'I'm not you know an aid worker….I'm there to apply the law.' Clinical negligence solicitors' experience of their work: An Interpretative Phenomenological Analysis

Thesis submitted for the degree of

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by

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Declaration

The research reported is my own and has not been submitted for any other academic award.

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Sarah Lawson

Thesis Abstract

Title: 'I'm not you know an aid worker….I'm there to apply the law'. Clinical negligence solicitors' experience of their work: An Interpretative Phenomenological Analysis.

Author: Sarah Lawson

Section One: Literature Review

Professionals working with traumatized clients may be adversely affected through their work. A systematic review of the quantitative literature of the evidence of distress in legal professionals was conducted. Eight articles met the inclusion criteria, reporting varying levels of distress. The review highlighted a dearth of rigorously conducted research in this area. Although tentative, the findings suggest that legal professionals are at risk of experiencing adverse psychological effects due to their work with potentially traumatised individuals. The implications of the findings emphasise a need for caution in interpretation, a coherent understanding of traumatogenesis, and better application of standardised tools to assess both psychological distress and any enduring psychological detriment. Findings also suggest a need for greater awareness of inadvertent distress arising via work in legal professionals and improved rigour in both conceptualisation of distress and its assessment.

Section Two: Research Report

The research report investigated clinical negligence solicitors' experience of working with clients, using interpretative phenomenological analysis to interrogate interview data from five participants. Emergent themes comprised; anxiety about their own and their family's health, threat and cynicism about the health system, and balancing the benefits and dis-benefits of their work. Participants also reported a conflict between their roles as a solicitor and offering clients emotional support. Legal professionals in the study disclosed pervasive issues relating to heightened affect and emotional containment, consistent with aspects of trauma and health anxiety. Recommendations are made regarding support and its delivery utilising clinical psychologists' skills in consultancy.

Section Three: Critical Appraisal

The critical appraisal provides reflections on the overall research process, as well as areas of learning and development that are pertinent to the author. These include; reflections of methodological issues, considerations of being a qualitative researcher and a critique of the limitations of the study.

Acknowledgments

I would like to thank all of the participants who agreed to take part in this study. I would also like to thank Dr Noelle Robertson for her time, expertise and encouragement throughout the process of completing this research project.

Thank you to my partner Pierre, for all his love, support and patience and for always believing I could do it.

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Section One: Literature Review

Psychological Distress in the Legal Profession: A Systematic Review of the Literature

Literature Review Abstract

Title: Psychological Distress in the Legal Profession: A Systematic Review of the Literature.

Author: Sarah Lawson

Increasingly, clinical and research studies suggest that indirect exposure to trauma can cause adverse psychological effects. Such effects have been conceptualised variously using terms such as burnout, compassion fatigue, secondary trauma and vicarious trauma; to encompass distress. Whilst health and social care professional exposure have been most studied, and the effects of psychological morbidity documented, there is growing research revealing those employed in non-therapeutic contexts may be similarly afflicted. Research is broadening to examine professionals whose work exposes them to trauma, violence and personal injury through the legal process.

The current review thus systematically assessed quantitative literature reporting distress and its extent in legal professionals. Eight studies were identified through systematically searching psychological and legal databases. All reported varying levels of distress. Findings were neither clear nor consistent and methodological weaknesses were common to all studies. Despite these limitations, the review found evidence indicative of mild to moderate symptoms of distress, and medium to high levels of reported burnout in legal professionals. The implications of the findings emphasise a need for caution in interpretation, a coherent understanding of traumatogenesis, and better application of standardised tools to assess both psychological distress and any enduring psychological detriment. Findings also suggest a need for greater awareness of inadvertent distress arising via work in legal professionals and improved rigour in both conceptualisation of distress and its assessment.

Introduction

Background

The psychological effects of direct exposure to a traumatic event have been extensively documented and researched since Post Traumatic Stress Disorder (PTSD) was first defined in the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed., *DSM- III*; American Psychiatric Association [APA], 1980). PTSD is defined as a serious mental health condition following, 'an individual experiencing, witnessing or being confronted with a traumatic event/s that involved actual death or threatened death or serious injury; or a threat to the physical integrity of himself or herself or others' (*DSM-IV-TR,* 4th ed., text rev.; APA, 2000). According to the *DSM – IV-TR* (4th ed., text rev.; APA, 2000) , the lifetime prevalence for PTSD ranges from 1% to 14%, with variability of prevalence data attributable to research and assessment methods employed, and the population sampled (Kessler, Sonnega, Bromet, Hughes, Nelson, 1995).

Over the past two decades, in clinical and research fields, there has been a growing awareness that it is not only those who directly experience trauma who are adversely affected (Sabin-Farrell & Turpin, 2003). By broadening the diagnostic criteria for PTSD, together with greater exploration of the phenomenology of traumatisation, it has revealed that indirect exposure to trauma also brings risk of significant emotional, cognitive and behavioural changes (McCann & Pearlman, 1990). Increasingly this has suggested that professionals, who work with clients who are traumatised may, through their work, inadvertently develop psychological symptoms.

Conceptual Understanding

As the understanding of distress experienced by professionals, as a consequence of work has grown, so too has the evolution of concepts to describe the phenomena.

Early research, revealing and explaining staff reactions and distress focused on burnout, the 'state of physical, emotional and mental exhaustion' resulting from lengthy exposure to 'emotionally demanding situations' (Pines & Aronson, 1988, p9). This has been extensively reported in diverse professional groups who have weighty human service responsibilities (e.g. Watts & Robertson, 2011; Keidel, 2002; Payne, 2001), and is characterised by three key elements; increased cynicism, decreased personal accomplishment and emotional exhaustion (Maslach & Jackson, 1981), of which the latter appears key (Sexton, 1999). Burnout is considered to be insidious in onset with a presentation that shows little overlap with symptoms of trauma.

By contrast, Figley (1995) coined the term Compassion Fatigue (CF) to encompass the range of emotional responses that develop following therapeutic work with trauma victims. It is a phenomenon frequently indistinguishable from Secondary Traumatic Stress (STS), the latter describing similar reactions, yet being used more directly to describe a trauma response (with symptoms more explicitly allied to the PTSD core elements of arousal, avoidance and intrusion). Common to both CF and STS is an emphasis on how quickly professional distress may arise as a consequence of exposure to others' trauma and empathic engagement (Kassam-Adams, 1999). To this extent they share similarities with another concept; Vicarious Traumatisation (VT), coined by McCann and Pearlman (1990), which also describes distress from indirect exposure to trauma. However, it is argued that those who experience VT go on to experience more profound cognitive changes through their internalisation of a client's intense distress, to the extent that their core schemas regarding identity, safety, dependency and agency are transformed, increasing the professionals' sense of vulnerability (McCann & Pearlman, 1990; Black & Weinreich, 2001).

In the research to date, these terms have been variously applied, with their use often a matter of researcher preference rather than phenomenological distinctiveness. Debate continues regarding the precision and validity of the constructs (Elwood, Mott, Lohr & Galovski, 2011), with empirical evidence suggesting that support for VT particularly, is incomplete and contradictory (Sabin-Farrell & Turpin, 2003). However, some refinement in these concepts is emerging, not least with the argument that whilst CF is likely to be evidenced in helping professionals only, STS and VT can arise in more diverse staff groups whose roles do not overtly embrace care (Elwood, Mott, Lohr & Galovski, 2011). This review will privilege secondary trauma/traumatisation as the term to encompass symptoms of distress akin to PTSD in professionals, given that this has been the preferred term found in most recent reviews (Elwood, Mott, Lohr & Galovski, 2011; Beck, 2011).

Professional Distress

Despite the caveats remaining about terminology used to describe professional distress, a growing body of research over the past two decades has demonstrated that clinicians who provide therapy or more general support to trauma survivors can develop physical, emotional and cognitive symptoms indicative of STS. This has been reported for professionals working with diverse client populations including survivors of sexual violence (Schauben & Frazier, 1995); disasters (Eidelson, D'Alessio & Eidelson, 2003); war zones (Kenny & Hull, 2008) and life-threatening illnesses (Sinclair & Hamill, 2007). Examination of the prevalence of symptoms in clinicians providing dedicated trauma services has shown substantial variation in reported severity (Elwood, Mott, Lohr & Galovski, 2011), though up to 50% of clinicians treating traumatised clients have reported trauma symptoms that are clinically significant (Way, VanDeusen, Martin, Applegate & Jandle, 2004).

Whilst prevalence data is less extensive for other professionals who may be exposed to traumatised clients, it is growing. Systematic review data has revealed a noticeable impact on nursing staff across specialities (Beck, 2011). Comprising of seven studies, reported rates of STS range from 25% in forensic nurses to 78% in nursing staff working in hospice settings. Findings echo Robertson and Perry (2010), who found the levels of PTSD symptomatology in institutionally-based, non-emergency health care workers to be equivalent to those reported for emergency personnel, with typical rates between 10-20%.

Predictor Variables

In addition to examining the extent of STS via prevalence data, research has sought to elicit risk factors for STS as well as factors which might mitigate professional distress. In Figley's (1995) early definition, four risk factors for STS were articulated: professionals' empathic engagement with the client, previous trauma history, unresolved trauma history, (potentially activated by client narratives echoing their own experience), and client narratives focusing on child trauma. Saakvitne and Pearlman (1996) broadened these individual factors (which they noted as gender, age and empathic engagement) to include organisational factors (such as stressfulness and size of caseload, lack of training/social support) and life situation factors (current stressful life events).

However, the structures underpinning work and the organisational contexts are not the sole contributors to distress. Figley (1995) brought to prominence the process of caring, 'There is a cost to caring. Professionals who listen to clients' stories of fear, pain and suffering may feel similar fear, pain and suffering because they care' (Figley, 1995). Empathy is seen as crucial to working with traumatised people and has been

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identified as an important risk factor in developing STS. Protective factors have also been identified, these include: amount of training and use of available support, such as supervision, organisational support and social support (Jenkins & Elliott, 2004; Lerias & Byrne, 2003).

Professionals operating in legal contexts

A focus on phenomenology and predictors has latterly been accompanied by an increasing consideration of those employed in non-therapeutic contexts who confront trauma, violence and personal injury. Early proponents of vicarious distress suggested a need to include other professional groups such as police officers, prison staff and judges (Saakvitne & Pearlman, 1996), due to the nature of their work, which puts these groups at risk of distress.

Police officers undertaking roles in which they may experience violence, abuse, suffering and witness death and its aftermath, have been most scrutinised, with evidence of levels of psychological morbidity and PTSD symptoms exceeding mental health professionals (Alexander & Klein, 2009; Follette, Polusny & Milbeck, 1994). O'Toole, Vitello and Palmer (2003) conducted a study to examine stress using a nationwide sample of Police agencies and explored why individual policemen had left the organisation. They found three distinct themes; physical threats while on duty, a general lack of support as well as pressures caused by the organisation. Police officers also viewed the judiciary as being too lenient on the sentencing of offenders and found the public's opinion of the Police and their performance as being a critical factor.

In a study of 23 prosecutors (Gomme & Hall, 1995), who were working with cases involving domestic violence, high caseloads were found to be predictive of secondary trauma symptoms. Even those performing a routine civic duty, such as jury

service, were reported to have suffered symptoms of STS as a result of graphic evidence presented in court, with no subsequent option to discussion (Ogloff & Chopra, 2001; Robertson, Davies & Nettleingham, 2009).

Legal professionals' risk of secondary trauma

Legal professionals are a body of individuals qualified to practice law. The term 'lawyer' is used broadly within the UK, incorporating professionals trained in law such as; barristers, solicitors, legal executives; as well as those who may not practice on behalf of clients but adopt an adjudicatory function, such as judges, or support legal processes, such as court clerks.

Legal professionals may typically not be seen as an at risk group for developing secondary trauma, given that they may not appear to be explicitly working therapeutically with traumatised clients. However, the focus of legal case-work may well involve trauma description and narratives, and traumatised clients. Client work may expose legal professionals to crimes that have been committed against a person, such as domestic abuse, violence, murder, rape, child abuse, divorce and mental illness. As part of their routine work, legal professionals may be exposed to graphic medical evidence, tape recordings of emergency service calls, photographs and videotapes of injuries, victim impact statements, victim testimony in court, and statements from family members, all of which may be highly emotionally charged. They are often required to record the minutiae of a client's traumatic experience in interviews, and repeatedly engage with this as a client moves through the legal process, often spending long periods of time with distressed clients/family members.

Relationships with clients may well be lengthy, and involve witnessing the extensive long term impact of distress, such as life changing events in the client's

family and work life (Murray & Royer, 2004). Yet, legal professionals are encouraged to remain emotionally detached from the cases they hold and manage. This detachment, it is thought to allow them to employ dispassionate judgment and enable them to provide independent advice.

Clearly, the role of a legal professional is one that shares many characteristics with other 'helping' professionals that have been recognised as at risk of developing STS, yet the profession itself also carries its own distinct risk factors; the legal training, for instance, does not prepare or offer support to professionals dealing with the emotional impact of working with clients. Research has identified that the lack of training and emotional support given to lawyers working with traumatised clients is an associated factor leading to STS and burnout (Sagy, 2006). Organisational and role-culture factors within the professional application of the law are also likely to contribute to the development of distress in legal professionals; such professionals, for instance, are seen as unlikely to share their personal distress or trauma with other colleagues for fear it would be perceived as a sign of weakness. This, in conjunction with high caseloads, the lack of support from colleagues and an excessive administrative burden are arguably contributory factors in the development of STS (Osofsky, Putnam & Lederman, 2008).

Implications in the legal profession

Whilst some effects of exposure to traumatic material are recognised as inevitable if distress is unrecognised or unmanaged, then personal and professional consequences can be substantial. Individuals affected may be compromised at work, providing sub-optimal professional care, withdrawing from potential offers of social support and experiencing disillusionment in their chosen career (Chamberlain & Miller,

2008). Professionals affected by STS are more likely to be at a higher risk of making poor professional judgements than those professionals who are not affected (Collins & Long, 2003). Given the centrality of decision making and judgement, when implementing and enacting the law, the presence of STS in those legal professionals would have major implications. In extreme cases, such professionals may experience lengthy periods of absence and may even leave their profession altogether.

Current Review

The purpose of this research is to systematically review existing published literature, which has attempted to quantify the distress reported by legal professionals, as a consequence of the work they undertake.

The term 'distress' was chosen as a key parameter since preliminary assessment of research in the area revealed the research to be limited, there was also a lack of homogeneity and consensus to describe the impact of exposure to trauma via work. Given the aforementioned confusion over terms and concepts used to describe the effects of working with traumatised clients, and a continued lack of specificity, the term 'distress' was selected to ensure that a breadth of literature was accessed.

Distress is defined in the literature as a unique, discomforting, emotional state, experienced by an individual in response to a specific stressor or demand, which results in harm, and can either be temporary or permanent to the person (Ridner, 2004). This review will use the term 'distress' to encompass terms used within the literature such as 'secondary traumatic stress,' 'burnout', 'vicarious trauma' and 'compassion fatigue'.

