. Most advantages mentioned by nurses and nurse assistants involved the concept of locked doors providing a more controlled environment providing patients with security, safety and efficient care, with protection from the outside world. Other advantages centre on the sense of relief of relatives and significant others in knowing that the patient is safe and unable to abscond. From an administrative viewpoint, staff noted that having a locked door and more control resulted in the need for less staff. The disadvantages of having a locked environment were reported in terms of the negative effect on patients by making them feel confined and more dependent. The nurse assistants mentioned that having the locked door caused extra work for staff and emotional problems for the patients, leading to frustration and resistance to treatment. The authors also noted the negative effect that this environment had on the staff's situation. These were reported to be the extra work and extra effort (although they do not state why there is extra effort or what form this took), having a dual role as a nurse and a 'guard', being emotionally effected and feeling locked in.

This study highlighted more disadvantages than advantages to having a locked environment, but it is not clear from the paper exactly what contribution this knowledge makes to practice apart from providing an opportunity for staff working in locked environments to reflect on the effect of a locked door on staff, visitors and patients. In relation to the prison setting, I suggest that the findings from Haglund et al. (2006) provide such an

opportunity to reflect not just on how a locked entrance door affects care but on how a locked exit and a totally locked environment (e.g. cells, treatment rooms, areas within the prison) affect both nursing staff and prisoner patients. I suggest that the effects demonstrated by Haglund et al. (2006) may indeed be exacerbated in the prison setting (given the higher level of security) and, given the effect on staff, the use of clinical supervision to provide support and insight for staff is highly appropriate.

The Nurse–Patient Prisoner Relationship

When working in a large male adult prison, I was often asked, 'how can you care for people who have murdered and raped people?' My answer was to explain that I often knew what my patients had done but that I did not feel I was there to judge them further, just to provide nursing care. Prisoners who have committed crimes 'look' like anybody else and were not committing the crime whilst I was treating them, so I ignored their offence which enabled me to care effectively. Naturally, if they were assessed as a danger to me then I would be cautious and, subsequently, my nursing care may have been affected by this. However, I do believe that by not thinking about their crime I was able to see them as patients and provide care. Ignoring their criminal past was my own coping mechanism.

In trying to articulate the meaning of caring for prisoners in the custodial environment where the overriding philosophy is one of security, Maeve & Vaughn (2001) suggest that the prison nurse adopts an 'ethical' approach to caring as opposed to 'natural' caring. This ethical approach has been referred to in part by Mercer et al. (2000), Glen (2005) and Olsen (1997) in terms of the way in which nurses approach patients who are perceived as evil, who have DSPD or who have some mitigation for their actions. A more moral, ethical approach to caring is afforded in this setting. This can be seen through examination and reflection on the nurse–patient relationship in prison.

The nurse–patient relationship in a prison setting is one where it is felt that boundaries are vital. As Norman & Parrish (2002:15) state, ‘Many of the clients with whom prison nurses work may present specific challenges with regard to manipulative behaviours that can be designed to compromise and undermine the essence of nursing care.’ This is supported by Schafer (1997:205) in her paper concerning boundary violations in the correctional setting. She states that ‘Correctional nurses encounter an environment where their clients employ manipulative and intimidating behaviours, and personal safety may be threatened. Hence, the correctional culture, coupled with a history of oppression, creates an atmosphere ripe for the potential to exploit and be exploited.’ It can be seen here that it may be difficult for a nurse to provide ‘natural’ care and it appears that the way in which nurses approach ‘difficult’ patients seems to be more ‘ethical’.

Briant & Freshwater (1998) discuss the nurse–patient relationship in terms of boundaries. Drawing on the work of Klein (1987), they assert three ways in which boundaries can be expressed: in physical terms, in social terms and in psychological terms. In the prison setting, physical boundaries between the nurse and the prisoner patient are clear to see because there are gates, locked doors and cells. The social boundaries are also written into the underlying culture of the prison on the part of both the prisoner patient and the nurse. The prisoner patient culture draws on the culture of the prisoner world, in which compliance with staff can sometime be viewed as undesirable; and the nurse operates within the constraints of the prison staff world in which the maintenance of security, both institutional and personal, are paramount. It is the psychological boundaries that, if poorly understood by the nurse and patient, will result in an increased risk of boundary violation. They suggest that this ‘often happens without the nurse being aware of when, where and how these transgressions have occurred’ (Briant & Freshwater 1998:204). This resonates with me in terms of the warnings to

staff about their risk of conditioning by prisoners, both as patients and as prisoners.

Briant & Freshwater (1998) continue to suggest that, although the nurse–patient relationship may not be equal due to the power and control imbalance, it can be mutual where mutuality implies a relationship based on what they term the ‘I–thou attitude’, rather than the ‘I–it’ attitude. It is suggested that the ‘I–thou’ attitude to the nurse–patient relationship results in an alliance with the patient in which the patient is empowered. It is suggested by Briant & Freshwater (1998) that to engender mutuality in a nurse–patient relationship the revealing of humaneness on the part of both the patient and the nurse is important but difficult. I suggest that this is especially so in the prison setting given the perception of prisoners by many staff and the general culture of the prison world which has a dehumanising effect on prisoner patients.

Chapman (1980) suggests that both the nurse and the patient have rights and responsibilities within the nurse–patient relationship. It is mentioned that the nurse has the right to co-operation, gratitude, recognition and a happy environment. The patient has a right to receive skilled nursing care, individual recognition and information. The responsibilities of the nurse are to provide skilled, individualised, non-judgmental care, to promote health, to alleviate suffering, to prevent illness and to restore health. The patient too has responsibilities: to co-operate, to recognise the nurse as an individual and to be grateful and open in communication. It is suggested that being open in communication implies that trust exists within the nurse–patient relationship. Johns (1996) in her concept analysis of trust highlights the importance of this notion in the nurse–patient relationship. She refers to it as ‘a necessary element in establishing a connected relationship between nurse and patient’ (Johns 1996:77).

If each of the rights and responsibilities is examined within the context of the prisoner patient–nurse relationship, it can be demonstrated that, due to the security element of the prison nurse's job and the nature of the environment, not all rights and responsibilities can be met by both parties. For example, if a prisoner patient prefers to be located in the hospital wing of the prison, it will sometimes be in the patient's interest not to co-operate with the health care advice given by the nurse if taking the advice means the prisoner patient will recover and be moved from the health care centre to the main prison. This pursuit of illness for secondary gain is discussed in detail by Davidhizar (1994) in which she defines it as, 'The advantage that occurs secondary to stated or real symptoms of illness. In this phenomenon, symptoms of illness are used to solicit care from others, for release from responsibility, and for attention from others' (Davidhizar 1994:10). I suggest that, in prison, the secondary gain can be seen in terms of an often more pleasant environment in the health care centre and one in which it is more preferable to spend time.

I nursed many prisoners who were keen to come into the health care centre or, indeed, who were unwilling to leave. On many occasions, my professional judgment was tested as I was faced with prisoner patients attempting to remain or indeed enter health care. At the time, I was working in a small unit where prisoner patients were unlocked for the majority of the day, had unlimited access to showers and telephones, and where the staff were predominately female nurses. In addition to the environment, the health care centre was, for some, a place of sanctuary away from fellow prisoners to whom they were in debt or away from threats of violence and bullying. The difficulty I faced on an almost daily basis was distinguishing the genuinely ill from those feigning illness or exaggerating illness for secondary gain. Indeed, if the underlying reason for relocation to health care was due to fear for personal safety, I question whether this in itself was cause enough to provide psychological care which, in some way, validated transfer in order to

receive care. This was not a view held by many of my colleagues and therefore caused tension for me.

Another example is the trust that Chapman suggests should be inherent in a nurse–patient relationship. A prisoner patient wanting to abuse painkillers will have to pretend to be in pain to elicit the painkillers from the doctor and then from the nurse. It will be the nurse and doctor who have to decide if the patient is telling the truth about the extent and severity of their pain. In unpublished material, Walsh (1998) found that mistrust of prisoner patients is common in prison health care and that nurses find they have to rely heavily on their experience and intuition when dealing with prisoner patients. Burrow (1993) states that this is a common problem in nursing in secure environments and comments that, ‘The forensic nurse must exercise a benign scepticism. This is not to say that a patient’s wishes are not to be entertained but that an awareness should exist that they may be actively exploited to undermine the integrity of security procedures and gain some personal advantage’ (Burrow 1993:23).

It is not suggested that this issue is unique to prison nurses because there are many nurses working in other secure environments where they have an important contribution to make in terms of security. However, prison is the only secure environment in which nurses work where health is not the primary focus. Special hospitals such as Broadmoor and regional secure units also have security as an important part of the nurse’s role. However, *secure health provision* is the main focus because all their clients are patients, whereas the prison nurse deals with all aspects of the prisoners’ lives and not just when they are an inpatient.

I feel some degree of resonance here with the work of Peternelj-Taylor & Yonge (2003) in which the discussion of the notion of fiduciary responsibility takes prominence. For me, this concept, which suggests that the patient trusts the nurse to act in their best interests, does not hold totally true in the

prison setting as there have been times when I felt that I was unable to act in the patients' best interests given the constraints within which I was working. Indeed, as mentioned earlier, one of my first difficult experiences working in prison health care concerned my having to lock an upset and crying prisoner patient into his cell with five other prisoners during the lunchtime. I had no option as the security of the prison required it, but I did not feel it was in his best interests. I felt the prisoner needed time to talk with me, or other staff. He needed time to drink tea, smoke a cigarette and sit down, away from the prying eyes of other prisoners, in a supportive environment. I may be wrong; he may well have been cared for by his fellow prisoners during lunch but personally, at the time, I felt it was not in his best interests to be locked up. Therefore, although I appreciate that the concept of fiduciary responsibility is central to the work of nurses outside the prison environment, I suggest that it is not true to the same extent in prison.

Chapman (1980) also speaks of the right of the patient to receive information. In the prison setting, the amount of information provided to the prisoner patient is sometimes limited, given the security needs of the prison. For example, the details of appointments outside of the prison, which necessitate prison officer escorts to local hospitals, are kept from the prisoner patient. Indeed, if the prisoner patient becomes aware of the appointment details, the appointment is changed. Obviously there are occasions when the prisoner patient may need to be nil by mouth prior to an appointment, or have some different medication in preparation for it, hence it would be difficult. However, the exact details of the appointment would be kept from the individual.

I sometimes felt this situation was very difficult to deal with. There were times when the prisoner patient was anxious or worried about an impending procedure in an outside hospital or, indeed, was concerned that he was actually going to be having an appointment with a consultant or surgeon. Allaying these fears and anxieties would have been easier if I could have told

the prisoner patient what was happening with regards to appointments. This, of course, was not possible.

I have discovered two major empirical studies that address the issue of the nurse–prisoner patient relationship. One, by Weiskopf (2005), addresses nurses' experiences of caring for inmate patients in the USA and the second, by Holmes and Federman (2003), that aims to describe the practice of nursing in the Canadian correctional setting. Work by Holmes has already been subject to review in this thesis (see Holmes 2002), but the paper by Holmes & Federman (2003), although reporting on the same study, provides a different focus.

Weiskopf (2005) used a phenomenological approach to her study in which she carried out in-depth interviews with a volunteer sample of nine registered nurses who had been employed in a variety of correctional institutions throughout their careers. These institutions included remand prisons, juvenile prisons, young offender facilities, female and male prisons, and high security and low security establishments. Only one of the interviews was conducted via the telephone whilst the others were face to face and tape-recorded. Phenomenological analysis was employed with the goal of constructing 'a vivid depiction of the experience of the nurse working with inmate patients' (Weiskopf 2005:338). The author describes four core elements that guided her inquiry: bracketing, intuiting, analysing and describing. Although I have undertaken very similar work myself and attempted phenomenology, I feel that the concept of bracketing is impossible. My philosophical stance on person-centred research deems the involvement of the researcher as important and unavoidable. This will be discussed in more detail in the methods section of this thesis.

Weiskopf (2005:339) suggests that the findings of her study indicate that nurses experienced caring as 'an attempt to negotiate the boundaries between the cultures of caring and custody'. She refers to complex

challenges, numerous frustrations and substantial limitations placed on the nurse–patient relationship. In addition, it was not only the nurse–patient relationship that was often difficult, but also the relationship with correctional officers. Weiskopf suggests that it is the boundaries, which are so central to the environment, that caused the greatest frustration for the nurses in trying to develop a professional relationship with inmates. It was reported that the relationship between custodial staff and nursing staff had a big impact on the success of the nurse–patient relationship. As in the study by Drees (1994), working alongside custodial staff with a positive approach to health care means that health care staff are afforded the opportunity of establishing health care priorities. Not being able to touch patients or disclose any personal information were cited as causing much regret amongst nursing staff. Given that these actions are seen as important aspects of nursing, the frustration felt is understandable.

Nurses in this study also reported the difficulty they had in developing a caring environment, given that the prisoner was not in prison for the good of their health and also given the negative attitude of some fellow nursing colleagues. However, all nurses suggested that they looked beyond the prisoners' past behaviour in order to care for them, which they felt took patience and perseverance. They recognised that putting aside an inmate's custodial history was one of the most difficult challenges they faced. However, they all described caring as accepting prisoner patients as human beings, showing respect, being non-judgmental, acknowledging their suffering and showing compassion.

Weiskopf identifies that it is the custodial boundaries that inhibit the nurses' free expressions of caring in the prison setting and that it is this barrier which has the most profound effect on the nurse–patient relationship. Weiskopf states that, 'No other health care setting imposes such a devastating impact on nurse–patient relationships' (Weiskopf 2005:341).

If the work of Weiskopf and indeed my own reflections on practice are considered in terms of the development of the nurse–patient relationship, I think it is likely that the nurse–patient relationship in prison probably reaches what Ramos (1992) suggests are Level 1 (instrumental) and possibly Level 2 to some degree (protective level with an emotional component). I think that reaching Level 3, i.e. the reciprocal relationship with resolved control issues, is unlikely and, indeed, could cause concern for security.

Holmes & Federman (2003) entitle their paper 'Constructing Monsters: Correctional Discourse and Nursing Practice'. The title alone, I feel, highlights by itself the impact of discourse on prison nursing practice. The research described in their paper aims to describe nursing practice in an environment where 'social control and psychiatric care are inextricably linked with one another' (Holmes & Federman 2003:942). This study has been reported earlier in this review (Holmes 2002) where the author addressed the issues of governmentality, power and correctional practice. In this paper (Holmes & Federman 2003), the same research study is reported but this time in terms of the effects of representation transformation and the effects of the security environment of nursing practice.

Holmes & Federman (2003) highlight the importance of discourse in shaping nursing practice within the prison setting. They suggest that the representations, discourses and practices of individuals (based on their own perceptions of inmates), correctional officers and the official discourse of the Correctional Service of Canada, cannot be disassociated from one another and, as such, impact greatly on the practice of nurses in this setting. An example they give of an issue to which all three sources of influence refer is that of keeping a professional distance from inmates. They suggest that, given the characteristics commonly attributed to prisoners such as manipulating, telling lies and being dangerous, it is this perception in addition to the dominant discourses which are 'superimposed on the nurses' common theoretical representation that a patient is a person to whom care is provided'

(Holmes & Federman 2003:945). It is the understanding of the impact of discourses, representations and common practices within the prison culture that enable the authors to present a concise and important contribution to the body of literature pertaining to prison nursing. Holmes and Federman continue to examine the literature surrounding monstrosity as a framework on which to base their discussion.

The testimonies of nurses and officers interviewed in their study illustrate that nurses' perceptions of the patient and the care they provide are 'transformed within the penal system' (Holmes and Federman 2003:946). They suggest that this transformation takes place as a result of what they term the 'conformation process' to the prison culture and norms. I suggest that a more appropriate term would be socialisation. It is reported that this socialisation process was regarded by some of the respondents as a 'moral contamination' while others saw the readjustment of the perception of inmates and nursing care as necessary to ensure safety. The authors report that the nurses' perception of prisoners as being potentially dangerous and manipulative occurred as a direct consequence of their socialisation, given the fact that newly appointed nurses did not initially have this perception.

Holmes and Federman (2003:946) suggest that, 'All staff members share certain representations, even though they adhere to different ideologies.' They note that assimilation into the dominant ideology is predominately achieved through the use of prejudice and stereotyping. From the work of Holmes and Federman, the development and establishment of the nurse–prisoner patient relationship can be seen to be influenced by the dominant discourses of the prison, as well as by the socialisation of the nurse into the prison culture. Where the dominant discourses and culture do not meet with the ideology of nursing, but where the nurse has the same representations of prisoners as officers, the difficulty in establishing a nurse–patient relationship such as that beyond the prison can be seen to be challenging. As Martin (2001:28) highlights, 'Too often nurses permit personal beliefs, fears,

stereotypes of patients to prevent the development of relationships.' This, coupled with the prison culture and the need to maintain professional distance, impacts significantly on the nurse–patient relationship in prison. In terms of professional distance, Holmes and Federman suggest that a process of dehumanisation occurs in prison. Prisoners are marginalised, which serves 'as a pretext for verbal catharsis from the dominant group' (Holmes & Federman 2003:949). They conclude that the dehumanisation of prisoners makes it easier for staff to distance themselves. One nurse in their study admitted that 'one has to overlook the human side of it', (Holmes & Federman 2003:949). The authors suggest that, as a result, nursing practice is less conflicting if prisoners are stripped of their humanity.

As I mentioned earlier, in my experience, dehumanisation occurs immediately the prisoner enters the prison. The reception process involves strip-searching, showering, the replacement of personal clothes with a prison uniform and the allocation of a number. Once the prisoners have completed this ritual, they see the nurse and/or doctor for a health screen. It was at this point where I felt compassion for many of the prisoners I saw. Despite their crime, I considered how traumatic it must be to have spent the day in court, ended up in prison, often with no idea what awaits. The thought of sharing a cell with another prisoner (and let's not forget that many individuals have only negative media representations of prisoners upon which to base their expectations) whilst feeling devastated at their situation must be a psychologically difficult place to be. I felt that the sanctuary of the medical room was an important place to help allay fears and anxieties whilst addressing pressing medical issues. As a consequence, there were occasions where I had to spend some considerable time reassuring and calming new prisoners. I often felt that although officers understood the need for reassurance for new prisoners they were anxious to keep the busy reception process moving which, at times, caused me to feel conflict between wanting to spend time with the prisoner and not wanting to delay the reception process and annoy my prison officer colleagues.

Holmes and Federman (2003:949) suggest that ideological distancing from an individual 'allows for the neutralisation of spontaneous emotions that normally draw the caregiver and the patient closer together'. They refer to this as 'objectification'. They report that, from their experience, nurses working in prison adopt a representation of inmates which characterises them as delinquents first and mentally ill second, which thus enables them to 'ward off emotions that may surge in the presence of an inmate, that is, a patient, and thus a person' (Holmes and Federman 2003:949). They suggest that it is easier for a prison nurse to modify their representation of prisoner patients than it is to modify their own behaviour.

Another impact on the nurse–patient relationship in prison as recognised by Holmes and Federman (2003) is the nurses' role and status as both carers and employees of the correctional service. Coupled with the influence of the role and status of the prisoner, these perceptions of the nurse by the prisoner and the prisoner by the nurse have a huge impact on the nature of the trust within the nurse–patient relationship. However, the authors do report nurses surreptitiously trying to decrease the distance between themselves and prisoner patients by touching inmates as a sign of support or by joking with prisoners.

Interestingly, Holmes and Federman (2003) refer to nurses in their study 'reconstructing' care in order to minimise the cognitive dissonance they felt when having to act as both carer and custodian. This strategy was reported to take many forms and was often undertaken without the knowledge of colleagues. As they state, 'They were surreptitiously "reconstructing" the care they provided, in order to regain some of the dimensions inherent in their nursing training and their previous work experiences' (Holmes & Federman 2003:957).

To ensure a good understanding of the context in which prison nurses are working and the culture into which they are socialised, the literature related to the practice of the prison officer is examined in the next section.

Prison Officer Culture and Role

When examining a system in which nurses are practising, where the dominant philosophy is that of the discipline staff, it is important to understand how that system has developed from its beginnings. Although it has previously been identified that prison health care has developed gradually over the last couple of centuries, with some of the problems raised during its early development still causing concern today, it has evolved as part of a wider institution: the Prison Service. The history of the Prison Service has already been discussed so what follows is the recent history of the service as it has affected prison officers and those working within the system.

The development of this service has been witnessed and experienced both internally by prison staff and politicians, and externally by the media and, ultimately, society at large. Criminal justice developments and the state of the prison system have traditionally been seen as important factors by Government and by wider society. Politicians often utilise the public demand for effective and efficient custodial services when formulating popular policy. To this end, it is felt that the impact on society of the development of criminal justice and more importantly prison services should be addressed. Nurses who have not worked in prison before will come to the system with many preconceptions and attitudes fuelled not only by their own value and belief systems but also by what they have witnessed in the media and in society.

If one can understand how the media and society have portrayed prison services over the last 30 years, assumptions and conclusions could possibly be drawn to explain why prison health care staff may have some of the ideas

about punishment and imprisonment that they demonstrate. These ideas may go on to have an impact on the way in which the prison health care workers approach their practice and ultimately the way in which they care for their patients. Holmes and Federman (2003:947) recognise the impact of the media on the perception of prisoners by nurses, stating, 'It is thus by feeding off popular fiction in novels or movies that a novice's imagination, to which institutional and nursing discourses contribute, exaggerates the "nature" of the prisoner.'

Having been interested in the way in which prisons are portrayed in popular literature, I departed from the more traditional academic work I felt I was expected to study and engaged in watching films such as 'The Green Mile', 'The Shawshank Redemption', 'Dead Man Walking' and 'Porridge'. I have also read many books written by ex-prisoners about their experiences in prison such as Norman Parker's 'Parkhurst Tales' (Parker 1994); Razor Smith's 'A Few Kind Words and a Loaded Gun' (Smith 2004); and for contrast I immersed myself in the writings of ex-prisoners who had been imprisoned in some of the worst conditions in foreign prisons (see Fellows 1998 and Gregory 2002). Clearly, I read and watched these works from the perspective of one who has worked in prison, and in reading the books written by ex-prisoners I felt there was some degree of sensationalisation, possibly in order to sell the books. This I recognise could be my natural suspicion of prisoners and their stories, socialised into me through my own experiences, or indeed their works could have been sensationalist. Whatever the case, through talking with friends, colleagues, family and others, I can see where the perceptions of prison life and prisoners are formed and thus how the perceptions of nurses new to prison practice are influenced.

Reflecting on my own practice as a prison nurse enables me to examine where my attitudes and beliefs about prison as a concept and prisoners as patients have been shaped. Being brought up in a house where my mother is a nurse and my father a prison officer exposed me to their ideas and beliefs

about patients and prisoners. Their beliefs, I suspect, were shaped in part by their parents but also their working experiences in both fields of work. Added to my exposure to my parents' professions are my experiences of being educated in a catholic boarding school. Quite to what extent these have shaped my beliefs and attitudes is difficult to articulate, but it would be untrue to say they have not affected me at all. This is highlighted in Alvesson (2002) citing Denzin & Lincoln (1994:12) who state that, 'Any gaze is filtered through the lenses of language, gender, social class, race and ethnicity. There are no objective observations, only observations situated in the worlds of the observed and the observer.'

As can be seen from earlier discussion, during the 1970s and 1980s the prison population began to rise with resultant overcrowding and prisoner unrest. In the 1970s, prisoner unrest resulted in rooftop demonstrations at Chelmsford and Parkhurst prisons and a major riot at Hull prison in 1976. The 1980s saw a further escalation of prisoner unrest and disturbances culminating in the riot at Manchester prison, known as Strangeways. During the 1980s, prisoner numbers rose by 7,000 inmates. The rise in the prison population resulted in more overcrowding and no increase in staff resources. Not only were prisoners restless but industrial relations between staff and the Home Office were also becoming strained. Black (1992), in his commentary regarding the privatisation of some prison establishments, suggests that during the 1980s and 1990s the Prison Service suffered from four main problems: under-resourcing, negative public image, bureaucracy and poor working conditions for both staff and inmates. According to Black (1992), the growing industrial relations crisis at the time was symptomatic of a growing penal crisis.

Liebling & Price (2001), in their book 'The Prison Officer', dedicate a whole chapter to the development and modernisation of the Prison Service and suggest that the current emphasis on modernising the service has its origins in the early 1980s following 'The May Report' published by the Home Office

in 1979. Pressures to modernise the service were both internal and external and were bound in practical problems of budget management and the philosophical concern of the nature of prisons and the role of prison officers. The role of the prison officer was traditionally based on the 19th century paramilitary model, which was seen to be no longer appropriate. Severe recession in the 1970s and the new Conservative government in 1979 promoted 'new right' philosophies that equated to strong ideas of efficiency and greater management control in the public sector, which in turn influenced the Prison Service. According to Carlen (2002:29), 'A determination to discipline the public service sector was central to the ideologies and strategies of governance favoured by the Conservative governments of the 1980s and 1990s.'

Added to the industrial and prisoner unrest reported in the 1970s, prison costs were rising, staff overtime was out of control and governors' accountability was increased. A more senior ranking officer, the chief officer, traditionally managed basic grade officers. However, in this new philosophical climate, it was perceived that officers were not being managed properly and should be overseen by governors. In 1987/1988, an initiative known as Fresh Start was introduced into the service to address the issues of excessive and costly overtime and to introduce new management practices in line with the philosophy of the moment. Carlen (2002) suggests that this initiative was introduced to decrease the power of the Prison Officers Association, the prison officers' trade union. Although Fresh Start abolished overtime and salaries were increased, the resultant changes concerning the management of officers were huge. Fresh Start promised a more efficient system of line management, clearer lines of responsibility and accountability but most notably, abolished the rank of chief officer, which was merged with governor grades. This resulted in prison officers feeling as though they had no 'champion' or leader on their side. In addition to this, the more junior governor grades were not adept at managing these changes as well as the changes to their own roles.

Prison Officer–Prisoner Relationship

According to Thomas (1972) the main role of the prison officer is primarily the maintenance of safe custody. For officers as for nurses working in prison there is reference in the literature to the sometimes manipulative nature of the prisoner group (Cornelius 1992; Walsh 1998; Finn 2000). Cornelius (1992), in his discussion of inmate culture, mentions that prisoners undergo what is termed 'prisonization', a term developed by Clemmer (1940) cited by Hemmens & Marquart (2000). This term explains how prisoners become assimilated into the informal structure of the prison. It is suggested by Cornelius (1992) that part of the inmate prison culture dictates survival and one way to survive is to manipulate the staff who control the environment. This clearly has implications for the forming and sustaining of professional relationships, whether nurse–patient or prisoner–prison officer. However, I suggest that it is not only prisoners who undergo the process of prisonization. Staff working with prisoners, both officers and nurses, must also undergo prisonization in which they assimilate themselves into the staff culture. The effect of prisonization on the staff, i.e. attitudes towards particular prisoners, cultural practices, etc., will also have an impact on the way in which they foster and maintain professional relationships with prisoners.

However, in a study by Liebling & Price (1999:20), it is noted that, 'Prisoners felt entitled, by the fact of their imprisonment, to feel frustrated, disgruntled and aggressive.' This could infer that prisoners may be more liable to becoming aggressive or difficult to manage in terms of behaviour and compliance with regimes, thus making the job of the prison officer more challenging.

The study by Liebling & Price (1999) examined how the relationship between prison officer and prisoner is established and how it operates. Given the

position of prison nurses in the prison setting as they undertake security and prison officer roles, it is reasonable to surmise that the findings from Liebling & Price's work will, to some extent, also provide insight into the building and maintaining of nurse–prisoner patient relationships. The study was mainly conducted in a dispersal (high security) prison. The researchers utilised a qualitative approach to the research and used non-participant observation, shadowing, attendance at formal aspects of prison life such as adjudication hearings and wing boards, collection of institutional information such as basic organisational structure, and semi-structured and unstructured interviews with prison officers and senior managers. The analysis of the data was undertaken using 'appreciative inquiry'. The literature concerning prisons has often painted a negative picture of prison staff and the prison system. However, Liebling & Price's study uses appreciative inquiry as it aims to shift the focus for prison staff from the deficits and deficiencies to the accomplishments and achievements.

Much of the prison officers' work involves what is referred to as 'peacekeeping'. From the study it was found that prison officers routinely employed peacekeeping skills but could not articulate exactly what these skills were or how they employed them. Crawley (2004), in her ethnography of prison officers and their lives, discusses the nature of the prison officer–prisoner relationship. Officers in this study are reported to be unclear about the nature of the relationship. However, I think that they are not unclear as such but more unable to articulate their skills in developing a prisoner–officer relationship. This difficulty in articulating practice both in terms of peacekeeping and developing relationships can be likened to the work of Benner (1984) in her discussions of the expert practitioner and the use of intuition in practice. Carper's (1978) ways of knowing can also be applied to the prison officer as it is clear from Liebling & Price's work that, in maintaining relationships with prisoners and 'peacekeeping', clinical artistry is employed. According to Liebling & Price (1999:83), 'Being a good prison officer involved being good at not using force, but still getting things done; it

meant being capable of using legitimate authority, and being in control without resorting to the full extent of their powers. It meant establishing relationships and investing those relationships with real aspects of one's personality.'

Officers reported the importance of consistency when dealing with prisoners, but at the same time flexibility was highlighted as vital to good staff–prisoner relationships. In this context, the importance of boundaries between staff and prisoner is reinforced, which has already been mentioned by Schafer (1997). Respect for prisoners whilst acknowledging the risk of manipulation by them was also highlighted in this study. This is a particularly fine line to walk for prison staff. As has been seen in Walsh (1998), one prison nurse mentioned the difficulty of maintaining a professional attitude towards prisoner patients once she had been a victim of manipulation without realising. One officer in the Liebling & Price (1999:88) study reported, 'Occasionally the relationships are strained a bit because there are lock downs and so on; at the end of the day there will always be "them and us", but most of the time that's forgotten about.'

It is felt that there are similarities here with the work by Goffman (1968). His seminal text, 'Asylums', talks of institutions having a basic split between a large managed group and a small supervisory staff. He goes on to state that: 'Each grouping tends to conceive of the other in terms of narrow hostile stereotypes, staff often seeing inmates as bitter, secretive and untrustworthy while inmates see staff as condescending, highhanded and mean' (Goffman 1968:18). Although this situation is alluded to in Liebling & Price (1999), it is not viewed as a major barrier to the prison officer–prisoner relationship. However, in relation to the nurse–prisoner relationship, this divide can have serious implications for care. The importance of trust in the nurse–patient relationship has been discussed previously and is documented in the literature (see Hinchcliff et al. 2003). The levels of trust inherent in the prison nurse–patient relationship could be affected because, as shown in the

literature, prisoners inhabit a very different world from that outside the prison, in which the boundaries between prisoners and prison staff are rigid (Goffman 1968; Cornelius 1992).

Crawley (2004), in her ethnographic study of prison officers, examined the nature of prison work and its effect on the lives of the prison officers and their families. Highlighted in her work is the nature of the relationship between officers and prisoners. The nature of this relationship has changed significantly since the 1970s and 1980s when prison officers viewed prison as a place of and a place for punishment (Crawley 2004). Although Crawley recognises some officers who adopted a slightly different viewpoint, it is this 'them and us' culture that led to the divided nature of the prison officer/prisoner relationship in the past. Anything nearing a close relationship was deemed to be inappropriate. It can be seen from the literature that this style of relationship is no longer the rule; it is more the exception as the Prison Service promotes a more humanistic approach to caring for prisoners with the emphasis no longer solely on maintaining security but also on care and rehabilitation. It is this change in role and subsequent role ambiguity and conflict that are highlighted in the literature as a source of stress for prison staff, not only in the UK but internationally (Reisig & Lovrich 1998; Dowden & Tellier 2004; Holmes & MacInnes 2003; Finn 2000; Triplett & Mullings 1996; Moon & Maxwell 2004).

Crawley (2004) highlights the findings from her study of prison officers and identifies that the nature of the staff–prisoner relationship is dependent on culture, both of the prison in which the staff are working and of the experiences of the prison officer. Situational and social factors influence this relationship, such as the type of prison, the category and type of prisoner, prior work experiences of the officer and the occupational subculture of the prison. Indeed, in his evaluation of correctional settings, Moos (1975) highlighted the importance of taking account of the environment when assessing behaviour.

Crawley discusses the 'fine line' that must exist between officers and prisoners, which identifies the need for a relationship of sorts to promote security (both physical and mental for both officer and prisoner) but one that is conducive to the aims of the Prison Service in terms of rehabilitation and support. This fine line was reported by officers in Crawley's study to demonstrate 'being friendly but not being friends'. The Home Office Control Review Committee (1984) cited by Crawley (2004:106) proposed that prisons 'depend on staff having a firm, confident and humane approach that enables them to maintain close contact with prisoners without confrontation'. Getting the prisoner–prison officer relationship 'right', therefore, is important but Crawley reports that the officers in her study were not clear about what makes the relationship 'right'.

To tread the fine line highlighted by Crawley (2004) in developing and sustaining relationships with prisoners demands a degree of emotional input from the prison officer and, indeed, anyone working with prisoners in this setting. The term 'emotional labour', common to those involved in 'people work', is defined by Hochschild (1983:7) as 'the management of feeling to create a publicly observable facial and bodily display'. The management of feeling is noted to be stressful for those engaged in people work (Mann 2004).

Role Conflict/Ambiguity

Having examined the literature concerning forensic nursing, prison nursing and the work of prison officers, it is clear to me that role conflict and ambiguity can be viewed as a source of difficulty, both physically and emotionally, for those involved in working with patients and prisoners in the context of a secure environment. For nurses working in prison and many forensic settings, the conflict is centred on competing philosophies of care

and custody; for the prison officer, the conflict is centred on the competing philosophies of custody and rehabilitation (Thomas 1972).

In the world of the prison officer, role ambiguity and conflict has grown over the last few decades as a result of the changing nature of punishment. Movement towards a more humane, caring perspective on custody has resulted in a change of role for the prison officer. The prison officer now occupies a dual role which encompasses security along with the support and rehabilitation of prisoners. This role conflict and ambiguity has been seen in the literature to be a cause of stress for the prison officer (Klare 1960; Reisig & Lovrich 1998; Dowden & Tellier 2004; Holmes & MacInnes 2003; Finn 2000; Triplett & Mullings 1996; Moon & Maxwell 2004).

Literature pertaining to the forensic nursing community also suggests that role conflict is a major issue for these nurses (Hammer 2000; Tennant & Hughes 1997; Murphey & McVey 2003; Rask & Hallberg 2000; Fisher 1995). In addition to the literature concerning the prison officer, the forensic literature also highlights the nature of the patient group as being an issue in terms of their criminal behaviour (Hammer 2000). As has already been discussed, there is evidence that prison nurses also experience role conflict and ambiguity in their practice (Droes 1994; Doyle 1999; Gulotta 1986; Walsh 1998).

Role conflict and ambiguity appear to be the main issue causing difficulty for those working with prisoners and is known to be a major cause of occupational stress. I suggest that while the cause of role conflict is known to be due to the caring and custodial nature of their occupations, the fact that those working with prisoners are engaged in 'people work' is also a major consideration. 'People work' is described by Mann (2004:205) as 'those occupations that have as their focus interaction with other people; usually those outside of the organisation, for example customers or patients, rather than colleagues, superiors or subordinates'. It is part of the nature of working

with people that necessitates emotional labour and hence emotion management.

Emotional Labour

The concept of 'emotional labour' appears in nursing (see Mann & Cowburn 2005), in sociology (see Opengart 2005) and in organisational psychology (see Brotheridge & Lee 2003), and is highlighted by Arlie Hochschild (1983) in her study concerning the work of flight attendants. She describes emotional labour as 'the management of feeling to create a publicly observable facial and bodily display' (Hochschild 1983:7). She elaborates on this statement by suggesting, 'This labor requires one to induce or suppress feeling in order to sustain the outward countenance that produces a proper state of mind in others...This kind of labor calls for co-ordination of mind and feeling, and it sometimes draws on a source of self that we honour as deep and integral to our individuality.' She continues by suggesting that emotion work is undertaken in the pursuit of commercial gain, be it in the form of more custom for the organisation or, for example, larger tips for the worker, and can also be viewed as a commodity that can be exchanged for a wage. Prior to Hochschild, according to Grandey (2000:95), emotions were largely ignored in the study of organisations because the workplace was viewed as 'a rational environment, where emotions would get in the way of sound judgment'. Hochschild (1983:147) suggests that jobs that have an emotional labour element share three common characteristics: they require face-to-face/voice-to-voice contact with the public; they require the worker to produce an emotional state in another person, gratitude or fear for example; and they allow the employer, through training and supervision, to exercise a degree of control over the emotional activities of employees.

Other authors build on Hochschild's concept of emotional labour and apply it to a range of occupations such as counselling (Mann 2004), call centre work (Mulholland 2002), police work (Stenross & Kleinman 1989; Rutter & Fielding

1988), fast food work (Leidner 1993) and beauty therapy (Sharma & Black 2001).

Emotional labour is described by Botheridge & Lee (2003:365) as the effort involved when employees 'regulate their emotional display in an attempt to meet organizationally based expectations specific to their roles'. Mitchell & Smith (2003:109) suggest that emotional labour 'involves using emotions and the appearance of emotions to provide security and confidence in others', whilst James (1992:500) states that emotional labour involves 'the regulation and management of feeling', continuing that 'it is about action and reaction, doing and being, and can be demanding skilled work'. Grandey (2000:95) provides an example to illustrate her understanding of the concept of emotional labour and refers to 'an employee changing how she feels, or what feelings she shows, in order to interact with clients in an effective way'. She continues to suggest that 'emotional expression (or suppression) results in more effective workplace interaction'. However, I question the cost of this effective interaction for the employee. Mann (2004:208) identifies three components of emotional labour: 'The faking of emotion that is not felt and/or the hiding of emotion that is felt, and the performance of emotion management in order to meet expectations within a work environment.'

According to Savage (2004), the terms 'emotional labour', 'emotion work' and 'emotion management' in the nursing world are contentious because they are not defined clearly in the literature. In her paper concerning the researching of emotion, she suggests that if there is thought to be a difference between emotional labour and emotion work, this must be clearly defined in any study that aims to explore these concepts. Smith (1992a:7) refers to emotional labour, emotion work and emotion management in that they intervene 'to shape our actions when there is a gap between what we feel and what we think we should feel'. Bolton (2000:580) suggests that emotional labour is that work which 'creates the "correct" emotional climate' and is seen in nurses who 'work hard on their emotions in order to maintain a professional

demeanour'. Savage (2004), in support of her claim that emotional labour and emotion work/management as concepts are contentious, cites Lupton (1998) who she suggests refers to emotional labour in terms of the way one responds to and manages another's emotions, with the intention of maintaining harmony. According to Gattuso & Bevan (2000:893), emotional labour is defined as 'work involving the self-manipulation of feelings in order to do the job of creating an environment of care'.

As has been demonstrated, there is a range of definitions of emotional labour, some of which emphasise the effort involved in displaying the 'correct' or 'expected' emotion and others that concentrate on the work involved in making the client/patient feel safe and secure. In my thesis, I use the terms 'emotional labour' and 'emotion work' to mean the action undertaken by a person to ensure that a professional appearance is presented (through observable expression and feelings) and, importantly, *accepted* by the recipient, despite real, inner feelings. I sense that it is this 'action' which nurses take to produce a convincing professional façade that causes emotional discomfort and stress for them. Indeed, Mann (2004:211) cites Festinger's (1957) theory of cognitive dissonance, which 'maintains that whenever an individual simultaneously holds two cognitions that are psychologically inconsistent, they experience a negative drive state called dissonance which is a state of discomfort or tension'.

