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**Working with people who have killed: the experience and attitudes of forensic mental health clinicians working with forensic patients.**

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Abstract

Forensic mental health clinicians sometimes feel unsupported and unprepared for their work. This article explores their experiences of working in a forensic mental health setting in Australia. The research examined the clinical context of clinicians working with forensic patients, particularly those individuals who have killed while experiencing a mental illness. A qualitative, exploratory design was selected. Data were collected through focus groups and individual interviews with hospital and community-based forensic clinicians from all professional groups: psychiatric medicine, social work, psychology, mental health nursing, occupational therapy, and psychiatric service officers.

The main themes identified were: orientation and adjustment to forensic mental health, training in forensic mental health, vicarious traumatisation, clinical debriefing and clinical supervision, and therapeutic relationships. Participants described being frustrated and unsupported in making the transition to working with forensic patients and felt conflicted by the emotional response that was generated when developing therapeutic relationships. Recommendations include the development of programs that may assist clinicians and address gaps in service delivery such as clinical governance, targeted orientation programmes and clinical supervision.

Key words:

Attitudes,
Forensic mental health services,
Forensic psychiatry, mental health nursing,
People diagnosed with mental illness
INTRODUCTION

Forensic mental health (FMH) clinicians have been subject to scrutiny from the public, politicians and health personnel (Mason et al. 2008; Jones et al. 1987). Their role involves interaction with forensic patients, victims, families and health care services, and also to the justice system and community (Mason et al. 2008). To address some of this criticism FMH services must provide appropriate professional support, education and supervision to enable clinicians to provide optimal clinical care. This paper reports on one aspect of a study that examined rehabilitation in FMH. FMH clinicians provided insight into their attitudes and experiences of working in FMH. In this study, the term forensic patient (FP) does not describe all patients within FMH but refers only to patients who have killed another person or persons while experiencing mental illness.

LITERATURE REVIEW

Electronic searches were made of Web of Science, Psychinfo, Proquest, CINAHL, Medline and Embase databases, using terms: rehabilitation, forensic psychiatry/forensic mental health, and exploding terms: forensic, rehabilitation, stigma, and coping. Date of publication was left open to retrieve as many articles as possible.

The culture of FMH has been referred to as undesirable. Morrison (1990) and later Mason et al. (2008) claimed that mental health services have an
abundance of overt macho clinicians who dominate workplace culture. Mason identified that FMH settings attract clinicians with strong personalities who may perpetuate non-professional behaviours such as bullying, coercion and disengagement. Such an environment may not model the preferred behaviour for mental health consumers (Mason et al. 2008; Martin & Street 2003). A recent study conducted in Scotland identified negative attitudes of clinicians as provides a barrier to forensic patient’s future employability (McQueen 2011; McQueen & Turner 2012). Nurses in FMH settings have been identified as traumatised (Tabor 2011) and fearful (Jacob & Holmes 2011), being major barriers to healthy therapeutic relationships. Attitudes and experiences or FMH clinicians toward FP have been researched (Coffee & Coleman 2001; McQueen 2011). However neither study reports on all disciplines working in FMH.

There are a small number of studies that discuss clinicians’ satisfaction with working conditions in FMH (Burnard et al. 1999; Lauvrud et al. 2009). Morrison (1990) noted the clinical atmosphere did not impact negatively on job satisfaction in a survey of 1172 clinicians. Early Australian studies (Happell et al. 2003; Clinton & Hazelton 2000) identified that mental health clinicians working in mainstream services viewed FMH as a stressful workplace but their views were not shared by FMH nurses themselves. Indeed, FMH nurses acknowledged greater job satisfaction and attributed this to organisational support (Happell et al. 2003). In contrast, international studies (Coffee & Coleman 2000; Coldwell & Naismith 1989; Kirby & Pollock 1995) found FMH nurses were dissatisfied and experienced higher levels of burnout and
emotional exhaustion due to higher caseloads (Coffee & Coleman 2000). Burnard et al. (1999) found that salary was the major source of job dissatisfaction and reported staff felt inadequately renumerated for their work. Other studies emphasise the need for aggression management (Flutters et al. 2010; Tenkanen et al. 2008; Dcaire et al. 2006; Martin & Daffern 2006).