Aims/Key Questions

Two key questions guide the review: What evidence is there of distress in the legal profession arising from their work? What factors appear to predict distress?

Method

A systematic review was conducted of published literature looking for evidence of distress in legal professionals. Initially, an electronic search was conducted embracing sensitivity (incorporating the breadth of phenomena constituting distress), yet sufficiently specific to capture a psychosocial descriptor such as distress. To that end the following databases were interrogated; PsychINFO, PILOTS, Pubmed, ISI Web of Science, WestLaw, Business Source Premier and Criminal Justice Abstracts. Legal databases were used in order to encompass relevant literature from the legal field. References from selected articles and reviews were searched by hand to ensure additional relevant articles were included, as well as using general search engines, such as Google and Google scholar. Searches were carried out by the principal investigator in October/November 2011 and again in April 2012. A broad range of search terms was used to encompass distress (burnout, secondary traumatic stress, secondary trauma, compassion fatigue, vicarious traumatisation, PTSD), and these were combined with legal professional terms (solicitors, lawyers, attorneys, barristers, judges, legal). All search terms were applied to 'topic', 'title' and 'abstract'. Truncations were used to ensure maximum search effectiveness. Initial searching revealed a circumscribed amount of research available, thus no restrictions on the date were set.

Studies were reviewed and examined for relevance and then short-listed using the inclusion and exclusion criteria described below. To be included in the review studies needed to meet all the inclusion criteria and not meet any exclusion criteria.

The following inclusion criteria were applied:

1)   Studies reported in English language;

2)   Published, empirical peer reviewed articles;

3)   Studies using quantitative methodology.

The following exclusion criteria were applied:

1) Studies on police officers/law enforcement workers (since this group have been reviewed);

2) Studies in which data was not specifically recorded/analysed for legal professionals;

3) Theses/dissertations/conference papers;

4) Intervention studies.

A PRISMA flowchart (Moher, Liberati, Tetzlaff & Altman, 2009), figure 1, illustrates the article selection process (Appendix A). Electronic and hand searching article references identified 216 articles. Initial screening eliminated 167 abstracts. Forty one articles failed to meet inclusion criteria and were then rejected; leaving eight papers that formed the basis of the review.

Accepted studies were then scrutinised and details and findings summarised via the data extraction form (see Appendix B). The form was devised by the researcher, informed by guidelines on conducting systematic reviews from the Evidence for Policy and Practice Information and Co-ordinating Centre's (EPPI) review guidelines (EPPI: Conducting Systematic Reviews, 2007). This permitted systematic scrutiny of included studies using a set of predetermined questions covering: (i) general descriptive information; (ii) results; and (iii) information on research methods to allow quality and relevance assessments.

Quality and relevance assessment

A critical review of each article was undertaken by both the principal investigator and research supervisor. Gough's (2007) weight of evidence scale was applied to assess study quality. This assisted in assessing internal and external validity during methodological quality assessment of the selected studies. The process involved assessing each article on the following criteria:

A)   Methodological quality - the trustworthiness of the results

B)   Methodological relevance – the appropriateness of the use of the study design

C)   Topic relevance – the appropriateness of the research focus for answering the literature review question

D)   Overall weight of evidence - based on the assessments made for each of the above criteria (combination of A-C judgements)

Each study was assigned a quality rating, 'good', 'fair', 'poor' (see table 1). These appraisal findings were used to assist judging the overall quality of the research papers and the relevance of the research in answering the research question. This tool was used to determine how much 'weight of evidence' should be given to a research study in answering the review question.

<div align="center">Results</div>

Characteristics of the studies

Eight quantitative studies were found in which distress (variously defined) was examined in legal professionals. Distress was operationalised using the following terms;

secondary trauma, burnout, vicarious trauma, and emotional well-being. Different

measures were used to assess these phenomena, often not consonant with the

operationalised term. This diversity precludes comprehensive comparative analysis and

synthesis given the lack of conceptual uniformity. These issues will be discussed in

more detail, later in the review.

The main characteristics of the identified studies are summarised in Table 1. All

studies were cross-sectional in design, and assessment of distress was achieved through

self-report questionnaires. One study (Levin & Greisberg, 2003) was supplemented

with qualitative evidence; a short written account from a participant. There was some

diversity in legal professionals examined: five of the studies examined lawyers, two

assessed judges and one assessed public procurators. Procurators work in the

inquisitorial system of law, as opposed to the adversarial system, and are involved in

both the investigation and prosecution of a crime.

Author / Year	Country	Profession of Authors	Aim	Sample/ Sample size	Design / Measures administered	Analysis	Results	Gough's overall quality
Levin & Greisberg (2003)	USA	Psychiatrist	To assess the presence of secondary trauma symptoms of burnout in attorneys working with victims of domestic violence	Attorneys/ mental health professionals/ social service workers. Similar age/ experience/ mostly female n=not recorded	Survey Design Questionnaires: STQ*, Items assessing burnout adapted from Figley Recorded: number of trauma clients encountered in last year/personal history of trauma/history of treatment	No stats reported	Attorneys experienced more symptoms of burnout/secondary trauma compared to both groups. Higher on subscales of secondary trauma. Increased client load predicted higher scores on secondary trauma and burnout	Poor
Vrklevski & Franklin (2008)	Australia	Psychologist	To investigate the impact of working with traumatised clients and their traumatic material on members of the legal profession.	50 criminal lawyers / 50 non-criminal lawyers Female (64%), Anglo-Saxons (73%), mean age 39.7 yrs. n=100	Survey Design Demographic questionnaire Standardised measures: *VTS, DASS, IES-R, TABS	T – test Mann-Whitney	Criminal lawyers reported sig. higher levels of subjective distress and VT, depression, stress and cog. changes in relation to self-safety, other safety and intimacy. Mean scores for both groups IES-R subclinical range.	Fair

Author / Year	Country	Profession of Authors	Aim	Sample/ Sample size	Design / Measures administered	Analysis	Results	Gough's overall quality
Jaffe et al. (2003)	Canada	Psychiatrist / Judge	Investigation into the types of vicarious trauma (VT) symptoms that judges experience over time.	Criminal Judges (81%) Males (54.35) Females (45.7%), Average age = 51 yrs. Average years' experience = 10yrs. N= 105	Survey Design Questionnaire distributed at a workshop- after attending presentation on stress, burnout, VT. Non-standardised measure-asked open ended questions about short/long term impact of their job, coping skills/prevention.	Symptoms recorded & coded into 39 categories. Grouped into symptom factors. No further info provided	Short term symptoms: sleep disturbance, intolerance of others, physical complaints. Long term symptoms: sleep disturbance, depression, sense of isolation. 63% judges reported 1+ symptom identified as work related VT, greater number reported by females/ more experienced judges.	Poor
Lustig et al., (2008)	USA	Psychiatrist	To investigate whether immigration judges suffer from secondary trauma	Immigration judges (IJ) 43% male, 57% female. Average age= 53yrs Average years' experience= 10yrs N= 96 (45.3% response rate)	Standardised questionnaires: STSS, CBI*	Percentage and Mean scores given	Females reported significantly more stress and burnout than males. Comparisons made with other professionals (hospital/prison staff) using same measures; IJ experiencing more burnout	Poor

Author / Year	Country	Profession of Authors	Aim	Sample/ Sample size	Design / Measures administered	Analysis	Results	Gough's overall quality
Jackson, Turner & Brief (1987)	USA	Business management researchers	To identify organisational conditions associated with employee burnout in public service lawyers	Public service lawyers N=391	Survey design Standardised measures to assess: 3 components of burnout (adapted from MBI) perceptions of job conditions, organisational commitment	Hierarchical Multiple Regression	Emotional exhaustion most strongly associated with role conflict and high work load. Burnout sig. related to organisational commitment.	Poor
Piwowarc zyk et al. (2009)	USA	Psychiatrist	To explore the impact of asylum lawyers work with trauma survivors on their emotional wellbeing	Asylum lawyers 60% male, Average years experience= 6yrs N= 57	Standardised questionnaire: Secondary Trauma Scale, Life Events Checklist	Not described	87% of sample had 2 or more symptoms of STS Number of hours worked per week were associated with symptoms of ST	Poor

Author / Year	Country	Profession of Authors	Aim	Sample/ Sample size	Design / Measures administered	Analysis	Results	Gough's overall quality
Tsai & Chan (2009)	Taiwan	Occupational medicine	To examine the association between occupational stress & burnout among judges and procurators	N= 211 (87 judges/98 procurators) Average age= 36.8yrs Years of experience= 8.5 yrs	Standardised Questionnaire: Chinese version: Job content questionnaire/effort and reward imbalance questionnaire/ Copenhagen burnout Inventory	Logistic Regression to determine the association between burnout and occupational stress	Judges at higher risk of client burnout than procurators Low work social support –sig associated with client related burnout	Fair
Tsai, Huang & Chan (2009)	Taiwan	Occupational medicine	To explore the associations between burnout & occupational stress amongst lawyers	N=180 lawyers	Chinese version : Karaseks job content questionnaire/Siegrusts ERI questionnaire (occupational stress) Copenhagen Burnout Inventory	Logistic Regression	High occupational stress-associated with high levels of personal and work related burnout Litigious lawyers-higher risk of developing client	Fair

Summary of key study characteristics

Sample

Sample size of respondents varied considerably, from 57 asylum lawyers (Piwowarczyk et al., 2009) to 391 public service lawyers (Jackson, Turner & Brief, 1987). Sample size was not reported in Levin and Greisberg (2003) and in none of the studies was an *a priori* power calculation reported. This absence of effect size calculation indicates that comments and conclusions regarding generalisations and significance should be examined with caution.

All studies, except Jackson, Turner and Brief (1987), included samples of both males and females. Where gender was reported, all included a higher percentage of males than females, with the exception of the Vrklevski and Franklin (2008) study in which 64% of their sample was female. This is consistent with the gender demographic within the legal profession, with 75% of partners in law firms being male (Sommerland Webley, Duff, Muzio, & Tomlinson, 2010). Again, conclusions drawn must be tentative and treated with caution. Studies in which gender split was articulated, and which explicitly compared impacts on men and women, found the latter consistently reported higher levels of distress. However, it is unclear what weight should be given to this, since typically women report higher levels of distress in other professions (Kassam-Adams, 1999).

In only one study (Lustig et al., 2008) was a response rate noted (at 45.3%) making assessment of representativeness difficult. It is possible that the research may bias distress presentation due to the "healthy worker effect," in that those suffering from distress leave their job with distress undetected (Guidotti, 1995), or that prevalence rates are inflated due to symptomatic workers more willing to participate in research.

In assessing professional distress, factors such as minimisation or exaggeration, lack of insight or denial of difficulties, have been previously noted (Beck, 2011). Studies also utilised self-report and this raises the possibility of a self-selection bias, questioning both the representativeness and the general nature of the findings. Priming may also have been present. Jaffe, Crooks, Dunford-Jackson and Town (2003) asked respondents to complete their questionnaire following a workshop presentation on stress and burnout. By attending the workshop the participants may have been informed about symptoms of which they were previously unaware. From the information provided in the methodologies this did not appear to be the case for any other study.

Procedure

Cross-sectional design was employed in all of the studies. The majority of studies described data solely from their sample, with two studies comparing data with another sample. Vrklevski and Franklin (2008) compared criminal lawyers with non-criminal lawyers on measures of VT. Levin and Greisberg (2003) compared their group of lawyers with social service workers and mental health professionals. Others made comparisons with available normative data (Tsai & Chan, 2009; Tsai, Huang & Chan, 2009).

Measures

Within the studies the following terms have been utilised to explore the effects of distress on legal professionals; secondary trauma, vicarious trauma and burnout. Seven of the eight studies used standardised measures. The only study not using standardised questionnaires asked open-ended questions to judges about STS and symptoms of burnout, which they then categorised (Jaffe et al., 2003). Those using standardised measures of STS applied a variety of tools; Secondary Traumatic Stress

Scale (STSS) (Lustig et al., 2008), Secondary Trauma Questionnaire (STQ) (Levin & Greisberg, 2003) and the Secondary Trauma Scale (Piwowarczyk et al., 2009). Measurements of VT were assessed using Impact of Event Scale-Revised, (IES-R), Vicarious Trauma Scale (VTS), and the Trauma and Attachment and Belief Scale (TABS) (Vrklevski & Franklin, 2008). Where burnout was measured, the Maslach Burnout Inventory (MBI) and the Copenhagen Burnout Inventory (CBI) were utilised.

Two studies (Tsai & Chan, 2009; Tsai, Huang & Chan, 2009) chose to use the Chinese version of the CBI (C-CBI) which has been validated for the Chinese language (Yeh, Cheng, Chen, Hu & Kristensen, 2007) and is shown to have a high internal consistency. However, the 'personal burnout' and 'work burnout' subscales are shown to be highly correlated, and measures of physical and psychological exhaustion share overlapping concepts. This may be due to cultural differences in the expression of personal distress. Research has shown that in Chinese culture people tend to express their personal distress with somatic problems (Mak & Zane, 2004). Differences in expression of burnout should therefore, be considered, especially when comparing studies cross-culturally. Furthermore, alterations to measures were noted in Levin and Greisberg's (2003) study that assessed burnout with items adapted from Figley (1995). The authors make no comment in this review regarding altered validity and it is, therefore, difficult to comment on the psychometric robustness of the tool as used.

The adequacy of the measurement of factors thought to predict experience of the construct also needs to be examined. The use of standardised questionnaires, which measure the concept of STS/VT, is open to criticism, given the inability to assess the concept as a whole (Sabin-Farrell & Turpin, 2003). This is further complicated by the terms being used inter-changeably. Levin and Greisberg (2003) state that they measure VT, yet they use three terms; VT, STS and burnout, and they use them interchangeably

throughout their paper. Similarly, Piwowarczyk et al., (2009) paper is entitled 'Secondary trauma in asylum lawyers' yet discusses many concepts of VT and describes this term in greater detail than the measure of STS. Lustig et al., (2008) chose to focus on STS and burnout and erroneously describes them as two closely related concepts.

In the papers that claim to measure VT, the assessment of disruption in beliefs, which is central to the definition, produced limited results. Cognitive changes were found to be significantly higher in criminal lawyers than non-criminal lawyers (Vrklevski & Franklin, 2008). The remaining studies failed to consider the concept of disruption in cognitions (Jaffe et al., 2003; Levin & Greisberg, 2003).

Empathy/Cynicism

Empathy has been identified as an important risk factor in developing STS (Figley, 1995). However, as a construct it appears to be inappropriately applied in two papers (Vrklevski & Franklin, 2008; Jaffe et al., 2003), being described as an important factor in the description of VT not STS. Whilst it is laudable that empathy has been acknowledged as a major factor contributing to distress (and this is absent in the other papers reviewed), neither paper uses a measure of empathy in their study. Given that empathy is discussed as a key mechanism but it is not measured, is an interesting flaw, this may suggest some confusion regarding an understanding of the phenomena, their definition, as well as methodological vulnerability.

