The Process of Adjustment and Coping for Women in Secure Forensic Environments

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<u>DEDICATION</u>

This piece of work is dedicated to my Uncle Phillip & Gregory Philippatos; two extremely special people who unfortunately did not see me finish this journey.

<u>Acknowledgements</u>

ABSTRACT

Clinicians working with women in forensic secure environments will be acutely aware of the diverse risks, complex treatment needs and unique responsivity issues found in this multifaceted marginal group. Women make up 5% of the prison population and approx 20% of the secure forensic psychiatric population (approx 4,500 and 1,085 women respectively). What animates the studies of women is not so much numbers of offenders but the particular circumstances of the women and girls "behind" the numbers. There is a common perception that women make up such a small number of the criminal justice service (CJS) population that devising gender sensitive environments and interventions is unnecessary. However studies of patients detained in high and medium security have identified significant gender differences. Women are more likely to commit minor offenses, be diagnosed with a personality disorder, present with self injurious behaviour and have suffered childhood victimization. Thus, women and girls who are caught up in the justice system enter it as a result of circumstances distinctly different from those of men.

Up until recently the needs of women were inadequately met in services centred on the needs of men and it is only relatively recently that the need to address these glaring differences has been thrashed out in the public arena. Following a number of high profile reviews and reports mixed sex wards have been become a exceptional, strip searches of women in prison have been abolished and large numbers of women have been reviewed and stepped down to lower levels of security. A less well researched area of women's secure care centres on the profound impact of adjusting to a new environment which involves coping with severance of social support networks.

OVERVIEW

Chapter one opens with a rapid systematic literature review surrounding adjustment to prison for women. This review aimed to inform the current ways in which women are supported and how women differ from men in terms of coping an adjustment whilst detained.

This is followed in Chapter 2 by a critique of the culture free self esteem-2 psychometric tool. This tool is often used within forensic services in order to measure self esteem and also due to the incorporation of a defensiveness scale which aims to measure an individual who may be attempting to fake or fake bad. Chapter 3 describes the mixed method research project investigating adjustment and coping by women in a low secure forensic psychiatric hospital. Reflections and comparisons of the information gathered about how women adjust in these two secure environments are drawn on to conclude this chapter.

Chapter four summarises an organisational case study focussing on two ward relocations within the women's medium secure service within a forensic psychiatric hospital. A mixed method approach comprising of two focus groups and the Essen CES scale allowed exploration of the impact on both the patients and the staff team. Chapter five allows for a final discussion and reflections. Additionally the model bore out of this research will be discussed in more detail.

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INTRODUCTION

To cope is an important necessity as a human being, especially vital when adjusting to an unfamiliar environment and/or when the environment is restrictive or out of the individuals' control. The issue of coping is therefore very much apparent in secure forensic environments and contributes to the difficulties faced by women on a day to day basis within these settings. It is noted that women who enter these establishments have a limited repertoire of coping strategies and skills in order to deal with the variety of hardships incarceration imposes (Zamble & Porporino, 1988; MacKenzie, Robinson & Campbell, 1989).

Victimization, abuse, insecure attachments, polydrug use and self harm typify many women who enter the criminal justice system (Slotboom, Kruttschnitt, Bijleveld, & Menting, 2011). Throughout their experiences individuals are taught or teach themselves how to cope. Linehan (1993) theorizes that early invalidating environments, which are common in the developmental pathways of many women residing in forensic settings, may teach poor strategies to cope with emotional distress.

Self injury or parasuicidal behaviour is a common form of behaviour attributable to women found to alleviate negative emotions and exert feelings of control (Favazza, 1992). Explanations for this psychopathology have observed a shift from a physiological to a psychological stance, in that, self injury is observed to be something more than just an act of self mutilation; it signifies an attempt to cope and communicate with others. The affect-regulation model supports this reasoning together with attachment theory, proposed by Bowlby (1973, 1982, 1988). Attachment theory highlights the protective functions of close relationships and emphasizes the importance of interpersonal experiences as a source of affect regulation (Mikulincer, Shaver & Pereg, 2003). This interpersonal aspect has been noted to be especially important for women and is illustrated as such by the relational self

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theory (Surrey, 1991). The underlying premise of the relational self theory is that individual understandings of self, and development of skills, will flourish within the context of relations with others. Thus, the experience of incarceration and severance of familial and social ties is very much contradictory to the positive development and rehabilitation of some of the most vulnerable women in our society

Consequently gender differences in terms of environments and interventions aimed at treatment and rehabilitation have been discussed (Bartlett & Hassel, 2001). A recurring major critique of psychiatric practice is the relatively small amount of clinical information and research on which to base treatment strategies and identify specific unmet needs for women residing in forensic facilities (Bartlett, 1993).

Various reports and reviews have detailed the unnecessary number of women in psychiatric forensic facilities for preventable amounts of time (Fallon, Bluglass, Edwards & Daniels, 1999; Tilt, Perry & Martin, *et al.,* 2000; Shaw, Davies, & Morey, 1999; NHS Executive, 1999). It is further noted by Aitken and Logan (2004) that once in the secure mental health system, women are at risk of losing their liberty for between three and four times longer than their women peers in prison, and longer than their male counterparts.

With the increase in time spent within secure forensic facilities comes the increased likelihood of transfer between placements as well as change in care team and peer groups. All of which can trigger negative emotions and can encompass distressing situations, of which, the women feel they have very little control. With every transfer, an individual can find themselves surrounded by a new group of people, who they have not yet built therapeutic relationships with, relying on a small repertoire of skills in order to cope as best they can.

It is noted that the initial entry into forensic secure establishments is the most difficult to deal with, and the most risky (Islam-Zwart, Vik, & Rawlins, 2007; Fogel, 1993). Findings have shown that over a quarter of self inflicted deaths in the prison estates occur in the first

seven days. In order to mediate this stressful period, and to be able to provide functional positive supports for women, an exploration of evidenced based factors concerning women and the experience of adjustment for women is required. The concept of coping and adjustment for women who are currently residing in secure care, and attempting to cope with the environment they find themselves in, is a highly original concept and will be explored within this paper.

CHAPTER 1

A Rapid Systematic Review on Adjustment to Prison

1.1 ABSTRACT

A systematic approach was used to investigate the effects of incarceration on female prisoners and their subsequent adjustment to prison. Research has shown that the growing female prison population has high levels of self harm and suicide and this may be linked to the high levels of depression and anxiety found in the prison population (Keaveny & Zauszniewski, 1999). So in order to safely manage women in a prison, and the risk this poses; it is vital to understand the contributing factors and possible outcomes which are associated with adaptation to prison.

Electronic databases were searched for relevant studies, additionally key academics in the area were contacted and grey literature was searched. The studies identified were initially subjected to a two stage inclusion/exclusion assessment by the primary reviewer. All included studies were then subject to a three stage quality assessment process which included two quality assessment forms and the use of a second reviewer. The final stage allowed the relevant data to be extracted, in order to make comparisons and conclusions.

Findings showed that importation and deprivation factors both seem to play a part in an individual's initial adjustment to a prison environment. However, the extent to which each type of factor interacts during this period of adjustment remains unclear. The findings were considered in relation to study quality and methodological limitations. Future research recommendations are discussed.

1.2   INTRODUCTION

1.2.1   Demographics of women in prison

The number of females incarcerated in prisons in the UK is rising rapidly; in the last decade the female prison population has risen by 33%, (Prison Reform Trust, 2011). It has been further noted that the rise in female inmates can be explained by an increase in more severe sentences. For example in 1996, 10% of women convicted of an indictable offence were sent to prison, this had risen to 15% by 2006 (Ministry of Justice, 2007; MoJ).

In the UK, eleven thousand and forty four women were received into prison in 2009, (MoJ, 2010a), and over half of women entering custody each year do so on remand. Women spend an average of four to six weeks in prison on remand and nearly 60% do not go on to receive a custodial sentence. Of the women who receive a custodial sentence 61% receive less than 6 months. However, as there are only 14 female prisons across England and Wales it is likely that women will be placed miles from their home area. The mean geographical distance adult women in prison were held from their home address was 57 miles. In 2007, around 800 women were held over 100 miles away (House of Commons, 2009). Together with the knowledge that the first seven days are the most critical period, the distance would only serve to increase feelings of isolation (Islam-Zwart, Vik, & Rawlins, 2007; Fogel, 1993).

Differences in gender have been documented throughout the psychology literature, so it is unsurprising that both men and women bring different needs, risks and protective factors to the prison environment. In a survey of prisoners, conducted in the late 1990's for the Department of Health, high levels of mental health problems were present in the prison population. The rates of prisoners with depression in a twelve month period ranged from 39% for sentenced men to 75% for women on remand.

1.2.2 Critical period

Statistics released by the Ministry of Justice show that between 2001 and 2010 that there were 714 self inflicted deaths, and of these 181 occurred in the first seven days of custody. Although it is unclear as to what proportion were male and female, the high number of deaths in the critical period accounts for over a quarter of all self inflicted deaths in custody; supporting the need for research and advancements in this area.

Moreover, the period immediately after incarceration appears to increase the chance of deteriorating health levels for women, this includes mental and physical ill health (Fogel, 1993). More specifically, Keaveny and Zauszniewski (1999) found that nearly 90% of newly incarcerated women voiced significantly higher levels of depression and anxiety when compared with females in the general population. Additionally, Fogel (1993) expressed concern when findings showed that the level of stress women encounter upon incarceration is related to health status six months later.

TABLE 1.

Self Inflicted Deaths in Prison Custody by Time Spent (In England and Wales)

Year	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Total No of Self- Inflicted Deaths	73	95	95	96	78	67	92	61	61	58
On first day of arrival	2	1	2	4	0	2	1	3	0	0
1st or 2nd Full Day	4	12	13	13	13	3	5	5	9	4
3- 7 Days	8	17	12	13	2	3	11	3	10	6
8- 30 Days	22	22	16	23	17	12	17	10	6	7
31 Days- 3 Months	15	20	18	19	12	20	23	15	16	15
3 Months- 6 Months	8	12	16	9	20	12	15	12	13	8
6 Months – 1 Year	9	8	6	12	4	7	9	8	5	8
Over 1 Year	5	3	12	3	10	8	11	5	2	10

TABLE 2.

Self Inflicted Deaths in Prison Custody by Gender (In England and Wales)

Year	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Prison Pop	66,301	70,778	73,038	74,657	75,979	78,127	80,216	82, 572	83, 560	84,725
Male	62, 561	66, 479	68, 613	70, 209	71, 512	73, 680	75, 842	78, 158	79, 277	80, 489
Female	3,740	4, 299	4, 425	4, 448	4, 447	4, 447	4, 374	4, 414	4, 283	4, 236
Total Deaths in Prison Custody	**142**	**164**	**183**	**209**	**174**	**153**	**185**	**166**	**169**	**196**
Total Self-Inflicted Deaths	73	95	95	96	78	67	92	61	61	58
Male	67	86	81	83	74	64	84	60	58	57
Female	**6**	**9**	**14**	**13**	**4**	**3**	**8**	**1**	**3**	**1**
Other*	69	69	88	113	96	86	93	105	108	138

*Other includes natural causes, other non-natural causes, homicide, and unclassified deaths.

Adapted from 'Safety in Custody' 2010 (MoJ Statistics Bulletin, 2011)

1.2.3 Responsivity issues

Andrews, Bonta and Wormith (2006) note that understanding the interactions of offenders' risks and treatment characteristics are essential. Andrews *et al.,* (2006) also recommended continued systematic exploration of various domains, which inform responsivity issues. However, the research needed to consider and respond to this recommendation seems to be lacking.

Although there is a body of literature on adjustment to prison per se, there is currently little agreement about measurement tools, and ways to investigate adjustment. This issue is further confounded by the diverse effects a prison environment can have on each individual, and the various outcomes that seem to arise from incarceration. Both male and female prison settings, although based on the same principles, have varied ways of working and hence have different effects on the individuals they contain.

1.2.4 Appraisal of previous reviews

To date, there are no systematic reviews looking at adjustment to a female prison environment. A study by Zamble and Porporino (1988) is referenced as the first longitudinal study in this field. Participants were followed for 16 months, over this period the researchers observed what they believed to be two characteristics of long term imprisonment 'coldness' and 'self-containment'. More recently a review by Flanagan (1991) provided a research synthesis based on the adjustment and adaptation of long term prisoners, highlighting their difficulties, and how they cope or adapt to this way of life. This study is focussed on male participants, predominantly from the USA and Canada. Although promising, in terms of

longer term prisoners, little has been etched for shorter term prisoners and especially shorter term female prisoners and their adjustment, adaptation and coping upon incarceration.

Flanagan then went on to discuss the difficulties and stressors faced by long-term male prisoners; generally they seem to ascribe more importance to the problems associated with incarceration, rather than the prison environment itself. Difficulties with external relationships, relationships within prison, fear of deterioration, indeterminacy and the prison environment were all flagged as important. In line with the many stressors and difficulties faced, several coping strategies were identified. Coping may take the form of a behavioural manifestation e.g. an active avoidance of trouble; or by completing courses/ programmes to improve their skills and their opportunities when released. However, the study by Zamble and Porporino (1988) suggests that ineffective coping skills are pre-cursors to offending behaviour, and these poor coping skills do not improve much over time, even with external aids. This lack of improvement was attributed to a "behavioural deep freeze" which occurs because prison does not provide accumulated experiences of normal learning opportunities in which coping strategies can be developed. To conclude, Flanagan notes that it is

"incumbent on the correctional system to work with the offender to plan a worthwhile career- one which will benefit both offender and others and will be transferable upon eventual release"

[1991: p. 50]

Similar conclusions have since informed strategies and policies regarding life sentence prisoners. For instance, the British Home office (1989) instituted a series of policies that incorporate a system wide career planning model for long term inmates.

1.3   AIMS AND OBJECTIVES

The purpose of this review was to identify all studies available for review up until 31st May 2011, which include data about the effects of incarceration, and adjustment in a female prison setting and possible outcomes.

- To determine what factors made adjustment difficult for female prisoners.
- To determine the range of outcomes elicited by women with varying degrees of adjustment to imprisonment.
- To determine what circumstances affect adjustment to imprisonment for females.

1.4   METHOD

1.4.1 Sources of literature

A structured review was conducted to capture publications from a range of databases available in the public domain, unpublished dissertations and studies which were uncovered with contact from experts in the field of forensic psychology with a special interest in prison adjustment and wellbeing.

1.4.1.1   Electronic databases

Six electronic databases were independently searched by one researcher; these were

- Campbell Collaboration
- The Cochrane Database

- ISI Web of Knowledge

- National Criminal Justice Reference Service (NCJRS)

- PsychInfo

- Applied Social Sciences Index and Abstracts (ASSIA)-

Within ASSIA a number of other databases are automatically searched these include:-

EconLit

ERIC

IBSS: International Bibliography of the Social Sciences

LISA: Library and Information Science Abstracts

CSA Linguistics and Language Behavior Abstracts

PAIS International

PILOTS Database

CSA Worldwide Political Science Abstracts

CSA Sociological Abstracts

CSA Social Services Abstracts

Recent References Related to the Social Sciences

1.4.1.2   Reference checking

The reference lists of all selected studies were hand searched to identify additional studies.

1.4.1.3   Personal communications

Professor Kevin Wright (University of Binghamton), Mr Edward Zamble (Queens University), Professor Ann Loper (University of Virginia), Professor Rudolph Alexander

(Ohio State University), Dr Derek Roger (Canterbury University, NZ) were contacted as experts in the field, and were asked whether they were able to identify and suggest relevant studies.

1.4.1.4 Grey literature search

The first 50 hits of various Google searches in the 'Web' and 'Scholar' options were hand analysed by one researcher. Additionally, Pro Quest dissertation database was searched, including the dissertation library at the University of Nottingham.

1.4.2 Search strategy

The search terms were devised in order to collect information, which would give outcomes after the exposure of incarceration. Database keyword dictionaries, thesaurus synonyms, truncation, Medical Subject Heading terms (MeSH) and Boolean operators were utilised in the search strategy where appropriate. The MeSH terms are a pre-selected topic of classification systems applied to all papers in each database. Use of MeSH terms within a database widens the scope of a keyword by considering categorised references. The keyword search strategy was defined by previous studies and research findings that identify outcomes of incarceration upon adult female prisoners. These included psychological distress, emotional distress, stress, hopelessness etc for the full list of final search terms see Appendix A.

1.4.3 Transfer of references into End-Note

Once all the references from each of the databases had been uploaded into EndNote, a duplicate search was conducted. A replica search was necessary, as many of the different databases reference the same articles when searched, using similar criteria. Once all studies had been transferred to EndNote, the two stage examination of the titles and abstracts began which then allowed for the identification of eligible studies for the review.

1.4.4 Study selection

Identification and assessment of studies for inclusion occurred at two stages. Studies identified were initially subject to a two stage inclusion/exclusion assessment by the primary reviewer. The included studies were then independently assessed by a second reviewer. This two-stage process enabled a more rigorous assessment prior to the dedicated quality assessment stage.

1.4.4.1 Inclusion/ exclusion stage

Studies that met the following criteria were included in the review:

Population: Adult female prisoners aged 18 or over.

Intervention/ Exposure: Incarceration (remanded or sentenced).

Comparator: N/A

Outcome: Effects of incarceration which may include psychological, emotional & physical signs of distress, hopelessness etc. No effects were excluded from this review.

Language: Any language.

Study Type: All study types were included in this review. However the most common form of research in this area is conducted with cross sectional or cohort designs; this is due to the type of exposure/ intervention being monitored. This is mainly because it would be unethical to comprise a control group and expose them to incarceration if it was not imperative. Also, the researcher is unable to change elements of the prison environment prior to exposure, and must only measure the outcome of the exposure.

Exclusion: Narrative, editorials, commentaries or other types of opinion papers.
(For full parameters see inclusion/ exclusion criteria protocol Appendix B).

The inclusion and exclusion of studies was carried out by the primary reviewer, using predefined parameters of two assessment forms. It was double checked by a second reviewer to minimise errors. All references that were identified as eligible were marked for collection of a hard copy reference

1.4.4.2   Quality assessment stage

Once publications that did not match the inclusion criteria were excluded, the quality of each study was assessed. All the included studies were either cohort studies, or cross sectional controlled observational studies, and these types of studies can be more prone to bias. The decision to use the STrengthening the Reporting of OBservational studies in Epidemiology Checklist (STROBE) was made prior to data collection. Quality assessment incorporating the STROBE assessment checklist was completed on all relevant studies before data extraction began (see Appendix C & D).

Each study was considered using the following categories from the STROBE assessment

- Title and abstract

- Introduction

- Methods

- Results

- Discussion

- Other Information

Additionally, a second quality assessment form was used to increase the level of quality in included studies; this form asked questions specifically pertaining to either cohort or cross-sectional studies and was based on the information given in the studies (see Appendix E & F). For example, questions encompassing measurement and definition attempted to ensure low measurement bias within the study, and depending on what information was given it was scored using the following scoring system:

- Met (Y)

- Partially met (P)

- Not met (N)

- Unclear (U)

This scoring system was deemed appropriate and suitable, as empirical research has shown that quality numbering scores are arbitrary, unreliable and hard to interpret (Juni, 1999). All the included studies (n=12) were critically appraised by the primary reviewer, and a randomly selected subsection of the articles (25%, n=3 papers) were also independently assessed by a second reviewer to ensure reliable ratings. Disagreements in ratings were resolved by discussion between the two reviewers.

1.4.4.3 Data extraction stage

Once a reference had undergone quality assessment checks the relevant data was extracted. Data extraction included general information about the identity of the reference, specific information regarding the study, and information about the outcome after subsequent exposure to incarceration. Reference data included: the type of report; name of the author; year of publication; and country of origin. Information regarding the study included: type of study design; study setting; sample size and outcome measures. Outcome measure data consisted of the outcome and the follow-up period for outcome measurement (or the full data extraction form, see Appendix G).

1.4.5 Research overview

As has been discussed, this research project was exploratory in nature: to identify outcome measures of incarceration in prison settings. To fulfil the aims of this study, a rapid systematic review was carried out. This included a comprehensive search within a range of databases which are available in the public domain, and also to capture those unpublished pieces of work whose results are relevant to the search strategy.

The review took place over a nine month period. The methods used in this structured literature review were considered at length by the primary researcher who worked on the project day-to-day, and by a review supervisor who reviewed the methods during different stages of the review process. This enabled the review to be guided by the primary researcher with experience in forensic psychology, and a supervisor with expertise in the area of health psychology. The aim was to ultimately incorporate experience, expertise and knowledge into the systematic methodology structured literature review.

1.5 RESULTS

1.5.1 Description of studies

Figure 1 shows that the search strategy described in the methodology generated a total of 13,981 results. A further four studies were identified from reference lists and correspondence with experts in the field; 594 studies were excluded due to duplication. 12,946 did not meet the inclusion criteria leaving 445 studies. During supervisory discussions, it was decided that due to the large number of identified studies, and time constraints of the review the population criteria of the PICO was refined from 'adult prisoners' to 'adult female prisoners'. 395 studies did not pass the inclusion criteria of the

refined PICO and 50 studies remained eligible. Of these 50 studies, 22 were found in the CSA ASSIA database, 12 in the ISI WOK database and 2 in Psychinfo. Three relevant studies were identified in Proquest Dissertation Abstracts, and 11 from the grey literature searches.

FIGURE 1.

Quorom Flowchart for Included Studies.

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┌─────────────────────────────┐        ┌──────────────────────────────────┐
│ Potentially relevant studies │        │ (Pre- Screening Stage)           │
│ identified and screened for  │───────▶│ Ineligible studies excluded;     │
│ retrieval (n= 13,985)        │        │ (e.g. not correct sample pop,    │
│                              │        │ gender on basis of title)        │
│                              │        │ (n=13, 540)                      │
└─────────────────────────────┘        └──────────────────────────────────┘
              │
              ▼
┌─────────────────────────────┐        ┌──────────────────────────────────┐
│ Abstracts of studies retrieved│       │ Studies excluded which did not   │
│ (n= 445). PICO refined in order│──────▶│ follow refined PICO (n=395).     │
│ to make results of systematic │       │ Refined PICO of 'adult women     │
│ review comparable.            │        │ prisoner'                        │
└─────────────────────────────┘        └──────────────────────────────────┘
              │
              ▼
┌─────────────────────────────┐        ┌──────────────────────────────────┐
│ After refined PICO (n= 50)   │        │ Studies excluded from review     │
│ CSA ASSIA- 22                │───────▶│ at quality assessment stage      │
│ ISI WOK- 12                  │        │ (n=27)                           │
│ Psych Info- 2                │        ├──────────────────────────────────┤
│ Dissertation Abstracts- 3    │        │ Unobtainable studies (n=11)      │
│ Grey literature- 11          │───────▶│                                  │
└─────────────────────────────┘        └──────────────────────────────────┘
              │
              ▼
┌─────────────────────────────┐
│ Relevant studies included in │
│ final review (n=12)          │
│ CSA ASSIA- 5                 │
│ ISI WOK- 7                   │
│                              │
│ Total= 12 Studies            │
└─────────────────────────────┘
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1.5.1.2   Unobtainable studies

The primary reviewer attempted to obtain studies through a variety of different methods including the University library, contacting the authors and other eminent academics in the area.

1.5.1.3   Characteristics of included studies

All included studies were nonrandomized observational studies. Eight of the included studies were cross sectional (66.7%) and four were cohort studies (33.3%). Cohort studies compare outcomes between participants; measuring potential causes before the outcome has occurred, usually with a follow-up period (Mann, 2011). In this case the outcome was adjustment to a prison environment and the various factors associated with this outcome.

Cohort studies have both advantages and disadvantages, for example when an RCT is unethical, a cohort study is usually used instead; especially when dealing with risk factors, which then allows calculation of relative risk. An advantage is that a single study can examine various outcome variables in chronological order which can sometimes demonstrate that certain "causes" preceded the outcome, thereby avoiding the debate as to which is cause or effect. The cross-sectional design examines relationships between variables at one point in time (Mann, 2011). Again, there are numerous advantages and disadvantages of this type of study. One main advantage of such studies is the low cost as only one group is used, data is collected only once, and multiple outcomes can be studied. The most pertinent problem with this type of study is differentiating cause and effect from simple association.

Tables 3 to 6 illustrate the properties of the 12 studies included in the structured review.

TABLE 3.

Type of report included in rapid review.

Report Type	N	%
Journal Article	8	66.7%
Government Report	1	8.3%
Book/ Chapter	3	25%

Due to the inclusion criteria and sources of studies in the review the majority of studies were sourced from journals.

TABLE 4.

Country of publication included in rapid review.

Country	N	%
USA	11	91.7%
UK	0	0%
Amsterdam	1	8.3%

The most frequent country of origin of the studies included in the review was the USA, producing eleven out of the twelve. Additionally, seven of the studies originating from the USA were funded by a grant, either from a government department or a university; whereas in other countries this type of funding or support may not be available. The bias generated by the high proportion of studies originating in the USA means that the conclusions drawn from this review are tentative, in terms of applying to settings and practices in the UK.

TABLE 5.

Sample size of studies included in rapid review.

Sample Size	N	%
1-50	0	0%
51-100	4	33.3%
101-200	3	25%
201-300	1	8.33%
301-400	1	8.33%
401-500	0	0%
501-600	0	0%
601-700	1	8.33%
701-800	1	8.33%
801-900	1	8.33%

The sample size of the included studies displayed a peak at 51-200. There is a substantial difference between the highest sample size and the most common sample sizes.

TABLE 6.

Study design included in rapid review.

Study Design	N	%
Cohort Study	4	33.3%
Cross Sectional	8	66.7%

Most of the designs included in this review were cross sectional (66.7%) and the remainder were cohort studies; this is due to the type of exposure/ intervention being monitored.

1.5.2 Descriptive data synthesis

Four of the cross-sectional studies (Van Tongeren & Klebe, 2009; Thompson & Loper, 2005; Warren, 2003; Warren, Hurt, Loper & Chauhan, 2004) used the widely validated and standardised tool, the Prison Adjustment Questionnaire (Wright, 1985; PAQ). Within these four studies the PAQ was given a two factor solution, (Conflict and Distress) instead of the previously reported three factor model, (Internal, External & Physical) by Wright. This was reported to be because of the differences between the female and male prisoner experiences preceding and during incarceration. Whilst the cohort studies report two types of adjustment; internal adjustment (discomfort around prison officers and other inmates, poor sleep hygiene & emotion management) and external adjustment (arguments and physical fights). Specifically, the study by Slotboom *et al.,* (2011) integrated two key theories related to adjustment; the importation and deprivation, (indigenous), model. These models allowed for an exploration of the interaction of factors and experiences prior to incarceration (importation) and the individuals current experience of incarceration (deprivation). Both types of adjustment, and the two factor solution seem to share an overlap in terms of importation and deprivation factors, and the presenting problems and associated difficulties.

1.5.2.1   Importation factors

Slotboom *et al.,* (2011) explored a variety of different factors and experiences, findings show that over one third of the inmates had been imprisoned before. Nearly a half of the participants (40%) reported experiencing physical and psychological abuse. Islam- Zwart and Vik (2004) found that overall the experience of previous sexual assault, whether as a

child or an adult, will have a negative impact on adjustment to a prison environment. Women with a history of both childhood and adult sexual assault reported lowest internal adjustment scores, whereas women with only a history of adult sexual assault report significantly more external adjustment problems.

Prisoners with no assault history showed elevations of internal adjustment problems in the early stage of incarceration however this significantly decreased after 2 weeks. However, internal adjustment problems for inmates with a history of both childhood and adult sexual assault, and those with only a history of adult sexual assault increased slightly after the early incarceration period. Subsequently, experiences of family/ relational violence, sexual abuse/ substance abuse or being a victim of a criminal offence were found to have an overall negative effect on an individual's ability to adjust. Over three quarters (80%) of the 251 participants had reported at least one negative life event prior to incarceration, and on average women reported five traumatic events prior to incarceration (Slotboom *et al.,* 2011).

Furthermore the presence of child abuse and child victimization was found to be a predictor of serious prison misconducts; which has also been used as an outcome measurement in terms of adjustment to prison. Alternately it was found that emotional abuse or victimization experienced in adulthood did not influence prison adjustment, but did affect adjustment back into a community setting. Similar to previous findings, Houck and Loper (2002) found that age was also significantly related to institutional misconducts.

In previous studies the amount of time served had been related to adjustment measures, yet MacKenzie, Robinson and Campbell (1989) found no significant relationship between time served and adjustment. Both previous treatments for mental health problems and previous traumatic experiences contributed significantly to predicting PTSD symptoms whilst incarcerated [$F(2, 70)=11.21$, $p<.001$, with R^2adj=.24].

Furthermore, Warren (2003) found specific demographic factors which appeared to be linked to adjustment. Results suggested that minority status and prior incarceration contributed significantly to elevated scores on the distress scale of the PAQ. Whilst age, marital status, crime type and time served contributed significantly to the conflict scale. Additionally, Warren *et al.,* (2004), noted that the presence of phobic anxiety & presence of a personality disorder, explained 27% variance of the conflict scale. Moreover, being married, being a victim of threats and physical assaults prior to age 18 explained a further 23% of the variance of the conflict scale.

1.5.2.2 Deprivation factors

In regards to deprivation factors, Slotboom's findings show that nearly two thirds, (60%) of the sample, felt they had good social support whilst imprisoned. Furthermore, Warren *et al*., (2004) reported that 91% of prisoners reported moderate to high levels of acceptance from other prisoners. Similar to previous studies it was found that women reported feeling safer and calmer in prison; 89% said they feel safer during the day, and 80% reported feeling safer at night, and physically more secure in prison than they did in the community. In addition 60% of the sample reported having no problems with prison rules, staff or fellow inmates.

The main difficulties reported when living in the community include feeling angry, having heated arguments, getting involved in fights, being injured, getting sick and fearing attack (as measured by the PAQ; Warren, 2003). Warren *et al.,* (2004) found no significant difference between the problems faced prior to prison compared to incarcerated life, however problems sleeping and feeling uncomfortable around people were found to be significantly

worse since incarceration for most of the sample. Fewer than 10% of the sample (n=777) reported that fighting or being injured was worse since incarceration.

In regards to relationships with staff, 10% felt disrespected by staff and 3% felt repressed by staff. The women reported considerable environmental stress which affected sleep and discomfort around prison officers and other inmates (Slotboom *et al.,* 2011).

1.5.2.3 Psychological effects of incarceration

Approx 75% of the inmates surveyed reported some sort of mental health problem; 28% of the sample was at heightened risk of self harm. 17% stated they had already harmed themselves, and 31% had experienced suicidal thoughts.

Additionally, a model to predict an individual's risk of self harm was formed. Comprised of five deprivation factors- repression, lack of respect by staff; problems in prison; lack of contact with family; and having young children while in prison. Integrated with three importation factors- prior treatment for mental health problems, prior detention and not being able to speak the native language. This model was significant [$F(8, 200)=17.60$, $p<.001$, R^2adj=.42], (Slotboom *et al.,* 2011).

The most prevalent psychological symptomology was anxiety and depression. Factors found to significantly raise levels of these symptoms include being held in two remand prisons [$F(3, 212)= 3.36$, $p< .05$] and being a recipient of treatment for previous mental health problems [$F(7, 201)= 25.62$, $p< .001$, with R^2adj $= .48$]; both appeared to predict depressive symptoms in the sample.

The studies by Paulus and Dzindolet (1993) and Islam-Zwart *et al.,* (2007) support the majority of the findings in early literature, which suggest that levels of psychological distress decrease over time and then remain relatively constant. Islam-Zwart *et al.,* (2007) reported

the most significant decline of psychological symptomology is observed between the first and second week of incarceration; with the first week remaining the most critical period. Both studies report that the most common psychological symptoms experienced by female inmates are depression and anxiety. Furthermore, Paulus and Dzindolet (1993) found that those inmates who report a high degree of tolerance towards the various deprivations of prison life reported more positive emotional, physiological and psychological reactions.

1.5.2.4   Being a parent

Houck and Loper (2002) found that the interactional effects of parental stress during the adjustment period were found to generate high levels of emotional distress, as measured by the Brief Symptom Inventory (Derogatis, 1993), just over a third of the 362 participants fell above the normal threshold for anxiety, and over half of the participants scored above the normative range for expression. Finally, one third of participants reported normative somatisation levels.

MacKenzie *et al.,* (1989) reports that the parental attachment score was not significant to any of the measures of adjustment, whereas the competence scale on the prison-specific parenting stress scale was consistently related to emotional adjustment. Furthermore, non-minority mothers, and mothers with elevated stress levels related to their competence and skill as a parent, report significantly more emotional and physical distress (anxiety, depression and somatisation) and were charged with more serious misdemeanours.

1.5.3 Outcomes related to different types of adjustment

1.5.3.1 Environmental adjustment

VanTongeren and Klebe (2009) focused on environmental adjustment. This was defined as "acquiescence toward the temporary environment of prison through effective understanding of the norms and standards of the system and effectively surviving". Societal rehabilitation defined within the study as "maintaining societal values of the culture at large and aiming toward reintegration" and criminality reduction defined as "the mitigation of criminal thinking and behaviours". Findings show that societal adjustment was significantly related to more positive overall adjustment as measured by the PAQ (PAQ total).

Additionally, perceiving the prison environment as temporary was related to significantly less criminal entitlement and cold-heartedness, as measured by the Criminal Thinking Styles (CTS) questionnaire, and also significantly related to better overall prison adjustment (PAQ total). Viewing the prison as permanent was related to greater problems with external adjustment.

The two factor solution of the PAQ was also found to apply to the participants in this study, and further analyses showed that viewing the prison as temporary is related to lower levels of distress. Furthermore, findings show that individuals who continue to engage in criminal thinking styles, view the prison environment as permanent, and have low self-esteem, are likely to face greater conflict in prison. Overall, greater self esteem seemed to be the best indicator of adjustment, and was related to better environmental adjustment, lower conflict, greater societal adjustment and lower criminal thinking (VanTongeren & Klebe, 2009).

1.5.3.2   Multidimensional construct of adjustment

Following on from these findings a multidimensional construct of adjustment was constructed and five subtypes of adjustment were defined;

- Maladjusted Criminal Thinkers (high PAQ, high CTS, low to mod SAS scores)

- Hardened Prisonized Offenders (low to mod PAQ, high CTS, high SAS)

- Externalized Adapters (low PAQ, high CTS, high SAS)

- Optimal Adjusters (low PAQ, low CTS, high SAS)

- Emerging Reformers (low PAQ, low CTS, low SAS)

The groups were found to be significantly different on the three scales (PAQ, CTS and Societal Adjustment Scale; SAS). However the types of adjusters did not differ significantly on locus of control, but did differ slightly on motivation to change. Furthermore, individuals scoring highly on the SAS tend to demonstrate a significant inclination to change problematic behaviours. There were also, significant group differences in regards to age with the Optimal Adjuster group, the Hardened Prisonized Offender group being significantly older than the other three groups. In addition, Warren (2003) found that younger inmates (<32 years) reported higher levels of hostility/ interpersonal sensitivity/ paranoid ideation and psychoticism than older inmates. Whilst older inmates (>32 years) scored significantly higher on the somatisation scale.

1.5.3.3   Procedural adjustment

Furthermore, VanTongeren and Klebe (2009) found no significant difference between security classification, sentence length, months incarcerated, number of incarcerations, total number of years spent in prison and type of adjustment displayed. Unlike the previous study by Thompson and Loper (2005) their results showed significant differences between adjustment patterns in relation to sentence length. More specifically, long and medium term inmates reported higher feelings of conflict, and subsequently committed significantly more nonviolent institutional offences than short term inmates. No group differences were found in relation to time served, and institutional adjustment, and no significant difference was found between sentence length and violent infractions whilst incarcerated.

Results from MacKenzie, *et al.,* (1989) highlight differences between time served and sentence length and the interaction of these deprivation factors. The sample (n=141) was initially separated into three groups;

- STST (short time served, short term sentence)
- STLT (short time served, long term sentence)
- LTLT (long time served, long term sentences)

1.5.3.4   Emotional adjustment

Findings showed no significant difference between the groups in terms of anxiety levels on entering the prison establishment. Subsequently, after initial admission to prison, scores pertaining to feelings of safety were found to be significantly different for all three of

33

the groups. The LTLT group ranked safety significantly lower and less of a concern than the other long sentence groups [$t(26)= 2.4$, $p < .05$]. Additionally the STST group reported feeling significantly less in control than the STLT group. Finally, the LTLT group reported significantly more situational problems than the STLT group. The groups also differ in relation to reported needs and problems. Those with long term sentences reported many more problems related to the environmental situation than those new to the prison establishment. Also the severity of problems seemed to increase for women serving long term sentences.

Findings from this study also show a large percentage of newly incarcerated prisoners who are involved in play families. These are defined as affectionate relationships which are established by mutual agreement between inmates, and usually different members are given titles such as 'mother', 'sister', 'aunt' (Giallombardo, 1966), this is much less frequent in longer serving prisoners. Negy, Woods and Carlson (1997) attempted to look at types of coping strategies in more detail and findings showed that some coping strategies employed by women in prison were positively related to psychosocial adjustment to the prison environment. The most positively related were both emotion focused and problem focused strategies.

Thus, it was found that inmates possessing a diverse range of coping strategies manifested better adjustment than inmates with smaller coping repertoires [$R^2 = .44$, $F(4, 148) = 8.67$, $p < .001$]. Moreover, inmates in this sample with a larger range of coping strategies had higher self esteem [$r(151)= .38$], lower anxiety [$r(151)= -.33$] and less depression [$r(151)= -.33$]. Furthermore, inmates who took a proactive stance towards problems interpreted stressful events in a positive way, accepted unpleasant events more often and tended to turn to religion for consolation. Additionally, they also reported feeling better about themselves, less depressed and less anxious.

TABLE 7.