In a Finnish study, the ability to control violence was identified as a core competency for FMH nurses; yet therapeutic relationships or clinical attitudes to FP did not rate as an important aspect of the clinical role (Tenkanen et al. 2008). Perron and Holmes (2011) asserted that FMH nurses conceptualise FP by types. This study does not identify attitudes of FMH nurses toward FP in light of occupational conditions.

FMH nurses require coping mechanisms, such as attitudinal detachment, to manage exposure to patient aggression (Lauvud et al. 2009; Mason et al. 2008). Ongoing exposure to overt aggression causes trauma and fear for newly qualified and experienced FMH nurses (Lauvud et al. 2009; Mason et al. 2008). Similar emotions have occurred in response to vicarious aggression (e.g. knowledge of the forensic patients’ psychiatric histories; Way et al. 2007). These emotions negatively influence nurses’ capacity to respond therapeutically (Gagnon et al. 2010; Lauvurud et al. 2009). A significant reason why attitudes need to be in the foreground of discussion is their importance in shaping interactions with patients (Jacob et al. 2009).
Kent-Wilkinson (1996) found FMH nurses tend to hold negative attitudes toward FP because of their criminal activity. Jacob and Holmes (2011) suggest FMH nurses have been socialised to accept that FP are dangerous and, consequently, create distance between themselves and patients. This may explain research findings describing the therapeutic relationship between nurses and patients as social chatting (Martin et al. 2003) or detachment (Fluttert et al. 2010). Holmqvist and Armetal (2006) identified that treatment outcomes were largely dependent on the clinician’s ability to demonstrate emotional flexibility and sensitivity towards patients. They did not however describe the context, the organisational support or training required to achieve this.

In contrast to a highly evolved body of knowledge in mental health, the personal impact of everyday work on FMH clinicians is relatively unknown. Clinicians work in challenging environments, which require them to balance therapeutic approaches with ensuring safety of patients and staff (Mason et al. 2008). The purpose of this paper is to report FMH clinicians attitudes and experiences with respect to FP.
METHOD

Design

This study examined the experiences of FMH clinicians and their attitudes toward the FP they were directly treating during a programme of rehabilitation. The research question was

*What are the unique rehabilitation issues during community transition for the FP as identified by clinicians?*

Given the scant amount of research in this area conducted in Australia, an explorative qualitative method was chosen (Tong *et al.* 2007; Patton 2002; Stebbins 2001).

Setting

A comprehensive FMH service based in Australia was chosen as the research site. The service provides clinical services to people with a mental illness and a history of offending. The service provides assessment, treatment and management of FP, provided by a full complement of health care disciplines.
Participants

Purposive sampling was undertaken to source 27 participants comprising 21 inpatient and 6 community-based clinicians. All disciplines were included; namely, three medical staff (including psychiatrists), and nine allied health clinicians (psychologists, social workers, occupations therapists and personal care officers). The largest professional group, 15 mental health nurses, was indicative of the workforce. There were 12 men and 15 women whose experience in FMH ranged from one year to 35 years.

Procedure

Participants responded to advertisements placed in the staffrooms of the forensic inpatient and community based services by contacting the researcher. Three focus groups were conducted (two for inpatient FMH clinicians and one for community-based clinicians). All staff members who responded to the advertisement were included in the focus groups. Focus groups were chosen so that in-depth discussions could take place and be strengthened by the multidisciplinary views.

All participants were offered an individual interview and six clinicians took up this opportunity. Their rationale was either they felt they had more to say following the conclusion of the focus group or they had concerns about confidentially. All interviews and focus groups took an average of 1.5 hours.
Data analysis

Data were analysed using thematic analysis (Braun & Clarke 2006). Data analysis was an ongoing process from the first interview onwards. This method involved identifying the groups of meanings within the data until patterns began to emerge. These were further categorised into subthemes allowing for greater understanding of the data (Stebbins 2001). As analysis proceeded, concepts became more abstract and those relating to the same subthemes were grouped into higher-level themes (Braun & Clarke 2006). The final part of the research process involved the writing a description of the situation, and generation of new descriptions in response to new understandings about the situation being examined.