I was working in the reception area of the prison one evening when I was asked to work with a prisoner who had just been convicted of theft. The prisoner displayed a somewhat laissez faire attitude to his conviction and felt that his incarceration was somewhat uncalled for. I undertook his health assessment and began to deal with his health needs. During our interaction, he spoke of his offence as though he had done nothing that warranted detention. I could feel myself getting annoyed with him, which made it difficult for me to focus on providing health care. He felt that stealing a car stereo was insignificant in the grand scheme of crime. I, however, had a different

perspective, having had my car stereo stolen the previous day! Even so, I still had to behave professionally and put aside the negative feelings I felt. Although I feel I managed to provide him with the same level of care I would have given anyone, I was left emotionally drained, very angry and questioning my ability to provide non-judgmental care.

Having examined the literature concerning emotional labour from an organisational psychology perspective and a nursing perspective, my sense is that the actual 'labour' component concerns the issue of the management of emotion. As McQueen (2004:103) notes, 'Emotional labour, however, is more than presenting a front to patients or observers; it also involves work on the emotions to correspond with this front.'

Emotion Management

Although I have previously described emotional labour as action(s) that ensure a professional and acceptable façade is displayed to and perceived by the customer/patient/prisoner, it is the actual management of the emotion that is the 'action' or 'labour'. As McQueen (2004:104) notes, 'When nurses do not feel as they think they ought to feel in particular situations they engage in emotional labour to manage, control or alter their emotional status to correspond with what they believe is appropriate for the situation.' This 'labour' occurs as a result of what Mann (2004:208) refers to as emotional dissonance and emotional deviance. Emotional dissonance refers to the situation where there is a match between displayed emotion and the expectations of the organisation but not with genuinely felt emotion. Emotional deviance refers to the situation where there is a match between displayed emotion and genuine emotion but not with the expected organisational norms. Expected organisational norms can be referred to as 'display rules' and are those rules that govern and influence the behaviour of employees in the workplace and are discussed later.

The literature suggests that we manage our emotions and appearance through acting in one of two ways: surface acting and deep acting (Hochschild 1983; Grandey 2000). It is suggested that we use surface acting to promote an observable appearance and deep acting to portray the correct emotions. I maintain that it is deep acting that is more stressful in the prison setting than surface acting. Managing to portray a convivial exterior through smiling, for example, is easier than conjuring up an acceptable and appropriate emotion such as sympathy whilst appearing sincere.

In her qualitative study examining the many faces of 45 nurses working in a National Health Service Trust hospital, Bolton (2001:86) states that nurses are 'accomplished social actors and multiskilled emotion managers who draw on different sets of feeling rules according to assorted motivations'. She continues to identify three main 'faces' presented by nurses upon which they appeared reliant in their everyday practice: a professional face; a smiley face and a humorous face. She suggests that the professional face requires 'a combination of contradictory elements – caring whilst remaining distant' (Bolton 2001:90). Nurses in Bolton's study suggest that they use this professional face often without thinking. They reported that they used this face when undertaking routine nursing care and that it did not require them to work hard on their emotions to produce it. At other times, however, they acknowledged the work that was needed to present themselves in this way, most notably when they were particularly fraught and emotionally exhausted. It is also suggested that nurses used this face 'as a means of creating distance and to mask feelings of anger' (Bolton 2001:92).

Bolton reports a second face used by the nurses in this study: a smiley face. She suggests that this face is now used more frequently, given the changing nature of the health service where patients are viewed as customers. Nurses in this study felt that they had to work hard on their emotions in order to produce this face. Bolton suggests that this face is used to protect the nurse

from complaints. However, the nurses in this study reported that their smiley face was really more of a 'cynical' face.

The final facial presentation suggested by Bolton is the 'humorous' face. According to Bolton, this face is the result of emotion work that is 'not controlled by organisational or professional feeling rules but by the implicit traffic rules of social interaction' (Bolton 2001:95). She reports that this presentation of self is seen in what she terms 'off-stage areas' and is often used to create and maintain bonds with other staff, to register resistance and manage anger and anxiety.

Bolton's study highlights the fluidity of movement between these three faces. It is suggested that the expert nurse moves seamlessly and appropriately through all three positions in various clinical situations and spaces. It is this movement that highlights the complexity of nurses' emotion work. Bolton refers to nurses in this paper as both emotional jugglers and synthesisers and, in discussing nurses as a professional group, suggests that 'as a distinctive occupational group, nurses are particularly adept at changing face; seemingly effortlessly moving from cynical to sincere, from backstage to frontstage' (Bolton 2001:98).

Reflecting on the work of Bolton in relation to my own practice in prison, I am minded to consider the extent to which I too employed these 'faces' in order to maintain a professional approach to my work. In considering the various incidents within which I was involved, and my 'faces' in each, I am led to examine the importance of getting it right in terms of not provoking and angering prisoner patients in what can be a volatile environment. Clearly, the use of a smiley expression in the face of prisoner patient anger will not improve the situation. Given the minimal problems we encountered in the unit within which I worked concerning violence and aggression, I believe that an intuitive understanding of the impact of our 'faces' on the prisoner patients was demonstrated. Christmas day on this inpatient unit is probably a good

demonstration of the way in which I managed to incorporate all three faces in a short space of time. For many prisoners, Christmas day is not a big event in their calendar as to dwell on it is a stark reminder for them that they are not with their families. For the staff, however, working on Christmas day does not involve working all day because shifts are organised so that staff can spend minimal time away from their families. As such, the atmosphere amongst the staff can be quite light hearted. A balance, therefore, must be struck between being professional, being mindful of the situation in which prisoner patients find themselves and maintaining a genial atmosphere. The use of the smiley and professional faces was visible outside the staff-only areas whilst the humorous face was seen within staff areas.

Display Rules and Feeling Rules

Hochschild (1983) reports that emotion is managed through acting in response to what she terms 'display rules' and 'feeling rules'. Display rules are more about the kind of observable front we should display in any given situation and, in many areas of work, may be explicit or written in codes of practice, taught in training or present in organisational policies. Alternatively, they may be more culturally based where employees are socialised into what is perceived as appropriate and professional behaviour. The display rules that guide appropriate behaviour within the sphere of nursing are often established from a cultural perspective (see Menzies Lyth 1988). In addition, there is the issue of a code of conduct for nurses, health visitors and midwives (see Nursing and Midwifery Council 2002), which lays down standards of professional behaviour and hence affects their practice. I understand feeling rules to be more personal. They are the rules by which we work internally, which I suggest are determined by one's own value system. For example, one simply 'just knows' that, as a professional nurse, it is inappropriate to become overly emotional in front of relatives at the death of a patient. Mann (2004:208) suggests that feeling rules are commonly used to guide those in the caring professions. In this arena, Mann (2004:208)

suggests that 'emotional expectations tend not to be prescribed by the organisation, and, indeed, many workers within the caring professions display appropriate emotions only because they want to and see it as an important part of their job-role rather than because their employer (or colleague) demands it'.

I return to the experience I have related previously in this thesis, as I feel it clearly demonstrates the impact of being unable to act in the patient's best interests. I was working with a prisoner who was distressed and I felt he would benefit from talking in a relaxed atmosphere, over a cup of tea. This, I felt, would be in his best interests. However, it was almost lunchtime and time for all prisoners to be locked in their cells. From a security (organisational) point of view I was expected to lock this prisoner in his cell. I was in a dilemma. I knew that the best thing for my patient was to talk but the rules of the prison stated that I could not let him stay unlocked. I therefore had to conjure up a façade of caring professional (in the eyes of the prisoner) who wanted to stay and talk whilst needing to be perceived by my colleagues as a nurse who understood 'where the line was' to avoid being manipulated, because there was always the chance that this prisoner could have been deceiving me so he could remain unlocked. Although this episode is a typical example of care versus custody, there is also the added, deeper issue in terms of the stress caused by the emotional dissonance I experienced in trying to stick to display and feeling rules simultaneously whilst aiming to behave as expected of a professional by all concerned.

Although I have suggested that emotion management is the action undertaken by people involved in emotional labour, and that it is this management of emotions that is stressful, Ashforth & Humphrey (1993) cited by Grandey (2000) suggest otherwise. They suggest that emotional labour is more of an observable behaviour rather than purely management of feeling. They suggest that a broader array of factors affect the emotional display of employees. It is suggested that methods of emotion management become

routine and effortless for the employee, rather than causing stress. If this view is accepted, the concept of the expert practitioner in the nursing literature (Benner 1984) could encompass the ability to manage emotion without stress. It could be that the tacit knowledge of the expert practitioner encompasses strategies for the management of emotion.

The issue of emotional labour is well documented in the literature, such as in flight attendants (Hochschild 1983), nurses (Smith 1992a; Staden 1998; Henderson 2001; Bolton 2000) and also prison officers (Crawley 2004; Tracy 2005). I have decided to look at the literature concerning the emotional labour of nurses and prison officers because I believe that it is the literature from these areas which will inform the sphere of prison nursing (prison nurses have a role in both security, as do officers, and nursing).

The Emotional Labour of Nurses

The concept of emotional labour has been studied and highlighted as an issue within many areas of nursing practice, such as gynaecology (Bolton 2000); palliative care (James 1992; Froggatt 1998); midwifery (Hunter 2004); operating theatres (Timmons & Tanner 2005); general nursing, both inpatient and community (Henderson 2001); mental health nursing (Mann & Cowburn 2005); learning disability nursing (Mitchell & Smith 2003); intensive and critical care (Beeby 2000); elderly care (Gattuso & Bevan 2000); and paediatric and neo-natal intensive care (Way 2003; Greenall 2001). The concept has also been examined from a student nurse perspective where reflection was utilised as a way to cope with emotionally challenging situations (Pfund et al 2004).

Although Arlie Hochschild is credited with bringing the issue of emotional labour into the academic arena within the sociological context in the early 1980s, work eluding to the concept can be found in the nursing literature in the early 1960s. Isabel Menzies Lyth published a series of essays

concerning 'the functioning of social systems as a defence against anxiety' (Menzies Lyth [1959] 1988). In essence, Menzies Lyth's work involved assisting a hospital that was examining new methods of carrying out nursing tasks. Using interviews with nursing staff, group interviews with medical and lay staff and observation of operational units, Menzies Lyth and her team examined how nursing in the hospital was undertaken. What became apparent during the research was and the focus of her publication 'The functioning of social systems as a defence against anxiety' was 'the high level of tension, distress and anxiety among the nurses' (Menzies Lyth [1959] 1988:45). Menzies highlights the issue of poor retention of staff and high levels of sickness as a consequence of the tension, distress and anxiety noted earlier. The nature of this anxiety is attributed to the nurses' work situation which 'arouses very strong mixed feelings in the nurse: pity, compassion and love; guilt and anxiety; hatred and resentment of patients who arouse these strong feelings; envy of the care given to the patient' (Menzies Lyth [1959] 1988:46). In addition, it is suggested that the projection of the feelings of patients onto the nurse add to the anxiety, e.g. patients may experience disgust at their illness; therefore nurses are not only dealing with their own feelings but also those of their patients. If this is translated into the prison setting it can be deduced that nurses working in prisons have to deal with their own emotions concerning prisoners as patients in addition to the feelings of prisoners, which include resentment at being incarcerated, fear and depression. Menzies Lyth highlights that nurses are, by the nature of their profession, 'at considerable risk of being flooded by intense and unmanageable high levels of anxiety' (Menzies Lyth [1959] 1988:50). In order to deal with and contain this level of anxiety, Menzies Lyth suggests that nurses develop particular strategies. She describes these strategies as a social defence system, which develops over time both consciously and subconsciously by members of an organisation, which eventually they come to terms with. This is not unlike the prisonisation that prisoners and prison staff undergo as described earlier (Cornelius 1992).

The social defence system described by Menzies Lyth can be clearly seen in the prison setting. She suggests that it is the nurse–patient relationship which is at the core of the anxiety for the nurse. It is suggested by Menzies Lyth that the nursing service attempts to deal with this by splitting up this relationship. It is accepted that when Menzies Lyth wrote her paper nursing was very task orientated, which clearly splits the nurse–patient relationship because nurses were allocated tasks that were undertaken with a number of patients, thus disabling the development of a close relationship. Nursing has developed since this work was undertaken and is now based more around the concept of holism and individualised patient-centred care where patients have a named nurse and a close working relationship is fostered (Walsh & Ford 1989). However, the notion of splitting up this relationship can be seen in the prison setting. Prison culture dictates that a close relationship with a prisoner patient is unacceptable due to the security risks of manipulation and claims of favouritism, which could lead to allegations of bribery (Walsh 1998). It is noted by Menzies Lyth that the depersonalisation, categorisation and denial of the significance of the individual is a second defence mechanism used by nurses to deal with anxiety. Referring to patients by their illness or bed number has long been common practice in nursing but is now discouraged as nursing is more individualised. However, what Menzies Lyth refers to in her work can be seen very clearly in the prison setting in general, not just in prison health care centres. Prisoners are given a number, prison clothes, prison cutlery, prison bedding, etc. and are inducted into a regime where the opportunity for self-care is almost totally removed and their day is governed by the regime. This environment depersonalises prisoners. And it is not just the patients who are depersonalised, according to Menzies Lyth. Staff, by nature of wearing a uniform, are also depersonalised. Again, this is evident in the prison setting.

Menzies Lyth suggests that other defence mechanisms can be seen in the nursing world such as the elimination of decisions by ritual task performance, reducing the weight of responsibility by the use of checks and counter

checks, purposeful obscurity in the formal distribution of responsibility, the collusive social redistribution of both responsibility and irresponsibility, the reduction of the impact of responsibility by delegation to superiors, idealisation or underestimation of personal development possibilities and avoidance of change. All of these defence mechanisms are seen not only in prison health care but also in the Prison Service in general. Research conducted into the development and promotion of clinical supervision within the prison setting suitably demonstrates many of the defence mechanisms reported here (Freshwater et al. 2001a; 2001b).

Upon reflecting on Menzies Lyth's work in terms of my own practice and experiences working in the prison setting, I can see many of the concepts she mentions as defence mechanisms both in my in own practice and in that of other nurses. Interestingly, I also saw them in action in the prison officer world. I feel that many of the defence mechanisms highlighted above involve the issues of responsibility and accountability, and in terms of the prison setting, the need for staff to ensure that they could not be blamed should anything go wrong. The use of checks and counter checks (such as double checking a locked door), elimination of decision making by the use of ritual tasks (such as in the prison regime), purposeful obscurity (for example sometimes unclear roles) and delegation to superiors (for example difficult decisions being forced upwards) were commonplace in this setting. I felt that when I worked in prison, the culture was such that, to ensure no blame could be attributed to you personally, there was always a perceived need by staff to ensure that prison documentation was sometimes witnessed, countersigned, multiple copies made and a copy kept by the member of staff should they need proof later on! In my experience, this culture was worsened following a major criminal investigation at the prison concerning staff and prisoners. In some of the anecdotal literature I have looked at, this culture is partially attributed to the fact that the environment can be very litigious where prisoners have ready access to their solicitors.

It is the suggestion by Menzies Lyth that one of the social defence mechanisms used by nurses is detachment and denial of feelings, which I feel has the strongest links with the notion of emotional labour in nurses. She states, 'A necessary psychological task for the entrant into any profession that works with people is the development of adequate professional detachment' (Menzies Lyth [1959] 1988:53). She does not elaborate on what is meant by *adequate* professional detachment but does give examples of how nurses need to control their emotion and refrain from excessive involvement. Interestingly, she highlights the need to maintain professional independence against manipulation and unprofessional behaviour. This is also highlighted in the prison setting where those caring for prisoners, both officers and nurses, must be aware of the possibility of manipulative behaviours (Walsh 1998; Cornelius 1992). According to Mann (2004), nurses actually value emotional engagement and see it as critical to nursing care. I suggest that some degree of attachment or engagement is needed in nursing to enable the development of a therapeutic relationship, but Smith (1992a) highlights distancing techniques as a method of coping with emotional labour. In Meyerson's (2000) work, the role of detachment in the medical profession is discussed. Detachment as a defence mechanism in the medical profession is commonplace. This can be seen in the practice of doctors who are taught to reduce whole people into bodily parts and diseases. This can be likened to Menzies Lyth's concept of depersonalisation as a defence mechanism. However, Menzies Lyth also discusses the notion of denial of feelings as a social defence mechanism. From my own experience and previous studies, I have found that the denial of negative feelings towards prisoners is seen in prison nurses (Walsh 1998).

Another seminal writer in the field of emotion labour in nursing is Pam Smith. Her book, 'The Emotional Labour of Nursing' (Smith 1992a) stimulates discussion of how nurses actually care through analysis of the socialisation of student nurses. This work examines the concept of emotional labour as part of caring, how nurses care and learn to care, and its effects on carers

and the cared for (Smith 1992a:19). Smith (1992a) studied the relationship between the quality of nursing and the ward as a learning environment for student nurses. Her main finding was that the relationship between quality of nursing and the learning environment was articulated through the emotional style of management, led by the ward sister. This has since been further studied by Smith and Gray (2001) where it was found that it is no longer the ward sister who has a pivotal role in supporting student nurses, and thus influencing learning to care, but the mentor and link lecturer. They report the link lecturer and mentor use reflective learning as a form of emotional labour to support the student's experience of caring. There are links here with the use of clinical supervision for registered nurses when supporting them in the development of their practice. I suggest that there is an element of emotional labour involved in the undertaking of clinical supervision for both supervisor and supervisee.

James (1992) conducted a study in which she examined the balance of the component parts of inpatient hospice care in contrast to the domestic care that is undertaken in the home. The model aspired to in the hospice setting is one similar to that seen in the domestic setting. However, following an examination of both, James concludes that one reason for the difficulty of transferring the domestic model to the hospice setting is the non-flexible, organisational element of care in a hospice which does not mirror the organisation of the domestic sphere. There are links here with the inflexible, regimented regime that can be witnessed in the prison setting. In addition, James highlights that the emotional labour element of domestic care can be seen in the workplace to be undertaken mostly by nursing auxiliaries. She suggests that this is because emotional labour takes time and requires considerable knowledge of the patient as a person. However, in the prison setting, one must ask how much knowledge of the prisoner as a person is permitted, given the cultural norms and how much of themselves the prisoner patient elicits. James also states that there are definite gender issues prevalent concerning the emotional labour of hospice nurses. She states that

'expressions of emotion appear to be legitimate in the domestic domain but anathema in the workplace' (James 1992:501). She also suggests that there is a gender issue as, ideologically, women have been associated with emotion and men with rationality. Subsequently, women are viewed as 'being better at dealing with emotion which renders them less able than men to control the pace and content of their work' (James 1992:501).

However, if I examine James' work in terms of the meaning of emotional labour, I am not sure that it is the ability to deal with others' emotions that is at the heart of emotional labour. I sense that it is more about being able to deal with one's own emotions in order to display the correct façade. There are links here with the concept of emotional intelligence in which the ability to relate to one's own emotions and high levels of self-awareness contribute to the ability to manage other people's emotions.

Staden (1998) attempted to recognise and value emotional labour and the skills embodied within it in her study where she undertook a case study of three experienced enrolled nurses who were training to convert their nurse qualification to registered nurse. Interestingly, she adopted a similar approach to James (1992) in that she also examined the emotional labour evident in both the clinical and domestic settings. It is suggested that women learn emotion management skills in the domestic arena, hence the study of emotional labour can include that of domestic emotional labour. A phenomenological philosophy was used to underpin the study in which an inductive, descriptive, qualitative research method was used. In addition, a feminist perspective was adopted in terms of methodological principles, which she states 'relate to the significance of gender, the validity of experience, the rejection of hierarchy in the research relationship and the goal of research' (Staden 1998:150). All three nurses involved in the study worked in different nursing specialities and all had different domestic situations. Semi-structured interviews, based on a pro forma compiled from the emotional labour literature, were undertaken with all participants in their

own homes. Staden (1998) examined areas such as the public/private spheres, appearing caring, giving of self, value and visibility, and coping within this study.

One of the major findings of this study is the immense job satisfaction from caring and the therapeutic relationships the nurses had with patients/clients. However, the nature of emotion work as unrecognised and unvalued by society was also highlighted. It is reported in this study that the invisibility of emotional labour is such that to articulate, document and explain it is problematic. Another issue discussed by the participants in Staden's study is that of coping. Staden attempted to explore and recognise the effect of emotional labour on these nurses. Emotion work is reported as being hard work and, as such, these nurses had adopted coping strategies including sharing out difficult patients, support from other staff and participating in clinical supervision. Hochschild (1983:197) claims that the problem is 'how to adjust oneself to the role that allows some self into the role but minimises the stress that the role puts on the self'. I feel that there are links here with the concept of emotional intelligence and hence the way in which nurses learn to adapt to the emotional demands of their practice. Although Staden's study examines the concept of emotional labour in a small sample, she justifies this in terms of her underpinning philosophy and study aims.

Bolton (2000), in her paper using data from a previous qualitative study of gynaecology nurses, suggests that the concept of emotional labour in nursing fails to conceptualise the occasions when nurses not only work on their emotions to present 'the detached face of a professional carer' (Bolton 2000:580), but also offer authentic caring behaviour. She suggests that when discussing emotional labour, both the emotion management and behaviour of the nurse need to be recognised. This highlights that emotional labour encompasses more than just management of emotions. Bolton highlights how nurses are able to escape from organisational feeling rules and 'offer additional gestures of caring which are not part of their job descriptions, but

which they believe are an essential part of their identities as professional care givers' (Bolton 2000:581). She suggests that these 'gestures' can be described as 'gifts' and as such are a separate entity to emotional labour. This perception of emotional labour is explained by Hochschild (1983) in terms of the commercial aspect of emotional labour, i.e. emotion work being sold for a wage and seen as a commodity. What Bolton (2000) eludes to is that emotion work undertaken is not seen as a commodity but as a gift and goes beyond what is expected as part of a nurse's job in terms of remuneration. Examples given of such 'gifts' appear to stress the deeper involvement of these nurses in emotion work, e.g. in dealing with the grief of parents following miscarriage. Although Bolton (2000) suggests that there is more to the emotional labour of the nurses in this study because they also offer authentic caring behaviour, I feel that this is true of all nurses who care about their patients and see nursing as a vocation rather than just a job.

Gattuso & Bevan (2000) examined the notion of emotional labour as women's work in the elderly care arena in Australia. A total of 16 female nurses from four geographical locations and of varying experience in elderly care were selected following the volunteering of themselves through radio phone-in programmes. Participants were advised of the study and sent a topic list of areas to be discussed during focus groups. These areas included the impact of personal caring and the working environment on experiences in aged care, the experience of comfortable and uncomfortable emotions in the workplace, and the experiences and consequences of emotional labour. It is not clear how these areas were constructed or how they were chosen. Group interviews were taped and transcribed prior to analysis. Participants also completed a 'Reactions to Ageing Questionnaire' designed to elicit their own personal attitudes to ageing. The general themes emerging from the focus groups and questionnaire included a relatively negative attitude to the participants' own ageing with few expecting to receive care themselves when they needed it. Most of the participants were concerned about who would care for them when they became frail, which was interpreted by the authors

as a reflection on their perceptions of elderly care provision and quality as well as feeling uncomfortable about needing to be cared for in the future. Many women in the focus groups displayed feelings of anger and frustration as they felt there was a lack of value placed on their labour and felt inhibited in complaining to management about staff shortages and the stressful situations they were placed in. Participants reported that they felt they may lose their jobs if they expressed concern to management. It is reported that few of the participants had made the link between their emotional experiences at work and the organisational/political environments in which they practised. Therefore, they reported individual coping strategies such as increased stoicism rather than what Gussato & Bevan term 'structural' solutions. In this paper, Gussato and Bevan examine further the concept of emotional labour from the perspectives of three women and their experiences of caring for their mothers. The main finding reported concerned the dissonance these nurses experienced in terms of being a professional and being a daughter, termed by Gussato & Bevan (2000:897) as 'a blurring of the public and professional'. The nature of the caring role in this field of nursing is reported to take the view that caring is a natural activity for women and, as such, this area of nursing takes little account of the nurse as a person. In addition, nurses working in aged care deal with the needs of the organisation in terms of efficiency and cost effectiveness, which in itself is often a different ideological perspective and incongruent with the nature of caring. Gussato & Bevan warn against the continued perception that nursing in aged care is 'natural' for the carers and suggest that 'if these conflicts go unrecognised and unsupported, or the emotions they evoke remain outside awareness, both the nurse and the recipient of her care are damaged by the emotional labour and energy needed to sustain self' (Gussato & Bevan 2000:897).

Henderson (2001) examined the concept of emotional labour in relation to the caring work of nursing. Forty nine nurses from both Canada and the UK, from community settings, emergency nursing and maternity clinical areas,

were interviewed both individually and in focus groups with the intention of eliciting nurses' approaches to care of women who they thought or knew were being abused. The interviews also sought to elicit personal information from the nurses about their own backgrounds, beliefs and values as these are also seen to have an impact on the care given to patients. This study was underpinned by a social constructivist approach. Caring is seen by the nurses in Henderson's study as 'relevant to their role and somewhat concur with a view of nursing as an altruistic vocation with caring as an imperative' (Henderson 2001:131). From the data gathered from the nurses during interviews, Henderson notes that one of the main issues concerning these nurses was the 'role of emotional engagement versus emotional detachment as a component of their approach to attaining excellence in their practice' (Henderson 2001:131). In referring to the work of Smith (1992a), Henderson suggests that 'nurse's willingness to engage also appears to vary accordingly to the opportunities and encouragement within particular work settings to develop strategies to cope with emotional situations' (Henderson 2001:132).

In her own study, Henderson highlights that nurses held a variety of different views about the value of attachment versus engagement in patient care. She suggests that their views of attachment versus detachment were related to the way in which they viewed themselves. The nurses themselves suggested that there was a continuum along which they moved in response to the patient and the situation in which they found themselves. She states that, 'The context and circumstances of a particular patient/nurse encounter also seemed to encourage or impede various levels of emotional engagement between the nurse and the patient' (Henderson 2001:133). Overall, Henderson suggests that the nurses in her study demonstrated a relationship between increased willingness and skill of being self-reflexive about their practice with valuing an emotional connection with their patients. In addition to being self-aware about their practice, these nurses also acknowledged the influence of their own experiences and themselves as people upon the care they offer. Although they highlighted the value of emotional attachment, they

also noted the importance of emotional detachment. A balance of appropriate attachment and detachment was recognised as important by the nurses in this study to safeguard the emotional health of the nurse. Henderson notes that nurses' beliefs about the perceived correct level of emotional involvement were shaped by their own specialist area of nursing. One nurse felt that, 'The profession demands that nurses involve themselves as people in an ongoing quest for professional improvement and self-awareness' (Henderson 2001:134). It is noted in this paper that this is a skill not taught or explored during nurse training. The issue of emotion work preparation will be discussed later.

In her study, Henderson also discusses the effects of being a nurse on the self. The nurses in this study reported the circular and interdependent nature of the relationship between themselves as nurses and as people. Their perception of themselves as people affects themselves as nurses and vice versa. It is suggested that, 'The self which is private person and the self which is nurse are constantly interacting and changing with one another' (Henderson 2001:135). Therefore, the nurses in this study felt that the skills derived from nursing are used in both a professional and personal capacity. This is not dissimilar from the issue as discussed by James (1992) in terms of domestic emotion work and professional emotion work.

Mitchell & Smith (2003) discuss the notion of emotional labour in learning disability nursing through a historical examination of documentation and oral histories. Their article discusses the conceptual links between emotional labour and learning disability nursing and, in doing so, highlights some interesting similarities with prison nursing. They use emotional labour as a conceptual tool to explore the role of learning disability nurses in the past and to identify their utility in the system in which they were working. This is addressed via four main themes: the economic imperative, experienced intuition, character and the maintenance of a cheerful environment. They suggest, through the examination of historical evidence, that emotional

labour has been integral to learning disability nursing and was 'perceived as a requirement within the role of the learning disability nurse' (Mitchell & Smith 2003:110). They suggest that emotional labour was not a defining element of nursing but was a shared experience and part of the image of nursing. In the arena of learning disability nursing, it is proposed that emotional labour was more concerned with the control of the environment as opposed to the individual interactions of nurses and their patients. Mitchell and Smith suggest that Hochschild's 1983 definition of emotional labour 'immediately raises conflicts within an examination of learning disability nursing because such nurses have been involved in both care and control, and present day images of past mental deficiency institutions defy any similarity with convivial places' (Mitchell & Smith 2003:111). There are immediate links to be made here with the concept of the prison as a place of punishment and control rather than a convivial place. They continue to suggest that, 'The preoccupation with care and control ensured a combination of competing purposes and was an inbuilt tension within the institutional system' (Mitchell & Smith 2003:112). When examining the concept of experienced intuition, the authors suggest that the concept of emotional labour is closely associated with this in terms of difficulty of articulation. Historical evidence suggests that the character of the learning disability nurse was important as they were expected to have or develop a certain emotional character 'not so much to deal with individuals but for control of the environment' (Mitchell & Smith 2003:114). Historically, it is suggested that the maintenance of a cheerful and ordered environment was crucial for those with learning disabilities and it is demonstrated that those nurses working in this setting were expected to have the personality and emotional skills to support and maintain this environment.

Literature concerning the emotional labour of nurses is not restricted to nursing publications. Indeed, Hunter (2004) examines the notion of emotional labour in the domain of midwifery. In her qualitative study, Hunter utilised focus groups, observation and interviews over three phases to explore how

midwives experienced and managed emotion in the course of their practice. In total, 67 midwives participated in the study and ranged from student midwives (post nurse registration and direct entry) to a wide range of midwives of various grades and from various clinical areas, both in the community and hospital settings. In terms of the emotion work in midwifery, Hunter examines the literature in the field and deduces that her study is the first to focus explicitly on the emotion work of midwives. She reports that other studies concentrate on other aspects of the emotional nature of practice, such as stress and burnout and the culture of midwifery practice. She suggests that it is important in midwifery to understand that whilst the emotional aspects of midwifery care are important in terms of the midwife, it also impacts on the cared for, i.e. the mother. It is the impact of the emotional support given by the midwife that is central to the perception of care by the mother. This variability in quality of emotional support offered may well, according to Hunter, be 'due to the ways in which midwives manage their emotions' (Hunter 2004:263).

Whilst interviewing midwives and midwifery students, Hunter did not elude to the concept of emotion work but instead opted to cover general questions relating to emotionally rewarding and emotionally difficult experiences. The decision to refrain from utilising a theoretical framework was adopted to ensure an inductive approach to theory generation. Despite finding that the emotion work undertaken by qualified midwives was somehow different from that of student midwives, Hunter does not elaborate on how or in what way. One major finding of this study was the 'existence of contradictory ideologies of midwifery practice which created dissonance for the midwives' (Hunter 2004:266). Interactions with colleagues and the organisation were viewed in this study to be the main site of emotion work rather than within the midwife/client relationship. Two primary midwifery ideologies were identified – one which was pertinent to the hospital based midwives and one pertinent to the community midwives. Hospital-based midwifery was driven by the needs of the institution whereas community-based services were more likely

to work with what Hunter describes as a 'with woman' model (Hunter 2004:266). When midwives were supported to work in the 'with woman' model, there was congruence between ideas and practice, and midwives reported a high level of emotional reward. In contrast, when midwives were working in what Hunter terms a 'with institution' model, more negative emotions were experienced. Within the hospital setting, Hunter (2004:267) reports that the main characteristics were, 'The dominance of organisational needs, the subsequent focus on task completion and the significance of relationships with other colleagues rather than clients.' In addition, the medicalisation of childbirth in the hospital setting, despite midwives' criticisms of it, was also highlighted as an issue causing dissonance for the midwife. There are interesting links here with the work of Menzies Lyth. Emotionally satisfying work was defined by the hospital-based midwives as having met organisational goals. More junior midwives reported a clash of ideologies within the hospital setting and frustration with more senior colleagues. As Hunter (2004:268) states, 'Emotion work was therefore needed in order to reduce the disparity between the "with woman" ideal and the "with institution" reality.'

In the community setting, however, midwives reported a sense of emotional satisfaction due to the ability to adopt a 'with woman' approach to care. In the community, midwives were able to develop a relationship with the woman and her family, and to focus on psychological processes to a greater extent than in the hospital setting. They spoke of 'knowing the woman' as making their work easier and, due to this more relaxed and less formal contact with their clients, these midwives' experiences suggested that, despite midwifery work being emotionally demanding, more congruence with the 'with woman' ideology caused less negative emotions and was more fulfilling.

This study does not support the idea that emotion work is situated within the client/midwife/nurse relationship and that it was the co-existence of two separate ideologies that created the most dissonance for midwives.

Reflecting on Hunter's studies within the field of midwifery, I suggest that there are definite links here with the work of the nurse in prison in terms of conflicting ideologies; those of care and custody. I do assert that emotional labour is undertaken in the prison setting as a consequence of relationships between nurses, prisoner patients, the establishment and other colleagues. Hunter recognises the impact of working relationships on the emotion work of midwives but does not see the emotion work as a consequence of the relationship with the client. In contrast, I suggest that the relationship with the prisoner patient is one of the determinants of emotion work for the nurse working in prison health care settings.

McCreight (2005) examined nurses' experiences in gynaecology wards when faced with death through pregnancy in Northern Ireland. McCreight notes studies which show that nurses caring for those who have lost babies often experience grief and fear and may find they are unable to cope with their own emotional distress. The concept of emotional labour in this context has not been studied by many authors and, as such, McCreight's qualitative study aimed to 'collaboratively explore with gynaecology nurses how they constructed meanings through their narratives in relation to the professionally defined, but personally experienced, event of pregnancy loss' (McCreight 2005:439). Semi-structured in-depth interviews were undertaken with 14 nurses working in gynaecology units in Northern Ireland. Nurses interviewed had a range of experience in this setting and came from various hospitals. A narrative method was employed during the interviews so that nurses could relate their personal stories in constructing an account of their experiences. McCreight found that the accounts of the nurses were 'transformed through reflection on their emotional experiences, which they have used both to enhance their effectiveness as carers and to communicate methods of effective coping to new nursing staff' (McCreight 2005:442). One of the main conclusions of this study was the perceived lack of input into nurse training and preparation regarding how to cope with and manage emotions.

Timmons & Tanner (2005) suggest that much of the research concerning emotional labour in nursing concentrates on that which is undertaken with patients/clients. In their study, they examine emotional labour as it pertains to work undertaken with colleagues, namely doctors. An ethnographic methodology was utilised when examining emotional labour in five UK NHS hospitals. A purposive sample was collated and consisted of operating theatre nurses who were broadly representative in terms of age, grade, gender and level of education. In total, 20 operating theatre staff were observed over the course of nine months. Seventeen staff were theatre nurses and three were operating department practitioners (ODPs). Staff were observed for a whole shift and subsequently interviewed using a schedule derived by the authors from a review of the literature. Data were analysed by the researcher using a coding system and with the support of software packages. Themes emerging from the observation and interviews with staff included the identification of the emotional labour of the theatre nurse performed for the benefit of the surgeon rather than the patient. Therefore, this is described by Timmons & Tanner (2005:89) as a 'hostess' role (as opposed to the more traditional conception of nurses as doctors' handmaidens), because 'one of the roles of the party hostess is to keep conversation going and the atmosphere pleasant' (Timmons & Tanner 2003:89). There were differences noted in the roles of the nurses and the ODPs. The ODPs in the study were male and it is suggested that there are gender roles present in the expectation of emotional labour because the ODPs behaved very differently with the surgeons when compared with the nurses. There were only two male nurses in the study. The costs of this emotional labour in the operating theatre were seen to be both negative and positive for the nurses. Many nurses expressed pride in the way they conducted themselves whereas others reported working with the surgeons as stressful and frustrating.

The concept of emotional labour has been examined in many fields of nursing. In their study, Mann & Cowburn (2005) aimed to understand the complex relationship between components of emotional labour and stress within mental health nursing. One psychiatric unit in England took part in the study where 35 mental health nurses agreed to participate. The 35 nurses completed a total of 122 questionnaires in which they were asked questions related to care episodes. Data were collected in relation to the duration and intensity of the interaction; the variety of emotions expressed; the degree of surface or deep acting the nurse performed; and the perceived level of stress that the interaction involved. Following statistical analysis, Mann & Cowburn conclude that emotional labour is a prominent feature in the daily work of mental health nurses. They note that, although mental health nurses are not experiencing high levels of emotional labour, they are experiencing chronic medium levels and, as such, this may be cause for concern. Overall, stress levels in this group are high as they report that two thirds of their interactions with patients involve medium or high levels of stress. In addition, they conclude that 'emotional labour is positively correlated with both daily stress and interaction stress such that the more emotional labour performed within an interaction, the more stressful it is, and the more emotional labour experienced overall, the more daily stress is involved' (Mann & Cowburn 2005:159).

They highlight the problem of deciphering whether it is the emotional labour that causes stress or the stress of the interaction which causes increased levels of emotional labour. Alternatively, another explanation could be that, as nurses experience more stress, they work harder to manage their emotions, which in itself could be stressful. Interestingly, this study did not highlight any relationship between the levels of emotional labour and the duration of the nurse-patient interaction, but they did find that, although duration was not correlated with emotional labour, intensity was correlated with duration and also with emotional labour. This study also found that deep acting and surface acting both correlate with emotional labour and hence

with stress, although it was found that surface acting is a more important predictor of emotional labour than deep acting and was therefore seen as more stressful. It is suggested that this is because of the inauthenticity of surface acting and the dissonance experienced in terms of one's own feelings. The authors suggest that development of emotion management skills, especially deep acting skills, could be addressed through education and training.

The criticism of inauthenticity as a result of emotional labour is addressed in a paper by De Raeve (2002) in which she discusses the trustworthiness of the professional relationship from the patient's perspective. De Raeve notes that trust is the foundation of health care relationships. However, it is suggested that trust in a professional relationship is fundamentally dishonest, given the fact that there is an element of 'acting' taking place in the relationship, and the distancing and professional façade that needs to be displayed. In the words of de Raeve (2002:466), 'Professional relationships require professional persons to control or modify their emotional reactions such that a relationship is bogus because it is inauthentic.' However, de Raeve's paper proposes a criticism of applying the work of Hochschild to the nursing profession, especially in terms of the concept of deep acting, as there is no acceptance of moral concern or justice also being the motivation behind a nurse's desire to change or suppress an unacceptable emotional response. Therefore, de Raeve suggests that the criticism of inauthenticity and therefore lack of trustworthiness in the nurse–patient relationship may not be the case if all the reasons why nurses modify their emotions are taken into consideration.

The literature concerning the emotional labour of nurses is wide and varied with the emphasis being on the nature of the emotional labour, the effects of the emotional labour and the place of emotional labour.

The Emotional Labour of Prison Officers

I have examined the literature concerning emotional labour as it pertains to prison officers as I believe that the custodial role of the prison nurse is in some ways similar to that of the prison officer. After all, they are both in effect caring for the same people. In addition, they are both working in the same culture and environment. Insights into the nature of the emotional labour of prison officers may help build a better understanding of the emotion work facing the nurse working in this setting.

From the prison officer/correctional officer literature I have reviewed, it appears that the concept of emotional labour amongst prison officers is not widely documented. Following a literature search, there only appear to be two authors who have addressed this issue directly: Crawley (2004) in her ethnographic study of the public and private lives of prison officers in England, and Tracy (2004; 2005) in her qualitative studies of correctional officers in the USA. Having looked more broadly at the literature concerning emotional labour, the concept of stress is commonplace as a consequence of emotional labour and emotion management. Therefore, literature concerning the concept of stress in prison officers was also included as it was felt that there may be links to the emotional labour of officers in the research that are not a major focus of the paper (Finn 2000; Triplett & Mullings 1996; Dowden & Tellier 2004; Holmes & MacInnes 2003; Moon & Maxwell 2004).

In her study, Tracy (2004:511) aims to illustrate the 'harnessed emotionality and disruptive nature of correctional work' through what she terms 'a layered account'. She discusses theoretical perspectives, notes about methodology and examples from her research as intertwined writings throughout her paper, where she uses asterisks to denote jumps from 'one rhetorical space to another' (Tracy 2004:511). This style of writing enables the reader to follow the author's train of thought through the reporting of observational episodes to their link with theory and methodological concepts/practical

issues. She undertook this study in two women's prisons in America and used observation and unstructured interviews over an unspecified period. She does, however, refer to six months at least in one of the prisons so it can be assumed that this study took place over a minimum of six months.