Overview of Observational Cross Sectional Studies

Title Author(s) Year Published Country	Description of Participants	No of Participants	Intervention / Exposure	Procedure/ Method of Study	Battery/ Measures	Outcome
Exploring prison adjustment among female inmates. Issues of measurement and prediction Warren *et al.,* (2004) **USA**	Female inmates in a maximum security state prison	777 inmates completed all relevant measures	Incarceration	Each inmate filled out one research protocol at one point over a six month period.	PAQ (Wright, 1985) BSI (Derogatis, 1993) SCID-II Screen-structured clinical interview (APA, 1994) A Prison violence inventory (based on a community violence inventory by Monahan *et al.,* 2001) Security Classification Institutional Misconduct- file review Demographic and	PAQ Feeling uncomfortable around people and problems sleeping were the only factors that participants found to be worse in prison than in the community. Other factors including heated arguments, being sick, fear, and fights were worse or the same when they lived in the community. Two factor solution based on the PAQ scores was found; distress and conflict Conclusion In contrast to previous findings for men on the PAQ who found prison harder to adjust to; this study showed that females had worse problems when living in the community. Suggesting that they may feel safer, calmer and physically more secure in prison than in the community which should aid adjustment. Confirming earlier findings by Linquist

						crime history variables	& Linquist (1997) psychological factors were central to adjustment. Anxiety contributed to 26% of the variance in the distress model and hostility and presence of a personality disorder accounted for the majority of the variance on the conflict factor model. It was unclear as to whether anxiety and hostility reflected enduring coping styles possibly related to the high rates of previous victimization or more unique reactions to prison life. Emotional responses are uniquely highly related to prison adjustment and not an artefact of distressed reporting styles on the PAQ and BSI. Inmates who had children experienced greater levels of distress and it exacerbated the problems these women experienced in adjusting to prison life. Additionally victimization as a child or being a non-minority also contributed to greater problems in prison adjustment. In contrast to prior research, prior incarceration was associated with higher levels of distress however it only explained a small amount of the variance in the distress and conflict model. Being married was associated with better

						adjustment.
Baseline psychopathology of a woman's prison its impact on institutional adjustment and risk of violence Warren (2003) **USA**	802 inmates at the Fluvanna Correctional centre for women.	Screening stage involved 802 inmates Second stage 311 inmates	Incarceration	Participants were approached in their unit and invited to take part. They were to complete the battery with pen or paper or could have it read to them. They were given cookies and soda and a fluorescent pen for taking part.	Demographic Summary (self report and file review) SCID II Screen PAQ (Wright, 1985)	Women under 32 yrs reported more behavioural problems on the external subscale of the PAQ Results reflect greater problems with adjustment among younger women compared to older inmates. Being married and having children were associated with greater adjustment difficulties. Participants included in the minorities (e.g. African American) reported fewer problems with adaptation. Cultural differences may cause white women to experience and describe their psychological distress in terms of symptomatic experiences and early victimization whereas minority women may express the same type of inter al distress through more outwardly oriented symptoms of personality disturbance and violence towards others. Women who have experienced prior incarceration also reported lower scores on the physical subscale. Higher maladjustment scores on the PAQ were found among participants who had experienced sexual

						victimization as a child.
						Women who reported being the victims of threats, assaults, and lies and rumours reported significantly higher levels of maladjustment on internal, external, and physical scales; which resulted in higher scores on the global scale as well.
						The women who reported being victimized by forced sexual encounters reported similarly higher levels of maladjustment on the PAQ,
Psychological well-being of incarcerated women in the Netherlands importation or deprivation Slotboom *et al.,* (2011) **The Netherlands**	251 Participants from four different prisons (Breda, Nieuwersluis, Ter Peel and Zwolle) completed the questionnaire The sample was generally comparable on background characteristics to the total population of prison pop at the time the	251 completed the full data set (60% response rate)	Incarceration	Some participants completed the questionnaires individually in their cells and some completed them in small groups accompanied by a researcher	The variables used in the analysis were derived from the following three questionnaires ISWI (International Study on Women's Imprisonment) Questionnaire Dünkel *et al.,*2005) The Impact of Events Scale (IES) Horowitz *et al.,* 1979) Negative Life Events (LE)	<u>Psychological complaints of incarcerated women</u> Most women scored high both on self-harm (85%) and irritability symptoms (76%). However, more than half of the women (56%) reported depressive symptoms. 63% of the women (N total=83) scored higher than 35, the cut-off score for PTSD diagnosis. Furthermore, 17% said they had deliberately harmed themselves and 31% had suicidal thoughts. Findings show that a majority of women report depressive complaints, one-third have had suicidal thoughts and two-thirds have PTSD symptoms. Although the last two factors were only measured in two institutions. Externalizing complaints and self-harm risk were less

	interviews were conducted. However, convicted prisoners and women with long sentences were over-represented. Most of the sample were incarcerated for drugs and property crimes and violent offenders were slightly under-represented.					prevalent. The prevalence of depressive complaints is comparable to the findings of the ISWI study (Dünkel *et al.,* 2005). Across all countries (excluding the Netherlands) 65 per cent of the interviewed women reported depressive complaints (ranging from 40.7 per cent in Denmark to 92.4 per cent in Greece). These findings also correspond with the findings from the survey of more than 25,000 inmates in State and Federal Correctional Facilities, conducted in the USA. This survey showed that approximately three-quarters of the female inmates reported mental health problems.
Reconceptualizing prison adjustment: A multidimensional approach exploring female offenders adjustment Van Tongeren & Klebe (2009) **USA**	Female offenders (*N* = 200) from a maximum security prison in a large urban city in Colorado were randomly selected and invited to participate in a study which examined their	88 adult female prisoners	Incarceration	A list of the entire population of the facility was obtained and 200 participants were picked at random. Case managers distributed the invitations those identified	PAQ; Wright, 1985) Societal Adjustment Scale (SAS) The Criminal Thinking Scale (CTS; Walters, 1995) Locus of Control (LOC; Rotter, 1966) Self-Esteem Scale (SES; Rosenberg,	Societal adjustment was also significantly related to greater physical adjustment as measured by the PAQ subscale; viewing the prison experience as temporary was significantly related to better overall prison adjustment (PAQ Total), whereas viewing prison as permanent was related to greater problems with external adjustment. Finally, criminal thinking (CTS) was related to poorer external and physical prison adjustment on various criminal thinking subscales (e.g., criminal

adjustment to prison life. Of the 200 who were invited, 88 offenders attended one of six testing sessions across two evenings and returned a packet. These offenders ranged in age from 19 to 59 years ($M = 34.99$, $SD = 9.82$) and had been at that current facility for 3 to 66 months ($M = 14.60$, $SD = 12.61$).			Six evening sessions, over 2 days (i.e., three sessions each evening), in a large visiting room, were arranged by the staff at the prison. Each invited participant was assigned a session to attend based on their security status and case manager. P's were briefed as to the purpose and procedure of the study and asked if they desired to participate. $5.00 was used as an incentive for participation.	1965) The University of Rhode Island Change Assessment (URICA; McConnaughy, Prochaska, & Velicer, 1983) Spiritual Well-Being Scale (SWBS; Ellison, 1983) The Santa Clara Strength of Religious Faith Questionnaire (SCSRFQ; Lewis, Shevlin, McGucklin, & Navratil, 2001),	rationalization, irrational thoughts). By employing the two-factor scoring method of the PAQ (Warren *et al.,* 2004) that has been used in previous research with female offenders (Loper, 2006). The Distress Factor was negative related to the temporary assimilation subscale of the SAS, suggesting that viewing prison as temporary is related to less distress. Greater self-esteem seemed to be the best indicator of adjustment: it was related to better environmental adjustment (low PAQ scores), lower conflict (as measured by the PAQ conflict subscale), greater societal adjustment, and lower criminal thinking. Motivation to change was related to greater societal adjustment. Existential well-being was related to better environmental adjustment. Similarly, greater signs of criminal thinking were related to a sense of permanency when considering adjusting to prison, as well as problematic experiences in physical and external environs within the institution. Therefore, a higher degree of criminal thinking, which is indicative of poor adjustment, is marked by an inability to get along with others, maintain one's physical health and environment while

				P's either completed the battery of questionnaires individually or in small groups,		incarcerated, and the maintenance of perceiving the prison environment as permanent rather than temporary. The results confirm that integrating the cultural standards of prison as permanent is related to poorer adjustment, both externally and physically. Likewise, measures of criminality were correlated with poorer physical adjustment.
Adjustment patterns in incarcerated women: An analysis of differences based on sentence length Thompson & Loper (2005) **USA**	The data for this study were collected as part of a larger longitudinal study. 692 women incarcerated at a maximum-security prison in central Virginia. The sample was divided into three sentence groups: long-term inmates had sentences of 10 years or more ($n = 199$), medium-term inmates had	Participants were 692 women incarcerated at a maximum-security prison in central Virginia.	Incarceration	Participants were approached and asked if they would like to participate. If so researchers contacted them over a 6-month data collection period. There were no exclusionary criteria. Researchers initially met with the women in groups of 5 to 25 at their	Prison Adjustment Questionnaire (PAQ; Wright, 1986). Brief Symptom Inventory (BSI; Derogatis, 1993) Measure of institutional misconduct	There was no significant relationship between sentence length and emotional adjustment, as measured by the GSI of the BSI, nor was there any effect after controlling for effects of age and time served. A significant relationship was found between sentence length and nonviolent institutional misconduct, $F(2, 605) = 4.08$, $p < .05$. Specifically, long-term prisoners committed significantly more nonviolent infractions than short-term prisoners ($p < .05$). Medium-term prisoners also committed significantly more nonviolent infractions than short-term prisoners A significant relationship was found between sentence length and the conflict scale of the PAQ; however no significant relationships were found between sentence length and the other three PAQ scales.

	sentences of 2 to 10 years (*n* = 350), and short-term inmates had sentences of less than 2 years (*n* = 143).			housing units.

Protocols were administered and informed consent sought

All self-report measures were distributed and p's were informed they may complete these in a group or individually

P's were offered soda and cookies as refreshment but was not deemed to be an incentive. | | Conclusion
Results imply that incarcerated women with short-term sentences are better adjusted to prison than incarcerated women with longer sentences. These results support the findings of past studies conducted with female inmate populations (Casey-Acevedo & Bakken, 2001; MacKenzie *et al.,* 1989).

No differences were observed in inmates' emotional adjustment related to sentence length. |
| **The relationship between female inmates coping and adjustment in a minimum security prison**

Negy, Woods & Carlson (1997) | Participants were recruited from a minimum security federal prison camp in Byran Texas, USA.

Made up of 78 | 153 Adult Female participants | Incarceration | Participants were recruited on a voluntary basis no incentive was offered although a note was put into their prison records | COPE (Carver, Scheier & Weintraub, 1989)

STAI (Spielberger *et al.,* 1983)

BDI (Beck & Beck, 1972) | Both emotion focussed and problem-focussed strategies correlate with psychosocial adjustment to prison.

Inmates who took a pro-active stance towards problems reinterpreted stressful events in a positive way, accepted unpleasant events and tended to turn to religion for consolation. They also reported feeling better about themselves, |

| USA | White, 40 Black, 30 Hispanic, 1 Asian and 4 'other' participants. | | | to say they had participated in a research study.

Questionnaires were administered orally to participants in groups of 10-20 participants. | Rosenberg Self Esteem Scale (RSE; 1979)

Demographic Questionnaire

Disciplinary infractions taken from prison records. | less depressed and less anxious.

Individuals possessing a wider range of coping abilities are more adaptable and therefore manifest better adjustment to prison.

Specifically inmates reporting larger coping repertoires had higher self-esteem, less anxiety and depression than inmates possessing a restricted range of coping abilities. |
| **Long-term incarceration of female offenders prison adjustment and coping**

MacKenzie *et al.,* (1989)

USA | All inmates of Louisiana's only adult female prisons were asked to participate. The mean age of the participants was 30 years; the majority were first time offenders and 63.1% were not White.

The majority of the sample was convicted for murder (32,5%), theft | 141 Participants in total volunteered to participate. They were then grouped into three groups depending on sentence length
(a) Had been in prison < 2years and had sentences of <48 months

(b) Had been in prison < 2 years but had | Incarceration | All participants were invited to sessions on a Saturday evening where cookies and refreshments were provided whilst they completed the hour long questionnaire. Inmates in solitary confinement were given their questionnaires in their cells. | Prison Preference Inventory (PPI; Toch, 1977)

Control of Events Scale (based on a scale by MacKenzie & Goodstein, 1985)

A question related to Play Families

Perceived Problems and Needs (Richards, 1978) | There was no difference regarding anxiety on entering the prison, however there is some evidence that the groups adjust differently- Newly entered/ short term sentenced prisoners report significantly less control of events than those who are new to prison but face long sentences.

A large percentage of newly received prisoners admit to being involved in play families – this change over time with is found in longer serving inmates who do not report being involved in a play family.

There are differences in reported needs and problems. Those with long sentences reported many more problems related to the environmental situation than those who were new to prison |

	(38.9%) or robbery (14.3%).	sentences of 96 months pr more (c) Had received long term sentences and who had been in prison for at least 48 months.				The long sentence long term prisoners were much less concerned about their safety than the short term long sentence. New arrivals in the prison system suffer less from situational problems and utilise more coping techniques whereas long sentence/ long term prisoners are more troubled with situational problems and not coping abilities.
The relationship of parenting stress to adjustment among mothers in prison Houck & Loper (2002) **USA**	Participants were part of a larger study concerning adjustment to prison ranging in age from 19-59 years (M=32.6 SD= 7.4). 76.5% of the women had assumed day to day responsibility for their child's care prior to incarceration and 91.1% had contact with children at least once a	Participants were 362 Female inmates who were also mothers with children under the age of 21.	Incarceration	The research team invited participants to voluntarily participate in the study. Informed consent given. Administration of questionnaires was most often done in groups of 5-25 individuals however if the women preferred they were allowed to fill them out individually.	Parenting Stress for Incarcerated Woman (PSI; Abidin, 1995) Brief Symptom Inventory (BSI; Derogatis, 1993) Measure of Institutional Misconduct- file review Legal issues relating to Children (seven stand alone questions)	Psychological Adjustment Most inmates in the study scored in the clinical range of the BSI subscales showing a high level of general emotional distress. 40% scored well above the normative range for anxiety; 51% scored over the norm range for depression + 33% scored well over the normative range on the somatisation scale. Parenting Stress and Adjustment Minority status was significantly related to all adjustment variables and age was significantly related to institutional misconducts. Non-minority mothers reported significantly more emotional and physical distress (inc anxiety, depression and somatisation) and were charged with more serious infractions of institutional misconduct.

| | | | | Participants were instructed to complete the parenting questionnaire in reference to the child under 21 to whom they felt closest. | | There was no relationship between time served and adjustment measures.

There was significant relationship between the competence subscale of the PSI and psychological distress and institutional adjustment; specifically women with elevated stress related to competence and skill as a parent tended to report more anxiety and depression symptoms as well as citations for institutional misconduct.

Parental attachment was not significantly related to any of the measures of adjustment whereas the competence subscale was consistently related to emotional adjustment. |

*See Appendix H for full list of measures with the validation and standardization status of each measure used within included studies.

TABLE 8.

Overview of Observational Cohort Studies.

Title Author(s) Year Published Country	Description of Participants	No of Participants	Intervention/ Exposure	Procedure/ Method of Study	Battery/ Measures	Outcome
Female adjustment to incarceration as influenced by sexual assault history Islam-Zwart & Vik (2004) **USA**	Participants were females incarcerated in a minimum security unit at a women's state prison. All participants were serving a conditional sentence usually associated with a first offense.	92 participants with 64 completers. 88 Participants data was used to test hypothesis 1 and 58 participants were used to test hypothesis 2.	Incarceration	This study was conducted as part of a larger drug use and HIV risk study. Women incarcerated within the previous week were approached and asked to participate. Once informed consent was established the participant completed a two part structured clinical interview	Clinical and Demographic Interview. Items pertaining to sexual abuse and sexual assault were guided by previous research. PAQ (Wright, 1985)	Significant group differences were found for internal ($p = .045$, $\eta2 = .076$)and external adjustment scores $p = .020$, $\eta2 = .094$). There was no overall change in internal adjustment after two weeks however internal adjustment was significantly dependent on type of sexual assault. External adjustment did not differ significantly by assault type over time but did show a significant increase in external adjustment difficulties after two weeks ($p = .046$, $\eta2 = .076$). Specifically, external adjustment increased from 0.15 ($SD = 0.60$) at incarceration to 0.39 ($SD = 1.22$) 2 weeks later. Finally, mean physical adjustment scores dropped from 0.89 ($SD = 1.72$) to 0.48 ($SD = 1.37$), indicating that inmates showed decreases in physical adjustment

| | | | | within the first two weeks of incarceration. Following the completion of the interview they were asked to complete a brief packet of questionnaires.

Participants were again asked to complete the same questionnaire packet once two weeks had lapsed following the completion of the first packet. | | problems after two weeks. |
|---|---|---|---|---|---|---|
| **Short-term psychological adjustment of female prison inmates on a minimum security unit**

Islam-Zwart *et al.,* | Participants were adult females incarcerated on the minimum security unit of an all-female state prison in | 62 adult female prisoners | Incarceration | Data were collected as part of a larger study assessing HIV risk.

All female inmates | The Brief Symptom Inventory (BSI; Derogatis, 1993)

2- Stage Demographic Interview (Islam-Zwart *et al.,* 2007) | On average, female inmates experience a mild level of psychological distress upon initial incarceration.

Repeated measures analysis of variance (ANOVA) showed a significant overall decrease in psychological symptoms over the initial 3 weeks of incarceration for female inmates, as measured by the |

| 2007

USA | the north western United States.

An initial 88 inmates were approached and began the study, but 26 did not complete the process due to various reasons | | | incarcerated within the previous week and placed on the minimum-security unit as part of the rider program were approached and asked to participate in a voluntary research project.

Inmates agreeing to participate completed a 2-part semi-structured interview in a private room with the experimenter. Then the participant was asked to complete the battery of questionnaires. The same questionnaires | | BSI measuring overall psychological symptoms significantly decreased from week 1 to week ; followed by only a slight decline from week 2 to week 3.

Depressive and anxious sub-scores between weeks 1 and 2 reflected a statistically significant decline. Whilst as predicted, hostility scores did not significantly change during the 3 weeks of incarceration, reflecting only a slight increase over time.

Finally, prisoners reported a significant decrease in phobia symptoms with time- this was reflected by a significant decrease from week 1 to week 2 however there was no change between week 2 and week 3.

Comparing scores with a non-patient adult female normative sample, the most distress was evident on the psychoticism, depression, and anxiety scales. |

				were administered weekly for 3 consecutive weeks.		
The predictive validity of a gender-responsiveness needs assessment an exploratory study Salisbury *et al.,* (2009) **USA**	Half of the women in the intake sample were white (53.2%), 28.8% were black, and 16.0% were Hispanic. The mean age of the sample at admission was 34.6 years. Convictions for the original sample were primarily for property (28.4%) and drug-related offenses (43.9%).	156 participants adult female. 76.3% placed in a minimum restrictive custody level and 23.1% placed in a medium security level.	Incarceration and adjustment to community	Part of a larger study; conducted between October 10th 2000- January 8th 2001. Institutional adjustment measures were taken 6 months after incarceration. Extended follow up of 44.2 months into the community for 134 participants. All participants gave informed consent and were asked to complete self report measures at	Two measures of recidivism (a) new crimes (b) technical violations while on parole. Level of Service Inventory-Revised. The (LSI-R; Andrews & Bonta,1995) Institutional Risk Assessment (Custody Classification scale). The Rosenberg Self-Esteem scale (Rosenberg, 1979) The Sherer Self-Efficacy scale (Sherer *et al.,* 1982) Relationship/ Co-dependency	Overall gender responsive factors were far more predictive of both community recidivism and institutional adjustment than offence related variables. The presence of child abuse, relationship issues, self-efficacy, and adult emotional abuse were associated with serious misconducts in prison. Conclusion Child abuse and relationships are associated with prison adjustment. Additionally, adult victimization, limited self-efficacy, and parental stress appear to be risk factors for women upon release Histories of abuse (child abuse) and mental health were more troublesome within institutional settings. Modest correlations suggested that for some women, self-confidence caused problems in prison, but later helped to insulate women from new offenses in the community.

| | | | | prison intake and pre-trial also files were analysed for all other information.

The last date of data collection was July 15th 2004. | Scale (Based on Spann-Fischer Co-dependency Scale, 1991)

Parental stress. (Based on scale by Avison, Turner & Noh, 1986). Adult Victimization and Child Abuse scales. | |
|---|---|---|---|---|---|---|
| **Reactions of male and female inmates to prison confinement: further evidence for a two component model**

Paulus & Dzindolet (1993)

USA | In total 106 Participants were recruited from a federal correctional institution in south-western USA and participated voluntarily.

But of the 80 chosen 65% were white, 23% African American, 11% Hispanic

Eligible inmates did not have a history of | 40 males and 40 females who participated in both stages of this study are the basis of the results found.

All participants were recruited from the same minimum security prison establishment.

Male and female participants were kept in separate dorms | Incarceration | All participants were assessed during their first month in prison and then were all contacted 4 months later to partake in the follow-up second assessment | Background/ demographic information

Evaluation of surroundings

A specifically designed mood scale (21item)

Social support (6 item)

Coping Scale (Lazarus & Folkman, 1984)

Specifically designed symptom checklist (56 item) | Females were bothered by the stressors of prison life and rated the physical problems of prison more negatively than males F(1, 57)= 19.50, p<.001.

Both systolic and diastolic blood pressures declined with time.

Evaluation of the prison became more negative over the four month assessment period; whilst outside problems decreased F(1, 79)=10.82, p<.01

The amount of individuals to support inmates declined over time as did the inmates satisfaction with the level of support.

Ratings of anger, depression, anxiety and degree of control did not differ between first and follow up assessment. |

violence.	however were allowed to interact in all other areas of the prison.			Problem Scale (21 item) Tolerance Scale (10 item) Other physical measure e.g. blood pressure taken.	Tolerance levels was a good predictor of inmate reaction at both initial and follow up; with high tolerance related to more positive responses. Similarly those inmates who reported high levels of environmental, social and outside problems tended to be depressed, anxious, angry and report a greater number of symptoms. No changes were found in regards to mood over time. Reports of environmental problems were associated with negative and physiological responses at the first session and reports of all three types of problems (social, environmental and outside) were related to a number of negative emotional responses at the follow up session.

1.6 DISCUSSION

The findings from this review add support to the three main theories of adjustment; importation model, deprivation model and the coping model. Distinct phases of adjustment were teased out of the results and the contributing factors and difficulties are highlighted at each stage. These phases have been realigned into a model accounting for adjustment to prison.

FIGURE 2.

Model showing the interaction and stages of adjustment to prison based on the findings from this rapid systematic review.

Biopsychosocial factors and individual differences interact with the importation factors to contribute to feelings of initial distress and conflict.

Importation Factors

(Factors and experiences prior to incarceration)

Incarceration

Coping Strategies Available

Shifting continuum of adjustment

Internal Adjustment/ Distress (Poor emotion management, poor sleep, discomfort around others)

External Adjustment/Conflict (Arguments and physical fights)

Prison Deprivations (current experiences of prison which remain on a shifting continuum)

1.6.1 Importation factors

The most common psychological symptomology observed within the female prisoner population was anxiety, depression and low self esteem. Particular importation factors were found to contribute to the significantly elevated levels of this symptomology. Depressive symptomology was significantly related to being held in two remand prisons and previous treatment for mental health difficulties. Whilst being a parent and of non-minority status increased feelings of anxiety (Houck & Loper, 2002). A large body of research maintains that experiencing previous victimization, (importation factor), is also related to psychological problems such as anxiety and depression. Wooldredge (1999) proposes that this may consequently affect how inmates react to the feelings of vulnerability, and possibility of potential victimization.

1.6.2 Deprivation factors

Toch and Adams (1986) posit that prisoners who are vulnerable to victimization may use aggression to prevent further victimizations, and Hochstetler and DeLisi (2005) found that even witnessing victimization may result in more rule infractions. This review continues to support these findings; specifically Salisbury, Van Voorhis and Spiropoulos (2009) reported the presence of child abuse and child victimization to be a predictor of serious prison misconduct. What's more, women with a history of both childhood and adult sexual assault reported lowest internal adjustment scores (Slotboom *et al.,*

2011). Women with only a history of adult sexual assault report significantly more external adjustment problems (Islam-Zwart & Vik, 2004).

The General Strain Theory (GST) has been proposed as a supplement to the underlying models of adjustment, which may aid the understanding of prison violence and misconduct (Blevins, Listwan, Cullen & Jonson, 2010). The theory purports that each individual has differing stress-vulnerability levels, and thus react to the strains of imprisonment in unique ways. The level of stress and strain experienced by an individual will shape behaviour and psychological well-being. Furthermore, chronic strain can impact on an individual's ability to cope and manage when responding to an environment. It is hypothesised that if the strain continues to accumulate without easy access for escape, the impact could be increased levels of persistent misconduct (external adjustment difficulties). Additionally, Agnew (2009) states that chronic or repeated strains may create a predisposition for, or a general willingness to engage in criminal acts, as well as fostering of negative emotional traits, and beliefs favourable to crime. It is however recognised that there are a variety of contributing factors, which could lead a prisoner to adapt to strain through maladaptive coping strategies; one being a lack of coping strategies available to the individual.

1.6.3 Coping styles

Results from this review found that emotion and problem focussed strategies were positively related to better psychosocial adjustment to prison. Furthermore prisoners who seemed to take a pro-active stance towards

problems were more able to accept unpleasant events, and reinterpret stressful events in a positive way. Overall they felt better about themselves, less depressed and less anxious (Negy, Woods & Carlson, 1997).

Feelings of anxiety and depression are also another factor which may hinder an individual's ability to engage in adaptive coping strategies. Rose, Bisson, Churchill & Wessely, 2009 These feelings are also two major presenting indicators of PTSD. Slotboom *et al.,* (2011) found that two thirds of their sample (n=251) displayed PTSD symptoms. Moreover, Mackenzie *et al.,* (1989) notes that previous traumatic experiences can contribute significantly to predicting PTSD symptoms whilst incarcerated.

1.6.4 Gender sensitive outcomes

On average women had experienced five negative life events prior to incarceration (Slotboom *et al.,* 2011) and factors associated with incarceration, such as low levels of perceived liberty and personal control, which are inherently related to prison experience, are related to cognitive and emotional problems such as stress, depression, and anxiety (Wright, 1991, 1993). These findings would suggest that female prisoners could be more susceptible to the onset of PTSD symptomology and re-traumatisation at some point during their prison experience.

It is also widely documented that women report significantly higher rates of psychological distress than men; however more recent findings are suggesting that a significant number of women find life in prison safer and more stable than life in the community (Warren *et al.,* 2002). This was

supported by the results in the review, which found that women report feeling safer, calmer and physically more secure in the prison environment than in the community (Warren *et al.,* 2004). It is noted that these results may be due to the experiences and lifestyles of the women prior to incarceration.

At different points during the prison experience, an individual may utilise different forms of coping strategies in order to buffer against the effects of imprisonment. MacKenzie *et al.,* (1989) found that the type of coping strategy chosen was highly correlated by time served; for newer inmates being involved in 'play families' as a form of coping, was common. This finding indicates that social support networks and prison peer groups are an important factor in buffering the stressors of imprisonment. This conclusion is supported by previous research, which has consistently demonstrated powerful correlations between psychological distress and perceived or experienced social support (Thoits, 1995).

In terms of the prison environment, research tends to support the position that female prisoners require more social support, originating within and outside the prisons, than do their male counterparts (Pollock, 2002). Differing factors can affect the influence of social structure and support networks within the prison environment, for example chronic strain has been found to be linked to increased association with delinquent peers (Blevins *et al.,* 2010). Additionally, the length of sentence an individual faces on incarceration can significantly affect the adjustment process, and the potential outcomes associated with incarceration (Thompson & Loper, 2005; Van Tongeren & Klebe, 2009).

There were, however, no significant differences found between time already served and institutional adjustment. Although it is not possible to change the amount of time a woman is required to serve in prison, the research highlights the need for thorough sentence planning as newer indeterminate sentences such as Imprisonment for Public Protection (IPP) have been shown to be hazardous to mental health (Sainsbury Centre for Mental Health, 2008).

1.6.5 Theoretical links

Overall the results from this review gave support to the previous three main theories of adjustment (Importation model, Deprivation model and the Coping model). This review did not uncover any specific interactions or circumstances which will have a significant effect on adjustment either way. However, the majority of the findings highlight considerably more deprivation factors, which seem to account for a large proportion of the variance in adjustment to prison. Nonetheless, individual differences and biopsychosocial characteristics play a large part in the variance of outcomes witnessed in the studies. There remain many questions regarding the hierarchical and complex relationship surrounding the endless number of factors which could potentially be involved in the adjustment process, and how these interact during the incarcerated period.

1.7   METHODOLOGICAL CONSIDERATIONS

Firstly, the majority of the studies are cross sectional in nature (8/ 12), due to the design it can be difficult to establish the chronological relationship between factors, adjustment and subsequent outcomes. Pertinent methodological aspects of the included studies are summarised in Tables 7 and 8.

All of the cross-sectional studies have an adequate sample size, clear definition of adjustment, and appropriate statistical analysis. Although, the measures seemed to have been carried out in a consistent manner, there appears to be a reliance on self-report measures albeit the majority are validated and standardised. Due to the similarity of some of the tools used across the studies, some results were able to be correlated. For example, high levels on the conflict subscale of the PAQ were significantly correlated with more counts of institutional misconduct, higher scores on the PAQ overall were associated with a maladjusted group characterised by criminal thinking (VanTongeren & Klebe, 2009).

It must be noted at this juncture that qualitative measures can be susceptible to biases and false depictions due to deceptive answering, which can be more common in the forensic population. However due to the nature of the topic captured by the review, self report was and remains to be a necessary tool in order to capture the inner feelings, thoughts and beliefs of an individual. It must be noted at this juncture, that eight tools used across the studies were validated but not standardised and three were not validated or standardised (see Appendix H for all tools used across studies). Furthermore, one cross sectional

study (Houck & Loper, 2002) clearly recorded double blinding, it remained unclear in the other studies as to whether the participants, researchers or both had been blinded, which can reduce the overall internal validity of the study.

TABLE 9.

Quality Assessment of Cross-Sectional Studies

Paper	Adequate sample	Measures used for adjustment	Clear definition of adjustment	Participant blinding	Assessor blinding	Measurement consistent across all participants	Attrition dealt with	Confounding factors dealt with	Appropriate statistical analysis	Limitations and generalisability
Warren *et al.*, (2004)	Y	Y	Y	P	U	Y	Y	Y	Y	Y
Warren (2003)	Y	Y	P	P	U	Y	P	N	Y	Y
Slotboom *et al.*, (2011)	Y	Y	Y	N	U	Y	Y	P	Y	Y
Van Tongeren. & Klebe (2009)	Y	Y	Y	N	N	Y	P	P	Y	Y
Thompson & Loper (2005)	Y	Y	Y	U	N	Y	N	Y	Y	Y
Negy *et al.*, (1997)	Y	Y	P	P	U	Y	N	P	Y	N
MacKenzie, *et al.*, (1989)	Y	Y	P	U	N	Y	U	P	Y	Y
Houck & Loper, (2002)	Y	Y	P	Y	Y	Y	U	P	Y	Y

TABLE 10.

Quality Assessment of Cohort Studies.

Paper	Adequate sample	Measures used for adjustment	Clear definition of adjustment	Participant blinding	Assessor blinding	Measurement consistent across all participants	Attrition dealt with	Confounding factors dealt with	Appropriate statistical analysis	Follow up dealt with	Limitations and generalisability
Islam-Zwart & Vik (2004)	Y	Y	Y	U	P	Y	Y	P	Y	Y	Y
Islam-Zwart *et al.,* (2007)	Y	Y	P	U	U	Y	Y	U	P	Y	Y
Salisbury *et al.,* (2008)	Y	Y	N	U	U	Y	Y	P	Y	Y	Y
Paulus, & Dzindolet. (1993)	Y	U	P	Y	N	Y	Y	Y	Y	Y	N

Y=Yes (met), N=No (not met), P= Partial (partially met), U=Unclear

1.7.1 Confounding factors

What may further weaken the results from the included studies is the lack of consideration for confounding factors. Three out of the twelve studies (Warren *et al.,* 2004; Thompson & Loper, 2005; Paulus & Dzindolet, 1993) fully dealt with confounding factors. Many studies did not give sufficient consideration to key factors, such as violent/ non-violent offending, marriage and family ties, family instability, education level and employment history. At other times confounding variables which were mentioned, were not considered in the final analyses. There may be a number of reasons for this, one being the observational cross sectional studies captured by the review may have limited potential to make causal inferences or because the time order of exposure and outcome could not be determined.

Yet the studies captured by the review have undergone stringent quality assessments and it would seem that in 7/8 cross sectional studies and 2/4 cohort studies dealt at least partially with confounding factors within the analyses. In one study, confounding factors were highlighted as age and ethnic minority and these were subsequently controlled for in the statistical analysis, and significant results were still found (Houck & Loper, 2002). In addition, none of the studies seemed to include the presence of current drug use during the study. Substance misuse may well be an important confounding variable which needs to be accounted for a number of reasons;

1) The majority of the women in the included studies were incarcerated for a drug related offence. The percentages ranged from 22% to 63% of the sample (Warren, 2003; Negy, *et al.,* 1997 respectively).

2) The complex and well documented link between drugs and other types of criminality in general. For example the US Department of Justice (1999) released statistics

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which show that approximately 60% of women surveyed in USA state prisons in 1998 reported illegal drug use in the month prior to arrest, and approximately ⅓ reported using drugs at the time of the offence. Furthermore, incarcerated mothers were twice as likely as fathers to have committed their crime under the influence of an illegal drug.

3) Drug use is a well documented coping strategy, which is more highly occurring in the forensic population (National Gains Centre, 2008)

A thematic review on women's prisons (2010) reported that between 2006 and 2008, just under a third (30%) of women surveyed reported arriving at prison with a drug problem and a fifth (19%) with an alcohol problem. This was higher on arrival at local prisons, with 42% reporting a drug problem and 27% an alcohol problem. This research supports the need for measuring drug use on arrival to prison, whilst bearing in mind that incarcerated individuals tend to under report and under estimate their involvement with drugs and alcohol (Lapham, C'de Baca, McMillan, & Hunt, 2004). Additionally, Zamble and Porporino (1988) note that substance use has also been found to significantly correlate with institutional misconduct, which was subsequently used as a measurement of adjustment in five studies within this review (Salisbury *et al.,* 2008; Warren *et al.,* 2004; Thompson & Loper, 2005; Negy *et al.,* 1997; Houck & Loper, 2002).

1.7.2 Measurement issues

As previous behaviour is a good indicator of future behaviour, it is worth noting that ten of the twelve studies in this review reported either the percentage of the sample that had been convicted of a drug offence or had histories of drug use. This may be used to indicate

women who may turn to substance misuse in order to cope with the deprivations of the prison environment.

Warren (2003) used drug crime as a confounding variable and found significant results relating to external adjustment to prison, measured by the PAQ. The lack of consideration regarding such a prolific factor within the forensic population raises questions. For example, were the results found by the studies due to true adjustment to the prison environment, or were they due to continuous drug use in order to cope with the prison environment, or sudden withdrawal on arrival to the prison environment? Maybe the sudden discontinuation and withdrawal of drugs, especially in the initial period of incarceration allows for manifestations in different forms of psychological, physical and emotional distress and has been mistaken for maladaptation to the prison environment.

Furthermore, eleven of the twelve studies captured in this review originate from the USA, and so may reflect particular biases relating to that culture and/or criminal justice system. There is much research which documents the 'sub-culture' associated with the prison environment, and the associated differences between male and female prison subcultures. Whether this is different from country to country remains unclear thus making generalisations difficult.

1.8   LIMITATIONS

Males were excluded from this review, and although this may be viewed as a limitation as parallels cannot be drawn from the results, in terms of gender differences, it was important in order to focus this time limited rapid review; as a result it may not be fully representative of the research in this area.

Another issue which was influenced heavily by the time constraints, was the number of databases and data sources searched. Although each individual search was thoroughly carried out with a pre-defined PICO and search strategy, (see Appendix A). A second reviewer was not used at the first inclusion/ exclusion stage but was however incorporated at the quality assessment stage. A second reviewer at the first stage was thought to be too time consuming, so was incorporated at the second quality assessment stage when there were considerably fewer studies to assess. It is noted that a second reviewer at the primary inclusion/ exclusion stage would have increased the internal validity of the review and reduced the potential for error or bias, however this was not possible and should be incorporated into future reviews on this topic.

When completing the quality assessment, the analysis was marked on the information provided within the study. If more time was afforded, the authors would have been contacted for full data analysis in order to ensure adequate statistical analyses was used within the study, and questions posed about the rationale for including or omitting particular confounding factors. Furthermore, it would have been extremely beneficial to complete a meta-analysis on the full data sets however this was also unrealistic in the timescale.

1.9   FUTURE RECOMMENDATIONS

In sum, the literature in the area of adjustment to prison has suggested there are interactions between importation and deprivation factors, but the variation, pervasiveness and conditions under which these interactions play out and remain, for the majority, unknown. This is partly due to the varying amount of potential factors which are involved in one individual's adjustment to prison, including culturally specific factors and individual differences. Although many of the factors which affect adjustment to prison for men and

women are similar, there is one factor which has been found to apply exclusively to the female prisoner population this is the use of pseudofamilies. It is noted by Bowker that:

"Female pseudofamilies have not only parents and children but also grandparents, aunts, and cousins. The families incorporate the jealousy and role-playing found in traditional male-female relationships. They provide a meaningful social life and interpersonal support for the prisoners"

[1981: p.411]

This phenomenon highlights the importance of social support for women, especially at times when interpersonal support from trusted friends and family is deprived. Deprivation of this aspect of life has been found to be far more damaging to females than to males. This deprivation factor may contribute to the significantly high rates of distress, and subsequent self harm and suicidal behaviour in the female prisoner population. World Health Organisation (WHO; 2007) further state that the promotion of social networks are essential, especially with prisoners affected by mental health difficulties. The proportion of female prisoner population with mental health difficulties has been reported to be as high as 90% (Taylor, 2004).

The use of narrative exposure therapy may be useful with the female prison population due to their previous average number of trauma experiences and prevalence of PTSD symptoms on arrival to prison (Slotboom *et al.,* 2011). Additionally, it is noted to be culture free, short term and can be facilitated on an individual or group basis factors which are vital if it is to be incorporated and accommodated by the prison regime.

A wider pool of tools based on the principles of structured clinical judgement to measure adjustment would be beneficial, as adjustment has often been partly measured by an

individual's number of adjudications and institutional misconducts. However, at times it appears that although the numerical number of the misconducts is reported, the underlying triggers or situation accompanying the misdemeanour is either not explored or misinterpreted by the onlooker. This may give a false impression regarding level of adjustment, risk, need and overall responsivity.

These conclusions are supported by a policy released by the Centre for Mental Health (2010) which recommends the development of new, effective ways to profile risks for commissioners, as they do not always hold the expertise to address such complex issues that are often found in the female prison population. Outcome measures can inform and help to guide dispersion of money and resources which are available to this particularly vulnerable group in the CJS. It was further noted that a set of indicators, which predict risk should be developed to 'enable commissioners to design and deliver effective services and to disinvest in those that are ineffective'. In addition, the use of social desirability scales must be acknowledged in the development of actuarial assessment tools especially designed for use with the forensic population.

Furthermore, future research studies could attempt to increase rigor using a cohort design. Although this method tends to be more expensive and time consuming, there is a definite need for further robust research in this area which incorporates and considers confounding factors such as current drug use, and integration of qualitative and quantitative methods. A systematic review comparing the risks, needs and responsivity of men and women in regards to adjustment to the prison environment would be beneficial.

Additionally, the development in risk assessments and research methods could be further aided by consistent arrival procedures within the female prison estates which would allow for a greater degree of comparison across studies and application to the prison estate as a whole.

Overall these results suggest that interventions focussing on promoting social support networks may be of benefit. Additionally, such interventions would also promote increased perceived and actual interpersonal support and may increase resiliency and self efficacy, whilst helping to lower levels of depression, anxiety and perceived ability to cope with external stressors. Such interventions could be facilitated in a number of ways including group intervention, individual intervention, self help, peer support and listener support.

Such evidence based workings may initiate a shift from adapting male orientated interventions to construction of specific gender sensitive interventions for the female forensic population. Such methodologies are incorporated into the development of the main research within the thesis.

CHAPTER 2

Psychometric Test Critique

Culture Free Self Esteem Inventory- 2

2.1 ABSTRACT

This chapter is both a theoretical discussion and a critique of a widely used psychometric tool. The rationale for focussing on the Culture Free Self Esteem Inventory-2, (CFSEI-2), was due to it being the only measure, which claims to record an individual's self reported self esteem level, in a culturally free manner. The ability of this tool is analysed and reviewed through a literature review. There is also a focus on women and forensic contents within the introduction. Outcomes of the research indicate that women in forensic settings experience low levels of self esteem which appears to be influenced by a variety of factors.

The review includes definitions of self esteem and its relation to other aspects of the self. A detailed overview of the CFSEI-2 is included, as well as pertinent findings from the research base of this tool, which has predominantly been utilised with a child and learning disability population. Following this, self esteem is explored in relation to forensic clients, in particular women. A final discussion and rationale for measurement of self esteem in this population is given. Internal and external validity of the CFSEI-2 is critiqued, and recommendations for future developments within the area of self esteem are illustrated in relation to a forensic population.

2.2   INTRODUCTION

2.2.1 Self esteem as a concept

Self-esteem, generally conceptualized as a part of the self concept, is the most commonly researched facet of the 'self' in social psychology (Baumeister, 1993). However there remains a distinct lack of understanding, definition, and agreement around the concept of self-esteem. Self esteem has been described as a deceptively simplistic construct which is used universally, that few can define accurately (Ashbury & Anderson, 2002).

The evolution of this construct began with William James in 1890, who, in his work 'Principles of Psychology', studied the splitting of our "global self" into "knower self" and "known self". According to James, it is from this split that self-esteem is formed (Buss, 2008).

Maslow (1987) then describes the 'need for esteem' in his hierarchy of human needs. He notes that this need for esteem is divided into two aspects

1)   The esteem for ourselves, (self-respect, self confidence, skill, attitude etc).

2)   The esteem we receive from other people, (recognition, success etc).

Rogers (1961) subsequently devised the Actualizing Tendency Theory, which states that an individual has an actual self and an ideal self. The actual self is made up of natural innate needs, beliefs and tendencies. The ideal self is guided by society and culture, and is a set of needs, values and tendencies dictated to us. Self esteem is incorporated into the actual self. If there is a large gap between the reality of the actual self and the ideal self, it can cause dissonance and thus results in lower levels of self worth, self-esteem, and overall self perception.

"Every human being, with no exception, for the mere fact to be it, is worthy of unconditional respect of everybody else; he deserves to esteem himself and to be esteemed"

[Bonet, 1997: p.1133-1134]

2.2.2   Definition of self esteem

There have been numerous definitions given to the concept of self esteem, Coopersmith (1967) defines self esteem as a "personal judgment of worthiness that is expressed in the attitudes the individual holds toward himself". Whereas other researchers have described it as simply a "willingness to endorse favourable statements about the self" as a result of "an ambitious, aggressive, self-aggrandizing style of presenting themselves" (Baumeister *et al.,* 1989). The author of the CFSEI-2, James Battle (1990) defines self esteem as an individual's personal evaluation of his or her own abilities and attributes, which contribute to an overall perception of self worth. He further states that once an individual's perception of self worth is established it tends to be "fairly stable and resistant to change".

Although the construct of self esteem seems to differ between research studies, and in different fields of psychology, on the whole researchers agree that self esteem comprises a number of components. Battle (1990) uses three different facets in his adult measure; a description of each follows:-

1)   General self esteem- The aspect of self esteem that refers to individuals overall perceptions of their worth.

2)   Social self esteem- The aspect of self esteem that refers to individuals perceptions of the quality of their relationships with peers.