Ethics

Ethics approval was granted by the relevant service and university Human Research Ethics Committees. At all times the researchers considered the privacy, dignity, confidentiality and self-respect of the participants as the utmost priority and were considered at each stage of the research (Moore & Miller, 1999; WHO, 2013). Participants were advised that participation was voluntary and informed consent was secured. An experienced mental health nurse academic without links to the research was available to debrief participants if required. This was not requested.
Rigor

Rigor of the research was enhanced through early planning of the research design and attending to the development of rapport. Multidisciplinary triangulation, examination of official documents, participant checks and peer debriefing were used (Humble 2009). Accurate and thorough data collection was maintained throughout the research process combined with the use of peer debriefing, auditing of interviews and analysis by an independent researcher. All interviews were taped and transcribed verbatim (Bogdan & Biklen 1992; Hatch 2002). The views expressed during focus groups were compared and contrasted (triangulated) between the groups and with data collected from official documents. This enabled a comprehensive view of the situation under investigation (Burns & Grove 2009; Lincoln & Guba 1985). The initial responses to the concept of clinician adjustment elicited 15 subthemes. These were then condensed into the five major themes being orientation and adjustment to forensic mental health, vicarious trauma, therapeutic relationships, training, and clinical debriefing and clinical supervision.

FINDINGS

Orientation and adjustment to FMH

For some FMH clinicians moving into a security conscious environment was difficult and they required time to adjust. They reported feeling frustrated in
their roles and unsupported in making the transition to FMH. Two sets of obstacles were identified as the source of the frustration: those outside the organisation and those within the organisation. The external obstacles included the stigma of working in FMH and its negative impact on their professional reputation. This gave the clinician a sense that there may be no further professional life after FMH. Internal obstacles were the culture and leadership of the institution and the sense of feeling powerless to confront a system that they felt was inherently flawed. They expressed that they had been little relevant discussion of what to expect from the organisation and what was required of them (orientation) when commencing in FMH. They described that any professional guidance was self initiated.

Clinicians expressed conflict when working with FP who they perceived as being unwilling to work towards their release and some clinicians felt the FP should be more enthusiastic about living in the community. Some compared their own quality of life to those of the FP and felt that the lifestyle of a FP was much easier than someone who was working for a living and had not committed an offence.

They get a level of comfort where they have pretty much all they want to do - all day unescorted leave, going out all day, buzzing around the community, doing all sorts of stuff and coming back here for three meals a day, into a structured environment and they really adapt to that. They have no interest in moving into the community.
However, this view must be compared to the view held by other clinicians who compare aspects of their own lives with those experienced by some forensic patients.

Sometimes it’s the absolute...horror of the life stories that people come with and just how awful that is. How the feelings of guilt I suppose, about the fact you had this great life and all these opportunities and there are these other people who, it’s just been crap since the day they were born.

While this quote describes the clinician’s response to an aspect of the FP personal history it was the offence that made forensic mental health practice unique. Clinicians were required to develop skills (either personal qualities or professional competence) to deal with the offence and described little organisational leadership. They felt powerless in their ability to confront these barriers. One FMH clinician commented that

I think if you have the community view of the patients as the monster then you are going to be frightened because they are mysterious and how different am I from him?

The quote is indicative of FMH clinician’s response to the crime committed by the FP. It made the clinician consider their own ability to commit a similar crime. Another clinician supported this assertion with
I've worked in psychiatry ...for the last five years or something,...and I've never had this notion that I was any different from the patients, it's all in the human experience, it's just where on the spectrum you are... there but for the grace of God go I ... so I find it interesting that people don't have a concept that they are capable of [killing another].

For many clinicians working in FMH was the first time they met a person who had killed. Several clinicians recounted their own self-awareness that while they previously thought killing someone was outside of their own capability, after working in FMH, they realised that they would be able to kill another person. They felt unable to discuss them with their peers or family.