Tracy (2004) discusses the emotion work of prison officers (termed correctional officers in her paper) and, in linking emotional labour theory to it, questions the accepted theory of emotional labour by highlighting a dichotomy of emotions which are portrayed as real and false. She comments that this distinction between the real and false self and hence where real emotions are perceived as 'personal, private and a priori to organisational life' (Tracy 2004:525) and false emotions, displayed at work, are somehow 'less true'. This does not address the fact that, when using a Foucauldian approach, and if emotions are 'formed through interaction, dialogue and societal and organizational rules' (Tracy 2004:525) then, regardless of whether they are real or false, there are discourses that affect them. Therefore, the discourse of an organisation, its culture, members, society, etc. all have an impact on the construction of one's emotional identity. As Tracy (2004:525) states, 'This understanding of work feelings as *constructed* challenges the dichotomy between "real" emotion and external fake expression,' as even fake expression is constructed by discourse.

For example, in opening her paper, Tracy (2004:509) describes an incident in which an officer was having difficulty restraining a violent prisoner in the segregation unit of the prison. The prisoner was both verbally and physically aggressive and abusive. Following the incident, the officer told her colleagues that she had been upset by the incident. Following this disclosure she was referred for mental health support. Tracy reports that the emotions felt by this officer were numerous: 'She felt anxiety and fear before taking down the inmate, excitement and pride after the group succeeded in taking the woman down without injury, and a mixture of guilt, disgust and confusion after the takedown' (Tracy 2004:510). These emotions can be described as

'real' emotions but they were felt at work in an organisational context and were affected by that context (which includes colleagues' presence, expectations, etc.). On one hand, I suggest that, in line with Tracy's challenge of the emotional labour literature that any emotion displayed in a work context is no more 'true' than another termed 'false', in the example given, the officer was frightened and anxious – these are 'real', felt emotions. However, the emotion which I suspect was expected to be displayed by her was not one of fear or anxiety but one of bravery. Therefore, if bravery was displayed, is that seen as a real emotion or is it a fake emotion because it was displayed but not felt? Either way, it was context and discourse that affected the emotional identity of the officer.

Interestingly, though, the emotions were felt at work and admitted to, which resulted in a mental health referral. The subject here states, 'I should be able to be bothered and not be labelled as unstable' (Tracy 2004:509). This labelling of the officer as unstable may be an overreaction by the officer because the manager may well have genuinely had the best interests of the officer at heart. It is, I suggest, the officer who may have an issue with being referred to mental health services. This could well stem from societal perceptions of mental health service users or indeed the culture of the prison setting, which may perceive mental health service users to be somehow weak.

Tracy reports emotional labour as common to the correctional officer, undertaken in the pursuit of meeting organisational norms and coping with paranoia, 'appearing respectful when feeling disgust or anger, maintaining wariness/suspicion even when they feel comfortable, and act calm when they are in tragic- or fear-inducing situations' (Tracy 2004:513). She reports that undertaking this type of emotional labour goes beyond manufacturing displays of phoney feeling and concludes that 'working to uphold emotion labor norms serves to construct emotional identity' (Tracy 2004:513). I suggest that the emotional identity of an individual in the prison setting not

only affects the mental well-being of staff working with prisoners but also affects the relationships between staff.

Upon reflection of Tracy's work in terms of my own experiences, the construction of my own emotional identity played a huge part in my practice and, indeed, in the pursuit of effective multidisciplinary working. In order to fit in with the multidisciplinary team, I was expected to display certain characteristics in my dealings with both prisoner patients and with other staff in which I needed to conform to expected emotional ideals, e.g. as a nurse by prisoner patients, but as a nurse with security and discipline awareness by officer colleagues.

In addition to discussing some of the emotion work undertaken by officers to meet organisational goals, Tracy also mentions emotion work that officers engage in to 'disassociate' themselves from inmates. She refers to this activity as avoiding the 'contagion effect' (Tracy 2004:517) which is explained as: 'The stigma associated with criminals rubs off onto workers, and correctional officers are sometimes regarded by outsiders as not being so different from the population they control.' Examples include the re-telling of stories about particularly brutal or gruesome inmates, and the discussion of inmate behaviour in derogatory terms. This, she feels, enables officers to feel in some way different to the inmates, which reinforces the inmate as 'the other'. Tracy (2004:521) reports that there is a 'cold, distant emotional construction' amongst officers, designed, I believe, as a defence against anxiety (see Menzies Lyth discussed earlier). The emotional identity of the correctional officer as concluded by Tracy (2004:529) is characterised by paranoia, withdrawal, detachment and an 'us-them' approach to inmates.

Although Tracy's paper highlights the emotional labour and management of correctional officers in the USA, some parallels can be drawn with prison officers in the UK. There will, however, be some differences as the factors

affecting officers in this country, e.g. the media and organisational culture, may differ from that found in the USA.

Crawley (2004) undertook her doctoral research in six male public sector prisons in England. Her ethnographic study was undertaken over two years during which time she spent many hours with prison officers both at work and with their families. In this study she highlights the central importance of emotions and emotion management as features of the prison environment alongside security and control, and notes as interesting how unprepared most new recruits to the Prison Service were for the emotional demands of prison work. In addition to the emotional labour of prison officers, Crawley also mentions the importance of 'impression management'. I feel that the two are linked. The impression one gives is influenced by one's emotions. For example, Crawley discusses the notion of impression management in her chapter concerning new prison officer recruits. New recruits are encouraged and advised to act confidently and to tell prisoners that they have worked in prison before. Crawley notes how hard some officers find it to act confidently. As confidence can be viewed as an emotion, acting confidently implies some kind of emotional labour. Crawley uses the term 'working personality' (2004:84) as something that has to be acquired and developed by the new officer. This incorporates 'the walk, the talk, the posture, the jargon, mindset, beliefs and values'. It is during this socialisation that new officers also begin to learn to manage their emotions.

In discussing what the prison officer actually does, Crawley notices that the majority of the day-to-day work of the officer is domestic and taken up with what she calls 'housekeeping'. Examples given include supervising the spending of money, supervising the laundry, ensuring prisoners receive their meals and shopping (canteen), and that cells are kept clean and tidy. Crawley refers to this domestic work as traditionally women's. However, although officers are involved in this domestic work, as prisons are domestic places, they often do so in a supervisory capacity which is not mentioned by

Crawley. This then brings issues of power and control of the domestic environment into play. It is this so-called 'domestic nature' of the prison setting, i.e. it is home for the inmates whilst they serve their sentences, that leads the prison to be so highly emotionally charged. As Crawley (2004:130) notes: 'In common with the home, where familiarity and boredom often degenerate into bickering and squabbles, I found that day-to-day interactions between prisoners and staff, and indeed officers, are punctuated by sulks, rows, fall-outs and minor disagreements. In the process of settling these disputes, officers and prisoners cajole, flatter, take offence, get angry, offer advice, placate, tease each other and so on.'

In her discussion of the emotional nature of the prison setting, Crawley highlights that the day-to-day life of prison is not widely discussed in academia compared with that which is highlighted in the literature concerning prison riots and escapes, i.e. when things go wrong. She continues to suggest that it is the day-to-day performance and management of emotions in this setting that makes prisons function without incident. Prison officers must ensure they manage their own emotions and those of the prisoners. The efficiency with which officers can manage their own emotions, or the emotions that the prison generates within them, is vital to the smooth running of the prison and also the relationships with fellow staff. Crawley continues to suggest that there are emotions that it is acceptable for officers to display in prison and there are those it is not. Interestingly, she deems these to be linked to gender. There is a long-standing macho culture within the Prison Service and the feeling rules of the organisation expect officers to be 'courageous, resilient, authoritative and fearless in all situations and that they will manage those emotions deemed to be feminine' (Crawley 2004:133). However, it is noted that female officers, whilst aware of the macho 'rules', use their traditionally female qualities, e.g. sensitivity, to prevent and manage difficult situations. However, in order to comply to some degree with the macho culture, female officers tend to try and dismantle the female stereotype, e.g. of being helpless, passive, etc.

Whilst there are some emotions that it is permissible to display in the prison setting, there are some that are not. In her discussion of the work stress prison officers endure, Crawley cites Kent (1998) who reports that prison officers have the most stressful job in the country. This stress is reported to be caused by a number of factors such as difficult inmates, long hours and working with unreliable colleagues (Crawley 2004). Although it is recognised that prison officers experience high levels of stress, reporting it in oneself is resisted due to officers fearing they will be labelled as mentally weak. There are other emotions highlighted by Crawley's work, such as anxiety, sympathy and fear, which are also unacceptable to display except in certain circumstances and with certain people. Again, it is the organisational and cultural rules that determine the appropriateness of emotional display.

Crawley (2004:148) identifies the presence of what she terms 'emotional zones' within a prison. She describes these zones as areas within the prison where it is acceptable for staff to perform emotions such as anger and distress, e.g. the gym, the gatelodge, places away from the prisoners' gaze. Emotional zones for prisoners are not discussed but I suggest that the health care centre is another place within the prison where it is more acceptable to display emotion than other places.

Crawley's work gives a very detailed insight into the world of the prison officer and the effect of emotions and emotional labour on their work. As I mentioned previously, the emotional labour of the prison officer is important to understand because the nurse working in prison undergoes similar socialisation into the prison culture and organisational norms. Although the prison nurse does not undertake the same training as a prison officer, the cultural rules and regulations still apply as nurses run and manage inpatient units and primary care services on residential units whilst working alongside prison officers.

Tracey (2005) reports on her 2004 study as discussed earlier but with a different focus. She moves away from the more traditional discussion of emotional labour and its links with emotional dissonance to explain the discomfort and highlight those factors that make emotion work easier or more difficult. In this paper, she discusses the dominant discourses and practices which affect emotional labour in the correctional setting and identifies those factors that ease or enhance the discomfort of emotion work. Tracy speaks of powerlessness, a lack of interaction with similar others, identification with the work role and the ability to view emotion labour as a strategic interaction of factors affecting the discomfort and easing of emotion work. There are two major factors that I feel are highly pertinent to discuss further in the context of my own study.

Tracy highlights the lack of interaction with similar others as a barrier to dealing more effectively with emotion work. She states, 'The availability of spaces for employees to associate with similar others affects the discomfort of emotional labor. Especially when it is outside the gaze of superiors or clients, peer interaction allows employees to co-construct preferred identities through "hidden transcripts" and "role-distancing behaviours"' (Tracy 2005:275). In my mind, this highlights the importance of peer support and perhaps even the importance of a supportive mechanism such as clinical supervision to help prison staff cope with the emotional labour they encounter.

A second factor identified by Tracy (2005) is the perspective of viewing emotion labour as strategic interaction, e.g. 'It appears that officers found emotion work less laborious when it was framed as a type of strategic interaction; that is, as a favour that would provide them something in exchange' (Tracy 2005:278). She continues to note an officer in her study who recognised the value of treating people as people rather than criminals and showing respect because, as they comment, 'You seem to get along better with them' (Tracy 2005:278). I suggest that the appreciation of

emotional labour as a strategic interaction demonstrates emotional intelligence.

I am aware that I have discussed emotional labour as it pertains solely to prison staff, both officers and nurses. Upon reflection, however, it is important to highlight the emotional labour that may be undertaken by prisoners in their daily lives. I have referred to the manipulation of staff by prisoners which, I now suggest, involves emotional labour, given that the prisoner may often work to produce an emotional state in another person, ultimately benefiting the prisoner. Relating this to my own experience, I encountered a prisoner who was (I later discovered) feigning illness to gain entry to the inpatient unit of the health care centre. In feigning this illness, or 'acting', he managed to produce feelings of sympathy and concern within me, which caused me to demand his relocation to health care. Upon reflection, I suggest that the emotional labour undertaken in prison is not just the domain of the staff.

Emotional Intelligence

Pfeifer et al. (2001) have identified problems with the construct of emotional intelligence, stating two main issues: a lack of precision as to how it is conceptualised and a lack of accurate, empirical measurement. I concur wholeheartedly with the first issue, that there is a lack of precision as to how emotional intelligence is conceptualised. Whilst reviewing literature for this study, it has become increasingly evident that there is no one clear, consistent definition or conception of what emotional intelligence actually refers to. In fact, according to Opengart (2005), there appear to be three main streams of definitions of the concept: one with an emphasis on ability (Salovey & Mayer 1990), another with a focus on personality (Goleman 1998), or a combination of both (Bar-On 1997a). However, Mayer et al. (2000) suggest that there are two main models of emotional intelligence: a 'mixed model' into which they categorise Goleman and Bar-On, and an

'ability' model into which they place their own model. They refer to the 'mixed model' as encompassing both mental ability and personality characteristics.

According to Opengart (2005), an aspect of emotional intelligence called social intelligence was first described by Thorndike in the 1920s and is defined by Grewal & Salovey (2005:330) as, 'An ability to perceive their own and other's internal states, motivations and behaviours, and act accordingly.' However, Weschler's IQ test, which was developed in the 1950s, gained more popularity than the work of Thorndike, and IQ testing became far more popular in the latter half of the 20th century than examination of emotional intelligence. In 1983, however, the idea of multiple intelligences was proposed by Gardiner and included linguistic, bodily-kinaesthetic, logical-mathematical, spatial, musical, intra-personal and interpersonal (Gardner 1983). It is the intra-personal and interpersonal intelligences highlighted by Gardner that have a relationship with emotional intelligence as we understand it today. Gardner wrote of personal intelligences, which he suggests are the 'inter' and 'intra' personal aspects of intelligence. Of intra-personal intelligence he states that, 'The core capacity at work here is *access to one's own feeling life* – one's range of affects or emotions: the capacity instantly to effect discriminations among these feelings and, eventually, to label them, to enmesh them in symbolic codes, to draw upon them as a means of understanding and guiding one's behaviour' (Gardner 1983:240). Of interpersonal intelligence, Gardner (1983:240) writes, 'The core capacity here is *the ability to notice and make distinctions among other individuals* and, in particular, among their moods, temperaments, motivations and intentions.'

Although there is a wealth of literature in the field of emotional intelligence, such as in psychology, human resources, management and the like, I have chosen to limit my review of the subject to the key authors in the field: Bar-On, Salovey & Mayer and Goleman. My rationale for this stems from the confusion I have experienced whilst trying to search for a consistent

description of the concept. Whilst I acknowledge the wider writings on this subject, I feel that the repeated reference to these authors by those who have come after them signifies the baseline I should draw on in my own study in seeking a definition of the concept.

Mayer & Salovey

Following a literature search, six key papers have emerged from Salovey and Mayer, commencing in 1990, when they first used the term 'emotional intelligence'. Further papers followed in 1997, 2000, 2001, 2002 and 2003.

Much of the literature cites Salovey & Mayer as those who 'coined' the term and proposed the first definition of emotional intelligence in 1990. At this time, they defined emotional intelligence as, '*The subset of social intelligence that involves the ability to monitor one's own and other's feelings and emotions, to discriminate against them and to use this information to guide one's thinking and actions*' (Salovey & Mayer 1990:189).

In their seminal paper of 1990, Salovey & Mayer propose a framework for emotional intelligence, which I have illustrated below. They suggest that models of intelligence 'are (generally) more restrictive organizations of the field that serve to describe interrelations among or causes of mental abilities' (Salovey & Mayer 1990:187). Interestingly, the motivation for the development of such a framework does, I believe, rest on similar confusion which I experienced in my travels through the literature surrounding emotional intelligence. As they suggest, 'There is an exciting body of research that, for lack of a theoretical concept, is dismembered and scattered over a diversity of journals, books, and subfields of psychology' (Salovey & Mayer 1990:187). It is this dismembering and scattering that I, too, have encountered some 16 years since the concept was identified.

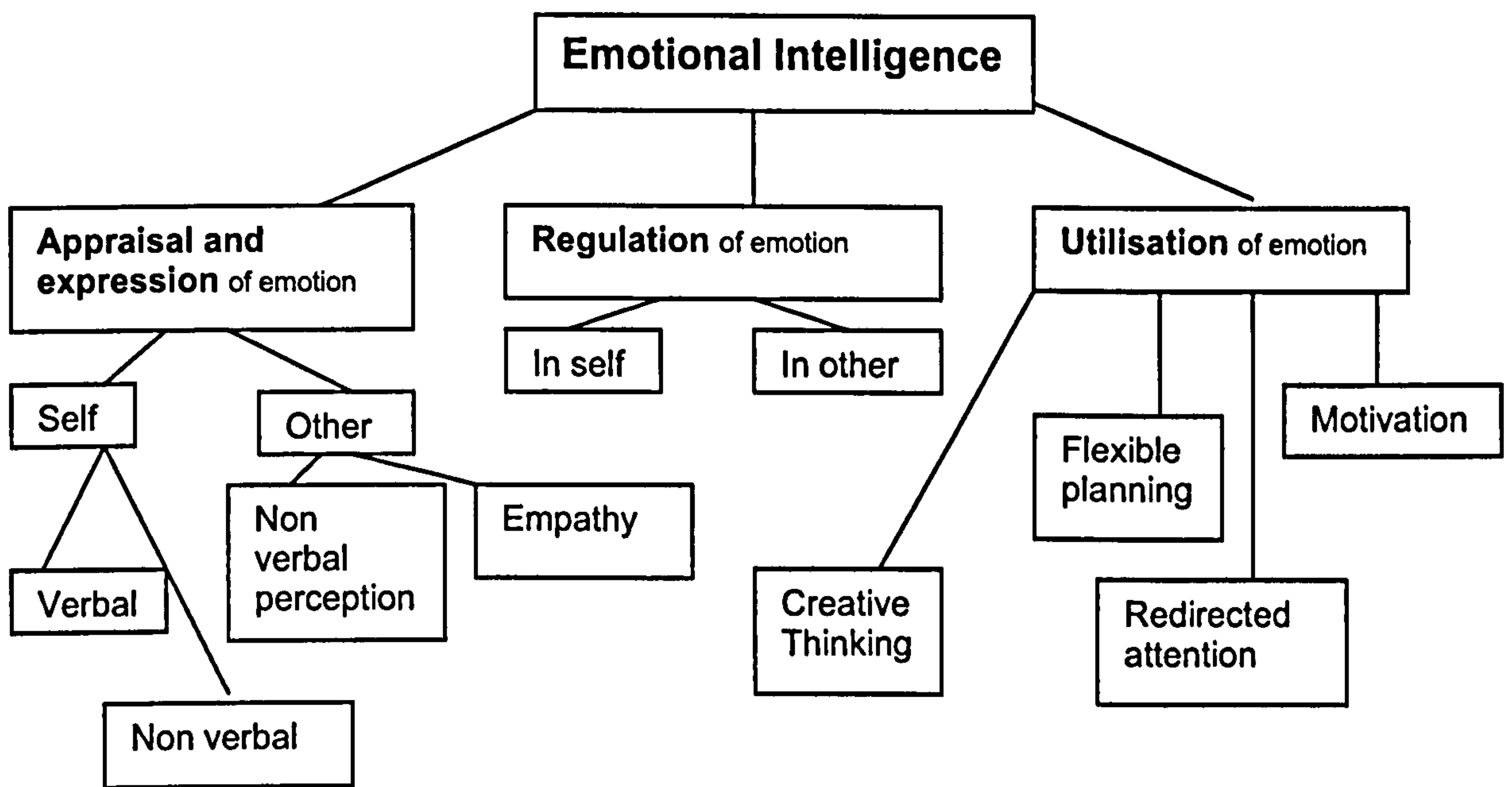


Figure 2: A framework for emotional intelligence, adapted from Salovey & Mayer (1990:200)

In their 1990 paper, the authors continue to examine the three subsets of emotional intelligence, i.e. appraisal and expression, regulation and utilisation of emotion in detail, whilst relating their thoughts to the literature of the time. In discussion of the appraisal and expression of emotion, Salovey & Mayer suggest that this is a key area of emotional intelligence given that those who are accurately able to recognise and respond to their own emotions can express themselves more appropriately to others and are better able to deal with the feelings generated by their emotions on account of the accuracy with which they perceive them. The skills with which they accomplish this are themselves emotionally intelligent ‘because they require the processing of emotional information from within the organism’ (Salovey & Mayer 1990:193). In summarising the importance of skilful recognition of others’ emotional reactions and response to them, the authors suggest that those who are emotionally intelligent can accurately gauge emotional responses in others *and* are able to choose suitable behaviours in response.

Salovey and Mayer also see the regulation of emotion in both the self and in others as a key component of emotional intelligence. They suggest that most people are able to regulate emotion in themselves and in others. However, in those who are more emotionally intelligent, higher levels of proficiency are demonstrated with the aim of achieving specific goals, both positively and negatively. When solving problems, Salovey & Mayer suggest that the emotionally intelligent will be at an advantage given the way in which problems are framed. They suggest that the emotionally intelligent are more likely to 'integrate emotional considerations when choosing among alternatives' and 'may be more creative and flexible in arriving at possible alternatives' (Salovey & Mayer 1990:200).

In 1997, following further thought and reflection, Mayer & Salovey revised their previous framework and definition of emotional intelligence. In this paper, they highlight further developments in the conceptualisation of emotional intelligence and suggest that earlier definitions seem 'vague in places and impoverished', referring to the focus on perceiving and regulating emotion without thinking about feelings (Mayer & Salovey 1997:10). They revise their definition thus: 'Emotional intelligence involves the ability to perceive accurately, appraise, and express emotion; the ability to access and/or generate feelings when they facilitate thought; the ability to understand emotion and emotional knowledge; and the ability to regulate emotions to promote emotional and intellectual growth' (Mayer & Salovey (1997:10).

When examining this definition as it relates to that of 1990, it is clear that the concept has been widened to include the previous facets of appraisal/expression, regulation and utilisation of emotions but with a broader sense of the ability to reflect on the regulation of emotions to support and encourage both emotional *and* intellectual growth.

There are now four clear elements to the concept of emotional intelligence as proposed by Mayer & Salovey (1997:11):

- Perception, appraisal and expression of emotion
- Emotional facilitation of thinking
- Understanding and analysing emotions/employing emotional knowledge
- Reflective regulation of emotions to promote emotional and intellectual growth

Mayer & Salovey continue in their 1997 paper to discuss the importance of emotional intelligence in the education of children. However, I suggest that the development of emotional intelligence need not be limited to childhood. It can potentially also be addressed during adulthood, and in nursing, through the promotion of reflective practice and clinical supervision.

In 2000, Mayer and colleagues published a paper that examined emotional intelligence with regard to model types (see Mayer et al. 2000). They suggest that models of emotional intelligence can be one of two types: mixed or ability. The mixed model includes various personality dispositions whereas the ability model removes the personality dispositions and concentrates on mental ability alone.

In this paper, they state their preference for viewing emotional intelligence in terms of an ability model, given their decision in 1997 to constrain emotional intelligence to a mental ability concept and separate out traits such as warmth, persistence and outgoingness. They felt that, by doing this, their own theoretical work would be more useful as they would be able 'to analyse the degree to which they independently contributed to a person's behaviour and general life competence' (Mayer et al. 2000:403). Examples of the mixed method type are given as those which 'expanded the meaning of emotional intelligence by explicitly mixing in non-ability traits' (Mayer et al. 2000:403). These include work by Bar-On (1997b), who developed the Emotional Quotient Inventory, and Goleman (1996) who found fame with his popular

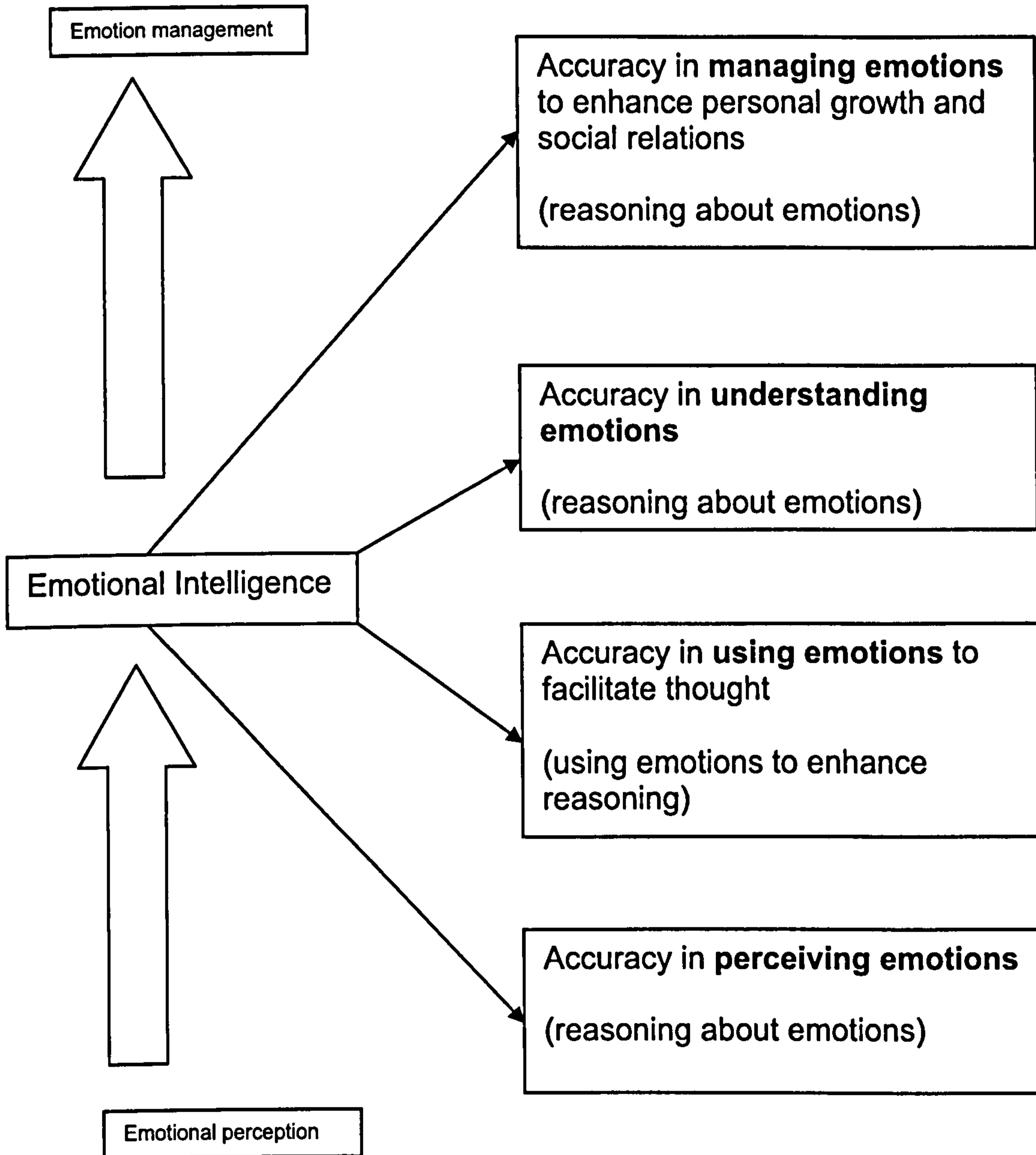
self-help book, 'Emotional Intelligence'. What is worth noting here is the focus of discussion in this paper on the quantitative measurement of emotional intelligence. Indeed, Mayer et al. (2000) report not only the work previously published by Bar-On but also their own work in developing emotional intelligence measurement. In this paper, they write about the Multifactor Emotional Intelligence Scale (MEIS) in which emotional intelligence is viewed in terms of being a set of mental abilities. Application of this scale can be found in Mayer et al. (2000a). I suggest that the use and development of assessment tools is indicative of the perceived need by traditional academics to conform to the scientific method of enquiry in order to generate and perhaps justify what the scientific community views as somehow more valid findings.

Mayer et al. (2000a) suggest that emotional intelligence can now be viewed as what they term a 'standard intelligence', i.e. one that meets stringent criteria, which they have described in three areas: conceptual, correlational and developmental. Conceptual refers to the need for an intelligence to reflect mental performance rather than a preferred way of being. Correlational criteria refers to empirical standards in that 'an intelligence should describe a set of closely related abilities that are similar to, but distinct from, mental abilities described by already established intelligences' (Mayer et al. 2000a:270). Finally, the developmental criterion refers to the fact that intelligence develops with age and experience. Both studies reported in this paper met the criteria for a standard intelligence. It is this paper that supports the concept of emotional intelligence as existing in its own right as an intelligence. Using the MEIS, Ciarrochi et al. (2000) suggest that emotional intelligence is related to people's ability to manage their moods, but not their ability to prevent moods from biasing their judgments.

Following criticism of their 2000a paper by Roberts et al. (2001), Mayer and colleagues responded with an overview of their current view of emotional intelligence. At this point in the journey, Mayer et al. (2001) are clearly

wedded to using the four-branch model as described in 1997 and explain further a distinction they feel is important between the second branch and the other three branches. They state that, 'Whereas branches one, three and four involve reasoning about emotions, branch two uniquely involves using emotions to enhance reasoning' (Mayer et al. 2001:234). In addition, they reiterate their view that the branches also form a hierarchy, with emotional perception at the bottom and emotion management at the top. I have illustrated this model overleaf.

Figure 3: Four Branch Model of Emotional Intelligence, adapted from Mayer et al. (2001)



Criticisms of their 2000a paper by Roberts et al. centred mainly on the low correlation between methods of scoring the tool used to measure emotional intelligence. My aim here is not to provide a discussion of the development of measurement tools and scales but to provide an overview from a theoretical perspective of the nature of emotional intelligence. Therefore, these criticisms and the subsequent response are not discussed here but can be found in the original paper (see Mayer et al. 2001).

In 2002, Salovey et al. published a paper concerning the Trait Meta Mood Scale (TMMS) developed by Salovey and colleagues in 1995 (Salovey et al. 1995). My purpose here is not to discuss the Trait Meta Mood Scale. My main interest in the 2002 publication and development of emotional intelligence is the importance stressed by the authors on reflection in emotional intelligence. They state that, 'An important aspect of emotional intelligence is the ability to reflect upon and manage one's emotions' (Salovey et al. 2002:611). Mayer & Gaschke (1988), cited in Salovey et al. (2002), suggest that individuals continually reflect on their feelings by monitoring, evaluating and regulating them. They called this process 'the meta mood experience'. From this work they developed the State Meta Mood Scale, which 'measures individuals' moment by moment changes in reflections about ongoing moods' (Salovey et al. 2002:612).

It has been clear during my search for literature pertaining to emotional intelligence that, since approximately 2000, the dominant discourse in the academic arena has been one of measurement and quantitative analysis. Despite describing and developing the concept through theoretical discussion during the 1990s, Salovey and Mayer have moved towards demonstrating rigorous measurement of the concept and development of measurement tools. Indeed, this has prevailed throughout the literature from around 2000, and hence qualitative discussion and development of the concept appears to have slowed significantly. The most recent publication I have been able to track from Peter Salovey concerns the report of two

studies in which emotional intelligence and social interaction were examined using the Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT). The two studies found positive relationships between the ability to manage emotions and the quality of social interactions (see Lopes et al. 2004 for further detail).

Daniel Goleman

Another key writer in the field of emotional intelligence is Daniel Goleman. His famous work, 'Emotional Intelligence', has been described as 'one of the most successful self-help tomes of the past decade' (Butler-Brown 2006:32). McManus (2001) suggests that Goleman can be credited with making emotional intelligence a trend in popular culture. According to Pfeifer et al. (2001:140), Goleman has as his thesis 'that the balance and management of our emotions determines how intelligently we will act and our ultimate success in life'. The focus of Goleman's 1996 publication centres on the importance of emotional intelligence in being successful both in business and in one's personal life. In doing this he refers to the work of earlier authors in the fields of psychology and intelligence but also broadens it out to include neurology and brain development. According to Mayer et al. (2000), it was the combination of both science and human potential in Goleman's book which caught the imagination and popularised his work.

Goleman (1995) categorises emotional intelligence into five distinct groups under the two headings: personal competence and social competence. The five groups comprise: knowing one's emotions, management of emotions, motivating oneself, recognising emotions in others and handling relationships. Goleman's definition and related characteristics of emotional intelligence are further developed in his 1998 publication, 'Working with Emotional Intelligence' (Goleman 1998). In this publication he suggests that emotional intelligence determines one's capacity to develop the skills/competencies related to self-awareness, self-management, social

awareness and relationship management and hence how these translate into success in the workplace.

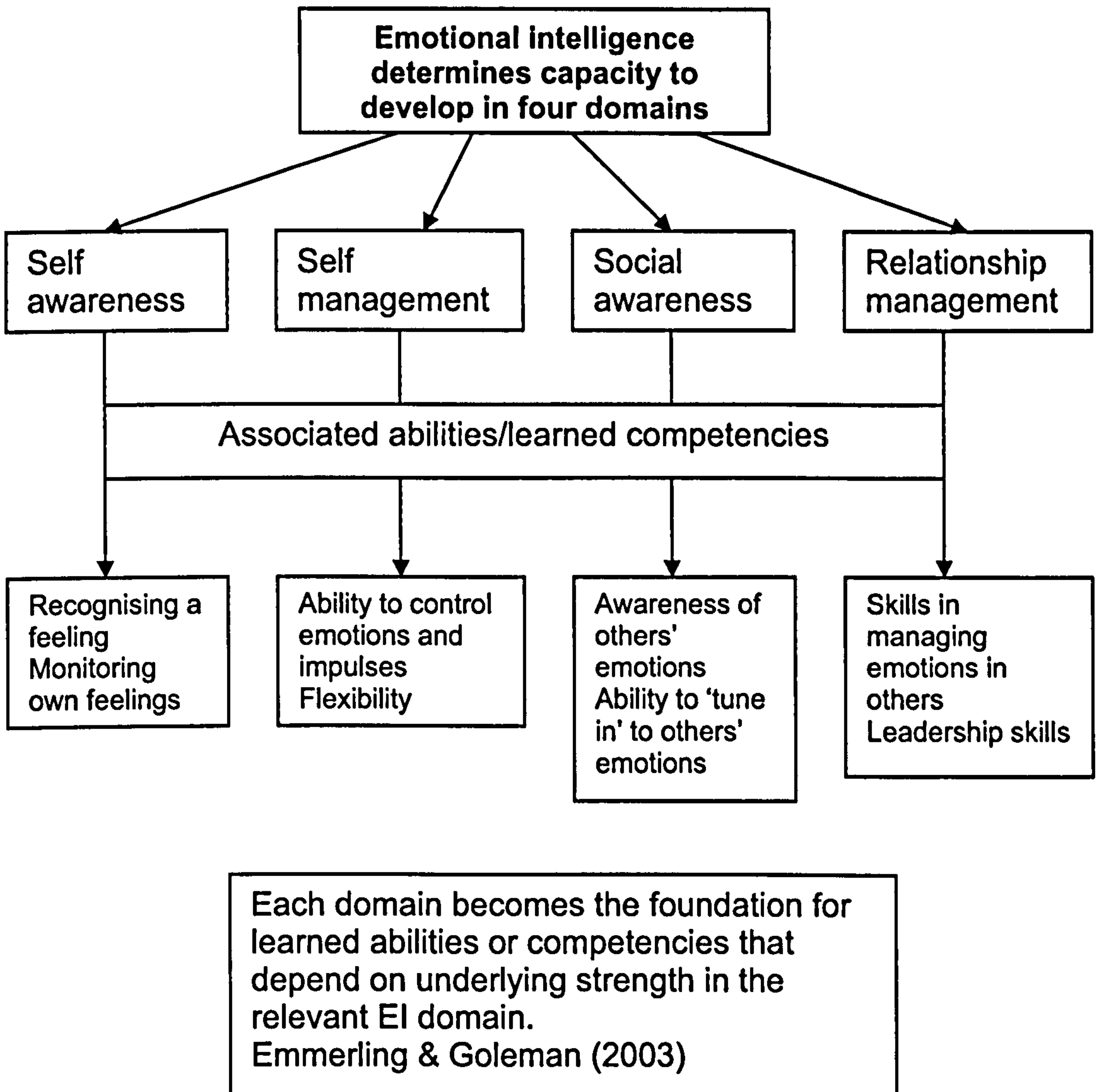


Figure 4: Goleman’s 1998 framework for emotional intelligence

Much of Daniel Goleman’s work centres on the importance of emotional intelligence in determining success and it is this strive towards success that I feel has promoted his work. However, my concern is with the term ‘success’. After reading Goleman’s work, I am left with a sense of disillusionment as I try to gauge the extent to which I am able to determine my own view of

success rather than be provided with a description of 'success' and the abilities I need to develop to achieve this.

Goleman's work has undoubtedly contributed to the development of emotional intelligence since 1996 but, according to Grewal & Salovey (2005), the popularisation of emotional intelligence has served to distort the original scientific definition. 'Many people now equate emotional intelligence with almost everything desirable in a person's make up that cannot be measured by an IQ test, such as character, motivation, confidence, mental stability, optimism and "people skills"' (Grewal & Salovey 2005:339).

Reuven Bar-On

In 1997, Reuven Bar-On proposed a definition of emotional intelligence as an 'array of non-cognitive capabilities, competencies, and skills that influence one's ability to succeed in coping with environmental demands and pressures' (Bar-On 1997a:14). Abilities, competencies and skills in the following areas were highlighted: interpersonal, intra-personal, adaptability, stress management and general mood. Following further thought and development, Bar-On now appears to refer to emotional intelligence as 'emotional-social intelligence' and defines it as 'a cross-section of interrelated emotional and social competencies, skills and facilitators that determine how effectively we understand and express ourselves, understand others and relate with them, and cope with daily demands' (Bar-On 2005:3). He continues to state that, 'Being emotionally and socially intelligent means to effectively manage personal, social and environmental change by realistically and flexibly coping with the immediate situation, solving problems and making decisions' (Bar-On 2005:4). Bar-On suggests that, in order to achieve this, emotions must be managed so they are useful rather than destructive, and stresses the importance of optimism, a positive outlook and motivation. I have illustrated this model in the following table.

Intra-Personal	Self-Awareness and Self-Expression
Self-Regard	Accurately perceive, understand and accept oneself
Emotional Self-Awareness	To be aware of and understand one's own emotions
Assertiveness	Effectively and constructively express one's own emotions and oneself
Independence	To be self-reliant and free of emotional dependency on others
Self-Actualisation	To strive to achieve personal goals and actualise one's potential
Interpersonal	Social awareness and interpersonal relationship
Empathy	To be aware of and understand how others feel
Social Responsibility	To identify with one's social group and co-operate with others
Interpersonal Relationship	To establish mutually satisfying relationships and relate well with others
Stress Management	Emotional Management and Regulation
Stress Tolerance	To effectively and constructively manage emotions
Impulse Control	To effectively and constructively control emotions
Adaptability	Change Management
Reality Testing	To objectively validate one's feelings and thinking with external reality
Flexibility	To adapt and adjust one's feelings and thinking to new situations
Problem-Solving	To effectively solve problems of a personal and interpersonal nature
General Mood	Self-Motivation
Optimism	To be positive and look on the brighter side of life
Happiness	To feel content with oneself, others and life in general

Figure 5: The Bar-On model of emotional-social intelligence, adapted from Bar-On (2005)

Thoughts on Emotional Intelligence

There are three main models of emotional intelligence, those of Peter Salovey & John Mayer, Reuven Bar-On and Daniel Goleman, all of which were proposed during the last 20 years.

What is common to all models, however, is the inclusion of Gardner's (1983) personal intelligences, i.e. intra and interpersonal intelligence. In addition, all models have as their overarching purpose the aim to both understand and measure the abilities and qualities related to recognising and regulating emotions in others and ourselves. Emmerling & Goleman (2003) suggest that the very fact there are three main models, each using different language to label theories and constructs, does not indicate a weakness in the field of study but, they suggest, serves to underpin the robustness of the field. They state the importance for academics to 'acknowledge that having multiple theories can often serve to elucidate additional aspects of complex psychological constructs' (Emmerling & Goleman 2003:9). Kemp et al. (2005) suggest that different conceptualisations of a concept can be viewed as complementary rather than contradictory.