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3)   Personal self esteem- The aspect of self esteem that refers to individuals most intimate perceptions of self worth.

These definitions are helpful in regards to understanding how the overall construct of self esteem is made up; however they are a little vague and ambiguous. More recently, researchers have begun to define facets of self esteem in much more detail (Guindon, 2002). Battle (1978) further notes that self esteem is an essential human requirement at each stage of development, it can affect achievement, adjustment to an environment, and general well-being. The professed importance of self esteem is supported by the number of studies which have investigated this concept. Self esteem has been the subject of many studies involving individuals and groups, and has been evaluated as both an independent and dependant variable.

2.2.3 Overview of CFSEI-2

The aim of the CFSEI-2 was to construct a robust psychometric that could measure an individual's self esteem regardless of culture or primary language. Battle, like many others, devised his own working definition as 'an individual's personal evaluation of his or her own abilities and attributes'. Further stating that it is multidimensional in nature and dependent on the individual's level of cognitive development.

The tool developed by Battle, based on this definition, was named the Culture Free Self-Esteem Inventory (CFSEI; Battle, 1981). After publication there were various critiques and recommendations made, thus the tool was revised and the CFSEI-2 was published in 1992. There has since been a revision called the CFSEI-3, however it is only applicable to children up to 18 years and 11 months. A detailed critique of the adult form of the CFSEI-2,

which may aid future revisions of the adult tool, will ensue. Conclusions will draw upon the applicability of the CFSEI-2 to forensic populations, and to the field of forensic psychology. Furthermore its validity and reliability will be evaluated in terms of its research uses.

2.2.4   Research base of CFSEI-2

From a thorough literature search, it has become clear that there is a distinct lack of research using the CFSEI-2 with adults, and more specifically with a forensic adult population. Early literature incorporating the CFSEI-2 has largely incorporated a child sample, and focussed more specifically on areas such as learning disabilities, motivation, educational attainment, depression, and cognition.

In the studies obtained, similar assumptions were made about self esteem and how it affects an individual. These assumptions encompass the belief that if an individual's self esteem is raised this will be positively beneficial, and it has been extensively reported that an individual's behaviour is determined by their level of self worth (Wylie, 1989; Rosenberg, 1965); although these assumptions allow for the concept of self esteem to be comprehended and measured. Staub (cited in Zahn-Waxler *et al.,* 1986) raised concerns around the simplistic context of the research and findings, noting further that "an extremely positive self-concept is less related to positive behaviour than a more moderate self-concept" (1986). It is important to note at this juncture, that there is no universal definition for what self esteem is, and no one method of measurement. These factors make appraisal and judgement regarding self esteem objective, and increasingly difficult to evaluate.

Within the criteria for some major mental health diagnoses, self esteem is included as an item, and clinicians are tasked with diagnosing individuals based on the predetermined criteria. For example, in the Diagnostic and Statistical Manual of Mental Disorders-IV,

(DSM-IV; American Psychiatric Association, 1994), narcissistic personality disorder, dysthymic disorder, and bipolar disorder (manic episode) include self esteem in the symptomology checklist. Thus, the ability to define and measure self esteem becomes ever more important and worthy of further research.

2.2.5   Self esteem and forensic clients

Forensic clients have been found to experience a number of issues which appear to be elevated, including symptomology of psychiatric diagnoses, levels of violence against self, and substance misuse. Levels of self esteem have been linked to these complicating factors; although again, it is not known whether they are etiological factors, or linked more to the typical demographic details of forensic clients in general.

There is a growing body of research with the forensic female population, which serves to link all these factors. This research base focuses on child abuse and trauma, with researchers widely reporting higher rates of abuse in forensic populations of women, (Fleming 1999; Ogloff, Cutajar, Mann, & Mullen, 2012). Furthermore higher levels of depression and lower self esteem have been associated with the experience of more severe abuse, and with the perpetuation of abusive relationships (Cascardi & O'Leary, 1992) which is also common in lives of the women in the criminal justice system.

In a pilot study, low self esteem was linked to increased frequency of deliberate self harming behaviours found in a sample of women in a high secure psychiatric hospital (Low *et al.,* 2000). Furthermore, a systematic review of the literature found support for the theoretical premise that low levels of self esteem are related to violent behaviour against self and others. Walker and Bright note that:

"[I]f self-esteem is inflated it is in reality covering low self-esteem, and that the inflation of self-esteem is part of the 'macho' coverup of embarrassment. Why would the violent person be vulnerable to taking serious (overstated) offence if they were genuinely secure in themselves with high self-esteem?"

[2009: p. 9]

Additionally, Widom (1989) compared a sample of adults with a history of substantiated cases of child abuse and neglect in the United States, with a sample of matched comparisons. It was found that adults with a history of abuse and neglect had a higher likelihood of arrests, adult criminality, and violent criminal behaviour.

Moreover, a relationship between alcohol dependence and substance misuse, another common complicating factor in the forensic population, has also been linked to lower self reported levels of self esteem (Silverstone & Salsali, 2003). It is noted by Whiting *et al.,* (2009) that the higher rates of substance abuse problems among adult survivors of child abuse and neglect, may, in part, be due to victims using substances to self-medicate from trauma symptomology such as anxiety, depression, and intrusive memories which can be linked to their previous traumatic experiences. Subsequently, women have also shown higher rates of self harming behaviours on adjustment to secure forensic settings. A thematic report by Government detailed the growing number of incidences of self harm in the women prison estates

"there remain areas of serious concern. The extent and seriousness of self-harm, particularly in women's local prisons, remains high, sometimes resulting in extreme measures, including the use of force"

[2010: p. 5]

Self-esteem is also said to be significantly related to quality of life, and physical and mental well being, (Mechanic *et al.,* 1994). It does not seem surprising then, that self esteem has been linked to various psychiatric diagnoses, and factors which are also commonly recognized in the forensic population. Thus, it is important to remain mindful of this intangible, and somewhat hidden factor, and how it might impact on assessment and intervention with this population.

Although it appears clear that there is a link between self esteem and psychiatric diagnoses, Silverstone and Salasi (2003) importantly note that the question of whether self esteem is an etiological factor of the diagnosis, or a product of the diagnosis, remains. There is also evidence in the literature of cumulative effects of psychiatric disorders on self-esteem. Patients who had co-morbid diagnoses, particularly when one of the diagnoses was a depressive disorder, tended to show lower levels of self-esteem (Silverstone & Salasi, 2003).

Another factor which serves to increase symptoms of depression is whether the women are indeed mothers as well. It is reported that two-thirds of women in English jails are mothers (Home Office Thematic Report, 1997). In a more recent thematic review, it was noted that much of the need for mental health services in prison was to address the need associated with previous trauma, and separation from children and family, which appears to be most frequently expressed, with similar symptomatology to that of depression and anxiety (Thematic Report, 2010).

These reports are consistent with relational developmental theory and previous research (Martin *et al,.* 1995; McClellan *et al.,* 1997), in that, the primary experience of self is relational. For women the self is organized and developed in the context of important relationships (Surrey, 1991). Research, which has concentrated on women who are parents, found early relationship disconnections, loss, and trauma, were associated with elevated,

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maternal, depressive symptoms. Even after controlling for early trauma and relationship disconnections, less frequent face-to-face contact with children during incarceration was associated with symptoms of depression, highlighting the importance of current relationship processes for women's psychological well-being (Young & Smith, 2000).

Women in secure settings have little control over the geographical area in which they are taken, many are placed over 100 miles from their home area (Daily Hansard, 2009 cited in Thematic Report, 2010). This can increase the likelihood of infrequent face to face contact with their children, family, and friends. Additionally, relocation and transfer between settings are often imposed with little or no warning, and can be a frightening process, especially for women in forensic secure settings. Briere and Elliot (2003) note that individuals who suffer childhood abuse develop an internal working model, where they see the world as a dangerous place. Relocation and frequent service transfers can increase feelings of danger, and serve to perpetuate feelings of lack of confidence and self worth, due to feelings of rejection/ abandonment or inconsistent therapeutic relationships and unfamiliar environments.

I feel it also important at this juncture to note, that forensic clients who experience childhood violence, or who have witnessed parental violence, are more likely to have low levels of self-esteem. Consequently they may also have learnt that violent behaviour is a normal response to dealing with conflict (Mouzos & Makkai, 2004 cited in Lamont, 2010). These findings emphasise the need for self esteem to be a integral part of assessment during the initial phase of adjustment and as a part of the risk assessments.

2.3   Administration of the CFSEI-2

2.3.1   AD Form of the CFSEI-2

The adult measure consists of 40 items; 16 items for general self-esteem, 8 items for social/ peer self-esteem, personal self-esteem, and for the lie scale. The scale was standardised on adults aged 16-65 from the Canadian population. Each item is rated as either high self-esteem or low self-esteem, and responses are of the forced-choice variety; either yes or no.

The manual states that the test has been standardized in the English language, but the tool is available in French, Spanish, German, Italian, Japanese and Vietnamese. The standardized norm group for the adult form is 585 adults, made up of 248 males, and 337 females, aged between 16 and 65. It does not give any other characteristics of the norm sample; neither does it give the methodology or the content validity. These omissions immediately raise questions about the sample and the validity of the norm population.

2.3.1 Administration and scoring

Administration of the CFSEI-2 can be carried out on an individual basis or in groups. Written or oral administration of the test generally takes from 10 to 15 minutes; it does not state that any formal qualification is required in order to score the test. The CFSEI-2 may be administered and scored by teachers and most responsible adults. However, it is noted in the manual, that someone knowledgeable in measurement, psychology of adjustment, and perceptual psychology would support interpretation. As there is no requirement of the individual to have a Level A or B qualification, they may misinterpret what the score means

in terms of need and intervention; they may even make a type 1 or 2 error depending on the misinterpretation.

The CFSEI-2 is scored on an ordinal scale, meaning that the variables are categorised by labels, i.e. General, Social, Personal and Lie, but then are interpreted in relation to normative numerical data. There are some valid uses of ordinal measurement and scales; however Stevens (1946) noted that this type of scale does not offer valid interpretations. A caveat summarising and reiterating the importance of caution and care during the interpretation and conclusion stage is imperative.

Furthermore, the manual denotes cut-off scores for each scale. The cut-off allows the interpreter to classify the scores into a category, ranging from very high, to very low, shown below in Table 11. Although this type of scoring method can be deemed helpful when constructing a needs analysis, there is no true rationale or reason given for any of the cut-off scores, and they seem arbitrary at best. In addition, the use of classification can diminish professional judgement and individual differences.

TABLE 11.

Classification of scores on the adult form of the CFSEI-2

Overall Score	Classification
30+	Very High
27-29	High
20-26	Intermediate
14-19	Low
-13	Very Low

Additionally the subscale scores are also classified into categories (See Table 12). It must be noted at this juncture, that the author does state that the classifications do not

necessarily conform to universally accepted classification; yet they are still recorded in the manual and used as part of the scoring profile.

TABLE 12.

Cclassification of the subscale scores for adults

Subscale	Very High	High	intermediate	Low	Very Low
General	15	13-14	7-12	5-6	-4
Social	8	6-7	4-5	2-3	-1
Personal	8	6-7	4-5	2-3	-1

The lie scale was only tested after the initial publication of the tool, and this was in response to numerous requests for normative data for this scale. The initial standardisation study used a cross-sectional sample of 434 individuals from western Canada.

Battle states the lie scale measures defensiveness; more specifically it will highlight individuals who refuse to attribute "valid but socially unacceptable actions" to themselves e.g. lying. It is then supposed that an individual who would deny that they have succumbed to this common human imperfection would tend to be more defensive than a person who would admit it. There have been some ethical issues raised with 'lie scales', the most widespread concern are the conclusions drawn from a relatively high lie scale score. This is especially worrying in a forensic, or court setting, where an individual's character and personality is under the spot light. Thus the score on the lie scale must be interpreted and qualified in terms of the testing situation; and must not be immediately interpreted as an individual trying to deceive the examiner. Defensiveness is a normal and adaptive response to the situation; and in certain situations a lack of defensiveness may also be interpreted as a negative characteristic (Graham, 1988).

All of the scales and subscales were initially tested on a sample of westernised Canadian women and men. The normative data was drawn from this sample, which is not representative of the tools audience or scope. The demographic variables of the sample, including education level, social class, or IQ were not listed in the manual. These factors are extremely important, as individuals from a higher social class typically produce higher scores on lie scales (Butcher, 1990).

2.4 RELIABILITY

2.4.1 Internal reliability

The 40 items that make up the adult form on the CFSEI-2 are the most discriminating factors from a pool of 85 preliminary ones. An analysis of internal consistency revealed the following: general self esteem, .78, social, .57, personal, .72; and the lie scale (defensiveness), .54. In order to interpret the alpha coefficient values, there is a commonly used rule of thumb, shown in Table 13 .

TABLE 13.

Description of scores in relation to Cronbach's alpha coefficient.

Cronbach's alpha	Internal consistency
$\alpha \geq .9$	Excellent
$.9 > \alpha \geq .8$	Good
$.8 > \alpha \geq .7$	Acceptable
$.7 > \alpha \geq .6$	Questionable
$.6 > \alpha \geq .5$	Poor
$.5 > \alpha$	Unacceptable

The CFSEI-2 scores would suggest that general and personal self esteem are at an acceptable level. However the internal reliability for social self esteem is poor. With short scales it is common to find low Cronbach values, thus it is more appropriate to report the mean inter item correlations.

A study by Coetzee, (2004 cited in Coetzee *et al.,* 2006), reports that the Cronbach alpha coefficients of the item analysis on the total and subscales indicated a relatively high internal reliability (0,85). Furthermore, test-retest reliability showed that all the correlations are higher than 0,74 for each of the subscales, and the total scale (0,91). These high internal correlations were found in a sample, (n=190), made up of approximately equal proportions of White (52.6%) and Black (47.4%) individuals which supports the culture free claims and properties of this tool.

2.4.2 Dimensionality

The mean inter item correlation scores for each of the subtests are denoted by Cronbach's alpha coefficient. It was noted by Cronbach (1951) that the alpha coefficient can suggest reliability of a multidimensional measure, and is most appropriately used when the different items are deemed to measure substantive areas within a single construct.

In order to illustrate the reliability of the CFSEI-2, Battle applied the Cronbach's alpha coefficient, and this seems appropriate based on the description given above. The mean inter-correlation of the three scales, general, personal and social are 0.759, 0.664, 0.617 respectively. Briggs and Cheek (1986) recommend an optimal range for inter-item correlation of .2 to .4 in order to detect unidimensionality. Thus the high intercorrelations of these items would suggest that the scales are not measuring different domains of the same construct. Kline (1979, cited in Boyle, 1991) notes that high correlations can indicate that a test is too

narrow and too specific. Moreover, inter-correlations above (0.7) could indicate repetition between scales, which would result in high internal consistency, but very low validity.

Battle gives pre and post test inter correlations in the manual, however it is not clear as to whether they are from the development of the CFSEI or the CFSEI-2. The alpha coefficient scores for the general self esteem scale show an increase at post-test from .892 to .914, indicating excellent internal consistency. Alternately, the alpha coefficient scores for social and personal self esteem decreased at post-test. The scores indicate weak to acceptable, internal reliability consistency, with alphas ranging from 0.15 to 0.77.

It must be noted at this juncture that the use of alpha coefficient to determine internal reliability and consistency has been challenged. Schmitt (1996) states that the alpha is a function of the interrelatedness of a test and the test length, rather than homogeneity or unidimensionality. Therefore, it is questionable as to whether Cronbach's alpha is the most dependable way of testing internal reliability. In terms of the CFSEI-2 it may be the length of the general scale which gives it the excellent internal consistency score.

Hattie (1985) further stated that, the alpha coefficient can be high even if there is no general underlying substantive concept since;

- It is influenced by the number of items and parallel repetitions of items.
- It increases as the number of factors pertaining to each item increases.
- It decreases moderately as the item communalities increase.

Therefore, a different statistical test may be needed, in order to determine whether the CFSEI-2 is truly reliable, for example the Menzel's coefficient of scalability, or the coefficient of homogeneity (Krus & Blackman, 1988).

2.4.3 Test-retest stability

The initial test-retest reliability study was completed on 127 educational psychology students. It remains unclear as to whether the scores are for the CFSEI or the CFSEI-2. They are however listed in the CFSEI-2 manual, and thus will be documented and critiqued. The test-retest overall score was .81, and when broken down into gender for males and females it was .79 and .82 respectively. Although the test-retest scores were statistically significant, it is noted that responses on a Guttman scale should have a test-retest coefficient of above .85, in order to be deemed stable and reliable (Kenny & Rubin, 1977).

Additionally, there have been numerous concerns regarding the use of undergraduate psychology students in order to determine reliability and/or validity. The main criticism is that they are not representative of humanity. What is more, it seems to be a totally inadequate sample to use, especially for a 'culture free' tool. Heinrich, Heine and Norenzayan (2010) note, that this population only share similar responses to individuals who are also western, educated, industrialized, rich, and democratic.

2.4.4 Translational validity

2.4.4.1 Face validity

On the outset the CFSEI-2 appears to measure self esteem adequately. However this is a poor indication as to whether a test has good strong internal validity or reliability. A study by Coetzee, (2004 cited in Coetzee *et al.,* 2006), using a sample of Black and White South

African adults, supports the reports of culture free measurement of the concept by the CFSEI AD form

2.4.4.2 Content validity

It must be noted that an element of subjectivity exists when determining content validity, in that it requires an element of agreement about what facets make up a particular concept or construct. In relation to self esteem, there is a high level of disagreement in regards to its definition, and the facets which make up the substantive construct of self esteem.

In order to determine content validity, one must first look at the initial stages of item construction and selection. The CFSEI-2 manual states that the final 40 items originated from a pool of 85 items; it remains unclear how they chose the initial 85 items. In future research, in order to increase this element of validity, reviewers could be utilised to score items in line with the Content Validity Index (CVI, Lynn, 1986).

The Kuder-Richardson coefficient was used to narrow down the most discriminating items. The Kuder-Richardson coefficient was an appropriate choice, as it measures internal consistency reliability in dichotomous measures like the CFSEI-2.

The analysis of internal consistency found that general and personal self esteem scored .78 and .72 respectively. These relatively high scores (.70 +) would indicate that the scales are homogenous, however it is noted that the score should be above .90, in order to reflect a true homogeneous scale. The social self esteem scale scored .57; a score of this magnitude would suggest that the scale is heterogeneous and incongruous with the two other scales. Finally the lie scale scored .54; a score of this nature was expected as this scale is unlike the other three in that it is not meant to be measuring self esteem.

2.4.4.3 Construct validity

In psychology and the social sciences, construct validity is the degree to which an instrument measures the construct it is intended to measure (Cronbach & Meehl, 1955). In order to be deemed valid, the scale must try to operationalize the concept into a working construct, which is then able to be measured. Battle states that content validity is built into this tool by defining the concept of self esteem, and writing items which relate to the concept of self esteem.

As this tool was created by Battle, and his definition and description of facets has been published, it seems that it measures two elements of the same construct (general and personal), however the third facet is unlike the others and has low internal consistency. The facets that Battle attempts to measure are, at times, much different from other theorists and researchers (Guindon, 2002).

Yet, Salmivalli (2001) argues that researchers may not be measuring all the components of self-esteem. Further noting that, "healthy self-esteem consists of not only seeing oneself in a positive light, but also of accepting oneself "as one is," and current self esteem measures do not directly attempt to find out if the individual is aware of negative characteristics, and whether they can be accepted as part of themselves.

The items in the CFSEI-2 were analysed using factor analysis, which resulted in three separate domains of self esteem. The results from the statistical methods revealed the subscales possess acceptable internal consistency, however due to high correlations it seems likely that General and Social subscales are measuring one common dimension, however whether this is actually self esteem remains unknown.

2.4.5   Criterion validity

2.4.5.1   Concurrent validity

Concurrent validity refers to whether one test correlates with other tests attempting to measure the same construct. In the CFSEI-2 manual the longer child form (A) was compared with the Coopersmith Self-esteem Inventory (1967). Although the outcome was favourable, and indicated similar correlations, the adult form was not captured in this comparison. A thorough search of the self-esteem literature has proved fruitless, no articles or papers have been found to compare the CFSEI-2 and any other self-esteem tool. Therefore, concurrent validity of the adult form (AD) cannot be assumed, and this is an area which most definitely warrants further research.

2.4.5.2   Predictive validity

Predictive validity is the ability of a test to predict something it should theoretically be able to predict. It is assumed that low levels of self esteem can negatively affect performance and behaviour. Yaniw (1983, cited in Brookes, 1995) administered the child form (A) of the CFSEI, and found a linear correlation between self esteem and academic achievement, and these correlations were significant at the $p < 0.01$ level for language arts (.59), social studies (.61) and science (.60). Additionally, the academic sub-scale was significantly correlated with maths at the $p < 0.01$ level. In terms of adults and employment, a study by Battle *et al.,* (1988) analysed the effects of a comprehensive training program on an individual's self esteem. The pre, post, and follow up scores showed the participants experienced positive shifts in all facets of self esteem as they progressed through the programme. These findings

support the premise which suggests that self esteem can influence academic attainment, and additionally self esteem can be influenced by employment performance.

2.4.5.3 Convergent validity

Convergent validity is used to demonstrate the accuracy of a measure, or procedure, by comparing it with another measure or procedure which has been demonstrated to be valid. During the development and validation of the CFSEI-2 adult form (AD), Battle compares the tool with the Relative Anxiety Scale (RAS), North American Depression Inventory (NADI), and the Minnesota Multiphasic Personality Inventory (MMPI), all tools which have been previously validated.

Comparison correlations with the NADI showed scores of -.74, -.73 and -.74 for total sample, males and females respectively. These findings support previous research which suggests that depression, and depressive traits, tend to be linked to low self esteem (Beck & Beamesderfer, 1974; Coopersmith, 1967). Furthermore, when compared to the RAS, results show negative correlations of -.77, -.72 and -.78 for total sample, males and females respectively. The high inverse correlations between self esteem and anxiety support previous research findings that higher anxiety correlates to lower levels of self esteem (Greenberg *et al.,* 1992).

2.4.5.4 Discriminant validity

Discriminant validity is designed to measure the degree to which a given scale differs from other scales, measuring different concepts or variables. Ideally, scales should also be found to rate highly with discriminant validity, as well as convergent validity, in order to

determine overall validity. No articles or results have been found in the literature that compare the CFSEI-2 to any other scales which measure a different conceptual variable which has not been found to link to the area of self esteem. Thus divergent validity cannot be surmised and overall construct validity cannot be assumed.

2.5 CONCLUSIONS

Taken at face value the CFSEI-2 seems like a valid and reliable tool, however under investigation it is clear there are some gaping holes in the underlying reliability, consistency, and validity. In regards to content validity, the KR (20) coefficient shows that both the personal and general self esteem scales are relatively high scoring (.78 and .72), which would indicate homogeneity. However, as the scores are not above .90 the true validity must remain questionable. The third scale, social self esteem, scored .57, which could suggest it is measuring something completely different, but it remains unclear as to what that is. It is also important to note that coefficients give us a good understanding as to whether scales are measuring similar, or dissimilar things; but they cannot describe or attribute names to these underlying similarities or differences. So in terms of the CFSEI-2, the general and personal scales may be measuring a similar concept, but whether this concept is self esteem remains unknown.

In order to have an educated guess at the underlying measurable concept, it is vital to analyse the definition and theoretical underpinnings of a tool. Battle gives a definition which is helpful, however Mruk (1999) notes that "the diversity of definitions tends to be impressive. Often, it is as though there are many ways to define self-esteem as there are people trying to do so". There are over 200 tools which claim to measure self esteem, and each one has a slightly different definition (Hansford & Hattie, 1982), so it is unclear as to

whether the definition Battle uses is accurate or acceptable in regards to construction of a tool.

In terms of construct validity, it is unclear as to whether the CFSEI-2 is measuring what it purports to measure. Although research supports the predictive validity of the CFSEI, it is important to note that this only appears to apply if the individual is answering truthfully. The outcome of a self report self esteem measure may reflect an individual's genuine acceptance of self and feelings of worth, or it may reflect a dissonance within that individual. For example, high self-reported self-esteem may be found, if an individual consciously wishes to portray an unrealistic elevated picture of themselves, which does not reflect internal feelings about oneself. Finally, an individual may be answering in a socially desirable manner, or may respond in a defensive manner, to cover underlying self doubts or unconscious low levels of self esteem. Unfortunately this cannot be empirically tested and could only be assumed by the tester. Walker and Bright (2009) further noted that the idea that self-esteem may appear high but is actually covering for low self-esteem, is very difficult to examine because of the problem of measuring something that people seem to need to hide.

Additionally, it is especially hard to prove or disprove content validity for self esteem scales, as it is a concept which is ethereal and intangible. Further research will aid clarification in this area. To convey the need for more recent research, a Google Scholar advanced search was carried out. The 'social sciences, arts and humanities' were searched with the words 'self & esteem' in the title with no date limits. The search returned 29, 500 results; of the first 100 hits only 17 of these were published since the year 2000.

The research base of self esteem is problematic at best and there are numerous inconsistencies in research findings. In terms of predictive validity, one is unable to assume that the CFSEI-2 has any predictive validity, as the findings are so diverse and contradictory.

In order to build a psychometric measure which is robust, reliable, and rigorous, it must be based on solid theoretical underpinning and a sound body of research, the CFSEI-2 lacks this.

In terms of forensic psychology, much work is carried out with the offending population which attempts to increase their self esteem. The premise being that by increasing an individual's self esteem, this will help to lower their level of risk and lessen their likelihood of recidivism. A reanalysis of old data was conducted by Wells and Rankin (1983), it found no evidence to suggest that offending was affected at all by low levels of self esteem.

Furthermore, when using with an offending population, caution must be exercised. The majority of the research for the CFSEI-2 is carried out with child and non-offending adult samples; which are usually small. The demographics and characteristics of the sample were rarely described, and when they were, the sample did not seem representative or substantial for a culture free tool.

2.6 FUTURE RECOMMENDATIONS

Future recommendations echo those of Keith and Bracken (1996) who called for "a clear operational definition, sound theoretical basis, or evidence for a strong technical adequacy with respect to scale development". This does not seem to have been accomplished as yet, but remains vital, as a formal definition would give a foundation on which to carry out further comparable research.

The results and recommendations of the systematic review and critique were considered during the planning of the main research project. Primarily the systematic review highlighted self esteem as a factor which contributed to an individual's ability to adjust. Also

it was linked to feelings of depression and anxiety which were also main factors in the adjustment process. Thus it was deemed necessary to measure these three concepts.

The conclusions and recommendations of the critique have also been carefully considered and the rationale for using this particular tool stems from the need to evaluate similar situations with tools which can be utilised in different countries and cultures. This culminates in findings which can be then compared cross-culturally and evaluated on a much larger scale. Additionally, due to the forensic setting chosen for the research, it was deemed appropriate to use a tool with a scale incorporated to measure defensiveness. The use of the scale was in order to capture individuals who may be responding in a particularly desirable or undesirable manner for the purposes of the research. Finally, the use of a mixed method approach incorporating a small number of psychometrics was finally constructed as it is good practice to record outcome and change. This is especially true of forensic psychology, as the interventions implemented are usually in order to help develop skills or facilitate change.

CHAPTER 3

Adjustment and Coping for Women in Secure Psychiatric Services. Group Reflections.

3.1 ABSTRACT

In line with the growth of the female forensic population there appears to be an increasing amount of literature focussing on women in forensic settings. Yet literature focussing on the adjustment phase does seem to be lacking somewhat. For some, this can be a highly distressing period of time, which serves to sever links with their familiar social support structures, and place them in a strange environment, with unfamiliar people whom they have to rely on to have their basic needs met.

Discussions within this paper will encompass theories, which serve to illuminate the experiences and difficulties faced by women in forensic psychiatric settings, and in particular those factors which appear to be pertinent in the 'critical period' or first seven days of incarceration. Also the concept of feminism, it's development, and how this has changed women's experiences in secure forensic settings will be explored. Mixed methods are used to measure the outcome of a six week focus group held on a low secure ward for women in the UK. The qualitative data gathered throughout these focus groups is analysed using an interpretative phenomenological approach (IPA). Results of this analysis show three main themes which are, coping individually, coping with others, and environmental factors linked to coping. Additional subthemes encompassing coping and social factors are also highlighted and incorporated into future directions. Furthermore, a model, constructed from the results of this study, which helps to illustrate factors affecting adjustment is described and discussed.

"A women's sense of self becomes very much organized around being able to make and then

to maintain affiliation and relationships"

[Miller, 1976: p. 83]

3.2   INTRODUCTION

3.2.1   A feminist approach to forensic psychology

There remains considerable debate around what it is to be a woman. There has been a shift in definition from those based solely on the biological differences, to a person-centred approach which accepts the individual as formed and evolved in a "web of socio/cultural forces" (Gilbert, 1999). The birth of the feminist standpoint theory seeks to go beyond analysis and description of the role played by social location in structuring knowledge; it aims to map and explore the epistemology of various political and socio-cultural power struggles which affect marginalised parts of society. The central tenet of the theory is captured by Harding

"Starting off research from women's lives will generate less partial and distorted accounts not only of women's lives but also of men's lives and of the whole social order."

[2004: p. 56]

Thus, feminist standpoint theory allows the woman's experiences and roles to be explored objectively as the main goal of the enquiry. Within feminist standpoint theories there is a commitment to fully explore and understand the whole social and political situation which revolves around a women and defines her in society. All information gathered including her class, race, ethnicity, sexuality and various other dimensions play a role in forming what we know, and also what we are limited to know about her.

It is important to recognise that an individual is bound by how their culture or society defines them; it plays a part in the answer to what it means to be a woman, and what values

and expectations are inherent to that role. Furthermore, the distinction, between men and women is created and maintained through interpersonal interactions, and other complex processes in the society in which they are living.

Culturally bound views, beliefs and expectations of women and men often guide treatment, inform how we conceptualize the clients presenting difficulties, make diagnostic decisions and decide on treatment pathways or goals. However, within forensic psychiatric care and prison settings, tailoring the service to the needs of women has been exceptionally difficult. Baroness Corston highlighted a difficulty which is illustrated in the following excerpt:

"women have been marginalised within a system largely designed by men for men" further noting that "there is a need for a 'champion' to ensure that their needs are properly recognised and met"

[2007: p. 2]

Being gender responsive means creating an environment through site selection, staff selection, program development, content and material that reflects an understanding of the realities of women's and girls' lives and addresses their strengths and challenges (Covington & Bloom, 2003).

3.2.2 Women in the criminal justice system

Research confirms that women offenders differ significantly from their male counterparts in terms of their personal histories and how they enter into crime (Belknap,

2001). For example, female offenders are more likely to share a history of physical and/or sexual abuse. They are often the primary caretakers of young children at the time of arrest, and they have separate distinctive physical and mental needs. Their involvement in crime is often economically motivated, driven by poverty and /or substance abuse. The women flooding our criminal justice system are mostly young, poor, and undereducated, with complex histories of trauma and addiction. Most are nonviolent and pose no threat to the community (Covington & Bloom, 2003).

Their greatest needs are multi-faceted treatment for addiction and trauma recovery, along with education for jobs and parenting skills. They need the opportunity to grow, to learn, to make changes in their lives, and currently the environment of most forensic secure facilities do not facilitate this growth or positive development.

3.2.3 Importation factors associated with women in the CJS

3.2.3.1. Demographic factors

There are 14 prisons in England and Wales which hold women, and in 2009 eleven thousand and forty four women were received into prison (MoJ, 2010a). There are currently various low and medium secure forensic psychiatric hospitals across England and Wales. Currently there are also three enhanced medium secure care pilot wards, and one high secure facility for women in the UK. The women received into prison and forensic psychiatric settings present with a unique complex variation of factors which have been moulded by their developmental pathways, intertwined with socio-cultural influences.

These varying factors and influences then shape the particular importation factors unique to each woman. Some of the most pertinent factors and experiences which are commonly found in the female forensic population are summarised below. It is noted, that

women are more likely than men to be victims of physical and sexual abuse as children, and victims of domestic violence as teenagers and adults (Coy *et al.,* 2008). Taylor (1997) conservatively estimates that it is likely that the frequency of physical and sexual abuse experienced by special hospital patients during their childhood is 80% for women. Research has found that a large proportion of women in psychiatric settings have experienced early abuse, victimization and an unstable family life with at least three changes of parental carers before the age of sixteen (Zlotnick, 1997). The high number of social risk factors which are apparent for women in the CJS, have been attributed to the onset of mental ill health (Mullen, 2001).

3.2.3.2   Diagnosis and criminogenic factors

Subsequently, on admission to medium or high secure psychiatric establishments, women are more likely to receive a primary diagnosis of personality disorder (PD), suffer with depression and anxiety, and present with eating disorders and elevated levels of self injurious behaviours (Long, Fulton & Hollin, 2008). In terms of the offences, which precipitate their move into forensic secure establishments, research shows that, women are more likely than men to be charged with or convicted of arson, and to have previous histories of fire resetting behaviour (Coid, Kahtan, Gault & Jarman, 2000). Hollin and Palmer (2006) suggest that while male and female offenders share some common criminogenic needs, this does not mean that the aetiology or level of importance of that need is the same for men and women.

3.2.3.3. Gender sensitive roles

Due to the differing care giver roles stereotypically assigned to each gender, it is noted that the prison experience will be significantly different for women than it is for men (Corston Report, 1997). The Social Exclusion Unit (2002) report found that a fifth of women were living as lone parents before imprisonment. What's more, a Home Office study showed that for 85% of mothers, their incarceration in prison was the first time they had been separated from their children for any significant length of time (1997). The effects of entry into prison or hospitalisation, for both mother and child, can be especially difficult and traumatising. It is also apparent that it is not a minority of women and children this applies to, a review on women in prison (2010) reported that 55% of women in prison have children under the age of eighteen.

"Many women still define themselves and are defined by others by their role in the family. It is an important component in our sense of identity and self esteem. To become a prisoner is almost by definition to become a bad mother. If she has a husband or partner then again almost by definition she will become a bad wife or partner. Separating her from her family is for many the equivalent of separating a man from his job."

[Baroness Hale, cited in Corston Report: p.20]

Research has shown that three quarters of women in hospital are mothers and two thirds have children under the age of eighteen. 40% of women detained in high security hospitals are parents (WISH, 1999). Gillian (1982) notes that a woman forms her identity in relation to others, and to strip a woman of this and subsequently expose her to a

psychologically negative, stressful environment can be devastating, highlighting how harmful separation from dependants and social support networks can be for women.

3.2.3.4   Severance of social ties

The separation, and, at times, severance from social support networks and family ties is but one of the trigger factors which has been found to increase levels of anxiety (Fogel & Martin, 1992; Koban, 1983). Change in environment can also precipitate an increase in anxiety levels (Sobel, 1982), as well as perceived threat by the environments or others (Linquist & Linquist, 1997). Self esteem has also been found to be linked to the ability to cope with threat of stressful events, and can be further associated with feelings of anxiety and helplessness (Beck & Clark, 1988; Beck & Lund, 1981).

3.2.3.5   Emotional factors

Whilst levels of depression have been found to be positively linked to stressful life events, such as admission to hospital, (Rosario, Shinn, Morch & Huckabee, 1988) they can also have a negative influence on levels of self esteem (Bifulco, Brown, Moran, Ball & Campbell, 1998; Weiss, Longhurst & Mazure, 1999). Although no direct causal links between gender specific, coping styles, and subsequent depression have been established in the research, research has indicated that avoidance, and some other emotion-focused coping strategies (Endler & Parker, 1990) are found to be utilized more often by women and depressed individuals.

A cross sectional survey by Thomas, Dolan and Thornicroft (2004) exploring the individual and placement needs of all women detained in three high-security psychiatric hospitals in England was undertaken. Findings indicated that there was a need for a significant reorganization of services, and efforts to understand further the relationship between traumatic histories, clinical presentation, and antisocial behaviour, and how these impact on assessed risk, treatment, care needs and outcome.

3.2.4 Deprivation factors associated with women in the CJS

As noted in the systematic review in Chapter 1, deprivation factors are those factors which are defined by the literature as features, which the environment imposes on an individual, for instance, the level of physical security, relational security, or distance from home area. One of the main deprivation factor characteristics of the forensic secure environment is noted to be the restrictions in order to manage risk. Significant gender differences uncovered throughout the literature highlight the need for new therapeutic regimes and environments, designed specifically for women who require secure forensic services. A Department of Health document suggested that a large proportion of women in medium secure units require less restrictive physical and procedural security, whilst continuing to require high levels of relational security. Relational security is defined as a function of the therapeutic relationship that exists between staff and patients. It relates to dynamic (e.g. empathy, relationships) rather than static security issues, such as the physical environment. It reflects staff/patient ratios, policies relating to staff/patient interaction, and gender-specific staff training and gender-specific therapeutic interventions (Long, Fulton & Hollin, 2008). These findings led the way for the first enhanced medium secure psychiatric care pilot study in England and Wales. This security level retains the high levels of relational

security required by women, whilst allowing management and supervision in the least restrictive environment possible. Sainsbury's Centre for Mental Health (2008) conducted a study in which findings showed that low staffing levels in psychiatric hospitals contributed to a lack of interaction between nursing staff and patients. It is noted that quality of interaction is an important element in the therapeutic alliance, and also levels of perceived support which can be vital when adjusting to a new environment (Dziopa & Ahern, 2009).

3.2.5   Theoretical link between importation and deprivation factors

This communication between the individual and the environment is widely documented. In terms of understanding the communication between these parties, it can be more fully understood with the aid of a recent adaptation of the cognitive-relational theory initially proposed by Lazarus & Folkman (1984). This recent adaptation assumes that emotions are complex processes composed of antecedents, mediating processes, and effects (Lazarus, 1991). Thus it is assumed that the emotions occur as a specific encounter between the person and the environment, and that both have an influence on each other. Secondly, emotions and cognitions are subject to continuous change, and finally the meaning of the interaction is derived from the underlying context.

Thus the underlying context for women in the CJS may involve their childhood experiences and the subsequent ways this has impacted on their individual coping strategies, interaction styles, and perceptions of others, themselves and the world. For example individuals who have experienced childhood abuse and trauma are found to be more likely to engage in self-destructive acts (van der Kolk, 1989; Briere & Elliott, 1994; Briere, Woo, McRae, Foltz & Sitzman, 1997; Kendall-Tackett, 2002). Green (1978) found that 41% of a sample of abused children engaged in head banging, biting, burning and cutting behaviours.

Freud, (1896), notes that the reason for the repetitive style of this self destructive behaviour was in order to "gain mastery," however this rarely happens and ultimately can cause further suffering for the individual and those around them. The repetition of this behaviour can often continue into adulthood and is observed to occur in a high proportion of women residing in forensic secure environments. Statistics show just over a third (32%) of women reported feeling depressed or suicidal on arrival to hospital. They found women in secure psychiatric environments were significantly more likely to be described as having self-harming behaviours (women 64%: men 27%). In prison, women make up only 5% of the prison population however they account for almost half (47%) of all self harm incidents across all prison estates. This is a rate of 333 per 100,000 compared with a rate of only 62 per 100,000 for men (Maden, Swinton & Gunn, 1994). This repetitive self injurious behaviour is noted by Ferenczi (1955) to be an apparent attempt at "repairing the cohesiveness of the self in the face of overwhelming anxiety".

Thus the interaction of deprivation and importation factors at the adjustment stage, which can interact to cause an increase in anxiety levels and stress for the individual involved, appears also to be linked to an increase in self injurious behaviour around this time. Many theorists have documented the increased levels of self harm to be a strategy of coping which helps the individual to deal with the change and distress caused by entry to the forensic secure environment. Other theorists such as Motz (2010) noted that self injurious behaviour is a form of communication at times of high internal distress, for example, admission to forensic psychiatric hospital or being received into a prison environment.

3.2.6 Gender differences in coping

Coping has been defined by Monat and Lazarus as,

"an individual's efforts to master demands (conditions of harm, threat or challenge) that are

appraised (or perceived) as exceeding or taxing his or her resources"

[1991: p.5]

Ways in which men and women cope has commonly been thought to be formed of distinctly different strategies and approaches, despite mixed empirical support. Stereotypes of male coping behaviour typically revolve around two seemingly opposite sets of behaviours. Men are believed to be more likely to confront a problem head-on, being instrumental problem solvers, and also are assumed to be more likely to deny a problem exists (Ptacek, Smith & Zanas, 1992). Women, on the other hand, are believed to exhibit a more emotional response to problems and are expected to spend more time discussing problems with friends or family (Tamres, Janicki & Helgeson, 2002; Brody & Hall, 1993).

Rosario *et al.,* (1988) discussed two theories that could account for gender differences in how individuals cope with stressful events. Firstly, socialization theory posits that women have been "socialized in a way that less adequately equips them with effective coping patterns" (Pearlin & Schooler, 1978). According to this theory, women are taught to express their emotions more openly, and to act in a more passive manner, whereas men are taught to approach situations in a more active, problem-focused, and instrumental manner (see Folkman & Lazarus, 1980; Macoby & Jacklin, 1983). In contrast, role constraint theory (Rosario *et al.,* 1988) argues that apparent gender differences in coping with stressors may be explained by the likelihood of men and women occupying particular social roles and the differential constraints which encompass these roles.