Clinicians also described the conflict of being required to be caring and compassionate toward someone who had committed a crime they found abhorrent. The following quote describes the response to a FP who had killed her children and the ambivalence experienced by FMH clinicians who were required to care for her.

The staff were falling over themselves to become understanding...Falling over to be kind and tolerant. Two things happened that were very interesting to me ... in the staff room of [the ward] you would hear “that .... bitch, how can any [parent] do that.” Of course, people would feel that. So where ... is this feeling? Then we had a female patient ...smashed her right on the face and flattened her... this [forensic patient] expressed the anger
and the outrage for everyone who has been so bloody kind … Everyone is over compensating. Oh, my god I can’t let her know that I think she is a bitch.

The clinician noted that there were no organisational systems in place to assist the individual clinician or the treating team to manage the emotional response an individual FP psychopathology or their offence.

**Vicarious traumatisation**

The patients’ crimes had a significant impact on the ongoing development of the therapeutic relationships between clinicians and forensic patients. Several clinicians stated that knowledge of the crimes contributed to the development of horrible images in their minds.

There are some of our people who...make the hairs on the back of your neck stand on end.

A small number of the clinicians interviewed described how they feared the shock of hearing the details of the crime.

So [the forensic patient] starts to describe oh there was blood all over the floor…. And I am building this picture and I went home and suddenly I
have got this damn picture in my head and it is bloody awful …I was moping around feeling like shit.

This clinician described wanting to be able to make connections with other clinicians so that he could debrief, discuss his feelings and his response to the forensic patient, but there were no mechanisms available. He described not being able to get the image out of his mind for several hours.

The image was really affecting me. What am I going to do with it?

Other clinicians described similar instances but they felt unable to informally or formally discuss these with colleagues. They described how this inability affected their ongoing work performance and impacted not only on their ability to interact with FP but also their respect for colleagues who had not acknowledged a change in their professional behaviour.

**Therapeutic relationship**

Clinicians described the lengthy period of custodial care as a barrier to therapeutic engagement. It is because of the length of the engagement that according to the clinicians the status of both the clinician and FP equalises and the clinician is no longer in a guaranteed position of power over the patient. Knowing the details of the crime may cause clinicians to maintain personal levels of caution with forensic patients, which hindered the development of
close therapeutic alliances and perhaps encouraged them to think of FP not as 
people but in terms of illness. Further, the length of engagement among FP 
themselves led to familiarity that may not be present in other clinical settings 
making confidentiality difficult to maintain because it became unclear what 
consent had been given to release information to other FP. This may account 
for some of the clinicians’ discomfort and avoidance of particular forensic 
patients.

We don't talk about patients - we are much more about mental state.

Clinicians felt some FP only received superficial attention meaningful 
interactions frequently avoided in an attempt to protect themselves from having 
disturbing images of the crime recurring well after any conversation had taken 
place. There was the fear that getting to know the FP at a deeper and personal 
level may result in a heightened sense of fear.

One of the interesting issues in [the] security issues training, [is] talk about 
this relational aspect of security and how relational security talks about 
knowing your patient and doesn’t just of course mean knowing who they 
are and what they did, but I mean really knowing the patient, really 
understand what it is that makes them tick. And it’s really getting into their 
mems, scary as that is.
The above quote describes the therapeutic relationship and its impact on security and predicting violent behaviour. Clinicians noted recent changes in what was expected of them. However, despite the expectation that they engage with FP on a closer level, supportive mechanisms aimed to assist clinicians remained scant.

**Training in forensic mental health**

Clinicians reflected that knowing the details of the crime caused them to be repulsed and fearful of their own safety. Their professional education (training) had not prepared them to deal with this knowledge at a personal level. This theme described instances where the victim had been a health care worker, a child or grossly mutilated, their response to the crime was worsened. They reported that they lacked the competence to counsel the FP if the crime was raised by the patient. As one FMH clinician described:

> Sometimes we don’t deal with the offence...you are told [by senior staff] not to talk about it.