In my search for a definitive description and definition of emotional intelligence, I have encountered much confusion. The concept appears vague, and understanding of it rooted in personal preference. As Kemp et al. (2005:42) suggest, 'The EI construct, however, is still regarded as elusive with "fuzzy" boundaries.' Indeed, I have found it very difficult to grasp, given my longing for concrete fact. Apart from the three main models described earlier, it has become clear that the terminology used to illuminate the concept has also added to my confusion. In his discussion paper, Caruso (2004) suggests that in order to develop the field of emotional intelligence, the use of a common language and terminology is vital. He highlights the problem of alienating clients and causing communication problems amongst researchers and practitioners as a major issue that will only serve to prevent the speedy development of the area.

Another area of study in the emotional intelligence arena is the concept of measurement. All three approaches and understanding of emotional intelligence propose different measurement tools and methods (see table below).

Model	Measurement Tool	Approach
Bar-On	Emotional Quotient Inventory (EQ-I), self-report	Ability & traits based
Mayer & Salovey	Performance/ability based measurement, Mayer, Salovey, Caruso Emotional Intelligence Test Version 2.0 (MSCEIT V2.0)	Cognitive/ability based
Goleman	360 degree tool Emotional Competence Inventory (ECI 2.0)	Competency based

Table 3: Summary of emotional intelligence approaches and measurement

My understanding of statistical analysis is lacking and something which I am addressing as a matter of urgent professional development. However, my main issue concerning the measurement of emotional intelligence is an innate feeling that one cannot accurately measure such a construct using a prescribed quantitative tool as I feel it does not take into account individual differences. I have always felt that quantifying people as units is inappropriate. Emmerling & Goleman (2003:24) appreciate this in their paper stating 'that the affective experience and abilities of individuals can somehow be quantified has made some uncomfortable'. They continue to suggest that this may be due in part to 'a philosophical view that has seen emotions as unpredictable, irrational, and something to be suppressed in favour of logic or reason' (Emmerling & Goleman 2003:24). They continue to suggest that if this view predominates, 'then emotions and emotional intelligence would hardly be worth measuring, even if one could'. My question is: why is it

important to be able to measure emotional intelligence using the traditional quantitative scientific paradigm? I am one of those who are uncomfortable with measuring individuals, given my belief that everyone is different and will be different on different days depending on a variety of factors for which it would be impossible to control. I understand the benefits to both individuals and organisations of being able to develop emotional intelligence and I suggest that, in order to do this, it is important to know which areas are in some way 'lacking'. However, I feel that this could be achieved through a more reflexive, qualitative paradigm.

Another issue that has not been addressed in the literature in any great detail by the majority of theorists, and one which is highly relevant to the prison setting, is the ethical/moral dimension to emotional intelligence. The majority of writing hails emotional intelligence as a positive concept, one which can change lives and improve interpersonal relations. However, the only authors to highlight the potential for the unethical/immoral application of emotional intelligence in human relationships are Emmerling & Goleman (2003) and Grewal & Salovey (2005). They suggest that some individuals, in order to manipulate and deceive others, may use emotional intelligence abilities, such as empathy and persuasion. As Grewal and Salovey (2005:339) state, 'Being emotionally intelligent does not necessarily make one an ethical person.' Emmerling & Goleman (2003) call for further thought, study and research in this area.

I suggest there are links here with my previous reflections on the emotional labour engaged in by prisoner patients. If the emotional labour they engage in is designed to elicit feelings in others (such as empathy), I suggest that it is emotional intelligence that enables effective emotional labour. If a prisoner patient can appraise the emotions of others whilst regulating their own, it places them in a strong position to manipulate staff through engaging in emotional labour.

My final observation, having studied the literature, is that of fierce debate and discussion between the key proponents of emotional intelligence. Although much of it is not overt or tangible, I get a sense of an atmosphere of academic competition, mainly between Salovey & Mayer and Goleman. My overall impression is one of an 'intellectual struggle' between academia and popular psychology. It is noted by Caruso (2004:6) that 'the EI debate amongst researchers has oftentimes been quite passionate and intense. Unfortunately, the debate has also, at times, been personal and overtly negative'. He continues to highlight the challenge for researchers to engage each other in constructive dialogue and debate in order to develop the field. The importance of addressing uncomfortable feelings between researchers and theorists working in the EI arena is stressed, given that 'uncomfortable feelings contain data, and we must stay open to such data in order to be effective' (Caruso 2004:6). On a different level, I suggest that there also needs to be consideration of the emotional intelligence of both researchers and theorists in addressing these uncomfortable feelings.

Fineman (2000) provides the reader with an alternative viewpoint to the discussion of emotional intelligence. He suggests that the discourse of emotional intelligence centres more on intelligence than on emotion in that 'it is processes of thinking and judgment that are being targeted – and refocused on emotions to enhance control of self and others' (Fineman 2000:110). He suggests that, given the supposition that feelings inform thoughts and thoughts inform feelings, making decisions about feelings and emotions will be an emotional process. He suggests that if emotional intelligence promises an ability to control thoughts and feelings, then that in itself deems it to be fake.

Secondly, he suggests that if the emotionally intelligent are more able to describe and label their feelings, then 'this will do something to them. It gives them a social and political context; a contextualised meaning' (Fineman 2000:110). It is this contextualising of meaning that, in effect, Fineman feels

may change them. He asserts that when consultants working in the field of emotional intelligence in organisations are involved, it is their constructs and preferred language that dominates how people 'ought' to be. As he states, 'One must presume that the emotionally intelligent manager can acknowledge such feelings and then turn away from those that fail to translate into effective managerial action or stardom' (Fineman 2000:111). Fineman's concern with this appears to be centred on what happens to the rejected emotion.

Fineman also discusses the psychoanalytic perspective of emotions in that there are times when replacing negative emotions with more socially acceptable 'positive' emotions may not be possible, even though it is suggested that the emotionally intelligent are able to control them. He states, 'What is missing from emotional intelligence formulations is a way of grasping the psychoanalytic reality that we very often do not know what emotions are compelling us because of a variety of defensive, displacement and screening processes' (Fineman 2000:111). He continues to suggest that many of our emotions may evade conscious control.

Emotional Intelligence in Nursing

The concept of emotional intelligence has gained popularity in the world of nursing over the last six years. The relationship of emotional intelligence to many areas of nursing has been addressed in the literature, e.g. in nursing practice, nurse education, recruitment and leadership (see McQueen 2004; Freshwater & Stickley 2004; Cadman & Brewer 2001; Skinner & Spurgeon 2005; Vitello-Cicciu 2002; Amendolair 2003; Muna 2005; Mann & Cowburn 2005; Henderson 2001; Gattuso & Bevan 2000; Smith 1991; McCreight 2005). In approaching this area I have chosen to look at the literature in the context of three areas: practice, education and management. However, it must be noted that there are overlaps in the literature as nurse education appears in many recommendations to support the development of emotional

intelligence in nursing practice as the benefits of emotionally intelligent health care staff are demonstrated through research.

Practice

A search of electronic health databases (CINAHL and MEDLINE) reveals a lack of literature explicitly addressing emotional intelligence in clinical nursing practice. Emotional intelligence as a concept in midwifery appears to be becoming more popular, but in nursing practice there is a paucity of empirical work. Three papers in particular stand out as making a significant contribution to this area: McQueen (2004), Akerjordet & Severinsson (2004) and Gertis et al. (2005).

In her paper, McQueen (2004) analyses the literature on both emotional intelligence and labour, whilst considering the value of emotional intelligence to nursing. The contribution of emotional intelligence to nursing management is acknowledged by McQueen but is not considered in this paper. Her focus is the examination of emotional intelligence in respect of its potential benefits to patient care. She concludes that the benefits to patient care are embedded in the emotionally intelligent nurse's ability to develop and sustain effective partnerships with both patients and the multidisciplinary team. However, McQueen does stray into the arena of nurse education in her discussion concerning the lack of appropriate training for nurses in self-awareness and the ability to provide psychological support. McQueen also reports a study by Carrothers et al. (2000) in which the emotional intelligence of medical school applicants was measured. The study concluded that women are more competent than men in interpersonal skills. McQueen continues to suggest that professional–patient relationships in both nursing and medicine are similar and share many of the same features, e.g. trust, and as such some use of a tool to measure emotional intelligence in nursing students and qualified practitioners may be beneficial. In addition to discussing the benefits of emotional intelligence in relationships, McQueen also discusses its importance within interprofessional working and the way in

which emotional intelligence is generated within teams as the team grows and develops. McQueen suggests that a high level of group emotional intelligence would be beneficial in team approaches to patient care. McQueen continues to discuss the implications of emotional intelligence for nurse education and curricula and supports the need for a greater input concerning emotional intelligence throughout nurse education. This will be discussed in more detail later in this section.

Norwegian nurse academics Akerjordet & Severinsson (2004) report on their study in which they explored mental health nurses' experiences of emotional intelligence in their nursing practice. Using a qualitative hermeneutic approach to their study, Akerjordet and Severinsson interviewed seven mental health nurses working in different general psychiatric wards, although they do not give any indication of the questions posed during these interviews. They do report that the questions were devised from the emotional intelligence literature but give no further detail. All interviews took place in the workplace and were tape-recorded. Purposeful sampling was employed to obtain a sample of nurses with over five years of experience working in acute mental health care. The rationale for this is not reported. All participants were women with an average age of 48. The majority of nurses were in full time employment and one was a head nurse, although the positions/grades of the other nurses are not reported. Four main themes emerged in this study: relationship with the patient, the substance of supervision, motivation and responsibility.

The meaning of the relationship with the patient was highlighted by all the respondents in the study and was found to include several aspects related to emotional intelligence: the genuine and authentic encounter; intuition and consciousness; understanding; and social skills. Different kinds of encounters were reported by participants in their clinical work, where their feelings were central to the nurse–patient relationship. The authors associate these feelings not only with emotional intelligence but also with existential

intelligence as described by Gardner (1983). The use of intuition and appreciation of consciousness in nursing are linked to intellect by the authors as they state, 'Intuition goes hand-in-hand with intellect and in practice they are interdependent' (Akerjordet & Severinsson 2004:166). In order to engage in a genuine and authentic encounter, it is necessary to build trust and confidence. Respondents in this study reported the importance of empathy in a good nurse-patient encounter. Empathy and good social skills are important for mental health nurses (and nurses in general) and are highlighted in previous models of emotional intelligence (see Goleman 1998).

Clinical supervision is also highlighted by the respondents in this study as important in terms of both using and developing emotional intelligence. The findings suggest that these nurses value reflection and supervision as a way to develop emotional, spiritual and linguistic intelligence. The aspects of supervision identified in this study as relating to emotional intelligence include reflection, coping with feelings, exchanging experiences, participation, creativity and new ways of thinking. Motivation is reported in this study as the third theme identified and the authors suggest that role models, inner motive power, personal mastery and commitment were all found to be areas in which emotional intelligence is central. Indeed, this can be seen in the model of emotional intelligence proposed by Goleman (1998). Responsibility as a moral value is expressed in this paper as an example of emotional intelligence in practice, given the opinion that to take responsibility relies on self-awareness. According to Akerjordet and Severinsson (2004:169), 'Self-awareness and responsibility reflect meaningful aspects of emotional intelligence.' This paper provides welcome empirical evidence of the importance of emotional intelligence in nursing but I do not feel that it has highlighted any issues which could not have been foreseen given our understanding of emotional intelligence. However, it is clear that there needs to be further research in this area. As Akerjordet & Severinsson (2004:170) state, 'The findings imply further research possibilities within the area of emotion...the importance of developing EI skills at all levels in health care

organizations and within an educational context should be further clarified by empirical research in the field.'

The most recent paper published to examine emotional intelligence in practice reports on a two-year longitudinal study in The Netherlands which measured the emotional intelligence profiles of 380 nurses caring for clients with severe behavioural problems (Gertis et al. 2005). The aim of this study was to identify clusters of the subcomponents of emotional intelligence in those nurses reporting the fewest symptoms of burnout, the least absenteeism due to illness and the least job turnover. Using a quantitative approach, the authors collected data from 380 nurses working in 56 Dutch residential facilities for people with learning disabilities. They refer to mental retardation instead of learning disability but I feel this term is inappropriate. In total, 146 men and 234 women who had been working with this client group for at least one and a half years and over 18 hours per week were included. The average age of the nurses was 33.1 years, with the majority working in residential homes and/or day care facilities. A Dutch version of the Bar-On emotional quotient inventory was used to measure the emotional intelligence of this sample. A 20-item Utrecht Burnout Scale, the Dutch version of the Maslach Burnout Inventory, was used to provide an indicator of burnout. In addition, data were provided by the personnel manager from each of the facilities in relation to job turnover and absence due to illness.

The findings from this study indicate a clear link between emotional intelligence and burnout in nurses when measured at two different points in time. However, the authors report that more specific insight into their emotional intelligence would be needed to specify the exact nature of the relationship with burnout. It was found that female nurses with high levels of emotional labour and median scores for the social skills element of emotional labour showed the most favourable outcomes with regard to burnout. Interestingly, it was found that those nurses with high levels of emotional intelligence and high levels of social skill did not protect against burnout. The

authors suggest that lower levels of social skill keep nurses from being too empathic and feeling overly responsible for their patients, thereby preventing over involvement which is therefore a good coping strategy. Conversely, in the male sample, the level of social skill was not a significant factor in burnout. This study also identified that the initial burnout scores appeared to be a better predictor of job turnover than emotional intelligence.

Although this study adds to the growing body of literature concerning emotional intelligence, it does not discuss the concept of emotional labour, nor does it look at the possibility of the development of emotional intelligence in the sample between the two data collection points. The authors suggest that further research is undertaken to examine newly appointed nurses and their adjustment to the stress of practice. They highlight the implications of their study for practice and identify the relevance of the Emotional Quotient Inventory as an instrument to be used in the training of nurses. They do not elaborate on this and it is left to the reader to make the connection. They also suggest that given the gender-specific results they obtained, for the purposes of preventing burnout, female nurses may need more training in distancing whilst male staff may need more training on stress tolerance and problem-solving. I suggest this has interesting application in the male adult prison setting where the majority of officers are male and the majority of nurses are female.

Education

Much of the literature concerning emotional intelligence in nursing is centred on nurse education, both pre-registration and post-registration. Indeed, even those papers that do not have education as a central focus highlight the need to incorporate emotional intelligence into curricula. The emotional aspect of nursing has long been acknowledged but it is only recently that the literature has begun to highlight a growing need to prepare student nurses for the emotional demands of nursing (see Muna 2005). Henderson (2001) recognises that some nurses are more adept at dealing with the emotional

side of nursing but stresses the importance of all nurses being able to accomplish this.

Although not explicitly addressing the issue of emotional intelligence in nursing curricula, Cadman and Brewer (2001) highlight the importance of the concept in the recruitment of student nurses into pre-registration training programmes. Using IQ as a measure of intelligence is commonplace in higher education where academic grades and performance are the key to admission. The authors highlight two different types of thinkers: divergent and convergent. Those who are successful in examinations and academic performance demonstrate convergent thinking patterns. Divergent thinkers tend to be better at problem-solving due to their more creative nature. They also tend to be more in tune with intuition and display social intelligence. Cadman & Brewer suggest that 'given the complex pluralistic nature of nursing, a balance between convergent logical thinkers and divergent lateral thinkers is needed' (Cadman & Brewer 2001:322).

For me, this is reminiscent of two other sets of competing paradigms prevalent in nursing and research. Firstly there is the 'art or science' debate in nursing and the qualitative/quantitative debate in nursing research.

Another facet of nurse education discussed by Cadman and Brewer is the issue of student retention. Nurse training today relies heavily on self-directed study which many people find difficult and, indeed, stressful. The authors suggest that this is related to confidence and motivation, as both are needed to engage efficiently in self-directed study. Mayer & Kilpatrick (1994) cited by Cadman and Brewer state that 'emotionally intelligent people are more likely to be able to cope with the stresses of clinical nursing practice and those engendered through independent study' (Cadman & Brewer 2001:323). They suggest that the acquisition of empathy through pre-registration nurse education is increasingly compromised as they feel that the opportunity to develop it through the student-teacher relationship is lacking, given the

increasing student numbers and pressures on lecturers. These authors feel that to introduce a tool to assess emotional intelligence would be highly beneficial in the selection of student nurses.

Freshwater & Stickley (2004:92) describe the concept of emotional intelligence as 'a core aptitude related to one's ability and capacity to reason with one's emotions, especially in relation to others' and continue to suggest that 'every nursing intervention is affected by the master aptitude of emotional intelligence'. Although other writings concerning emotional intelligence in nurse education highlight its importance in developing the nurse-patient relationship and in promoting interprofessional working, Freshwater & Stickley go further and accuse nurse education that fails to appreciate the value and development of emotions and focuses on propositional and practical knowledge alone, as failing to capture what they term 'the very essence of nursing care' (Freshwater & Stickley 2004:93). They caution against ignoring the emotions in nurse education because of the danger of producing unbalanced practitioners. Not only do the nurses of tomorrow have little exposure to emotional development, but they are prevented from developing intellectually. Freshwater and Stickley propose that nursing is becoming more technical at the expense of the human qualities of empathy and compassion.

Both McQueen (2004) and Freshwater & Stickley (2004) suggest means of introducing emotion work into the nurse curriculum. Both studies advocate the use of approaches that incorporate reflective practice and self-awareness. However, Freshwater & Stickley (2004) elaborate further with cautionary words as nurse educators begin to include this area in education. Given nursing's attraction to didactic propositional and practical teaching, there is a danger of introducing models without critique or evaluation. Freshwater & Stickley also comment that the levels of self-awareness and emotional intelligence of nurse teachers must be addressed in order for curriculum development to be properly developed. They continue to propose

that rather than an addition to nurse education, emotional intelligence must be placed at the core. Both McQueen and Freshwater & Stickley also speak of the learning environment which must be developed in order to provide a trusting and supportive setting in which students can feel safe. For Freshwater & Stickley, the learning environment is not only important for the student but also for the staff. They state that, 'Much work needs to be undertaken to support the highly stressed, often underpaid and disillusioned teachers who themselves are not only removed from the caring environment, but also find their own working environment uncaring' (Freshwater & Stickley 2004:96).

Management/Leadership

Writing from an American perspective, Freshman & Rubino (2002) stress the importance of emotional intelligence in the leadership of health care organisations. They state that, 'EI is now considered fundamental for getting along in the workplace and is a primary leadership and managerial competency' (Freshman & Rubino 2002:1). There are many reasons supplied by these authors for emotional intelligence in managers and leaders. They include the need to be able to work effectively with other professionals, negotiate contracts, remain optimistic, acknowledge the effects of stress on family relationships, accept responsibility, deal compassionately with employees, and listen to providers and governing board members.

There is a huge resonance here for prisons given the current climate of change in commissioning arrangements. Prison managers are now dealing with the NHS, a totally separate organisation outside of the Prison Service and then having to deal with new staffing arrangements whilst supporting current staff.

Freshman & Rubino (2002) continue to suggest ways in which emotional intelligence can be developed in organisations. Their main suggestion is

through the use of a programme developed by the Consortium for Research on Emotional Intelligence, called 'The Optimal Process for Developing Emotional Intelligence in Organisations', which utilises the four steps of 1) preparation, 2) training, 3) transfer and maintenance and 4) evaluation. They suggest that the development of what they term 'emotional management skills' is now more critical than ever before. Changes in society and indeed, after Sept 11th 2001, 'the new world we live in', have led the authors to suggest that, 'These bombardments take their toll on our sense of well-being....in times of tragedy and strain, realignments occur on individual, family and social levels' (Freshman & Rubino 2002:8). It is this backdrop of societal change and trauma that the authors suggest supports the development of emotional intelligence.

Vitello-Cicciu (2003) adds to this body of literature in her report of her own research into the emotional intelligence and leadership practices of 50 nurse leaders. In her descriptive, exploratory study, Vitello-Cicciu reports 11 nurse leaders who scored highly for emotional intelligence and 3 who scored low. The author then interviewed these 14 nurses to identify the characteristics that foster the development of emotional intelligence. Nurses who measured high levels of emotional intelligence were reported to have used self-help books and to have engaged in meditative practices. Others stated that they used strategies to manage stress, have empathy for others and not take things personally. All were seen by Vitello-Cicciu as indicators that help develop emotional intelligence. She also found that high scoring nurses also had a heightened self-awareness compared with those who scored low. Vitello-Cicciu states that emotional awareness of self and of others is 'the cornerstone that underlies an individual's ability to become emotionally intelligent' (Vitello-Cicciu 2003:30). She reports that successful nurse leaders 'adeptly analyze the emotional side of issues, anticipating how people will react and creating programmes that will assist staff with the emotional impact of work-related issues' (Vitello-Cicciu 2003:31). This is interesting as it highlights the issues raised by both McQueen and Freshwater & Stickleby

concerning the importance of nurse education in addressing the emotional side of nursing and the significance of nurse educators being emotionally intelligent. Another important conclusion mentioned by Vitello-Cicciu is that of having the freedom to choose how to respond to events. In addition, she recognises that emotionally intelligent nurse leaders both model their emotional approaches to nursing whilst managing the emotional responses of their colleagues, patients and their families.

In her paper, Vitello-Ciccu (2003) suggests five strategies that could be used to enhance emotional self-awareness and strengthen emotional intelligence abilities. She suggests that one should keep an emotional reflection journal, meditate daily, engage in positive visualisation, use appreciative enquiry and practice empathic listening. Although this paper by Vitello-Ciccu is cited by many authors writing about emotional intelligence, labour and leadership, I have found it to perpetuate the confusion discussed previously by Caruso (2004). She states that, 'Emotional awareness is the cornerstone that underlies your ability to become emotionally intelligent' (Caruso 2004:32). Although this is a question of linguistics, from my own experience of reading around emotional labour, emotional intelligence, emotional competence, emotional literacy, etc., the concept of emotional intelligence appears to vary to some degree depending on whose work you are reading, what country they are writing in, whose model they base their ideas on and, finally, what audience they are writing for.

Given that this thesis concerns the work of prison nurses, I have felt it necessary to include discussion and review of literature from work undertaken with prison officers. To reiterate, this is for two reasons. Firstly, prison nurses have responsibility for both health care and security. Because they are working in all areas of the prison, in inpatient and primary care settings, they are caring for patient prisoners who are sometimes acutely ill, chronically ill and undergoing health screening, and often engage in a pastoral caring role as part of general nursing care. It is this dual role in both

a caring and a custodial role that is not dissimilar to that of a prison officer, who not only has a custodial role but also a caring role, be it in a pastoral sense. Secondly, it must be remembered that, just as the prison officer does, the nurse must create the conditions for a relationship with the prisoner in order to provide care. Therefore, it seems appropriate to examine the nature of emotional intelligence as it pertains to prison officers.

The Emotional Intelligence of Prison Officers

Tracy (2005) has provided a basis for my train of thought around emotional labour and intelligence in prison work in that she links the importance of viewing emotion work as a strategic interaction in terms of reducing the labour. I suggest that the ability to view and use emotion work as a strategic interaction is only possible with a high level of emotional intelligence. If one examines the examples provided by Tracy to demonstrate the strategic interaction through the use of emotional labour, they all use the ability of the correctional officer to effectively interact on an interpersonal level with prisoners. To me this is more than mere social intelligence as it requires an understanding of the officers' emotions and how they must be presented in order to receive the desired behaviour from the prisoner. Officers in Tracy's (2005) study not only reported presenting with the correct emotion to promote the right response from prisoners but also mentioned the importance of having the ability to suppress 'unhelpful' emotions, e.g. 'Officers also masked anger, fear and disgust because they did not want to "allow" inmates to "push their buttons"' (Tracy 2005:278). She continues to state that, 'By using emotional expression and suppression strategically, officers framed themselves as powerful, knowledgeable and in control of making a trade: they did emotion work in exchange for inmate manageability' (Tracy 2005:278).

It is important to stop here and reflect on the way in which Tracy (2005) suggests officers utilise emotional intelligence in order to manage inmates.

Given the way in which I suggested earlier that prisoners may utilise their emotional intelligence to engage in emotional labour in order to manipulate staff, it is interesting to note that this behaviour is happening in both worlds; those of the staff and the prisoner.

Another interesting facet involving the concept of emotional intelligence and its relationship to prison staff is the debate that surrounds gender and emotional intelligence. Kemp et al. (2005) suggest that females score significantly higher than males in tests of emotional intelligence. Boyd & Grant (2005) studied male prisoners' perceptions of prison officer competence, asking the overall question as to whether gender is a factor. They hypothesised that female officers would be more empathic, better communicators and less disciplining. The Prison Officer Rating Scale, developed by the authors for this study, was administered to 57 prisoners. Surprisingly, the results of this study indicate that gender is not a factor in perceived prison officer competence; however, prisoners indicated that female officers were in some way more professional than male officers. High scores on the professionalism scale suggest that female prison officers are more honest, better able to avoid argumentative situations, better able to remain calm in difficult situations, more respectful of prisoners' privacy, smarter and more presentable, better at getting things done for prisoners and more polite (Boyd & Grant 2005). Although there were no reported differences in what is immediately identifiable as emotional intelligence, e.g. empathy, I feel this study indicates that female officers may well have higher levels of emotional intelligence in terms of being aware of themselves (better able to remain calm), the way they present themselves (smarter and more presentable) and aware of others' feelings (more respectful of prisoners' privacy).

Crawley (2004) asked the officers in her study about aspects of their job that had disturbed or troubled them. Interestingly, she found that, 'On the whole, officers who had previously worked in the armed forces, or who had done

nursing at some point in their lives, claimed to be more able to cope' (Crawley 2004:178). However, most officers reported that they felt they had in some way become 'hardened' by prison work. I suggest that high levels of emotional intelligence equip officers with the ability to cope more effectively with the emotional labour of their work but, conversely, I would not expect the emotionally intelligent to become 'hardened'. I see this hardening as a defence against anxiety as discussed previously. Does this mean that to defend against anxiety by becoming 'hard' equates with a low emotional intelligence? From the work I have been involved with and my own experiences working within prison, I suggest that prison staff use a high degree of cynicism as a means to detach from the emotional labour of their work. Institutional cynicism is an accepted approach within this system and manifests itself in the roots of the culture. However, those with high levels of emotional intelligence may not adopt this coping strategy and will therefore manage their emotional labour in other ways. Conversely, those with lower emotional intelligence may submerge themselves in this cynical culture as a way to cope which, in turn, is passed on to new staff. The cycle is perpetuated.

In her publication 'Prisons and Their Moral Performance' (Liebling 2004), criminologist Alison Liebling discusses 'those aspects of the interpersonal and material treatment of prisoners that determine how dehumanising prison life can be' (van Zyl Smit 2005:765). As a result of a long history of research in English prisons, Liebling proposes a Model of Moral Performance in which she identifies those elements of prison life that are important in assuring prison quality and moral performance. Decency, family contact, safety, support, order, well-being, respect, relationships, humanity, fairness, personal development, trust and power are ranked in order of importance, with decency the most important and power the least. In the main, these elements of Liebling's model have sections to them which, in order for officers to address them, will require emotional intelligence. For example, decency will necessitate both officers and prisoners to exercise emotional

intelligence in recognising and responding to the emotions and needs of each other.

My Study

I am aware that following the review of the literature it is traditional to conclude with a synopsis to provide an overview and, as a consequence, to provide a justification for my own study. Given the reflexive nature of my study, I want to retain ownership of its development and progress and, as such, do not want to rely solely on previous studies, other academics' perspectives and obvious gaps in the current literature to provide justification for my work. I feel that the idea of undertaking a study in order to fill a gap in the literature somehow 'commodifies' my research. I suggest that by the very fact I am engaged in this work with a passion demonstrates the frustration I have experienced in my search for other work in this field. There are some studies I have reviewed (Holmes & Federman 2003; Weiskopf 2005) which do address some of the areas I am examining in my study. However, my philosophical position leads me to believe that there is no 'one' truth. Indeed, all human experience differs depending on many factors; not least the way one feels on any given day. Therefore, the area in which my study is based is unique and deserves study. I propose that a reflection on the journey that led me to this study would provide more understanding of my rationale than would a summary of previous work in the field undertaken by fellow academics.

This study began life following my Master's work where I looked at what exactly nurses working in male prisons thought they were doing. I wondered how my own conceptions of caring were being altered by the constraints of the prison setting and, from observation and discussion with my peers throughout my Master's degree, it was clear that nurses worked on a continuum between viewing themselves as nurses first and foremost and, at the other extreme, viewing themselves as custodians.

My subsequent work as a practice development nurse in a cluster of prisons, at the time when partnership working with the NHS was beginning, led me to build on this when I observed the difficulties nurses and health care officers were having incorporating new ways of working and working alongside colleagues from the NHS. I also noticed that staff coming into the Prison Service from outside were having difficulty adjusting to the prison environment and health care culture, in terms of working in a well-established, closed system and also in terms of working with prisoners where the nurse–patient relationship is so vastly different to that outside.

As a practice developer, my first thought was how we could make the transition for all parties smoother and less stressful. I came to the conclusion that if nurses joining this culture could have a more thorough induction and training then that may ease their transition from ‘outside’ to ‘inside’. Lacking in the induction at the time was any focus on the uniqueness of the nurse–patient relationship in this setting, the importance of reflection on and in practice and ways of coping with dissonance. My first thought was that this study could aim to elicit knowledge from current expert practitioners, which would then support and inform the development of new induction materials.

What became clearer to me as time progressed was that the foundation of what was needed from the expert nurses was an answer to the question:

‘How do you care for people who don’t like you, or who you don’t like?’

It is this answer that I felt would provide the basis for training staff new to the area. Once this question was deconstructed, areas such as emotional labour, emotional intelligence, reflective practice, the nurse–patient relationship, prison culture, interprofessional working and such like would need to be investigated. In addition, I felt it was important to get experts to reflect on their practice in order for me as a researcher to see what

processes and emotion work they were engaging in and how they managed it.

It was soon apparent that developing training materials and testing them would be unfeasible in a study of this size. What would be more useful at this juncture would be to look at the question in terms of the emotion work involved in prison nursing. This led to thoughts about the importance of emotional intelligence in this work. In addition, my own ideas about research in practice being transformatory and having some practical value meant that I wanted to work with nurses and give something back in the process of undertaking the research. I settled on providing clinical supervision to two nurses over a fixed period to not only do something in return, but also to see if clinical supervision would be a way to elicit tacit knowledge and develop emotional intelligence. Further detail about the methods used in this study can be found in the next chapter.

In order to make some sense of this study and to distinguish its relation to other well-established concepts and theories, I have examined work in psychology, sociology, criminology, social psychology, organisational psychology and nursing, including mental health nursing, general nursing and forensic nursing. To place this study into cultural context, a great deal of other work has informed this review, such as biographical accounts from prisoners, historical literature, and political and philosophical work which underpins both the development of health services in prison and demonstrates the importance of political and public attitudes to the penal system and the delivery of health care within it.

This study has evolved considerably since its conception, partly due to supervision, partly due to recognition of my limitations and partly due to engaging with the literature concerning the emotion work and coping skills of nurses and prison officers. Given that prison nurses are working with some of the most difficult patients in one of the most difficult settings, an

examination of the nature of their work from an emotional perspective felt both appropriate and a useful addition to the current discourse.

Chapter Three: Context & Process

In order to place my research in the 'real' world, this chapter provides a detailed description of the context and process with which I engaged in undertaking this study.

Research Sites

Three prisons were chosen as sites from which to obtain the study sample. All the prisons are large, inner city, local prisons with prisoner populations of between 400 and 950. They all have both inpatient and outpatient facilities and provide health care cover 24 hours a day, 7 days a week. These three prisons in particular were chosen for a variety of reasons. The size of the health care provision in the chosen prisons was important, as those with large health care facilities have larger numbers of health care staff. Prisons with less health care provision tend to have a smaller pool of health care staff. This ensured a larger number of staff from which to recruit my sample. The prisons chosen are also similar in size and provision to that in which I had worked previously. As such, I felt there would be a good degree of understanding between the nurses and me, which would help in developing a good working relationship.

These prisons were also chosen by virtue of their operational role within HM Prison Service. Prisoners are categorised from A to D depending on the levels of security they necessitate to ensure the safety of the public. Category A is the highest level necessitating high secure conditions and category D is the lowest where prisoners are often in open conditions. A 'local' prison is one which serves the local courts and hence the local population.

Prisons 1 & 2 are category B, male, adult, local prisons housing both remand and convicted prisoners, although Prison 2 also takes some category A

prisoners. Prison 3 is a category B, female, adult, local prison housing both remand and convicted prisoners.

I felt it was important that, given the nature of my study, nurses were recruited from both male and female prisons. Nurses working in young offender institutions were omitted from this study because, in my experience of these settings, I feel that the health care needs and nurse–patient relationship are somewhat different to that in an adult setting. I also felt that it was important to recruit nurses from prisons where high profile prisoners were being cared for. Given my prior understanding of the prison system, and nurses' coping mechanisms when caring for prisoners, I wanted to include nurses who were caring for high profile prisoners and who were thus unable to escape knowing about their offences.

Sample

There were only two criteria for sample selection in this study. Firstly I wanted registered nurses, as this study examines the emotional labour of nurses; and secondly, they had to be employed by HM Prison Service. Some nurses working in prison are employed by a Primary Care Trust and are therefore not direct employees of the Prison Service. I chose to exclude nurses employed by Primary Care Trusts because this is a relatively new development within prison health care and, as such, I felt that these nurses would not have the same level of cultural understanding as nurses directly employed and indeed inducted by the Prison Service. A second reason for including nurses employed by the Prison Service and not by Primary Care Trusts also enabled a swifter journey through the ethical approval system, as approvals for the study were only necessary from the Prison Service and Bournemouth University.

Initially, I met with all health care managers/heads of health care individually at each of the chosen sites to discuss my study, its aims and my

methodology. I provided each health care manager with a copy of my original proposal, a copy of the letter of agreement from HM Prison Service Headquarters (see appendix 1) and information sheets for staff (see appendix 2). Each health care manager agreed to circulate the information sheet to all registered nurses (both civilian nurses and health care officers). At the end of the information sheet was a form that participants could complete and send directly to me at the University or pass to their health care manager who would pass them on to me. In reality, the majority of those nurses expressing interest in my study approached their health care manager. Some completed the form, others replied verbally. Only two of the participants (from Prison 1) approached me directly. No one contacted me separately to ask for further information.

In total, nine registered nurses participated in phase one of this study, which involved participation in semi-structured interviews, most of which were tape-recorded. Two of these nine nurses also participated in phase two, which involved engaging as a supervisee in monthly clinical supervision sessions, with me as their supervisor. The registered nurses in this study had worked for HM Prison Service for between 1 and 16 years. The average length of service was just over eight years. Of the nine nurses, three were also prison officers (referred to as health care officers). Four of the nurses were mental health nurses (RMN) and five were general nurses (RGN/RN).

It is important that the reader of this thesis understands the choices I made concerning the study sample and sites, which I have highlighted. I also feel that there needs to be some consideration of the way in which I have presented this information. Reflecting on the way in which I have related my decision making to you, I have noticed a presentation which could align itself with the more positivist, scientific paradigm. For example, I have given you information regarding the length of service of the participants, the number of nurses who are also prison officers and the nursing specialism of the participants. However, does this information really matter to you, the reader?

Is the fact that you now know that the range of experience in the Prison Service for this sample was 1-16 years important, given that you will not always find out if experience and length of service affect participants' perspectives because I have not consistently correlated individual tenure with data?

I have chosen to leave this type of information in this thesis for two reasons. Initially, I included it as I felt it was what is expected. In my experience, traditional academic discourse demands this level of detail. Secondly, and as a result of supervision and development through the study, I have chosen to include it because it serves to provide a useful contradiction in my work which may lead to further reflection by the reader as to the nature of academic discourse pertaining to sampling, its presentation and indeed its usefulness.

Data Collection

Semi-structured Interviews

Semi-structured interviews were used to collect data in phase one of this study. I chose to use semi-structured interviews for this phase because I felt that other methods would not provide the depth or flexibility necessary when working in a prison setting. I did not choose to use an open-ended interview technique as I had identified some particular areas I wanted to explore with the participants. According to Dearnley (2005:22), 'Semi-structured interviews allow all participants to be asked the same questions within a flexible framework.' It is this flexible framework to which I was attracted. In order to provide some clarity of rationale, I feel that inclusion of my interview schedule as an appendix will not suffice in providing an understanding of how and why the questions were devised. I have therefore noted the questions used but have reflected on their purpose and development.

Question: How do you see your role as a prison nurse?

This question was used in my Master's research (see Walsh 1998) where I examined the lived experience of being a prison nurse in a male, adult prison. I wanted to use it here as I see this current study as an extension of my Master's work. I also felt that this question would elicit information concerning the nurses' own perception of their role, thus providing insight into their own understanding of what it means to nurse in a prison.

Question: What is it like to be a nurse in this environment?

I devised this question after reflecting on what it was that I really wanted to know. I wanted to know not only what it is like to work in a prison, but also how it feels. I felt that this question would prompt nurses to explain more about the system in which they practice and their emotional labour, and provide some insight into the organisational culture.

Question: Is nursing in prison much different to that outside?

I wanted the nurses in this study to relate to me *how* and *if* they felt that working in this environment is different to more traditional nursing. This question provided the nurses with an opportunity to reflect on their practice in prison in terms of their experiences of nursing outside the prison. This provides the study with an understanding of the differences between nursing in a prison and nursing in the wider community.

Question: Can you describe to me, without naming names, an example of caring for a prisoner that you found difficult and another that you found rewarding?

I wanted the nurses to tell me about their practice, to give me the details of what they do, how they do it and how it makes them feel. I felt this could be best achieved by asking them to give me examples of their practice. I think

this question enabled the nurses to reflect on their practice in such a way that issues of organisational culture, emotional labour, nurse–patient relationships in prison, job satisfaction and professional development would emerge. In addition, work that the nurses found rewarding may be so for different reasons to how nursing outside the prison setting may be. It would also be possible for the nurses to discuss a case which, although difficult, was rewarding. Either way, I felt that this question would encourage reflection on practice and provide rich data.

The nature of these questions and the resulting framework through which I travelled allowed further examination of salient points, further questioning to enable deeper understanding and reflection, but most importantly, it provided a context within which I, as the researcher, could assess and react appropriately to the responses and emotions of the participants without concerning myself that I was deviating from a predetermined script. Allowing the conversation to develop naturally also enabled me to work with the participants in building a trusting relationship and hence a meaningful encounter.

Holstein & Gubrium (2003) suggest that the postmodern interview is ‘active’ in that both interviewer and interviewee contribute to the interview. The interview is a space where both interviewee and interviewer construct information together, through dialogue. Positivist research traditions warn against interviewer involvement in interviews in order to reduce bias. I assert that this approach to interviewing is inappropriate in my study and, I would suggest, almost impossible in any study. Because I see my own experiences as important data to be included in this work, I feel that my involvement within the interviews was crucial.

Kvale (2006) discusses this idea in a paper concerning the power dynamics inherent in an interview situation. Kvale states that, ‘Creating trust through a personal relationship here serves as a means to efficiently obtain a

disclosure of the interview subjects' world. The interviewer may, with a charming, gentle, and client-centred manner, create a close personal encounter where the subjects reveal their private worlds' (Kvale 2006:482). However, he continues to warn of the problems that can unfold when using this strategy. The asymmetrical power balance inherent in interviews (as seen by Kvale) is reported to have the potential to lead to manipulative behaviours. I suggest that when the researcher is adopting a fully reflexive stance in the interview process, this becomes less of an issue. Kvale also suggests that the notion of an interview as a dialogue is misleading as 'it gives an illusion of mutual interests in a conversation, which in actuality takes place for the purpose of just the one part – the interviewer' (Kvale 2006:483). I contest this assumption. The interviews undertaken as part of my study were designed to support and encourage the participants to reflect on their practice whilst simultaneously discovering and uncovering the participants' stories. I propose that by reflecting on practice and, indeed, being encouraged to confront their own practice, the participants gained insight into their work by virtue of participating in the interviews. I therefore suggest that the narratives constructed through the interviews did not only serve to provide me with data for this study, but also served to provide the participants with opportunity and space to talk about and reflect on their practice.