Therefore, socialization theory would predict that apparent gender differences in coping strategies used, would be found across situations and social roles. Whereas role

constraint theory would predict that if individuals occupy the same social role, gender differences in coping strategies would disappear.

It has also been noted in the literature that men and women may also differ in how the same coping style affects each sex, for example, venting frustrations through crying could leave a woman feeling relieved and less distressed, but might leave a man feeling uncomfortable and more distressed (Tamres, Janicki & Helgeson, 2002). A meta-analysis carried out in 2002 by the same authors showed that women were more likely to use strategies that involved verbal expressions to others or the self. Furthermore, women were found to be more prone to seek emotional support, ruminate about problems and use positive self talk.

3.3   RATIONALE

The factors contributing to adjustment and the impact that this period can have on a woman is an under researched area of study in forensic psychology. Also, adjusting and coping are entrenched parts of everyday life and are important in terms of the study of human behaviour and adaptation. As such, it is vital to recognise that this adjustment period may be difficult, especially if the individual arrives with a number of importation factors which lead her to cope and communicate in self injurious ways. This subsequently could lead a woman to feel unable to cope with the deprivation factors which are imposed by the environment.

Women within the CJS are a distinctly marginalised group with growing numbers who are at higher risk of retraumatisation. Therefore a greater understanding of the factors surrounding the unavoidable process of adjustment is necessary, in order to lessen the likelihood of retraumatisation. Whilst supporting the possibility of this group increasing their skills and abilities whilst residing in forensic environments.

The Department of Heath reported that, gender-specific service differentiation is in its infancy, and there are large gaps in knowledge in relation to the impact of gender-specific treatment programmes. It is further noted that "there are fundamental differences between male and female offenders and those at risk of offending that indicate a different and distinct approach is needed for women". The need for gender specific services and approaches in secure hospital environments has been recommended numerous times (WISH, 1999; Bartlett and Hassell, 2001)

Additionally, environments and provisions which were initially designed and implemented with males in mind, are now being adapted and implemented with the female population, without prior valid and reliable testing, or research. Due to this, we are unsure of the implications and possible detrimental effects of these interventions on women.

3.4   AIMS AND OBJECTIVES

This piece of research will attempt to focus on a group of women and their individual adjustment experiences and coping strategies within the psychiatric hospital environment. During this time, the research will monitor and assess levels of anxiety, depression and self esteem. These three specific areas have been found to be closely related to adjustment (Wilkinson, 2008).

In order to fully understand the meaning of the interaction between a woman and her environment, and the process of adjusting, a qualitative semi-structured focus group was employed. In conjunction with this, quantative psychometric data which was gathered at two intervals; prior to the focus group commencing and following the completion. The primary aim of the group was to explore a range of women's adjustment experiences and coping strategies, whilst the secondary aim of the group was to provide a forum and a support

strategy for the members. The data gathered from the group sessions was analysed using IPA, and the quantative results were used to indicate significant changes. The results and recommendations will be summarised in order to develop theory/ practice links, and to educate professionals who work with women in the CJS in order to support them through the adjustment period.

3.5 METHOD

3.5.1 Design

The current study utilises a predominant phenomenologically based methodology. An interpretative phenomenological approach (IPA) constructionist approach has been adopted, in order to explore the ways in which women cope and adjust in secure environments through lived experience. Pre and post psychometrics were also used in the study in order to document any change in the levels of depression, self esteem, or shift, in coping styles throughout the period of the group.

3.5.2 Participant selection

Participants in this type of focus group based research are approached based on the criteria that they share, a commonality in that they are within the same age range, and have similar socio-characteristics etc (Richardson & Rabijee, 2001). This approach to selection relates to the concept of 'applicability', in which participants are selected because of their knowledge of the subject area (Burrows & Kendall, 1997). In this case the women were all inpatients and had experienced the process of adjusting to a hospital environment. Twelve

women residing as inpatients were initially approached to take part in the study. Six participants agreed to partake in the study.

3.5.3 Participant demographics

Although the ward was primarily for personality disorders, the primary diagnosis of the patients differed somewhat, four out of the five participants had a primary diagnosis of emotionally unstable personality disorder as classified by the ICD-10, and one participant had a primary diagnosis of Schizophrenia (See Table 14). Their respective secondary diagnoses also differed somewhat but it was thought that this aspect helped to reflect the complexities of this client group.

Emotionally unstable personality disorder is defined by the ICD-10 as:

"a personality disorder in which there is a marked tendency to act impulsively without consideration of the consequences, together with affective instability. The ability to plan ahead may be minimal, and outbursts of intense anger may often lead to violence or "behavioural explosions"; these are easily precipitated when impulsive acts are criticized or thwarted by others. Two variants of this personality disorder are specified, and both share this general theme of impulsiveness and lack of self-control"

Client 4 was diagnosed with EUPD of the borderline type which is captured by the ICD-10 as unclear or disturbed self-image, aims, and internal preferences (including sexual). There can also often be chronic feelings of emptiness and higher probability of the individual becoming involved in intense and unstable relationships. Such abusive relationships may

cause repeated emotional crises and may be associated with excessive efforts to avoid abandonment, through a series of suicidal threats or acts of self-harm (although these may occur without obvious precipitants). Client 1 has a secondary diagnosis as mixed personality disorder which is characterised by the ICD-10 as personality disorders and abnormalities that are often troublesome, but do not demonstrate the specific patterns of symptoms that characterize the disorders described in F60. As a result, they are often more difficult to diagnose than the disorders in that category.

Client 2 has a secondary diagnosis of Aspergers disorder (F84.5); this developmental disorder is noted by the ICD-10, to be characterized by the same kind of qualitative abnormalities of "reciprocal social interaction that typify autism, together with a restricted, stereotyped, repetitive repertoire of interests and activities. The disorder differs from autism primarily in that there is no general delay or retardation in language or in cognitive development". Most individuals are of normal general intelligence, but it is common for them to be markedly clumsy; the condition occurs predominately in boys (in a ratio of about eight boys to one girl). There is a strong tendency for the abnormalities to persist into adolescence and adult life, and it seems that they represent individual characteristics that are not greatly affected by environmental influences. Client's 1 and 2 are also classified with eating disorders; Client 1 with binge-purge type bulimia, and Client 2 with anorexia nervosa.

TABLE 14.

Participant Demographic Information

Name	Age	D.oA	Section	Primary Diagnosis	Secondary Diagnosis
Client 1	26	14.02.2013	3	Emotionally Unstable Personality Disorder	With Characteristics of Mixed Personality Disorder
Client 2	22	20.10.2011	3	Emotionally Unstable Personality Disorder	Anorexia Nervosa and Aspergers
Client 3	31	12.10.2012	47/49	Schizophrenia	Emotionally Unstable Personality Disorder
Client 4	21	12.05.2011	3	Emotionally Unstable Personality Disorder	of the Borderline Personality Disorder type
Client 5	43	07.11.2012	3	Emotionally Unstable Personality Disorder	N/A

3.5.4 Environment

Participants were recruited from one private low secure forensic psychiatric inpatient ward in the UK. This inpatient unit included facilities for both men and women, the wards are single sex only. The hospital provides low secure services for mental illness, personality disorder, and locked rehabilitation. It must be noted that the current study took place during a time of change for the women on this particular ward. This was unforeseen prior to the study, and occurred in week three.

The admission criteria for the ward are as follows:

- Female (minimum age of 18 years)
- Detained under the Mental Health Act 1983 (amended 2007)
- Are classified as suffering from a mental disorder / dual diagnosis or personality disorder
- Present with complex behaviours
- Require assessment and / or treatment by a specialist women's service
- May or may not have forensic history
- Referrals are accepted on the authorisation of the responsible funding authority and in accordance with NHS Commissioning Guidelines.

3.5.5 Ethical approval

Ethical review was undertaken by both the University of Nottingham Ethics Committee and an NHS Research Ethical Committee (REC) who specialises in forensic

healthcare. Approval to carry out the research was granted by both committees and copies of the letters can be found in Appendix I and J.

3.5.6 Obtaining consent

Potential participants were approached on 09.11.2012 and invited to participate in the research, they were able to sign informed consent on that day, or were given the option of having a week to think about the research with a view to signing the consent form on 16.11.2012. A participant information sheet (Appendix K) was provided for each patient on the ward. A consent form (Appendix L) was provided for those participants who chose to partake in the study. Initial interviews to convey the details of the research and complete the informed consent form and initial pre psychometrics lasted approximately 60 minutes and took place in a room off the main communal area of the ward.

3.5.7 Data collection methods utilised

3.5.7.1 Rationale for using IPA

The objective of the study did not set out to prove or disprove hypotheses or to test theory; rather it sought to explore and understand how a number of women have experienced their adjustment to a secure environment, and the coping strategies they employed in order to do this. Also it was primed to contribute to the small literature base around this marginalised group of individuals.

Due to the main objectives of the research and the semi-structured methodology, an interpretative phenomenological approach (IPA) was deemed appropriate for the analysis of the qualitative data.

IPA is based on the principles of phenomenological psychology in that it involves detailed examination of the participant's personal life and social world; it attempts to explore personal experience and is concerned with an individual's personal perception or account of an object or event, as opposed to an attempt to produce an objective statement of the object or event itself. Smith and Osborn describe IPA as a method which allows exploration of the meanings of a particular experience for the participants involved (2007), allowing the researcher to theorise language and to analyse the social meaning of this. Braun and Clarke further note that *"frequently it goes further than this, and interprets various aspects of the research topic"* (2006). The main premise of IPA also links neatly in with the principles of both feminist standpoint theory, and cognitive relational theory, in that the individuals' experiences, thoughts, emotions and socialisation are taken into account, and this integrative approach helps to shape the overall meaning and interpretation of the data.

Conrad notes that by using this approach one is trying to get close to the participant's personal world, to take, an "insider's perspective" (1987). At the same time, IPA emphasizes that the research exercise is a dynamic process, and within this the researcher takes an active role. Therefore, in order to complete the analysis to a high quality, and in an impartial manner, the author acknowledges the active role which is taken when analysing the data. This active role involves selection of data, editing, and restating of information, and finally, to summarise and conclude on the argument or position (Fine, 2002). Additionally, it is imperative that the researcher's beliefs, theoretical positions and values in relation to the research are acknowledged, as this lessens the probability of biased final outcomes and conclusions.

The main form of data collection was to be the qualitative data, collected from six focus groups and analysed with IPA. The focus groups occurred on a Saturday morning in a designated room for six consecutive weeks. The majority of the qualitative information, which was analysed, was taken from the six focus groups (including recordings, written notes and flip chart). The rest of the data was made up of psychometric quantitative data, 1:1 interview time with some participants and the final debrief interview. There were two types of communication strategies employed within this research and will be briefly described below.

3.5.7.2 Focus groups

Focus groups have become more and more popular within the literature, with the growth of qualitative studies being published on a variety of topics within a range of disciplines including the social sciences. Focus groups have been defined as 'a technique involving the use of in-depth group interviews in which participants are selected because they are a purposive, although not necessarily representative, sampling of a specific population, this group being 'focused' on a given topic' (Lederman cited in Thomas, MacMillan, McColl, Hale & Bond, 1995).

Focus groups however are distinct from other talking groups in that the goal is not to discover a consensus or single solution. It is distinct in the sense that decision making occurs after all the groups have been completed. In contrast to a nominal group which is encouraged to make a decision at the end of the discussion. The aim is to gather and document the range of opinions, experiences and recommendations by the group members which then form the basis of the decision making process (Kruger & Casey, 2002). One of the other distinct

features of focus group interviews is the group dynamics. Hence the type and range of data generated through the social interaction of the group is often deeper and richer than the data obtained from one-to-one interviews (Thomas *et al.,* 1995).

Another key aspect of focus groups is that the environment in which it is conducted is intended to feel non-threatening, safe and containing. Wherein, the facilitator should attempt to be perceived as a person who is open to hearing anything, and responds in a non-judgemental manner. There are grounds rules and no right or wrong answers- all views are welcome. The focus group then offers a validating environment in which individuals feel their views and opinions will be respected and treated in a fair and dignified manner. The size of the focus group can differ considerably from four to twelve participants at any one time. There is no right or wrong in terms of ideal size; it depends on the complexities of the participants and the moderator's experience. Seldom would only one focus group session occur, it is normal for a number of group sessions to occur consecutively in order to fully explore the topic area. It has been noted that statistical formulae for working out the ideal number of participant or group sessions should be avoided. This is also the case for devising the 'appropriate' number of sessions and instead a method referred to as 'redundancy' or 'theoretical saturation' should occur. This is the point at which no new information is revealed about the particular subject matter with a particular group of individuals. It is thought that this occurs after approx three or four group sessions with one audience type.

The quality of the focus group can also be improved by involving a co-facilitator; especially in terms of the analysis. The co-facilitator can take extra session notes; summarize the discussion at the end of the group, and also check understanding and meaning with the group members. Finally, during the post group debrief, the co-facilitator can reflect their ideas and opinions regarding the group and the interactions with the group discussion. In

terms of analysis these post group reflections can bring added depth, understanding, and meaning and as Hogan (2005) stated, it can be an essential part of the process.

3.5.7.3   Phenomenological interviews

Phenomenological interviews are conducted to obtain rich descriptions of a particular experience. Prior to the interview beginning, it is important to remind the participants about the focus of the study and that nothing is too trivial or unimportant to mention (Fall-Dickson & Rose, 1999). The major task with the interview is to explore the participants responses to questions posed around a certain topic or experience, and the goal is for the participant to reconstruct her experience of the topic being studied (Groenewald, 2004).

It must be noted at this juncture that it is vital to consider the context in which questions are posed, or comments are made. In order to gather data in the most unbiased or non-judgemental manner the concept of bracketing was adhered to. Bracketing can be used in a variety of ways, however in this study is was used in line with the definition given by Miller and Crabtree

"a researcher must bracket his/her own preconceptions and enter into the individuals lifeworld and use the self as an experiencing interpreter"

[1992: p. 24]

However there remains an understanding that an individual such as the researcher will never be truly free from judgement, bias, or error, and due to this the interview is acknowledged as reciprocal; in which the researcher and participant are both engaged in

dialogue (Bailey, 1996), although this style of data gathering can leave room for bias or misinterpretation. The overall aim, which should never be lost, is captured beautifully by Bentz and Shapiro.

"At the root of phenomenology, the intent is to understand the phenomena in their own terms — to provide a description of human experience as it is experienced by the person herself"

[1998: p. 96]

3.5.7.4   Data collection opportunities

In order to clarify, there were six participants in total. Of the six, three participants were actively involved in the weekly focus group sessions and so together experienced six, one hour group sessions; giving each of the participants an average communication time of around two hours. Another participant was not able to join in the group process due to various issues, thus was seen twice individually for one hour at a time, and discussed the same semi structured topics used in the focus groups. The final participant was approached at the beginning of the research to take part, however due to ongoing anxieties and lack of trust; she did not feel able to participate in the weekly group sessions. However, on the final week this participant approached the researcher and asked about the rational and purpose of the research. Once she had been given information about the research and talked through the participant information form she asked if she could discuss the issues which had been covered over the six week period. At this point she was guided through the informed consent form and stated she understood the information provided and would like to continue with the

discussion. This participant was interviewed on an individual basis for two hours, again covering the same topics as were covered in the weekly focus groups.

3.5.8   Qualitative data collection

3.5.8.1   Focus group structure

The focus group structure is broken down into different parts as follows:

Refreshments

Opening

Check in with members

Recap group rules

Convey the focus of the group that particular day.

Discussion

Activities to elicit discussion were to be used if no spontaneous discussion occurred.

Reflection/ relaxation

End

Within the final ten minutes, reflection and relaxation strategies were drawn upon in order to bring the group to a close. These strategies were employed in order to ensure that all loose ends of the discussion were finalised. The facilitators also were able, at this point, to check any unclear information within the session, and finally the women were asked individually if they felt ok to return to the busier ward environment.

The six group sessions were semi structured and based around a certain topic each week. The focus group was flexible enough to not restrict discussion, but also to allow for

guidance on particular points around the topic of that particular session. Some of the focus groups were recorded and transcribed. They were anonymised at the point of transcription.

3.5.8.2 Focus group topics

The overarching focus of each group session which was informed by the findings from the systematic review was as follows:

1. *Admission into first secure establishment (hospital/ prison).* The most memorable experiences of this within the initial seven days (critical period).

2. *Dealing with feelings.* Initially the session began with a discussion, which included psychoeducational elements that explored the members knowledge about the differences between thoughts and feelings. This will enable accurate distinction between thoughts and feelings in preparation for sessions two and three. Once the differences and confusing issues between thoughts and feelings were discussed, the focus of session two was made clear. Feelings will be the focus of this group and how the members coped with these feelings.

3. *Management and behaviour.* Way in which the women were managed within these first few days. How information was communicated to the women, and how they chose to communicate to the staff.

4. *Current ward relocation with Alpha*. Semi structured sessions which encompassed questions around thoughts and feelings from before, during, and following the relocation of the ward. The patients are within the seven day critical period.

5. *Factors which affect coping strategies and adjustment.* Thinking about designing a psychiatric hospital. What factors would be most important?

6. *Reflection and Consolidation*. The group will reflect on the journey to date and the information shared. The members will be allowed time to share experiences of the group, and facilitators are able to check understanding of all information, and also give feedback to the group.

3.5.8.3 Debrief interview

Following the six group sessions a final debrief interview was facilitated. The aim of this was to complete a final battery of psychometrics and record overall feedback about the group sessions and their personal reflections. The interview also provided an opportunity for facilitators to check understanding of any vague or unclear information given over the six weekly focus groups. The concluding interview was accepted by three of the participants.

It must be reiterated at this juncture that at no point in the process were the participants asked to directly talk about anything except their adjustment. All other information gathered was elicited as part of these discussions.

3.5.9 Quantative psychometric assessments

3.5.9.1 Coping Styles Questionnaire (CSQ-3)

The CSQ-3 is a revised version of the CSQ (Roger, Jarvis & Najarian, 1993) comprising of 41 items (11 reversed). Participants are asked to indicate 'typical' reactions to stress on a likert scale of one to four [ranging from 'always' to 'never']. The CSQ-3 investigates emotional, avoidant, detached and rational coping styles. Emotional coping refers to a tendency to feel overwhelmed e.g. ''Feel overpowered and at the mercy of the circumstances'', whereas avoidant refers to a failure to deal with the stressor directly e.g. ''Try to forget the whole thing has happened''. Rational refers to adopting a problem-focused approach e.g. ''Try to find out more information to help make a decision about things'', and detached to a more disconnected approach e.g. ''Feel independent of the circumstances''. Roger *et al.,* (1993) showed the CSQ to possess a higher-order two factor structure comprising two adaptive (rational and detached) and two maladaptive coping styles (emotional and avoidant). The CSQ-3 emotional, rational and avoidant subscales (items = 10) proved reliable (a = .83, a = .84 and a = .79) with the reliability of the detached scale (items = 11) moderately reliable (a = .63). (See Appendix M).

3.5.9.2 General Health Questionnaire (GHQ-28)

This is a 28-item measure (Goldberg & Hillier, 1979) detecting the presence of psychological distress, assessing four dimensions: psychosomatic symptoms, anxiety and insomnia, social dysfunction and severe depression. There are no reversed items, with each item on a scale of four (e.g. ranging from 'better than usual' to 'much worse than usual' for

psychosomatic symptoms and anxiety/insomnia). A total score is computed by adding all 28 items. In the present research the scoring of GHQ-28 followed the test manual recommendations (0, 0, 1, 1) using the binary scale method. A cut-point of 5 is used to detect psychological distress. Examples of items include, ''Have you recently found everything getting on top of you'' and ''Have you recently felt that you are ill?''. The overall GHQ-28 and each subscale (items = 7) proved reliable (overall a = .93; n = 141): somatic (a = .83), anxiety and insomnia (a = .87), social dysfunction (a = .83) and depression (a = .94). (For copy see Appendix N).

3.5.9.3   Culture Free Self Esteem Questionnaire (CFSEI-2)

The adult form is a 40 item measure (Battle, 1992) it is broken down into 16 items for general self-esteem, 8 items for social/ peer self-esteem, 8 items for personal self-esteem and 8 items in order to indicate deception on the lie scale. Each item is rated as either high self-esteem or low self-esteem and responses are of the forced-choice variety; either yes or no. General self esteem relates to the aspect of self esteem that affects the individuals overall perceptions of their worth, and includes statements such as 'are you a failure?' Social self esteem measures the individual's perceptions of the quality of their relationships with peers and includes statements such as, 'are you as happy as most people'. Finally personal self esteem relates to the individuals most intimate perceptions of self worth and includes statements such as, 'do you feel uneasy most of the time without knowing why'. The lie scale attempts to identify if an individual is 'faking good' and gives an indication as to whether the final results are reliable as a true indication of that individual. This scale includes statements such as 'do you ever get angry?'. The Cronbach alpha coefficients of the item analyses on the total and subscales indicated a relatively high internal consistency reliability (0,85).

Furthermore, test-retest reliability showed that all the correlations are higher than 0,74 for each of the subscales and the total scale (0,91). (For copy see Appendix O).

3.5.9.4   Beck Depression Inventory (BDI-II)

The BDI-2 is a revised version of the BDI (Beck, Steer & Brown, 1996). It is a 21 question multiple-choice self-report inventory, and has been designed for individuals aged 13 and over. It is composed of items relating to symptoms of depression such as hopelessness and irritability, cognitions such as guilt or feelings of being punished, as well as physical symptoms such as fatigue, weight loss, and lack of interest in sex. The Cronbach alpha coefficients of the item analyses on the total scale indicates a relatively high internal consistency reliability (0,80).

Furthermore, test-retest reliability gave a score of (0,93) for the total scale. (For copy see Appendix P).

3.6   ANALYSIS OF RESULTS

Analysis of the data occurs concurrently with data collection. Krueger (1994) suggests that a helpful way to think about this is in terms of a continuum which shifts from the accumulation of data to the interpretation of the data. It is further noted by Ritchie (2003) that the process of reduction is a vital part of performing qualitative analysis. This is so the sources of the themes remain rooted in the data, preventing the participant's meaning of their reality and experiences disappearing. If this is not adhered to the analysis can become a process of simply overlaying themes from the researcher's perspective which in turn discounts and restricts true understanding.

3.6.1   Quality assurance during the analysis

Throughout the literature qualitative research methods have come under scrutiny due to an absence of clear and concise guidelines. It seems that throughout the literature there has been an 'anything goes' critique of qualitative research (Antaki, Billig, Edwards & Potter, 2002).

In order to overcome this critique, and to ensure high quality methodology, a number of stages were followed. The stages involved clear shifts from the particular (each individual participant) to the general (across participants), and from the phenomenological to the interpretative. The stages followed in this study are based on the 'Framework Analysis' method described by Richie and Spencer (1994). The five key stages outlined by the framework analysis are:

- Familiarization- Refers to the process of sifting and sorting data. This is in order for the researcher to become familiar with the range and diversity of the data gathered. An essential part of this process involves immersion in the data. How the material is selected at this stage will rely heavily on time but it is important to ensure a variety of sources, time periods and cases are selected. Key ideas and recurrent themes are noted (See Appendix Q for the final fifty codes).

- Identifying a thematic framework- The data must now dictate the themes and issues. It is imperative at this stage to maintain an open mind not force the data to fit a priori issues which may have been the basis for the initial research question. Applying the thematic framework or index systematically to all the data in textual form by

annotating the transcripts with numerical codes from the index, usually supported by short text descriptors to elaborate the index heading can be helpful. This stage also involves making numerous judgements as to the meaning, relevance and significance of each piece of data, no matter what the source of the data i.e. transcript, flip chart or session notes. An intuitive mind is required to link implicit connections and ideas. (See Appendix R).

- Indexing - Identifying all the key issues, concepts and themes by which the data can be examined and referenced. This is carried out by drawing on a priori issues and questions derived from the aims and objectives of the study, as well as issues raised by the respondents themselves, and views of experiences that recur in the data. The end product of this stage is a detailed index of the data, with corresponding labels ready for subsequent retrieval and exploration. (See Appendix S)

- Charting- Rearranging the data according to the appropriate part of the thematic framework which they relate, and forming charts. For example, there is likely to be a chart for each key or theme with entries for several respondents. Unlike simple cut and paste methods that group verbatim text, the chart contains distilled summaries of views and experiences. (See Appendix T)

- Mapping & Interpretation- This stage is carried out by using the charts to define concepts, map the range and nature of the phenomena, create typologies and find association between themes, with a view to providing explanations for the findings. The process of mapping and interpretation is influenced by the original research objectives as well as by themes that have emerged from the data themselves. It allows

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the researcher to pull together key characteristics of the data in a logical and creative way whilst conceptualizing the data as a whole and making connections to theory. At this stage Figure 2 was constructed in order to guide mapping and link the data to theory.

The five point framework was followed concurrently with a stringent ten point quality checklist developed by Patton (2003; Appendix U). This was used in order to retain high data quality analysis whilst attempting to elicit the shifts in the data.

3.6.2 Analysis of qualitative results

3.6.2.1 Subordinate Theme 1: Self

All of the participants contributed to the theme of 'self'. This theme includes three dimensions, including what they individually feel they need in order to be 'well' or 'OK'; inherent negative associations about self and having to prove things to one's self.

- ***Ideas about what people need to be well***

Most participants described familial ties, visits and engagement in activities to help them cope with the restrictive and repetitive elements of the forensic secure environment. Although some participants recognised the benefits of the activities which were provided, others appeared to focus on what they would rather be doing. They also reflected what they felt their day consisted of.

"Yeah, and all I feel like all I'm doing here is sitting in my room watching TV or being made to do things like, baking, arts and crafts and (1) and you know stuff. T said it is to get me

involved with stuff so I'm not bored at home, I said I'm not bored at home I have my grandkids I have my friends. It's just day after day (1) it's just, it's boring just sat here for no reason and I sit here thinking another day is gone and look what I could have been doing if I was at home. I think if I was at home I would be going to see the kids and that"

[Client 5, Line 1424 -1430, Week 6]

In this example and at other times, participants, when reflecting on their day to day life and how they cope with this, voiced that they wanted to be doing different things, and would often give examples of things which they had previously engaged with in the community such as go to the gym, see family, and go to the doctors. At times when the restrictions of the environment impede these activities and the women thought the staff did not show sensitivity or flexibility, these negative attitudes and feelings can then be turned from the restrictive environment to the staff on duty.

4: it's like when we ask them to do stuff it's like no, you can go home at the end of the day
F: yeah
4: and we cant
1: can I go to the gym, well no you can't because we haven't got enough staff. Well you can go to the gym when you finish work you don't need staff it's not fair
4: I was asking about my paperwork bringing up for a doctor's appointment and a member of staff had a go at me 'oh this isn't all about you there are all these other patients' and I'm like I never once said it was all about me and then I said it's alright for you to go to the doctors whenever you want, we cant
1: that was me yesterday want it
2: yeah

[Client 4, Client 1 & Client 2, Lines 396-409, Week 2]

At times of negative feelings the need for fairness in an environment which does not always appear fair is important. When something isn't able to be done immediately, all the

participants voiced a want for an explanation. This implies the women would like to understand the rationale for the sometimes restrictive nature and 'unfair treatment" they feel is forced on to them. Finally, a lack of control in terms of activities and the environment was a common code which arose throughout the data and with all participants. It appeared that at times when they felt they were not in control of anything; it precipitated negative feelings and unhelpful behaviours such as restricted eating as seen in the example below.

4: if you lose weight then you're not going to get out
2: it's almost like you can take everything from me but you can't take my not eating from me. It's my thing that I've got
1: its control isn't it

[Client 4, Client 1 & Client 2, Lines 321-324, Week 2]

At times, the ways in which forensic secure care attempts to provide, containing, helpful and supportive care can become shrouded with recurring unhelpful thoughts and feelings. These can, in time, contribute to the length of stay in forensic secure care. This can then have negative impact on the individual involved. Additionally, it appears there is some dissonance between the woman's personal perceptions of her community lifestyle and circumstances than those identified by professionals. These can often present when each person is relaying a subjective summary of the risks, needs and vulnerabilities which they think are important. An individual's want to defend her previous lifestyle and behaviour may trigger internal defence mechanisms or it may precipitate engagement with self injurious coping strategies in order to reduce psychological distress created by the dissonance.

- *Negative associations about self*

The second main subordinate theme was the negative associations, views and beliefs about the self and the impact this then has on their ability to cope and interact with others in the environment.

"The pain and hurt you feel (1) and the rejection and abandonment. Yeah. Being abandoned, neglected. And that no one cares, no one gives a shit. No one gives a shit so why should you give a shit about yourself"

[Client 4, Lines 280-285, Week 2]

"I feel like I always wish I had died"

[Client 4, Flip Chart p.10, Week 2]

"I've got to a point in my life when I have thought surely everybody can't be wrong, person after person keeps hurting me surely they can't all be wrong I must be useless and crap"

[Client 2, Lines 288-290, Week 2]

Previous experiences and their associated feelings was a common feature within the data. It appeared that these early life experiences continue to influence and shape thoughts about the self. Thus the concern, patience and justification they reserve for themselves can then impact on an individual's ability to cope. This contempt for the self can stem and be heavily influenced by beliefs, perceptions and memories of a younger self.

"cause as a kid I was very violent I used to hurt my mum which I'm not proud of. But I did some serious damage to her and I was not a nice person and then when I got older I turned on myself, it was my way of protecting them"

[Client 2, Lines 265-266, Week 2]

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In this excerpt Client 2 is describing previous behaviour towards a family member and the strategies she put in place in order to protect her family. Client 2 also attributes feelings of not being proud of herself and not being a nice person, but then talks about protecting others that she cares about which would contradict the latter belief about herself. Again the dissonance between beliefs which developed at an early age, and comparison with behaviour since this time, is not always enough to challenge and break cycles of maladaptive behaviour and unhelpful roles which we re-enact through the lifespan. For example, being victimized and controlled by others and then whilst in hospital feeling controlled by others and unconsciously slipping into a victim role can precipitate similar thoughts and feelings which were present during a prior experience of victimization. These previous relationships and feelings can also then be played out in the staff-patient relationship and could also have potential detrimental effects on the individual's ability to cope on their own. This could then lead to other damaging aspects including institutionalisation.

Another element which appeared to support internal negative beliefs was the diagnosis. A diagnosis is attributed in an attempt to define the difficulties that an individual woman can face when she interacts with the world and those around her. As a part of this all of the participants discussed their primary diagnoses and what this means to them.

"I don't like term personality disorder, it feels defective. The word 'disorder' implies there is something wrong. I prefer the word difficulties"

[Client 1, Flip Chart p. 8, Week 2]

"I feel guilty like I've done something wrong"

[Client 4, Flip Chart p. 8, Week 2]

"I'm diagnosed with emotionally unstable personality disorder but I'm embarrassed about the other bit (1) traits of multiple personality disorders"

[Client 1, Flip Chart p. 3, Week 1]

These examples give a flavour of the negative connotations the labels evoked for the participants. Beliefs and opinions around their diagnoses also appeared to heavily influence what they thought other people knew and understood about the diagnosis and how this can affect a person. Client 1 also shared comments and parts of discussions with staff which she felt were helpful in terms of accepting and understanding her diagnosis. She stated that staff had said that there are "elements of PD in everyone" and this had made Client 1 feel somewhat better about the initial diagnosis.

- ***Having to prove myself***

Most of the participants voiced feeling like they had to prove themselves and this was by not self harming.

"Yeah sometimes I feel like I'm going to prove people wrong when they say I'm always going to be in hospital and I'm always going to self harm well actually fuck you lot. I'm not going to do that, I'm going home"

[Client 4, Lines 306-308, Week 2]

When exploring the rationale for engagement with self injurious behaviour there were two distinct dichotomous stances, one being positive objectives and the other negative. One of the main positive implications was that self harm, or the amount an individual has self harmed, became the gauge of how progression within the secure forensic environment.

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Additionally participants spoke about being rewarded for resisting the urge to use self harm as a coping strategy, for example, being awarded local leave.

4: well last night I, someone gave me two glass bottles

F: and what did the staff do?

4: I didn't want to hand them in but then I thought about it and then eventually, and then I eventually handed everything in

F: why did you eventually hand it in?

4: Because I had leave today

F: right, OK

4: I'm working towards other goals and it would just put everything back.

[Client 4, Lines 620-628, Week 2]

Consequently another use of self injury was revenge. In the example below Client 2 states that self harming is rewarded as it is seen as a progression towards discharge, but she also has used it as a form of 'comeback' or punishment for the staff who have highlighted the maladaptive elements of this behaviour to her. This remains the case even when the person being affected the most is Client 2.

"I have never actually said it before, but when people say things to me like, don't do that you will never get out of hospital I always think I'll show you I'll lose weight that's like my come back. And I've never said that out loud"

[Client 2, Lines 312-314, Week 2]

Whereas one participant voiced that for her, self harm was a "normal" thing which she had been doing for seven years, and one she was in control of, and did not want anyone to take that away from her. In order to ensure she felt in control and consequently cope with any

environment Client 4 stated she would go to extreme lengths in order to conceal cutting instruments.

"When I first come here I wouldn't hand anything in. I hid () in my bra one time. They would have to restrain me to take them out of my bra wouldn't they? I wouldn't hand anything in"

[Client 4, Lines 654-656, Week 2]

Following this, a connection between using control as a coping strategy was alluded to. There appeared to be an irony in this discussion in that they felt more in control when engaging in self injurious acts however to the observed this act was seen to be evidence that an individual was out of control and not managing. This is illustrated in the subsequent excerpt.

4: they can shove it up their arse
F: yeah
4: its my life if I want to self harm, I'll fucking self harm. Yep ↑You can't control me all that kinda stuff

[Client 4, Lines 765-768, Week 2]

The thoughts around self harm and the use as a method of control, and a sense of proving how well they are progressing can, at times, be extremely stressful for the individual. This is illustrated by the example below

"Yeah, like, it was like if you self harm you're not going to get your local leave. If you self harm it's just gona prove that you have no control, when I know in my mind I am talking to myself in my mind saying I have control, do not give into this. Causing me so much stress, it's like weighing things up"

[Client 5, Lines 1235-1238, Week 6]

3.6.2.2   Sub-ordinate Theme 2: Environment

- *Teaching and learning*

All of the patients spoke about activities through which they could learn from, and also help to teach others, both now and in the future. This arose in a number of different ways, one of which was learning about them and new ways to cope with their individual difficulties and diagnoses.

2: *"I had a friend who she had a lot of crap in her life and it had not affected her at the time, but years later she had started making herself sick (1) and it wasn't until she got admitted and went through therapy, when she got <u>really</u> underweight that they realised that, she realised that all that crap had just caught up with her. Does that make sense? (0.5) Am I making sense?"*
4: *"so they can blank it out at the time"*

<div align="right">[Client 2 & Client 4, Lines 140-144, Week 2]</div>

Most of the participants spoke of the benefits of engaging with therapies and what they could learn about themselves. This could serve to empower the women, and allow them to feel some control and responsibility in their journey of recovery. All the participants spoke about learning from other people who have come through similar experiences and difficulties, and how this could benefit them

4: *I would like to see people that have self harmed and got through it. I want that in a group I want that. If someone came who self harmed what's now recovered and same for eating. Because at the minute I don't feel like I'm ever going to get there but if somebody comes in there is hope. At the minute we haven't got the hope that we are going to get recovered so for someone to come in that has been through it, it might help us and I think*
F: *Do you agree? Because you are nodding there 2. (Looking at 2)*
2: *(Nods head)*

The participants then spoke about how they could turn their experiences into something positive. In the following excerpt Client 2 and 4 hope, one day, to be the survivors that speak to women in similar situations, in order to offer encouragement, empowerment and hope. Throughout the group sessions the participants emphasised the importance of these factors in the recovery journey.

4: Because I want to turn my negative experiences into positives for other people. (1) That's what I wanna do.
2: If it helps someone it hasn't all been for nothing.
F: right OK.
4: But then I think if I can get through it someone else can get through it

[Client 4 and Client 2, Lines 941-945, Week 3]

One participant spoke about using her time in hospital in order to learn new skills whilst and how this helped her to access information online about her concerns/ difficulties and eventually led to an interaction with another individual with similar difficulties. In the quote below the individual relays how this made her feel.

"and I've never ever sat down and, I've never told anybody exactly what's going through my mind it's there from the minute I wake up to the time I go to sleep. And my feelings about it, how much it's hurting me or what I think about myself you know stuff like that I've never told anybody. But if I go on the internet I'm not looking at that person I can go on a website and someone else is experiencing the same thing as what I am. I can type in and you know just chat to them (?) there was months leading up to me coming in and she was relatively young and she (?) my history and she said something to me about it, about how she felt and it was like listening to how I feel and I said something back to her and started talking and I said that's the first time I have started talking about anything and it feels like a weight has been

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lifted I actually found a connection and I'm not all alone with it so. That's another reason I wanted to learn it but I've never told them that is the reason I wanted to learn it"

[Client 5, Lines 1531-1545, Week 6]

In this excerpt Client 5 is talking about being able to research the difficulties she felt she had in her life, and to connect with people who appeared to understand her thoughts and feelings around this sensitive topic. Client 5 speaks about conversing with a young woman prior to her admission who listened to her and how this had felt like having a weight lifted because of the connection to someone else.

The internet is allowing people to relay intimate feelings and thoughts and connect with other people without leaving the safety of their home. The internet allows for people to connect without having to be in close proximity, or be trapped in an environment which they feel they cannot leave. These additional factors which Client 5 also spoke about in regards to speaking to others appear to have aided this connection to strangers on the internet.

"Yeah but that wasn't all I did. Erm I used the internet a few times, (staff member) was trying to teach me the internet. Then I made a cookery book for my daughter"

[Client 5, Lines 1480-1481, Week 6]

This excerpt is also centred on the internet and it was an activity which was carried out on an acute ward during an admission. A theme that ran through the need for activities and engagement was the rationale and purpose of each of these things. All of the women highlighted the need for a purpose in the short term and long term. This is also highlighted in the following examples

Have more recovery groups instead of activities like making a paper tree. It's not nursery.
More recovery focussed groups, skills, anger management, leaving less time to sit and dwell,
thinking I'm stuck in hospital under a stupid section.

[Client 2, Session notes, p. 3, Week 4]

It appeared to help the participants if they felt that their experiences and their time in hospital was not being wasted and could contribute to something positive. Thus the need for a purpose was important in terms of what they had been through and what they were living through on a day to day basis. Client 2 noted the need for a purpose and rationale for the environmental restrictions which are in place.

"they are too forceful when having room searches, I would want staff to be more sympathetic
and give an explanation in a way that patients would understand. Staff could then explain
what they were taking so they could manage self harm"

[Client 2, Session Notes, p. 1, Week 5]

In this example Client 2 notes the benefit and, at times, need for sympathy and explanations when carrying out routine security checks. For example when room searches are conducted it can be a very upsetting experience; as this is the place which all participants identified as their safe space. Client 2 acknowledged the need for restrictions in order to manage levels of self harm but implied a wish for it to be more collaborative. Furthermore, the importance of learning the restrictions and rules of the ward on admission was noted by Client 3. As she stated she had not been informed of these and she

"had done something wrong and this had really upset her"

[Client 3, Session Notes p. 2, Week 5]

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- *Feeling safe*

All of the participants spoke about the need to feel safe in the ward environment and with the other patients. The adjustment phase was deemed a difficult time, as feelings of safety are not cemented and there are restrictions placed on familiar belongings and visits with previous supportive individuals. Client 1 and Client 4 give an indication as to why it can be a difficult environment to adjust to.

"I feel trapped, controlled with no freedom and no capacity to say or do anything because of section"

[Client 4, Flip chart p. 14, Week 2]

"it's an unpredictable environment, you want to get out but its locked doors with no escape"

[Client 1, Flip chart p. 23, Week 4]

As presupposed the longer an individual spends in the environment the more familiar it became, which in turn lessened feelings of being unsafe. Another common factor which arose for a number of participants which contributed to feeling less safe as they became more familiar with the environment is illustrated by the following excerpt:

"You should not put more risky people in with less risky people"

[Client 3, Session Notes p. 3, Week 6]

At times when they felt unsafe in the environment all of the participants spoke of spending a lot of time in their 'safe space' which was their bedroom. They also spoke of how and why their bedroom was the most comforting place within the environment and this is highlighted by the following quotes.

"erm I have to, it's where you feel safe isn't it? Because I made it my room with pictures of my grandkids and its immaculate how I would have it at home. Everything in place, all my toiletries and everything like that. It's comfortable and it's where I can escape to, and I can pretend it's not part of this hospital. I'm not in this hospital and again I still don't open my curtains"

[Client 5, Lines 1065-1077, Week 6]

This is an interesting example as not only does it portray the importance of the bedroom as she keeps it, "immaculate how I would have it at home" with her personal belongings, pictures of her grandchildren and toiletries, but she also uses it as a place of safety and an "escape" from the ward environment. Client 5 intimates that in this room with all her familiar belongings from home she can pretend to be anywhere but not in hospital.