The clinicians spoke about this theme in an emotive way. There were many explanations offered as reasons for issues not being discussed with the FP such as the crime or the forensic patient’s violence. The explanations for these issues being ‘overlooked’ or avoided during psychiatric treatment were the delicate nature of the topic, the fear of recreating the psychological
environment of the crime (unleashing the psychosis) and the fear that clinicians lacked the skills to deal with the patient’s behaviour. For some clinicians the fear had the ability to affect their role as therapeutic agents.

Staff feel unskilled themselves in dealing with the issues [of the crime].

At the same time, they came to realise that FP were people who, although they had killed, were not unlike themselves.Clinicians then realised that they were therefore capable of killing just like the FP.

I wonder too if there’s an element of personal, emotional, psychological safety. When you go home at the end of the day not having these images of ourselves, because if we know the exact detail about it all, we’ve got to deal with that which is pretty shitty.

They described how frightening it was to come to this level of self-awareness. It was put emphatically that forensic psychiatry needs to begin to train clinicians in managing vicarious traumatisation.

Clinicians expressed not only feeling unskilled but also fearful of what may happen if they encouraged the FP to discuss the crime.

Murderous rage is uncontainable. Someone you are with has enacted it and the person couldn’t contain that themselves and the act resulted. The
fear is that psychologically how do you contain someone who is putting their material on the table?

It was not only the consequence to the patient that was of concern to clinicians but the personal impact of hearing the details of a crime may have on them as clinicians. Clinicians spoke of FP and the need to be able to work with them over long periods, in many instances for several years. While clinicians were aware of the crime that had been committed, they may not have accessed the specifics of the crime, if indeed, it was recorded in detail in the medical record that was available.

Clinical debriefing and clinical supervision.

An integral part of many workplaces are the informal educative and supportive collegial discussions that take place. An organisational leader suggested to clinicians that informal professional networks, such as the discussions that occur in staffrooms, need to divert their attention from their current focus and to become supportive of clinicians and that this was not the responsibility of the employing agency but rather the responsibility of those who felt support was required. However, it was pointed out that these take time to develop and are often not open to newer clinicians. Further, several participants who were new to FMH were not prepared to discuss the emotional impact that interactions with FP had on them, as it may indicate limited suitability for their clinical roles and may jeopardise their employment. Further,
they were concerned how their colleagues would perceive their fears and were not prepared to risk their employment and professional respect.

While some attempts had been initiated by the organisation to provide clinical debriefing and clinical supervision (individual or group support aimed at exploring a particular situation or event) they had been offered to groups mostly (e.g. new graduates in preference to individuals). Under these circumstances, the clinical debriefings and clinical supervision had become irregular and had ceased.

They in fact wouldn’t go ...[clinical supervision] because they felt it was too touchy feely ...that was spilling your guts in front of their peers, that they didn’t want other people to know.

However, some clinicians expressed that clinical supervision could be offered differently e.g. individually to all staff and then it may address the issues they had identified as needing to be addressed such as debriefing about their own response to specific FP or the crime.

**DISCUSSION**

The major findings of this study have revealed that working in the FMH is different to mainstream mental health settings. Some of the most confronting issues were the phases that clinicians went through when working with forensic
patients. At times, some clinicians have found it too threatening to discuss their own responses to a patient’s crime with their peers and remained silent. The adjustment to working with FP instilled a sense of horror and fear (Jacob & Holmes 2011). In particular, there was no support for people who were trying to manage their own fear while trying to be therapeutic. These issues impacted on the clinicians’ ability to develop therapeutic relationships resulting in the clinicians preferring to have superficial interactions with forensic patients.

It has been recognised (Aiyegbusi 2009; Cashin et al. 2010; Holmes et al. 2006; Jacob & Holmes 2011; Jacob et al. 2009) that the crime significantly affects the nature of the therapeutic relationship. However, there has been no acknowledgment, guidance or support mechanisms offered to clinicians to assist them to cope with their own responses to the FP history of violence. Some patients’ histories provide not only a threat but also a thrill, being both disgusting and fascinating (Holmes et al. 2006). Particular individuals prompt greater emotional responses than others and are medically and socially described as being at risk (Holmes et al. 2006). Understandably, individual FP generated fear being experienced in different ways by the clinician, according to their own assessment of their dangerousness. However, these issues are not discussed in an open manner. This is particularly stressful for new clinicians.