Clinical Supervision

According to Davey et al. (2006) there is no one clear definition of clinical supervision. Bond & Holland (1998) suggest that this stems from the nature of clinical supervision as being 'a relationship between two human beings' (Bond & Holland 1998:11). They continue to suggest that definitions proposed by authors tend to highlight the elements of clinical supervision that they themselves feel are most important.

In the key document 'A Vision for the Future', the Department of Health state that clinical supervision is 'a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex clinical situations' (Department of Health 1993:15).

In a position statement, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) suggest that, 'Clinical supervision brings practitioners and skilled supervisors together to reflect on practice. Supervision aims to identify solutions to problems, improve practice and increase understanding of professional issues' (UKCC 1996:3).

Following a concept analysis of clinical supervision, Lyth (2000) asserts that, 'Clinical supervision is a support mechanism for practising professionals within which they can share clinical, organisational, developmental and emotional experiences with another professional in a secure, confidential environment in order to enhance knowledge and skills. This process will lead to an increased awareness of other concepts including accountability and reflective practice' (Lyth 2000:728).

Although I agree that there is no one definition that provides a 'one size fits all' solution, the central tenets of clinical supervision can be clearly identified. The extent to which each assumes more or less importance depends on the practitioner and the setting in which they practice. Bond & Holland (1998) take the model proposed by Proctor in which it is suggested that clinical supervision has three functions: normative (ensuring quality and standards), formative (enabling learning from experience) and restorative (providing support and increasing self-awareness), and propose that it is the restorative and formative functions of clinical supervision that assist in meeting the normative function. However, I contest that the importance that the supervisee and supervisor place on each of the three functions as described

by Proctor will depend on the context and needs of the supervisee. Therefore, the working definition of clinical supervision used by one practitioner will be very different to the next practitioner.

Bond & Holland (1998) add to the definitions proposed by the Department of Health and the UKCC and suggest that clinical supervision is not only able to facilitate self-assessment and analytical and reflective skills but also enables those engaged in supervision to develop their emotional skills. Bond & Holland (1998) suggest that awareness and acceptance of emotions go hand in hand. As such, the more one can accept one's feelings, the easier it becomes to raise the awareness of emotion and the subsequent energy that results. They suggest that, 'Repression and suppression take up a lot of energy and can leave you feeling exhausted, whereas awareness and acceptance of emotions liberate energy which you can use positively. Using clinical supervision to put your feelings into words can help develop your self-acceptance provided your clinical supervisor can listen non-judgmentally' (Bond & Holland 1998:125). This idea is confirmed by psychiatric nurses in a study by Akerjordet & Severinsson (2004). They suggest that clinical supervision was deemed to be important to the nurses in their study in both using and developing emotional intelligence. However, I have yet to find any studies in which clinical supervision is used as a data collection method in order to identify practitioners engaging with their emotions and developing their emotional intelligence and awareness.

Studies concerning clinical supervision have tended to focus on nurses' experiences of clinical supervision (see Skoberne 1996; Marrow 1997; Kelly et al. 2001); clinical supervision as a method of supporting interprofessional working (see Clouder & Sellars 2004; Davies et al. 2004); the evaluation of clinical supervision and the supervisory process (see Sloan & Watson 2001; Hyrkas & Paunonen-Ilmonen 2001; Cheater & Hale 2001; Teasdale et al. 2001; Bowles & Young 1999); clinical supervision in nurse education (see Hancox et al. 2004; Landmark et al. 2003; Jones 1998) and the examination

of various strategies and models of clinical supervision in a multitude of clinical settings (see Rizzo 2003; Sloan & Watson 2002; Titchen & Binnie 1995).

The underpinning philosophy of my study lends itself naturally to engaging in clinical supervision with individual nurses. Viewing all participants as individuals with their own story to tell, without searching for one defining truth, whilst supporting the growth and development of practitioners and their practice, led me towards the use of clinical supervision as a method for both collecting data whilst simultaneously developing practice. Given the nature of clinical supervision, it was inappropriate to tape-record sessions hence data collected from clinical supervision were in the form of a reflective narrative of each session written by me, the supervisor.

Despite searching the literature for other studies that utilised clinical supervision as a method of data collection, I found none. My background in practice development and the desire to undertake a study which would benefit the participants at the same time as furthering the knowledge base of prison nursing, led me to conclude that clinical supervision would be an ideal way of collecting data whilst developing practice. However, I considered my use of clinical supervision as a method of data collection carefully, knowing from past experience how suspiciously clinical supervision is viewed in prison. In addition, there are many ethical issues associated with undertaking clinical supervision in any case, let alone as part of a doctoral study. One of the main issues, which I considered carefully, was the way in which I could develop a confidential, supervisory relationship in which nurses would feel comfortable to share their concerns, thoughts and feelings about practice whilst knowing that I would be analysing their experiences and feelings as data for my study. Although this could be seen to be similar to the data I obtained through interviews, clinical supervision had an added dimension of being dynamic and continuous, as these nurses would work with me over a fixed period of time, with each session building on previous work. Interviews

had an element of facilitated reflection, as did supervision, but supervision, by its nature, revisited experiences and sessions that had definite consequences for practice. In order to provide a psychologically comfortable space for these nurses to engage in supervision, I continually considered their feelings about supervision and reacted/acted accordingly, e.g. relocating the venue, relinquishing the need for written reflection, etc. Reassurance was provided concerning confidentiality and both nurses were fully aware of the reasons behind our work. I, too, entered into a supervisory relationship as a supervisee with an external supervisor throughout this period in order to manage my own practice as a researcher.

Reflective Diaries

Each participant was also asked to maintain a reflective diary. I was aware that this may be difficult, so in an attempt to assist, I suggested that the participants use a structured reflection sheet which I provided for them (see appendix 3). I assumed that a structured reflection sheet would enable the participants to document their reflection more readily. The use of a diary to collect data for studies is evident in the literature (see Richardson 1994; Glaze 2002; Murphy 2000). Richardson (1994) suggests that diaries allow for rich data collection and allow the researcher to see events as they develop and thus support a more dynamic analysis. However, she does note that there are some disadvantages, most notably that it is time consuming and that the quality of the data is very dependent on the motivation of the participant. In my study, the use of a reflective diary was intended not only to provide rich data but also to provide a mechanism to support experiential learning (Moon 2004) and reflective practice (Heath 1998; Glaze 2002). I was also eager to use reflective diaries as a method of data collection to enable an alternative connection with the feelings of the participants.

Reflective writing has also been suggested as a useful way for the researcher themselves to contribute to the data. Jasper (2005:257) highlights

that 'researchers' reflective writing is central to the research process and therefore needs to be incorporated into any study as a data source and to be central to establishing the trustworthiness of a study'. In this study, my own reflective writing is evident in three areas. Firstly, I maintained a reflective diary in order to assist in contextualising my data and as a method of enabling me to consider my own professional development as a researcher. Secondly, I used reflective writing in order to develop written narratives of my experiences of the clinical supervision sessions I undertook with participants. Finally, reflective writing throughout this thesis enables the reader to follow my own thought processes and decision making.

Documentary Evidence

In addition to the data collected through the use of interviews and clinical supervision, documentary evidence was also collected in the form of reports, policies, minutes from meetings, media articles and reflection/notes from television programmes/relevant experiences. According to Appleton & Cowley (1997:1010), documentary evidence, in their study concerning clinical practice guidelines, consisted of 'official records, protocols and clinical guidelines'. Cheek (2004:1144), in discussing textual evidence, refers to 'pictures, interview transcripts, poems, procedures, field notes; in fact texts can be any representation of an aspect of reality'. Miller & Alvarado (2005:349) suggest that 'documents are produced in and reflect specific social and historical circumstances'.

I suggest that the documentary evidence gathered in this study serves two main functions. Firstly, documentary data were collected over a fixed period to contextualise and demonstrate the dominant discourses present in both the National Health Service and Prison Service at the time of data collection. Secondly, daily newspapers were collected from each day when interviews took place. This was done in order to keep a record of the current affairs of the day which may (or may not) have influenced the thinking and feelings of

the nurses interviewed. The use of documentary evidence is important in a study of this nature as it informs the context and reality of the research.

I feel it necessary to take some time away from the discussion of the context and process of this research in order to reflect on the dominant discourses surrounding the nature of research as they pertain to my own study. I am basing this discussion on my own experiences of research, which I have been exposed to through my reading, and information I have obtained through attendance at conferences and discussion with academic peers. I have to admit to feelings of being on the margins of the research community at many of the conferences I have attended as I question the dominant approaches to research. For example, I was incredulous when, at one conference, a researcher presented his study looking at the experiences of paramedics. After a very interesting presentation, he was drawn into debate about how he managed to remain objective, given that he too was a paramedic. I began to feel marginalised as I appeared to be the only voice in the room supporting this researcher in his attempts to justify his position.

In my experience, the aim of objective, unbiased research predominates as the dominant discourse within the world of research, albeit within the quantitative arena. However, these discourses are still prevalent within the qualitative research forums that I have engaged with during the course of this study. At many of the presentations and discussions of researchers' work, underpinning philosophy is not raised and discussions concerning what is traditionally known as rigour centre on trying to persuade the audience that research is unbiased and robust. There appears to be minimal effort to address this 'vener of objectivity' or indeed to question its necessity as researchers accept, support and ultimately perpetuate the dominant discourses.

Data Collection: Phase One

Interviews

Prison One

Three staff at this prison expressed an interest in participating in phase one of my study. I was advised to contact them directly to arrange a time to conduct the interview. I made appointments with all three and we decided to carry out the interviews inside the prison. This necessitated contact with the security department in order to obtain permission to take a tape recorder into the establishment. Two of the three nurses were interviewed in an office inside the health care centre. Interviews lasted approximately an hour and were tape-recorded. The third nurse did not arrive for our appointment and did not respond to any further attempts I made to rearrange it. However, the third nurse I did interview was on secondment from this prison at a local university. He had expressed an interest in my study via discussions over other work I was conducting at the time. This interview took place at his office, outside the prison. This interview was not tape-recorded as it was opportunistic and I did not have my recorder, so notes were taken of our conversation.

Prison Two

At this prison, interested staff informed their manager of their interest in participating in the study. The manager informed me of the staff who had responded to my information sheet. We arranged an afternoon when all three staff were on duty and could be released for an hour each. We also decided to hold the interviews outside of the prison because, given its high security nature, it avoided lengthy paperwork for me to be cleared as a visitor and placed no restrictions on my use of recording equipment. Interviews at this prison were held in a staff area, outside of the prison. My initial plan to interview all three staff in one afternoon was not achievable at this prison due to staff workloads and unavailability of the venue. However, a second

appointment was arranged for me to interview the final two nurses at this prison. The same venue was used and organised by the health care manager. All interviews with staff at this prison were tape-recorded.

Prison Three

At this prison, staff expressed their interest in participating in the study to their clinical services manager. Negotiations took place with the manager to secure dates and venues acceptable to both the prison and the participants. Interviews were held outside of the prison in a staff training facility over the course of an afternoon. Interviews lasted from 35 minutes to one hour. One nurse at this prison declined to be tape-recorded, so field notes were taken.

Participants from all prisons signed a consent form, a copy of which can be found in appendix 4.

Documentary Data Collection

The documentary data collected were chosen as they provided an example of the dominant discourses present in the Prison Service and health service at the time. This provided a very broad scope for inclusion in the study and it was solely my decision as to what was included and what was rejected. As such, Prison Service publications for staff ('Prison Service Journal' and 'Prison Service News'), job adverts for both clinical and inspectorate positions in prison health care, application packs for prison nurses, minutes from workforce development meetings, circulars to staff concerning Agenda for Change, personal reflections on media representations of prison work and news stories concerning the prison and health services were collected.

Data Collection: Phase Two

Clinical Supervision & Reflective Diaries

Prison One

The first nurse I interviewed in this prison also expressed an interest in participating in phase two and engaging in regular clinical supervision over a period of six months. As I only wanted one nurse from each prison, I did not discuss phase two with the subsequent interviewee apart from in conversation about the study as a whole.

Nurse A and I met six times between November 2005 and June 2006 for clinical supervision. I intended for supervision sessions to take place monthly but, due to holidays and other operational constraints at the prison, we met in November, January, February, March, May and June. All meetings took place during the nurse's shift and inside the health care centre of the prison.

At our first meeting, we agreed a contract (see appendix 5) which would support our subsequent meetings. I also asked Nurse A to maintain a reflective diary and discussed ways in which she could undertake this. It became clear by the third meeting that maintaining a reflective diary was difficult for this participant. One structured reflection sheet was given to me which, interestingly, rather than being a reflection on practice, was a reflection on our previous clinical supervision session.

Upon reflection at this point in the study, I chose to abandon the reflective diary for both phase two participants as I felt they were more focussed on the clinical supervision sessions rather than the reflective diary. Given the reflexive real world nature of my study, I felt it entirely appropriate to remove the requirement of the reflective diary because not only did I think that the two nurses were finding it difficult to complete, but also that it was causing them some guilt.

Prison Two

It was suggested to me by the health care manager that Nurse B would be an ideal participant for clinical supervision. At the start of my interview with this nurse in phase one, we spoke about clinical supervision and my proposal for phase two. She readily consented to be involved and agreed the contract in appendix 5. We met on six occasions from January 2006 until August 2006. Again, as in the case of Nurse A, we had planned to meet monthly, but due to staff off-duty arrangements, we met in January, February, March, May, June and August. We held our initial meeting in the staff facility outside the prison. However, this venue proved unsuitable as we had to relocate our first meeting to Nurse B's car midway through because the venue had to be locked. Following discussion with the health care manager at this prison, it was agreed that Nurse B would be given time to attend supervision sessions with me, outside the prison, but during work time. The following five sessions were held in a local café with the majority of them taking place during Nurse B's days off.

Nurse B never managed to engage in any reflective writing. As I have discussed previously, I decided to remove the reflective diary from this stage of the study, given the added pressure I felt I was putting on the participants by asking for it. I felt that the inability to complete the diary was, in itself, data.

Prison Three

In this prison, I had intended to recruit a supervisee during the afternoon of interviews. However, it became clear when I spoke with the clinical services manager that all interviewees (herself included) were already in supervision. It was not felt that these nurses would be given time or indeed feel the need to have clinical supervision with me in addition to their current supervision. I decided to omit the sample from this prison from phase two of this study.

Rigour

This study has utilised reflection on practice through semi-structured interviews. Criticism could be levelled at this approach citing the common problem of inaccurate recall leading to inaccurate data. This can be addressed in this study by referring to the work of Rolfe (2002:94) who suggests that, 'Quantitative research can *explain*...qualitative research can help us to *understand*...neither can connect us with the *feelings*...These must either be experienced first hand, or else vicariously through writing or other media which deliberately attempt to invoke them, that is, which resonate with our own feelings.' Although Rolfe is discussing the use of stories and narrative, I link this to my own study where the narratives of participants are central. I suggest that the participants in my study were asked to reflect on their practice during both interview and clinical supervision sessions. It was very clear throughout the study that reflection on action was enough to invoke feelings in both me as the researcher reflecting on my own experiences with the participants, and in the participants as they re-lived experiences and listened to mine. Even if the participants had not had exact recall of the detail of their experiences, the emotional sentiment was most definitely there. I suggest that, in recalling experience, it is often the emotions that were felt at the time which enable the narrator to re-visit the experience.

It has been suggested to me that the rigour of this work has been compromised by my own involvement, the recall of the participants, and by the time taken from interviewing to analysis of transcripts. In addition, the data collected through clinical supervision sessions were in the form of reflective writing, completed after each session. Naturally, I will have influenced the interviews, the data collected from the clinical supervision sessions and, indeed, I have influenced the data purely by the way in which I have analysed and reported my findings and by the way in which I entered into discussion with the participants in order to construct our reality. This is

inevitable. As Charmaz (2004:981) states, 'Active involvement with the data shapes the analysis.'

I suggest that if my work is viewed from a positivist perspective, then these issues will most certainly be seen as contaminants leading to bias, and will therefore cast concerns on the rigour of my work. However, I am not suggesting that this study is providing objective and therefore generalisable findings. This study allows the reader access to the thoughts and feelings of the participants and the researcher within the context of data collection. It is the reflexive nature of this work that provides access for the reader to my own thought processes and thus, in turn, provides insight into the work and its subsequent usefulness as an addition to the knowledge base. More importantly, though, I assert that, although there are stages in this work at which bias and influence are exerted, none is more notable than that exerted by the reader as they read, deconstruct and reconstruct my original work. I suggest that this is unavoidable. However, if viewed within the methodological and philosophical traditions within which I write, the reader is encouraged to consider the quality of my work and assimilate it in such a way as they deem appropriate.

Ethical Considerations

Ethical Approval

Undertaking research in the prison setting is fraught with red tape and ethical issues that need careful consideration if rigorous and accurate research findings are to be produced. The red tape is in place for a variety of understandable reasons: to protect the vulnerable prisoner as a research subject, to protect the prison staff from an increased workload and to protect prison security. This 'red tape' is seen in O'Brien & Bates (2003) and Drake (1998) in their discussions of their own research endeavours in the American correctional system. Although the official procedures in place for gaining access to American penal institutions for research purposes are different to

those of HM Prison Service in England and Wales, the concepts are the same in terms of obtaining security clearance and spending time in the establishment. Undertaking health care research in HM Prison Service demands ethical approval from the NHS if health care staff are employed directly by the NHS. Ethical approval (be it from a university ethics committee or the NHS) must then be submitted to the Prison Service in addition to completing an application to undertake research in prison. It is within this application directly to the Prison Service that issues of timescale, purpose and nature of the research, and information on confidentiality, anonymity and data protection are addressed. Ethical approval for this study was obtained through the Research Committee at Bournemouth University and HM Prison Service in April 2005.

Although the process for ethical approval for my study was not as fraught with difficulties as some of the stories I have heard, I found that it did not fit with my philosophical outlook or the nature of my study. Coupled with my experiences of the wider research community of late, I am left wondering why qualitative research is not seen to be as robust as quantitative. I did not find any barriers to ethical approval for my study from the University – far from it – but in completing the paperwork for the Prison Service to gain access to the research sites, it was clear to me that they are very much focussed on quantitative research. I have attached my Prison Service application to this thesis as I feel the nature of the information they require is very empirical and does not allow for flexibility in the study, something that the ‘real world’ nature of my study demands. I also found it somewhat difficult to decipher the process I needed to go through in terms of which ethics committee I needed to approach. As prison health care is currently in a transitional phase in working with the NHS, it was not clear which way I should proceed. I could not find anyone in authority who could tell me and, as such, I had to use my initiative and continue in the fashion I felt most appropriate.

Access & Sampling

In order to obtain the sample for this study, the heads of health care/health care managers in each prison were contacted directly and a meeting set up in order for me to explain the study and negotiate prison involvement and access. Given my experience of working in prison and with prison staff, I feel that gaining access to the sites and sample was made easier than it may otherwise have been. I am already known to these health care managers through previous work in practice development and have built up good working relationships with them. In addition, I knew that the nature of my study, focussing on staff rather than prisoner patients, would appeal.

I am also aware that, although prisons are approached frequently by researchers, there is often very little offered by the researcher in return for access. Although I feel that this is sometimes unavoidable, my own approach to research with practitioners does not morally allow me to enter a research site, gather my data and leave without giving something back. The inclusion of clinical supervision for staff as part of my study felt congruent with my values about research but also proved to be a useful incentive for managers to assist me.

Although asking the health care managers for assistance in gathering my sample could be seen to introduce bias, I felt that the nature of real world research (see Robson 2002) in this setting makes this unavoidable. I knew that I could have sent a sealed envelope containing information sheets and participant application forms to all registered nurses working in each prison in order to obtain my sample. However, I did not feel that the staff would respond positively if the request did not come via the health care manager. If the request had come directly from me, staff may have felt they lacked permission to become involved. Indeed, two of the health care managers, although asking staff to contact me directly, still wanted me to inform them who had been in contact. I also felt that, by asking the health care manager to approach staff for me, my credibility would not be questioned by the staff

because the very fact the health care manager had agreed to the prisons' involvement would indicate that the research was in some way worthwhile and credible.

I do not know to what extent the health care managers approached selected staff for involvement or indeed if they approached all staff via email or through a staff meeting. I feel that it is possible that they may have made direct approaches to particular staff. If this is the case, I do not feel this is a problem as the staff they approached would have been targeted for their experience and ability to articulate their practice. It could be suggested that health care managers would choose staff who would provide a positive view of the prison. However, I felt that with appropriate interviewing and my ability to develop a relationship with the nurses this would not be a concern. Having completed the data collection, I am sure that the sample was not targeted for their ability to provide a positive view of their prison.

In prison two, once the sample had been established, the health care manager suggested to me that one participant in particular would benefit greatly from clinical supervision and requested that I ask for their involvement in phase two. I did not see this as a problem. Firstly, my respect for this health care manager led me to believe that there was a good reason for this particular nurse to engage in phase two and secondly, underpinning my research is an aspiration for supporting and developing practice where possible. I was aware that I still needed consent from this nurse to be involved in phase two so I chose to speak to the nurse at length about it, to satisfy myself that she was giving her consent freely. She readily agreed her involvement.

Privacy & Safety

Confidentiality and anonymity are concepts adhered to in ethical research to ensure participant privacy and, as Christians (2000:139) suggests, 'Confidentiality must be assured as the primary safeguard against unwanted

exposure.' Baez (2002) asserts that the concepts of anonymity and confidentiality are inextricably linked and that confidentiality can often be achieved by the use of anonymity.

Anonymity is described by Holloway & Wheeler (1996) as ensuring that study participants' details are not linked in any way to the data. All participants in this study were made aware that tape recordings would be deleted as soon as transcripts had been typed and that, although their responses would be anonymous, interview transcripts and field notes would be shared with the study supervisors. In preparing the transcripts of participant interviews, I ensured there were no identifying details present. I also offered all participants the opportunity to see their transcripts if they so wished and offered them the chance to read the appropriate chapters of my thesis. The two nurses who engaged in phase two asked to see the chapters. In addition, participants were advised that quotes would be used in the final report and in any subsequent publications but were reassured that they would be anonymised. All participants accepted this although one nurse refused to be tape-recorded, citing nerves. The only people who know the identity of the staff involved in my study are the health care managers at all sites, the detail officers in two of the prisons and, in all prisons, all participants were aware of which of their colleagues had taken part. Unless these staff informed others who were not involved in my study, no other staff were aware.

Baez (2002) suggests that, in academic discourse, confidentiality is frequently framed in one of four ways: in terms of protecting participants from harm, in relation to privacy, in relation to ensuring accuracy and integrity of research, and concerning the ethical standards of research. In my study, confidentiality was assured to the extent that the information that participants expressly asked me not to share was subsequently not shared. Participants were informed prior to engaging with the research that quotes from their interviews may be used, but they were guaranteed to be anonymised.

In his paper concerning confidentiality, Baez highlights the ethical nature of confidentiality when undertaking qualitative research that has transformation at its centre. For Baez, the concept of confidentiality is problematic in work where confidentiality and hence secrecy only serve to maintain the current situation. He suggests that there is a balance between protecting the privacy and, sometimes, safety of the participant and effecting transformation. His example concerns his own research in which he investigated 16 university workers from black and ethnic minorities to study their experiences of promotion and tenure. His participants' requirement for confidentiality in order to feel safe to express their feelings meant that he felt unable to report his findings which could ultimately lead to better awareness of racism and racist practices. In recognising the need to protect his participants from harm by respecting their wishes for confidentiality, he was faced with a problem. As he states, 'Transformative political action requires researchers and respondents to consider themselves involved in a process of exposing and resisting hegemonic power arrangements, but such action is thwarted by secrecy and the methods used to protect it' (Baez 2002:35).

In my study, participants may have shared sensitive information with me which they may have been less likely to share had we not been working within a confidential space. However, I do not know to what extent this was due to the confidential nature of the space or the relationship that we developed. Although I feel that sensitive information was shared, I do not feel that those who divulged it felt uncomfortable or indeed regretted anything they said. They were all given the opportunity to contact me post interview if they felt uncomfortable or wanted to rescind their words. In the case of undertaking clinical supervision, the clinical supervision contract clearly addressed confidentiality but also highlighted my own professional requirement to alert others to matters of bad practice or breaches of security. In terms of reporting the findings and analysis of data, all participants remain

anonymous and any information that may identify them to those who may know the prison(s) in which these nurses work is omitted.

Prising Open Practice

In previous studies involving practice development and prison staff, I have encountered cynicism, suspicion and a reluctance to 'open up' (see Freshwater et al. 2001b; 2002; 2007). Given the closed nature of the prison and its culture, this is unsurprising.

Reflection on why this is unsurprising has directed me to consider the nature of prison culture. Furthermore, the underlying issues of power and control in relation to knowledge are important to consider here. This is clearly related to the work of Michel Foucault. Given that from a Foucauldian perspective power is exercised through dominant discourses, which are themselves underpinned by regimes of truth or knowledge, it appears to me that the Prison Service as an institution supports dominant discourses within the service through its government of the system. Therefore, dominant discourses are partly perpetuated and governed by the institution. In the case of staff feeling unable to open up and examine their practice, I suggest that the disciplinary effect of the institution manages the extent to which staff will discuss their work with outsiders. For example, one of the dominant discourses in prison concerns secrecy. This dominant discourse is supported by the staff working within the prison as they go about their work with the knowledge that they must abide by guidelines and rules issued by the institution, which, if not adhered to, may result in disciplinary sanctions. These guidelines and rules are seen as the regimes of truth that underpin the dominant discourse which then supports the power relations within the system. So, in considering this in relation to the fact that prison staff can be suspicious, cynical and unwilling to examine their practice with outsiders, I suggest that it is the power relations between staff and institution which are the cause of reluctance (as a consequence of the dominant discourse of secrecy). Coupled with a dominant discourse of secrecy, a discourse of

'blame' is also prevalent in some areas. It is the consideration of both discourses, secrecy and blame, which leads me to conclude that I am not surprised there is reluctance to open up to outsiders.

The ethical and moral dilemma in this study centred on the extent to which the staff could be encouraged to discuss their practice openly and, indeed, question it without feeling uncomfortable or possibly inadequate. I was aware that providing the nurses in this study with the opportunity to examine their practice, either through interviews or clinical supervision, could potentially cause them anxiety. Clarke (2006:19), in her paper concerning interviewing in qualitative research, warns that, 'Researchers must be mindful of the impact their questioning can have on subjects.' She continues to propose that a reflexive approach to interviewing can assist in addressing this issue.

In my experience in this study, one participant became particularly distressed at recalling the nature of some of the crimes of his patients. The reflexive, real world nature of this study allowed me, as the researcher, to identify and react appropriately when I felt both this and, indeed, any of the participants becoming uncomfortable or anxious about their story. I also suggest that my own experience as a prison nurse enabled me to engage with participants on a level that would otherwise have been impossible. I feel that this level of engagement helped provide the participants with the confidence to speak freely. I also feel that my shared experience of prison nursing and my ability to reflect on it enabled me to respond appropriately and effectively.

Use of Self

The use of researcher as participant is well documented in research literature. I do not suggest that there is an issue of bias regarding researcher involvement; that is discussed elsewhere. However, in terms of the ethical issues inherent in this study, I suggest that there is potential for exploitation of the researcher in this situation. From my own reflection of involvement in

this study, I have at times found it difficult to judge how much information regarding myself to provide. Given my passion for this work, I have had to be mindful about what is appropriate, relevant and acceptable in terms of my input. This is not autoethnography. I have addressed this issue through regular reflection and supervision. Coupled with the sharing of information with others referred to in this thesis, I eventually managed to reach a happy medium where I feel I have shared enough of my experiences and story in order to illuminate and support my work, without feeling exploited.

Data Analysis

Using the steps of analysis proposed by Carabine (2001) to guide my thinking, I began to view my data with the aim of uncovering the dominant discourses and identifying relationships between them. In addition, I examined the data for resistances, silences and absences and attempted to identify contextual factors affecting dominant discourses. In addition to reflecting on the work of Carabine, I was also drawn to the work of Holmes (2002) and Holmes & Gastaldo (2002) and their use of the concept of governmentality to discuss the Foucauldian notions of power in nursing in order to underpin my analysis.

Phase one interview data from each prison were initially analysed separately. Given the need to examine the context from which the data were collected, I initially felt it was important to recognise that each prison has its own culture and institutional approaches which may have impacted on the data, and which therefore needed to be recognised. In order to capture these and examine the contexts within which the data originated, the prisons were kept separate. However, it became clear following this initial analysis that, although the prisons are different in terms of their operational function within the service, data from both the male prisons were similar, despite each having their own culture. Data from the female prison were slightly different and, as a result, I have chosen to present the two male prisons together but separate from the female prison. Data obtained from clinical supervision

sessions with two nurses from different prisons were analysed together. Documentary data were analysed separately although included where specific to each prison.

Chapter Four: Findings & Discussion

I want to note here that my perception of the various relationships that the prison nurse engages in and their relation to the emotional labour experienced by them as a consequence, is just that... my perception. It is based on examination and consideration of the literature I chose to review and accept, my interactions with the study participants, and the intellectual space I inhabited at the time I considered the issues. The postmodern underpinnings of this work highlight the concept of the rejection of grand narratives, meaning that there is not one 'truth'. As you read this analysis, do not forget that the conclusions I make and the direction in which I travel in order to make these conclusions are personal to me, the researcher, and are offered to the reader as just one perspective in considering the emotional labour of prison nurses. If my work is taken and read as 'the truth' this will limit the possibility that it will be developed further. I reiterate the words of Foucault: 'I would be very pleased if at the end of each lecture you would voice some criticisms and objections so that, insofar as possible and assuming my mind is not yet too rigid, I might gradually adapt to your questions and thus at the end of these five lectures we might have done some work together, or possibly made some progress' (Foucault, in Faubion 2002:1).

Following extensive reading and re-reading of the interview transcripts, I suggest that the way in which the nurses in this study experience and work with emotional labour is evident on two levels, both based on relationships. One level centres on three relationships: the relationship with the prisoner patient; the relationship with discipline colleagues; and their relationship with the prison as an institution, governing their overall practice. The second level, and perhaps the level at which the emotional intelligence of the nurse is of paramount importance, is the relationship the nurse engages in internally, with themselves. Given the relationships with which the nurse engages, both externally and internally, it must also be noted that those with

whom they engage are also operating on two levels. As the focus of this work is the nurse, the operation of the other actors is not under analysis but is important to recognise.

In order to provide a visual representation of my thinking, the following figure illustrates these two levels and their interactions with one another.

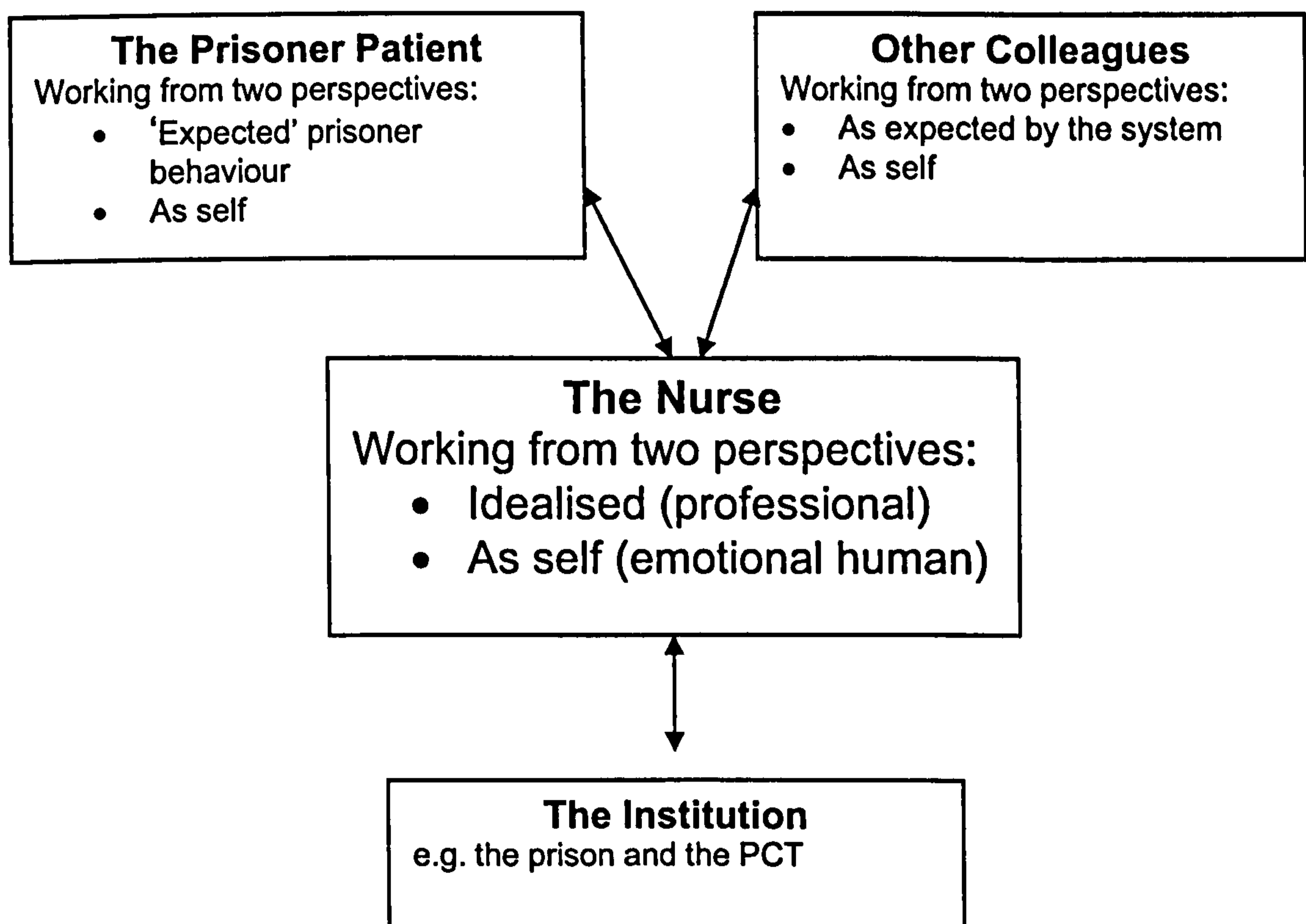


Figure 6: Key Relationships

The effect of these relationships on the nurse, both internally and externally, has an impact on the care they give and the way in which they practice. These relationships will also affect how they feel both internally and in their public displays. Therefore, the web of relationships within which the nurse is involved is what I believe necessitates their emotional labour. As Hochschild (1983:7) notes, 'This labour requires one to induce or suppress feeling in

order to sustain the outward countenance that produces a proper state of mind in others.' Each relationship will necessitate the nurse to engage in emotional labour, be it to ensure the prisoner patient feels confident in the nurse's ability, for example, or the prison officer to feel as though the nurse understands the officer's perspective. I suggest that the relationship with the institution affects the emotional labour of the nurse on a more internal level, e.g. the routine of the prison (imposed by the institution) may restrict the nurse's ability to undertake particular care, which may cause the nurse conflict. This is discussed later in this chapter.

If these relationships are indeed at the core of the emotional labour of the prison nurse, I suggest that the nurses' own levels of emotional intelligence dictate the way in which they manage the emotional labour. From the perspective of Salovey & Mayer (1990:189), emotional intelligence is 'the subset of social intelligence that involves the ability to monitor one's own and other feelings and emotions, to discriminate against them and to use this information to guide one's thinking and actions'. I therefore suggest that in order to undertake emotional labour the prison nurse must be able to monitor their own and others' emotions and feelings and be able to use the information to guide their own actions. Therefore, I suggest that nurses' ability to undertake emotional labour effectively is determined by their level of emotional intelligence.

Reflecting on the emotional labour of nurses working in prison as a consequence of their relationships with others leads me to use my own experience to illustrate my point. The reception area of a prison is very busy, especially so during the evening when the courts have closed and prisoners are returning. This deluge of prisoners being received back into the prison occurs mainly between 4.30pm and 8.00pm. During this time, prisoners have to undergo the reception process (to a greater or lesser degree depending on whether they are new to the prison or returnees) during which health care staff are involved. My input into the reception process was to see prisoners

last, before they were transferred into the main prison. Therefore, prisoners could not be moved until I had seen them. Undertaking a health screen on these prisoners could be quite lengthy depending on their health care need. However, I could not see them to begin the screen until they had cleared the rest of reception, and they could not be moved until they had seen me. Understandably, reception officers wanted the prisoners moved onto the wing as fast as possible, given that the prison evening duty staff would be off duty at 9.00pm. I often felt under tremendous pressure to complete my health screening as quickly as possible so as not to hold up the system and cause staff to leave late. However, I refused to compromise my practice. Feeling stressed, I had to engage in emotional labour with prisoners, often to allay their fears/anxieties and to present a professional demeanour; with the officers to prevent deterioration of our working relationship and with myself in managing the conflict I experienced.

In order to place the ideas I have posited concerning the relationships of the nurses with others and themselves into focus, I feel it is important to discuss the Foucauldian perspective of power as it relates to nurses and their relationships. Given that I have clear Foucauldian influences in the analysis of this work, I have identified clear links with the theoretical perspective with which I am considering my data. I have mentioned the relationships with which the nurse engages, which demonstrate the underlying causes and effects of emotional labour upon the prison nurse. However, in addition to consideration of emotional labour and, hence, emotional intelligence, there is a need to contemplate the power relations inherent in the practice of the prison nurse, as these power relations are affected by the dominant discourses, accepted knowledge and processes of governmentality which are central to practice in the prison setting. As Holmes & Gastaldo (2002:559), suggest, 'Power acts upon individuals, and they in turn act upon others. Therefore power is relational.' It is important therefore that the analysis undertaken in this thesis examines these power relations because

the way in which power flows affects all aspects of the prison nurses' practice.

Not only are the relationships between the nurse and the prisoner patient/colleagues and institution subject to consideration from this Foucauldian perspective but also, importantly, the relationship nurses have with themselves. Holmes & Gastaldo (2002:559) suggest that, 'The construction of the self (subjectivity) is linked to established forms of knowledge and institutionalised practices. Self is not an essence; it is created by the influence of multiple forms of power.' It therefore seems natural to consider the power relations inherent within the world of the prison nurse in terms of the dominant discourses they are engaged with, when one is exploring their space and practice in relation to their emotional labour.

If we consider the diagrammatic representation of the relationship between power, governmentality, dominant discourses and knowledge as discussed previously, it can now be developed further to take into account the relationships entered into by the prison nurse and demonstrate the complexity of the prison nurses' situation.