At times, patients are required to return to an environment in which they had previously been unwell or unable to cope, and the memories associated with this can in turn trigger distress and anxiety. Client 1 had this to deal with this situation during the study, and shared her thoughts and feelings prior to the ward relocation.

"S ward has lots of bad memories. It was horrible, I didn't cope well. I was scared it would send me downhill. So I requested for them not to put me in the high dependency bedrooms"

[Client 1, Flip Chart p. 19, Week 4]

In this example Client 1 identifies the stressor or trigger to bad memories and anxiety and then relays what she attempted to do to relieve this anxiety. Client 1 also noted at this point that she is at a stage in her recovery where she is taking control, if it had been at a point

where by she had felt less able to deal directly with her emotions she may have communicated her distress and anxiety in other ways.

All of the participants spoke about the communal ward environment and how this can influence perceptions about a ward and how this can affect internal thoughts and feelings.

5: they did things to make it more homely

F: could you tell me a little bit more about that?

5: Because it was a mixed ward we had a (mumble) right at the bottom they had a little key and you could get into your room down there and the women's bit, the men couldn't get into it. There was a massive lounge with cushions and coffee tables erm they even put a fake fireplace up with vases on and flowers in and they painted feminine pictures and it was just more dining room they got all our opinion on it and you could choose and it was like a bistro sort of thing

F: oh ok

5: where we had table cloths and pictures on the wall of like, like something from Paris, like coffee shops and things like that and again vases on the tables and flowers and although the menus were the same each week but they were in the middle of the table. You could choose it wasn't like you had to tick it the day before you choose what you want on that day

[Client 5, Lines 1065-1077, Week 6]

In this example Client 5 talks about her previous hospital feeling "homely" and she appeared to have good, positive memories of this aspect of the hospital. Something which Client 5 seems to hone in on is the separate area for women, and how this was locked off, with only certain patients holding the keys, and emphasised this private aspect by stating "the men couldn't get into it". It's almost something to call their own and because they helped to decide on the decor and the way it was managed, they felt a part of it. Similar feelings were

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also noted by Client 1 in terms of being able to have her own belonging and a place to put her mark on i.e. her bedroom.

"In my first hospital in the acute ward you couldn't put your own stuff on the walls and were only allowed certain items of clothing, like one teddy, one pillow, one duvet and two sets of clothes"

[Client 1, Flip Chart p. 24, Week 4]

Consequently, Client 3 noted that she felt patients should be able to choose the colour of their bedroom upon arrival. Again this shows choice and decisions in regards to the physical environment and how important these aspects can be to an individual's recovery.

3.6.2.3   Subordinate Theme 3: Others

- ***Caring and protecting others***

The participants often became preoccupied by not wanting to upset the other members of the group, either by voicing their opinion or talking about an incident on the ward.

2: I don't want to upset anyone
F: ok
1: you're not going to upset me (laughs)

[Client 2 & Client 1, Lines 108-110, Week 1]

Not wanting to upset other members of the group arose in each session, and indicates a level of care and protection of others. Another common theme in regards to caring or protecting others was experiences prior to hospital. In which the participants described engaging with self injurious behaviour in order to protect others. However, there was a clear dichotomy between two types of protection. One reason noted for self injurious behaviour is

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to be "in control of the hurting" instead of the perpetrator. In contrast a number of participants voiced their rationale for utilising self injurious behaviours which was in order to protect close others from the extreme emotions they were struggling to cope with. Client 1 speaks about protecting her Father who was hurting her and the negative outcome this had. The experience culminated in Client 1 beginning to hurt herself so she could be in control of "the hurting".

"I lied to protect my dad, I wanted to be in control. I didn't understand why I hurt myself, maybe I wanted to be in control of the hurting"

[Client 1, Flip Chart p. 10, Week 3]

Client 2 also spoke about protecting her mother and in order to do this also began to hurt herself. Thus, initially the aim of self harm for Client 2 was not to hurt herself, it was a form of protection and a way of releasing emotions as violent acts whilst not physically hurting those around her. This is also highlighted by a quote previously used in order to illustrate subordinate theme 1, Self.

"Cause as a kid I was very violent I used to hurt my mum which I'm not proud of. But I did some serious damage to her and I was not a nice person and then when I got older I turned on myself, it was my way of protecting them"

[Client 2, Lines 265-266, Week 2]

- ***Influence of others***

The participants spoke about the influence of others. This was mainly in the context of either learning or normalising unhelpful or maladaptive behaviours.

4: After denial that there is nothing wrong with me. I I'm in big denial because I'll never admit there is anything wrong with me, do I? I always say self harming is normal, overdose is normal, swallowing glass is normal. I just think it is all normal

1: I used to be like that, but I accept I have problems.

4: And plus being around others self harmers it just makes me think it's even more normal.

1: I've learnt ways of self harming before I came here I didn't know of

[Client 1 & Client 4, Lines 966-967, Week 3]

Client 1 speaks about the influence of new admissions to the ward and how this can be a potential destabiliser especially if the new admission is acutely unwell and another individual sharing the same environment is at the other end of the recovery spectrum and nearing discharge.

"they are ill and it reminds me of what I was like and I don't want to go back to that"

[Client 1, Flipchart P. 20, Week 4]

It is unclear as to whether this influence would be potentially negative, in that it may evoke unnecessary anxiety at a potentially crucial time, or whether it would be a positive reminder of how far they have come and how well they are doing. In terms of adjustment to an environment the behaviour of other patients can affect feelings and thoughts in this critical period and Client 5 gives an example of this from her recent adjustment to the ward within the hospital.

5: I watch a lot, I'm quite a quiet person I don't talk and I'm always aware of what's going on around me and like I watch people it's not that I'm judging them I see their behaviour and I just don't want to be around it, it's not the sort of thing that. I find it quite disturbing at times to be around behaviour like that.

F: Does it ever affect you or make you feel like you would engage in that behaviour or set you back at all?

5: No I just, no it wouldn't affect me or do something because of it, it's just (2) I don't know it's just you don't want to see it do you. It's just (2) I don't know I'm not used to this sort of environment, I'm not used to this sort of setting.

[Client 5, Lines 1290-1298, Week 6]

In this example Client 5 is talking about the self harming behaviours of the other patients on the ward. She stated that it would not influence her but she does not want to see it in the environment where she has to live. It is unclear as to what factor in particular appears to placate the perceived negative influence of others; it may be age, sense of self or coping repertoire developed.

All of the participants spoke about the influence of external social networks such as family and friends.

"missing my family (3) I miss my grandkids so much it's just heart (...), it's just really tears me apart they are such a huge part of my life in so many ways when I do get ill (2) it's like when I first got ill to end up here my mum said she would bring my eldest grandson I said don't bring him I honestly wasn't very well erm and she did about two days later and just looking at him I thought to get better because he's my grandson and you know that's my reason, it gives me the world they are so important to me and I miss them and (0.5) and I don't, I feel like I don't belong here as well"

[Client 5, Lines 1144-1151, Week 6]

This example gives an understanding of the positive influence family and friends can provide to someone who is in hospital. Client 5 is recalling a visit with her children and grandson who are very important to her, describing them as her "world". In the same instance thoughts about how much she misses them and how she does not belong in the hospital enter her mind. This then gives her a 'reason' to recover and be back in the community closer to them as they are a "huge part of my life" (Client 5).

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- ***Interactions with others***

"*And I said why have you just done that when she has just seen me? And she wouldn't explain she said about checks and things like that. So I tried to speak to her about it and I said you know it's Christmas day you know it's very hard for me all I was trying to do was ask you. She said what's your problem what's your problem, she kept repeating herself and it really hurt me because she had, I had no one to go to on Christmas day 'cause like (1) if that was the way she was responding to me trying to speak to her how was I going to talk to anybody about how bad I felt that day?***"*

[Client 5, Lines 1698-1705, Week 6]

After one negative interaction with a staff member Client 5's feelings and thoughts around attempting to interact with anyone about anything seem to be negatively influenced and tainted. Additionally, Client 3 spoke about the negative way in which her interaction style is perceived by staff and other patients, and also gave an example of what staff could do with her, instead of verbally communicate.

"people don't listen to people, they don't want to listen to what they have to say. Some people just want to talk. Just because she doesn't want to talk don't leave her. Don't be put off by her quietness. You could watch tele together or get a drink"

[Client 3, Session Notes p. 5, Week 6]

In this quote by Client 3 she is attempting to express the way in which she would like staff to respond to her. In this case, she does not want staff to be put off by her quietness; it appears that Client 3 feels that because she is not necessarily as chatty as the rest of the patients this can then lead to hr being excluded from the ward group. However, Client 3 did not want to feel like this and was hoping that staff would come to understand her communicative style. Further stating that although she may not want to verbally

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communicate with someone else she would appreciate company and someone to take their time to do things with her, such as watch television or get a drink.

In the few days after admission patients spoke about interactions around their diagnosis or reasons for admission. Some interactions with staff members appear to have triggered negative feelings and connotations around the diagnosis they have been given. Client 1 described an interaction with a staff member which had occurred after someone had read her notes and not understood the meaning of the diagnosis for Client 1.

"so you pretend to be someone else that's sick"

[Client 1, Flip Chart p. 3, Week 1]

Additionally, some of the participants shared that they felt that they could tell whether someone really understood their difficulties and diagnosis or had only read about the diagnoses, or learnt about it through their training. A few examples of how they felt they could differentiate between the two are given below:

2: They wouldn't get it
4: Lack of understanding
2: This might sound weird but I have Aspergers and people don't understand Aspergers
F: OK
1: My other Aspergers friends understand me completely
F: hmm hmm
1: But rest of world (shakes head)
F: yeah so lack of understanding
4: Lack of understanding, erm they haven't got life experience of it
F: right, OK
4: They have just read it out of a textbook, they haven't (trails off). I would rather work with people that used to be self harmers
F: right

4: Or people that have had an eating disorder and recovered

F right

4: Because they understand more. None of these staff can understand, <u>they say they do but they can't</u> because they have not gone through it.

<div align="right">[Client 1, Client 2 & Client 4, Lines 864-881, Week 3]</div>

Subsequently the participants vocalised a want for staff who have either recovered from or have had life experience of the difficulties the patients face on a day to day basis. This for the participants was important, as it appeared to form the basis of positive/ measured responses from staff. This connection and understanding appeared to aid adjustment to the service and heighten feelings of support.

- ***Relating to others***

Being able to relate to others and be a part of something arose as a topic over a number of sessions. It appeared that previous experiences of relating and connecting to others played a significant part in how the patients could relate to their fellow patients and staff on the ward. Client 4 speaks about her difficulties relating to others, and then ties this back to her childhood and the negative interactions she encountered with significant others.

"Well growing up I have always wished that I had died and at three months old I wished <u>I had died</u> and then I wouldn't have gone through all this crap. 'Cause my adoptive family put me in a children's home and then took me back and then kicked me out and put me into a hostel but then they stuck by my brother and sister, and my sister got pregnant (1) and had an abortion at 16 but my mum stuck by her, my mum gave her support around that, but she didn't give me support by putting me in a children's home or putting me in a hostel (1) and I've always felt like its meant to be the four of them and not me, since I was a little girl I have felt I'm not a part of this family"

<div align="right">[Client 4, Lines 237-244, Week 2]</div>

Within this example, Client 4 speaks about some of the rejection and hurt she has experienced within her life. Also she relays that she wished she had died at the age of three months old so she wouldn't have had to suffer the negative experiences that followed. It appeared that Client 4 may have developed a view of the world and others as unreliable and not permanent; this outlook may make it difficult to attach, settle and adjust to.

"Whereas this might sound really weird but we are not really allowed to discuss each other's shit. Is that the right way to put it? And its (erm) in a way it's a good thing, but in a way it's a bad thing because we could relate to each other if we were allowed to discuss it. Does that make sense? Yeah. Like at the eating disorder units that I've been in, we've sat and had a group and talked about how we are feeling and stuff, and we don't do any of that here "

[Client 2, Lines 420-432, Week 2]

In this example Client 2 was able to give a balanced overview of a forum or group where patients could share feelings and thoughts about their difficulties, and their unique experiences. Client 2 implied that although there are cons about this type of interaction, the ability to relate to someone else through commonalities and lived experience has previously been helpful. Client 2 implies that sharing thoughts and feelings can bring people together and help them to relate and come together cohesively instead of thinking they might be 'weird' for thinking a certain thing, or in a certain way. In contrast Client 5 spoke about not feeling any connection to the other patients on the ward.

5: I don't feel I can connect with any of the patients here. Right. I've never seen patients who behave the way they do and (...)
F: What do you mean?
5: Openly display emotions like they do.

[Client 5, Lines 1159-1161, Week 6]

Client 5 stated that she did not relate to the level of emotions the other patients displayed at times. This appeared to encompass incidents of self harm. In regards to this behaviour specifically, she stated that although she did not judge anyone who she saw engage in this behaviour she just did not want to be around it.

"I watch a lot, I'm quite a quiet person I don't talk and I'm always aware of what's going on around me and like I watch people it's not that I'm judging them I see their behaviour and I just don't want to be around it, it's not the sort of thing that. I find it quite disturbing at times to be around behaviour like that"

[Client 5, Lines 1290-1293, Week 6]

Client 5 then goes on to give some insight as to why she finds it hard.

"*Yeah, it's just I don't belong here at all because I just feel (1) I have nothing in common. I can see me twenty years ago with some of these but (1) it's just (1) what they are going through now I have already done a long time ago"*

[Client 5, Lines 1277-1279, Week 6]

Although in this example Client 5 states that she feels she has nothing in common with the younger patients she then stated that she sees similarities between her younger self and the younger patients on the ward, which would imply there is some common ground however now Client 5 finds this behaviour difficult to observe and be around.

Client 2 vocalised that the patients on the ward were not allowed to share experiences which could in turn allow the patients to relate to each other on a deeper level, and potentially learn from each other.

"whereas this might sound really weird but we are not really allowed to discuss each other's shit. Is that the right way to put it? And its (erm) in a way it's a good thing but in a way it's a bad thing because we could relate to each other if we were allowed to discuss it. Does that make sense?"

[Client 2, Lines 425-428, Week 2]

Previously, Client 2 suggested a forum to discuss each other's difficulties and problems may make connections and commonalities more overt which would in turn allow individuals to understand and related to each other. During the sessions the younger participants appeared to have good quality positive interactions with one another and would continue the discussion without much need for prompts. They discussed similar feelings, thoughts and experiences but also talked about things which evoked different responses and the reasons why.

- **Perceptions of others**

The younger participants discussed their perceptions of staff following various communications.

1: Yeah I hate having a chat with a member of staff and they are like I'm finishing in five minutes. I was just going to say can you not just wait until I've finished telling you how I feel.
2: I don't have one to ones anymore.
F: Is that you're choice Client 2?
2: I just don't trust them I think that at the end of the day they come to work to do their work, no offence

[Client 1 & Client 2, Lines 529-541, Week 2]

Client 1 and Client 2 indicate a lack of support and sensitivity when talking about their thoughts and feelings with staff. Client 2 talks about the concept of trust, because she

doesn't trust the staff, this can then taint her decision when deciding whether to engage in 1:1 sessions. Client 2 then commented that staff, come to work to do their work, but this is not necessarily something which the staff should not be trusted for. It is unclear as to what Client 2 thinks staff should do in order to restore the trust. I feel it important to note at this juncture that Client 2, Client 1 and Client 4 stated that the most important qualities in staff members are honesty, being trustworthy, and neutral in response to the patients especially early in the admission (critical period).

The control that staff members appear to have over the patients was a common topic of discussion within the sessions. In the quote below, Client 2 talked about staff in a previous psychiatric setting. In this setting she was having difficulties with eating and was describing her feelings around being tube fed.

"I felt horrible, degraded with them in control. The voices returned but it felt like they were nice voices and a way of coping"

[Client 2, Flip Chart p. 2, Week 1]

From this quote it appeared that the lack of control felt by Client 2 and the non-collaborative approach contributed to the onset of auditory hallucinations which were, at that point in time, a form of coping with her feelings and situation. The importance of being heard and listened to by staff, is shared by Client 5.

"You are just sat here and nobody bothers with you. I have (XX) as my named nurse and she does, we do lots together as much as she can. She is often put in charge of the ward. But she does sit down with me and have an hourly session with me when she can like. Most of the time once a week. That's what she does but I'm lucky to have her as my named nurse. As far as anything else other than that no staff really bother with you"

[Client 5 Lines 1435-1444, Week 6]

Client 5 shares her feelings about her named nurse and specifically how she feels about the individual time she is allocated to discuss any problems. She then compares this to other staff members who she does not spend as much time with. It would seem that the amount of time given by staff to the patients to discuss their personal thoughts and feelings is important and does influence patients perceptions of different staff members on the ward. Client 5 also shares her thoughts and feelings about other patients. In particular the way in which they do not appear to be bothered with her or take time to interact with her.

5: it's even when I try to engage with them it's like they're there and I'm here it's like they speak to me and (1) say things to me but they don't talk to me I try and come out and try and do, want to do what they're doing
F: hmm hmm
5: you know watch TV or something but they just don't involve me in it. Making me feel really isolated
F: yeah
5: You can feel really isolated and really lonely

[Client 5, Lines 1317-1324, Week 6]

Client 5 also alluded to a factor which may be partly responsible for the lack of connection with other patients on the ward.

5: "yeah, and I've never seen people just walk around (2) just not bothered about their scars being shown, I've never been around people like that (1). How does it make you feel? I don't like it, I don't like having to look at it me personally, this is my personal view, they are entitled to do that but me personally would not leave my room without a jumper on it doesn't matter how hot it is. Yeah. I will always have my arms covered up, I will always make sure everywhere I have self harmed is covered, it doesn't matter what it is, summer or anything, I'm not used to seeing that. I don't like it, it makes me, it makes me not want to be here then"
F: "How do you cope with that Client 5?"
5: "I stay away as much as I can, in my room"

When Client 5 sees other peoples scars and injuries it makes her feel as though she does not want to be around it, and consequently she will take herself off to her room. Client 5 in the previous comment did state that other than the 1:1 time with her named nurse "no staff really bother with you". This appears to be a similar feeling to that of Client 3 who echoed these feelings of isolation and exclusion.

Client 2 then explored thoughts and feelings around how she may feel if patients were able to have contact with individuals who had lived experience or had recovered from their difficulties.

"feels like there is no hope that we will recover from it, it's like give us the chance"

[Client 2, Flip Chart p. 16, Week 3]

Client 2 states that at times it seems that patients perceive staff to have no hope that patients will recover. This then does not offer 'the chance' of recovery and is almost perceived as a barrier. Having individuals who have lived through and 'survived' similar difficulties and overcome them or can teach new ways to cope can offer hope and a sense of not being alone. Client 1 subsequently stated that she did not believe that when you are ill, which is often the initial period of adjustment, you can have goals or hope. This is when it is most important for staff and the MDT to retain the hope, and set goals until there is an improvement in mental state and then the individual can take over this role.

"you can't have goals or hope when your ill, well I don't think so"

[Client 1, Flip Chart p. 21, Week 4]

Perceptions of professional intervention seemed similar across participants and there appeared to be a common theme which indicated that in most of their experiences they had not received the required intervention until they had become extremely unwell, or had behaved in a risky or dangerous way. Intervention did not take place until it had escalated to extreme levels and due to this the participants found themselves in secure settings.

"staff wait until they had to take action"

[Client 2, Flip Chart, p. 2, Week 1]

Client 1 also speaks of previous admissions which had been terminated she thought by premature discharge. Following this treatment was not offered until she became very unwell. It was implied that an earlier intervention may have benefitted her in the long run and may have diverted her out of psychiatric services instead of escalating to a point when she was deemed to require low secure psychiatric care. Furthermore, Client 2 also recalled an incident involving her friend in a previous unit. This friend had entered therapy only when the staff had realised she become drastically underweight and then this began to unearth some of the underlying factors of her eating difficulties.

"but years later she had started making herself sick (1) and it wasn't until she got admitted and went through therapy, when she got underline really underline underweight that they realised that, she realised that all that crap had just caught up with her. Does that make sense? (0.5) Am I making sense?"

[Client 2, Lines 140-143, Week 1]

- ***Perceptions by others & people making judgements and assumptions***

   The younger participants described how they felt they were perceived by staff and it was predominantly negative as shown in the quote below.

2: Judged.

4: Criticised.

1: Patronised. Sometimes when they are positive I think they can be patronising.

F: Can you explain that Client 1?

1: It can be unrealistic.

2: Yeah because like they say you're the one in control and (you) can change it.

1: Urgh I hate it when people say that

<div align="right">[Client 1, Client 2 & Client 4, Lines 368-377, Week 2]</div>

Discussion between the younger participants encompassed the negative light in which they perceived staff comments when they may have been meant in a positive motivational manner; aimed at empowering the women.

"It's like I've been here five or six weeks and they expected me to self harm or something because it's the reason why I came here. They expected me to self ham over Christmas because I wasn't allowed home for Christmas but I didn't because I've got coping strategies, (1) I go through (2) it's like having a list once I get that starting feeling that erm the urge to self harm"

<div align="right">[Client 5, Lines 1181-1186, Week 6]</div>

Expectations said or unsaid by staff and how to cope with these, alongside the adjustment process can be difficult to hear and comprehend, especially when they are dissimilar as Client 1 describes:

1: Like you'll always self harm well actually no I won't I haven't self harmed in six months and I don't think I will go back to it. Then someone (0.5) a member of staff turned round and said to me, I don't know if I told you two but (..). Yeah. Are you going to try and kill yourself over Christmas?

4: Yeah you told me.

1: Because I've had bad Christmases in here. Last year I jumped in front of a car and broke my leg, the year before I ended up in hospital so he just said are you going to try and kill yourself this Christmas? It just really upset me.

F: What upset you the most?

1: Because he had read my notes looked at my past and not asked me the question.

[Client 1 & Client 4, Lines 326- 341, Week 2]

There is an understanding that there are risks, and these are predicted from prior events and behaviours, however instead of people making assumptions Client 1 would rather be involved in the discussion. Client 1 emphasised that she has not self harmed for over six months and feels like she is 'proving herself' which links to another sub-theme which was pertinent for the women in hospital.

3.6.3 *Analysis of quantative results*

3.6.3.1 *Significance calculations*

Significance of results will be calculated in line with the procedure proposed by Jones, Daffern and Shine (2010) and displayed in regards to the different areas of measurement. Reliable change and clinical significance was calculated with the reliable change indicator developed by Evans (1998, and was utilised using a PERL program obtained from http://www. psyctc.org/stats/rcsc.htm. Finally Jones *et al.,* (2010) notes that although it is also important to determine whether the change is relevant using statistical calculations, it is also necessary to establish whether the movement or change is in the 'correct' or desired direction in regards to the therapeutic intervention.

3.5.3.2 CSQ-3 quantative results

TABLE 15.
Quantative Results: CSQ- 3 (Rogers et al., 1993)

Participant	Pre-Intervention Score	Post-Intervention Score	Difference	RCI	Significant treatment effect?
Client 1	12- Detached	21- Detached	Detached- 9	4.29	Yes
	15- Emotional	20- Emotional	Emotional- 5	6.22	No
	11- Rational	17- Rational	Rational- 6	7.15	No
	18- Avoidant	13- Avoidant	Avoidant- 5	6.82	No
Client 2	5- Detached	5- Detached	Detached- 0	4.29	No
	8- Emotional	7- Emotional	Emotional- 1	6.22	No
	9- Rational	10- Rational	Rational- 1	7.15	No
	16- Avoidant	17- Avoidant	Avoidant- 1	6.82	No
Client 3	19- Detached	16- Detached	Detached- 3	4.29	No
	25- Emotional	26- Emotional	Emotional- 1	6.22	No
	25- Rational	27- Rational	Rational- 2	7.15	No
	23- Avoidant	27- Avoidant	Avoidant- 4	6.82	No
Client 4	13- Detached	Declined to complete	-	-	-
	16- Emotional				
	10- Rational				
	17- Avoidant				
Client 5	Did not enter the study at this point.	17- Detached	-	-	-
		19- Emotional			
		20- Rational			
		17- Avoidant			
Client 6	6- Detached	Transferred to MSU	-	-	-
	26- Emotional				
	16- Rational				
	24- Avoidant				

The results shown in Table 15 give an indication of the coping repertoire of each of the participants; where higher scores indicate a greater tendency toward that style of coping. Most of the results show no significant change in the individual coping styles; however there are a number of smaller shifts which indicate that the individual has changed their most dominant type of coping style. For example Client 1 prior to the intervention scored highest on the avoidant coping style and following the intervention scored highest on the detached coping style.

3.6.3.3 BDI-2 quantative results

TABLE 16.
Quantative Results: BDI-2 (Beck, Steer & Brown, 1996)

Participant	Pre-Intervention Score	Post-Intervention Score	Difference	RCI	Significant treatment effect?
Client 1	39	15	24 (-)	7.11	Yes
Client 2	37	44	7 (+)	7.11	No
Client 3	10	10	0	7.11	No
Client 4	29	-	-	-	-
Client 5	-	27	-	-	-
Client 6	33	-	-	-	-

Table 16 shows results of the BDI-2 for each participant. Only Client 1's scores reflected a significant shift in levels of depression; however Client 2's scores are very nearly significant, falling just 0.11 short of significance. Client 3's pre and post scores reflect a low stable level of depressed mood which did not differ at all over the intervention period.

3.5.3.4   CFSEI-2 quantative results

TABLE 17.
Quantative Results: Overall levels of self esteem measured by the CFSEI-2 (Battle, 1981)

Participant	Pre-test	Post-test	Difference	RCI	Significant change
Client 1	10	27	17 (+)	5.01	Yes
Client 2	19	10	9 (-)	5.01	Yes
Client 3	24	26	2 (+)	5.01	No
Client 4	12	-	-	-	-
Client 5	-	15	-	-	-
Client 6	15	-	-	-	-

Table 17 shows the overall score for each participant on the CFSEI-2; where a higher score reflects a greater degree of self esteem in each particular area. As is shown in the table above only Client 1's score showed a significant shift in the desired direction (pre 10- post 27). Although Client 2's scores were also significant, they were not in the desired direction and show overall levels of self esteem to decrease. Whereas Client 3's scores reflect a shift in the desired direction but this shift was not significant.

TABLE 18.

Quantative results: Subscales of the CFSEI-2 for Client 1

CFSEI-2 subscales	Pre-test	Post-test	Difference	RCI	Significant change
Overall Self Esteem	10	27	17 (+)	5.01	Yes
General Self Esteem	2	11	9 (+)	3.94	Yes
Social Self Esteem	1	7	6 (+)	2.43	Yes
Personal Self Esteem	0	2	2 (+)	3.31	No

Table 18 shows the breakdown of scores for the subscales within the CFSEI-2. Three of Client 1's scores reflected a significant shift in the desired direction. The biggest shift observed for Client 1 was on the overall self esteem scale. Although levels of personal self esteem moved in the desired direction the shift was not deemed significant.

TABLE 19.

Quantative results: Subscales of the CFSEI-2 for Client 2

CFSEI-2 subscales	Pre-test	Post-test	Difference	RCI	Significant change
Overall Self Esteem	19	10	9 (-)	5.01	Yes
General Self Esteem	7	1	6 (-)	3.94	Yes
Social Self Esteem	4	0	4 (-)	2.43	Yes
Personal Self Esteem	3	1	2 (-)	3.31	No

Table 19 shows the breakdown of scores for the subscales within the CFSEI-2. All but one of subscales observed a significant shift in scores. Scores on the personal self esteem scale did not observe a significant shift. It is important to note although the shift were mostly all significant, all of the significant shifts were in the undesired direction, indicating significant reductions in levels of general, social, and overall self esteem.

TABLE 20.

Quantative results: Subscales of the CFSEI-2 for Client 3

CFSEI-2	Pre-test	Post-test	Difference	RCI	Significant change
Overall Self Esteem	24	26	2 (+)	5.01	No
General Self Esteem	12	15	3 (+)	3.94	No
Social Self Esteem	8	6	2 (-)	2.43	No
Personal Self Esteem	3	2	1 (-)	3.31	No

Table 20 shows the breakdown in scores on the subscales of the CFSEI-2 for Client 3. Results indicate no significant shifts on any of the subscales. Two of the results were in the desired direction; these were overall levels of self esteem and general self esteem. However social and personal self esteem witnessed a reduction in scores.

3.5.3.5 GHQ-28 quantative results

TABLE 21.
Quantative Results: Overall scale of GHQ-28 (Goldberg & Hillier, 1979)

Participant	Pre-test	Post-test	Difference	RCI	Significant change
Client 1	45	17	28 (-)	8.29	Yes
Client 2	52	45	7 (-)	8.29	No
Client 3	18	19	1 (+)	8.29	No
Client 4	46	-	-	-	-
Client 5	-	44	-	-	-
Client 6	26	-	-	-	-

Table 21 shows the overall score for each participant on the GHQ-28. Higher scores on the GHQ-28 subscales reflect poorer functioning, psychological distress, and psychiatric problems (Sahar, 2012). As is shown in the table above, only Client 1's score showed a significant shift (pre 45- post 17). Client 2's scored nearly reached significance, just requiring 1.29 in order to reach significance. As previously noted, it is also important to consider whether the scores have travelled in the desired direction. On exploration it can be seen that Client 1 and Client 2 scores have indeed travelled in the desired direction which reflects lowering of psychological distress. Whereas Client 3's scores reflect higher levels of psychological distress.

TABLE 22.

Quantative results: Subscales on the GHQ-28 for Client 1

GHQ-28	Pre- test	Post-test	Diff	RCI	Significant change
Somatic Symptomology	10	3	7 (-)	3.15	Yes
Anxiety/ Insomnia	14	8	6 (-)	2.97	Yes
Social Dysfunction	10	5	5 (-)	2.85	Yes
Severe Depression	11	1	10 (-)	2.51	Yes

Table 22 shows the breakdown of scores for the subscales within the GHQ-28. All of Client 1's scores have reflected a significant shift in the desired direction. The biggest shift observed for Client 1 was on the depression subscale. This is also supported by the significant shift in scores on the BDI-2 scale.

TABLE 23.

Quantative results: Subscales on the GHQ-28 for Client 2

GHQ-28	Pre- test	Post- test	Diff	RCI	Significant change
Somatic Symptomology	7	9	2 (+)	3.15	No
Anxiety/ Insomnia	14	11	3 (-)	2.97	Yes
Social Dysfunction	14	11	3 (-)	2.85	Yes
Severe Depression	7	14	7 (+)	2.51	Yes

Table 23 shows the breakdown of scores for the subscales within the GHQ-28. All but one of subscales observed a significant shift in scores. Somatic symptomology was the only subscale which did not observe a significant shift. Interestingly the subscale of depression observed a significant increase and this is supported by results on the BDI-2 indicating increased levels of depressed mood.

TABLE 24.
Quantative results: Subscales on the GHQ-28 for Client 3

GHQ-28	Pre- test	Post- test	Diff	RCI	Significant change
Somatic Symptomology	4	5	1 (+)	3.15	No
Anxiety/ Insomnia	12	8	4 (-)	2.97	Yes
Social Dysfunction	2	5	3 (+)	2.85	Yes
Depression	0	1	1 (-)	2.51	No

Table 24 shows the breakdown in scores on the subscales of the GHQ-28 for Client 3. Results indicate significant shifts on the anxiety/ insomnia subscale and the social dysfunction subscale. Analysis shows that the significant shift on the anxiety/ insomnia subscale is in the desired direction; however the results on the social dysfunction subscale indicate an unfavourable shift, which reflects higher levels of social dysfunction.

3.7   DISCUSSION

3.7.1   Summary of individual findings: Client 1

Client 1 scored highest on the detached coping scale which is deemed to be an adaptive coping style. This particular coping style is characterised by the individual enabling themselves to detach themselves from the problem or the stressful situation. This coping style could be reflective of her current personal situation, which is awaiting transfer to a locked rehab unit. Significant increased scores on the detached, rational, and emotional coping scales were observed. These shifts were in the desirable direction, and allude to Client 1 garnering skills and strategies during the eight week period which appeared to build and develop her repertoire of coping styles. The larger this repertoire, the better equipped an individual is noted to be able to deal with difficulties and stressors in day to day life (MacKenzie, Robinson & Campbell, 1989) and also an increase in emotion focussed coping has been linked to decreased problems in the critical adjustment period (Zamble & Porporino, 1988; Negy, Woods & Carlson, 1997).

Again this pending transfer may have also had an impact on the significant decrease in depression scores on the BDI-2 which were supported by a significant reduction on the depression subscale on the GHQ-28. In terms of the remaining three subscales on the GHQ-28, scores indicate a significant desirable reduction in all areas of measurement including anxiety, insomnia, social dysfunction, and somatic symptomology which are closely linked to psychological distress. Finally, the CFSEI-2 scales showed a significant desirable shift on the overall, general and social self esteem scales, which would indicate a rise in overall self worth and increase in quality of relationships with peers. However personal self esteem was also noted to increase, but not significantly, remaining classified as 'low'. This significant increase in overall self esteem reflecting self worth could possibly reflect the amount of

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progress she felt she was making and how this had allowed the perceptions she had held about herself to positively shift; viewing herself in a more positive light. It is important to note that levels of personal self esteem moved from very low to low; this is a reflection of intimate self worth, so although Client 1 perceives herself to be making good progress and doing things to aid transfer, she may not completely believe this is all down to her own doing, or she may not feel fully able to sustain this progress. The low levels of personal self esteem may become an obstacle when attempting to cope with the new environment.

3.7.2   Summary of individual findings: Client 2

No significant shifts were observed on coping style scales for Client 2. Client 2 scored highest on the avoidant coping style, which is characterized by efforts to avoid dealing with a stressor, and fearing commitment due to a fear of rejection Such withdrawal behaviours manifest themselves in the personality as indecision and lack of confidence. At times individuals who are presenting with PTSD symptomology can withdraw into themselves, allowing them to avoid the trauma. This lack of confidence could also be linked to the significant decrease in scores on the overall, general and social self esteem scales of the CFSEI-2. These areas reflect overall perceptions of self worth and also quality of relationships with others. It must be noted that Client 2 was diagnosed with Aspergers and this may contribute to the low levels of social self esteem. She did state she found it difficult at times to connect with others.

Towards the end of the eight week period Client 2 appeared at times to be struggling with her mental state, even though she stated she wanted to continue to be involved in the group sessions. This deterioration may have occurred due to stressors in the environment coupled with only a small repertoire of coping strategies in order to deal with them. Scores

for Client 2 on the three remaining coping scales, DET, EMO and RAT are relatively low in relation to normative data for psychiatric inpatients. In terms of depression scores on the BDI-2, scores came close to significance however they didn't quite reach significant levels, requiring a shift of another 0.11. It must be noted that this shift was in the undesirable direction and was supported by an increased scored on the depression subscale on the GHQ-28. Finally, a desirable shift in social dysfunction and anxiety/insomnia was observed indicating less psychological distress associated with anxiety/ insomnia or ability to complete day to day tasks.

3.7.3   Summary of individual findings: Client 3

Highest scores on each of the coping styles reflects Client 3's large repertoire of coping styles which should help to buffer against the day to day stressors of institutional life. No significant shifts to report on the CSQ-3 subscales. Additionally, no significant change was observed on the BDI-2 with lower than average scores of depressive mood than the normative psychiatric inpatient population. This is supported by a 1 point shift on the depression subscale of the GHQ-28.

No significant shift on the somatic symptomology subscale of the GHQ-28 was observed. Overall these results would indicate a low level of overall depressed mood throughout the eight week period and no worsening of symptomology in terms of psychological distress. A desirable significant shift was observed on the anxiety and insomnia subscale indicating that Client 3 had improved on these particular items. Whereas a significant undesirable shift on the social dysfunction subscale was observed, this would indicate a decreased level of satisfaction in perceived ability to carry out day to day tasks.

Finally, in terms of self esteem Client 3's scores showed no significant shifts, however social and personal self esteem witnessed a reduction in scores by two and three points respectively. So although Client 3 portrayed a heightened general and overall level of self esteem; her social and personal self esteem were reduced and this may have been linked to an assault during the eight week period whereby Client 3 was the victim and a peer was the aggressor.

3.7.4 Main findings from qualitative data

A framework incorporating five main themes was constructed. These five main super-ordinate themes, under which the initial fifty codes appeared to fit are listed below:

- Importation Factors

- Deprivation Factors

- Communication Factors

- Internal Adjustment

- External Adjustment

The five themes under which the fifty initial codes are charted are heavily linked to the literature. Briefly the five themes included importation factors which are defined as the features which an individual would bring with them to any given situation, for example this could include beliefs, early childhood experiences, learnt behaviours, or ways of coping and communicating. Deprivation factors which were defined by the literature as features which the environment imposes on the individual. For instance, the level of physical or relational

security which is maintained in each environment or the distance the environment is from the individual's home area. The literature highlighted that the interactions between the importation and deprivation factors can present in a various number of ways which can then consequently impact on internal and external adjustments. Internal adjustments are defined throughout the literature as primarily distress caused by poor sleep, hyper vigilance which can subsequently affect emotion management and feelings around others. These factors can also affect an individual's external adjustment which can present itself as fights, arguments, and general conflict with others. Negative adjustment also encompasses communications between self and others, beliefs about self, others and the environment.

It is further noted that there is a wealth of knowledge around the importance of interpersonal and communication factors for women, however, these have not been as widely reported in terms of adjustment to forensic secure environments. There was a steady process of development which led to the decision to magnify and explore the communication umbrella, and subsequently expanding this to encompass three distinct themes which emerged from the data, as listed below:

- Individual communication
- Communications with others
- Communication and the environment

See Appendix V for a more thorough overview of the three distinct themes with encompassed under the umbrella of communication.

3.7.4.1.1 Individual communications

- Thoughts and beliefs surrounding what it is to be well

- Negative associations about themselves and their diagnosis.

- Feelings and thoughts about having to prove themselves.

- ***Thoughts and beliefs surrounding what it is to be well***

In order to buffer against the changes and adaptations required, and to adjust to the new environment, contact with external support networks and meaningful activities were found to be important and to aid the adjustment process. Participants reported that it was important for them to feel as though their time in hospital wouldn't be a waste. For example it was suggested that in the future they wanted to help others with similar diagnoses or with similar difficulties and this would make their situation easier to cope with as they would feel like "it isn't all for nothing". This supports previous research which noted that the need to contribute to something worthwhile was important in terms of recovery. Similar findings have been noted in previous qualitative research with both men and women (Halsall, 2006; MacInnes, 2005).

In order to be classed as a 'worthwhile activity' it appeared that the participants meant that they wanted to engage in activities which related to developing their skills to aid their transfer back to the community. There were a range of views as to what was considered helpful, such as discussion groups or skills based activities. This is supported by the good lives model which suggests that incorporating treatment programme factors that build skills to assist patients in achieving their goals (e.g. community reintegration) rather than an exclusive focus on dynamic risk 'factors' will maximise motivation to change, and general satisfaction within the unit (McMurran & Ward, 2004).

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All the patients who discussed boredom described its negative effects on them. Some spoke of previous hospitalizations, or other placements in which they were able to engage in activities like talking groups on the ward, or learning how to work the internet to occupy their time and also allow them to develop their skills. Additionally, when discussing the negative impact of boredom or free time it appeared that patients, more often than not, thought about the time they were missing with close others, such as family and friends. This is supported by previous research in which time between therapy sessions was deemed 'detrimental' to well-being, this was on account of having too much time to think about what you could or should be doing. Also previous research has established that family ties and links to external support networks are significant, not only to buffer against the deprivation factors but also to achieve social goals (Fishman, 1990). What's more, Dowden and Andrews' (1999) conducted an analysis on female offenders and identified familial variables as the strongest predictors of female offenders' success. Whilst Slaght (1999) found family relationships to have a significant influence on relapse prevention and reoffending rates.

The statement below highlights the importance of success and change when working with forensic clientele, for both the individual and future generations.

"Children and families can play a significant role in supporting an offender to make and sustain changes which reduce re-offending. Many offenders' relationships are broken or fragmented as a result of their offending and their families are left bewildered and unsupported, increasing the likelihood of intergenerational offending, mental health and financial problems".

[Social Care Institute of Excellence, 2008]

This quote also highlights the negative effect separation can have on family members who remain in the community, and especially on child development and prevention of offending in future generations (Tolan, Guerra & Kendall, 1995). The more nurturing aspects of parenting or absence of parental involvement, attachment and feelings of rejection have also consistently shown a strong association with delinquency (Larzelere & Patterson, 1990).