Three papers (Levin & Greisberg, 2003; Piwowarczyk et al., 2009; Lustig et al., 2008) discuss, in their introduction, the importance of 'cynicism', as a result of working with distress, yet only Levin and Greisberg (2003) discuss this appropriately, that is, as a concept linked to the measure of 'burnout'; this is in contrast to Piwowarczyk et al.,

(2009), who discuss it as a defining element of VT. Lustig et al., (2008) describe cynicism as a symptom of stress and burnout. However, similar to the construct of 'empathy', no study explicitly measures the construct of 'cynicism', despite citing it as a consequence of VT/burnout.

Direct/indirect exposure

Questionnaires designed to measure the impact of indirect trauma may, instead, lead participants to respond in terms of their own traumatic experiences. For example, the IES-R, used in Vrklevski and Franklin's (2008) study to measure VT, was initially designed to assess PTSD in people who had been directly, not indirectly, exposed to trauma, and has not been validated on samples of secondary traumatised populations (Elwood, Mott, Lohr & Galovski, 2011). Conversely, the STSS differs from other instruments used to assess secondary trauma in that the items were created so that the traumatic stressor was described in terms of exposure to their clients' traumatic material.

Where measurements of indirect exposure have been used, it is not clear whether participants have been asked to rate clients with whom they currently work, or as a cumulative total of the number of clients with whom they have ever worked. This has implications both for the generalisation and comparability across studies. It also raises questions about the appropriate application of the concept measured, since STS is understood to be a relatively immediate and reactive response to client work, whereas VT is arguably more of an accumulative response. This question of conceptual clarity could be applied to all studies within the review.

Prevalence/Severity of Distress

All studies reviewed reported elevated levels of distress in legal professionals. Many presented levels of distress as being significant when compared to other occupational groups, but provided little information on the clinical significance of the distress within the measured sample.

Where data was specifically documented on levels of secondary trauma, participants generally endorsed low levels of distress, below clinical cut-offs for significant symptoms. Vrklevski and Franklin (2008) reported mean scores for both groups of lawyers (criminal/non-criminal) on all measures that were in the sub-clinical range. Only when the groups were compared with each other were significant levels found; the comparison showed that criminal lawyers reported significantly higher levels of subjective distress, VT, depression, stress and cognitive changes.

Piwowarczyk and colleagues' (2009) findings revealed that 87% of their sample reported two or more symptoms of secondary trauma. However, closer scrutiny of the data showed that 22% of the sample presented mild levels of secondary trauma, and 9% with moderate levels. Lustig's study (2008) reported mild to moderate secondary trauma symptoms amongst immigration judges. However, levels of burnout using the Copenhagen Burnout Inventory were found to be in the 'high' range for personal and work-related burnout. Conversely, high levels of client and personal burnout were reported in litigation lawyers (Tsai, Huang & Chan, 2009).

Findings are further muddied given the prominent measures of STS/VT to assess the presence of symptoms rather than assessing individuals functioning in role. In neither Vrklevski and Franklin (2008) nor Piwowarczyk and colleagues' (2009)

studies are measures of subjective distress utilised, which might provide proxy data for impairment. This is arguably a significant weakness.

Predictive Factors

The majority of studies identified one or two predictive factors of the type of distress they sought to measure. Previous trauma history and previous mental health treatment were reported (Levin & Greisberg, 2003; Vrklevski & Franklin, 2008). The number of hours worked per week was also significantly associated with symptoms of secondary trauma (Piwowarczyk et al., 2009) and longer work experience correlated highly with the number of reported symptoms (Jaffe et al., 2003), as did a high work load (Jackson, Turner & Brief, 1987). Although not discussed by these authors, it is possible that more experienced people have a higher work load and consequently work longer hours; so it is probable that these concepts are related. However, no such analysis was offered. Finally, impoverished social support and high occupational stress were significantly associated with burnout (Tsai & Chan, 2009; Tsai, Huang & Chan, 2009).

Again, comparison of predictive factors across studies is precluded given the lack of conceptual consistency and multiple forms of measurement. The common finding that shows distress as predicted by high case load/years experience, should be treated with some caution. However, constant exposure to distressing or traumatic material may have adverse effects, if there are few strategies in place to buffer the impact. Interestingly, only one study (Vrklevski & Franklin, 2008) asked respondents what coping strategies they used to manage the distressing elements of the job. They found that 86% of their sample had sought professional assistance in coping with work-related distress. Further strategies included using peer/supervisory support.

Work-related characteristics

A number of factors may contribute to distress in legal professionals. These may be both personal and work-related and may interact with each other. It was difficult from the studies in this review to gauge whether the extent of distress could be attributed to the stressful nature of the legal work itself, or as a result of specific work with traumatised clients. Such analysis was not evidenced in the reviewed studies. However, where work stress was measured, findings from Tsai, Huang & Chan (2009), Tsai & Chan (2010), and Lustig et al., (2008), show that measures of burnout on personal, professional and client stress differ slightly. The findings all show 'high' levels of burnout on personal and work measures compared to 'medium' levels of client burnout, suggesting that work and personal stress have more impact on the individual than client stress. However, work and personal stress could be attributed to the stressful nature of client work; therefore, further work is needed to determine the nature of the relationships and the possible interactions between these factors.

All papers were appraised for quality and study relevance using Gough's (2007) weight of evidence scale. Five studies were judged to have a 'poor' overall rating of weight of evidence and three were given a 'fair' rating. These ratings highlight the lack of methodological quality and relevance of the research focus at answering the review question. Whilst the research does provide some evidence of distress in legal professionals, the overall 'weight of evidence' of the papers within this review is not strong and caution has been applied when interpreting the results. This highlights the need for high quality and methodologically sound research within this area before conclusions can be drawn.

Discussion

Consideration of the current research echoes previous conclusions (Sabin-Farrel & Turpin, 2003; Elwood et al., 2011), in that the findings are neither clear nor consistent. Due to the dearth of prospective studies exploring the impact on professionals throughout their legal careers, the findings need to be treated with some caution. In addition, the effect of working with different types of trauma, with different clients, in different professional roles, all requires further investigation. However, this does not preclude the research already available, which evidences levels of distress in the legal profession and highlights the need for further exploration and analysis.

This review identified eight studies that assessed psychological distress in legal professionals. Of the five studies that explicitly examined secondary trauma, varying levels of distress were found. Vrklevski and Franklin (2008) indicated mean scores on all measures were in the sub-clinical range. Piwowarczyk et al., (2009) in their analysis of the data showed that 22% of the sample showed 'mild' levels of secondary trauma and 9% showed 'moderate' levels. Lustig et al., (2008) found 'mild' to 'moderate' secondary trauma symptoms amongst immigration judges. Jaffe et al., (2003) found that 63% of judges reported one or more symptoms that they identified as work-related secondary trauma. Levin & Greisberg (2003) attorneys experienced more symptoms of secondary trauma compared with comparison groups.

Three studies used measures of burnout (Tsai & Chan, 2009; Tsai, Huang & Chan, 2009; Jackson, Turner & Brief, 1987) to assess distress. All showed 'high' levels of burnout on personal and work measures compared to 'medium' levels of client burnout.

Ranges in severity may be due, in part, to the different measures used across the studies, as well as with the construct validity of the measures used. Consistent with the

proposal that STS symptoms mirror those of PTSD, standard PTSD measures have been used in assessing STS. However, since many PTSD measures were initially designed to assess symptom severity with individuals who have been directly exposed to trauma, they have not been validated on samples of indirect exposure. Researchers have also questioned whether these measures are sensitive enough to detect secondary trauma (Kassam-Adams, 1999; Figley, 2004). The reported prevalence rates may, therefore, be minimised by the use of such measures.

The use of different measures in the studies also restricts the ability to make comparisons and draw conclusions. It is unclear from a number of the measures used whether they actually measure the concept they describe. For example, Vrklevski and Franklin (2008) used the IES and the TABS to investigate levels of VT in solicitors. However, both these measures have been shown to be more highly correlated to burnout and general psychological distress than to PTSD symptoms (Kadambi & Truscott, 2004). While correlations with burnout and general distress are related to secondary trauma, they are not specific to people working with traumatised clients. Sabin-Farrell & Turpin (2003) state that with the exception of the MBI, which was designed specifically to assess the concept of burnout, there is not yet one questionnaire which specifically measures VT/STS. This is complicated further due to the difficulties in the definitions and interchangeable terminology employed across studies. The findings therefore, provide neither clarity nor consensus, and substantially better research studies are warranted.

A review by Mounteer (2004), states that due to high rates of job dissatisfaction and burnout, lawyers are four times more likely than the general population to experience depression. A survey conducted by the American Bar Association (2000), found that 44% of lawyers surveyed stated that they would not recommend a career in

the legal profession to younger individuals; it was also reported that, on average, law firms lose approximately 20% of their associates every year. Although it does not state where people move to, having left their current job, it could be assumed that with such high rates of depression and dissatisfaction, a large percentage leave the profession altogether.

The research provided in this review suggested a lack of social support networks as a predictive factor for experiencing distress. However, due to the dearth of data on coping strategies and the lack of exploration into resilience, there is little information provided about how legal professionals cope. This review has highlighted a need for this.

Profession of researcher and diversity in legal system

The majority of the studies in this review were conducted by psychiatrists/ psychologists and were found in the social science rather than the legal databases. This may assume interest/perspectives that are psychosocial rather than legal, and it may highlight a lack of awareness, or acknowledgment of professional distress within the legal arena, as well as implications regarding the use of the findings. A greater understanding of the rationale for why these studies were undertaken would be beneficial.

The studies under review were from countries where an adversarial legal system is in place. Legal professionals have very different roles in the adversarial as opposed to the inquisitorial systems. The adversarial system expects loyalty and an arguably partisan engagement with a client, and only presents favourable evidence. The lawyer is there to protect their client, and judges/ jury have a more passive role as observers. In inquisitorial systems the judge's role in examining witnesses and arranging evidence is more active. It is clear that caution needs to be employed when generalising evidence

across different legal systems, since legal professionals have very different roles, and their respective experiences will be very different.

Similarly, just as the systems are diverse, the areas of legal work will also be very different. Legal professionals working in the area of asylum, where clients may be significantly traumatised, requires evidence to be prepared – this requires the legal professional to listen repeatedly to stories of abuse, torture and fear of persecution, and this may well invoke more distress. Further consideration also needs to be given to the various contexts, since not all legal professionals will work with traumatised clients; others will do so on a frequent basis. Comparisons with other professions would also improve this area.

Recommendations

As with other syntheses examining quantification of distress engendered by work, this current review emphasises the need for the development of standardised tools to assess both psychological distress and cognitive changes. Future research should attempt to assess the specific effects of working with traumatised clients and its association with other sources of work stress.

Whilst greater recognition from the legal field itself is needed in this area, further work focusing on the prevalence and severity of distress, and the exploration of resilience is also needed. Though preventative interventions, as highlighted in the literature, may benefit individuals at high risk of developing distress, it could have adverse effects on others. Interventions that encourage the awareness of emotional reactions, and provide education about the impact of their work, may actually lead to a self-fulfilling prophecy, and potentially bring about an increase in levels of distress. Conversely, if left with no form of intervention then this may leave legal professionals

feeling overwhelmed by unidentified emotions. Alerting the legal profession to protective factors, such as self-care, would be beneficial.

Due to the paucity of research within this professional group, further investigation is warranted before the implementation of preventative interventions. Further examination and clarification of the constructs and the measures are also required. Furthermore, clarification of normal and abnormal stress responses is needed, as well as an increased understanding of clinically significant distress.

Due to legal professionals not falling into the typical 'helping professional' arena, there is clearly a slower growth in understanding their levels of distress. This review calls for more robust studies, which include sample size calculations. Qualitative research would also compliment and help clarify the terminology surrounding the concepts used. Longitudinal research would also aid information on the aetiology and development of distress.

Limitations of the review

This review is not without its shortcomings. Although a sensitive search strategy was employed, it is possible that some research was missed, in large part due to the varied terminology used within this area. Additionally, the exclusion/inclusion criteria may have excluded articles from the review that demonstrated important findings; specifically the omission of qualitative research. The inclusion of qualitative research may have contributed to the experience and understanding of distress. However, in order to answer the questions that guided the review: 'what *evidence* is there of distress in the legal profession arising from their work?' and 'what factors appear to *predict* distress?' focusing on papers that used standardised questionnaires rather than those that described legal professionals' accounts appeared more relevant.

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Section Two: Research Report

'I'm not you know an aid worker….I'm there to apply the law'. Clinical negligence solicitors' experience of their work: An Interpretative Phenomenological Analysis

Research Report Abstract

Author: Sarah Lawson

Title: 'I'm not you know an aid worker….I'm there to apply the law'. Clinical negligence solicitors' experience of their work: An Interpretative Phenomenological Analysis.

Background: Professionals' whose work entails involved and sustained contact with clients who are, or who have been traumatised, may experience significant emotional difficulties and may, indirectly, experience trauma symptoms themselves. However, relatively little attention to date has explored the impact on legal professionals and that which has, has focused largely on those working in criminal and asylum seeking contexts. Legal professionals working in clinical negligence have not been studied to date, despite their work requiring them to listen to clients' detailed accounts, obtaining medical reports and relevant treatment reports, as well as exposure to and consideration of photographs and images. Being exposed frequently to detailed traumatic narratives is extremely demanding and adds an important emotional dimension to legal work. Thus in order to gain understanding of the impact of this work with clients, a qualitative research investigation was conducted.

Methods: Five solicitors working in clinical negligence participated in one-to-one semi structured interviews, which were then transcribed verbatim and analysed using Interpretative Phenomenological Analysis.

Findings: Emergent themes comprised; anxiety about their own and their family's health, threat and cynicism about the health system, and balancing the benefits and dis-benefits of their work. Participants also reported conflict between their roles as a solicitor and offering clients emotional support; many feared the consequence of showing emotion.

Discussion: These legal professionals disclosed pervasive issues relating to heightened affect and emotional containment consistent with aspects of trauma and health anxiety. Recommendations are made regarding support and its delivery utilising clinical psychologists' skills in consultancy.

Introduction

Clinical Negligence

Clinical negligence, (also referred to as medical negligence), is a term used to describe avoidable harm that has been caused as a result of treatment, or through the failure to treat appropriately (Vincent & Coulter, 2002). It involves a breach of duty of care from clinical or medical professionals, involving injury or death. Negligence can arise within a variety of clinical contexts but is most prevalently seen in; anaesthetics, mental health, oncology, paediatrics and surgery, and can range from surgical misadventure and cosmetic errors, to neonatal death (Vincent & Coulter, 2002).

Clinical Negligence and the law

It is estimated that clinical negligence affects around 1 in 10 NHS patients (The Public Accounts Committee, 2011). In 2011 there were 8,655 claims of clinical negligence against the NHS, which accounted for £863 million claims paid in just one year (NHS Litigation Authority, 2011). In England, UK, the law states that; an individual may be entitled to compensation if they have been injured as a result of negligence of another person. In order for a patient to obtain financial compensation there needs to be proof that: the health professional acted in a way which did not meet acceptable professional standards and that the harm suffered by the patient must be demonstrated to be directly linked with the failure of the health professional to meet appropriate standards (NHS Litigation Authority, 2011).