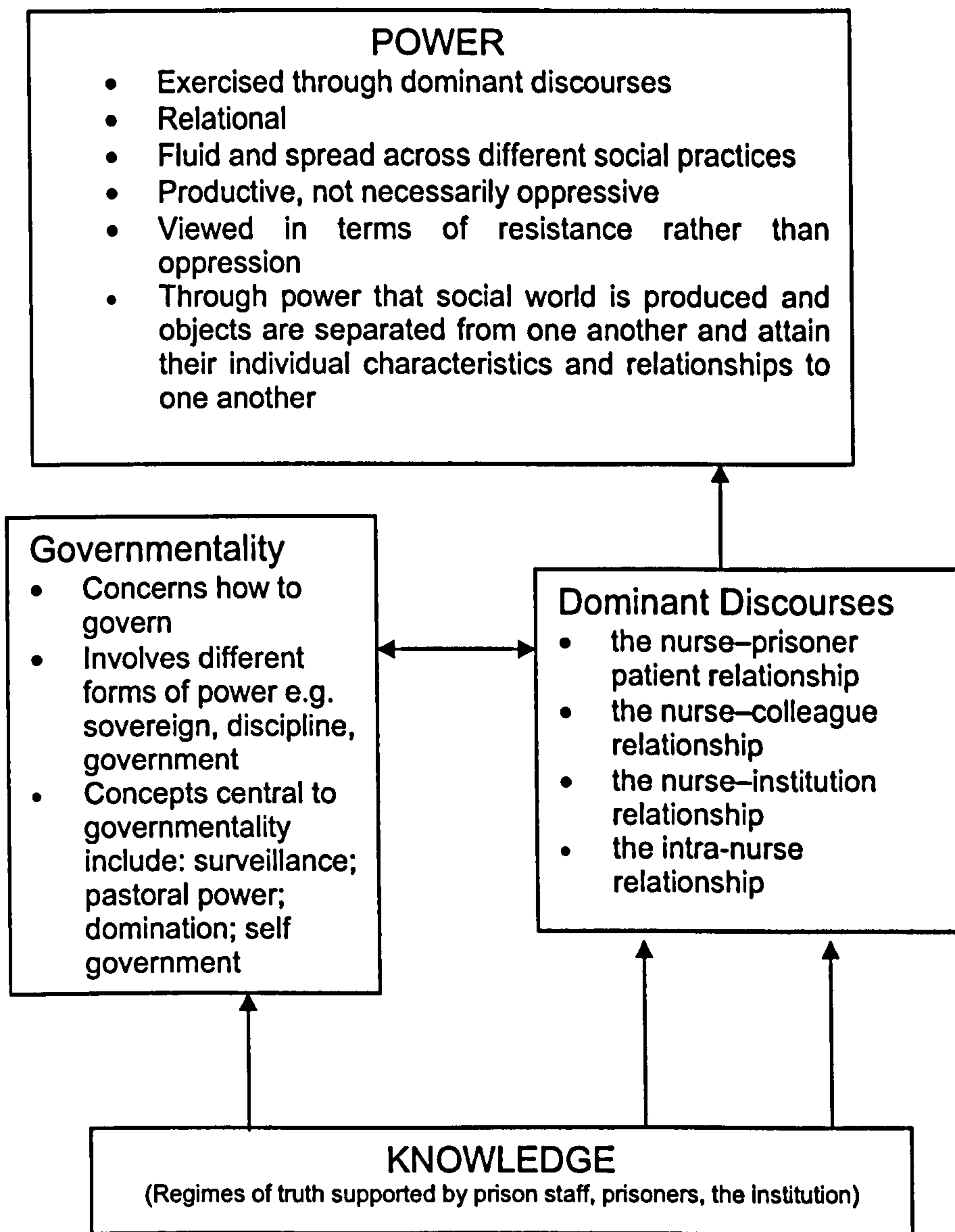


Figure 7: The Prison Nurse Knowledge–Power Relationship

I have chosen to report the findings from phase one of this study (interviews and documentary evidence) in terms of the three external interpersonal relationships with which prison nurses engage i.e. the nurse–patient relationship, the nurse–colleague relationship and the nurse–institution relationship. The intra-personal relationship that nurses enter into with themselves, from here on referred to as the ‘intra-nurse relationship’, is discussed in terms of phase one of the study separately and incorporates findings from all prisons. Phase two of the study (clinical supervision), focuses solely on the intra-nurse relationship as, given the nature of clinical supervision, this was the focus of the sessions.

I have presented the findings of this study in this way because, during the analysis of data, the narratives of the participants and my own experiences led me to consider the dominant discourses present. The dominant discourses embedded in prison nursing practice can be seen as discreet headings in the following text.

Prison One & Prison Two

The dominant discourses evident from the interviews conducted with the staff in these prisons were, on the whole, negative and centred on relationships with prisoner patients and relationships with colleagues. Working within a structured environment under the rules and regulations of the prison and Primary Care Trust systems was also dominant throughout. This I have termed 'the nurse–institution relationship'. Relationships with other staff in the prisons appeared stressed, and the changes currently underway as a result of the transfer of commissioning responsibility for health care to the Primary Care Trust also appear to be causing difficulties. From the way in which staff readily spoke openly with me at both prisons, I felt as though they were excited at the opportunity to explain their situation to the outside world.

The Nurse–Prisoner Patient Relationship

Aggression & Manipulation

Managing aggression and working with 'difficult', manipulative prisoner patients was noted as one of the dominant issues causing stress for staff, and forcing them to engage in emotional labour:

The prisoners that are coming in, their ways of doing things, dealing with people is to do it aggressively and get angry. It's almost becoming the norm. It's expected now that a prisoner will get

aggressive and angry if they don't get what they want...Prisoners don't really respect staff anymore. (N2)

When questioned about the impact this has on staff, the nurse replied: 'It is stressful, yeah, it's very tiring. It's tiring being confronted with aggression all day' (N2). She continued to suggest that the nurse's personality had a significant impact on their ability to manage aggressive prisoners:

I don't know how I manage to do it, because I've had a lot of aggressive prisoners to deal with. A lot of it depends on your personality and what you are like, how professional you are. (N2)

Another nurse discussed the impact of manipulative prisoners on her feelings: 'They wear me down and well, I'm not terribly cynical, I'm not a hard person, but they do wear me down and I do get fed up with it' (N4). She continued to mention her feelings towards the prisoner patients who manipulate the system through feigned illness: 'The people that really wind me up and I dislike them are the manipulators, the bad not mad, who try to play the mad card to try to get away with things and they're the ones I despise really' (N4).

Throughout the interviews, it became clear that these nurses also place the need for very rigid boundaries in high regard in order to manage aggressive or demanding prisoner patients. Indeed, in some instances nurses must resort to security measures in order to manage. One nurse recalled an incident where she was faced with an aggressive prisoner at the treatment room:

It was a gated room. There was a gate at the door, but, but it's important. I was having an argument with him, well, he was arguing with me and I was not so much arguing as trying to put my point across and there was all these other prisoners watching and standing

at the door. He walked away and eventually backed down a bit...you have to rely on your own skills to deal with them as sometimes there aren't any other officers. I mean, if it got too bad, I would just press the alarm bell. (N2)

This nurse continued to discuss the need for clear boundaries between the nurse and the prisoner patient:

You see, one way or another, prisoners will always try to con you. One way or another, and it's how they do it that's annoying. If a prisoner comes up and is very, very angry or aggressive, my attitude is I just don't want to know him. It's like, you come back and speak to me when you're calmer. I won't put up with it. Then my instant reaction is I don't want to know, I'm not going to help you. If they come back and they've calmed down, then of course, I will do whatever needs to be done. (N2)

Another nurse discussed the importance of zero tolerance towards aggressive behaviour and demonstrated the way in which he manages it, but remains caring:

Yesterday, I worked on the wing. I said to the prisoner 'you're not getting it, thank you very much but you're not getting it' [meaning medication], but later on they came back, they said sorry and I said 'forget about it, what can I do for you?' you know, so for that kind of thing, I don't use their behaviour against them at all. (N3)

In recruitment literature developed by HM Prison Service and the local Primary Care Trust for prison two, the issue of aggressive prisoners is addressed as a potential issue for nurses considering a position within the prison. In this promotional literature, the question is posed 'Are prisons safe places to work?' It is suggested that, 'Specialist training is offered to all

prison staff in dealing with aggression, and highly trained prison officers are also available to assist health care staff if needed.' This booklet continues to note that prison staff often remark on how prisons are 'far less threatening environments to work in than many other nursing environments, particularly A&E'. (I have not referenced this literature as I would normally, given the need to maintain anonymity of the sites used in this study. Accurate referencing to this literature would identify the prison involved.)

In facing aggression and manipulative behaviour from prisoner patients, the nurses in this study demonstrated a clear, bounded approach to dealing with it. However, what is clear to me in considering this issue is that there is a power struggle inherent in their practice. It would appear as though the prisoner patient is exercising power over the nurse by way of their behaviour, by being aggressive or manipulative, and are seen to be trying to gain in some way. However, this is counteracted with displays of disciplinary power by the nurses in terms of using security techniques such as pressing the alarm bell in order to resist. Nurses are also seen to be adopting dominant, repressive actions akin to sovereign power, in which they refuse to interact with prisoner patients who are behaving inappropriately.

Interestingly, there are no references from the participants as to why the prisoner patients may be behaving in this way, which would arguably provide them with a better understanding of the actions of the prisoner patient, and hence may provide better insight into how to deal with the difficult situations in which they find themselves. This is in keeping with the conclusions drawn by Stevens (1993) in which the norms of the prison and health care cultures dictate that, in a health care setting, anger and hostility are acceptable behaviours when someone is ill, and where help is offered and anger redirected. In contrast, prison culture is a place where anger and hostility are unacceptable and necessitate higher security.

The Effect of Offence on Care

In dealing with the effect of the prisoner patients' offence on care and feelings, the dominant discourse was one of the importance of being non-judgmental. For some, this was achieved through awareness of the need to be non-judgmental, and for others this was achieved through purposeful ignorance of the offence.

I try not to let it influence me. I try and portray a professional façade, for want of a better word. Yet the fact is that the cases I'm aware of, I may see them in a different light but as regards the care I give them (pause). They are obviously in custody for a reason but I think 'who am I to judge them' in that respect. I'm only here to provide them, err to give them care but in the fact that they've been found guilty, it wouldn't affect the care I give them. I try to treat everybody the same. (N2)

I try not to pre-judge. It's very difficult because you know what the person's done before you meet them to a certain extent, but I try to stay open minded about the person until I meet them. (N6)

Most of them, I don't know what they've done...I don't sort of go into their index offence. I don't know if whether that if their index offence, if like I hear what they've done, whether it will affect me or put me off, I try not to go into it. I just don't go there. I tend to, unless there is a need for us to look into it, like if you're doing some kind of risk assessment or something like that. I don't tend to go into it. I don't. I don't. Unless, well, I sort of, not ignore their index offence, but I don't take it as a priority. (N3)

If the nurses in this study knew about the prisoner patient's offence, perhaps through media publicity or a need to know for security reasons or risk

assessment purposes, and the offence was one they found hard to deal with, they demonstrated an ultra professional persona in dealing with the prisoner that was based on total reliance of their professional side and suppression of their emotional side. When the participants reported that they ignored the offence or did not make it their business to know about it, they adopted a position where, by not knowing, they did not have to confront the emotions it may trigger, which was found to be a common technique for managing emotions in this situation.

One respondent in particular gave a very frank and emotional account of caring for one particular high-profile prisoner patient which highlights very clearly the emotional labour these nurses face. Given the importance of this nurse's view in this context, I have chosen to report the transcript including my own comments.

N4: Generally you just think they are the same as everybody else but then sometimes you think that what they've done is ten times worse than what you could possibly imagine you know, you can't (pause) and that is very hard (begins to become quiet and appears upset).

Liz: It's understandable though isn't it; I mean we are all human, with feelings.

N4: Yes, I mean you can't help it sometimes. It does affect you...I mean, yes, I wouldn't like sometimes to give them the steam off my tea, that's how I feel and then they go 'oh, I've got a headache, have you a couple of paracetamol?' or whatever, and I think to myself, why don't you go and rot somewhere. I don't want to help them and I think that's human. I don't, I don't punish myself for that because I only think it; I wouldn't say it. Much as I might like, I wouldn't. I'd just be 'yep, there you go'. It would be like that but, yes, of course it affects you. Sometimes when I go home and I (pause) because my husband

is the sort, I couldn't actually sit down and tell him how I feel about that because he would say well they're all scum anyway, like a lot of the general public think, you know, that they're scum and they don't deserve to breathe the same air as we do, when you and I both know that's not the case. I mean some of them are victims of, not necessarily the really high profile, but some of them, even the druggies, and I'm not making excuses for them, but some of them never got the best starts in life, and they do deserve our help and sympathy. And yes, it does, you know, it does, it kind of affects the way you behave towards them. Definitely does. Yes it's hard. You know what though, I'm a smiley kind of person, it's just the way I am, yes, and I try not to when I was dealing with one particular inmate, very high profile, I don't even need to say his name, came from [participant identifies prisoner patient by location]. I wouldn't, I just couldn't, I couldn't bring myself to smile at him. I just used to mumble. I was never rude but it was erm, because he was on medication, I would say 'do you want this today – do you want this now or tonight'; that was how I would say it when normally I might on the houseblock I would say to them 'do you want this now, or later or do you want to take it away with you', something like that, a bit more chatty. It did, it wears you down. It wore me down because I'm not like that you know.

Another nurse reported how he deals with those prisoner patients for which he provides care but which he does not like to look after:

I don't like looking after the er, you know the paedophiles and sex offenders you know, if I did have a preference I wouldn't want to but then, as I say, I've found over the years in the Prison Service, the way I deal with them, if I don't particularly like them I just deal with them on a very basic level, you know, 'what's your problem...take that...go away'. I don't, I mean engage them in any other interaction whereas if they come up and I've known them for a while and I know that, you

know, that would be different. With some of them, you can have a laugh with them. The thing about it is that being an officer, you are always quite in control about who you are going to have a bit of a laugh with. Because, if you just want to dismiss them, you can, it's a skill you pick up very early on. You know, take that, go away. It's very easily done. (N5)

Another respondent recalled his feelings when caring for a prisoner patient who had committed child abuse:

I think there are certain crimes, you know, we are all human and sometimes...it gets me. There was one...erm, a child abuser. I read about it in his medical notes, he was in health care. You know that the time it really gets me really, it was a baby, a baby. I went into the toilets and cried you know. It was a baby boy and the partner, you see there was a picture, it was a booklet I was looking through and he was smoking and (demonstrates the stubbing out of a cigarette on my forearm) you know, so many marks. I cried that night. (N3)

This nurse became quite upset at recalling this incident so I stopped recording the interview as I felt it to be inappropriate. I suggest that I was using my own emotional intelligence at this point in identifying the feelings of this participant and using my own experience to act appropriately. We discussed things further and it became clear that he felt guilty and ashamed, as he perceived that his feelings about the offence had affected the way in which he provided care for the prisoner patient.

Some of the nurses in these prisons alluded to the way in which they have their own hierarchy of illness, and sometimes type of offender, as a way in which they determine prisoner patient need and hence their reaction to them:

Career criminals are easier to handle aren't they. It's because it's an occupational hazard for them. They do their crime and they do their time. It's not like that with the younger ones. Oh, the druggies, they're whining and whingeing and everything again is your fault. They do go on. Mind you I can still feel sympathy for them when they are feeling ill because they must feel very ill...I can be sympathetic still, I can be sympathetic when I need to. (N4)

When asked if he saw prisoners as patients or prisoners, one nurse remarked:

It may sound cynical but I see them in both ways. I choose to make the decision myself. I mean, if I go upstairs [to the inpatient unit] I will view those people who I consider to be unwell as patients. But if I go up there and I quite clearly see someone who has been brought there for diplomatic reasons rather than medical reasons, I do tend to take the view that they are inmates. But as I say, I do purely personally, when I go up there, I do, if I see someone who is unwell I will look at him and view him more as a patient than an inmate. (N5)

Droes (1994) suggests that the nurses in her study stated that they looked beyond the prisoner patient's past behaviour which, although took perseverance and patience, enabled them to accept prisoners as human beings which, in turn, made it easier for them to care. However, Holmes & Federman (2003) report that nurses working with prisoners modify their own representation of inmate patients in order to care, as modifying their own representation of the patient is easier than modifying their own behaviour.

Interestingly, one nurse who had only been working at the prison a short time stated:

I know when I first came here I was talking to the training manager and the thing was I was talking to him about the patients and the thing he picked up on, he said 'oh, it's nice to hear someone calling them patients and not prisoners'. That is how I viewed it from the beginning. I think it's easy to lapse into the 'them and us' scenario, you know, they're prisoners. I think it's easy to lapse into that once you have been here a while, but I'm hoping that I will still see them as patients first, really, rather than prisoners. I guess time will tell but I hope that I can keep that attitude really because I think that is why I'm a nurse as opposed to anything else. (N6)

During September 2006, Ian Huntley, a high profile murderer, attempted suicide in HMP Wakefield. He was admitted into intensive care at the local hospital. The Sun newspaper reported his release from hospital back to the prison in a sensationalist fashion, providing a three page 'special' report including pictures of the prisoner patient being taken in a wheelchair by prison officers to waiting transport. Although the British public are witness to such reporting on a frequent basis, there was something about the way in which staff at the hospital were portrayed that I felt was worth further examination in light of this study. Although this study concerns the emotional labour of nurses working in prison health care settings, the importance of this news item and the way in which it was reported, does, I feel, send a message out to the public about the way in which offenders, deemed by society to be 'evil', are treated, and, more importantly, the acceptability of their treatment. Given that nurses working in prison are also part of society, it must be remembered they are not immune to media influence.

The newspaper report centred on the allegation that a nurse working at the hospital 'vented her fury at Ian Huntley...screaming, "why didn't you die, you bastard"' (Taylor & Askill 2006:5). The nurse was described in the report as 'a uniformed angel', whilst Ian Huntley was referred to as 'a bloated beast'. The report indicates that a member of the public told prison officers

transferring Ian Huntley 'they don't pay you enough to be near that thing' (Taylor & Askill 2006:6). It is acknowledged in this report that the nurse who shouted at Ian Huntley could potentially lose her job if she was identified. However, a 'source' at the hospital suggested that, given the depth of anger towards this patient, no one would report her. In one sense, this response almost sanctions the unprofessional behaviour of the nurse. However, nurses working with prisoner patients on a daily basis strive to maintain a non-judgmental approach to their patients in order to provide care. For me, this newspaper article further demonstrates the emotional labour which nurses working with prisoner patients undertake daily in their practice.

Given the way in which those who work with offenders are subjected to the influences of the media, it is important to consider the effect of the media in terms of the way it promotes dominant discourses, underpinned by what they perceive and promote as 'truths'. Appreciation of the way that Foucault suggests power is exercised, i.e. through dominant discourses which are underpinned by knowledge or accepted regimes of truth, the influence of the media on public and hence prison worker attitudes is marked. Soloman (2006) suggests that the development of sensationalist reporting of crimes and offenders in recent years is as a consequence of the dominant political discourse, which reflects prevailing penal consensus.

Developing Relationships

Humour and banter was deemed to be of paramount importance when developing a relationship with prisoner patients, as was the ability to 'speak their language':

You have to remain professional and they have to feel like they can approach you and that you are on their level whatever their problem is...It's a whole different culture and way of talking. Because when they come up and they say they've got a headache I might say 'oh my

heart bleeds, it really does' you know, but you wouldn't do it on a ward would you. You see, you can get away with a lot of stuff, you know, the banter and all that. That's the good part. It's a really comfortable level. (N4)

The use of humour in developing relationships is well documented; see Astedt-Kurki & Arja Liukkonen (1994); Astedt-Kurki & Isola (2001) and Olssen et al. (2002). In their study, Holmes & Federman (2003) noted that nurses surreptitiously tried to decrease the distance between themselves and their prisoner patients, which is what I suggest happened to the participant in this study. It is interesting to consider the way in which a particular use of banter is acceptable in this environment, and would be unacceptable elsewhere. It is as though prisoner patients accept the way in which they are spoken to in jest, as there is an implicit understanding of its real meaning. This implicit understanding will be noted through the truths that emerge from the culture and which underpin dominant discourses. The way in which the humour and banter is used is referred to as pastoral power; a method used by nurses in order to understand their patient and develop trust.

Whilst discussing the issue of banter and humour in the prison setting with this respondent, I was reminded of my own practice during which a great deal of humour was used, both with prisoner patients and between staff. Indeed, it was a different sort of humour that I had experienced inside the prison to that outside. Although we were professional in our behaviour, anyone from outside the prison may have been shocked at some of the jokes we shared with our prisoner patients. Upon reflection, we engaged in banter and humour in order to manage some very difficult situations and also, in an unconscious way, I suggest we were also demonstrating some understanding with our patients on the same level.

The Nurse–Colleague Relationship

The relationship between the health care staff and the discipline staff is an important one in the prison environment, given that the overriding aim of all who work with prisoners is to care for them, sick or well. Throughout the interviews, it became clear that the working relationship between health care and discipline can be fraught with tension, given the philosophical perspectives that each is working from; officers from a security/custodial perspective and nurses from a caring perspective. However, the dominant discourses surrounding this relationship were not all negative. Health care staff readily acknowledged the support they receive from discipline staff.

Professional Divide

The attitude of some officers was reported to be old fashioned and unco-operative in some instances, especially when some of the participants first joined the Prison Service:

There was initially, like a divide between officers and nurses. Not because you were female but because you were a nurse. It's like because you were new, you had to like, prove yourself, deal with prisoners, toughen up and deal with them accordingly. (N2)

The impression I was given in terms of new staff having to prove themselves was also suggested by another nurse. Talking of her initial impressions of officers when she first arrived at the prison, she remarked that 'there was much hostility and prejudice' (N4). I asked her if it was still like that at this particular prison: 'Up to a point, to a degree, yes. And even from some of the younger ones. They're coming in and it's like a learned behaviour, picking it up from the older ones' (N4).

Some understanding of the prison officers' position and attitude towards nurses can be gained from consideration of their historical situation. As Black

(1992) noted, during the 1980s and 1990s, the Prison Service had suffered from under resourcing, negative public image, bureaucracy and poor working conditions. In the late 1980s, new initiatives were introduced into the system, causing unrest and anxiety amongst the staff. At around the same time, nurses were beginning to be introduced into prisons. It can be seen that the changes introduced through Fresh Start led to prison officers feeling as though they had no champion, no one on their side. Low morale and dissatisfaction with their treatment led officers to feel undervalued. If one considers the effect of introducing civilian nurses into the system to undertake the job previously carried out by the hospital officer, it is no wonder that nurses did not receive a warm welcome, especially given that their philosophies are so different. I feel that this is important as it demonstrates the way in which the officer group demonstrated resistance to the introduction of nurses. Their regimes of truth, underpinning their dominant discourses concerning how prisoners should be treated and how prisons should function, affected the way in which they did not readily accept nurses into their workforce. This occurred almost 20 years ago, and things are reported by the respondents to have changed significantly. However, the hostility and prejudice are still evident to some degree today as one participant mentioned, due to the fact that the new officers are learning from the older ones. This leads me to consider the way in which the dominant discourses of a culture are resistant to change and development.

There is a need in this setting for nurses to become socialised into the culture in order to gain acceptance. I see that part of this socialisation or 'prisonization' as mentioned by Clemmer (1940, cited by Hemmens & Marquart 2000) entails newcomers gaining an understanding of the knowledge, which informs the dominant discourses of a culture. One way of gaining this knowledge and, indeed, proving one's ability in the culture is to be left to manage a situation alone, thus allowing onlookers to judge suitability of membership into the system.

Responsibility

The issue of responsibility was raised throughout as an area of concern. Officers were reported to have wanted difficult and disruptive prisoners transferred to health care in order to have their behaviour managed and often cited mental illness as a rationale. The conflict for health care staff centres on the need to support their officer colleagues but to maintain the prison health care centre as a place for the treatment of sickness and not one of behaviour management. It was felt by some respondents that these officers wanted to relinquish responsibility for these prisoners and provide themselves with some much needed rest from dealing with them. One respondent mentioned the strain that is evident between health care staff and discipline staff as he recalled a recent incident:

The reason it becomes strained is because they'll have someone who is proving difficult, and their reaction is that he must have a mental health problem so they want him in health care. Invariably he will come in. I mean we've got a guy in at the moment who is in between us and the seg [segregation unit] like a blinkin' yo-yo. He came in, he was, you know, everyone thought he was a bit odd and we had him in health care. It became clear quickly that he didn't have any front line mental health problems; he was just an aggressive, nasty piece of work. So we moved him to the seg and of course, in seconds in the seg he thumped one of the officers down there so they had him moved back to health care because 'would you do that if you were sane?' That was their argument. So, we had him back in health care for a day, still no mental health problems so back to the seg only this time he punched a governor. Back up to health care, 'he needs mental health assessment'. I mean, how many times?! (N5)

Depends on the officer. Some will work with you, others won't. It all depends on their staffing. On the one hand they are under pressure

themselves. If they've got a stropky prisoner and there are health issues, they try and palm them off on health care. (N2)

Another reason provided by the participants for the need for officers to move prisoners to health care centred on the reluctance of officers to engage with difficult prisoners for fear of litigation and allegations.

The discipline staff, they don't want to know. When they kick off, when they kick off and use threatening behaviour, they want them to be in here [health care]...I see that's why at times I think the discipline staff, they push to make it more cushy for themselves. You know, to have it more cushy so that at the end of the day, they finish their job and can go home without having to answer any questions. So we have them here [in health care], when they come here, they're not health care material, they do sort of threaten but we cant move them...the governor or the governors are imposing more powers on who we have to take...we have to take them because they want life easier for them on the wing. (N3)

I suggest that there are links here concerning Foucault's concept of disciplinary power. It is alleged that officers prefer prisoners to be located in health care so they themselves can avoid any litigation or allegations commonly posed in such a litigious environment. This avoidance of risk for the officer by moving the prisoner to health care leads to a more stress-free working life, and can thus be seen as rewarding behaviour. It appears from what the respondents in this study suggest that prison management sanctions this behaviour, leading to frustration and irritation for prison nurses. This sanctioning leads to an implicit understanding within the culture that it is acceptable to move difficult prisoners into health care, and it becomes a normal practice. Given that the dominant workforce in a prison consists of discipline officers, their practices become part of the intricate workings and knowledge of the establishment. As Ceci (2004) suggests, knowledge is only

perceived as truth if the community within which that knowledge is based agrees that it is true.

Communication & Understanding

Nurses in this study reported the importance of having the right approach to officers and, more importantly, the right kind of personality in order to work effectively with officers. The need to communicate effectively with officers was cited as crucial. A sense of humour was deemed by one nurse to be useful in understanding the different perspectives between discipline officers and nurses:

It's a good laugh really. Like, different staff, the different kind of people you work with, discipline and health care officers and that, when you are sharing ideas, cracking jokes, you feel their, you can get their own bit from each other which is very interesting. You are discipline, that's why you are saying this. It is a good laugh, it's what I like, it is a nice environment. (N3)

I also suggest that the use of humour amongst prison colleagues serves to assist in the management of difficult situations. Beck (1997) demonstrated that humour was used amongst nurses as a coping mechanism and Astedt-Kurki & Isola (2001:457) suggest that humour use amongst staff can not only assist in managing difficult situations, but can also relieve tension, resulting in a 'more liberated and improved working climate'. Holmes & MacInnes (2003) report that Prison Service staff use black humour to manage stress.

An understanding of the prison officer role and culture was also cited as important in developing good relations with officer colleagues. In highlighting the cultural differences, one nurse (N1), whose interview was not tape-recorded, talked about the difficulty of his transition from health care officer to civilian nurse within the prison, and suggested that it was very difficult

because he has loyalty to his officer colleagues but was now working as a nurse. He suggested that his officer colleagues felt betrayed by him. He stated that he felt divided loyalties, which initially made work difficult, suggesting that his insight into the prison officer culture enabled him to manage this difficulty effectively.

One respondent suggested that the way to win over the officer was to demonstrate clinical credibility. Having experienced some initial problems when he started as a nurse, a qualified health care officer at the prison stated:

I think that what did happen over a period of months was the fact that because I did have such big experience in psychiatry, that eventually won a lot of the staff over. (N5)

Indeed, when asked about situations in which these nurses felt they had done a good job, many respondents talked about occasions when their clinical credibility was confirmed by outside hospitals and nurses working in the community. This affirmation of practice engendered positive feelings for participants. For example, one nurse recounted her story of effectively linking with the community TB nurse to organise treatment as being an episode of care that she was pleased with. Another highlighted a case where she instigated an outside hospital visit for one prisoner patient whom she thought had appendicitis, and another cited an example of diagnosing an alcoholic with acute withdrawal symptoms. In both of these cases, discipline staff and even fellow health care staff were sceptical of the importance of immediate treatment, suggesting that both prisoner patients were manipulative.

The positive feelings produced as a result of outside affirmation of clinical credibility does, I feel, demonstrate two issues. Firstly, there is the personal satisfaction gained by the participant. Secondly, there is a feeling that affirmation of practice from outside the prison in some way proves the clinical

credibility of the nurse inside the prison. However, the importance of relying on external verification of practice does lead me to consider the power relations inherent between the nurses working in prison and the nurses working outside the prison and, consequently, the status conferred on them by prison nurses. In addition, if a positive relationship between the prison nurse and the prison officer is based partly on affirmation of practice from external sources in order to prove credibility, what does that say about the officer's perception of prison nurses and hence their position within the prison hierarchy? I suggest that the prison nurses' perception of nurses working outside the prison, and the way in which they perceive officers view them, suggests a possible ensuing dominant discourse of subservience. This position leads me to consider the power relations and networks inherent in the prison officer–prison nurse relationship and the effect they have on practice.

The Nurse–Institution Relationship

Deskilling

One of the most striking discourses throughout the interviews with prison nurses centred on the feeling of becoming deskilled due to the nature of the environment and the legal and security implications of undertaking certain clinical skills: 'I find that working in the prison environment, can make you deskilled if you don't keep yourself up to date' (N2). In giving an example of how she felt deskilled, this nurse talked about clinical skills in particular.

Where I last worked, all we seemed to do was IV antibiotics. I don't think we do it here because we don't have the facility. It's like a standard. The equipment we have here is very old fashioned. You notice that. But yes, I think it's more to do with policy. It's a shame really because a lot of us could administer IV antibiotics. That's what I mean about deskilling, that's kind of lost. (N2)

I think there's a lot of skill here that we don't use and that will be lost... I mean, prison nursing is specialised to a certain extent, you know, in one sense. The trouble is, that the skills you would use outside, you wouldn't use in here. (N2)

A psychiatric nurse reported his awareness of the potential for the loss of therapeutic skills:

When I first came into the job I very quickly realised that unless I did something about it, if I relied purely on on-going experience in the Prison Service, I would fall behind quite considerably with my peers who worked in mainstream psychiatry. (N5)

Another nurse offered some insight into the types of therapeutic skills he felt he was unable to undertake effectively, due to the prison environment:

It's a bit difficult for us as nurses to utilise our skills as nurses properly...like one-to-one basis, able to get time to listen to them when they need it. There are certain times that you need to talk to the person, but the regime, because of the regime, it will limit you, you have to cut it short. (N3)

Interestingly, however, promotional literature designed to support the recruitment of nurses into these prisons reassures prospective nurses that they will be able to use their full range of skills within one environment. This is in stark contrast to the discourse of the participants in this study.

It appears that the nurses working in these male prisons viewed this issue negatively. From my own reflection on practice, I often felt that, although I was losing practical clinical skills, I was gaining others, such as better communication skills, better skills in mental health nursing (as I am a general

nurse), improved skills in managing difficult people, but in retrospect I also gained skills in managing my own emotions.

In order to address the issue of the deskilling of prison nurses in this study, I am drawn to engage in reflection not only on the role of the institution in unwittingly promoting this situation, but also on the way in which nurses take responsibility for ensuring they maintain their skills, or conversely, replace superfluous skills with new ones more applicable to meeting the needs of their patients. The issue of self-government is key here; with the need for prison nurses to understand the obligation they have to both themselves and their patients to maintain their skills.

Prison Routine & Health Care Priorities

The prison routine, which is rigidly imposed on nurses and limits access to prisoner patients, was highlighted as having a marked impact on care provision and possibilities, which, in turn, caused stress for the participants. One nurse cited the difficulties in undertaking neurological observations at night:

We'd had a head injury come in and you know with a head injury you have to do neuro obs fifteen minutely or something...Anyway, it was a case of 'no, we're on patrol state, you can't'...security is paramount they say and you couldn't do it. I found that difficult. Very difficult. (N4)

It's difficult really. You are trying to ensure that they get the health care they need, but sometimes it's difficult in the environment to provide it. It's like sometimes the person only needs a cup of tea and a chat, but finding the time when you can actually do that is very difficult. (N6)

A lack of staff, both health care and discipline, was also given by some respondents as an added barrier to care provision. Some participants attributed staff sickness to be predominantly caused by work-related stress while some was perceived to be initiated by rigid routines.

I mean, if you are up there [inpatient unit], you know, and you are the only nurse, well, the discipline staff, they want to do their things, they want to take them on association, er, exercise you know because that's a legal requirement and they want to sort out all their visits obviously, and it seems that anything you'd like to do from a clinical point of view other than give out their tablets or see the doctor is a task which is pushed down the list of priorities. (N5)

It's stressful. It's very tiring. We do have a lot of staff sickness. It's tiring being confronted with aggression all day. Having to deal with situations. Like for example, when you are working in a treatment room and it's busy. Depending on the wing and how busy it is – on the busiest wing you'd see about 60 to 80 prisoners in the course of an hour, hour and a half. It's like a conveyor belt system. It's really stressful. (N2)

The effect of the routine and regime of the prison is clearly a barrier to practice for these nurses. In viewing the situation from a Foucauldian perspective, the institution appears to repress and dominate the practice of nurses by controlling the time in which they have to work. This overt control exerted over nurses' practice can be considered as sovereign power, in which the institution dictates what is to happen and how it can happen by virtue of controlling access to patients. The sovereign power of the institution manifests itself by way of inflexible timings, strict policies and protocols and rigid routines, to which all prison staff must adhere to promote security and order. This demonstrates the way in which the dominant discourse of the

establishment is security not health care, and the way in which this discourse affects nursing practice.

I have considered the effect that the routine of the prison has on the practice of nurses in some depth. However, having read a book written by an ex-prison officer (Dawkins 2005), I was led to further consider the effect of routine on the prisoner. Dawkins' book discusses corruption in the Prison Service and, while that is not the focus of my work here, it does initiate some interesting thoughts about routine. He states, 'The easiest way for staff and inmates to get along inside is to respect people's routines. Many prison staff, both junior and senior, have caused some very serious but totally unnecessary incidents by messing about with someone's routine' (Dawkins 2005:87). This led me to deliberate on the opposing views held about routine from the prisoner patient perspective and the nurse's perspective. The routine constrains the nurse but provides security for the prisoner patient.

Managerial Support

Participants reported their disillusion with the way in which they perceived they were treated by those managing the establishments and health care. They suggested that over the last few years, possibly as a reaction to human rights legislation and litigious behaviour by prisoners towards the Prison Service, prisoners have been given more power over staff. The perceived changes in power relations and boundaries have proven to add to the dissonance and subsequent stress felt by some of the respondents.

So many times, and I've long stopped feeling any emotion about it, I could work a shift and I could see many people, certainly in psychiatry, you know, when they, you can see things which you know, become obvious to you when a patient is at play if you like, or at ease and not feeling like he's being watched and you can make an observation and you could document that observation and you think in

your own mind that the observation is perfectly right and you can put the patient in front of the doctor and you will say 'look, I saw this patient who is supposedly depressed but er...his presentation is not of that'. You know, you can give him your observations but then the patient will come in and say 'oh doctor, I feel dreadful, blah blah blah' and the doctor's not going to take any notice of what you say. It wears you down really. That hits the nail on the head. I mean, it does, it really wears you down. After years of experience of that you think to yourself, well hang on a minute, is it absolutely worth it? (N5)

This respondent suggests that the voice of the prisoner is placed in a higher position than his own, which leads to feelings of despondency. In considering this situation, which is not unique to this participant, I suggest that due to changes and developments in the legal position of prisoners, some key staff are now fearful of litigation and have therefore developed their approach to minimise the risk. This has the effect of shifting power relations between prisoner patients and prison staff. In addition, the power being exercised through the dominant discourses of policies and procedures impressed upon individual prisons and prison governors from Prison Service headquarters has also had an impact on the way in which senior managers operate within individual prisons. As Carlen (2002:31) states of policies for implementation from Prison Service headquarters, 'They have certainly added to the prisoner-management burden by further reducing the discretion of already heavily circumscribed prison governors, themselves governed by numerous auditing measures and under scrutiny from a variety of regulatory bodies both internal and external to the Prison Service.' I suggest that this demonstrates the web of power relations inherent within the Prison Service and their effects on the practice of governors, often directed by headquarters, and the effect on the practice of officers and nurses by governors and external professional bodies.

The majority of respondents offered no explicit insight into their coping strategies in their dealings with the institution. There was a sense of general acceptance from many participants that, although there were some barriers to practice in place as a result of the environment, there was little that could be done to change things. I am unsure as to whether this is due to general acceptance of the situation or a genuine feeling of disempowerment due to the participants' perception of the dominant power of the institution.

Prison Three

The dominant discourses seen in the interviews at this prison were markedly different to those of the male prisons. There was a more positive feel to the practice of these nurses; however, the operational and regime constraints were highlighted as problematic. One of the most striking differences in the discourse of nurses working with female prisoners to those working with male prisoners was the way in which prisoners are referred to. Male prisoners are referred to as 'the prisoners' and female prisoners referred to as 'the women' or 'the girls'.

I am aware that there are issues relating to gender inherent in the findings of this study. However, I have chosen not to discuss this in depth previously as I feel that it could change the focus and scope of my study. I know the issue of gender is important within this study, given that there are marked differences in the findings from the female and male prisons; nurses are traditionally female, emotions are often seen as strongly related to women, and prisons have been described as domestic places, traditionally the domain of women. There are also issues surrounding women working in male prisons, men working in female prisons, the working relationships that are built up between male and female prison staff working with male and female prisoners, and the influence of different cultures in male and female prisons on working and caring practices. Whilst I recognise and fully appreciate that there are questions to be considered and issues to discuss concerning gender in prison work, I feel that it is such a wide and complex

area that I would not be able to address in enough depth in this study and suggest it deserves separate consideration. I also feel that focussing on the gender issue in too much depth may distract the reader from the focus of this study. However, I have mentioned the issue of gender where I have felt it to be appropriate and in context, but have resisted the temptation to consider it further at this time.

The Nurse–Prisoner Patient Relationship

Focus on Care

The nurse–prisoner patient relationship in this prison is similar to that of the male prisons in that there are clear boundaries. However, the nurses working in this female prison paint a picture of care that is more care focussed than security focussed. They speak of manipulative behaviours affecting the relationship, but suggest that they are more likely to give the prisoner patient the benefit of the doubt or ignore the act, rather than primarily assume they are lying:

I suppose to a certain extent I am a little naïve with them. I'm like, you know, I feel a bit sorry for them, but like you say, officers would say to me 'oh, don't trust this one, she's only after x, y or z' sort of thing, but, I don't know, I tend to give them the benefit of the doubt. (N7)

I did find that they used to lie to me. They'd be like 'nurse, nurse, I've been asking all week for my medication, my GP prescribed it' and it's like 'the nurses haven't been listening to me' and I thought at first, how awful. These people should be struck off...but when you've been here a while, you think 'ah, what rubbish' and you say to them 'no' then they'll wait until the next nurse comes on and it's 'oh, the last nurse was awful, she didn't listen to me'. You know, it's just a pattern and you just have to let it wash over you really. (N9)

One nurse, N8, refused to be tape-recorded hence her views are represented from the notes I made following our interview. In terms of managing manipulation, N8 said that she tends to believe what her patients tell her. If she does not believe them, she lets them know by making a joke of it rather than confronting them.

These participants have demonstrated the ways in which they manage manipulation by giving the prisoner patient the benefit of the doubt, refusing to engage with the behaviour and by using humour to demonstrate understanding of the real situation. Overall, however, these coping strategies are employed within a caring philosophy. In considering why these nurses behave in this way, which is markedly different to my experiences of nurses working in male prisons, I suggest that the overall discourse within the prison itself concerns caring rather than security. One reason for this could be that there are women caring for women prisoners within the main prison, and the nurses I interviewed for this study were all female, again caring for a female population. This in turn leads to thoughts concerning the power relations amongst the prisoner patient population and the nurse group. Although clear boundaries are in place in this prison, necessary for the maintenance of security, it feels as though the concept of the inmate world and the staff world, as noted by Goffman (1968), is less distinct in this prison than in the male prisons. This could be the situation; alternatively, it could be due to the levels of respect afforded by the staff group and inmate group to each other.