Attachment theory (Bowlby, 1973) captures and explains the possible realities of incarceration and detention on dependents. Also it proves to be a useful framework for applying to emotion regulation and mental health. In particular, research on adult attachment processes and individual differences which affect coping with stress, managing distress and remaining psychologically resilient in difficult environments (Mikulincer & Shaver, 2007). Bowlby (1973) postulate that each individual has an innate psychobiological system called the attachment behavioural system that motivates individuals to seek support from significant others (attachment figures) in times of need. Incarceration to prison or admission to a forensic psychiatric secure hospital can decrease the availability of these trusted supportive individuals and this in turn can activate negative models of self and others, which has been found to increase the likelihood of emotional problems. This could be associated with an increase of infractions and self injurious behaviour observed in women in the initial critical period.

Negative associations about the self and their diagnosis

Just like many other women in the CJS, the women in this study had previous experiences characterized by negative life experiences including rejection, abandonment, abuse and trauma. The women in this study recalled various negative experiences which they had survived prior to their current admission. Some encompassed the way in which they were

treated by others and some experiences were in regards to their residential surroundings and the conditions under which transfer, relocation or discharge occurred. Gilligan, Lyons and Hammer (1990) reported that women who have experienced a lack of positive mutual and empathic relationships can appear to lack empathy for self and others, or are highly empathic towards others but lack empathy for self. The participants in this study appeared to assimilate the latter depiction, and the need to change these patterns of behaving experience of relationships that do not re-enact their histories of loss, neglect and abuse are vital. Unfortunately, throughout their developmental pathway similar negative experiences had been repeated and due to this the women appeared sceptical about how much they could be helped by the treatment at this hospital. The women in this study stated their negative beliefs which included being inherently flawed in some way, either by their own actions or behaviours, or by the way they had been treated by others. These types of beliefs during the adjustment period can seriously affect engagement in the ward routine and the therapeutic activities on offer.

Additionally retraumatisation can occur if the admission and/ or adjustment period to hospital is perceived as negative or evokes negative emotions in the individual. This can also increase the risk in the initial critical period. Jewkes (2006) notes that if the life course is interrupted by a period of incarceration or admission to a psychiatric hospital can negatively affect identity. This can stem from cultural and societal beliefs about what it is to lead a healthy and happy life. For example, depending on the cultural and societal beliefs, the individual may feel a failure as they may feel they have missed out on certain aspects of life, such as romantic relationships or children if they had experienced an admission or period of incarceration from early in their lives, and lasting for a long period of time. Research has found that negative self judgements are strongly implicated in the high rates of anxiety, depression and attempted suicide. All of which have been found to increase during the

adjustment period (Harter & Marold, 1994; Laufer, 1995). These findings were echoed by the women in this particular study. Often the negative social stigma or taboo was discussed as well as the impact their diagnoses may have on future prospects or job opportunities. The potential for the future to be able to offer worthwhile goals and pathways also seems vital to women. Therefore the importance of how their diagnoses and treatment is conveyed is vital in maintaining future goals and levels of self worth. If an individual is given a diagnosis which is not explained or has negative associations this can also serve to heighten maladaptive emotions during the adjustment phase.

In order to negate such high feelings of anxiety, depression, and suicidal ideation research suggests that self-compassion could be helpful as it is strongly related to psychological well-being, including increased happiness, optimism, as well as decreased anxiety, depression and rumination (Neff, 2009). Neff and Vonk (2009) found that when trait levels of self esteem and self compassion were compared, self compassion was associated with more stable feelings of self worth over time, and offered stronger protection against social comparison, public self consciousness and anger, which can all be products of stigma of mental ill health.

Having to prove something

There can also be a stigma surrounding self harm and the rationale for engagement in this type of coping behaviour. Some of the various rationales have been documented earlier in this report. For the participants of this study, self harm played an integral part in their intimate perception of progress and as a form of communication. For them non-engagement in self harming behaviour was thought to be a way of 'proving something' to themselves and/ or to their care team. More often than not it appeared to be a conceptual gauge of progress and mental stability, being on the road to recovery and being well. Whereas engagement in

self harm, was perceived as being 'unwell' and had an associated negative social stigma and various connotations attached.

Self injurious behaviour was also viewed, at times, as a revenge tactic against perceived wrong doing by staff. It is noted by Motz (2009) that fantasies of self-harm, whether acted on or not, also play a significant role and can offer solace, imagined revenge, and a release. It was felt that by engaging in some form of self harm (anorexia nervosa in particular) that this would "show them". This view suggests that the participant has some knowledge about the negative effects self harm can have on people who witness self harm or suicidal acts or support people who engage in self injury or suicidal behaviour.

The women in this study noted that it was a way of coping in such a restrictive highly controlled environment. This is supported by previous studies which have also reported consistent results regarding repetitive self harming behaviours as a way of managing with unbearable situations including the wish to die (Mental Health Foundation, 2006; O'Connor, Rasmussen & Hawton, 2009). If the wish to die is coupled with having to adjust or cope with an unfamiliar, at times, an unbearable situation, the risk of self injury or suicide is increased.

The women highlighted the need for self harm to be viewed differently for example, there to be less severe consequences of self injurious behaviour, as they described it as a form of coping and due to the rationale of the behaviour this then should not be reprimanded. Some of the women highlighted the need for the use of more verbal communication following an act of self injury. This was borne from the suggestion to move away from disengagement and stripping of the bedroom area, to the idea of having a 1:1 with trusted staff member. It was acknowledged that a collaborative and candid approach is not always possible but an increase in this management style would be appreciated.

The women in this study support the findings of Craigen and Foster (2005) whose findings also discouraged against the forceful management of self harm. It was further noted

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by the women in this study that a "heavy handed" response may lead to individuals becoming more secretive about self injury and less inclined to talk to staff about their emotions and thoughts of self harm.

3.7.4.2 Communications with others

- Care and protection of others.

- Interactions and relations with others

- Perceptions of others and perceptions by other people.

Care and protection of others

In terms of the fundamental roles women play throughout their lifespan, the most likely is the role of caregiver. It is also a role which many of the women in the CJS are familiar with as previous research confirms (Thematic Review, 2010; WISH, 1999).

It is therefore not surprising that one of the themes which emerged from the data was that of caring for others. In terms of protecting others, the participants shared experiences prior to admission in which they had used self harm in order to protect others. Further stating that self harm was used as a way of channelling their anger. Two of the participants spoke of "lashing out" at close family members when angry. Thus, in order to protect others close to them, they began to harm themselves instead. This finding supports previous research which suggests that although men and women do not experience different levels of anger and aggression, they do react to these emotions in different ways (Kopper, 1993; Kopper & Epperson, 1991). It is recognised that contextual and social factors will play a part in an individual's reaction to anger. Research has also explored the extent to which an individual identifies, with various characteristics of each gender role and their individual reaction to

anger, Milovchevich, Howells, Drew and Day (2001) found that participants classified as adopting a feminine gender role reported higher levels of inward anger expression. This finding can be explained by gender schemas which process information in line with gender role categories (Bem, 1984). In this context, gender roles are taught and validated as relational schemas which help to mediate an individual's relationships with the world and other people. Therefore, masculine individuals are given examples and are validated when expressing greater intensity of anger and outward behavioural responses whilst feminine individuals learn to control anger experience and expression. In order to buffer from the likelihood of women expressing anger inwardly, it has been suggested that women be encouraged to explore effective ways of expressing anger including increased outward expression of anger (Kemp & Strongman, 1995). Such skills may be helpful and useful, if the process of adjustment appears to have heightened levels of anger or aggression against the self. Another significant finding concerning anger as an emotion is that it is primarily interpersonal (Deffenbacher *et al.,* 1996; Denham & Bultemier, 1993). This is coupled with the vast number of findings which suggest that the interpersonal aspect of life is especially pertinent for women. This would suggest that an enhanced awareness of interpersonal factors during the adjustment period would also be useful for women.

The majority of the participants also reported wanting to protect or care for their fellow group member, and there appeared to be a clear affection towards other members of the focus group. Numerous times consolation was offered when a member reported previous abuse or a difficult experience, as well as words of support, and suggestions in order to solve a problem or difficulty. It must be noted that the group members who were observed engaging in this protective behaviour were younger participants who had been in psychiatric hospital settings three years or less. In previous research newly incarcerated women prisoners

admitted to being involved in 'play families' which are defined as affectionate relationships which are established by mutual agreement between inmates (Giallombardo, 1966), this appeared to decrease as time served increased. It is further noted by Bowker that these 'pseudofamilies' provide a meaningful social life and interpersonal support for the prisoners' (1981). Interestingly, similar research and/ or findings have not been replicated in psychiatric settings.

Interactions and relations with others

Connections with others are basic human needs and this is especially true for women (Jordan, Kaplan & Miller, 1991). Findings from this study support this statement and also highlight the importance of interactions and connections during the adjustment period.

It is noted by Covington (2007) that the ways in which women attempt to communicate and relate to each other differs. In order to understand and respect each style, it is important to consider how women's life experiences may affect this function. Furthermore, the diverse life and interpersonal experiences found in the patients of forensic psychiatric environments require more emphasis to be placed on relational security (Department of Health, 2002).

Relational security has two elements; the quantative element encompassing the staff to patient ratio. The ratio of patients to staff has been found to be closely linked to the perceived quality of care patients receive. The qualitative element is the shifting continuum of interaction between staff and patients. For example, high levels of relational security require striking a balance between intrusiveness and openness between patients and professionals (Kennedy, 2002). Therefore it could be defined as the quality of care the patients receive and the quality of these interactions during the caring process. However, research has suggested that, relational security may not be as closely linked to staffing levels

and staff to patient rations as first thought. A study by James *et al.,* (1990) found more violent incidents on a locked psychiatric intensive-care ward when nursing shifts included higher proportions of staff. Within this study the high numbers of staff were made up of bank and agency staff which suggests that therapeutic rapport and the therapeutic alliance is extremely important for the management and care of individuals in psychiatric settings.

Therapeutic alliance is a multidimensional concept in the therapeutic relationship, encompassing communication, integration, collaboration and patient empowerment (Kim, Boren & Solem, 2001). If one of these aspects is not maintained and nurtured, the relationship can deteriorate with dire consequences for all individuals involved. Findings from this study reported on the communication aspect; in that negative interactions with staff members tarnished future interactions and the desire to engage at all. Additionally, lack of empathy, trust and honesty was associated with negative feelings towards staff members. This finding was similar to that of MacInnes (2005) who conducted a qualitative piece of research and noted that the most important perceived characteristics of staff were how caring and interested the staff appeared; whether they could be trusted and whether they were helpful. Overall it was deemed that the interpersonal skills of staff were judged as being more important than clinical skills in developing a trusting and positive relationship. Godin and Davies (2005) also found that negative experiences were related to thoughts regarding staff being dishonest which led to patients lacking trust and also negative thoughts were linked to staff not acting with compassion and respect. Hamrin, Iennaco & Olsen (2009) assert that the therapeutic alliance is both a key moderator of the likelihood of inpatient violence and disturbed behaviour in psychiatric settings.

Relational-cultural theory allows us to consider the implications of unhelpful interactions as this may unknowingly recreate maladaptive relationships or interactions which

the woman may have been subject to prior to admission. Additionally, the way in which a woman will choose to interact will be informed by individual differences, including her class, race, ethnicity and cultural aetiology. This can lead staff members to be drawn into the trap of "cultural encapsulation" (Wrenn, 1962). This can emerge when an individual is unable to perceive others through a "different cultural lens" which may then lead us to pathologise instead of realise what is normal for that minority (Falicov, 1998). Individual differences can also account for why some individuals are influenced more so by deprivation factors than others. In the following statement Covington highlights the importance of understanding and incorporating individual differences in the care and treatment of women

"All women exist in the same circumstance as women; no two women exist in exactly the same circumstance"

[2007: p. 7]

The influence of other patients during the adjustment period can impact on the ability to adjust to the environment. The participants in this study report unpredictable patients as a source of stress during the adjustment period. This runs concurrently with an already unpredictable, unfamiliar environment serving only to heighten anxieties. Specific admission wards may be helpful in providing higher staff to patients ratio; smaller numbers of patients in order to increase the likelihood of interactions and then the ability to move the individual to a more settled rehabilitation ward once they show they are more psychologically equipped to deal with a busier environment with shorter term treatment goals.

Furthermore attachment theory allows conceptualisation of attachment and connection to others. Most of the women in forensic secure settings have been found to have insecure attachments which have been linked to early childhood trauma (Bifulco *et al.,* 1998). This

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early insecure attachment style can precipitate attachment anxiety which can contribute to more interpersonal problems in general. During the lifespan, certain adult attachment styles have been linked to an individual's ability to seek appropriate help from support networks (Florian, Mikulincer & Bucholtz, 1995; Hazen & Shaver, 1987). Also in a previous study Bartholomew and Horrowitz (1991) found that individuals characterized with an avoidant style generally had problems with nurturance (being cold, introverted, or competitive), and individuals characterised with an anxious style had problems with emotionality (e.g., being overly expressive) coupled with relatively low relationship satisfaction, more frequent relationship breakups, and more frequent interpersonal acts of aggression (Mikulincer & Shaver, 2007). Covington emphasises that such interpersonal connections are so crucial for women, that women's psychological problems can be traced to disconnections or violations within relationships. These can occur in families, with personal acquaintances, or in society at large (2007). Miller (1976) notes that true connections are mutual, empathic, creative, energy-releasing, and empowering for all. Whilst Bylington notes that the relational model defines a connection as

"an interaction that engenders a sense of being in tune with self and others, of being understood and valued"

[1997; cited in Zaplin, 2007: p. 35]

Even though people can develop an ever expanding repertoire of coping responses as they mature, they are still found to intensely depend on social support to prevent and overcome traumatisation (Field, 1987). Traumatisation and onset of post traumatic stress symptomology has been linked to involuntary admission to forensic psychiatric services,

(Krystal, 1978; van der Kolk, 1985), and appears to be closely linked to the sudden, uncontrollable loss of attachment bonds (Department of Health, 2002).

Additionally, some of the participants in the research spoke about the abuse they experienced in their childhood, this abuse and/or neglect can cause long-term vulnerability. These vulnerabilities at times are expressed by a decreased ability to modulate strong affective states. At these times the individual may be observed to resort to self injurious behaviours in order to cope with heightened emotional states and especially negative emotions which can be associated with the severance of social support structures imposed by restrictive forensic environments.

Perceptions of others and perceptions by other people.

The severance of external social support structures can drive an individual towards attempting to connect with others in the environment in order to buffer themselves against the adverse effects of adjustment. However, this can also work in the opposite way in that due to the severance of trusted, safe people, the individual retreats and withdraws, building defences in order to shut out the unfamiliar people and ward environment. It is suggested by Fischer and Phillips (1982) that individuals who lack sociable and intimate relations are disadvantaged in other ways that may lead to both a lack of support and distress. Additionally, research conducted with women prisoners found that individuals who had engaged in near-leathal self harm scored significantly lower on a social support scale (Meltzer, Jenkins, Singleton, Charlton & Yar, 1999).

It was noted by two of the participants that because they were quieter than other patients on the ward, they thought they were ignored by staff. Additionally, Client 5 noted that she did not feel she "belonged" or had anything in common with her fellow patients,

however she did compare the behaviour of younger patients to her own twenty years before. As she found this behaviour distressing to see, she would often retreat into her bedroom. Yet this appeared to feed into the cycle of isolation in which she felt trapped. This participant noted that one staff member had been persistent in trying to find out what was wrong on a particular day, and her efforts were viewed favourably by Client 5. All participants commented that they felt being listened to by the staff as being beneficial, however, similarly to previous research the patients in this study thought that staff could be judgemental, critical and patronising. These perceptions can then have a detrimental impact on the therapeutic alliance and patients' individual journey to recovery (Forchuk & Reynolds 2001). Patients' perceptions of staff and how much effort is spent attempting to interact in the initial adjustment period appear to be an important feature in the perceptions of the adjustment period as a whole.

Another aspect of the patient, staff relationship which has the potential to have detrimental effects on the adjustment process is the power imbalance. The participants stated that they perceived staff to wait until an aspect of the patients behaviour had become extreme or "out of control" and only then would staff take action. This can be viewed in terms of 'Betrayal Trauma', a term coined by Freyd (2012) in which trauma occurs when the people or institutions on which a person depends for survival significantly violate the individuals trust or well-being.

Patients trust staff to put their best interests first and behaviour which contradicts this belief could be misconceived as a betrayal of trust. For example, a discussion involving setting goals with the patient could be perceived in a negative light and quite unhelpful instead of empowering and collaborative. These perceptions can be tarnished or altered according to their stage of treatment. This was highlighted by Client 1; she noted that during the adjustment period "it is not possible to have goals or hope" because at the time of

admission to a psychiatric hospital you are usually "out of control" which precipitated the need for the admission. Therefore to tell someone that they have control is unrealistic and sometimes unhelpful.

Additionally, the betrayal of trust can also occur if the patient is communicating psychological distress with her body either through an eating disorder or self harm and the persons trusted with duty of care do not appear to respond until it is too late. Client 2 stated that she knew of a woman who had been engaging with more and more extreme levels of self harm. The escalations in this behaviour appear to have been dismissed until the staff could no longer manage the behaviour. She further went on to describe her quick transfer to a more secure environment which she thought to be a reactive decision made on the pretence of managing the risk she posed to herself. The act of transfer and escalating levels of self harm can be doubly unsettling for the individual involved and supporting staff or carers. It can also lead to higher levels of psychological distress and more extreme attempts at communicating internal negative emotions. It appears a shared dialogue of understanding encompassing the individuals unique function of self harm and the tailored response to self injury are vital at the earliest stage of the adjustment period. These understandings can help to build trust and honesty and can allow for collaboration and integration of shared goals and definitions of "being well".

In addition, another factor which appears to be extremely helpful during the admission period is staff having an understanding of various diagnoses pertinent to women in forensic secure psychiatric environments such as personality disorder and PTSD. Social representation theory can be helpful when thinking about staffs perceptions of diagnosis and the subsequent effect of this. This theory allows us to explore how social and cultural knowledge about a certain topic i.e. diagnosis then shapes an individual's perceptions, experiences and responses (Howarth, Foster & Dorrer, 2004). By encompassing this element

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into training it may allow for a reduction in unhelpful misconceptions surrounding particular diagnoses within a safe training environment which can then be addressed prior to working with service users and their families.

3.7.4.3 Communication within the environment

- Teaching and learning
- Feeling safe

Teaching and learning

As previously noted, social support and communication is important for women (Surrey, 1991; Covington, 2007; Motz, 2010). In terms of adjustment to hospital this remains a vital mediating factor. Participants in this study spoke of their own friends and family members experiences of psychiatric hospital settings, and how this influenced their opinions and beliefs about whether hospitalisation can help. For example Client 2 spoke of a friend in a previous hospital who had engaged with psychological therapies. Her childhood had been explored and it emerged that she thought she had found the root cause of her eating disorder. Subsequently she worked through this and was reported to be living in the community. This example highlights the feature of 'hope' which arose a number of times within the manuscripts, this crucial element has been justified and acknowledged in a number of different documents, policies and approaches in mental health. It is noted in a policy by the Sainsbury Centre for Mental Health in its opening principles of recovery that:

"Hope is central to recovery and can be enhanced by each person seeing how they can have more active control over their lives ('agency') and by seeing how others have found a way forward"

[Shepherd, Boardman & Slade, 2008: p. 2]

Gaining information from others and perceiving themselves to be in the same boat as other people was a comforting aspect of adjustment. Previous research found that when patients were allowed to describe their experiences, coping styles were shared and comfort was offered on the basis of shared experience (Bowers, Brennan, Winship & Theodoridou, 2009). The participants in this study also spoke about wanting to help other women who may experience psychiatric inpatient stays. This want to support others developed in to volunteering with charities in the future, further stating that if it "helps someone it hasn't all been for nothing". Although future goals and hope are central to recovery, Client 1 notes that she did not think an individual is able to have these in the acutely unwell stage. At the earliest point in the initial adjustment period the most helpful qualities are for staff to be neutral and supportive. This finding is also echoed by Bowers, Brennan, Winship and Theodoridou (2009) who found this to also be true when working with acutely mentally unwell patients in psychiatric inpatient settings.

In terms of accepting the environmental rules and policies, all participants understood that each patient was bound by the same rules. However this understanding did not make dealing with the procedures i.e. pat down or room search any less upsetting or intrusive. In order to make this element of adjusting to new rules and guidelines a little easier, the participants noted that a rationale or purpose is helpful. This is also helpful when coming to terms with diagnosis and hospitalisation.

Another important factor was the response of staff, this was especially apparent when looking towards the future and coming to terms with living with a mental health diagnosis. It was explicitly noted that if staff have unrealistic goals or respond to incidents of self harm with statements such as "you're the one in control" and "you can change it" when instead, the precipitating factors for admission would suggest otherwise this can be extremely unhelpful and at times damaging.

It is noted by a joint position paper that central to recovery are goals. However, these are to be self defined, tailored to the individual, and culturally informed. Guidance is for them not to be prescriptive or subjective and defined in collaboration with the individual and not imposed so much so that the conclusion of the paper notes that:

"central to recovery, services to be respectful of self-defined goals in

recovery and to fully support self-care, self-management and self-directed care

although as yet there is little experience or guidance on good practice"

[Social Care Institute of Excellence, 2007: p. 22]

This tenet allows retention of empowerment and control which was also found to be an important factor for women in psychiatric secure settings.

Feeling safe in the environment

It has been found that humans are strongly dependent on social support for a sense of safety, meaning, power, and control (MacLean, 1985; van der Kolk, 1989). These four aspects have been highlighted throughout the data collected in this study and previous research, whilst Karlin and Zeiss (2006) have noted the importance of the hospital

environment within the initial critical period. Reviews of the literature have highlighted that over the past fifty years patient centred design can improve functioning.

The most common emotions attributed to the environment were feeling "safe" and also "trapped" with "no escape". It is a commonly held notion that the secure environment should not allow for escape of absconsion, however there has to be a balance in terms of containment and comfort. Guidelines set out by NICE emphasised the need for patients, and women especially, to live in the least restrictive environment necessary to manage their levels of risk (2009). In terms of safety Client 3 raised the issue of feeling safe around others in the environment. This was in terms of placing "more risky people with less risky people"; therefore it is important that individuals are able to control their level of social contact. This is further supported by Harris, McBride, Ross and Curtis (2002) who accentuate the need for spaces where patients can retreat. Further noting that privacy may increase environmental satisfaction and "place attachment".

'Place attachment' described by Harris, McBride, Ross and Curtis (2002) is defined as one's emotional or affective ties to a place, and is generally thought to be the result of a long-term connection with a certain environment (Baird & Bell, 1995). This can then increase the likelihood of an attachment forming; only once the attachment is formed and the individual does not question the "security and availability of her home base" only then can an individual attempt to manage negative feelings activated by separation (Bying-Hall, 1995).

Ainsworth's (1976 cited in van der Kolk, 1989) definition of a 'safe base' is an attachment figure who appears more able to deal with a difficult situation. More recently a safe base has been found to encompass environments as well as particular figures or people. Furthermore a 'safe base' is imperative for development in a particular environment, as feelings of safety can increase the capacity to mentally process experiences which have the potential to retraumatize (Krammerer & Mazelis, 2006). An example of a potentially

retraumatizing experience was given by Client 3 whereby she perceived that individuals with differing levels of risk were placed within an environment in which there was no escape, and this for her made her feel vulnerable and unsafe.

Also most of the participants in this study noted the feeling of being trapped in their environment. In order to relieve this temporarily, the bedroom was often attributed with the characteristic of "escape". The importance of having somewhere to go to, or a sense of "escape" has been highlighted in previous research. (Gilburt, Slade, Rose, Lloyd-Evans, Johnson & Osborn, 2010) found that the sense of being able to escape or temporarily leaving the environment was noted to be stronger when it was perceived as unpredictable and risky. This is important in terms of adjustment, as a new environment is unpredictable in the sense that it is unfamiliar and new.

Harris *et al.,* (2002) discusses interior design features and one aspect of this is noted to be 'familiarity'. Within this aspect the notion of patient bedrooms has been roused within the literature, and common themes reveal that patients prefer familiar rooms, with soothing artwork and carpets wherever possible. This ties into one of the most consistently reported recommendations for psychiatric environments, which is to reduce the institutional look of the whole environment by incorporating a home-like feel whenever possible. This type of atmosphere has been associated with enhanced emotional and intellectual well-being, and improved patient behaviour. Medical staff have also been noted to prefer non-institutional environments.

Another important element explicitly highlighted by Harris *et al.,* (2002) encompasses social features of the environment and communal areas in which patients and staff can come together to interact (Bowers, Brennan, Winship, & Theodoridou, 1995).

The need for homely furnishings and a homely atmosphere was also highlighted in the study by Client 5. These material aspects were thought to aid feelings of safety and comfort which can in turn, allow for a smoother adjustment with lower risks of retraumatisation. Another aspect which appeared to evoke similar positive emotions and feelings was the proximity to personal belongings, most of which are kept in their bedroom or "safe space". Personal belongings which had previously been allowed to aid adaptation to the environment were then removed following incidents of self harm. In the literature this response has been alluded to as a punitive response to self harm (NICE, 2004; Craigen & Foster, 2009). The clients who recalled this response described the urge to self harm being satisfied and the function of the self injurious behaviour being fulfilled. So, when their bedroom is searched and stripped the risk of continuing to self harm and the need to remove risk items from the bedroom is low. This response only appeared to increase negative feelings at a time when the aim was to communicate their low feelings. The majority of clients reported just wanting someone to know how they felt, and wanted to talk to someone. These findings again highlight the importance of communication with women and the need to assess all responses to self harm on their own merits. As at the point of someone feeling low and helpless and out of control, taking familiar items from their place of safety may only serve to heighten unsettling feelings and prolong the adjustment period.

3.7.5   Final reflections incorporating theoretical links

The rationale behind the interpersonal focus of this study arose, because of the distinct lack of research in this area as a whole, especially for women and their adjustment to forensic psychiatric secure environments. This type of study has allowed in depth analysis and the ability to link very real experiences back to theory and current literature, which gives a solid

foundation on which to draw conclusions and develop new more effective, science practitioner approaches when working with women in the CJS.

Socialization theory and cognitive relational theory highlight the need to remain wholly aware of the emotions attached to incarceration and adjustment to a restrictive setting. The emotions felt and subsequently portrayed will be related to .situations and experiences which typify the individual's life prior to admission. Additionally it is also vital to be aware of the social and cultural restraints in which they grew up and developed as women. This will give a more thorough understanding of the context in which the woman entered the CJS and will also widen perception regarding an individual's presentation. The entry to a forensic secure environment, and the initial adjustment phase will hopefully guide professionals away from pathologising and diagnosing certain behaviours and characteristics, which are sometimes observed in marginalised populations such as women in the CJS. According to Kaplan (1984), three major concepts which need to be acknowledged are a woman's cultural context- as this allows others to recognise the powerful impact of the cultural context on women's lives. Secondly, the importances of relationships as a central organizing feature in women's development. Finally, gender sensitive pathways and developmental models to describe and explain the growth of women. This can be further elaborated with the understanding of role constraint theory in which gender differences are accepted as part of an individual occupying certain social roles. For example, women may express emotion more frequently and with more intensity. An understanding based on this could encourage acknowledgment of behaviours instead of pathologising behaviours.

In order to address these three concepts within the adjustment period, it may be necessary for staff and carers to be trained in the social and cultural context of the women with whom they work. As this can differ dramatically, depending on parentage and country of origin. Furthermore, women should be encouraged to maintain external supportive

relationships and familial ties; this could potentially be aided by more localised services so women would be held closer to their home areas, allowing for more frequent visits, especially if children are involved. Furthermore, gender sensitive services and responses are required in front line services as there remains widespread misunderstanding in regards to behaviours and characteristics often typifying women entering the CJS. For example, in an unannounced inspection on a number of custody suites in the UK, results showed interaction to be professional, however too little attention was paid to specific needs of different group (i.e. women). In addition, poor provision for mental health was identified including no specialist mental health service offered to individuals being held in custody suites, and also individuals being held in custody suites as a place of safety rather than being taken to somewhere more appropriate e.g. Section 136 suites. Finally, police custody officers confirmed they received training in mental health awareness as part of their development; however this was limited to two hours per annum (HM Inspectorate of Prisons and HM Inspectorate of Constabulary, 2011). Following these results, front line diversion and liaison teams specialising in mental health difficulties were recommended for every primary care trust service within England and Wales. What's more, a report by the Sainsbury Centre for Mental Health noted that the Government should consider the scope for improving the identification of mental illness by police officers, court officials and other criminal justice staff (2009). Social representation theory captures the importance of providing training to staff around communication, multiple diagnoses, complex presentations, vulnerabilities and the various ways in which women typically enter the CJS.

The promotion of a shared level of understanding between professionals, and the ability to communicate this understanding to service users is especially important during the adjustment phase. It has also been highlighted as a key component in the development of the therapeutic alliance and relationship (Dziopa & Ahern, 2009). This is also supported by

research and the relational-cultural theory which emphasises interaction, communication and understanding, as an essential aspect for women throughout the life course and especially when external social ties are severed.

The use of attachment theory and its corresponding framework is also pertinent to women in the adjustment phase, as it allows for incorporation of previous experiences and childhood abuse and traumata, to inform ideas for treatment and intervention. This is further supported by its more recent uses to explain the study of psychological processes, such as interpersonal functioning, emotion regulation, coping with stress, and mental health issues (Mikulincer & Shaver, 2012). This is coupled with the realisation that the ward environment may offer a "safe base" in which to develop skills and abilities the women may require. It is also noted that the quality of interaction is the key to building an attachment, and is also imperative in the management and support of individuals in the adjustment process to a secure forensic psychiatric environment (Kim, Kim & Boren, 2008).

All factors highlighted and discussed in the final section of the report can contribute to the development of a therapeutic ward climate and milieu for both patients and staff (Long, Anagnostakis, Fox, Silaule, Somers, West & Webster, 2011).

As this main piece of research was focussed on the individual patient experience of adjustment, it seemed to be appropriate to also explore organisational aspects of adjustment with both patient and staff populations. Thus the concept of ward climate was explored using a common clinical scale which is popular within forensic psychiatric settings in Europe.

This discrete piece of research was carried out within a regional medium secure women's service. It follows two medium secure women's wards during relocation within a psychiatric hospital in the UK. It is written from an organisational viewpoint and results are evaluated from both the service user and staff group. This allows the focus of the thesis to

shift from that of an individual view of adjustment, to a service evaluation of relocation, and

the impacts for two distinctly different groups in the same environment.

CHAPTER 4

Ward Relocation in the Women's Service of a Regional Forensic Medium Secure Unit in England. Individual and Organisational Reflections.

4.1   ABSTRACT

This case study is primarily an organisational needs analysis which explores the experiences of patients and staff of two medium secure women's wards within a forensic psychiatric hospital. The exploration took place in part during an evaluation of ward climate, which is continually evaluated within the hospital. The rationale for this organisational case study was to provide the patients and staff an opportunity to feedback anonymously on the ward climate and their overall experience of the ward relocation. The secondary aim was to capture whether the intervention plan, based on the initial Essen Climate Evaluation Scale, (Essen CES; Schalast, Redies, Collins, Stacey & Howells, 2008), evaluation in June 2011, had any impact over an eighteen month period (See Appendix Y for an edited version of the intervention plan).

The outcome of the needs analysis within the women's service recommended a forum in which the patients and staff could build a narrative which may help to lessen negative feelings about the ward and experiences within the ward environment. It is also hoped that this analysis could reveal important aspects pertinent to relocation, and information which the organisation could use in order to improve future ward openings and relocations within the Trust.

Within the qualitative research discussed in Chapter 3 one of the main themes captured was that of the environment. Research conducted in hospital environments have often found strong, long lasting effects which appear to be somehow linked to the tangible and non-tangible aspects of the environment. These results have been found cross culturally and in various clinical and non-clinical settings with the diverse groups of individuals they contain (Long *et al.,* 2011; Wilkinson, 2008; Karlin & Zeiss, 2006; Dyall, Bridgman, Bidois, Gurney, Hawira, Tangitu & Huata, 1999, Kagan & Kigli-Shemesh, 2004; Pablo, 1977; Rothwell, McManus & Higgon, 1997; New South Wales Department of Health, 2005). With these previous findings in mind it was thought to be useful to investigate the short and longer term effects of ward environments and the impact of relocation on both staff and patients.

4.2   ETHICAL CONSIDERATIONS

The following case study is based on the experiences of patients and staff in a forensic medium secure women's service. Different aspects of the ward climate were explored in order to create relevant effective recommendations. The intervention plan based on these initial evaluations will be discussed. The identity of the staff and patients involved in the study will remain confidential. In order to do this all information which could potentially identify the location or persons in the study will be omitted and replaced with pseudonyms where necessary.

4.3   SERVICE INTROUCTION

This particular women's service consists of both low and medium secure forensic wards. The medium secure service was initially made up of two wards (one assessment and one treatment) which will be referred to throughout the study as Ward A and B. These two wards moved to a new building within the walled perimeter. This organisational relocation to a new building would allow the service to expand to accommodate additional medium secure wards.

4.4 REVIEW OF RELEVANT LITERATURE

4.4.1   Relocation within psychiatric services

Following an extensive literature search, which centred on the relocation of patients within mental health services, it has become apparent that research into this area stems back to the 1960's. Most research since the 1960s has studied transfers of physically unwell or elderly people. The increase of research is linked to the post-deinstitutionalisation era, in which reformation of mental health services moved from the Victorian 'asylums', to 'short-stay treatment centres'. In the UK this was known as a shift to 'care in the community' and has been linked to individuals being placed under section for shorter lengths of time, which could possibly also be linked to the increased number of transitions experienced by individuals during their recovery (Chaboyer, James & Kendal, 2005).

Some of these relocations and transfers are voluntary and some involuntary and although good intentions underlie the relocation, the changes are liable to impose stress on all involved. (Melamed, Lublinsky & Elizur, 2002). Furthermore it is noted that as patients

adjust to new settings and acclimatize themselves to their new territory, their behaviours also adjust. It is noted that this happens in every environment, but is particularly marked in a psychiatric ward (Kagan, Kigli-Shemesh & Bar-Tal, 2004).

4.4.2 Effects of relocation

The variety of relocation studies, have captured moves from a community residence to an institution, from an institution to a community residence, from one institution to another, and within institutions. The preponderance of evidence from studies, with adequate statistical power and methodological control, shows adverse effects associated with all types of transfer. As such the condition 'transfer trauma' was coined by Carpenito (2000) and has allowed the symptoms and outcome factors of relocation to be acknowledged and defined. Transfer trauma refers to the set of symptoms and outcomes which result from the transfer from one environment to another. The concept of this type of trauma has been incorporated in current research surrounding the environment that psychiatric patients create for themselves (Gralton, Pearson, Sutherland, Donovan & Lewis, 2001). Additionally, the inter-relationships between people and their socio-physical surroundings and their relation to other factors have reported overwhelmingly adverse findings.

Early findings regarding the effects of the environment on psychiatric patients are expressed by Goffman, (1961), in which he notes that on entering a hospital setting an individual "begin a series of abasements, degradations, humiliations and profanities of self".

Findings since this time have shown that bodily reactions to the stress, caused by relocation, can cause additional emotional, psychological, and physical stressors to a patient (Kagan, Kigli-Shemesh & Bar-Tal, 2004. Likewise, transfer trauma effects such as depression and anxiety can predispose or exacerbate conditions of ill health. It is noted that

one of the important factors within psychiatric care is the therapeutic milieu, during relocation, this milieu can be altered, and this can in turn cause additional stress and anxiety for all involved.

4.4.3 Ward climate within secure forensic services

During the literature review it was noted that some studies gave no definition of 'ward climate' (Nesset *et al.,* 2009; Schalast *et al.,* 2008), suggesting that there is a need for researchers to use terminology that is consistent with their approach to measurement, theory, and analysis. Discrepancies were highlighted throughout the literature. In some research the term 'ward climate' was used interchangeably with 'social environment' (Smith *et al.,* 1997), 'psychosocial atmosphere' (Brunt & Rask, 2005), and 'climate perception' (Parker *et al.,* 2003). To define 'ward climate' was thought to be important for this research as it encourages understanding and gives a non tangible concept some structure and boundaries This is deemed to be helpful when disseminating findings to an audience with a range of learning styles and levels of understanding.

Wright, (1993), highlights that the ward climate is contingent on the environment and subject to continual change. Three particular characteristics of ward climate, which can be applied to any environment, are noted below:

1. The ward climate distinguishes one organisation from other organisation.
2. Ward climates are relatively enduring.
3. Ward climate can influence the behaviour of participants in the organisation.

As the Essen CES is utilised within the service it was deemed more appropriate to incorporate the key characteristics, captured by this tool, and construct into a working definition. This definition and familiarity of the tool would potentially increase levels of understanding by service users and staff. Greater understanding of the concept of ward climate could potentially also increase in uptake to complete the tool. The three characteristics proposed by Schalast et al (2008) are noted below

1. Supportive of therapy and therapeutic change.
2. Mutual support is present.
3. Level of tension and perceived threat of aggression and violence which exists.

These aspects are especially important to consider as the ward climate has been found to be an important factor which can influence treatment engagement and outcome for patients (Howells & Day, 2003; Casey *et al.,* 2007) it has also been found to impact upon a person's overall satisfaction with their care (Middleboe, Schjødt, Byrsting & Gjerris, 2001). Yet it is a concept which has not been widely researched in single gender forensic mental health setting (Brunt, 2008; Long *et al.,* 2011).

Previous research has shown that individuals residing in secure forensic environments express a range of concerns about their personal circumstances. This includes negative feelings associated with failure, loss of hope and self worth (Carmen, Rieker & Mills, 1984; Hawton, Fagg & Westbrook, 1993) along with an impairment of social identity, feeling marginalised and labelled (Stefan, 2003). Also individuals have noted concerns regarding surveillance, restrictions, high levels of monitoring and personal safety (Davidson, 1997; Graham, 1994; Zamble & Porporino, 1990; Toch & Adams, 1986). Elements of these factors can be captured to some degree on ward climate scales which appear suitable for the complex

diverse settings which characterise forensic mental health settings (Long *et al.,* 2011). Such experiences are likely to be particularly distressing for an individual who has to also attempt to adapt to this setting without any attachment figures or trusted others.

Living in an environment which is perceived to be either unsafe or disempowering potentially acts to counter any therapeutic progress that might be made in treatment or therapy sessions (Davies, 2004). Furthermore, Gordon and Wong (2002) have further noted that environments that do not support pro-social attitudes and fail to encourage positive peer group pressures are unlikely to be successful in rehabilitating offenders.

Ward climate can be a difficult aspect to manage, and capture, especially in a secure forensic psychiatric environment in which there is a continuous complex balance between security and therapeutic interactions.

In order to capture this sensitive intangible concept, a variety of methods have been utilised. The most popular of these methods has been by ward atmosphere rating scales, (Cory, Wallace, Harris & Casey, 1986; Christenfeld, Wagner, Pastva & Acrish, 1989), and multi-method research, which has included both qualitative and quantitative questionnaires (Lawson & Phiri, 2003). The most popular ward atmosphere rating scale is that of Moo's (WAS; Moos & Houts, 1968) however various limitations have been attributed to the scale including the length, which can make its completion with mentally unwell patients extremely challenging.

More recently the Essen CES (Schalast *et al.,* 2008) has been developed. It is a short fifteen item tool which has been validated on British forensic inpatient samples (Schalast *et al.,* 2008; Howells *et al.,* 2009). Although results so far have revealed promising results as a predictive tool, the samples used were small and more research across differing levels of security is required. Also it must be noted that measurements of the effects of the relocation/ transfer have been limited to a few weeks following the transfer. Consequently, such studies

may underestimate the incidence of adverse health outcomes that develop over longer durations.

4.4.4 Factors pertinent to women's forensic services

It is important to remain aware of gender sensitive issues which relate to women in secure forensic services. Women in such services are a marginalised group and have distinctly different risks, needs and responsivity issues. The differences between genders can be observed in every culture and remains acutely evident in the forensic psychiatric secure environment. It is noted that the composition of male and female wards is different (Coid, Kahtan, Gault & Jarman, 2000) and that the largest differences are due to social climate (Brunt, 2008).

One of the most overtly different aspects is communication and the different styles of communication used on male and female forensic wards. Attachments also appear to play an important role for women in the presentation of their symptoms and the prevalence of relational/ interpersonal difficulties which women present with. Women also have different personal needs and these differ at times of crisis and relapse hence the need for gender specific services. Although 'gender specific care' is a recurring recommendation throughout the literature there is little guide as to what this means in terms of ward climate. Subsequently managing differing treatment needs in small pockets of a service can be difficult (NIMHE, 2004).

In order to address the differing needs from this population especially if the women's service is based in a larger male secure services site it is appropriate and necessary to obtain feedback from service users and staff to continually evaluate the shifting ward climate which incorporates perception of safety, levels of therapeutic milieu and perceived support.

Furthermore there has been a clear shift within the NHS to incorporate patient experiences. This focus group allows for the patients experience to be heard and to be acted upon. The importance of the patients experience is noted by a Department of Health document called 'Shifting the Balance'. The following is a quote which stresses the importance of empowering patients and allowing their thoughts and feelings to be heard and validated.