Poor communication following a medical accident has been suggested to increase patients' distress with many pursuing legal action primarily because they failed to obtain a clear explanation of what happened (Action for Victims of Medical

Accidents, 2012). Thus, a patient who has suffered a medical incident and the responses from it, following alleged malpractice, may well be suffering from significant psychological morbidity, including traumatisation.

Psychological Impact

There is substantial evidence of adverse psychological outcomes from medical accidents. Individual who have experienced such events are likely to report consequences which are sustained and severe (Vincent, Pincus & Scurr, 1993), with over 70% considering that the incident had a severely detrimental impact on their lives. Such catastrophic and life-threatening events can produce a variety of symptoms over and above physical injury, such as; disturbing memories, depression, anxiety and trauma. The initial incident may be considerably less important than the long-term sequelae of the accident in terms of disability, pain, social relationships and ability to work (Vincent & Coulter, 2002).

Even routine procedures or events considered 'normal', such as child birth, may produce post-traumatic symptoms (Olde, van der Hart, Kleber & van Son; 2006). Therefore when negligence occurs the psychological impact is likely to be much more severe. Sudden, dangerous or uncontrollable events are likely to lead to psychological problems, especially if accompanied by illness (Brewin, Dalgleish & Joseph, 1996).

Impact of working with individuals who are traumatised

Research has highlighted that professionals working with traumatised clients may be adversely affected through their work (Sabin-Farrell & Turpin, 2003). Indirect exposure to client trauma has been shown to have a negative impact on the well-being of professionals, putting them at risk of significant cognitive, behavioural and emotional changes (McCann & Pearlman, 1990). Various concepts have been used to

describe the negative impact of working with traumatised clients with terms often used interchangeably. However, where attempts have been made to distinguish the terms (Elwood, Mott, Lohr & Galovoski, 2011) there appears to be two distinct theoretical constructs: Vicarious Trauma (VT), (McCann & Pearlman, 1990) which focuses on changes in cognitive schemas, meaning and belief systems and Secondary Traumatic Stress (STS), (Figley, 1995) which does not specifically consider disrupted beliefs but focuses on symptomatic changes (Bride, 2004).

Both VT and STS propose that indirect exposure to trauma, (listening to others traumatic experiences), is necessary for their development. The fundamental feature of STS involves the development of trauma symptoms similar to Post Traumatic Stress Disorder (PTSD) (Figley, 1995). These include; arousal, avoidance and intrusion. In contrast, VT extends the effects further and suggests that in addition to the presentation of trauma symptomology, there is also a disruption of cognitive schema, change in one's self-identity and view of the world. Thus, individuals may construe a more threatening and dangerous world, due to others repeated disclosure to them, of pain and suffering.

If distress is left unrecognised or unmanaged, then this can have a considerable impact both professionally and personally. Individuals affected may be compromised at work, providing substandard professional care, withdrawing from social support and experiencing disillusionment in their chosen career (Chamberlain & Miller, 2008). Professionals affected by STS/VT are also more likely to be at a higher risk of making poor professional judgements than those who are not affected (Collins & Long, 2003).

Clinical negligence solicitors

Clinical negligence is a highly complex and specialist area of law. Solicitors working in this field are required to have medical and legal expertise, as well as empathy with people who have been harmed by negligence. Solicitors who deal with clinical negligence claims may work with clients who have suffered considerable trauma. In order for a solicitor to conduct an assessment of a case, comprehensive information must be gleaned from the client. This will include listening to a client's detailed account of what happened, obtaining medical reports and relevant treatment reports, as well as exposure to and consideration of photographs and images. Solicitors will read and re-read detailed documentation of the traumatic material contained within cases and can often be engaged with their clients for lengthy periods after a claim is initially registered. Thereby, witnessing the impact of the trauma and sequelae on their client over an extended period of time. Being exposed frequently to detailed traumatic narratives is extremely demanding and adds an important emotional dimension to legal work. Legal professionals do not appear to be specifically trained to acknowledge or address work related emotions that the impact of their work may have on them (Sagy, 2006).

These factors coupled with the organisational culture of law firms, indicate a high risk for becoming distressed, and experiencing STS/VT. In contrast to mental health workers who are well informed about the potential impact of their work on both mental and physical health, and are offered explicit support (Ennis & Horne, 2003). Despite this support, the research evidence shows that mental health workers experience STS/VT (McCann & Pearlman, 1990; Sprang, Clark & Whitt-Woosley, 2007; Adams & Riggs, 2008). The legal organisational culture is very different and may suggest that

solicitors whose work concerns clinical negligence may be at high risk of experiencing some form of distress from their work.

Although increasing research on the impact of STS/VT on professionals is growing, there is a dearth of research on legal professionals. What research there is, has focused on those employed to adjudicate as judges, in asylum processes and within criminal contexts (Lawson & Robertson; in press). Findings from this quantitative review revealed evidence indicative of mild to moderate symptoms of distress, and medium to high levels of reported burnout in legal professionals. Many studies presented levels of distress as being significant when compared to other occupational groups. Distress was operationalised using a variety of terms, which were used interchangeably. However, findings were found to be neither clear nor consistent and methodological weaknesses were common. Findings also suggested a need for greater awareness of inadvertent distress arising from work in legal professionals and improved rigour in both conceptualisation of distress and its assessment.

To date no peer reviewed research has explored how those working in clinical negligence might be affected by their work. If left unaddressed, it may be harmful to both solicitors and their clients, potentially affecting client distress further. Given the more explicit helping nature of their work, the thoughts and experiences of clinical negligence solicitors are crucial to gain a deeper understanding of their work, as well as offering findings to the field of trauma.

Method

Design

The main aim of the study was to gain a rich and detailed understanding of clinical negligence solicitors' experience of working with clients. Solicitors working in

clinical negligence were chosen both because of the paucity of research on the impact

of work within the legal profession, and also because of their close contact with clients'

who have suffered potentially traumatising clinical negligent events.

Methodological Framework

Qualitative Research

A review of the literature on the impact of work on legal professionals

highlighted inadequate assumptive research and the focus on clinical trauma was absent

(Lawson & Robertson; in press). To date, no research has examined the experience of

being a solicitor working in clinical negligence. Given that a key aim of the study was

to achieve an in-depth understanding of individual experiences of the phenomena being

investigated (Smith, 2003), a qualitative approach to data collection was adopted.

Qualitative methodologies aim to develop an enriched and conceptual understanding of

the experience of individuals. This methodology particularly suited to exploratory

research, by eliciting in-depth data within individual accounts (Lyons, 2000) was

deemed appropriate to the aims of this research.

Interpretative Phenomenological Analysis

With the possible approaches available, Interpretative Phenomenological

Analysis (IPA) (Smith & Osborn, 2008) was considered to be best suited to this

particular investigation as it allows the rigorous exploration of idiographic subjective

experiences (Smith, Flowers & Larkin, 2009). Other methodologies were considered

during the initial planning phase of the research, including Discourse Analysis,

Grounded Theory (GT) and Template Analysis. (See Critical Appraisal section for a

further detailed analysis). Whilst there are similarities between GT and IPA, GT focuses

on capturing social processes rather than individual experience. IPA enables a

comprehensive investigation of individual experiences, which GT does not. Since previous literature also revealed a lack of research of the experience of legal professionals, from the perspective of the individual, IPA methodology was determined as best suited for this research.

Transparency and Reflexivity

As a measure of quality, transparency of the results and reflexivity in the process of interpretation was prioritised throughout the research process. Transparency involves the researcher providing a clear account of how the research was conducted, enabling the reader to see how the findings were derived (Spencer, Ritchie, Lewis, & Dillon 2003). Self -reflexivity describes the sensitivity of the researcher to the way in which they influence the research process, and is one of the key mechanisms through which transparency is achieved. Whilst acknowledging that it is not possible to completely separate their own beliefs and perceptions, qualitative researchers attempt to 'bracket' their own values. Thus permitting more adequately 'understand[ing] and represent[ation]' of the experiences of their participants than would otherwise be possible (Elliott, Fischer & Rennie, 1999). Bracketing was facilitated by keeping a reflective diary. Additional notes relating to the quality and rigour of the research can be found in the appendix (Appendix C).

Researcher's background

My position as a researcher in the present study was as a trainee clinical psychologist conducting the research as part of course training requirements. In particular I have interest in professional distress potentiated within the work environment. I believe this interest came about through my previous experience of working in a large in-patient healthcare setting where staff were expected to deal with difficult and challenging client behaviour with little training or support. I became

curious about how professionals make sense of and cope with stressors, interpersonal experiences at work and resilience. An interest in phenomenological understanding emerged through my Masters study in which I was exposed to theories and models in which appraisals and beliefs of those with chronic illness were privileged.

I have no prior personal experience of the legal system or of clinical negligence. However, I was aware as an NHS employee working with those adjusting to trauma and medical related illness, that this may have had an impact on my own views and beliefs about solicitors' experience. The aid reflexivity, the use of a reflective diary after each interview was used. The researchers epistemological position can be best described as 'contextual constructionist', which argues that results will differ depending on the context in which the data was collected and analysed (Madill, Jordan, & Shirley, 2000) (See Appendix D for further discussion).

Ethical considerations

Approval to conduct this research was obtained by the University of Leicester Ethics Committee. Relevant documentation is provided in Appendix E. Participants were made aware that any data collected would be kept confidential, audio-recordings would be password protected and subsequent transcriptions would have any potentially identifying information removed. Participants were given the option to withdraw from the study during or after the interview. All participants gave informed consent to take part in the study.

Participants

The study aimed to examine narratives of solicitors' experiences of their work within clinical negligence. With the notion of not enumerating, but offering a variety of representations of an issue/experience and that sample size should follow from

approach selected, this project recruited five respondents consonant with

recommendations on sample size sufficiency (Smith, Flowers & Larkin, 2009). These

volunteer participants were recruited via email advertisement sent to solicitors

specialising in clinical negligence. The email included a short paragraph detailing the

study and attaching the participant information sheet (see Appendix F). Potential

participants interested in taking part were asked to contact the researcher by email or

telephone. The participants were all white British solicitors working in the Midlands

area of England, UK. Their ages ranged from mid-twenties to mid-fifties. Duration of

work within clinical negligence ranged from 18months to 10 years. Participants' names

have been changed and pseudonyms used.

Inclusion and Exclusion Criteria

The aim of this research was to be as inclusive as possible. In order to meet this

aim, other than requiring participants to be clinical negligence solicitors there were no

specific inclusion/exclusion criteria.

Table 2. Participant Characteristics.

Pseudonym	Gender	Age group	Number of years' in role
Lucy	Female	20-30	2 years
Samantha	Female	30-40	3 years
Harriet	Female	20-30	18 months
Joan	Female	40-50	8 years
David	Male	40-50	10 years

Procedure

This study employed semi-structured interviews as a means of data collection, planned in accordance with the research questions. A semi-structured interview approach using open questions was selected. An interview schedule was used to guide the researcher, reviewed by their research supervisor (see Table 3). According to Smith, Flowers and Larkin (2009), the purpose of an interview schedule is to encourage the participant to talk openly and that respondents ideally be allowed 'a strong role in how the interview proceeds'. The final schedule aimed to elicit an understanding of solicitors' experience of working with clients who had suffered clinical negligence.

Table 3. Semi-structured Interview Schedule

1.	Can you start by telling me what you like most about working in this area of law? - And what do you like the least?
2.	How would you describe the culture around being a solicitor?
3.	What would you say are the harder cases to work with? -Can you tell me about how you cope with these cases? -Is there anything you think could help with working with these cases?
4.	How does it feel when you're with a client and they are describing a difficult experience they've had?
5.	Can you tell me if you have ever been surprised by an emotion when working with a client?
6.	How, if at all, have your views changed since working in this area of law?
7.	Is there anything else you think I should know to understand your experience better?

Pilot Interview

A pilot interview was conducted with a solicitor known to the research supervisor in order to test the interview schedule and obtain feedback regarding the process of the interview. There were no modifications following this.

Interviews

Interviews were offered at times and locations convenient for the participants. All chose that the interview be conducted during working hours, at their place of work to facilitate participation given work and time constraints. It is acknowledged that the context of the interview in terms of location and timing may influence disclosure regarding aspects of work, and in the way in which it is framed and discussed. Participants were asked to allow up to 90 minutes for the interviews. The first 10 minutes of the interview was to ensure the participants were fully informed about the study and had the opportunity to raise any concerns and ask questions. After they had agreed to participate and asked any questions, participants were asked to sign a consent form (see Appendix G).

The interview schedule was reviewed after each interview and refined where necessary. Interviews lasted between 55 and 80 minutes and were recorded using a digital voice recorder. Following each interview, a reflective diary was used;this was aimed at increasing reflexivity.

Transcription and analysis of interview data

Two interviews were transcribed in full by the researcher; a professional transcriptionist was employed for the remaining interviews. The nature and content of recordings were discussed with the transcriptionist before she agreed to undertake the work, to allow her to decide whether she wanted to proceed. She was also offered a full

de-briefing with the researcher following each transcription. All recordings and transcripts were re-checked by the researcher to ensure accuracy and to become familiar with the data. Pauses, laughter and other major paralinguistic elements were included as a particular representation of the data, and within it a transcription convention and style reflecting the theoretical position held by the researcher (Lapadat & Lindsay, 1999)

Analysis

Individual case analysis

The data analysis was undertaken using Interpretative Phenomenological Analysis (IPA), following the four stage model recommended by Smith and Osborn (2008). An idiographic approach to analysis was followed with each interview analysed individually, allowing the researcher to detect repeating patterns whilst remaining open to new themes emerging (Smith & Osborn, 2008). Interviews were read repeatedly, with descriptions and initial ideas on interesting or significant aspects, connections, contradictions and preliminary interpretations noted on the left hand margin. Interviews were read again, and the right hand margin was used to record emerging themes.

The next stage utilised a more analytical approach, making sense of connections between emergent themes, listing them and clustering them together. Smith and Osborn (2008), use the metaphor of a 'magnet' to describe this process, with some of the themes pulling others towards them, facilitating sense-making. The clusters of themes were given names which became the superordinate themes, aiming to capture the core meaning from the text. This process involved regular checking of interpretations and themes within the text. An example of the analytic process from an excerpt from one interview is given in Appendix H.

Cross-case analysis

Once all interviews had been analysed and tables of themes produced, a further table was created incorporating the themes from all five interviews. A similar process to individual analysis was followed, with the themes clustered using the 'magnet' method into superordinate and subordinate themes. Interview transcripts were reviewed to ensure accuracy of the themes, and thus a framework representing the participant's experiences of clinical negligence legal work was developed. These themes were then expanded into a narrative account which is the basis of the Results chapter.

Results

The systematic analysis of interview transcripts elicited a total of 15 themes, which were then organised into six super-ordinate themes (Table 4). Each theme is described below and illustrated with example quotations taken from the interview transcripts. Quotes are accompanied by pseudonyms, and line numbers to facilitate location. Table 5 provides a summary of the use of grammar in quotations.