Respect

A significant strategy used by the participants from this prison to manage manipulation appears to be rooted in developing respect through giving the prisoner patient the benefit of the doubt. A positive approach is adopted which, in turn, is felt to promote a respectful relationship built on trust rather than fear of sanctions. It is this respect which it is felt leads to a reduction in

the use of manipulation and illness for secondary gain. Respect was mentioned by all the participants at this prison as being central to a good working relationship. They reported that, on the whole, there was a great deal of respect on both sides of the relationship which enabled a more positive nurse–prisoner patient relationship. Indeed, one nurse reported that she felt some of the prisoner patients almost became her friends:

I suppose you get to know them but then I suppose to a certain extent...but they kind of get to be your friend. (N7)

N8 mentioned that she ‘felt sorry’ for the prisoner patients but felt positively that they had been given an opportunity by being in prison to sort out their lives and regain their health. Another respondent was affected by the self-neglect of some of her prisoner patients:

A lot of the problems are self-inflicted. And, you know, some of the girls as well, they’ve really neglected their health so badly. You know, basic things, basics. They might say to you ‘I need my BP checking’ and you check it and say it’s high and they say ‘yes, it’s been like that, the doctor said that last time I went’ and that was like two or three years ago. Smear tests, they’ve had smear tests but they’ve never had them followed up. You know, when they’ve had abnormal smears. It’s this lack, lack of looking after themselves, I find it quite sad. (N9)

These participants note the feelings they experience when caring for prisoner patients. Rather than feeling indifferent or hostile towards their patients, and having to engage in emotional labour in order to present a professional façade, these respondents report feelings of sympathy and sadness, which may result in engaging in emotional labour but with a different focus. It is possible that, in this environment, these nurses may have to engage in emotional labour, not with their prisoner patients, but with their discipline colleagues, in order to provide reassurance that the potential for security to

be compromised is not an issue, given that from a discipline point of view there may be concerns of manipulation. For example, Crawley (2004:107) talks of the need for prison officers to maintain a fine line of 'being friendly but not being friends' in order to maintain security.

There are interesting links here with the paper by Briant & Freshwater (1998) in that they propose mutuality as an important facet of the nurse–patient relationship. I suggest that the nurses in this study, working in this prison, appear to have embraced the concept of mutuality, which manifests itself in their practice in the form of respect.

The Scope and Aim of Health Care

All participants from this prison reported that they experienced a great deal of gratitude from their prisoner patients, which was what made their job worthwhile. They also acknowledged that caring for the prisoner patient was much broader than just providing health care. The emotional care and practical day-to-day assistance with non health care related problems was also important to them:

I mean, they've all got so many problems and it's like you sort out something that seems really simple, I don't know, organise for them to have a flask of hot water during the day and they're so grateful. You know, there are silly rules, well I think they are silly, that you know, hatches have to be up at all times, and my argument is well, if they're asthmatic, you know, the windows don't open, they have a vent in to let the air through, it's silly, we have to write a letter, a memo to say this person has asthma, you know, things like that. They're really grateful, trivial things, it's the little things that we take for granted...it's about their day-to-day lives. (N7)

It is clear that this nurse views the health care needs of the prisoner patients as important and links other aspects of their lives in prison, e.g. being incarcerated without ready access to hot drinks, to their well-being. In suggesting that she 'has to write a letter, a memo' in order to allow what she sees as 'silly rules' to be reconsidered in individual cases, this nurse is using her authority in order to advocate for the prisoner patient. It is interesting to note this nurse's attitude towards the sovereign power of the institution, in that she confronts it head on, questioning the importance of its rules and regulations.

N8 described the clinic that she ran on a daily basis as providing a bit of sanctuary for the women. She said that she and her colleagues try and make it like a clinic outside, so the women can forget they are in prison for a few hours. This is in stark contrast to the work of Stoller (2003) who suggests that clinics within the prison setting can be seen as 'nested' places that are characterised by the way in which access to them requires movement through the prison and therefore its culture. She suggests that the culture of the prison inevitably affects the culture and atmosphere of the clinic. I suggest that, in this instance, although the nurse running the clinic is well aware of its position and the nature of its patients, she is clear in her aim of trying to make it somehow different to the rest of the prison. In order to do this, this participant suggested to me that she was flexible in her approach to her prisoner patients, allowing them hot drinks and conviviality. It is as though this nurse appreciates her role within the structure of the organisation and, indeed, provides a quality health care service for the prisoner patients she works with. However, this is only possible due to the fact that she has a degree of power over how the clinic is run.

Communication

The participants in this prison also noted the importance of listening and good, honest communication with their prisoner patients in order to maintain

a positive relationship. In order to promote this, these nurses understood the importance of speaking the same language as their prisoner patients:

I listen to them. I get down to their level erm...like, I'm not offended when they swear because that is how a lot of people talk but some of the nurses here do find it offensive...I don't care if they're swearing, it doesn't offend me, that's how they speak. I don't swear back at them or anything but I speak their language and I think that because I do listen, you know, the girls appreciate that because a lot of times they say 'oh I've had a problem for a couple of days but I knew you were back on so I waited'. (N9)

Although the respondents in this study provide a predominantly optimistic view of prison health care in their prison, they were quick to provide me with examples from their practice where they encountered difficulty. Interestingly though, the difficulties were not viewed as a consequence of prison patient behaviour, but in relation to other staff and the institution and are discussed in the following sections on institution and colleagues.

Effect of Offence on Care

Through discussing the impact of the offence on care, all participants from this prison reported that they tried not to think about the offence. They blocked it out for fear that it would affect the care provided. However, high profile prisoner patients are often placed in this prison so it is impossible not to know the offence in some cases. One nurse reported that even when she had known about the offence, which was particularly gruesome, she surprised herself by being able to maintain a friendly, professional approach:

When I first came here, every woman I saw I wanted to know what they had done or what their offence was but, looking back, it was just curiosity more than anything. I mean we've got a really high profile

woman in at the minute and, I must admit, I hadn't seen it on the news...but I made the mistake and I read the statement before I went in to see her and it was really graphic, horrendous, awful and for a split second I wished I hadn't read it. But I was really surprised with myself because I went in there and I sat down and I have a twenty minute chat with her – not about the offence or anything but about how she was, if there was anything I could do for her and I came out and thought she's just an ordinary woman. I'd actually blocked out the nature of the offence and just sat and chatted to her. (N7)

N9 also discussed her feelings about caring for women who have committed offences:

We've had a couple of high profile women in recently which have been in the newspapers so you can't help knowing. I would never be rude to their face but you do think 'Oh no, I've got to look after you' which can be quite hard but then you've got to be professional haven't you. You know, you're working in a hospital, you don't know, they could be child murderers, you know, anyone you are looking after. It's just because you are in a prison and you often know what they've done. I don't like to know. I don't really want to know because I don't want it to change the way I treat them. At the end of the day, I'm a professional and a nurse and I'm there to care for them and well, that shouldn't make a difference. If they've stabbed ten people to death that shouldn't make a difference to how I care for them. (N9)

Although these participants acknowledged the difficulty of nursing prisoner patients whose offences they were aware of, they suggest a coping strategy in which they rely on their professionalism and professional attitude towards patients in general. I suggest that emotional intelligence plays a huge part in the way in which these nurses manage this emotional labour. By being aware of their emotions, and aware of the potential for their emotions to

affect their attitude, they are able to implement coping strategies and continue to provide non-judgmental care. One respondent reported the way in which she reflects on her practice outside of prison, in terms of who she is caring for, and suggests that she views prisoner patients as no different to patients outside of prison, as a way of reinforcing and articulating the way she provides non-judgmental care.

Building Relationships

There was a strong emphasis in this prison, as in the male prisons, on the importance of the use of humour and 'banter' in building relationships with prisoner patients. It is the absence of this humour and banter in the relationship that demarcates the way in which nurses in this prison deal with the more disagreeable prisoner patient.

N8 discussed this issue at length with me and highlighted the way in which she deals with those prisoners with whom she has difficulty, either because of the nature of their offence or indeed their personality. She mentioned that she is more cautious around them and tries to get them moved out of the clinic as soon as possible. She also remarked that she does not feel as warm towards them and tries not to engage them in conversation or banter as she would the other prisoner patients. N9 echoed some of these strategies:

I wouldn't say I give a lesser standard of care but I think sometimes we have more banter with the other women than I would those ones...It's really about being a bit more professional, you know, I'm a nurse, let's get on with what we've got to do. (N9)

By not giving permission to prisoner patients to engage in humour and banter when performing in a professional manner, the participants demonstrate the way in which the relationship they have with more amenable prisoner

patients is different from the relationship they have with the more difficult ones.

In addition, one of the respondents remarked on the importance she places on informality in order to build relationships. She was keen to impress that she still maintained clear boundaries, but felt that a more informal approach helped to distinguish her from prison officers. The use of first names and showing interest in all aspects of her patients' lives were important to her in maintaining a good nurse–patient relationship:

I don't like to be called Nurse [surname]. I tell them to call me [first name] because I'm not an officer and I want to distinguish myself in that I am a nurse. (N9)

To me, this is important as it demonstrates the perception this nurse has of the differences between the roles of the prison officer and the nurse. She sees that by using pastoral power as opposed to the disciplinary power of the prison officer, she is more able to develop and maintain a nurse–patient relationship.

Effect of Self-harm

Although the nurse–prisoner patient relationship in this prison appears positive for these participants, one nurse commented on the nature of the prisoner patients' illness as affecting her reaction to them. Indeed, two of these nurses reported the use of their intuition to decide the severity and genuineness of illness. In turn, this determines the approach they take to the prisoner patient's care. For instance, frequent self-harmers who self-harm through tying ligatures around their necks or by cutting their arms cause one participant a great deal of frustration, which she manages through reverting to her very professional persona.

We've got one who does it regular as clockwork, ligatures every couple of days...I get called to her, she's craving it. You can see her pupils are dilated, she's agitated and once she's ligatured, she calms right down. It's almost like a drug to her. I feel like, she's on constant watch, but I can tell, I think 'you're going to ligature tonight' and nine times out of ten she does. You can just see that she's going to do it. (N9)

I asked this nurse how she feels about this prisoner patient.

Frustrated. When I've gone through a long day and I'm about to go off duty and she does it, I have to be honest, very frustrated...She's full of negativity – 'what about me, what about me, I'm the victim' (N9)

I then proceeded to ask N9 how she cares for this prisoner patient when it is clear that she causes her great frustration.

I go in, do what I've got to do and come away...it works best if you do what you've got to do medically, you know, are you OK, alright then sit on your bed, have a cup of tea, a cigarette and chill. I know we're not supposed to as nurses but well...you know what I mean? Sometimes I just think 'Oh no, not again'. It's just that once, when she went out of prison, she didn't do it once, and that's frustrating. You know, it's OK, I don't want to go home on time, I've been here for fourteen hours but that's OK! (N9)

I suggest that the power issues displayed here revolve around the prisoner patient attempting to control the staff by way of self-harming. The nurse in this instance appears to be frustrated and becomes sarcastic in her reaction, which to me could indicate a subconscious appreciation of the power that has been exercised by the prisoner patient over the situation, and sarcasm is used as a way to cope with her feelings. The prisoner patient in this instance

is dominating the nurse's time and preventing her from leaving on time, so I suggest that the frustration she feels, coupled with the emotional labour she must engage in to present the professional exterior, causes stress for this nurse.

From the interviews undertaken at this prison, it was clear that all three nurses valued the nurse–prisoner patient relationship and viewed it as central to providing good quality care. All three reported the use of intuition in determining honesty from prisoner patients, and were also keen to highlight the need to maintain professional distance and suspicion. However, they appear to have reached a comfortable balance in order to care for this group.

The Nurse–Colleague Relationship

The nurse–officer relationships in this prison appeared to be very positive in comparison with those in the male prisons. I suggest that this is most probably due to the underlying culture of the female prison, which I feel appears to value a caring philosophy on a level with custodial philosophy. Although this would appear contradictory, given that it is assumed discipline officers have a strong custodial focus, the narratives of the participants indicated that the officers in this prison either adopted that caring philosophy whilst maintaining a discipline role, or, alternatively, they were more aware of the role of the nurse and worked with them in supporting them to meet that function.

Officers' Perceptions

One nurse reported that the officers' perception of nurses who had recently begun working at this prison was that they were 'super-nurses' and knew what they were talking about because they had come from outside. This is similar to the male prisons in so much as the nurse's credibility is central to a positive view from officers:

When my colleague and I first came here we were labelled as 'super-nurses' and still are, and we're like, we're actually normal nurses. Certainly no different, I mean outside we'd not be seen as special or anything like that but because the nurses here in the past, they've had a bad reputation. I mean that is definitely improving now. I hear that from officers saying that the nurses are so much better now. (N7)

Some of the nurses have been here quite a long time and they're not respected by the officers. I don't know if it's the same in other prisons. I think a lot of them should have moved on years ago. Coming in as a fresh nurse, I think you get a lot more respect from them and they think 'you're a real nurse, you've come in from the NHS, I'll take what you say'. (N9)

Again, however, these nurses related examples of good practice to me, which involved affirmation from outside hospitals of their clinical judgment, thus increasing their credibility with colleagues. However, N8, who had been working in the prison for many years, discussed her perception of prison officers as being too hard and too judgmental, which led her to try and ensure her interactions with prisoner patients and the environment in which she worked was as calm and relaxed as possible. In no way did this nurse, or indeed any of the others from this prison, align themselves with the custodial philosophy.

Teamwork

It was clear from one of the interviews that one of the nurses fully understood the importance of good working relationships with prison officer colleagues in terms of making her own working life less stressful. She remarked on how nurses working in residential areas of the prison are included in daily unit meetings, which she felt provided a sense of teamwork:

It's a good relationship with the officers. We do get on very well because we are the regular nurses on the landing. It's nice because they've started to include us in their unit meetings. I always try and hand things over to officers, you know, I'll say look I've got to go out of the prison, I've got to go to a meeting but my colleague whoever will be covering for me but I'll be back in an hour if there's anything that can wait. I always tell them what I'm doing, oh I'm going for lunch now, so I think that really helps because they know where I am if they need a nurse. We try and work as part of a team. There's a lot of respect.
(N9)

I suggest that this nurse is operating on a level which is underpinned by high levels of emotional intelligence, given that she has identified the importance of social awareness (see Emmerling & Goleman 2003) in so much as she is aware of the emotions and needs of her discipline colleagues – she sees the importance of handing things over to them and letting them know where she will be. When I consider the nature of the prison officer's world as seen in the male prisons, where prisoners are transferred to health care for non-health care reasons, I suggest that this nurse is providing the officers she works with, with a sense of security that she is around. The nurse in turn is helping to prevent inappropriate referrals by fostering a sense of teamwork with her officer colleagues, providing them with support and instilling confidence.

In February 2006, the BBC screened a documentary filmed at HMP Styal, a female prison in the North of England called 'Women On The Edge: Inside Styal Women's Prison'. The primary issues covered in this film were predominantly concerned with self-harm, suicide and mental illness. Viewing the documentary from the perspective of a doctoral student examining the emotional labour of prison nurses, it became clear that the emotional labour of the officers at this prison was also very demanding. However, not only was their emotional labour clear to see, but so was the high standard and

efficiency of the teamwork between officers and nurses. In a report following this documentary in which 'a deeply traumatic scene unfolds as officers dash from cell to cell, saving inmates from suicide attempts', Coughlan (2006a:1) describes her thoughts and feelings during the making of the documentary: 'The warders and nurse went from cell to cell – literally running at times – cutting ligatures, taking plastic bags from heads, patching up cuts and dealing with a suspected overdose...What struck me was the casualness with which all of this was dealt with...It's not that no-one cared, more that it was obviously so normal. Several staff told how after a bad night they tried to block out their thoughts of work' (Coughlan 2006a:1). 'Nearly every officer I spoke to told me that they save lives on a regular basis but many seemed wary of speaking on camera. Some who had been involved in the six recent deaths at Styal were still dealing with the emotions that surrounded these events' (Coughlan 2006b:1).

One officer featured in this documentary, Senior Officer Linda Horsfield, highlighted for me the importance of effective teamwork between health care and discipline staff in the way in which she worked alongside nurses at some of the most traumatic incidents they attended. She later won the Prison Officer of the Year 2006 award (Prison Service News 2006).

I assert that what is evident in this instance, again in a female establishment, is the way in which self-harm events have in some way been normalised by the staff, which I suggest is their way of managing both the situation and their own emotions. However, I suggest that this is the way in which staff managed these events whilst with the prisoner patient. Coughlan (2006b) suggests that many of the staff were still dealing with the emotions surrounding suicides and, I suggest, probably some self-harm incidents, which highlights the way in which the culture of the prison does not lend itself to reflection on practice and subsequent management of feeling. This is evident in the way in which she reports that some staff tried to block out their thoughts, and hence emotions. Whilst watching this documentary, I did

notice how some of the staff spent time in between incidents, talking briefly together away from prisoners, and indeed spent some time in tears. I relate this to the work of Crawley (2004) in which she describes the presence of emotional zones within prisons, where it is acceptable for staff to display their feelings.

The Nurse–Institution Relationship

Routine

It is the relationship that the nurse has with the institution in this prison which appeared to cause the most stress for these nurses and provided the most negative discourse. Again, the focus of the prison as a place for security rather than health care caused frustration as the regime and routines impacted on provision of care by dictating the time available to undertake clinical work:

The main difficulty I have found was that the health care came second, is secondary to the security side of the prison. You know, we have to fit in around the certain regimes, but you know, security is the first priority. That's what I found hard. I'd like to go and see a woman at a certain time but you know, they're locked up, it's very difficult. I have to fit in around the core day. (N7)

Interestingly though, N9 demonstrated how she uses her relationship with her officer colleagues in order to manage some of the difficulty of needing to work to a rigid regime:

I've got quite a good working relationship with the officers and you know, like today, at lunchtime, everyone was locked in but one of the girls hadn't had her methadone because her chart went walkabout. I just said to the officer, I know everyone's locked in and that but it's

really difficult as it's not her fault that she hasn't had it so can we please just quickly get her out, we'll give it to her and put her back in, and that's not a problem...Some officers will say no, definitely not, everyone's locked in, no one's coming out, but if you explain it's for a medical reason, we need to do this, it will only take a minute, they're OK about it. (N9)

Two of the nurses expressed incredulity at some of the rules by which the prison operated and hence their effect on prisoner patient well-being. N8 suggested that she felt everything was such a big deal for the prison as there is so much red tape and paperwork which causes her a great deal of frustration.

The relationship the prison nurses in this prison have with the institution highlights the power networks in operation in terms of the sovereign power of the institution appearing to clash with the government of the nurses' own practice. The repression of the institutional regimes and regulations serves to restrict the nurses' practice which, in turn, causes conflict with their decreasing power to self-govern. One of the factors leading to one of the biggest issues facing these nurses is the effect of the system on their ability to engage certain clinical skills. As in the male prisons, participants from this prison also felt deskilled due to the way in which they were constrained by the prison system. However, in contrast to the male prisons, they did report that there were training opportunities available and acknowledged that they had begun to develop skills in other, prison-related areas:

I do get frustrated sometimes. Mind you, last week, we had two women with chest pains. Well, I've never been so excited in my life to get those calls. Instead of just a ligature or fit, because I've only ever been to about two proper fits, the rest have been prison fits, you know, made up. But, I do feel a little bit deskilled at times...I've done all my cardiac courses but I looked at an ECG last week and I was like

'wow', I don't know what this is and it really worries me. I felt totally deskilled so I've asked to do that update. (N9)

The way in which nurses in this setting have identified new skills in addition to admitting the loss of others, strikes me as important to consider. I suggest that these nurses are demonstrating some awareness of the way in which the loss of skills has affected them. However, they counteract this feeling of loss by concentrating on the skills they have developed as a result of their current positions. Altogether, I suggest that this demonstrates emotional intelligence as they aim to replace negative feelings with positive.

Summary of Dominant Discourses

As I have shown, the analysis of my data has led me to present it to the reader under discreet headings concerning the dominant discourses prevalent in the context of the relationships within which the prison nurses engage in the course of their practice in prison. My choice of presentation is in itself indicative of the dominant discourses surrounding academia. However, my presentation of the data in this form demonstrates to some extent the way in which I think. Having undertaken some training in neurolinguistic programming (NLP) whilst conducting this study, I gained insight into my own way of processing information. As you may have gathered, I tend to consider information in a very digitised, structured way. This way of thinking leads to provision of structured headings and tables through which my data are organised. I am not suggesting that this way is the 'right' way or even the 'best' way to organise this data. However, given the way in which I think, it is the best way for me to clarify my work in my own mind, which I suggest is more likely to lead to a presentation that is clear and transparent for the reader.

The Intra-Nurse Relationship

I feel it is appropriate at this point to provide the reader with an overview of my thinking about the two sides that constitute 'the nurse'. I consider the nurse as self to be that side of the nurse through which emotions and personal feelings are evident. The nurse as professional is that side in which nurses view the idealised portrayal of their role, governed to a large extent by the Professional Code of Conduct and their perceptions of what is expected by the employer and patient. I believe that these two sides to the nurse are in constant conflict and the dissonance that nurses experiences as a result of this conflict is at the heart of their emotional labour. The way in which this labour is managed depends on the levels of self-awareness that nurses possess and the processes they engage in to manage the dissonance. This resonates with me in terms of the care custody debate in which the prison nurse must be both carer and custodian. Dissonance is a dominant issue for the prison nurse, both in practice and internally.

There are some links here with the work of Rafferty (1996) in which she discusses the politics and nature of nurse education, nurse training and the history of nurse regulation. In particular, the debate and reformation of nurse registration, which occurred in Britain in the late 19th and early 20th century, is of central importance in illustrating the concept of the intra-nurse relationship. Rafferty (1996) details the debate that occurred between nurse reformers such as Mrs Bedford-Fenwick and more traditional nurse educationalists such as Florence Nightingale. During this debate, the reformers felt that nurses should be regulated from a central regulating body, to elevate the professional status of nursing and bring it in line with the medical profession and away from its poor image of the past.

The debate concerning nurse registration links closely with my concept of the intra-nurse relationship as the two sides in the registration debate mirror the two sides of the nurse, i.e. a professional side and an emotional, 'feeling' side. Mrs Bedford-Fenwick and her reformers were promoting nursing as a

profession, with professional standards and uniformity in training and education. Conversely, Florence Nightingale and other key figures such as Henry Burdett argued that registration was unnecessary because all schools of nursing kept a register of all the nurses it trained and provided them with a certificate after three years. The reputation of the school of nursing should, it was felt, be proof enough for the public that the nurse was well qualified and able. In terms of nurse training, however, Florence Nightingale argued that it was impossible to assess the quality of a nurse as it 'lay in her character' (Rafferty 1996:45).

Rafferty (1996) describes the tensions that occurred as a result of the two approaches to nurse training, and hence nurse registration, as coming from two different perceptions of nursing: the 'girl's domestic academy' model and the 'professional' model. The domestic academy model had as its focus 'disciplining the passions and exercising self-control over "brute" emotions' (Rafferty 1996:55) where the nurse's character was of paramount importance. The professional model focussed on intellectual competency-based education. When comparing this with the intra-nurse conception I propose in this thesis, the emotional side of the nurse is in keeping with the Nightingale perception of nursing, whereas the professional side to the nurse is more in keeping with the Bedford-Fenwick idea of nursing. Interestingly, as will be shown, it is the professional, regulated side of the nurse that provides a way for prison nurses to keep their emotional side under control.

What follows are the findings from phase one of the study which pertain to the intra-nurse relationship in which nurses are constantly in dialogue with themselves, experiencing contradiction and developing coping strategies in order to maintain psychological well-being.

One nurse in prison three discussed the qualities she felt were important for nurses working with prisoner patients to have:

I think you need to be strong, other than being professional, you need to be strong and be able to detach yourself from situations. I think it helps to be a little bit older too. (N7)

This nurse has demonstrated that, although she understands there is a professional side to her work, there is also an emotional side by the very fact that she recognises the need for detachment. The detachment that this nurse refers to has resonance with Isobel Menzies Lyth's seminal work, 'Managing Anxiety in Institutions' (Menzies Lyth 1988), in which she discusses the ways in which nurses utilise strategies such as detachment and denial of feelings in order to defend themselves against anxiety, thus enabling them to practice as a professional. Another way in which nurses in this study demonstrated the importance of detachment was how they spoke about the line between home and work in very clear terms:

You are here to do a job, not for twenty-four hours but for nine hours. So do what is right and then when you are finished, that is it. (N3)

I also like the fact that you can hand your keys in at the end of the day and go home and you don't necessarily have to think about things. For me, the handing in of the keys is the cut off point. Whereas when I worked on a ward, I was like 'how's that little old lady in bed two, is she OK tonight?' so I find that my cut-off point, actually doing that, makes me feel like, no, I'm at home now...I think to myself when I went home, they were all alive and happy – tomorrow's another day. (N9)

I suggest that the way in which these two nurses have a clear delineation between work and home demonstrates a subconscious but emotionally intelligent way of coping with the stress of prison work.

It must be remembered that it is not only the handing in of keys at the end of a shift that delineates work from home. The collection of keys at the start of a shift is also a powerful act. Obtaining a set of keys allows the nurse access to a new world, i.e. the prison, and indeed provides them with the ability to control the movement of prisoner patients. As keys cannot be taken outside a prison under any circumstances, being in possession of a set of keys is a strong signal that one is not only present in a very different world to that outside, but also that one has power over others in terms of gaining access to all parts of that world.

When I was working in practice, travelling in and out of prison on a daily basis, I was often struck by the different atmosphere I experienced the minute the electronic gate slid open and I was suddenly on the other side of the wall, be it going in or coming out. I found the stark difference in atmosphere to be the key to my division of thought from work to home. The atmosphere in a prison can be noisy and sometimes highly charged emotionally. The sounds and smells of prison are different to outside and it is this change in environment that I found eased the transition and made it more obvious. However, throughout my training in a London teaching hospital, which aligned itself with a very vocational approach to nursing, I was led to believe that nursing was a way of being rather than just a job and therefore I found it very difficult to switch off. It was one of my prison officer colleagues who suggested I ask myself two questions before I left for home every day in order to satisfy myself that I had fulfilled my role and was permitted to forget about work: 1) Has anyone escaped? 2) Has anyone died? I suggest that this was said to me in the context of humour; however, I feel that at the root of this humour was the coping strategy endorsed by prison culture.

In terms of the intra-nurse relationship, the inner conflict between personal and professional, I see the way in which N9 refers to 'when I went home, they were all alive and happy' as being a way in which she reverts to her

professional side in order to justify leaving safely and relinquishing her responsibility. The relinquishing of responsibility is an issue that I have illustrated in discussion concerning discipline officers.

The intra-nurse relationship has been demonstrated perfectly in the discussion of participants concerning the way in which they manage and cope with prisoner patients who have committed offences the nurses find difficult to deal with. The findings from the interviews suggest that the nurses exhibit a way of interacting that is devoid of emotion in order to care for these prisoner patients:

The way I deal with them, if I don't particularly like them I just deal with them on a very basic level, you know, 'what's your problem...take that....go away. (N5)

In considering this coping mechanism, I suggest that nurses are relying heavily on their professional, regulated side in order to suppress their emotional side, which in itself is interesting given that the regulated, professional side of a nurse is intended to enable the nurse to provide high quality nursing care. This leads me to question how nursing care in a prison actually appears and is felt by the prisoner patient. In addition, I suggest that traditional nursing requires some emotional input from the nurse in order to demonstrate the qualities associated with nursing, e.g. sympathy, empathy, and care. However, for the nurse working in prison, exhibition of these qualities may make them more vulnerable to manipulation and being taken advantage of. Not only is the possible consequence of exhibiting emotion psychologically difficult for the nurse, but there is also a risk to security. Therefore, overt emotional action is seen as a weakness in this culture and nurses often suppress the very emotions that are deemed to make them 'nurses' in order to practice safely and securely in this environment. In a recent Royal College of Nursing definition of nursing, Waters (2003:22) suggests that, 'Nursing is an intellectual, physical, emotional and moral

process, which includes the identification of nursing needs; therapeutic interventions and personal care; information, education, advice and advocacy; and physical, emotional and spiritual support.'

In a BBC Three documentary concerning life at HMP Birmingham, 'The House of Correction', shown in August 2006, one nurse articulated his perception of the role of the nurse in prison, demonstrating perfectly the situation into which prison nurses are placed. This, in turn, through the relationships in which they engage, places heavy emotional demands upon them: 'You have to be all things to all inmates; carer to custodian, all in the space of a few seconds' (BBC Three 2006).

Documentary Data

Much of the documentary data I have gathered throughout the data collection period of this study have been referred to previously, although some have not, such as the scrapbooking I undertook regarding the interviews I carried out. Although such data have not been explicitly referred to within these pages, they have provided me with an overview and assisted me in contextualising data prior to discussion. However, there is some evidence I have obtained which I feel is important to highlight in terms of the way in which other dominant discourses prevalent within the Prison Service and Department of Health have addressed the emotional aspects of nursing in prison. The revised pay structure known as Agenda For Change was embraced by the Prison Service during this period, and a new way of training prison officers to work in health care settings was also adopted. Data were collected concerning these two initiatives through attendance at meetings, informal discussion and department of health circulars.

Health Care Officer Training

In 2005, a foundation degree was developed for the Prison Service to provide an academic training opportunity for prison officers wanting to work

as health care officers. The previous qualification to enable officers to become health care officers was in the form of an National Vocational Qualification (NVQ). However, in 2005, this was revised and a new qualification was piloted in one region. Whereas the NVQ in custodial health care addressed both security and health care competencies, the foundation degree focuses solely on health care. What is interesting about this qualification in terms of this study is the inclusion of emotional aspects of prison health care work, in addition to it addressing some of the issues raised by nurses in this study and viewed by them as difficult. For example, the new foundation degree in Offender Care encourages participants to reflect on their practice, their own professional development and examines ways in which prison health care staff can work with prisoner patients who challenge services. Anti-discriminatory practice is addressed with a key learning outcome examining the qualities and skills required to work in a people-valuing and anti-discriminatory manner. Another key issue addressed in this course of study is teamwork, including how to manage role conflict and implement solutions to ethical dilemmas. In providing an opportunity to reflect on teamworking, the course also enables participants to examine role boundaries, role overlap and power issues. Although this foundation degree is aimed at prison officers wanting to work in health care rather than nurses, I feel a sense of relief that some of the key issues facing nurses working alongside officers are being addressed through validated study.

Agenda for Change

Agenda for Change is a new pay system whereby staff are paid on the basis of the jobs they are doing and the skills and knowledge they apply to those jobs. In order to facilitate accurate pay awards, prison nurses were subject to job reviews in order to match their roles to a nationally agreed pay band. Therefore, job descriptions played a central role in ensuring staff were graded at the right level. Initially, Agenda for Change was implemented in the NHS and it took some time before HM Prison Service adopted it as the pay

structure for its nurses. In May 2006, a letter was sent to all health care managers and heads of health care in order to ensure that all prison nurses would have their job descriptions reviewed to enable 'job matching' against agreed pay bands.

From the perspective of this study, it is interesting that, for the first time, the emotional effort employed by the prison nurse was deemed important enough to be considered for inclusion in the job description and thus recognised in their pay banding. Previously, nurses working in prison were awarded an environmental allowance in addition to their grading which was in line with NHS pay grades. For many nurses, myself included, this environmental allowance was seen as 'danger money' rather than recompense for the stressful nature of the role.

In July 2006, I received a copy of the guidance notes for the review of job descriptions and person specifications from the Department of Health, which had been disseminated to all appropriate prison health care staff. In terms of the emotional effort of a nurse's role, managers reviewing job descriptions were asked to consider the extent to which nurses are expected to give unwelcome news to staff, carers, patients and relatives, care for terminally ill patients or patients with long-term degenerative diseases, or deal with difficult family circumstances or situations. As these guidelines are not prison health specific, they do not address some of the emotion work that prison nurses engage in. At the time of writing I had hoped to have seen some of the job evaluations undertaken with reference to the emotional labour of prison nurses, but this has not been possible.

Clinical Supervision

Given that I view the relationships the prison nurses engage in as being central to the discussion concerning their emotional labour, I argue that the role of the nurses' relationship with themselves as individuals is also crucial.

The interview data analysed in the previous section focussed on the three relationships I identified as important, and provided further discussion concerning the intra-nurse relationship. Although the clinical supervision sessions the nurses in this study engaged in during phase two also highlight examples of these three relationships, I feel that the focus of the analysis of these sessions should centre on the nurses themselves – the intra-nurse relationship. While clinical supervision addresses nursing practice directly, I feel that it also focuses on the inner nurse in helping them to reflect on themselves. As such, this analysis examines the intra-nurse relationship in more detail. In order to achieve this without providing any information that might identify the nurses concerned, I have chosen to discuss the dominant issues that arose from our clinical supervision sessions without giving examples or attributing information to any one or other of the nurses in particular.

The clinical supervision sessions were not tape-recorded. It was felt by both supervisees that this would be inappropriate and would in fact make them feel uncomfortable. In order to collect data from our sessions, I made notes during the sessions of the issues we discussed, and then, immediately afterwards, recounted my perception of the session in a reflective narrative.

The dominant issues arising from the clinical supervision sessions can be seen in terms of the three relationships that were identified previously, i.e. the nurse–prisoner patient relationship, the nurse–colleague relationship and the nurse–institution relationship. However, what is important here, and what is of interest given the depth with which the supervision sessions examined the nurses' own relationships with themselves in terms of these other relationships, is the way in which the nurses identified, coped and managed these relationships. I suggest this is indicative of their emotional intelligence and development of it throughout the course of the supervision sessions.

I have examined the reflective writings I completed after each clinical supervision session with a view to revealing the dominant discourses brought to the sessions by the supervisees. The following issues became apparent in the supervision of both supervisees: the position of the supervisee in the prison hierarchy, nursing practice, peer conflict, professional safety, confidence, empowerment, accountability and socialisation. In considering each discourse, it is clear that there are definite links with some of the philosophical discourses with which I have been engaged and it is from this perspective that I write, rather than reporting the individual sessions.

Positioning & Conflict

Through reflecting on the narratives written following each supervision session, I consider that one of the dominant discourses notable throughout both participants' sessions concerns the issue of the supervisees' position within the hierarchy of their establishment and the effect this had on both their practice and themselves as practitioners and people. The degree to which the issues they brought to supervision were understood by the supervisees as being relevant to their position and brought about as a consequence of the power networks operating within the organisation was variable. I suggest that, although their understanding of the underpinning reasons for their issues was not deep, their emotional intelligence enabled them to reflect and consider their positions, which ultimately led them to some resolution. Through supervision, a better understanding and appreciation of what was happening to these nurses, in terms of their official rank in the hierarchy and their unofficial place in the prison world, enabled both supervisees to view the issues with more insight into what exactly was happening, which led to conclusions and actions about ways to resolve problems.

The work of Foucault concerning power is demonstrated here in terms of the way in which power within a prison setting is exercised through its dominant

discourses and the subsequent discourse of its members. It was clear through engaging in supervision with these nurses that they were entrenched in the power relations inherent in the culture of their establishments but accepted that what was happening in their worlds was inevitable and that their ability to change practice was non-existent due to the position they were working in within the hierarchy. I suggest that this is as a result of becoming socialised into the setting, in which dominant power discourses prevail through the actions of officers, the routines, the regulations and their instinctive, intuitive need to self-govern. This last point is what I suggest causes the heaviest emotion work for these nurses in that this need is restricted through the dominant discourses of the prison culture.

Both supervisees brought issues to supervision that were causing them anxiety. In common with many approaches to managing anxiety, one of the supervisees considered that changing the practices and culture of the prison health care setting within which she worked would be the best way to alleviate her problems. Through discussing the power that this nurse felt she had, and the power invested in her by others, it became clear that changing the system was very difficult. Despite initial despondence to this realisation, we confronted the problem and examined it from a different perspective, one that this nurse had not considered previously. The perspective usually adopted was to change or fix the problem causing the emotional dissonance. However, thinking differently and considering the way in which this nurse could look more closely at her own reaction to the problem stimulated a more fruitful solution to her issues. Indeed, with both supervisees, the issue of concentrating firstly on the internal self and one's own reactions to situations rather than looking externally for solutions became an important part of our discourse throughout the six months. This resonates with me in terms of the issue of empowerment and self-government. I suggest that the ability to self-govern is determined by both internal confidence and energy, and is also facilitated externally by the culture in which one practices.

Much of the discussions throughout the clinical supervision sessions centred on difficulties with other health care colleagues and their practice. Having to work alongside colleagues whose practice was below the standard expected by these nurses caused them anxiety. Interestingly for me as a researcher, I experienced these issues from both a managerial and peer perspective, which encouraged me to supervise both nurses, who were experiencing similar problems, from two angles, drawing on my clinical and managerial experience. Both aspects called for reflection on the position in which these nurses found themselves within the hierarchy of the prisons. For both supervisees, the underpinning issues that we ultimately addressed meant reflecting on the way in which they viewed themselves in their roles, whilst also reflecting on how others viewed them. The two distinctly separate levels at which these nurses were operating meant that we engaged in discourse aimed at developing strategies concerning how to address the issues from a practical perspective. We also looked at how to develop individual approaches with which both were comfortable, because challenging colleagues in this environment was seen as confrontational and thus potentially detrimental to working relationships.

Given some of the issues brought to supervision concerned the nurses' relationships with their peers and colleagues, I introduced them both to the Karpman Drama Triangle. Fulkerson (2003) cites Dr Stephen Karpman's 1963 work in developing an analogy to explain the dysfunctional patterns in families, which he called a Drama Triangle. This triangle can help members of a family identify dysfunctional patterns of behaviour through examining their role within the family. Karpman identified three roles in this triangle: the persecutor, the victim and the rescuer. Fulkerson (2003:12) reports that, 'Persecutors demean others and invite others to assume the position of victims. In the guise of helping, rescuers work to keep others in dependent positions. They depend on "saving" others to feel good about themselves. Victims assume a passive, helpless stance.' Although this model is situated in transactional analysis and psychoanalysis, and is aimed at supporting

developmental work with families, I decided through my own supervision that it was an excellent way for these nurses to examine the roles they assumed within the prison multidisciplinary team. Although this team is not a family, I suggest that the nature of the environment is such that members of it are working closely together and are, to some extent, dependent on each other. Therefore, utilising the ideas of the Drama Triangle seemed a useful way to interpret and possibly support transformatory behaviour.

From a Foucauldian perspective, there are many issues enmeshed within the Drama Triangle that are related to the networks of power inherent in institutions, exercised through dominant discourses. For example, the dominant discourses highlighted in this study concern the relationships the prison nurses have with their colleagues, the institution, the prisoner patient and themselves internally. These dominant discourses are underpinned by accepted truths about the way in which the system operates and the way in which those working within it also operate. Given that it is the dominant discourses through which power is exercised, and it is the dominant discourses through which nurses employ their emotion work, it can be seen that the power relations inherent in the relationships with which the nurses engage are also as a consequence of the way in which they are positioned, and indeed position themselves, with regard to the Drama Triangle. Analysis of the supervisees' position within the drama triangle therefore firstly allows the nurses to identify what is happening with regard to others who may occupy positions in the triangle, which enables them to consider their options for moving their position. Secondly, analysis of positioning also allows the supervisee to consider the power relations that are at work and, therefore, once understood, can empower the supervisee to act, thus alleviating some of the stress of their emotion work or, indeed, eliminating the need for emotion work.

When we reflected on their situations in light of this model, both supervisees became very animated and interested, as it appeared to resonate clearly with

them in their own predicaments as they identified with the positions of victim and rescuer. They often viewed their more difficult colleagues as persecutors.

Nursing Practice & Professional Safety

Given the nature of clinical supervision and its purpose, I considered that discussion of clinical practice would be inevitable. However, encouraging these supervisees to discuss their clinical practice was a struggle to begin with. I did not want to force the supervisees to discuss clinical practice, as I had been clear with them both that they were to set the agenda for our sessions. After some discussion, one of the supervisees embraced the opportunity to discuss her clinical practice issues but mainly in terms of difficult colleagues and conflict with peers. Interestingly, these issues were only discussed when this supervisee felt safe. Indeed, the fact that she was anxious about talking to me at all highlighted for me the problems of engaging nurses working in this culture in supervision, as she required extreme reassurance and further assurance of confidentiality. For the other supervisee, the clinical focus of her work was not of concern to her as she felt that she managed it well. For her, the focus of her supervision was the managerial issues that she had to engage with in a role that was new to her.