"Empowering patients: We need to develop a patient centred service were patients are seen as active partners in their care. Patients need to have more information about and more influence over their care. The NHS must re-engage local communities to involve patients and the public in the design, delivery and development of local services"

[2001: p.12]

The opportunity to gain patient experiences and feedback allows contributions to be passed to the hospital management and the women's service teams. Decisions can then be made which may alter the trust policies and procedures regarding relocation or closure of wards. It may also precipitate a change in practices in the new environment.

4.5   AIMS AND OBJECTIVES

This organisational case study will use the relocation of two medium secure women's wards to a new building in the same hospital. It will address the patients and staff views in a retrospective style study using a mixed method design. In order to learn from this relocation it was thought that a case study approach may uncover details which had not been measured or assessed, and may be able to inform and improve future relocations within the hospital.

4.6 ASSESSMENT METHODS

In order to evaluate the relocation of the wards a mixed method approach was used in order to capture the thoughts and feelings of staff and patients around the topic of the ward relocation. Quantative data made up of recorded incidents on the ward, and the Essen CES ward climate scale which is routinely carried out as part of the key performance indicators within the Trust (See Appendix W for a copy of the Essen CES tool).

The Essen CES is a psychometric questionnaire, originally developed for assessing essential traits of the social and therapeutic atmosphere of forensic psychiatric wards. Social climate refers to the interaction of aspects of the material, social, and emotional conditions of an environment, which may influence the mood, behaviour, and self-concept of the persons in that environment (Schalast *et al.,* 2008).

The Essen CES Scale was used to measure ward climate before the ward relocation and once again after the relocation. This instrument is a questionnaire, originally developed for assessing essential traits of the social and therapeutic atmosphere of forensic psychiatric wards. It is a 15 item measure which measures both patients and staff's perception on the three following dimensions:

- **Therapeutic Hold-** is defined as the extent to which the climate is perceived as supportive of patients' therapeutic needs. Rogers (1961) notes that therapeutic hold is an essential of any therapeutic setting and relationship. The concept of therapeutic hold is primarily based on Robert Zaslow's rage-reduction therapy

from the 1960s and '70s and on psychoanalytic theories about suppressed rage, catharsis, regression, breaking down of resistance and defence mechanisms.

- **Experienced Safety**- Refers to the level of perceived tension and threat of aggression and violence in the environment. Maslow stated that safety is a basic human need (1943). It is further noted that effective treatment cannot be facilitated in an atmosphere of constant aggressive tension or with the threat of violence (Schlast *et al.,* 2008).

- **Patients Cohesion-** indicates whether characteristics of a 'therapeutic community' (Kelly *et al.,* 2004) could be approximated on the ward. In group psychotherapy, patients' cohesion is strongly linked to treatment outcome (Beech and Fordham, 1997).

4.6.1 Quantative data collection

Essen CES was disseminated to the whole forensic mental health directorate in July 2011. Following this, an intervention plan was devised specifically for the forensic women's medium secure unit (MSU); the main aim of this was to increase patient's level of perceived safety within the ward environment. The Essen CES was then redistributed across the wards within the service in order to evaluate shifts in ward climate and to analyse whether the intervention plan had had the desired outcome.

4.6.2 Qualitative data collection

The qualitative data was gleaned from two individual groups made up of staff and patients from each of the medium secure women's wards. The questions asked in each focus group can be found in Appendix X. This narrative form of data collection allowed patients and staff to expand on their answers and to incorporate feelings and individual experiences which are difficult to capture on quantative psychometrics tools.

A small element of the interaction with patients allowed for psychoeducation which was to counteract a common confusion between thoughts and feelings. This low level pschoeducation was loosely based on the foundations of CBT. For example, patients were asked for an example situation whereby they were asked to describe the activating event (what happened), their thoughts about the activating event (what I thought about it), feelings about the event (what I felt) and how I behaved in response to the event (what I did). The differences between each process were important to distinguish before discussing the relocation.

In terms of the relocation the women were initially asked about their thoughts prior to the ward move, followed by associated thoughts and feelings activated by this event. Finally the questions moved towards the patient's thoughts, feelings and behaviour in response to the relocation. Similar questions were asked in regards to the actual day of the relocation and following the move.

The question format was similar for staff members of the women's service and medical staff, however, the questions themselves altered slightly in order to incorporate their differing roles within the relocation.

4.7   RESULTS

4.7.1   Quantative results

Figures 3 and 4 illustrate the Essen CES patient scores prior to, and immediately after the relocation to a different ward within the hospital. Results show that following the ward move patients on the Ward B scored higher on each sub-scale; however inpatients on the Ward A scored lowered on patient cohesion and therapeutic hold. Inpatient levels of experienced safety increased significantly on both wards following the ward relocation.

FIGURE 3.

Bar chart showing patients scores before and after relocation on Ward A
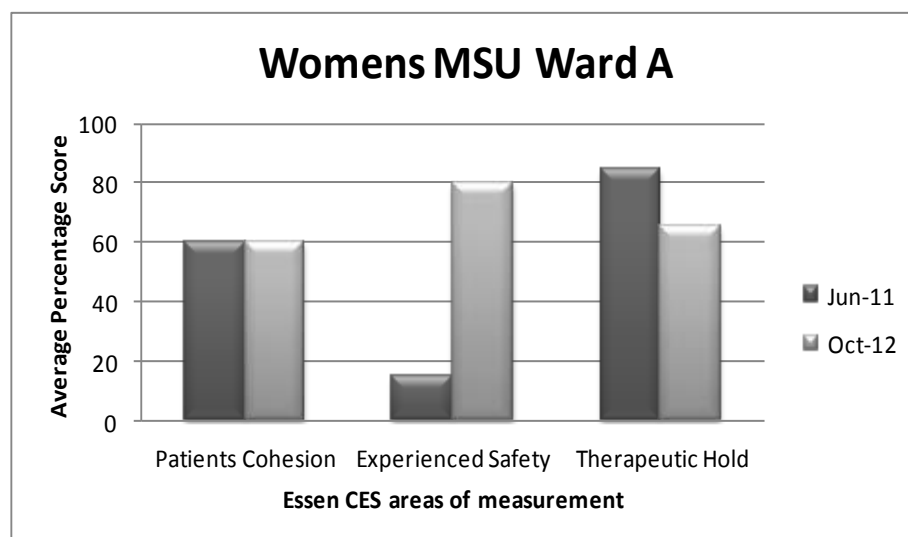
FIGURE 4.

Bar chart showing patients scores before and after relocation on Ward B
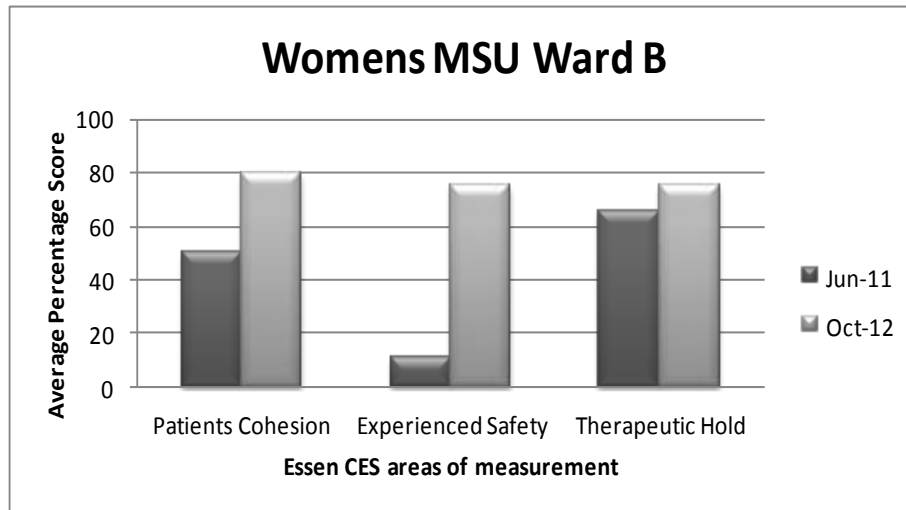
Figures 5 and 6 show the average percentage scores for staff following the ward relocations within the MSU.

FIGURE 5.

Bar chart showing staff member's ratings before and after relocation
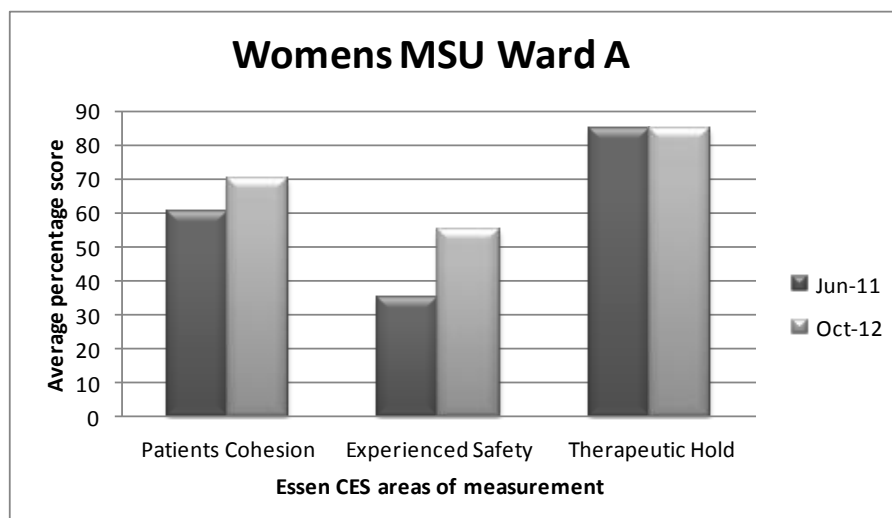
FIGURE 6.

Bar chart showing staff members rating before and after relocation
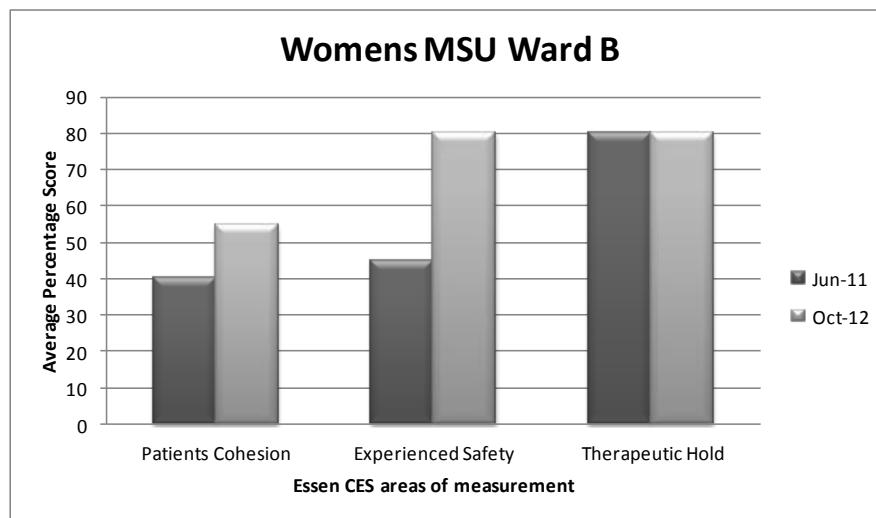
Figures 5 and 6 show the Essen CES staff scores prior to the relocation to a different building. Results show that following the relocation for Ward A and B, the staff scored higher levels of patient cohesion and experienced safety. Whereas staff perceptions of therapeutic hold, decreased on both wards following the relocation. Also staff perception of perceived safety on Ward A was considerably lower than on Ward B.

FIGURE 7.

Bar chart showing the comparison of staff and patient scores prior to ward move on Ward A
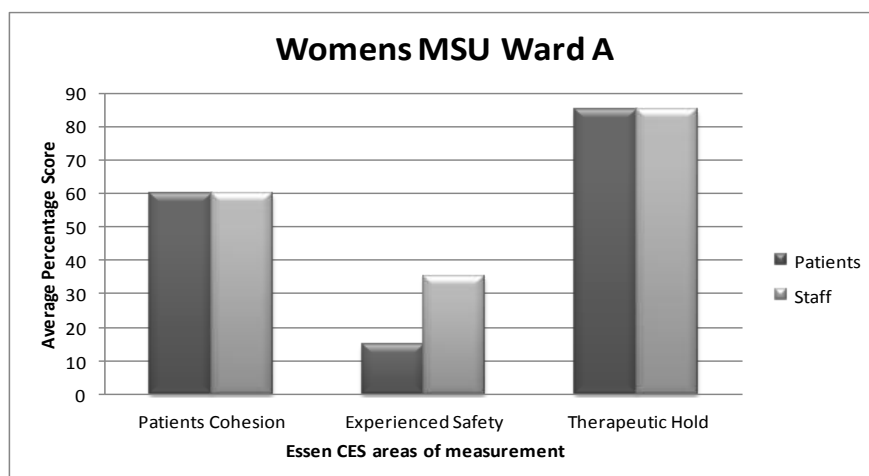
FIGURE 8.

Bar chart showing the comparison of staff and patient scores prior to ward move on Ward B
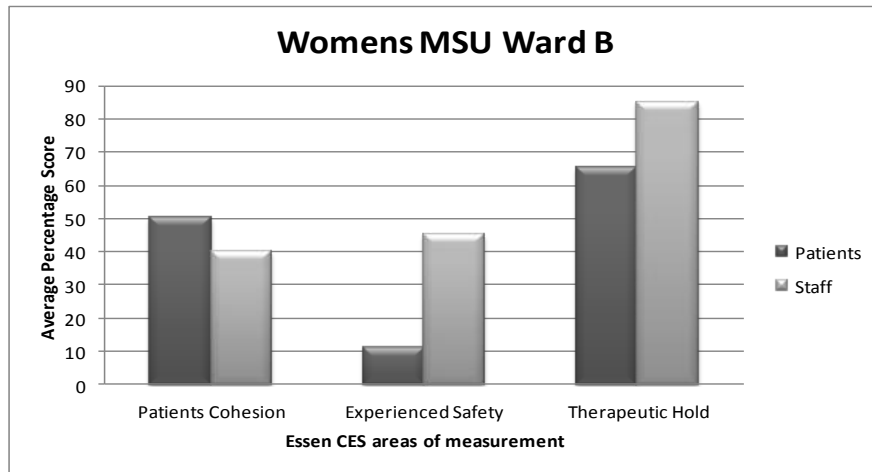
FIGURE 9.

Bar chart showing the comparison of staff and patient scores following the relocation of Ward A
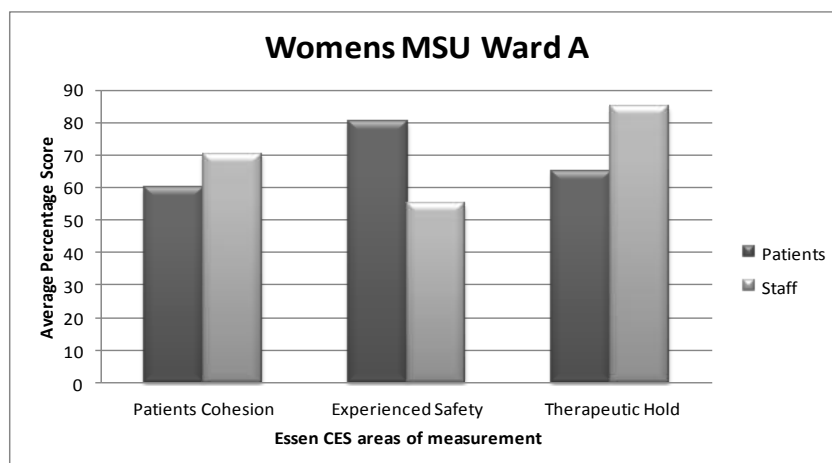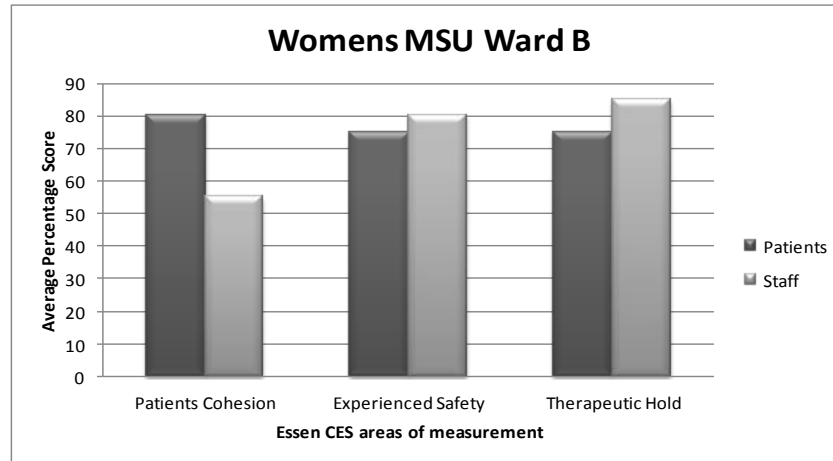
FIGURE 10 .

Bar chart showing the comparison of staff and patient scores following the relocation of Ward B

A report encompassing the results of from each ward was submitted in June 2011, as part of the Commisioning for Quality and Innovation (CQuIn) targets that particular year. The report included recommendations focused on the area of experienced safety. Within this, the overall aim was to increase patients' perceptions of safety in their living environment. In order to do this, an intervention plan was devised. Some of the actions recommended to aid the increase of perceived safety levels include:

- 1:1 offered on a daily basis.

- A suggestion box will be displayed on the ward for patients and staff to voice concerns. These will be discussed in patient experience meetings and reflection group.

- Regular staff members are used on the ward wherever possible.

- Patient behaviour is recorded on the electronic recording system and taken to the weekly MDT.

- Patients participate in anger management groups and Problem Solving Skills Training (PSST).

Reports were also written for the October 2012 results, however action plans were not devised as they did not continue to be a part of the CQuIN targets. However recommendations were noted and they reflect the findings. There were higher levels of perceived therapeutic hold from a staff point of view. Furthermore, in terms of experienced safety across many of the wards, including Ward A, levels of perceived safety were lower for staff than for patients. Recommendations encompass attempting to increase staff levels of experienced safety in order to allow both groups of individuals to perceive a high level of safety in the environment. Additionally, attempts to increase perceived levels of therapeutic hold for patients which include increasing the level of staff support and interest for patients. Roger (1961) notes this to be an important factor in therapeutic settings and therapeutic relationships.

TABLE 25.

Showing levels of self harming behaviour, violence and aggression towards staff since relocation at the beginning of October 2012-March 2013 for the women's medium secure wards.

Wards	Numbers of self harming incidents	Number of violent and aggressive incidents towards staff
Ward A	95	38
Ward B	17	11

4.7.2   Qualitative results

Feedback from ward staff and patients has been analysed and condensed into concise points in order to capture the main areas of focus within the discussions.

4.7.2.1   Qualitative feedback from staff

There was consensus amongst the staff was that they felt informed of the planned relocation. However, there was some dissonance between the level of detail and how much information they had been given prior to the ward move. Some members of staff just state they were informed, some relay that there was a definite date given, and a plan detailing which staff and patients were to move first at which times etc. Whereas other staff state that "little information was given to ward staff".

Feedback regarding the actual move was that it went extremely well "thanks to the regular staff on shift". In terms of logistics it was thought that maybe patients belongings and items in the security checks should have all been moved separately. It was not detailed whether this should have been the same day or whether inanimate items should have been brought over first, and patients following this, or vice versa.

Initial impressions of the ward, elicited some common themes, one of which appeared to be the lack of space on the new wards. It was noted that the Ward A had a variety of rooms and a seclusion room in the previous building, which they now did not have. This was emphasised in terms of the patient numbers, which had not changed. It appeared that if the patient group had got smaller this may have been acceptable, but this was not the case. Additionally, the wards had been allocated a shared office and it was thought the shared office was also too small for the staff teams it was meant to accommodate. Additionally, as

the office was based between both wards, the issue of confidentiality was raised by one member of staff who felt that at times confidentiality could be compromised.

Furthermore, on initial inspection of the new ward it appeared that there were some unfinished jobs which could potentially pose a risk to both patients and staff; for example screws which hadn't been screwed in properly and visible ligature points.

In contrast the staff noted the improvements that they liked, which included surround sound, nice decor, big activity room and an ADL kitchen.

In terms of changes, which the staff felt could be made, there were again some main themes which included a bathroom, a seclusion room, calm room, toilet on the ward for staff, and separate offices with more computers. Overall this appeared to be linked to the amount of space which was available on the wards in order to accommodate both patients and staff comfortably.

When asked to note the biggest differences between the previous ward and the current ward one of the main themes was distance. Firstly, the distance the ward was perceived to be away from the rest of the forensic mental health wards, and the activity centre. This may be because the previous ward was in the same walled perimeter as the activity centre and the other forensic mental health wards whereas the new ward is in a separate part of the site. This was perceived to affect both patients and staff as it was noted that patients appeared to get less use out of the hub, due to the distance and the need for escorts to pass through internal perimeters.

The distance the ward was from the seclusion room was also raised as a negative difference. The geographical location of the new ward in terms of distance from forensic mental health wards was noted to be important. It appeared to be directly linked to perceived safety as it takes longer for response to arrive from the rest of the hospital and also the effort

required moving an unsettled patient to seclusion. The second theme was again space which was noted to be considerably different, with the new wards being much smaller than in the previous building. Finally the layout of the previous ward was preferred by some staff.

Finally the staff members were asked whether there were any final thoughts about the new ward and its direction. It was noted by a number of staff members that the ethos of the ward appeared to have changed, for example, in the previous building the ward referred to as 'assessment' has changed title which appears to imply it has a new function however it has not changed in terms of staff or client group. Staff stated that "nobody knows what this means" and this has left some staff feeling unclear as to the goal of the ward; how to work with the patients, and overall feeling "less competent" in their role.

Another issue which increased confusion was the fact that the patient group had not changed, even though the label of the ward had changed. Additionally, patient transfers between wards were perceived as adhoc at times with little or no consultation with ward staff. This decreased staff feeling of safety, and led to the conclusion that decisions made by the MDT "did not reflect the management issues faced by the nursing team everyday".

4.7.2.2 Qualitative feedback from service users

Overall all patients consulted from both the MSU wards knew in advance about the relocation, however the amount of notice given to each patient appeared to be different, for some they knew well in advance but did not have a specific date, whereas other patients were informed the day before the relocation. Most patients stated they would have preferred to have had a specific date as "something to work towards" and the actual relocation itself "came as a shock". Overall, most patients relayed that they would have liked to have been given a specific date a couple of weeks prior to the move, in order to get their "head sorted".

One patient stated they would have preferred to be just taken to the new ward. However, in direct contradiction, when asked about her thoughts she did state that she would have liked to have been shown around the ward and shown her bedroom before relocating.

The patients were asked to recall any emotions which they felt prior to moving wards; overwhelmingly the response was feelings of anxiety, being scared, nervous, not wanting to move or relocate. There were some positive emotions associated with the transfer including excitement and happiness at moving to a new building, however one of the patients that voiced positive emotions followed this up with the following statement "I don't cope well with change and find it very stressful". In terms of thoughts about moving wards some of the patients voiced statements of hope in regards to the new building in that it would be a more settled atmosphere but would miss people from previous wards.

On the day of the ward relocation some of the patients recalled that they felt supported, whereas other patients stated they did not feel supported. Feelings of not being supported were noted to be because, staff were busy sorting everything out. In terms of support, and factors which would have aided perceptions of support, the patients noted two specific factors which include having activities to do once in the new ward environment and familiar staff to sit and talk to them instead of being bored and "stewing".

Initial thoughts about the ward were mixed in that some patient's report liking the new ward environment thinking it was "nice", however other patients felt uncomfortable in the new surroundings. Following the ward relocation, and allowing time to settle into the new environment, all patients reported positive statements about the ward, including that it is "quiet", however one patient reported that although she liked the new ward building, she felt it to be to clinical and wanted to be allowed to put pictures up on the walls.

The final question put to the patients was if there was anything about the ward that you would change, what would it be, and why? In response to this question there were a

number of aspects which would be changed, which included having Free-view channels (as this was available in the previous ward),

An aspect which was resoundingly popular across the MSU wards was the number of staff allocated to each ward, however it is unclear as to whether staffing levels have changed at all since the relocation. This may be linked to the location of the ward, requiring escorts to accompany patients to the activity centre and cafe, whereas before they could utilise this without staff if they had the required leave. The final aspect incorporates activities, thus patients voiced they would like to have more rooms, and also be able to do more activities, for example, they cannot play in the communal space with the games console as the TV is boxed in and leads cannot be plugged directly into the television.

4.8   CONCLUSION

Prior to ward relocation, Ward A and B had lower levels of experienced safety for both patients and staff. Ward B had the lowest levels of experienced safety for patients across the two wards. Both groups of individuals observed a rise in levels of experienced safety overall. In comparison it appeared that the patients from Ward A had higher levels of experienced safety than staff members. The biggest disparity between pre and post assessment measures occurred on Ward A, with low levels of experienced safety for patients prior to relocation, and high levels of experienced safety following relocation (15%- 80% average percentage scores). This is coupled with Ward B patients reporting higher levels of patient cohesion, and lower levels of therapeutic hold. Whilst on Ward A, prior to relocation, patients relayed similar levels of patient cohesion and therapeutic hold.

Following relocation there have been 98 incidents of self harm within a five month period compared to seventeen incidents on Ward B in the same period. Additionally, there

has been a higher incident of violent and aggressive acts towards staff in this five month period for Ward A and B (38 and 11 incidents respectively). Their findings showed support for lower levels of perceived safety from staff on Ward A.

Following the relocation, staff on both wards perceived there to be higher levels of therapeutic hold than the patients. On Ward B, patients perceive there to be higher levels of patient cohesion, whereas on Ward A it is staff who perceive there to be higher levels of cohesion.

In terms of whether the intervention plan implemented following the June 2011 assessment of ward climate had been a success; results suggest that it had the desired effect. Patient levels of experienced safety had increased, however this culminated in patients feeling safer than staff in the environment. Recommendations from the October 2012 report note, that actions should aim to increase perceived levels of experienced safety for staff to bring them up to similar levels.

Comparing these results with the qualitative information gathered, it seems apparent that there may be a number of reasons as to why staff members are not feeling as safe as patients following the relocation. This experienced safety scale centres around tension, and perceived threat of aggression and violence. These factors may contribute to this heightened fear and will be drawn upon. The two themes central to these perceptions appear to be based on location and communication. The location and the distance of the ward from other parts of the hospital appear to be one of the main reasons affecting perceived levels of experienced safety. This encompasses the amount of time it takes to get response staff from other wards, in order to deal with incidents, and the distance of the seclusion room from both Wards A and B, which serves to decrease perceptions of experienced safety for staff.

Secondly, communication appears to be a central issue, which plays a significant role in the levels of perceived safety with staff. Staff members fed back issues surrounding the

assessment of risk by the MDT; it was noted that staff do not feel involved in decisions about management which ultimately involve them. One staff member stated that they, "do not feel risk is properly assessed" whilst another member noted that they felt unable to "enforce consequences, which constantly increases risk towards staff". These perceptions were captured by the Ward A staff team who seem to be faced by a higher rate of self harming incidents, involving violence and aggression , than the staff on Ward B.

Additionally, the lack of concrete information disseminated to the nursing staff team appears to create the perception that they find out information after it has been decided, and they do not feel involved in the decisions made. Most of the decisions described were thought to affect staff directly, either in the form of care plans for the patients, or in regards to the environment in which they had to work.

What's more, in regards to therapeutic hold, prior to the ward relocation, the staff and patients on Ward A rated this area with similar levels, whereas on Ward B the patients rated this area lower than staff. However, following the ward relocation, staff teams on both wards rate the perceived levels of therapeutic hold as higher than patients. The therapeutic hold scale assesses perceptions to the extent of which the climate is supportive of therapy, and therapeutic change. It is vital that the patients perceive there to be high levels of therapeutic hold, as it is essential to any therapeutic setting or therapeutic relationship. Consequently both therapeutic environments and relationships have been found to be vital in precipitating positive change within patients in forensic psychiatric settings (Dzopa & Ahern, 2009).

Patient cohesion was found to be at similar levels prior to ward relocation for Ward A. Although following the ward relocation, the patients reported slightly lower levels of cohesion. Ward B prior to relocation again showed relatively similar levels, with patient levels peaking slightly. Following the relocation patients level of cohesiveness continue to be higher than staff; however the increase is significant (50% to 80% respectively).

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4.9 RECOMMENDATIONS

The data provided within the organisational case study allows for some recommendations to be made, which are grounded in theory, and pertinent to secure forensic psychiatric services. Previously in June 2011 the outcome of the Essen CES assessment showed lower levels of perceived experienced safety for patients, thus an action plan was devised, and this appears to have had the desired impact. Consequently results from the needs analysis are to try and increase staff perceptions of experienced safety within the MSU women's service. The overall aim is to bring them in line with patient's perceptions of experienced safety.

Staff members gave indications as to why they felt unsafe within the ward environment, thus addressing these issues may be an initial step in increasing levels of safety for staff. The main themes incorporate location and communication. As the ward cannot be moved to another location, communication will be addressed in order to attempt to increase staff members' perceptions of safety.

Communication and dissemination of information from the management and MDT could be made more formal. For example, one of the action points from the June 2011 Essen assessment noted that the suggestions, ideas, thoughts and opinions could be captured by a suggestion box and discussed in the weekly reflective and patient experience meetings. Therefore information from the management, which requires discussion, could be taken to weekly staff reflective meetings which occur within the women's service, and feedback from nursing staff could then be fed back to management.

Feedback from this organisational needs analysis will be fed back to each of the ward teams in order to emphasise the importance of their opinions and ideas. This will help to reiterate that the thoughts and opinions of the staff team have been acknowledged and

included in a document, which aims to highlight areas of potential development and policy for future ward openings or relocations within the hospital site.

Additionally, the lack of rationale behind decisions which are imposed on the staff team appears to be an issue connected to experienced safety. In order to address this, the MDT electronic notes could record full conversations and consequent decisions, in order for staff to read and understand the path which led the team to a particular outcome. In terms of management decisions, which are not recorded on the electronic record system, it might be helpful to ask a member of the nursing team to attend these meetings in order to give a clinical perspective, and highlight any issues which the nursing team may have, following the decision.

Levels of therapeutic hold were the second area in which differences were observed for patients and staff. As previously noted therapeutic hold is linked to therapeutic environment, and therapeutic relationships between staff and patients. Thus, in order to increase perceptions in this area, previous research by Nesset, Rossberg Almvik and Friis (2009) found that training staff in the foundations of milieu therapy was linked to improvement in ward atmosphere

This specific goal of the milieu therapy in this particular study was to raise the nursing staff's awareness of the therapeutic environment, and its impact on the patient's rehabilitation. In order to do this, lectures were provided to the nursing staff to enhance their knowledge and understanding of this form of treatment, and thereby improve the treatment environment as perceived by patients. The main focus was on the relationship between patients and nursing staff. In order to create awareness around this topic, discussions focused on staff members' behaviour in the treatment environment, and their attitudes towards the patients. This also links into the patients qualitative feedback, in terms of the relocation, and an area which could have been improved, was having familiar staff to talk to

CHAPTER 5

Final Discussion

This thesis attempted to highlight the various factors which appear to be inherently linked to the period in which a person attempts to 'adjust' or 'cope' with an unfamiliar environment or setting. In this case a forensic psychiatric environment. All of the elements discussed at length within the chapters appear to be captured under the umbrella of communication, and can arise following a first admission, relocation, or a transfer within the same hospital building.

5.1 The individual and their communication

On entry to a forensic secure environment an individual can feel particularly alone; this can be especially true for women, who depend on social supports and structure in order to give their life meaning (Miller, 1976). An ever increasing number of women are entering forensic secure psychiatric services; however they still remain a marginal group, and one with distinct needs and complex presentations. Within this varied group, women present to services differently, yet have the same diagnoses. For women this is often borderline personality disorder, or bipolar disorder (Long, Fulton & Hollin, 2008). These unique women, captured under the same diagnosis label, can often present in disparate ways and can be unresponsive to typical approaches and interventions, which can often lead staff to feel lacking in knowledge and ability. These feelings can then elicit barriers between the service user and staff member, which may also heighten levels of distress and apprehension in both groups.

Heightened levels of negative emotions and internal distress in the adjustment period can often lead to an increase use of coping mechanisms. It must be noted that women who enter the CJS usually have a limited repertoire of coping strategies, (Zamble & Poporino, 1989), which often encompass strict control or harmful act against their own bodies. At times, the functions of these behaviours do not appear to be addressed in the earliest stages, or as openly as the women would prefer. The findings in Chapter 3 suggest that early preventative strategies and open frank discussions about individual behaviours, and symptoms they present with would be helpful.

An avoidant / detached style of coping can leave a women feeling particularly unequipped to deal with the severance of social support networks, and the unfamiliar forensic psychiatric environment. Furthermore, research encompassing attachment theory has also suggested that severance of attachment figures and social / familial ties is linked to the onset of psychiatric symptomotology in women (Krystal, 1978; van der Kolk, 1985). At this stage, questions pertaining to the benefit of pathologising early adjustment reactions, or behaviour, could be raised. A woman may need a period of time, prior to assessment and during the act of attempting to cope. This time could be acknowledged as a natural feminine response to an unusual experience, which is being experienced without the buffer of social and familial ties.

In order to counter these adverse effects, therapeutic, psychologically informed groups, aimed at forming bonds and therapeutic relationships, as well as developing skills (i.e. DBT skills) or addressing specific needs of women, e.g. sexual health, may be useful. Such 'worthwhile' activities have also been noted in previous research. The clients in this study considered it helpful in order to pass time and refocusing their mind (Halsall, 2006; MacInnes, 2005). Also, in the critical period, new admissions often have little to do and only have a small number of personal belongings with them. Usually the individual will not be granted leave, or have the ability to engage with off ward activities. Thus the need for

activities, which can be led by nursing staff, which also help to manage negative emotions, would be useful for the women.

Furthermore, incorporating a psychoeducational element to the groups around specific mental health diagnoses may be functional for women who want to further understand their own difficulties, and what that means to them individually. These could be informed by aspects of positive psychology, which would hopefully increase levels of engagement, hope, and motivation, which are difficult to muster following admission and initial diagnosis. It is noted by clients in the study, that if the individual is mentally unwell, groups may be difficult to manage, however positive, hopeful engagement with staff is required.

Additionally, therapeutic groups or group activities can open the verbal communication pathways; the difficulty of expressing needs and emotions verbally, are more often observed in women in forensic psychiatric settings, due to the traumatic experiences and trauma they have experienced throughout their lives. Although they experience difficulties, the need to express these emotions does not reduce, and often culminates in communication using their bodies (Motz, 2010).

The clients in this study indicated that they had a degree of understanding regarding the impact of their self injury behaviour on others and themselves. However this did not appear to be enough to counteract strong negative emotions, which triggered the urge to engage in such acts. Previous research supports the claims of participant in this study, who note that self harm is a coping strategy. To diminish the need to cope in this way, they required time to talk to people who they perceived to be trustworthy, caring, and interested (MacInnes, 2005). A pathway of communication around the function of self harm and personal triggers could aid understanding for both staff, and service user. An individual distress signature, as part of the Trauma and Self Injury multi-modal model of working, has

been piloted, and implemented, in the High Secure Forensic Services for Women at Rampton hospital. Results are overwhelmingly positive; evaluations are still ongoing.

5.2   Communication between staff and service users

It is widely reported that women and men communicate distress differently, thus research recommendations are supported, in so far that there is a greater need for tailored, individual approaches to need, risk and responsivity, instead of prescriptive interventions or adaptations from male services. Consequently, research has also recommended gender sensitive approaches to forensic psychiatric care; however recommendations for good practice have been vague (Social Care Institute of Excellence, 2007).

Importation factors linked to women in the CJS, include previous experiences of abuse, trauma, and feelings of depression, feeling overwhelmed and consumed by past failures can be common. In order to negate feelings such as anxiety, depression, and suicidal ideation, triggered by importation factors, imposed deprivation factors, self compassion, and compassion focussed therapy, have been found to have positive effects on many areas. Neff (2009) found that self-compassion could be helpful, as it is strongly related to psychological well-being, including increased happiness, optimism, as well as decreased anxiety, depression and rumination. Additionally, the aspect of self compassion is also noted to improve resilience, overall well-being and progress (Neff & McGhee, 2010).

In terms of responsivity with women offenders, certain approaches and characteristics have been found to have positive effects on well being and overall progress. Most of the approaches centre on aspects gained from positive relationships with others; including empowerment, empathy and self compassion (Dziopa & Ahern, 2010; Covington & Bloom,

2003; Wilkinson, 2008). Importantly, self compassion can ultimately be applied to any circumstance a woman finds herself in, however she perceives the situation to be:

"Compassion can be extended towards the self when suffering occurs through no fault of one's own—when the external circumstances of life are simply painful or difficult to bear. Self-compassion is equally relevant, however, when suffering stems from one's own foolish actions, failures, or personal inadequacies"

[Neff & McGehee, 2010: p. 226]

In order for the staff to be able to practice and teach the foundations of self compassion, they must first develop an understanding of women in secure services. In order to do this, mandatory training in gender sensitive issues is extremely important. The clients within this study supported this need and also relayed the importance of shared understanding, and a non-judgemental approach, especially at times of heightened emotion (i.e. critical period). Judgmental, patronising, unrealistic staff responses were noted to be unhelpful, and such negative interactions have been found to tarnish the whole adjustment period Godin and Davies (2005).

All the aspects noted above, contribute to the goal of building a therapeutic alliance between the service user and the MDT, which has been found to be imperative in order to increase feelings of hopefulness, self worth, and motivation to engage. It has also been linked to overall patient progress and patients' satisfaction (McMurran & Ward, 2004). Vitally, it also forms the basis for positive communications between the two parties; which is fundamental to monitoring and managing risk to self and others in a forensic psychiatric setting for women.

It is further reiterated by Covington (2007) that treatment and rehabilitation programs with women are more successful when they focus on relationships with other people, and

offer ways to master their lives, while keeping these relationships intact. Self help groups or 'buddy' systems, which allow interaction with another individual who has lived experience of forensic psychiatric environments, psychiatric diagnosis, or overcoming self injurious urges, could be extremely useful and powerful. These activities could then promote hope and encouragement to work towards their goals, and a future in which they feel worthwhile, valued and empowered.

5.3   The effect of the environment on communication

If a woman requires the security that a forensic secure psychiatric environment provides, it is important to incorporate buffering factors to counteract the high levels of internal distress, which are evoked by such a situation. The physical environment has been found to offer some relief. Research has shown that environments which feel homely, safe and comfortable are important to women. It is also noted by Surrey (1991) that in order to construct environments and interventions tailored for women, the connection with others must be incorporated.

The environment must then be staffed with individuals who show empathy towards the women, compassion in terms of the experiences they have had, and most of all understand the many ways in which women communicate their wide range of emotion which can shift rapidly at times.

As previously stated, the ward climate can play an important part in terms of adjustment. It encompasses unspoken, non-tangible aspects of the ward. The importance of non-tangible aspects of secure forensic psychiatric environments has been highlighted in the NICE guidelines (2009). NICE promotes the use of therapeutic communities, which are based upon close therapeutic relationships; challenging negative cognitions in a safe and therapeutic

environment, and re-learning of emotions that may be due to past trauma. All of these aspects appear to be vital for women in forensic secure settings, and are the basis for the Psychologically Informed Planned Environment projects, which are currently in pilot stages in numerous forensic environments across England. Some of these are specifically for women and are based on a holistic approach incorporating elements such as gender sensitivity, trauma informed, women-centric, issues of self harm, and caring responsibilities, devised in consultation with the individual service user (National Institute for Mental Health England, 2003).

Furthermore, milieu therapy has been used as a more effective far-reaching approach in forensic psychiatric environments. It is an approach which nursing staff can learn, and then adapt their work in order to adhere to the principles. The main focus of the milieu therapy, utilised within research, has focussed on the therapeutic relationship between service users and staff. It also allowed for a framework within which behaviour, attitudes and interactions in the ward environment can be reflected upon (Adlam, Aiyegbusi, Klienot, Motz & Scanlon, 2012). A study exploring attitudes of staff, when communicating with individuals in an inpatient setting, found it imperative not to display anxiety in the face of psychotic phenomena, psychological distress, or overt hostility and aggression. Final conclusions noted that, an optimistic outlook benefitted both service users and fellow staff members (Bowers, Brennan, Winship & Theodoridou, 2009).

The consideration of therapeutic milieu also highlights the need for assessment of the ward climate. However, because this is only a quantative tool, incorporation of a more qualitative component may be helpful for smaller pockets of a forensic service, such as the women's service. This will help to inform management decisions and policies, which can ultimately alter the experience of both service users and staff alike.

In forensic settings, the competing demands between therapeutic rehabilitation and security (Hodge and Renwick, 2002) can be difficult to balance. For the women within the settings it can shift feelings of being settled, comfortable, and empowered, to restricted, uncared for and disempowered (Kim, Kim & Boren, 2008). This also supports the need to measure and promote awareness of the ward climate as a tool in recovery.