Table 4. Emerging themes

Super-ordinate themes	Themes
Hyper-vigilance and the perception of threat	Becoming anxious and checking own and family's health Bad things happen to normal people Fear of the NHS and doctors
Affective response to work	Cynicism regarding medical professionals Hierarchy of empathy
Balancing benefits/dis-benefits of work	Enjoyment of working with 'real' people vs listening to horrific stories Managing clients: The good vs problem client Building and learning vs commercial pressures
Conflict of Cultures	Being a legal professional / Being a counsellor Impact on sense of self
Impact of emotion	Feeling helpless Detachment from emotion Fear of being seen not coping
Containing client distress	Burden of outcome Disclosing to a client the value of their loved ones life

Table 5. Use of grammar in quotations

Symbol	Meaning
TEXT	Indicates verbal emphasis on these words e.g. by volume spoken
(pause)	Indicates a pause in speech
……..	Indicates some words have been omitted from the quotation in order to enhance clarity for the reader
*****	Indicates text has been omitted to protect confidentiality

In all data extracts 'P' refers to participant and 'I' the interviewer.

Super-ordinate theme one: Hyper-vigilance and the perception of threat

All participants spoke anxiously when talking about their own or their family's health. As they reported their experiences to the researcher they appeared slightly uncomfortable and spoke quickly (this could also have been attributed to the pressure of time). All described a need to be vigilant about health and medical procedures to prevent medical disaster befalling them or their family.

Becoming anxious and checking their own and family's health and related issue

Lucy and Harriet both express their fear about their family's health as a consequence of knowing about adverse medical events. Lucy pleads for things not to go wrong using a superstitious mantra to invoke a sense of control:

> P: there is, there is kind of a little bit inside you now and when I go and have, in hospital my family, it's kind of like ok, please get this right, please, just because you know it can happen (Lucy: 493-496).

Harriet voices her need for active vigilance with a checking litany and articulates symptoms to check for severity, again because of knowledge of possible risks:

> P: And err I thought, I had a slight panic and I was like oh my God, have you
>
> got these symptoms, have you got this, have you got that
>
> I: Yeah
>
> P: And it, it makes you panic a bit more because you know more medical things
>
> (Harriet: 369-374)

There is a strong sense expressed about the need to look out for others which implies vulnerability beyond the self. Samantha explained how she told her brother what to do at hospital and expresses a sense of responsibility to inform him and to protect him:

> P: I told my brother what (laughs) to do, what to say, making sure everything
>
> had been checked (Samantha: 371-372).

Participants were both explicit and inexplicit about using their professional expertise to guard against threat. Finding out in more detail about certain conditions and interrogating health professional behaviour appeared to enable some participants to feel more in control. Joan discusses using her knowledge when visiting her GP, to assure herself that things have been done correctly, yet not letting them know what she thought. She uses this encounter to test the practitioner and to ensure his rigour:

> P: And, yeah, and I would just, I would just do everything to make sure and I
>
> wouldn't just rely on one doctor, if I wasn't, if I was 'cause I would always go
>
> to the doctors with a preconceived idea about what was wrong
>
> I: Yeah

P: I wouldn't go in with a completely open mind but I wouldn't tell them and

then I'd see what they said and if they kind of agreed with that I'd be fine

(Joan: 556-562).

Lucy on the other hand felt it important to let her doctor know that she was a solicitor to ensure a better standard of treatment. She discloses that she threatens him:

P: I'm a clinical negligence solicitor and er he was like oh right. I was like yep

so if you don't make a referral kind of making a joke about it but I did feel that

like he maybe took a little bit longer with me because I knew kind of what he

had to do or the consequences if he didn't (Lucy: 1156-1160).

In both these accounts there is an implicit challenge to the health professional to behave with rigour and to prove their credibility as a doctor. These excerpts also emphasise a defensive 'set for threat' perspective.

Bad things happen to normal people

All participants related their professional experience privileging evidence that bad things could happen to anybody. Whilst they acknowledged exposure to the more severe and extreme cases in their role as professionals may reflect skew, and that this might not typify a universal experience, they still expressed anxiety and their discomfort with a realisation that things could go wrong, and their revealed vulnerability to this. Within the interviews participants appeared hesitant when discussing these issues. This was reflected through their tone of voice (quiet and wavering) and dry mouth (needing to drink).

I: I think it's more erm, it's kind of more about, its more life you know life as

we know it. It's people. Every day people

I: Yes

P: With everyday problems who've been going along quite happily and then something disastrous happens and their lives are turned upside down

(Joan: 25-30).

And similarly:

P: I mean I think that example I just gave is because it's quite upsetting to see someone in that condition and, and on that particular case I've got CCTV footage of the client coming out of the club erm actually walking the, walking, talking, just doing normal things then ten minutes later you know that they were hit..er by a car (David: 321-326).

In both these extracts Joan and David describe sudden and catastrophic events unpredictably emerging from the routine of activities, magnifying the shocking nature of the situations. These descriptions suggest that participants' basic assumptions about life have been challenged, with life viewed as something which is unsafe and unpredictable.

Participants disclosed that shocking events are reported even when risk has been assessed, highlighting that although prevention has been attempted or risk pre-empted, medical interventions cannot necessarily be controlled. Lucy outlines that catastrophe happens even when a client specifically requests something not to be done:

P: we've got one client where they erm took away both ovaries during an operation. She was quite young and she said under no circumstances take away

both. I mean only take away one erm and they took away both and, and that case really, I'm like oh it really petrified me (Lucy: 237-241).

Lucy is indicating that despite preliminary measures, adverse events cannot be entirely prevented, are uncontrollable and have to power to terrify.

Fear of the NHS and doctors

Most participants spoke of their fear of the NHS and doctors due to their experience of negligence cases through their work. Participants expressed a lack of trust in the medical profession and the need to question their opinion or actions. Samantha indicates that her knowledge of what goes on is terrifying:

> P: ..I'm always very wary very wary of the medical profession because it's frightening it's absolutely terrifying what we see and what we know goes on (Samantha: 366-377).

Harriet describes her lack of trust:

> P: Erm I suppose. I don't think I fully trust the, the doctor or erm or a hospital (Harriet: 397-398).

Joan also describes her shock at the naïve opinions others express about the NHS:

> P: Whereas a lot of people, a lot of really intelligent people are like oh god, it's the NHS, it's fantastic and you know doctors are great. They always do a really good job and you don't need to worry and

I: Mm

P: I'm thinking oh god, that's really naive. It's nice to think like that and nice to go through life thinking everything's fine and you go to the doctor and they always do the right thing and but it's not like that so that's what I mean (Joan: 525-537).

She describes 'a lot of …really intelligent people' implying a common view held by many, even those who are 'intelligent'. She also appears to imply there is less hope for the more unworldly. It seems that when Joan says 'they always do the right thing, but it's not like that', she wants to alert others that they are not necessarily safe and that they should be less trusting. Joan presents herself as having 'insider knowledge' yet appears isolated by this as she wishes to share with others.

Lucy and David offer a different perspective of their view of the NHS which is less damning. David places blame on the press as well as other outlets and their focus on adverse not positive events:

P:…because they don't emphasise, they don't say bloody good job. Ninety eight per cent of operations have gone really well this year. You never see a report like that (David: 1236).

He is aware, through his marriage to a clinician, of other mitigating factors and views human error as an error of systems and people under pressure:

P: Well they must be (pause) pretty under pressure and so on and I see my wife coming home from work and she's quite stressed sometimes and so that, that I suppose if, if I wasn't married to someone who was working within the NHS

I: Mm

P: Then maybe I'd be a bit more

I: Mm

P: Gung ho and think

I: Mm

P: I'll just sue them. They're naff and blah di blah and how dare they (David: 1173-1183)

Lucy discloses discussions with a friend who is employed by the NHS which enables her to adopt a more balanced perspective. Talking with her friend about these issues appears to have challenged her view of threat and mitigated fears:

P: It's not necessarily as clear cut and I think that helps you being, maybe a little bit more less emotive sort of thing because you're not thinking oh you know oh you know, it was only down to the doctor's fault. How, how did this happen and then cos she'll be like well actually you know, that is possible and then you go ok, yeah. We all make mistakes and so do we as lawyers or people so

I: Yeah

P: Erm, so that's helped, that, that really has helped me a lot. Just having the kind of, her perspective on it (Lucy: 471-477).

Both David and Lucy are acknowledging that medical care can go wrong, but that much goes right and can be explained through more rational processes.

<u>Super-ordinate theme two: Affective response to work</u>

This theme incorporated the affective responses participants experienced through their work. Participants described feeling cynical about aspects of their job, both in respect of clients and healthcare professionals. Many disclosed that their work had contributed significantly to this. They also had stronger feelings of empathy towards some clients more than others.

Cynicism regarding medical professionals

Joan expresses that her cynicism is specific to hospitals and doctors. In stating 'what they've done' implies an unremorseful blame and reveals her anger towards the medical profession:

> P: I think erm, I think it's, I mean it's a very specific kind of cynicism focused on erm hospitals, really that and doctors and that administration generally because of what they've done (Joan: 511-513).

She later describes her lack of trust due to her experience with clients:

> P: because I just don't trust
>
> I: Yeah
>
> P: The medical profession at all because of what I see (Joan: 520-522)

David on the other hand, feels that cynical is too much of a strong word to use but that he applies caution with medical professionals:

> I: Yeah. You said it's made you more cynical
>
> P: Not, in terms, cynical's the wrong word. I think it's maybe more cautious
>
> I: Right
>
> P: In terms of how I approach medical professionals (David: 1284-1288).

He later goes on to describe in what way:

> P: And therefore I'm more likely I suppose to ask questions. It's not because I'm just being a difficult arse at a pre-consultation meeting or whatever but it's just because I know what can go wrong and I just want to be informed as any client should be (David: 1296-1300)

Samantha describes that her cynicism has magnified. This does not appear welcome and appears at variance with her earlier self and aspirations to help. Her use of laughter implies a rather wry perspective on her own naivety, as well as sadness that her role does not meet her preconceived objectives:

> P: I think I'm more cynical than I was. I came into (pause) this is going to sound so so bad as well I came into this area of work to HELP people (laughs) and I laugh because it's not I don't I don't feel like I'm doing that at all (Samantha: 360-361).

Hierarchy of empathy

Participants appeared to be able share some clients' perspectives and distress more than others. Comparisons are made over the seriousness of an injury; with a less serious injury engendering a less empathic response. There is also hierarchy of legitimacy; with clients who report less obvious catastrophic experiences; being less emotionally engaged with:

> P:..I just think cos we hear about people that have like serious problems, you just think people that, like other people are like complaining about minor things and you think why are you complaining about that? (Harriet: 410-413).

Empathy also appears affected by the personal resonance or identification with an event:

> P: You try not to have your favourites but there's some clients who you really like and some clients who you're like, oh and some clients who you know that you think this is, they've been through something horrible or its particularly relevant to you so you kind of want to you know deal with them first.. (Lucy: 953-959).

Although acknowledging that their main role in medical negligence is to sue and achieve compensation for clients most participants reacted adversely to clients construed as mercenary. Expressions of conflict in seeking out compensation for those clients seemed more apparent. The intent, drive and motivation and legitimacy of a client also affected empathy. Some clients were not regarded as genuine cases:

P: In, in some ways if you've got a client and she's really pestering or its not particularly strong case but you know you think she's really just after money or just after the suing aspect and sometimes I, I attach a little bit less emotion to them rather than you know the really nice clients who genuinely need the help (Lucy: 302-307)

Loss of a child seems particularly affecting. Joan speaks strongly about this and her language seems to reflect the pain and anger she feels. There is also a sense of helplessness that she is only able to get compensation and cannot make things better:

P: That annoys me a bit because compensation is never going to get you right, never going to put you back to where you were. It's never going to make you better. It's not going to bring back your DEAD BABY is it? (Joan: 928-934)

In his efforts to help and please his clients, David feels despite the money he gets for people it is wasted energy as he does not receive acknowledgement from his clients on his efforts:

P:…and I do find it a bit annoying really when you bend over backwards, get a couple of hundred K settlement or whatever or, I mean it doesn't, or even a settlement. It doesn't matter about the money and it's just the money they want. They don't even say thank you even though it's like a two, three year process sometimes (David: 461-466).

<u>Super-ordinate theme three: Balancing benefits/dis-benefits of work</u>

All participants identified elements of work which they enjoyed and were rewarding and other areas which they found more challenging.

Enjoyment of working with 'real' people vs listening to their horrific stories

All participants disclosed that they elected to work in medical negligence because of a wish to work more closely with 'real' people rather than faceless, corporate clients. As Harriet states:

> P: Erm working with the kind of clients I like the everyday kind of person rather than
>
> I: Mm hm
>
> P: These business clients
>
> I: Yeah
>
> P: I just like normal people (Harriet: 17-22).

However this was balanced with listening to their stories and taking evidence. Lucy's description of a 'rollercoaster' is perhaps reflecting her own experience of being with clients throughout the process:

> P: They go through quite emotional turmoil, rollercoaster throughout the whole procedure because they have to keep bringing it up (Lucy: 127-129).

Managing clients: The good client vs the problem client

Clients were described as being either the 'good' or 'problem' client. Those that demanded a lot more time and more emotional investment from the participants were seen as a 'problem' client. 'Good' clients were those who were more grateful and more

rewarding to work with. All participants talked about having a mixture of clients and the need to deal with them differently:

> P: I think it really depends on which client it is and what mood you're in that day and how many bad or good clients you've had that day as to kind of how you feel (Lucy: 959-962).

Samantha talks with unease about some clients. She feels a lot of pressure and control from them. Using the word 'unleashed' carries meaning about 'threat' and implies a fear of being attacked. She may feel clients have suppressed distress or anger and felt vengeful:

> P…and the only way the only thing that we've got when it goes right and they're happy, but when it goes wrong and they're not happy they get unleashed on you because they're not happy with what you've told them (Samantha: 147-148).

David's use of the term 'bite me' also implies being attacked or feeling threatened:

> P: Cos I need to be cos I know what's going to come back and bite me at a later stage, yeah (David: 1096-1097).

Harriet discusses the way she attempts to manage these clients and suggests the need to stay in control, reining in something is implied when she talks about 'bring them back in and say no':

P: I know when I worked with **** in **** she had a few difficult clients and you have to be able to stay in control with them cos they'll tell you all, I want to do this. I'm not happy with the way this case is being run and you have to kind of like bring them back in and say no, this is what we're doing (Harriet: 779-783).

These quotes suggest that participants experience threat and heightened vigilance to client ferocity of affect that is suppressed and waiting to be let loose.

Building and learning vs commercial pressures

Many participants described pleasure whilst learning about the clinical dimensions of their work and building a case to support their clients' claims. However, all reported stress and feeling pressured by commercial dimensions of their work.

David talks about synthesizing material for a case and researching a satisfactory consensus:

P: So I find it fascinating. I find it satisfying as well when you pull all the evidence together on a, on a case and you get a settlement for the client (David: 265)

Later he talks about the pressures from multifaceted dimensions:

P: You've got targets. You've got budgets. You've got client expectations (David: 591-592)

Samantha highlights that the interpersonal side of the work is more challenging:

P: As opposed to the client side of it, I really enjoy going through the records, looking at end err building the case (Samantha: 12).