Clinicians described that being seen as capable by their peers and managers took precedence over their fear of the crimes committed by FP. Consequentially, some clinicians, particularly new clinicians did not wish to
participate in informal methods of support such as collegial conversations and developed other methods of managing their anxiety such as creating distance. As a means of addressing this situation, Aiyegbusi (2009a) purported that for mental health nurses to have therapeutic alliances with FP they must explore their own feelings, thoughts and actions and develop self-awareness.

According to Holmes et al. (2006), nurses may feel the need to separate themselves both emotionally and in concrete ways such as having less face-to-face contact with patients to maintain their own subjectivity and integrity and retain the comfort of having a clean and ordered self-image as a nurse. The findings indicate that many FMH clinicians felt that they needed to maintain emotional distance from FP to maintain their own sense of safety and prevent their own vicarious trauma. As a means of avoiding further frightening self-awareness and therefore threats to the clinicians understanding of themselves Holmes et al. (2006) proposed that clinicians may not engage in the therapeutic relationship but maintain a level of emotional distance of safety that is therapeutic to the clinician.

Effective clinical supervision can assist clinicians to deal with situations where vicarious traumatisation may occur. Martin and Street (2003) emphasised that an integral role of the mental health nurse is to establish meaningful therapeutic relationships with patients. To achieve this they aver that mental health nurses must acknowledge and accept the effect of the patient’s offence on themselves and their ability to be therapeutic. Thorpe et al.
(2009) identified similar issues and recommended the use of clinical coaching as a method of addressing them. In the current culture of the institution, such practices were not wholly supported, particularly clinical supervision for experienced nursing staff.

Aiyegbusi (2009) stated that it is the clinician’s task to assist FP to recover their lives. Such a task requires a skilled and supported environment that encourages clinicians to achieve excellence in their work. Without systematic support, led by a programme of organisational governance, clinicians are unlikely to gain the competence or confidence in such work. They will continue to create a non-therapeutic distance from FP as a defence against their own anxiety (Cashin et al. 2010; Dale et al. 1995; Holmes et al. 2006; Jacob et al. 2009), protection from violence (Fisher 1995) and to manage their own feelings while trying to provide a caring environment (Dhondea 1995; Weikopf 2005).

Clinicians felt that the organisation would regard their fear as an indication that they allowed the patients’ crimes to dominate therapeutic relationships and that this indicated a misfit between the clinician and the clinical setting. They felt that the organisation would ask them to reconsider their career choice.
Limitations

A limitation of the study is that it took place in one forensic setting and may therefore describe the experiences of working only in that FMH setting in Australia. If the study were repeated in another FMH setting, it may or may not produce different results. However, given the paucity of research in this area it provides an important beginning point to further consider these important issues.

CONCLUSION AND RECOMMENDATIONS

The data revealed that while some FMH clinicians felt that there was a very strong and positive aspect to the therapeutic relationship within FMH this did not paint the whole picture. Most clinicians spoke of a lack of service support and the fear of unleashing patients’ psychoses. They felt that these two issues significantly influenced their approach to their work. They reported that there was little assistance given to making the transition to working in FMH and found that they were concerned at revealing their own response towards FP because they feared being seen as unsuitable for the role.

FMH must begin to use strategies to develop and support the professional skills of clinicians, including providing clinical supervision, team support, improving communication, and enhancing the functioning of multidisciplinary teams. These strategies may include developing practices that
increase the awareness clinical debriefing. This knowledge is not widely reported in forensic mental health literature but is accepted in mainstream settings. One of the central issues that must be recognised is that working with FP is a unique area with specific training needs.

The relationship between FMH clinicians and FP are very important to both individuals. Both invest significant time and emotional energy with the one person’s being accountable for the outcome. FMH clinicians cannot operate at highly skilled levels, however, without the support of teams and governing bodies assisting them. These supports are essential to maintaining a healthy and effectual functioning clinician and operating without them is beyond human expectation. To ask an individual to continually hear, see and be able to empathise with another individual’s painful experience is unrealistic.
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