Concerns expressed through supervision often involved anxieties surrounding professional safety. Prisons are notoriously litigious environments in which to work and this appears to cause staff to become cautious and often obsessive about maintaining records, which will exonerate them should legal proceedings follow any incident. The dominant discourse concerning professional safety was discussed at length with both supervisees. Although both brought this issue to supervision, for one nurse it was anxiety provoking whereas for the other, who had worked in prison for much longer, it was something with which she had learned to work. Through supervision, this nurse gained reassurance that her actions were appropriate

but, for the other nurse, this issue was more problematic. Various incidents were discussed through supervision in which this nurse felt uncomfortable and unsure of the most appropriate course of action. Guided by reflection on standards and codes of practice, most issues were worked through methodically. However, it became clear that the supervisory needs of this nurse were not particularly educative but more supportive as she grappled with working in a culture where security was the priority, not health care.

In considering the nature of professional safety from both supervisees' perspectives, i.e. from a managerial perspective and a clinical perspective, they were influenced by the internal governance involving the ethical perspective of self-governance. Externally, however, they were meeting the effect of the complex web of power relations surrounding the control of their practice by both the institution and the Nursing and Midwifery Council (NMC) through their need to adhere to guidelines and protocols. In terms of the disciplinary power experienced through these channels, the anxiety provoked in them was caused by concerns and fears of punishment, e.g. losing their registration or being disciplined. The surveillance they engaged with on an internal level, and indeed the surveillance to which they are potentially subjected to through external examination, e.g. coroner's inquests and litigation, produced feelings of anxiety in both supervisees. Through exploration of practice under the gaze of authority, these nurses were placed in a contradictory position, which I suggest was the cause of their anxiety and need to manage their emotions. Where the dominant discourse of the workplace is one of custody in which nurses must practice whilst being affected by the dominant discourses in nursing, dissonance is inevitable. The emotional labour in which these nurses engage is caused by their attempts to achieve harmony between both discourses. However, in attempting to achieve this, they are affected by the complex web of power relations inherent in a culture that serves to ensure custodial philosophy prevails.

Through the specific issues raised in supervision, both supervisees experienced emotional labour in terms of having to manage the dissonance and related emotions caused by engaging in practices that were constrained by the system. The frustration of having to compromise was, for both nurses, a huge issue. In order to work through this frustration and determine suitable approaches to dealing with the issue, we spent time reflecting on the individual nurse, their own preferred ways of working, and the ways in which they could view their practice differently in order to manage, rather than to examine ways in which they could relinquish responsibility through subservience to the custodial position.

Confidence, Empowerment & Accountability

Participation in clinical supervision sessions improved the confidence of the nurses and the suggestions enabled them to feel supported in adapting to new challenges. Through discussing practice, one nurse in particular clearly felt that the prison environment placed a greater emphasis on accountability than anywhere else she had worked. This was, she perceived, due to nurses working in this setting experiencing more autonomy. In addition, the anxiety this nurse felt concerning her professional safety led us to engage in reflection pertaining to self-confidence.

Throughout the supervision sessions with both nurses, there were underlying issues pertaining to the nurses themselves that were at the root of their concerns. Once we had addressed these issues, we were able to engage in looking at their own behaviours as a way to deal with problems. Lack of confidence was uncovered as a reason for some of the concerns brought to supervision in some instances. Feeling disempowered was another, which often led to feelings of despondency and low morale. In discussion with both supervisees, it became clear that feeling disempowered was common amongst their peers. Indeed, some respondents highlighted this during my interviews with them. Disempowerment leading to low morale affected both

supervisees in different ways. Disempowerment for one led to feelings of low self-worth and unimportance. For the other, acceptance of being unable to change anything had taken place long ago and, although not a primary issue for her, frustration caused by dissonance experienced because of what she wanted to do and what she felt she could do as a result of the limits placed upon her, produced feelings of job dissatisfaction.

In analysing this data, I have been considering the link between the supervisees' position and ability to change practice, and Foucault's notions of agency, subjectivity and their links to power. Through the work of Foucault, it has become clear that his perspective on power asserts the perception that, 'Individual subjects/agents don't come into the world fully formed; they are constituted in and through a set of social relations...all of which, are imbued with power' (Allen 2002:135). It can be seen that, given the social relations into which the individual enters are concerned with power, which, as Foucault suggests, have both positive and negative applications, the individual is both subjected to the complex and dynamic power relations within their social sphere and 'enabled to take up a the position of a subject in and through those relations' (Allen 2002:135). Therefore, if power is a precondition for the possibility of individual subjectivity, as Foucauldian thought would suggest, and therefore subjectivity is a precondition for agency, how does this affect the position of the nurse working in an environment in which their agency is restricted, given the extent to which the power relations within the setting are repressive? One cannot embrace agency without the ability to deliberate or be a thinking subject. However, if development as a thinking subject is dependent on the context within which you exist, and that context is laden with dominant discourses that often serve to constrain nursing practice, the effect of this situation on the nurse is emotionally difficult and requires careful consideration.

As Schaff (2004:53) suggests, 'Investing agents with power is a process of normalisation that targets individual bodies in order to regulate and maintain the social body as a whole.' In the prison setting, this is seen to be carried out with regard to the officers in the system; those who need to implement a custodial philosophy in order to maintain the prison in carrying out its primary function of custody. Although nurses as agents are invested with power to some extent in order to support them in providing a health care service, the dominant discourse, and therefore the one to which these nurses are both exposed to and influenced/constructed by, places constraints on this power, which in turn places limits on their ability to act and hence their agency.

Development through Clinical Supervision

As I have discussed, there were dominant discourses that pervaded the supervision sessions. However, it seems appropriate to discuss my perception of the changes I saw in these nurses during our supervisory relationship. I am not suggesting that it is solely through working with these nurses that changes occurred, as there may have been a host of other events and experiences that may have affected them. Reflecting purely on the supervision sessions we undertook, I noticed a change in their levels of confidence. Both participants appeared more confident in their approaches to their work. In coming to terms with some of the dissonance they had discussed with me, both appeared much more comfortable. I suggest that the development of our relationship could well have affected the way in which they presented themselves to me, as we became more relaxed with one another. However, in terms of the way in which they described their practice to me, some significant changes occurred. Both suggested that they were now engaged in reflecting more frequently on their work, and that they had gained a different perspective. One nurse mentioned that, as a result of engaging in supervision, she had developed new ways of thinking and was feeling more positive about working in the prison now that she was more able to cope with the challenges to her practice. She mentioned that coming to

supervision had given her the space and time to think about her practice, and that the supportive element of our sessions had resulted in her staying at the prison, whereas she had been thinking of leaving. The other supervisee highlighted the significance of supervision for her in terms of its supportive element, and the importance of having a supervisor who was external to the prison but who understood the context within which she works.

Chapter Five: Conclusions & Recommendations

Following discussion with nurses working in three prisons and reflection on my own practice in the prison setting, I have suggested that the emotional labour of nurses is affected by both the interpersonal and intra-personal relationships with which the nurses engage. It is the effect of these relationships that necessitates engagement with emotion work. However, the extent to which the emotional labour of the nurses is challenging is, I suggest, related to the emotional intelligence of the nurse. If we consider emotional intelligence to involve 'the ability to monitor one's own and others' feelings and emotions, to discriminate against them and to use this information to guide one's thinking and actions' (Salovey & Mayer 1990:189), then I suggest that it is in the 'thinking' and 'action' that emotional intelligence and emotional labour are interlinked.

In order to clarify this position, I will present an example from my own practice in which I engaged in emotion work that was underpinned by my use of emotional intelligence.

I was working in a treatment room administering afternoon treatments to prisoner patients located in the inpatient unit. I was tired and looking forward to a few days off. The previous few days had been stressful with a heavy workload. The prisoner patients were called for their medication and duly came to the treatment room and queued up outside. I administered medication to a handful of patients with no problems. However, following a dispute with one particular individual over his medication, the atmosphere turned hostile. His tone of voice and general demeanour towards me had initially caused me to become defensive. However, I could tell by looking at him that he was getting angry, which resulted in some anxiety on my part. In order to manage the situation and prevent any escalation, I used my emotional intelligence to consider the situation I was in and to engage in appropriate emotion work to de-escalate the event.

In considering my emotional intelligence, I rapidly had to assess my own emotions and those of the prisoner patient in order to be sure I would act appropriately and not inflame the situation. I had to regulate the emotions I was feeling throughout (beginning with anger and moving to anxiety) in order to present an appropriate emotional response. I also had to assess the emotions of the other prisoner patients still waiting for their medication. I could tell the prisoner patient was getting angrier which increased my anxiety. However, if I had demonstrated that anxiety, there would have been a shift in power and I would have been unable to manage the situation. I therefore had to suppress my anxiety and engaged in emotional labour to present a professional exterior to all those watching. In addition, I had to ensure that those prisoner patients who were seeing this incident unfold did not become involved and end up making things worse, hence I used to my emotional intelligence to monitor their reactions. I remained calm, although I felt anxious, and presented a professional face to those watching, asking them politely to return to their cells. The majority did as I asked but two prisoners appeared to ignore my request and began talking with the prisoner, asking him to calm down. Despite my initial reservations about fellow prisoner patient involvement, I could immediately see the benefits of their involvement and, whilst allowing them to engage with the aggressive prisoner patient, I was able to assess the feelings of the aggressive prisoner patient through his reaction to their pleas for him to calm down. I was then able to maintain the appropriate approach myself, and aligned myself with the two prisoners who had intervened. In addition, by understanding the emotions involved in this situation in myself, the aggressive prisoner patient and the two other prisoner patients, I was able to moderate not only my own behaviour but that of my officer colleagues who had come to my assistance having heard the commotion. From my perception of the development of the situation from the start, I felt that officer involvement would only serve to escalate a delicate situation, which I could see was calming down. I consequently redirected the officers' attention to the rest of the unit, to make

sure everyone else was back in their cells. The incident concluded with the two prisoner patients convincing their fellow prisoner to calm down. Myself and the aggressive prison patient subsequently talked through the incident a while later. I wanted to understand the real issues behind his outburst whilst aiming to reinforce behavioural boundaries. I received an apology and he, a review of his medication. We had no further problems.

The approach to the emotion work I engaged in, in this instance, was centred on the consideration of the situation from an emotionally intelligent perspective. My ability to assess and judge the emotions and feelings of all involved enabled me to adapt my own emotional labour to ensure my actions were appropriate and helpful in de-escalating the situation.

I believe it is possible to develop emotional intelligence through reflection. For example, the experience I have just presented to you details a successful conclusion through appropriate action. However, consider how I could have reacted had I not appreciated the importance of monitoring the situation through appreciation of the emotions and feelings of the key actors in this drama. Had I not used my emotional intelligence, but relied on the custodial textbook and reacted to my emotions, I would probably have pressed the alarm bell which would have resulted in the speedy arrival of a group of prison officers. Their arrival would probably have resulted in an escalation of the situation. Reflection on this fictional outcome through clinical supervision would almost certainly have enabled me to consider alternative ways of managing the situation and, I suggest, through challenging and supportive clinical supervision I would start to use and develop emotional intelligence.

In this study, those participants who entered into a supervisory relationship with me appeared to develop a better understanding of both their practice and the relationships within their practice. They also obtained a clearer insight into their own ways of thinking about their practice and relationships

with others that led, on occasion, to consideration of ways to manage these relationships and, consequently, their emotional labour. It is hoped that those participants who did not enter into supervision, but with whom I spoke in depth about their practice, may also have gained more insight into their practice through the very act of reflecting on it, with me, in the interviews.

The conclusions concerning the emotional labour, emotional intelligence and importance of reflection for prison nurses is based on data collected from prison nurses at a particular point in time, in a particular context. I am not suggesting that the issues raised by these nurses are true for all prison nurses but I am proposing that it is possible that consideration of the relationships with which one engages may provide insight into the main causes of emotional labour, in any context. A person's reaction to this emotional labour is, I suggest, governed by their own emotional intelligence. I am also suggesting that emotional intelligence can be developed through reflexive thinking, be it facilitated by another, such as a supervisor, or alone.

Recommendations for Practice

I sense that there are many ways in which this work can be utilised, developed and progressed in order to improve care and standards within prison health care settings for both prisoner patients and staff. Further research and practice development activities within prison health care settings in order to examine and develop the emotional intelligence of health care staff would be highly beneficial to prisoner patient care. Indeed, I suggest that this should not be restricted to health care staff, as all staff caring for prisoners would benefit from a better understanding of emotional intelligence. Not only would prisoner patient care be improved, but I suggest that staff morale would also be enhanced through more efficient multidisciplinary working and better staff–prisoner relationships, ultimately leading to higher job satisfaction. Improved multidisciplinary working, achieved through a better understanding of different roles and relationships,

could possibly reduce stress levels amongst staff and lower staff sickness rates.

In order to promote multidisciplinary working, I suggest it is imperative that new entrant prison officers are provided with some experience of prison health care, either through being given information during their training or perhaps by spending time shadowing health care staff. This approach could also work with nurses who are new to the Prison Service in enabling them to shadow prison officers.

The impact of the prison culture on both nurses and their practice has been highlighted in this study. From the dominant discourses surrounding security to the nature of the nurse–prisoner patient relationship, the prison culture has a profound effect on the practice of the nurse. As Primary Care Trusts are increasingly involved in prison health care services through commissioning and, in some cases, provision of health care, it is of paramount importance that nurses who have not previously worked within prison health care settings are inducted into the service appropriately and provided with the opportunity to engage in reflective practice and clinical supervision in order to consider the impact that culture has on practice.

Recommendations for Further Research

As mentioned previously, gender issues are inherent within prison work. I did not feel that the scope of this study allowed for a substantial examination of this area and, as such, suggest that it would be appropriate to address this through further research. This study has highlighted differences in the practice and emotional labour of nurses working in male and female prisons. Further exploration of the emotional labour of nurses working in female prisons as opposed to male prisons would, I suggest, be a valuable addition to the knowledge base in order to understand, support and develop practice.

Having reflected carefully on my own experiences as they relate to emotional intelligence, I have considered how the use of emotional intelligence and reflection on action are closely linked. Further examination of the way in which expert nurses use both reflection on action and emotional intelligence simultaneously in order to undertake appropriate emotion work, would be another dimension through which the work of the expert could be examined. I suggest that the use of clinical supervision as a data collection method would be the most appropriate way to examine this.

The concepts of emotional intelligence and emotional labour are under examined within the prison health care setting. I suggest that there would be value in understanding the role of both emotional intelligence and emotional labour in the socialisation of prison nurses, not just in their daily practice as in this study. As prison culture plays a significant role in the practice of both officers and nurses, I conclude that a better understanding of the socialisation of staff into this culture, through examination of their emotional intelligence and emotional labour, would serve to highlight the way in which practice develops within this culture.

This study has highlighted the emotion work of nurses working in three prisons, two of which are male, and the other female. Nurses working with young offenders were omitted from this study. From my experience, the nature of the nurse–patient relationship in a young offender setting is very different to that in the adult prison setting. I suggest that an examination of the emotional labour of nurses working with young offenders would be beneficial in understanding the challenges facing these nurses.

In all my recommendations for further research, I support the position of the researcher to challenge dominant discourses. From a Foucauldian perspective, power only exists because there is resistance to it. Resistance to dominant discourses serves to encourage researchers to establish and support new discourses. The research I suggest as a result of this study

entails examination of the practice and culture of prison officers and prison nurses. Instinctively I am led to qualitative approaches to research and development, where people and their feelings are examined. In addition, I feel it is important to consider the effect of research on the study participants. Where possible, I suggest the use of methodologies and approaches that seek to involve participants not only in providing data but also in developing practice.

Chapter Six: The Research Journey

This thesis has centred on the examination of the emotional labour undertaken by nurses working in prison. There has, at times, been reflection on my own experiences as a prison nurse and, indeed, reflection on my thoughts and understanding of philosophy. However, through discussion with my peers and supervisors, it has become clear that engaging in doctoral study is a physical, mental and emotional process. Following on-going dialogue with fellow researchers, I suggest that there are two routes to PhD success. One appears to involve a journey of subject discovery, in which the researcher engages in a structured investigation of a particular topic, and where pure determination and self-discipline are key. The other route appears to follow a detailed and in-depth examination of a particular subject but which, in contrast to the first route, also involves experiencing and admitting to a journey of self-discovery and transformation.

The wider question concerning the purpose of a PhD needs to be considered in determining the route taken. If a PhD is undertaken in order to add the title 'Dr' to one's passport whilst gaining expert knowledge in a particular area, then the first route is probably appropriate. However, if a PhD is undertaken to gain expertise in a subject area whilst learning to be a researcher, then I suggest that the second route is more appropriate. I liken these two routes to obtaining a PhD to nursing. Is nursing just a job, or is it a vocation? Likewise, is studying for a PhD just a job, or is it more of a vocation – something that becomes part of who you are, not just what you do? Throughout my own PhD journey, there have been periods of elation and enjoyment, times of despair, and life experiences that have changed both me as a person and my approach to my work. For me, this PhD journey has been truly transformatory and has become part of my life. As I conclude this work, it has become more of an obsession. Friends and relatives asking me how I am at the moment does not lead to 'fine thanks' but leads to a reply involving an update on the progression of my thesis. This work has become so much a

part of me that, even at a recent family funeral, I found myself reflecting on the emotional labour of funeral directors.

Given the underlying reflexive approach I have taken throughout this work, I feel that it is important for the reader to gain some insight into my own expedition and have therefore chosen to step aside from the world of the prison nurse and to move into my world as a researcher. As we know, I have a love of structure, and have decided to look at the PhD road in terms of the more traditional steps associated with research. Attendance at a qualitative research conference in Australia in 2006 provided me with the inspiration to examine my experiences in this particular fashion.

Literature Reviewing

I began reviewing the literature with a huge sense of excitement. What a position for someone like me, who loves to read and study, to be in. Being able to spend days reading the literature, pouring over databases, tracking down references and immersing myself in a subject about which I am truly passionate. Little did I realise that this passion would at times be a hindrance, lead to much confusion and, indeed, cause me to re-evaluate the aims and direction of my study. Staying focussed became difficult as I was keen to examine all kinds of areas and, indeed, discovered interests I never even realised I had. For example, there is little written about nurses working in prison but there is work out there concerning professionals who care for offenders. I never knew I would become so interested in the workings of the police force. However, the feelings generated in me at having to discard work that I found interesting and ripe for further examination ranged from resentment and disbelief to utter annoyance. Frustration at having to leave this work and refocus on what I was supposed to be doing and anxiety in trying to determine what I was really doing and if it was correct given that I had seen an alternative route, were commonplace throughout this period.

Reflection on my developing interest in my chosen subject caused me to question the importance of my original plans and whether I should change them, given that I had been advised to make sure I was truly passionate about my work as the effort required to undertake a PhD was huge and disinterest would make the journey even more difficult. Changing my plans at this stage would require a further application to ethics committees and HM Prison Service in order to continue and this, in itself, would be time-consuming and stressful. During this time, I managed to remain focussed through excellent supervision and support. I began to allow myself time to read the literature which, although not directly applicable to my work, provided me with information that, in turn, caused me to reflect on my own subject. I began to realise that embracing literature not directly linked to a course of study has an affect in that it can sometimes spark ideas and change perception. This was a turning point for me as I began to broaden my understanding.

Reflecting on this point now, I can see that I was working under the assumption that there was a 'right' way to research and that there were constraints and boundaries placed on the researcher by 'academia'. This was reinforced for me in terms of my experiences of having to submit paperwork and updates at regular intervals to the university and obtain 'permission' to continue. I continued to work with this belief throughout the literature review and data collection phases of this study, believing that there was an 'official' or 'right' way to undertake research.

Data collection: interviewing and clinical supervision

This period in my study led me to reflect on my own experiences of nursing in prison in some depth. Hearing the stories from the participants stimulated thought about my practise and caused me to reflect on a level at which I never did at the time. Not only did this add to my own understanding of nursing in prison, but also led me to consider how my attitudes to nursing

practice in prison and, indeed, my attitudes to those working with prisoner patients had changed significantly since I left practice. I suggest that this change is most notable through my development as a clinical supervisor through this study. Being able to view practice in prison through the lens of a researcher involved in practice development and exposed to strategic developments as opposed to operational developments through close contact with the Department of Health, enabled me to approach supervisees from a different perspective to that of a nurse in practice. The tension for me came as I identified with the practical issues arising for these nurses in supervision but approached them from a position of an outsider, with an understanding of the philosophical basis of their work and an understanding of the strategy operating on the level above the individual establishment. I felt torn between empathetic understanding and a feeling of closeness to their stories and the need to challenge in light of my broader understanding of the bigger issues. I managed this emotional labour through my own supervision, which enabled me to identify my issues and take steps to address them without feeling as though I was compromising the identity I have with nurses working in practice.

One of the main issues I have learnt through undertaking this research is the need to be flexible in terms of organising and carrying out interviews and clinical supervision. For me, the need for flexibility resonates with the work of Robson (2002) where he highlights the nature of real world research. Although I thought I had everything planned, there were times when I would arrive at a prison to undertake interviews and supervision, and staff were unable to be released from their duties, resulting in rescheduling or waiting around. It was at times like these when I felt the emotional labour of the researcher. I needed to remain friendly and co-operative in order to seek a solution to my problem; however, inside I was furious, given that I was under the impression that everything was organised. My coping strategy was to reflect on the perceived importance of my study by the prison, given that prisoner patient care was the priority and, understandably, not my study.

However, adopting this coping mechanism meant that at times I felt that my work was undervalued and that, as a researcher, I was not important. Again, this led me to question why I was undertaking the research and, indeed, why it was important. This was discussed and resolved through supervision as I came to accept that my work is valuable and makes a contribution to the knowledge base. The tension for me centred on a feeling that I identified with prison nurses, understood their position, but that somehow I no longer belonged in their world. This led me to reflect on my own identity and my felt need to belong which led to further examination of the broader issue of 'belonging' and why I personally wanted to experience this feeling. I began to realise at this point that a PhD journey is lonely. This became more evident to me when I would return home from an afternoon inside a prison, armed with interesting and exciting data, only to discover that others did not share my excitement to the same extent.

Data Analysis

In analysing the data from this study, I have experienced a whole spectrum of emotions. From feeling elated at discovering a theoretical framework, to feeling extreme anxiety that the data collected was irrelevant. I have come to realise that it is not only the time given to data analysis that is crucial in being able to document findings, but the frame of mind within which it is done. I have spent many frustrating hours examining my data, re-reading the proposed method of analysis and trying to connect the two, only to discover that my efforts were futile, as I perceived little or no progress. With deadlines looming, this lack of progress then stimulated anxiety. A seminal moment in this thesis came during the data analysis phase when, through supervision and discussion with fellow students, two important issues emerged in sharp focus: self-imposed stress and having the courage to take time out. The following extracts from my research diary highlight the discovery I made about my work and myself:

August 16th 2006

Having a bit of a tough time. Had decided that an inability to write was in some way a failing but spoke about it today and it turns out that I am so immersed in studying emotional labour in others, that I have neglected to realise that my inability to write and the feelings it leaves me with, are part of the emotional labour of doing a PhD. It has been suggested to me that I am what constrains myself by making things too hard for myself, and place demands on myself which I perceive are from other people. Turns out that I set too high a standard for myself and assume that it is what other people expect. Having spoken to Mum about this it sounds like a pattern I keep repeating. Happened all the time when I was at school.

I feel guilty when I can't write and feel like I'm wasting time, precious time that I have been given in order to do this. Makes me feel like I am letting people down by not coming up to scratch. Have discovered today that this is all my own doing, my own perception, and no one else sees it this way.

September 5th 2006

Having a nightmare with this at the moment. Am questioning why I am doing it at all! I know it would be silly to give up now, but the thought of not having to do it is really nice. Have been struggling to get some order to the final document – typical!

September 6th 2006

I can't fit it into sections and it's a mess in my head. Then I end up avoiding writing and feel guilty for not working. When I talk about the philosophy stuff with Bill, it all makes sense but when I try and write it – I can't get it straight. I think it's because I need to write it academically, but problem is, I don't speak academically! Not sure I have the courage not to write academically and then I get annoyed that I am constrained by academic discourse. But then I think, am I really constrained by academic discourse, or is it just my own self-

imposed expectations of what is required? Here we go again, self-imposed stress!

October 27th 2006

I sent some draft work to my supervisors so have had a bit of a break from it all. I figured that I should do some work on the analysis now. I felt I needed a break, some time away from my data as I was a bit overwhelmed by it all, and finding it hard to put it in some kind of order. I started back at it today and it's really surprising how much better I can see it now.

Writing

When I commenced this work, I reflected on my usual method of studying in order to anticipate the most effective way of producing the final thesis. I was never a student who relied on pressure and deadlines to complete work and throughout my academic career I have planned and organised myself adequately. I felt that frequent writing and addition to this thesis would be the best approach, yet throughout the early stages of writing, I found that I was readily accepting of any distraction. Through reflection and supervision, I began to realise that I enjoyed thinking and talking about my work, rather than the actual writing. In retrospect, I think that I perceived no urgency for writing. I was stimulated sufficiently to provide written work for my supervisors and, indeed, to meet the requirements for the university, but I did find it difficult to sit down and write. However, following the realisation during the data collection phase of the study that my thesis was in fact my work and that it was acceptable to write it in whatever way I wanted to, writing became easier. It was in understanding and overcoming the tension I felt between what I thought was expected of me and what I really wanted to do that writing became easier as I felt a growing confidence and freedom to express my own thoughts. Writing then became more appealing and producing this thesis more enjoyable.

Finishing

Once I had collected my data, I quickly realised that what I thought was the bulk of the work was in actual fact just the beginning. Initially this frightened me as I saw the height of the mountain that I had yet to climb. I assumed, incorrectly as it transpires, that once the data had been collected, it was just a case of writing it up and linking it to previous work. I did not expect the wealth of information and ideas I was confronted with which deemed the data collection phase small in comparison with the work that followed.

I also found that I was again beginning to avoid writing. Having discussed this at length in supervision, I was reassured that avoidance at this stage was common. After all, my PhD had been such a huge part of my life for so long; finishing it would result in the production of a gap. Not only would there be a gap, but I was also somehow giving up control of my work to the reader. As writing now meant that finishing would be inevitable, it was avoided. In order to manage this, I reflected on my initial motivation for starting this journey in the first place. I considered my debt to the participants in the study, all of whom had given me their time and shared their stories with me. I contemplated their motivation for involving themselves in my study and concluded that not to finish would render their input worthless. Consequently, I once again wrote, with renewed enthusiasm.

Sadly, my brother died during the last few months of writing this thesis and consequently my work was no longer a priority. However, this major event not only interrupted my studies, but also caused me to reflect on wider issues, including my work. Fortunately though, through encouragement from family and friends, the importance of this work was realised and I began to write once more. Upon reflection, re-engaging with my thesis in its final stages and in a different frame of mind has caused me to understand even more the effect that life events have on perspective and how fragile understanding can be. In addition, my changed perspective on life has also led me to consider why this thesis is important. I suggest that its importance

is rooted in its capacity to change practice and to provide a better understanding of the world of the prison nurse. I am acutely aware that this work provides a snapshot of the here and now, and suggest that, although it is now complete, it is not the end. This thesis is part of a dynamic and transformatory process which is ongoing both for me as the researcher and hopefully for those who read it, who may or may not take its ideas further to develop practice in prison.

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Appendices

Appendix 1

APPLICATION TO UNDERTAKE RESEARCH IN HER MAJESTY'S PRISON SERVICE

Name of researcher(s)	Elizabeth C L Walsh
Project title	An examination of the emotional labour of nurses working in prison

Please type or print, using black ink

RESEARCHER(S) DETAILS

Surname: WALSH
etc...)Miss

Title: (e.g. Mr. Ms. Dr.

Forename(s): Elizabeth Clare Louise

Home Address:

Address to which all correspondence should be sent (if different from above):

Contact Telephone Number: *****

Name, Status and Address of Research Supervisor (if appropriate):

Professor Dawn Freshwater
Institute of Health & Community Studies
Bournemouth University
Royal London House
Christchurch Rd
Bournemouth

Name and Address of Sponsoring Body (if appropriate):

N/A

If more than one researcher will be engaged on the project, please copy this page and provide details on all.

Please attach a CV for all researchers

PROPOSED RESEARCH - AIMS AND OBJECTIVES

Reason for undertaking research project:

(e.g. for Ph.D. thesis, for commissioning body, or as part of the programme of study of a research unit)

For PhD thesis

What is (are) the research question(s)?

An examination of the emotional labour of prison nurses

Is there related published research of relevance to the study?

If so, please describe:

There is published research concerning emotional labour in nurses in general practice, research concerning prison nurses roles and experiences of practising in prison and published work concerning the emotional labour of prison officers.

What are the potential benefits of the research:

- **to the Prison Service?**
- Evidence based recommendations for the induction and preparation of nurses working in prison
- Improved patient care
- Improved retention of nursing staff

- **to academic knowledge in the field of study?**

- First study to examine this concept in prison nurses
- Adds to the limited literature available in the field of prison nursing in England

RESEARCH PLAN AND METHODOLOGY

Briefly describe the research methodology:

This study will utilise a qualitative methodology, underpinned by a reflexive action research framework, see Freshwater & Rolfe (2001) and Robson (2002). A reflexive approach will be used as I have a background as a prison nurse and will be contributing to the research using my own experiences. Nurses involved in this study will be supported in using a reflective approach during data collection, which, it is anticipated will encourage changes/development and improvement in practice.

What data gathering and sampling techniques will be employed?

Please include with this application any research tools such as questionnaires, interview schedules etc... Where data on prisoners is required, details of the information sought should be attached.

Sampling: 3 sites (high security, female and male local). A purposeful sampling strategy will be employed to obtain 3 nurses in each prison, employed by HM Prison Service, to participate in the study. One nurse from each site will also be asked to engage in clinical supervision for a period of one hour per month over six months.

Data Collection: data will be collected using semi-structured interviews, clinical supervision/reflective diaries and documentary evidence

How will internal and external validity be established?

In order to remain congruent with the qualitative nature of this study, appropriate estimations of rigour will be applied through a systematic audit trail and will address trustworthiness, credibility and dependability, see Denzin & Lincoln (2000)

Which (if any) measurement tools will be used?

N/A

Please list any equipment, which you are intending to bring into the prison establishment.

E.g. tape recorders, etc...

Tape recorder where appropriate and permissible

What is the proposed timetable for the research?

Data collection will take place over a period of 8 months maximum allowing for the operational constraints of establishments.

When is the research due to be completed?

Fieldwork: April 2005 – December 2005

Report: Thesis due for submission early 2007

RESEARCH ANALYSIS AND DISSEMINATION

How will the research results be analysed?

Analysis will be conducted using discourse analysis, see Cheek (2004)

How long will the research materials be retained?

5 Years

How will the results of the research be disseminated? (e.g. thesis, article, book etc...) Indicate how the results will be made available to the Prison Service.

Via publication of reports in peer reviewed journals, Prison Service Journal, Prison Health publications

Through presentation at appropriate conferences e.g HM Prison Service Sharing Good Practice Conference, RCN Prison Nurses conference, Queens Nursing Institute Prison Health Network

Presentation to NHS Workforce Development Confederation/ PCT prison leads

Report for Prison Health at the Department of Health

ACCESS TO PRISON ESTABLISHMENTS, PRISONERS AND PRISON STAFF

What establishment is access being sought for (name(s) or type(s) of establishment)?

High Security Estate e.g. HMP *****

Male Local e.g. HMP *****

Female Estate e.g. HMP *****

Have these establishments (or any others) been approached separately about this research? If so, please provide details:

No

How long will the researcher(s) need to be inside each prison establishment (number of days and numbers of hours a day)?

For each establishment (3 in total):

Sampling: approximately 1 day (8 hours)

Data Collection: Interviews: 3 staff (3 x 1 hour) & Clinical supervision sessions: 1 x 1 hour monthly for 6 months

How long will the researcher(s) need to be in contact with prisoners?

N/A

How many prisoners would be involved?

N/A

Are there any special requirements (random selection, specific prisoner groups etc.)?

Nurses or nurse registered health care officers must be employed directly by HM Prison Service

How long will the researcher(s) need to be in contact with prison staff?

Data collection will take place over a period of 8 months. During this time it is anticipated that sampling will take one day (8 hours), interviews (9 hours) and clinical supervision sessions (18 hours).

Total contact time of 35 hours.

Which type of staff would be involved?

Registered nurses and nurse registered health care officers employed directly by HM Prison Service

How many staff would be involved?

Minimum 9, maximum 12

Are there any resource implications for Prison Service Headquarters? (anticipated demands on staff time, office requirements, information etc...)

No

RESEARCH ETHICS

What procedures are there in place to ensure that the consent of inmates will be obtained on a valid and informed basis and that the information will comply with the Data Protection Act? (Attach examples of consent forms)

No prisoners are involved in this study. However, staff wishing to participate in the study will be required to sign an informed consent form (see attached).

Under which ethical guidelines will the research be conducted?

Bournemouth University Research Ethics Policy (see www.bournemouth.ac.uk for more details)

Has a relevant Ethics Committee approved the research?

Please attach a copy of the submission to the Ethics Committee and its response:

This study has been reviewed and approved by the Research Committee at the Institute of Health and Community Studies at Bournemouth University.

Signature:

Date:

Please return this form, together with

- ❑ Copies of the CVs of all researchers
- ❑ Copies of any submission to an Ethics Committee and its response
- ❑ Copies of any questionnaires, topic schedules, and consent forms

To ONE of the following:

Prison Governor/ Research Contact

Area Psychologist

Prison Service Headquarters – Applied Psychology Group

Appendix 2

An Examination of the Emotional Labour of Prison Nurses

Purpose of Research

To examine the notion of emotional labour as it pertains to nurses or health care officers with a nurse qualification, working in the prison setting.

Emotional labour is defined as 'the management of feeling to create a publicly observable facial and bodily display'. This concept has been applied to studies concerning both nurses and prison officers, however, literature pertaining to emotional labour and its impact on the work of nurses working in prison who undertake both a caring and a custodial role is notably absent. I am interested in looking at this concept in terms of the way in which working with prisoners as patients affects the emotional labour of staff and the effect that this emotional labour has on the nurse themselves.

The Researcher: Liz Walsh

I am conducting this research for my PhD, which I am undertaking at Bournemouth University. I have worked as a nurse in prison for 5 years and then as a practice development nurse with South Bank University and the London prisons for 4 years. I moved to Bournemouth University in July 2004 where I have been working on developing the mental health awareness for prison officers training package for the Prison Service and the roll out of clinical supervision across prisons in England and Wales.

Participants

I am looking to recruit 3 nurses or health care officers with nurse qualification from each of three prisons: [Establishment Names]. There will be 9 nurses/health care officers in total involved in phase one of the study and three in phase two.

What is involved?

During phase one of the study you and I will meet for a taped interview (if you agree to be taped – if not I will take notes), which I anticipate to last for about an hour. I hope to conduct the interview during August. You will be able to stop the tape at any time, ask any questions or raise any issues. I will be asking you for your views, thoughts and feelings about working with prisoners as patients and will do this by asking you to reflect on your practice and experiences. I can come and interview you at the prison or we can arrange to meet elsewhere.

Phase two of this study involves undertaking clinical supervision with three of the nine nurses/health care officers with nurse qualification involved in phase one, once a month, over a period of 6 months. If you chose to continue participating in this study into phase two, I will provide clinical supervision for you and ask you to maintain a reflective diary. I will help you regarding the possible format of the diary. The time spent keeping the diary will be up to you. I envisage that you will write about episodes of care and experiences you have that we can discuss in your supervision sessions. With your agreement, the supervision sessions will be tape-recorded and I will ask for a copy of your diary, which I will use in the analysis of the study findings.

I will ask you to sign a consent form, however, you are free to withdraw from the study at any point.

Anonymity/Confidentiality

In the final thesis and any publications from it, I will protect your anonymity and will refrain from identifying the prison in which you work. Tapes and transcripts will be stored in a locked filing cabinet and will only be seen by myself and my supervisor.

What will happen to the findings?

The findings will be written into my PhD thesis, a copy of which will be sent to the Prison Service (as per the conditions for me to undertake the study). Another copy will be retained in the library at Bournemouth University. Findings will also be submitted for publication in the form of journal articles and papers for presentation at professional conferences.

Any further information

I am more than happy to answer any queries you may have about this study. Feel free to contact me on ***** or email: *****

What do I do if I want to get involved?

If you would like to participate in this study in either phase one (interview only) or phases 1 & 2 (interview + clinical supervision for 6 months) please complete the attached slip and give it to ***** as soon as possible or send it to me directly at:

1st Floor, Royal London House
Bournemouth University
Christchurch Rd
Bournemouth BH1 3LT

Kind regards

Liz Walsh, Researcher in Prison Health Care

An Investigation of the Emotional Labour of Prison Nurses – Reply slip

- Name:
- Job title / grade:
- Preferred contact details:

- Email address:
- Contact phone number:

I am interested in being involved in (please tick which one you prefer):

Phase one: Interview only

Phase two: Interview & clinical supervision

Many thanks.

Please return either to ***** or directly to me at:

Liz Walsh

Researcher Prison Health

1st Floor, Royal London House

Bournemouth University

Christchurch Rd

Bournemouth BH1 3LT

Appendix 3

Reflection Sheet

Date & Description of event

Your feelings (what were you thinking)

Evaluation (what was good/bad)

Analysis (what have you learned/what do you need to look at further)

Conclusion (what else could you have done / what would you do differently next time?)

Appendix 4

Informed Consent Form

Research project: An examination of the emotional labour of nurses working in prison

Researcher: Liz Walsh MSc BSc RGN

The purpose of this research is to develop an understanding of the emotional labour of prison nurses and its effect on practice.

Semi-structured interviews will be conducted and will be tape recorded and transcribed. During this interview you will be asked about your experiences of working in the prison health care setting. These tapes will not be shared with any other members of the Prison Service, but the final report, containing anonymous quotations may be published in widely read nursing journals. The results will also be submitted in the form of a PhD thesis to Bournemouth University.

THIS IS TO CERTIFY THAT I, _____ (print name)
Hereby agree to participate as a volunteer in the above named project.

I hereby give permission to be interviewed and for these interviews to be tape recorded. I understand that, upon completion of the research, the tapes will be destroyed. I understand that the information may be published, but my name will not be associated with the research.

I understand that I am free to deny any answer during the interview. I also understand that I am free to withdraw my consent and may terminate my participation at any time, without penalty.

I have been given the opportunity to ask whatever questions I wish, and all questions have been answered to my satisfaction.

Participant Name (Print)	Signature	Date
Researcher Name (Print)	Signature	Date
Witness Name (Print)	Signature	Date

Appendix 5

Clinical Supervision Contract

(for supervision sessions undertaken as part of doctoral research)

As supervisee and supervisor, we agree to the following:

- To work together to facilitate in-depth reflection on issues affecting practice, so developing both personally and professionally
- To meet for approximately an hour, once a month until April 2006
- To protect the time and space for clinical supervision by keeping to agreed appointments and time boundaries.
- We will work to the supervisee's agenda, within the framework of reflection discussed at the start of supervision
- We will both be open to feedback about how we handle the supervision sessions
- The supervisee will keep any notes used during the session. However, as this is part of a doctoral study, the supervisor will also keep a copy of the notes to serve as data. Notes will be anonymised and remain confidential

As a supervisee I agree to:

- Prepare for the clinical supervision sessions by completing a reflection sheet and/or having an agenda for meetings
- Take responsibility for making effective use of time, including punctuality, and any actions I may take as a result of clinical supervision
- Be open to accepting support and challenge, and be willing to learn

As a supervisor I agree to:

- Keep all information you share in clinical supervision confidential unless you describe any unsafe, unethical, illegal practice or practice which compromises the security of the prison, that you are unwilling to go through the appropriate procedures to address. In the event that you disclose any of the above, I will attempt to support you to deal appropriately with the issue directly, yourself. If I remain concerned, I will reveal the information only after informing you of my intention to do so
- Offer you guidance, support and supportive challenge to enable you to reflect in depth on issues affecting your practice

- Use my own clinical supervision to support and develop my own abilities as a supervisor without breaking confidentiality

Anything else?

Frequency of meetings: Monthly

Venue:

Duration of supervisory relationship: 6 months

Signed (supervisee)

Signed (Supervisor)

Date