Super-ordinate theme four: Conflict of cultures

Being a professional vs being a counsellor

A theme participants repeatedly described reflected experiencing of conflict of cultures. Respondents felt tension in roles that they occupied; both being a legal professional enacting legal processes and being their clients' counsellor given horrific and catastrophic events that had been described and evident continuing distress.

Samantha relates a duty of care for her clients and onus on her to talk to them, despite such consultation not being integral to her role and having insufficient time to do this. She expresses a strong sense of obligation to provide time and space and a fear of consequences for her clients if she does not. Samantha, in emphasising 'you can't tell these people I haven't got time', appears to emphasise clients' intense emotional need and fragility:

> P: like it's not part of my job but it becomes part of your job, you can't tell these people I haven't got time or this isn't what I get paid for so, I'm sure there are people that would but I ended up counselling them for 2 hours. I think I'd be a better counsellor than I would (laughs) but no I find that really awkward I don't like that part of the job, it's quite draining for me, it's quite emotionally draining (Samantha: 226-230).

Samantha recounts her counselling role as one that she feels coerced into undertaking, and she dislikes the role which is sapping of her energy and she feels emotionally drained. Her description suggests a lack of training to provide counselling and an

absence of coping strategies to address her response to client needs that exceed her brief.

Lucy describes a similar situation also disclosing the pressure upon her and the need to help. Both accounts appear to reveal empathy for their clients and an acknowledgement that they require more time and support than perhaps clients in other areas of law. Similar to Samantha's experience, Lucy describes feeling 'upset' but this is overridden by her need to help:

> P: …I had a lady last week who had lost her mother and I think she actually called me for just someone to talk to. She literally was grieving on the phone and I found, I felt a little bit like a counsellor but you kind of feel, you're upset but then you kind of feel like you want to help them or you want to at least make them feel a little bit better (Lucy: 842-851).

However earlier on in the interview, Lucy expresses what her role of a lawyer is:

> P: …it is my job erm and I'm not you know an aid worker who is there to help this person. I'm there to apply the law… (Lucy: 327-329).

Her use of 'aid worker' conjures a 'crisis' - a threat of challenge associated with warzones. The term suggests that Lucy sometimes acknowledges that the emotional support required of her exceeds her role and that she simultaneously gives yet resists this role.

Impact on Sense of Self

Respondents disclosed a divide between individual belief and the work demands of being a solicitor. Participants managed these demands differently.

Joan reflected on her evolution as a solicitor and how she could feel trapped between spending time talking to clients yet the cost implications using time in this way. Her experience over her career appears to have mitigated her worries and stress regarding cost, and she now finds it easier to put clients first:

> P: Now I probably think well you know, forget that. This client wants to talk to me and you know, so what if we lose half an hour's worth of fees (Joan: 98-101).

Samantha describes that she finds it difficult to split herself from the emotion that she experiences through her work. She is aware of the cultural demand of the law to approach her work in a very precise and structured way:

> P: I've got to look at it very clinically and very legally but I find it really hard not to get emotionally involved in what they're going through and how difficult it is for them (Samantha: 201-202).

Lucy also appears to experience discrepancy between how she views cases personally and professionally. She appears uncomfortable reporting disparity in her view of human suffering: both horrific, but also a way of making money:

> I know this sounds, it sounds very horrible but the other day I had, I took a new enquiry and it was a, a birth injury case and the business side of you kicks in a little bit so it was like oh right, well this, you know this is horrendous. This is a good case for us. (Lucy: 254-258).

Super-ordinate theme five: Impact of emotion

All participants talked about expectations from their work colleagues and their clients. Most respondents expressed a fear of showing emotion; to clients given their role as a solicitor and supposed expert, and to peers the professional identity as detached and incisive. Participants found being with a client who was distressed, challenging and many felt quite helpless that they could not do more for them.

Feeling helpless

Fear of client emotion was frequently noted; as were concerns about being unable to contain this:

> P: if you've got a client there that's really upset. Erm it's really hard to, obviously you feel their, their pain and see it but it's a lot harder then to kind of sit back and think, and gather yourself together and, ok I'm the lawyer and I've still got to give this bad advice even though they're sitting there and, and see it (Lucy: 437-442)

Many felt that they began to share client emotions, creating a drive to help them:

> P: ..when you see them emotionally sad or angry it kind of, I kind of feel the same for them and kind of want to help them more…(Lucy: 434-436).

And similarly:

> P: … and they say well how would you feel, well I know how you feel, and I know how I would feel but I can't do anything about it… (Samantha: 272).

Samantha articulates her own empathic response, via identification, which appears to cause her discomfort she describes, ambiguously, that she may be helpless to help or manage her emotions.

Detachment from emotion

There was a sense that as a solicitor you need to show controlled compassion. The least experienced solicitors reported that they felt they needed to learn what to do and how to behave. Lucy has received specific advice on how she should relate with clients:

> P:..i've been told kind of extract the emotion if possible. Not so much as you can't interact with your clients, but only use as much as necessary (Lucy: 331-334).

Similarly, Harriet has observed other colleague's behaviour on what is acceptable:

> P: ...you do have to like not show emotion and things
>
> I: Yeah
>
> P: I think that's what's expected: I've got a feeling
>
> I: Right
>
> P: Yeah cos I've never known anyone that I've sat, sat in with like erm *****, they don't really show much emotion at all (Harriet: 515-521).

There appear to be inexplicit rules about detached use of affect and more junior members are learning the correct way to be with clients.

Fear of being seen not coping

In addition to expressed compassion, respondents all evinced an expectation that as a solicitor you needed to be seen as in control and able to cope. There was a fear of adverse peer judgement if this was not the case. Joan spoke about needing to ask for a colleague's help with a case earlier on in her career and worried about the implications of this:

> P: But I do remember thinking oh does this look like I you know I can't handle it (Joan: 1429-1430)

Whilst some could see the benefit of using supervision to talk about the emotional impact a client had had on them, most felt that this would reveal weakness and be alien to legal culture:

> P: Yeah. I think it's just accepted that you know, if you can't hack it, do something else really. It's just what it; it's just what the job involves (Joan: 501-503)

David also describes this in terms of gender self-identity, highlighting the masculinised nature of working in the law:

> P: Yeah. I mean in theory it all sounds very nice and fluffy but in practice I don't think I'd get to a stage personally where in the current team I'm in, I could actually do that and I know this sounds really sexist but maybe it would be easier for females to do that (David: 178-182).

Super-ordinate theme six: Containing client distress

Participants had to deal with containing their client's distress and uncertainty given there could be assurance of outcome. They also reported fear of having to tell their clients bad news. Respondents disclosed feeling responsible for managing clients' expectations of outcomes and their responses if recompense from distress was insufficient.

Burden of Outcome

There was a fear amongst participants about the outcome of a claim, its potential to harm already vulnerable clients and whether their involvement might exacerbate distress. Client vulnerability seemed to make respondents feel a magnified need to get everything right:

> P: that's the worry I've got on the big case I'm dealing with now is that they've made an offer and I, I'm worrying myself to death really about, I mean not every minute of every day or anything like that but I am worrying about the cost cover in terms of if we fail to meet the offer and I'm doing things to put protection in place (David: 795-802).

Samantha spoke with fear at creating further damage to a client by having to tell her bad news and expecting the worst, she was anxious of the responsibility that this would carry:

> P: ..but my evidence wasn't supportive of the claim and I had to tell her, and I'd just convinced myself that she was going to kill herself and I couldn't cope with the thought that she might and I felt like it'd be my fault (Samantha: 95-98).

Disclosing to a client the value of their loved ones' life

A large part of respondents' roles involve deciding which client cases to pursue, and for those who are not acted for, why their experiences were not suitable to pursue. Lucy describes this as distressing since she is judging degrees of awful experiences:

> P: Tell you about the facts and going over it and over it and a lot of time it's quite, it's obviously very important to them so the hardest thing is to tell someone that basically their injury kind of, not means nothing, but you know even though the doctor made a mistake, there's nothing that they can do about and they need to accept it (Lucy: 131-136).

Respondents might also have to inform current clients that their claim was not worth very much, irrespective of significance and impact on the client. In claims where somebody had died, participants found this one of the hardest things to do:

> P: so you have to kind of explain that to them and try and explain that their dead loved ones are not worth much in money terms is quite hard, difficult to do and erm obviously I think that, that's the, that's the hardest part (Lucy: 984-988).

Diminishing the value of somebody's life is challenging and a very distressing part of their role:

> P:..it's not very nice to say to someone well even though they've died and we think you've got a claim, it's not worth a lot so we're not going to take it on (Harriet: 216-219)

And similarly:

> P:I have to tell the family how much the claim is worth and I had to explain to
>
> them that their child's death, no matter however traumatic it had been for them
>
> was worth very little (Samantha: 86-89).

Discussion

Summary of findings

This study aimed to gain a detailed understanding of clinical negligence solicitors' experience of working with clients. To access rich, contextualised accounts of work in this role, as distinct from other lawyers, a phenomenological approach was used to understand clinical negligence solicitors' experience, and explore its impact given the more explicit helping nature of their work.

Clinical negligence solicitors were interviewed about their experiences, and the data was analysed using Interpretative Phenomenological Analysis (IPA). Findings revealed pervasive issues relating to heightened affect and emotional containment. Participants expressed anxiety about their own and their family's health due to their acquired knowledge of clinical negligence. This appeared to affect their world view and many felt that they had become threatened by, and cynical about the health system and those who deliver care. Participants described a conflict between their roles as a solicitor and offering clients emotional support; and they feared showing emotion would result in them being perceived as weak or unable to cope.

A theme running through all categories was containment of emotion. This involved both an external orientation (containing their clients' emotions) and internal orientation (containing their own emotions). External containment required listening to

and empathising with clients' distress as well as counselling them. Internal containment involved controlling anxiety in light of threatening information acquired via work, managing the affect engendered by conflict of their role as a solicitor and detaching themselves from both their own and their clients' distress in order to operate professionally.

The Health Care Commission report (2007), states that there has been a steady rise in patient satisfaction over 5 year period from 2002-2007, with nearly all patients (92%), rating their care as good, very good, or excellent, and eighty per cent stating they always had trust and confidence in their doctors. Respondents in this study expressed beliefs at variance with this norm, with the majority stating that they were 'very wary' (Samantha: 36), of medical professionals. Narratives suggested fear, hyper-vigilance, a lack of trust and fear of the NHS and doctors, evolving through experience of working in clinical negligence. Views offered, described changes to fundamental life assumptions; that life is safe and predictable, to transformed beliefs; that sudden and catastrophic events can happen to anybody.

Within the study there was marked expressed anxiety which appeared to be underpinned by a realisation that things could go wrong, from which they could not be immune. Joan (30) describes how 'lives are turned upside down', implying catastrophic events as sudden and unpredictable. Such descriptions echo Janoff-Bulman's (1992) perspective of shattered assumptions of self and the world following traumatic experiences. The respondents in this study described changes in key assumptions noted by Janoff-Bulman (1992) regarding the belief in personal invulnerability. It is clear that participants felt vulnerable to the possibility of harm happening to them or their family members, Harriet (374) describes 'makes you panic a bit more because you know more

medical things'. Knowledge about medical procedures which can go awry seems to reveal vulnerability.

Exposure to traumatic material can affect an individual's sense of self, and has been described as Vicarious Trauma (VT), which is based on Constructivist Self-Development Theory (CSDT) (McCann & Pearlman, 1990). CSDT states that people construct their realities based upon their perceptions and schemas. When individuals are exposed to events that do not fit with their perceptions, their change in view or distorted beliefs help to protect them from harm caused by the trauma. These are adaptive responses to hearing clients describe a traumatic event. There is a notable discrepancy on how participants view cases personally and professionally.

CSDT resonates with descriptions encapsulated by the theme 'bad things happen to normal people', implying that the solicitors may, as a result of hearing traumatic narratives from clients, view the world as an unsafe place. From the perspective of CSDT, the traumatic information from clients may not fit with the solicitors own schemas, resulting in a disruption in schemas. Disrupted beliefs in relation to the self and others can involve issues surrounding safety, trust, and control, as well as elicit cynicism (McCann & Pearlman, 1990). By maintaining the assumption 'bad things happen to normal people' the solicitors engage in behaviours in an attempt to protect themselves from harm ('I wouldn't just trust one doctor', Joan: 557) as well as 'becoming anxious and checking their own and family's health'. This also evokes as sense of 'cynicism' and 'lack of trust' (Joan: 501) towards the medical profession.

Participants reported affective responses from their work, such as panic (Harriet: 374), sadness (David: 321), fear (Lucy: 241), terror (Samantha: 377), and anger (Joan: 513). These negative emotions were unexpected within the context of their work, with many participants feeling that the emotional support required of them was 'emotionally

draining' (Samantha: 329) and exceeded their role as a solicitor (I'm not you know an aid worker, Lucy: 327-329). These roles were not consistent with their sense of self, with many participants finding it difficult to separate themselves from the emotional experiences and 'not to get emotionally involved' (Samantha: 201).

Anxiety

Feelings of anxiety regarding health related issues seemed prominent and consistent with aspects of health anxiety: anxiety resulting from a perceived health threat (Salkovskis, 1997). Whilst participants did not express fear of having specific medical conditions themselves, they were explicit in their need to be vigilant about health ('I would always go to the doctors with a preconceived idea about what was wrong', Joan: 558) and medical procedures ('because you know it can happen', Lucy: 396). Across most participants there was a 'set for threat' perspective, this involved some participants testing their GP to assure themselves that things had been done correctly.

Most participants described the need to check either specific health symptoms or practitioner knowledge. The cognitive theory of checking behaviours (Rachman, 2001), proposes that habitual checking occurs when people who believe that they have a special, elevated responsibility for preventing harm, are unsure that a perceived threat has been reduced. It appeared from the interviews that participants felt they had an elevated sense of responsibility to protect others 'I told my brother what to do' (Samantha: 371). Many felt this was due to their knowledge of 'medical things' (Harriet: 374) which also isolated them from others.

Cognitive formulations of anxiety (Eysenck, 1992) propose that anxiety is caused and/or maintained by a bias in information processing, and that anxious individuals scan potentially threatening external situations for threat and focus greater

attention when it is present. Many participants appeared 'set for threat' and were vigilant of medical situations and professionals. Threat was also alluded to in participants descriptions of some clients, and the fear of them being 'unleashed' (Samantha: 148) or indeed 'bite' them (David: 1096). This could imply a hyper-vigilance to threatening situations.

The use of mantra's (please, get this right, please, Lucy: 496) and checking litany (have you got this, have you got that, Harriet: 369) suggests an active vigilance and generalised anxiety surrounding health. This also implies the need for checking and repetitive behaviours to ensure safety (Rachman, 2001). Participants may have believed superstitiously that by working in this area of law may prevent them from harm.

Isolated knowledge

The CSDT model proposes that, as a result of their work, individuals who work with people who have suffered trauma have differing worldviews to others, which sets them apart from those around them. Within the study Joan talked about knowing what the NHS is 'really like', implying her insider knowledge, similarly Samantha reports 'what we know goes on'. This knowledge may lead to feelings of isolation from those around them. Pearlman (1999) states that there is a 'sense of isolation' that comes from working with traumatised people due to issues of confidentiality and being unable to share one's altered worldview with others.

Isolation may also highlight the lack of containment that participants experience and the need to contain their client's emotions. Feelings of isolation and the need to share their experience and to shock were apparent to the researcher, in particular in Joan's interview. There were times in the interview where she described in great detail cases she had worked on and emphasised words such as 'dead baby' (934), which appeared to be used to shock the researcher and show how horrific some of her cases

were. The interview may have provided a safe space to share some of these experiences, which are otherwise unavailable in her routine work.

Organisational conflict

Almost all participants alluded to the expectation of a solicitor to be seen as being in control. As Joan (501) explains, 'if you can't hack it, do something else'. Highlighting the masculinised nature of legal work, David (182) also felt 'it would be easier for females' to ask for support or help with a case.

Many participants struggled with the conflict of culture, needing to be empathic with clients and contain emotions, yet at the same time needing to appear in control and examine a case dispassionately. There appeared to be a sense of participants struggling to contain their emotions when with clients, as well as beginning to share client emotion, as Samantha (272) describes 'well I know how you feel and I know how I feel', this could imply a sense of emotional contagion.

Emotional contagion involves a process of observing and feeling parallel emotions to those of somebody else (Figley, 1995). It is thought to be an unconscious process involved in an empathic engagement with someone else. A lack of self-awareness of this process has been suggested as a contributing factor towards VT (Saakvitne & Pearlman, 1995), as the individual may experience these emotions as their own.

Empathy

Strong feelings, which also seemed to drive help, are motivated by emotion, as Lucy (436) states 'help them more'. Legitimacy of cases affected empathy, with clients who reported less obvious catastrophic experiences; being less emotionally engaged with (I attach a little bit less emotion, Lucy; 304). Empathic engagement has been suggested to be a contributing factor towards VT (Saakvitne & Pearlman, 1995).

Through empathically connecting with another person's overwhelming feelings, the professional may also become overwhelmed; challenging the professional's view of themselves and their world view. Figley (1995) notes that, 'the process of empathising helps to understand the person's experience of being traumatised, but in the process we may become traumatized as well'. This is apparent when Lucy states, 'obviously you feel their pain', (Lucy 437) highlighting the emotional affect to her, through her empathic engagement. This also highlights issues of identification with a client's trauma (I know how you feel, and I know how I would feel, Samantha: 272), and involves responding to clients emotions as though they were their own.

Participants also described attending with more priority to cases that were 'particularly relevant' to them (Lucy: 359). These could be identified as 'hotspots', (Ehlers & Clark, 2000) referred to as past experiences or unresolved trauma which cause high levels of personal emotional distress. External issues can recall or remind individuals of past events or emotions. 'Hotspots' can cause professionals to become over focused on one issue and make misjudgements, due to increased stress and vulnerability caused by an emotional response. Avoidance or un-identification of individual 'hotspots' can lead to further emotional vulnerability (Grey, Young & Holmes, 2002).

Engaging empathically with clients and becoming motivated by emotion could conflict their role as solicitor and the objective attainment of best settlement for the client. Legal training (Grad, 2005) involves the ability to analyse factual situations for their legal significance and apply the law to the facts. This was evident in Samantha's (201) description 'I've got to look at it very clinically and very legally but I find it really hard not to get emotionally involved'. This highlights the difficulty in splitting herself away from the emotional aspects of her job and the demand of the law to

approach her work in a very structured and precise way. The arguably superstitious use of mantras (as described earlier) may also appear to conflict with a rational and objective role of a solicitor.

Developmental change

Participant's response to their work appeared to develop over time, this highlights that the distress they experienced was linked to their specific work rather than a response to other external triggers. For some this was a negative change, and for others a positive change. There was an increase in cynicism for some participants, for example, Samantha (360) described how her cynicism magnified 'I think I'm more cynical than I was'. This suggests that her work has impacted on her view and perception of the NHS. Lucy on the other hand discusses how she has made some adaptation to her work stress through discussions with a friend, enabling her to adopt a more balanced view 'that really has helped me a lot' (Lucy: 477). Although both provide different responses to the impact of distress, this highlights that the change is a developmental one and supports the view that the lawyers are experiencing distress through their particular work.

Support and Supervision

Healthcare professionals who work with traumatised or distressed people routinely engage in supervision. Supervision has been shown to be both preventative and ameliorative of VT (Sabin-Farrell & Turpin, 2003). Evidence within this research suggested that some solicitors sought social support which helped one participant mitigate fear and alter her construction regarding the NHS (Lucy: 471-477). The current study revealed that although some participants felt that some sort of supervision or support may be helpful, many felt that asking or using this would be portrayed as a sign of weakness (Joan: 142, 'does this look like you know I can't handle it'). Many

participants also stated that they would view less experienced colleagues as unfit for the job if they continually asked for support. Rosenbloom, Pratt & Pearlman (1995) suggest that a work culture that 'normalises' the stresses of working with traumatised clients provides a supportive environment for workers to address the impact their work and on their professional and personal life. This highlights the difference in work cultures and the need for caution when applying knowledge and suggestions from a healthcare background to a legal culture.

Methodological Considerations

A criticism often directed at qualitative research is the limited ability to generalise findings (Willig, 2008). This was true of the current study; it has not been possible to represent the views of clinical negligence solicitors within the accounts of five individuals. A small sample size also meant that other factors which may contribute to distress such as age, gender, years' experience and social support may have been less privileged for these participants experiencing work in clinical negligence.

This study however did not intend to be representative but rather an in-depth exploration of clinical negligence solicitors' experience of working with clients. The use of an IPA approach has provided access to the way in which clinical negligence solicitors construct their experience of their work, and has provided a rich, complex and rigorous account of individual experiences. Given the dearth of literature in this area to date the current study can be seen as generating valuable insights worthy of further investigation in other samples of solicitors.

Previous Research

Previous research on solicitors is predominantly quantitative and investigates those working in criminal law (Vrklevski & Franklin, 2008), public service law (Jackson, Turner & Brief, 1987; Tsai, Huang & Chan, 2009), asylum (Piwowarczyk et al., 2009) and domestic violence (Levin & Greisberg, 2003). All studies report varying levels of distress contributed by working with clients who are or who have suffered trauma. However, the findings were neither clear nor consistent and methodological weaknesses were common to all studies. The current qualitative research has provided grounded and rich accounts which are non-assumptive. There is currently, no reported peer reviewed qualitative studies on clinical negligence solicitors. This study has highlighted dimension to the legal work of clinical negligence which may differ from other aspect of law, due to engagement with clients and medical systems. This research therefore contributes to the legal field as well as the area of trauma, which also lacks in qualitative research (Sabin-Farrell & Turpin, 2003).

Study limitations and directions for future research

The location in which the interviews took place may have created a methodological constraint. It is acknowledged that a participant appeared less relaxed talking about their experiences whilst in their work environment and checking who was in the rooms adjacent to the one used for the interview. However, conducting interviews at the participant's place of work may have enabled better access to material which was consonant with their professional experiences.

Furthermore, it is acknowledged that an additional limitation of the study may be that participants were not asked as part of the back ground information, nor in part of the interview the number of clients they work with who are clearly distressed or

suffering mental health difficulties. This information would have been helpful in providing further evidence of the type of client's medical negligence solicitors work with but would have increased the directedness of the interview, when the main aim was to allow participants to raise topics that were of importance to them.

Clinical Implications

Clinical psychologists, both in state and private practice are likely to be involved in case work with clinical negligence potential. They thus, conduct legal work and work alongside solicitors. Highlighting and addressing these issues, provides an awareness of some of the concerns which may affect their legal colleagues, as well as making recommendations around training and support.

The implications of this study within the field of clinical psychology are that it will provide a new evidence base which investigates the experience of clinical negligence solicitors working with clients. To date a very limited qualitative literature has explored the experience of solicitors and this research is the first of its kind to investigate the experience of medical negligence solicitors. Research clearly shows a link between psychological distress in those who work with people who have suffered trauma or distress and that supportive environments or training would assist in reducing some of this distress. Clinical psychologists have expertise in the understanding of client distress as well as strategies that help mitigate this. Sharing this information with other professions, such as solicitors will benefit individuals as well as clients.

Future Research

The current study offered an exploration of clinical negligence solicitors experience of working with clients. Further research to expand the experience of solicitors could be developed within the following areas:

- Longitudinal research into transition experiences of clinical negligence solicitors when new in post and how their experiences and views change throughout their career would be useful. Finding out what training or support solicitors would value when starting out in their career and in terms of on-going training needs.

- Further research as to whether solicitors could use and benefit from supervision and how this could be applied within a legal setting.

- Further research which provides quantitative data to support exploratory findings into whether clinical negligence solicitors experience significant clinical levels of distress.

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Section Three: Critical Appraisal

Critical Appraisal

This chapter is an account of my personal reflections on designing, conducting and writing the current research. It is based upon notes kept in my research diary throughout the process and aims to summarise my learning from the research experience.

Background to Study

Whilst studying for a Masters in Health Psychology I became interested in traumatogenesis and more specifically the impact on individuals who experience trauma through their work. My Msc research project explored the impact of traumatic material on paramedic students. Through informal discussions with paramedics regarding their work, they openly discussed some of the psychological impact their work had on them and the lack of support and training they received. At the time of developing my ideas for this research I attended a research conference and met with some researchers who were investigating trauma in paramedics, in a large national project. Through discussions it was felt that this was an area that was already being investigated and I then began to search other areas of interest within the field of trauma.

As my ideas developed I became keen to conduct research on trauma and its impact on professionals who did not work within the healthcare profession, but through their work came into contact with people who had experienced trauma and distress. I was also fortunate to have a supervisor who had familiarity and experience in this area. In preliminary discussions with my supervisor she acknowledged how, whilst working through cases (in the context of clinical negligence), this had had an impact on her. This led on to a discussion about trauma and its impact on professionals generally, in particular on legal professionals and more specifically, on solicitors. Since this had had an impact on an experienced clinical psychologist, working in a supportive professional

environment, we considered the potential impact on solicitors who did not have this knowledge or background. Furthermore, we questioned how legal professionals managed the effects of trauma and its resultant impact.

In undertaking this project it was planned to use mixed methods, encompassing both quantitative and qualitative data collection. Ethical permission was granted for the research to collect data in both of these forms. However, due to sampling difficulties, the quantitative aspect of the project has been postponed and will be revisited as a separate research project, after completion of this thesis. Respondents may have felt safer, boundaried and more contained in giving face-to-face interviews rather than filling in an anonymous online questionnaire, which could have affected the nature and scope of the sample. As a result, this thesis has undergone a change to a more focussed study on solicitors' experience of working in clinical negligence.

It is acknowledged that the quantitative element will provide a more detailed evidence base to assess the extent of trauma and potential explanatory variables on respondents. I intend to continue this element of the research following submission of this thesis, when I will seek more creative ways of collecting data. Indeed, I will be presenting my research to clinical negligence solicitors at a legal conference in July 2012 and anticipate that this will generate interest, enabling further study.

Through interrogating the research base it was clear that gaps existed in studies exploring the emotional impact of work on legal professionals and its potential psychological consequences. During my preliminary reading, focusing on secondary traumatisation, there was evidently substantial work conducted on those in therapeutic roles. Examination of what could potentiate trauma-like symptoms suggested that roles and clients in legal settings might create similar issues for those working with them. Thus, selection of my research topic came about through my interest in health

psychology. Whilst health psychology has previously privileged patient research there is now an expansion of the discipline to consider health models and their applicability to professionals.

Working with other professionals

Clinical psychologists are increasingly being sought as expert witnesses due to their knowledge and expertise. This involves working with a variety of different professions, many of whom work in the legal profession. I felt the conduct of this research would inform my work with legal professionals and give a greater understanding of the impact their work has on them.

Study Design

A review of the literature (Lawson & Robertson; in press) on the impact of work on legal professionals revealed a circumscribed research base which was assumptive and appeared crude in its assessment of legal professionals' experience. Given the dearth of previous studies, a variety of qualitative methodologies were considered during the initial planning phase of the research, including discourse analysis, grounded theory and template analysis. Starks and Brown Trinidad (2007) examined the contributions to qualitative exploration permitted by phenomenology, (how people make sense of lived experiences), discourse analysis (how people use language to construct knowledge, meaning and identities) and grounded theory (frequently used to build a theory in the context of social process). Due to its focus on individual experience, a phenomenological approach, specifically Interpretative Phenomenological Analysis (IPA), was considered the most appropriate to meet the aims of the research.

The aims of the research seemed to fit more closely with the idiographic approach embodied in IPA. This would enable me to focus on each participant's subjective experience, and better understand the level of impact from working with individuals whose lives had been blighted by medical negligence (Smith & Osborn, 2003). Given the lack of qualitative research on solicitors and, more specifically, on clinical negligence solicitors, I felt it was important to explore the experiences of this group. My aim was to understand what it meant to be a solicitor working with people who had suffered traumatic experiences, and I felt this could be achieved using IPA. This would be important given that it was a new area of research without any pre-conceived ideas about what might be found.

Data Collection

Ethical Approval and Recruitment

The ethical approval required for this project was through the University of Leicester Ethics Committee as my research did not involve NHS staff or patients. Applying for ethical approval allowed me to refine existing skills in terms of how to make an application, giving consideration to such issues as: providing clear information to participants, taking informed consent, ensuring confidentiality and safe storage of data. Due to time constraints in research I have learned that applying well in advance of anticipated deadlines is a necessity. I am aware that ethical approval sought via university is less fraught than for peers undertaking research in clinical settings, which has made me think about the different requirements for different ethic committees. NHS ethical guidelines mainly focuses on issues associated with clinical trials and it could be argued that they are not wholly appropriate for social science research (BPS, 2005). It

has been suggested that rigid ethical frameworks risks ethical issues being seen as a set of 'procedural tasks, before the "real" research starts' (Small, 2001). Through not partaking in this process it gave me more time to familiarise myself with the British Psychological Society (BPS) ethical principles, described in the professional Code of Conduct (BPS, 2006). However by not undertaking NHS ethical procedures I avoided consent training and Research and Development processes. I feel that this is a competence worth acquiring post qualification.

Recruitment for the interviews was surprisingly easy, as quite early on two solicitors agreed to take part and they recommended a further two who were also recruited. The use of 'snowballing technique' was a useful way to recruit participants. However, I am aware that recruiting in this way may have contributed to a sampling bias with participants selecting colleagues who they viewed best fitted the research. This is an issue that I am mindful of in the current research as well as in any future research.

Five participants volunteered to take part, consonant with aspirations of Interpretative Phenomenological Analysis (IPA) study (Smith & Osborn, 2003). A relatively small sample size enabled me to examine transcripts over time, with rigour and permitted me to hold consecutive interviews in mind during analysis. I think this facilitated the constructions of connections across interviews and enhanced confidence that I was capturing their phenomenological essence.

Saturation and Sufficiency

Throughout the course of completing this thesis, when evaluating previous research, I was mindful of sample sufficiency and how I would attain this for the quantitative aspect of this research, but due to time constraints this was not achieved. In

then considering sample size within qualitative research the concept of saturation has been used by many reviewers as a measure of sufficiency of data. There remains a debate within qualitative research about what constitutes a sufficient sample size. Smith and Osborn (2003) note that sample size for an IPA study depends on a variety of factors and that there is no 'right' sample size (p. 54). Small sample sizes are regarded as acceptable in IPA since it is the depth and quality of the analysis, rather than the number of participants, that defines the quality of the research. In terms of saturation, Smith et al. (1999) state that it is problematic, due to the "cyclical or iterative nature of analysis, in which passages are analysed repeatedly in the light of insights obtained from other sources. This is a process which could theoretically continue ad infinitum." (p. 95).

In considering the arguments about sufficiency and saturation, saturation has not been used within the current research. Upon reflection it would appear that saturation is not a measure to be applied generally across all qualitative methodologies, but applied in specific methodologies, such as grounded theory which is a key element of the methodological process.

Reflexivity and Bracketing

The concept of 'bracketing' involves suspending pre-suppositions and prior knowledge (Husserl, 1999). This allows the researcher to focus on material that is presented and discourages interference with data collection. I have reflected on the process of 'bracketing' and used my research diary to aid this.

Within the interview process I found that running the interviews very close in time was not helpful as this impacted on the focus within the second interview. I found it difficult to 'bracket' things off and found myself pursuing similar areas that were said

in the first interview. Consequently, in subsequent interviews I gave myself time to process and reflect by 'bracketing' my thoughts in my research diary before embarking on the next interview.

A further issue, in relation to bracketing, was my differential roles as a trainee clinical psychologist in conducting research. At times I found my role as a researcher challenging as a result of listening to accounts of distress, yet was unable to offer strategies to help. This felt alien and engendered a sense of inadequacy given my professional instinct to help others. At the end of one interview a participant asked how I cope with my own work and the type of strategies I would recommend. Whilst the questions were appropriate, and I was able to signpost the participant to further information, this alerted me to the dilemma of my dual role.

Indeed, my own feelings of wanting to help and the conflict of my dual role mirrored some of the feelings and experiences expressed by the participants and their 'conflict of roles' and wanting to help. The experience interviewing participants talking about wanting to help their clients, whilst also having feelings of wanting to help them was an interesting dynamic. I used my research diary to reflect on this process and had an awareness of any impact it may have had on subsequent interviews.

Finally, there was a sense in which conducting my literature review may have impacted upon my analysis of the data. There were certain words and emerging themes which I searched for, seemingly due to my acquired knowledge about secondary trauma. Again, I attempted to 'bracket' off this knowledge and immerse myself within the text and the participants' own world. This became easier as the analysis progressed, although it made me consider to what extent a researcher can ever fully discount previous knowledge, however explicitly attempted.

Interview process

The interview was piloted with a solicitor working in clinical negligence known to the research supervisor. This interview generated a number of interesting findings, such as the lack of support/supervision, the culture of solicitors and a fear concerning medical procedures. From this interview, no adaptations to the research schedule were made. The pilot was not included in the final analysis as it was not digitally recorded.

Interviewing was an enjoyable yet initially anxiety provoking process. I had anxieties about interviewing a participant group that was very different from those I encounter in psychological practice. After my pilot interview, and the detailed information that came from this, I grew in confidence and learned that I have transferable skills from my clinical role: namely, empathic engagement and building rapport.

Initially, I was uncertain about how much I should adhere to the interview schedule and how directive I should be. Smith and Osborn (2008) suggest that the researcher should decide in advance how much movement from the interview schedule would be permitted. In the first two interviews I felt that I was inclined towards trying to keep to the schedule. This was in part due to my anxiety and the need to 'get it right', as well as wanting to be perceived as professional.

Following the first two interviews I did not feel such a need for rigid adherence. In contrast to my initial doubts I was struck by how easily most participants talked about their experience. The less rigid process enabled a more relaxed interview process and more detailed material from the participants was gleaned. As the interviews progressed I was more confident that participants would take the lead in telling their

own story. By allowing the participant to take the lead it enabled them to talk more freely, sharing what was important to them.

At times, when participants disclosed an experience, I found it difficult not to reflect this back to them, or help guide the structure of the session, as I would normally do in my therapeutic work. This experience of the 'one-sided conversation', whereby the researcher says very little (Smith, Flowers & Larkin, 2009), raises the importance of using the interview schedule as an aid and not as a restrictive protocol. In my research diary I reflected that 'I need to remember to let the participant lead and keep my research hat on, not my therapeutic hat'. I believe that by allowing the participant to lead this helped me focus on my role as a researcher, which ultimately had a positive impact on the interviews.

This issue of conflict in roles is something which I have reflected on throughout this process. Clinical psychologists have key skills which enable them to undertake qualitative research, such as their therapeutic skills in listening and being empathic, and understanding the clinical context. However, an awareness of the distinct roles is important. Thompson and Russo (2012) highlight the need to reflect on the different purposes of the roles; one as a therapist, with a focus of facilitating change, and the other as a researcher with the aim of gaining information. They state that there are likely to be many ethical dilemmas associated with being a clinical psychologist conducting research. I have learnt to consider my own position and the influence that this can have on all stages of research, as well as the need to be transparent about my role, and clearly explaining this to participants. This may become especially pertinent in any future research I embark on in healthcare settings, where my role may be better known and I may encounter therapeutic expectations from participants.

Factors affecting power balance in the participant/researcher interaction

Generally, a facet of research is a power imbalance between participant and researcher, possibly underpinned by education, class or professional status (Smail, 1994). Power issues are often described in research in relation to the interviewer exerting more power over the interviewee. However, in this case I felt that the participants could hold more power.

This may reflect some insecurity on my part about interviewing solicitors, equally it may also have been the participants' portraying their control when talking about their experience. An explicit interpreted theme, and one I dynamically felt during interviews was 'the fear of being seen not coping'.

Conducting the interview at the solicitor's place of work may have affected interaction and material generated. Solicitors appeared to be familiar with interviewing their clients at work rather than being interviewed, and I speculated on how our respective roles might be challenged. That I was made comfortable, offered coffee and found some respondents asking how they could help me, created an unfamiliar power dynamic for both me and possibly the solicitors.

There were also certain points throughout interviewing which suggested that the participants themselves had decided how much they chose to share with me, and thus there could be limitations regarding whether the data truly reflects the phenomenon. For example, a couple of the more experienced solicitors referred to me as a 'research student', which suggests a different role from being a trainee clinical psychologist. They may not have felt comfortable enough to disclose certain aspects of their emotional experiences to a 'student', which may have restricted some of the detail in the accounts.

Conversely, one of the less experienced solicitors appeared very interested in my role as a psychologist and asked me a lot of questions following the interview. She spoke about her wish to have studied psychology and how rewarding my job must be. This highlighted the theme of 'conflict of culture' and the desire by some participants to 'help people'. It also made me aware of my role and how this may have affected her ability to express her experiences due to the fear of talking to a 'psychologist'; equally, it may have allowed her to feel more comfortable.

The process of recording also seemed, at times, to create a barrier. It was noticeable that at least one participant, with some sense of relief, spoke more freely when I turned off the digital recorder at the end of the interview. This highlighted the unnatural setting of the interview and that I was only accessing information that was situation dependent.

Before the start of one interview, one participant made an effort to check whether the adjacent office was occupied stating 'the walls are very thin'. This might suggest nervousness about acceptability of self-disclosure or distress, and equivocation about talking freely and confidentially whilst in their work place. Similarly, a couple of participants checked half way through the interview that it was confidential. On reflection, I believe it would have been better to have conducted the interviews in a neutral place to eliminate such barriers. However, interviews were undertaken at their work place due to time restrictions from both the researcher and the participants.

Furthermore, a couple of participants apologised for 'going off' whilst talking or asking if their answer was 'ok', and one said at the start of the interview that she unsure she met my criteria; and then expressed a lot of emotive material. This implies some denial concerning their experiences and again suggests a dynamic where

participants may have selected the information they shared, based on what they thought I wanted to hear, and on what they felt comfortable sharing.

This demonstrates that presentational elements in research, and the content delivered, are likely to be influenced by the context and highlights whether interview material ever truly reflects the phenomena under investigation. A limitation of IPA has been noted as the reliance on the 'representational validity of language' (Willig, 2008; p. 66), in that the words used to describe an event may be carefully selected, and the same event could be described in a number of different ways. This can, therefore, limit the extent of how much the account tells us about the experience.

Data Analysis

Familiarisation with IPA

I was familiar with IPA, through my Masters level research, but this felt superficial, so I immersed myself in texts, undertook a short course and participated in an IPA peer group with fellow trainees. As a result of this I then felt more confident to undertake the analytic process.

Conducting the analysis

Smith, Flowers and Larkin (2009) recommend that an IPA analysis should begin with the researcher immersing themselves in their data. Whilst I transcribed the first two interviews, the use of a transcriptionist enabled time to be freed for later immersion and theme interpretation. Although this was considerably helpful at the time, in hindsight it may have been more beneficial to transcribe the interviews myself. Having personally transcribed some of the interviews, the analysis was easier and I could recall

the content and remember quotes that I found significant. Whilst I do not think it had an overall impact on the analysis, in some ways it made it easier.

During transcription I also noticed how I sometimes asked long, complex questions, which I have since tried to reflect upon within my clinical work. As a result, I have attempted to monitor the way in which I phrase questions with clients. I will also be mindful of this is in any future qualitative research I conduct.

Before analysis I listened again to my interviews and felt that I had some rich data. Yet I found the interpretative process challenging and felt initially reluctant to interpret. Perhaps the struggle to make psychological interpretations was particularly distinct given my role as a trainee clinical psychologist. To address this perceived weakness I undertook further training via an IPA workshop offering practical experience of data analysis. This workshop was invaluable and as a result I did not feel constrained to or the need to 'get right'.

Reflexivity

My research diary entries, prior to conducting the interviews, debated whether participants, given their roles as lawyers, would be able to engage in the reflecting space of a research interview. This reflected preconceptions based in relative ignorance and media portrayals as manipulative, brusque and mercenary. The research interviews, however, revealed the money-driven culture of clinical negligence but, more importantly, how altruistic motives of the solicitors were in conflict, causing significant distress. This revealed that qualitative research can provide a deeper level of understanding and experience about participants and the contexts in which they work and find meaning.

My difficulties regarding the need to follow guides, when writing my interview schedule, and keeping to this schedule when conducting the interviews, is parallel to my journey over the three years training as a clinical psychologist. When new to something, I am often in search of guidelines on how to do things. When I started the course I was often in search of 'how to' guides for therapy, and often made detailed session plans, which I tried to stay with during sessions, and felt uncomfortable when the session moved away from the plan. However, with clinical experience I have been able to stop searching for set guides, and appreciate the clients' own agenda, and that 'being with a client' allows a better understanding of their world. Through conducting my interviews in a more open way this has highlighted the need to listen and allow the client/participant to tell their story. It has also highlighted the richness that qualitative data can provide.

Though initially concerned I was not undertaking the mixed methods approach, as originally planned, I am nevertheless satisfied that I focused on a qualitative approach. Having more time to engage with a qualitative method, I was able to feel more competent and it gave me a richer understanding of participants' experiences.

Throughout the process of conducting interviews, and then transcribing and analysing data, I was aware of how some of the content had an impact on me. All participants talked about their fear of illnesses being misdiagnosed or failed operations and the fear that this gave them. I also felt that it had an impact on my view of medical procedures and the NHS. I continue to reflect on whether this information is shaping my own beliefs regarding quality of care, as well as on the political and financial drivers which affect our care.

At the time of interviewing I had personal experience of being an NHS outpatient when having medical investigations. During this time I found myself questioning the doctor's opinions and I was researching the evidence base on the internet more than previously. Whilst this was manageable, and did not create too much anxiety or stress, it made me empathise and understand more how participants may feel when working everyday with accounts and claims of medical negligence. It also made me consider the impact that interviewing has on qualitative researchers.

There is limited literature on the psychological impact of conducting qualitative research on the researcher. However, the research available (Dickson-Swift, James, Kippen & Liamputtong, 2007) provides evidence that collecting emotionally demanding data, often in isolating environments, with inadequate space to share or reflect, can lead to feelings of anxiety, threat to security and social isolation. Conducting research as a trainee clinical psychologist was helpful in enabling me to reflect on the process and use supervision. I also found my research diary very helpful for placing my own thoughts and feelings to one side and to help me understand the participants' experience, without my own experience getting in the way. Rager (2005) has discussed the importance of research diaries that allow the researcher to obtain a reflexive distance from the experiences they document.

This experience also highlighted the impact that research data can have on others who listen to potentially emotive material, and it also drew my attention to the transcriptionist in the research process. Having had the experience where some of the interviews made me think about my own health, I took time to check with my transcriptionist that she was OK and reiterated the availability of supervision and support. Through using a transcriptionist and thinking about the possible impact on her, it made me realise that transcriptionist are often overlooked within the research process.

Qualitative researchers have been found to experience VT due to their repeated exposure to traumatic stories (Pennebaker, 1990). This could also be an unexplored issue for transcriptionist. I have learned that supporting all members of the research team is important when conducting qualitative research.

<div align="center">Learning Outcomes</div>

I have learned a number of competencies throughout the process of conducting research at doctoral level:

- I have gained a sound understanding of Ethical Principles and Good Clinical Practice in Research. I have strived to apply these principles in my research, specifically giving clear information to participants, taking informed consent, ensuring confidentiality and the safe storage of data. I have also become acutely aware of the issues associated with occupying multiple roles as a clinical psychologist and as a researcher. The use of reflection throughout the qualitative research process has been invaluable.

- Conducting research, with very few professional contacts in the field I was researching, was a learning curve for me. I am now more aware of how uncertain some aspects of research can be. Additionally, I am more aware of the difficulties of recruiting participants, particularly professionals working outside of the healthcare system. I have learned to be aware of obstacles, that previously I may not have anticipated, as well as the need for flexibility. It has taught me the need for careful organisation as well as planning for all eventualities.

- Completing a research project in a set timescale and working as an individual qualitative researcher, without the support of a research team, has its challenges.

At times this felt overwhelming, especially in the analysis phase, where engaging with the participants' world often felt chaotic and unpredictable. What has helped to balance some of these challenges is conducting research in an area of individual interest for me. I also learned how invaluable it is working with a supportive and dedicated supervisor who is experienced in research. The importance of having support and belief from others allowed me to push through the more challenging elements of the process.

• The process of writing a thesis, amidst everyday life and personal stresses, has developed my project management skills, including time management, organisation and flexibility.

Overall, I have enjoyed the process of conducting this piece of research and hope that my future career will provide me with opportunities to further develop the skills I have learned. Through this process I have come to a different position regarding qualitative research and the value that it can have in deepening our understanding of an individual's experience. I feel more confident and would be keen to embark on further research in the future.

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