Ward climate can also be affected by the physical environment. The style of the decor and furniture, as well as best use of nature and views from the psychiatric unit could be maximised, in order to lessen feelings of being trapped and wanting to escape. Lessening feelings such as these could help to reduce internal distress, and ultimately allow for an easier or reduced period of adjustment. An important part of the environment for women appeared to be the bedroom in which she felt safest; she felt in control of that space. Also in this space she could "escape" from the sometimes chaotic, frightening, forensic secure environment; these feelings have been supported in previous research (Gilburt, Slade, Rose, Lloyd-Evans, Johnson & Osborn, 2010).

The women stated that in order to aid adjustment, it would be helpful if belongings could be risk assessed within the first day, so that they can have personal items in their possession which can buffer against the severance of social support networks and engagement in harmful coping strategies.

## 5.4   Implications for practice and further research

As each woman is unique, there are a variety of factors which intertwine, in order to elicit the varying presentations which are observed in the secure forensic psychiatric environment. It is important to capture the context and circumstances surrounding her admission. A screening tool which captures a number of factors pertinent to women and their

common experiences is thought to be of use. The prison service currently have screening tools which are routinely used to assess prisoners on entry, however screening tools are not routinely used within the critical period on entry to a secure forensic psychiatric environment.

In order to capture these feelings, which could impact on an individual's ability to adjust and cope, a screening tool could be devised. This tool could be based on Figure 11 which incorporates the factors elicited from the systematic review, and mixed method research within the present enquiries.

FIGURE 11.

A model of adjustment and coping for women. Analysis of qualitative data using Interpretative Phenomenological Analysis (IPA).
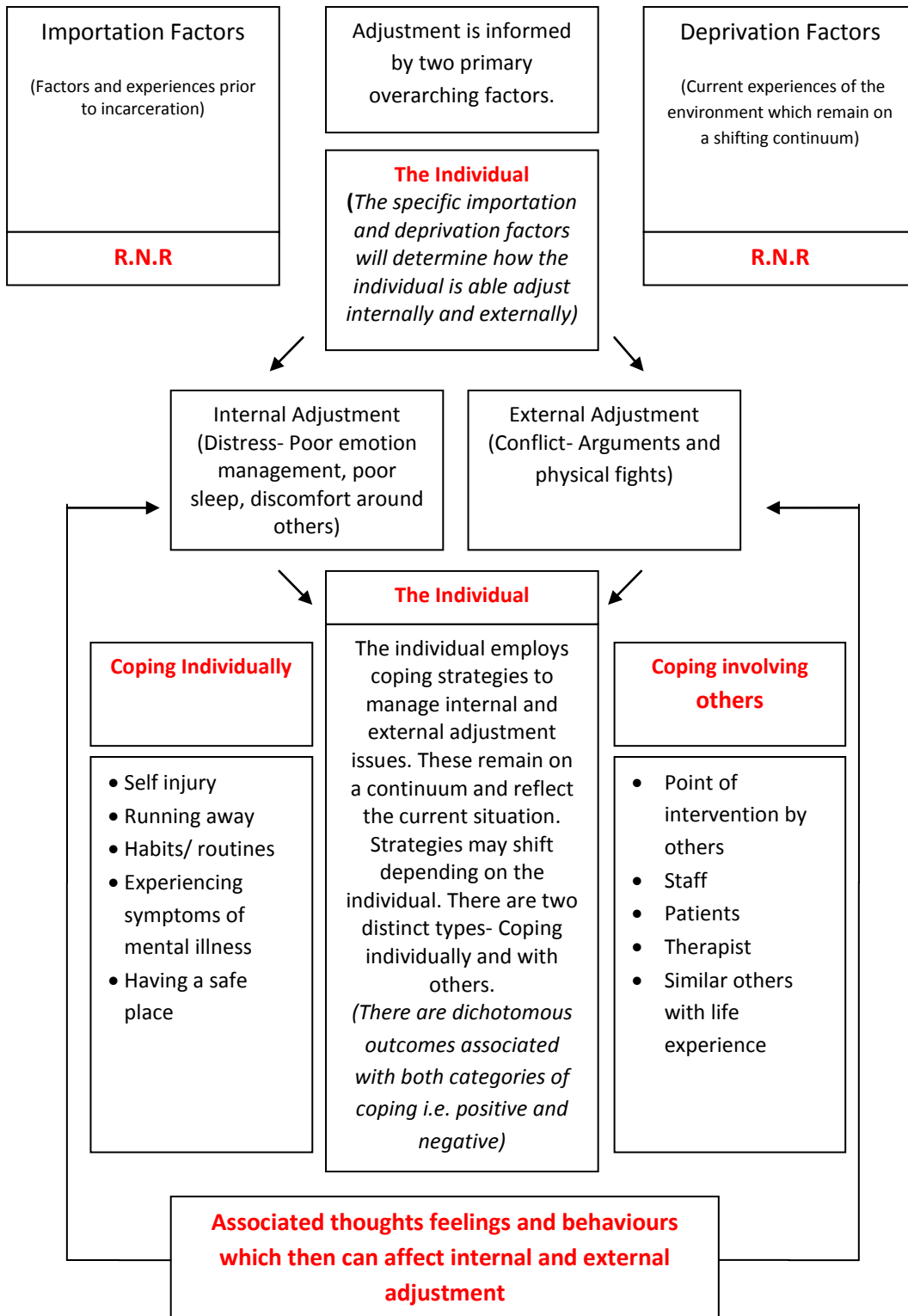
The screening tool could attempt to capture feelings of anxiety, depression, and self esteem, which seem to play a key role in the ability to tolerate the strong emotions which can be evoked on admission to hospital (Morgan & Hawton, 2004; Palmer & Connelly, 2005; Mann, 2003). Additionally, more specific gender focussed importation factors, such as the individuals repertoire of coping styles, has been found to be important, in terms of dealing with stressors (Zamble & Porporino, 1989), and could be loosely based on a widely validated tool like that of the CSQ-3 (Rogers, 1993). In addition, specific importation factors such as childhood trauma and attachment type could also be indicated by a short psychometric assessment, such as the Trauma Symptom Inventory (TSI; Briere, 1995; Briere, Elliott, Harris & Cotman, 1995) or the Relationship Style Questionnaire (RSQ; Griffin & Bartholomew, 1994). This could be helpful in predicting women who may embody factors which are linked to poorer long-term adjustment. Consequently, explorations of these factors may also be useful in highlighting individuals who may be more vulnerable to suicidal ideation during the initial adjustment phase into a restrictive forensic environment (Jenkins *et al.,* 2005).

In terms of deprivation factors the tool could incorporate elements of ward climate tools, which aim at assessing the individuals' perception of safety and therapeutic hold which have been found to be important in the development of the therapeutic alliance, and overall progress within a therapeutic environment (Dziopa & Ahern, 2009; Rogers, 1961)

Finally, in order to prevent unnecessary escalation of risk, tools and risk assessments can be further developed which incorporate screens for relatable emotions, feelings, and issues which appear to be significant for women residing in secure forensic psychiatric environments. A table of factors highlighted by the study in Chapter 3 can be found in Appendix Z.

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Appendices

APPENDIX A.

Detailed search terms for each database

ISI Web of Knowledge

1) Topic=(convict*) OR Topic=(crimin*) OR Topic=(felon*) OR Topic=(inmate*) OR Topic=(detainee*) OR Topic=(offend*) NOT Topic=(juvenile*) NOT Topic=(delinquent)
2) Topic=(gaol) OR Topic=(jail*) OR Topic=(borstal) OR Topic=(penal*) OR Topic=(penitentia*) OR Topic=(prison*) OR Topic=(remand*) OR Topic=(correction*) OR Topic=(detention*) OR Topic=(secure facility*) NOT Topic=(hospital) NOT Topic=(community)
3) Topic=(anx*) OR Topic=(depress*) OR Topic=(distress*) OR Topic=(helples*) OR Topic=(hopeless*) OR Topic=(loss of control) OR Topic=(trauma*) OR Topic=(PTSD*) OR Topic=(self esteem) OR Topic=(adjust*) OR Topic=(attach*) OR Topic=(cop*)
4) #3 AND #2 AND #1

PsychInfo
1) prisoners*:Full Text OR convict*:Full Text OR inmate*:Full Text OR detainee*:Full Text OR juvenile*:Full Text NOT delinquent*:Full Text OR offend*:Full Text OR perpetrator*:Full Text
2) ({Environment} OR {Facility Admission} OR {Maximum Security Facilities} OR {Prisons}):Full Text OR (remand* OR detention*):Full Text OR (correction* OR forensic*):Full Text NOT hospital:Full Text NOT community:Full Text
3) ({Abandonment} OR {Aggressive Behavior} OR {Agitation} OR {Anxiety} OR {Depression (Emotion)} OR {Distress} OR {Emotional Adjustment} OR {Emotional States} OR {Emotional Trauma} OR {Environmental Stress} OR {Fear} OR {Helplessness} OR {Institutionalization} OR {Internal External Locus of Control} OR {Loneliness} OR {Panic} OR {Psychological Stress} OR {Resistance} OR {Sadness} OR {Self Esteem} OR {Self Injurious Behavior} OR {Separation Anxiety} OR {Separation Reactions} OR {Stress} OR {Suicide}):Full Text OR (trauma* OR cop*):Full Text OR (adjust* OR attach*):Full Text
4) FullText:("Abandonment" OR "Aggressive Behavior" OR "Agitation" OR "Anxiety" OR "Depression (Emotion)" OR "Distress" OR "Emotional Adjustment" OR "Emotional States" OR "Emotional Trauma" OR "Environmental Stress" OR "Fear" OR "Helplessness" OR "Institutionalization" OR "Internal External Locus of Control" OR "Loneliness" OR "Panic" OR "Psychological Stress" OR "Resistance" OR "Sadness" OR "Self Esteem" OR "Self Injurious Behavior" OR "Separation Anxiety" OR "Separation Reactions" OR "Stress" OR "Suicide") OR FullText:(trauma* OR cop*) OR FullText:(adjust* OR attach*) AND FullText:("Environment" OR "Facility Admission" OR "Maximum Security Facilities" OR "Prisons") OR FullText:(remand* OR detention*) OR FullText:(correction* OR forensic*) NOT FullText:(hospital) NOT FullText:(community) AND FullText:(prisoners*) OR FullText:(convict*) OR FullText:(inmate*) OR FullText:(detainee*) OR FullText:(juvenile*) NOT FullText:(delinquent*) OR FullText:(offend*) OR FullText:(perpetrator*) AND Adulthood (18 yrs & older):Age Group AND Human:Population

Cochrane Library
1) (convict* OR crimin*):ti,ab,kw or (offend* OR felon*):ti,ab,kw or (detainee* OR inmate*):ti,ab,kw or (juvenile*):ti,ab,kw not (delinquent*):ti,ab,kw
2) (jail* OR gaol* OR maximum* OR facility*):ti,ab,kw or (borstal* OR penetent* OR detention*):ti,ab,kw or (prison* OR remand* OR forensic*):ti,ab,kw not (community):ti,ab,kw not (Hospital):ti,ab,kw
3) (anx* OR cop* OR depress*):ti,ab,kw or (distress* OR hopeless* OR helpless):ti,ab,kw or (control* OR adjust* OR attach*):ti,ab,kw or (self esteem* OR trauma OR PTSD):ti,ab,kw or (suicide*):ti,ab,kw
4) (#1 AND #2 AND #3)

Campbell Collaboration
1) convict* in All text or crimin* in All text or felon* in All text or detainee* in All text or inmate* in All text or offend* in All text or perp* in All text

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2) jail* in All text or gaol* in All text or prison* in All text or penal* in All text or penitenti* in All text or remand* in All text or correction* in All text or detention* in All text or forensic* in All text

3) anx* in All text or cop* in All text or depress* in All text or distress* in All text or hopeless* in All text or helpless* in All text or control* in All text or self esteem* in All text or adjust* in All text or attach* in All text or trauma* in All text or PTSD in All text

4) 1 and 2 and 3

ASSIA

1) KW=("**offender***" or "**prisoner***" or **convict***) or KW=(**inmate*** or **detain*** or **crimin***) and not KW=(**juvenile** or **deliquent**)

2) KW=(**jail*** or **prison*** or **gaol***) or KW=(("**penal institution**") or "**penitentiaries**" or **remand***) or KW=(**detention*** or **maximum***)

3) (KW=("**offenders**" or "**prisoners**" or **convict***) or KW=(**inmate*** or **detain*** or **crimin***) and not KW=(**juvenile** or **deliquent**)) and(KW=(**jail*** or **prison*** or **gaol***) or KW=(("**penal institution**") or "**penitentiaries**" or **remand***) or KW=(**detention*** or **maximum***)) and(KW=(**attach*** or **adjust*** or ("**psychological distress**")) or KW=(**hopeless*** or **helpless*** or **control***) or KW=(**cop*** or **trauma*** or **depress***) or KW=(**distress*** or **esteem***))

4) ((KW=("**offender**" or "**prisoner**" or **convict***) or KW=(**inmate*** or **detain*** or **crimin***) and not KW=(**juvenile** or **deliquent**)) and(KW=(**jail*** or **prison*** or **gaol***) or KW=(("**penal institution**") or "**penitentiaries**" or **remand***)) and(KW=(**attach*** or **adjust*** or ("**psychological distress**")) or KW=(**hopeless*** or **helpless*** or **control***) or KW=(**cop*** or **depress***) or KW=(**distress*** or **esteem***))) and NOT **war***

Within ASSIA: Applied Social Sciences Index and Abstracts the following databases were also searched:-
EconLit
ERIC
IBSS: International Bibliography of the Social Sciences
Index Islamicus
LISA: Library and Information Science Abstracts
CSA Linguistics and Language Behavior Abstracts
National Criminal Justice Reference Service Abstracts
PAIS International
Physical Education Index
PILOTS Database
CSA Worldwide Political Science Abstracts
CSA Sociological Abstracts
CSA Social Services Abstracts
Recent References Related to the Social Sciences

Dissertation Express

prisoner* or offend* or crimin* or inmate* or detainee* and prison* or jail* or remand* or penitentia* or forensic* and adjust* or attach* or anx* or cop* or control* or hopeless* or helpless* or trauma* or distress* or depress*

APPENDIX B.

Inclusion/ Exclusion Criteria Protocol

	Inclusion	Exclusion
Population	Adult prisoners (18+yrs) held in a secure prison setting either on remand or carrying out a sentence.	➢ Juvenile prisoners, ➢ Offenders on license in the community ➢ Mentally disordered offenders in hospital.
Intervention/ Exposure	Imprisonment in a prison establishment.	➢ Incarceration as a prisoner of war, ➢ Detained under the mental health act in hospital ➢ Detained/ restricted in a community/ probation setting.
Comparator	N/A	N/A

Outcome	➢ Psychological effect
	   i. Hopelessness
	   ii. Helplessness
	   iii. Loss of Control
	   iv. Psychological distress
	➢ Emotional affect
	   i. Depression
	   v. Anxiety
	➢ Self harm/ Suicide
	➢ Adjustment
	   i. Quantitative data
	   ii. Qualitative data	

Study Design	➢ All study types ➢ Qualitative research will also be included.	

APPENDIX C.

Quality Assessment Scale- Cross-sectional Observational Studies

STROBE Statement—Checklist of items that should be included in reports of cross-sectional studies

Item	No	Recommendation
Title & Abstract	**1**	(*a*) Indicate the study's design with a commonly used term in the title or the abstract (*b*) Provide in the abstract an informative and balanced summary of what was done and what was found
Introduction		
Background and Rationale	**2**	Explain the scientific background and rationale for the investigation being reported
Objectives	**3**	State specific objectives, including any prespecified hypotheses
Methods		
Study design	**4**	Present key elements of study design early in the paper
Setting	**5**	Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection
Participants	**6**	(*a*) Give the eligibility criteria, and the sources and methods of selection of participants
Variables	**7**	Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable
Data Sources/ Measurement	**8**	For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group
Bias	**9**	Describe any efforts to address potential sources of bias
Study size	**10**	Explain how the study size was arrived at

Quantitative variables	11	Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen and why
Statistical methods	12	(*a*) Describe all statistical methods, including those used to control for confounding (*b*) Describe any methods used to examine subgroups and interactions (*c*) Explain how missing data were addressed (*d*) If applicable, describe analytical methods taking account of sampling strategy (*e*) Describe any sensitivity analyses
Results	13	(a) Report numbers of individuals at each stage of study—eg numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed (b) Give reasons for non-participation at each stage Participants 13* (c) Consider use of a flow diagram
Descriptive Data	14	(a) Give characteristics of study participants (eg demographic, clinical, social) and information on exposures and potential confounders b) Indicate number of participants with missing data for each variable of interest
Outcome data	15	Report numbers of outcome events or summary measures
Main Results	16	(*a*) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (eg, 95% confidence interval). Make clear which confounders were adjusted for and why they were included (*b*) Report category boundaries when continuous variables were categorized Main results 16 (*c*) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period
Other Analyses	17	Report other analyses done—eg analyses of subgroups and interactions, and sensitivity analyses
Discussion		
Key results	18	Summarise key results with reference to study objectives
Limitations	19	Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias

Interpretation	20	Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence
Generalisability	21	Discuss the generalisability (external validity) of the study results
Other Information		
Funding	22	Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based

*Give information separately for exposed and unexposed groups.

Note: An Explanation and Elaboration article discusses each checklist item and gives methodological background and published examples of transparent reporting. The STROBE checklist is best used in conjunction with this article (freely available on the Web sites of PLoS Medicine at http://www.plosmedicine.org/, Annals of Internal Medicine at http://www.annals.org/, and Epidemiology at http://www.epidem.com/). Information on the STROBE Initiative is available at www.strobe-statement.org.

APPENDIX D.

Quality Assessment Scale- Cohort Studies

STROBE Statement—Checklist of items that should be included in reports of cohort studies

Item	No	Recommendation
Title & Abstract	**1**	(*a*) Indicate the study's design with a commonly used term in the title or the abstract (*b*) Provide in the abstract an informative and balanced summary of what was done and what was found
Introduction		
Background and Rationale	**2**	Explain the scientific background and rationale for the investigation being reported
Objectives	**3**	State specific objectives, including any prespecified hypotheses
Methods		
Study design	**4**	Present key elements of study design early in the paper
Setting	**5**	Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection
Participants	**6**	(*a*) Give the eligibility criteria, and the sources and methods of selection of participants (b) For matched studies, give matching criteria and number of exposed and unexposed
Variables	**7**	Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable
Data Sources/ Measurement	**8**	For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group
Bias	**9**	Describe any efforts to address potential sources of bias
Study size	**10**	Explain how the study size was arrived at
Quantitative variables	**11**	Explain how quantitative variables were handled in the analyses. If applicable,

		describe which groupings were chosen and why
Statistical methods	**12**	(*a*) Describe all statistical methods, including those used to control for confounding (*b*) Describe any methods used to examine subgroups and interactions (*c*) Explain how missing data were addressed (*d*) If applicable, describe analytical methods taking account of sampling strategy (*e*) Describe any sensitivity analyses
Results	**13**	(a) Report numbers of individuals at each stage of study—e.g. numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed (b) Give reasons for non-participation at each stage Participants 13* (c) Consider use of a flow diagram
Descriptive Data	**14**	(a) Give characteristics of study participants (e.g. demographic, clinical, social) and information on exposures and potential confounders (b) Indicate number of participants with missing data for each variable of interest (c) Summarise follow up time (e.g. average and total amount)
Outcome data	**15**	Report numbers of outcome events or summary measures
Main Results	**16**	(*a*) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (e.g., 95% confidence interval). Make clear which confounders were adjusted for and why they were included (*b*) Report category boundaries when continuous variables were categorized Main results 16 (*c*) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period
Other Analyses	**17**	Report other analyses done—e.g. analyses of subgroups and interactions, and sensitivity analyses
Discussion		
Key results	**18**	Summarise key results with reference to study objectives
Limitations	**19**	Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias

Interpretation	20	Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence
Generalisability	21	Discuss the generalisability (external validity) of the study results
Other Information		
Funding	22	Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based

*Give information separately for exposed and unexposed groups.

Note: An Explanation and Elaboration article discusses each checklist item and gives methodological background and published examples of transparent reporting. The STROBE checklist is best used in conjunction with this article (freely available on the Web sites of PLoS Medicine at http://www.plosmedicine.org/, Annals of Internal Medicine at http://www.annals.org/, and Epidemiology at http://www.epidem.com/). Information on the STROBE Initiative is available at www.strobe-statement.org.

APPENDIX E.

Second Quality Assessment Form – Cross-sectional studies

1. Was the sample representative of the define population? Was the sample size appropriate?
   - *50> participants for partial fulfilment of criteria and;*
   - *Representative of the defined population for full fulfilment of the criteria*

2. Was adjustment appropriately measured?
   - *Validated and standardised measures used =1*
   - *Interview conducted to assess adjustment =1*
   - *Collateral Information obtained from official records= 1*
   - *None of the above methods used= 0*

3. Was adjustment appropriately defined?
   - *Robust definition for partial fulfilment and;*
   - *Comprehensive behaviour specification for fulfilment of the criteria*

4. Were the participants blind to what the study was measuring?
   - *Not blind to either exposure or outcome= Not met*
   - *Blind to either exposure or outcome for partial fulfilment of criteria*
   - *Blind to both exposure and outcome for full fulfilment of the criteria*

5. Was the measurement method consistent across all participants?
   - *At least one measure consistent for partial fulfilment of the criteria*
   - *All measures consistent for full fulfilment of the criteria*

6. Does the study report attrition/ respondent rates? Did the researchers look at the differences between those who responded and those who did not?
   - *Attrition/respondent rates reported at least for partial fulfilment of the criteria and;*
   - *Differences between respondents and non-respondents accounted for full fulfilment*

7. Have confounding effects been identified?
   - *Evidence of identifying at least one confounding factor for partial fulfilment of the criteria*
   - *Evidence of identifying more than one confounding factor for full fulfilment of the criteria*

8. Did the study employ methods to counteract confounding factors?
   - *Appropriate statistics used to control for at least variable for partial fulfilment*
   - *Appropriate statistics used to control for more than one variable for full fulfilment*

9. Was the appropriate statistical analyses performed?
   - *Appropriate analyses based on sample size for partial fulfilment and;*
   - *Appropriate analyses based on data for full fulfilment of the criteria.*

10. Was missing data addressed in the analyses?
    - *Missing data was documented but no clear explanation of how it was addressed for partial fulfilment and;*
    - *A clear explanation of how missing data was addressed for full fulfilment of criteria.*

11. Acknowledge limitations of the study and its generalisability.
    - *An explanation of the limitations of the study for partial fulfilment of criteria and;*
    - *An explanation of generalizability to population for full fulfilment of criteria.*

APPENDIX F.

Second Quality Assessment Form– Cohort studies

1. Was the sample representative of the define population? Was the sample size appropriate?
   - *50> participants for partial fulfilment of criteria and;*
   - *Representative of the defined population for full fulfilment of the criteria*

2. Was adjustment appropriately measured?
   - *Validated and standardised measures used =1*
   - *Interview conducted to assess adjustment =1*
   - *Collateral Information obtained from official records= 1*
   - *None of the above methods used= 0*

3. Was adjustment appropriately defined?
   - *Robust definition for partial fulfilment and;*
   - *Comprehensive behaviour specification for fulfilment of the criteria*

4. Were the participants blind to what the study was measuring?
   - *Not blind to either exposure or outcome= Not met*
   - *Blind to either exposure or outcome for partial fulfilment of criteria*
   - *Blind to both exposure and outcome for full fulfilment of the criteria*

5. Was the measurement method consistent across all participants?
   - *At least one measure consistent for partial fulfilment of the criteria*
   - *All measures consistent for full fulfilment of the criteria*

6. Does the study report attrition/ respondent rates? Did the researchers look at the differences between those who responded and those who did not?
   - *Attrition/respondent rates reported at least for partial fulfilment of the criteria and;*
   - *Differences between respondents and non-respondents accounted for full fulfilment*

7. Have confounding effects been identified?
   - *Evidence of identifying at least one confounding factor for partial fulfilment of the criteria*
   - *Evidence of identifying more than one confounding factor for full fulfilment of the criteria*

8. Did the study employ methods to counteract confounding factors?
   - *Appropriate statistics used to control for at least variable for partial fulfilment*
   - *Appropriate statistics used to control for more than one variable for full fulfilment*

9. Was the appropriate statistical analyses performed?
   - *Appropriate analyses based on sample size for partial fulfilment and;*
   - *Appropriate analyses based on data for full fulfilment of the criteria.*

10. Was missing data addressed in the analyses?
    - *Missing data was documented but no clear explanation of how it was addressed for partial fulfilment and;*
    - *A clear explanation of how missing data was addressed for full fulfilment of criteria.*

11. Was the length of follow up appropriate? Were the methods used to follow up robust and thorough?

- *Adequate follow up time scale for partial fulfilment of criteria and;*
- *Standardised measures or thorough robust methods used to follow up all participants for full fulfilment of criteria.*

12. Acknowledge limitations of the study and its generalisability.
   - *An explanation of the limitations of the study for partial fulfilment of criteria and;*
   - *An explanation of generalizability to population for full fulfilment of criteria.*

APPENDIX G.

Data Extraction Form

Adjustment to a Prison Setting

Administration Details

Paper ID No			

Extractor initials	

Type of Report		1= Journal article 2= Book/ Chapter 3= Conference	4= Dissertation 5= Government Report 6= Other (*Specify*)
Published?		0= Yes	1= No

First Author	
Study Name	
Year of Publication	
No of studies included in paper	
Country of Origin		1= UK 5= Mid E/ Asia 2= USA 6= Africa 3= Canada 7= Australia/ NZ 4= Other EU 8= Other (*Specify*)

Study Design

Type of Study		1= RCT 4= Case Control Study 2= Cohort Study 5= Qualitative Study 3= Cross-Sectional Study 6= Other (*Specify*)
Setting		1= Remand 3= YOI Prison 2= Sentenced 4= Other (*Specify*)
Describe in full:		

Participants

1. Sample Size

Entire Study (N)	Males (N & %)	Females (N & %)

2. Age

Adolescent		0= Yes	1= No
Adult		0= Yes	1= No

3. Outcome

Effects of incarceration		1= Psychological effect 2= Emotional effect 3= Self harm/ Suicide 4= Maladjustment (self report) 5= Maladjustment (reported by others)
Period of measurement		1= 0-2 weeks 4= 3-6 months 2= 2-4 weeks 5= Over 6 months 3= 1-3months
Full description of effects		

APPENDIX H.
.
Measurement Tools used in Included Studies

Papers	Measurement Tools	Validated and Standardized
Female adjustment to incarceration as influenced by sexual assault history Islam-Zwart, & Vik 2004	*Prison Adjustment Questionnaire* (PAQ; Wright, 1985) *Clinical and demographic interview* (Developed for this study)	Validated and Standardized Validated but not standardised
Short-term psychological adjustment of female prison inmates on a minimum security unit Islam-Zwart, Vik & Rawlins 2007	*Brief Symptom Inventory*. (BSI; Derogatis, 1993) *Demographic Interview* (Islam-Zwart, Vik & Rawlins, 2004)	Validated and Standardized Not Validated or Standardized
The predictive validity of a gender-responsiveness needs assessment an exploratory study Salisbury et al. (2008)	*Level of Service Inventory-Revised*. (LSI-R; Andrews & Bonta, 1995) *Mental Health Questionnaire*. Developed for this study *Relationship scale*. Developed for this study (Influenced but not identical to the Spann-Fischer Co-dependency Scale Fischer, Spann, and Crawford; 1991) *Parental stress*. Developed for this study. (Modifications were made to a 20-item Likert-type scale developed by Avison, Turner & Noh, 1986). *Adult Victimization and Child Abuse scales*. Developed for this study. *Rosenberg Self-Esteem scale*. (Rosenberg, 1979).	Validated and standardized Validated but not standardised Validated but not standardised Validated but not standardised Validated but not standardised Validated but not standardised

	Sherer Self-Efficacy scale. (Sherer et al., 1982)	Validated and Standardized
Reactions of male and female inmates to prison confinement: further evidence for a two component model Paulus & Dzindolet (1993)	A questionnaire was devised for this study in order to assess a variety of factors including prison evaluation, depression, coping and anger et cetera.	Not Validated or Standardised
Exploring prison adjustment among female inmates. Issues of measurement and prediction Warren et al. (2004)	*Prison Adjustment Questionnai*re (PAQ; Wright, 1985) *Prison Violence Inventory* (Monahan et al., 2001). *Brief Symptom Inventory*. (BSI; Derogatis, 1993) *Structured Clinical Interview for DSM-IV Personality Disorders Screening Questionnaire (*SCID-II Screen*;* American Psychiatric Association, 1994).	Validated and Standardized Validated and Standardized Validated and Standardized Validated and Standardized
Baseline psychopathology of a woman's prison its impact on institutional adjustment and risk of violence Warren 2003	*Brief Symptom Inventory (*BSI; Derogatis, 1993) *Prison Adjustment Questionnai*re (PAQ; Wright, 1985) *Barratt Impulsivity Scale* (BIS; Barratt & Patton, 1991) *Violence and Aggression During Incarceration Questionnaire* *Victimization During Childhood and Before Incarceration Questionnaire* *Parenting Stress and Attachment Questionnaire* *Structured Clinical Interview for DSM-IV Personality Disorders Screening Questionnaire (*SCID-II Screen*;* American Psychiatric Association, 1994)	Validated and Standardized Validated and Standardized Validated and Standardized Validated but not standardised Validated but not standardised Validated but not standardised Validated and Standardized
Psychological well-being of incarcerated women in the	*The Impact of Event Scale* (IES; Horowitz et al., 1979)	Validated and Standardized

Netherlands importation or deprivation Slotboom et al. (2011)	*International Study on Women's Imprisonment* (ISWI; Dünkel et al., 2005)	Validated but not standardised
Reconceptualizing prison adjustment: A multidimensional approach exploring female offenders adjustment Van Tongeren & Klebe (2009)	*Prison Adjustment Questionnai*re (PAQ; Wright, 1985)	Validated and Standardized
	*Societal Adjustment Scale (*SAS; Van Tongeren & Klebe, 2009)	Not validated or standardised
	Criminal Thinking Scale (CTS; Walters, 1995)	Validated and Standardized
	Locus of Control. (LOC; Rotter, 1966)	Validated and Standardized
	*Self-Esteem Scale. (*SES; Rosenberg, 1965)	Validated and Standardized
	Spiritual Well-Being Scale (SWBS; Ellison, 1983)	Validated and Standardized
	The Santa Clara Strength of Religious Faith Questionnaire (SCSRFQ; Lewis, Shevlin, McGucklin, & Navratil, 2001)	Validated and Standardized
	Motivation to change. The University of Rhode Island Change Assessment (URICA; McConnaughy, Prochaska, & Velicer, 1983)	Validated and Standardized
Adjustment patterns in incarcerated women: An analysis of differences based on sentence length Thompson & Loper (2005)	*Brief Symptom Inventory (*BSI; Derogatis, 1993)	Validated and Standardized
	*Prison Adjustment Questionnai*re (PAQ; Wright, 1985)	Validated and Standardized
The relationship between female inmates coping and adjustment in a minimum security prison Negy, Woods & Carlson	*The Coping Scale* (COPE; Carver, Scheier & Weintraub, 1989)	Validated and Standardized
	State Trait Anxiety Inventory (STAI- Form Y; Speilberger et al., 1983)	Validated and Standardized
	Beck Depression Inventory (BDI; Beck & Beck 1972)	Validated and Standardized

(1997)	*Self-Esteem Scale.* (SES; Rosenberg, 1965)	Validated and Standardized
Long-term incarceration of female offenders prison adjustment and coping MacKenzie et al. (1989)	*Prison Preference Inventory* (PPI; Toch, 1977)	Validated and Standardized
	State Trait Anxiety Inventory (STAI; Speilberger, Gorsuch & Lushine, 1970)	Validated and Standardized
	Control of an Events Scale (Developed for this study. Based on the Control of Events Scale by MacKenzie & Goodstein, 1985)	Not Validated or Standardised
	Perceived Problems and Needs (Richards, 1978)	Validated and Standardized
The relationship of parenting stress to adjustment among mothers in prison Houck & Loper (2002)	*Parenting Stress Index* (PSI; Abidin, 1995)	Validated and Standardized
	The Parental Attachment Scale (Abidin, 1995)	Validated and Standardized
	Brief Symptom Inventory (BSI; Derogatis, 1993)	Validated and Standardized

APPENDIX I.

Copy of University Ethical Committee Approval Letter

APPENDIX J.

Copy of NHS REC Ethical Committee Approval Letter

APPENDIX K.

Participant Information Sheet

APPENDIX L.

Participant Consent Form

APPENDIX M.

Copy of Coping Styles Questionnaire-3

APPENDIX N.

Copy of General Health Questionnaire- 28

APPENDIX O.

Copy of Culture Free Self Esteem Questionnaire- 2

APPENDIX P.

Copy of Beck Depression Inventory- 2

APPENDIX Q.

Final fifty codes from the thematic analysis in table

Having to prove myself	Perceptions of staff	Being in Control	The point of intervention
Protecting others	Length of time attributed to a certain diagnosis	Interactions	Talking and sharing experiences
Motivations	Treatability	Length of time	Early experiences
Goals	Being labelled	Being flexible	Not wanting to upset other members of the group
Adjustment	Meaning of words	Teaching and learning	Trust
Caring for others	Perseverance	Relating to others	Sharing thoughts and feelings
Purpose/ rationale	Negative associations about self	Feeling safe	Factors which make coping harder
Feeling trapped	Habits and routines	Influence of others	How much time to prepare
Ability to change	Expressing releasing emotions	Uses of self injury	
Feelings and thoughts about the physical environment	Understanding of mental health diagnosis and their origins	Hope	
Emotions associated with diagnosis	Ideas about what people need to be ok	Feelings and thoughts about self harm	
Assumptions about receiving diagnosis	People making judgements/ assumptions	Forms of coping	
Physical environment	Being well/ unwell	Choice	
Periods of life	Aspirations	Perception of ourselves by others	

APPENDIX R.

Example of detailed indexing of data. Including line numbering and free coding

Initial Free Coding	Transcript- KH, AW & DW
Emotions associated with diagnoses	32 4: horrible, it's like, oh you've got a personality disorder. It's like (...) it's like we are a 33 freak 34 1: it's not like being diagnosed with psychosis or bipolar because they are treatable, 35 there (.) they are a medication treated illness 36 4: It's like we are a freak 37 2:it depends what illness (.) cause like when I was diagnosed with my Aspergers 38 syndrome that was a very different feeling to when I was diagnosed with anorexia 39 nervosa.
Treatability	40 F: Let's think about the two feelings you have had and your diagnoses. Being diagnosed 41 with ASD, and you have had a diagnosis of anorexia nervosa. 42 F: What were your feelings? 43 2: ASD I was relieved 44 4: I can't tell you've got any sign of autism
Length of time associated with the diagnosis	45 2: thank you, erm, i was a bit scared of what the future held, because obviously this is 46 (something) I'm stuck with. If it was a mental health problem it probably get treated, 47 but Aspergers you're stuck with. 48 F: ok, is that something about this being lifelong? 49 2: yeah (2)
Emotions associated with diagnoses	50 2: erm but i was relieved to know what was wrong because I had always known there 51 was something 52 F: we talked about that a little last week didn't we? 53 4: yeah I was kinda relieved even though I got diagnosed with PD. I was kinda relieved

APPENDIX S.

Chart showing initial fifty codes under five main themes running through qualitative data

Importation Factors	Deprivation Factors	Interpersonal Aspects	Internal Adjustment	External Adjustment
Trust- Due to previous experiences with close others do they feel able to trust or is it difficult to build up the therapeutic relationship with them?	**Being labelled**- What is their diagnosis? Are they aware of what this means in clinical terms and what this means for them individually?	**Ideas about what people need to be ok**- Explore their belief system about what it means to be OK?	**Expressing/ releasing emotions**- Do they describe themselves as able to express or release emotions? How does this make them feel?	**Forms of coping**- Are the chosen ways of coping causing conflict or argument with others?
Hope- What does the individual hope for? Is it positive or negative?	**Length of time attributed to a certain diagnosis-** Is it lifelong?	**Negative associations about self-** do they hold negative associations about self? Stemming from own beliefs or others? What is their level of self esteem	**Feeling Trapped-** Are they feeling trapped by the environment or due to intangible feelings/ thoughts? Are they feeling trapped by their behaviours/ cycles?	**Sharing thoughts and feelings**- Do they communicate conflict with words or behaviour?
Goals/ Aspirations- Did the individual have any prior to incarceration?	**The point of intervention**- Was the individual left until requiring secure environment?	**Not wanting to upset others**-Are they cautious of others feelings above their own?	**Sharing thoughts and feelings**- Do they communicate distress with words or behaviour?	**Talking and sharing experiences**- Are they able to talk and share experiences even though it may cause conflict? Or be based on previous conflict?
The point of intervention- Was the individual expressing a need for support and how long for and in what way?	**Forms of coping**- Does the individual voice wanting to learnt alternative ways of coping or have they learnt alternative ways from others?	**Protecting others-** Do they feel the need to protect others? Or do they seem to want protection?	**Talking and sharing experiences**- Are they given a forum in which they can talk about their distress? Has this previously been reprimanded?	
Early experiences- Childhood abuse, traumatic experience,	**Uses of self injury after admission**- has the goal of	**Caring for others**- What type of person are they? Are they	**Feelings and thoughts about self harm**- Do they utilise	

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bereavement, various residential settings?	their self injury changed since admission?	deemed to be a carer? (Schema Therapy)	self harm in order to manage internal distress?	
Forms of coping prior to admission- How did they cope with life prior to admission?	**Understanding of mental health and the origins-** Do staff and carers have a good understanding of the diagnosis and the factors associated with this?	**Influence of others-** Are they easily influenced by others?		
Uses of self injury prior to admission What were the goal/s of self injury prior to admission?	**Being in control-** What have they currently got control over? Could we increase this? (positive risk taking)	**Interactions with others-** Do they lead interactions? Do they avoid social interaction?		
Being in control- Was their life chaotic prior to admission or were they admitted from another secure environment?	**Teaching and learning-** What are we currently teaching the individual? What could they be learning from other patients/ staff?	**Having to prove myself-** Do they feel as though they have to prove themselves? Are they trying to achieve a certain level/ goal?		
Habits and Routines- What was their routine before admission. Any habits/ hobbies?	**Feelings and thoughts about self harm-** Explore what they are after admission?	**Teaching and learning-** What are their views on being taught? Do they feel they have nothing left to learn?		
Ability to change-Did they think they had the ability to change prior to being admitted with or without intervention?	**Feelings and thoughts about the physical environment-** How does this make that individual feel? What are their initial thoughts on the environment or setting? Is it necessary?	**People making judgements/ assumptions-** Do they think people have made judgements or assumptions before? Have they got any assumptions or judgements which they hold about themselves or others?		
How much time to prepare- How much time did they have to prepare prior to	**Choice-** How many choices do they have? Can we increase this through	**Relating to others-** Do they relate to the other individuals in the		

admission or relocation?	positive risk management?	environment? Are they given a forum in which they can attempt to relate to others?		
Feelings and thoughts about self harm-Explore what they were prior to admission	**Being flexible-**In what ways are we being consistently flexible in response to risk, need and responsivity?	**Perceptions of others**-What are their perceptions of the staff? Do they hold judgements/ assumptions?		
Physical environment- What type of environment did the individual come from? More restrictive/ less restrictive?	**Purpose/ rationale-** What is the purpose or rationale for bringing them in to this setting? Do they understand the rationale?	**Perception by others-** How do they think people see them? Is there a large area of dissonance or is it fairly accurate?		
Feeling safe- Did you feel safe prior to admission? Did you have a safe space? What made you feel safe?	**Feeling safe-** Is there anything about the environment that makes you feel safe? Have you got a safe space here?	**Feeling safe-** Do they feel safe around others? Is there anytime they don't feel safe? What things do they feel important when trying to feel safe?		

Importation Factors: Factors and experiences prior to incarceration.

Deprivation Factors: Current experiences of hospital environment which shift in response to the individual.

Social Factors: View/ beliefs of self world and others.

Internal Adjustment: Distress caused by or causing things like poor emotion management, poor sleep, discomfort around others etc.

External Adjustment: Conflict which includes fights and arguments with others.

APPENDIX T.

An example of charting

Codes	Extract	Experiential claims
Being labelled	**Focus Group 1 Page 1** Don't like the word "mental". Would rather use not well. 1 **Focus Group 1 Page 3** Differentiated between current and previous diagnoses. **Focus Group 1 Page 3** "Don't like term personality disorder, it feels defective" 1 **Focus Group 2 Lines 3-15** *I said he is a mental health doctor not an eating disorder doctor so he can't say things like that to me. I said () If I () someone who is from the eating disorder service tell's me that I might have a little bit more leeway for them, but at the* moment I *haven't been diagnosed with one so I haven't got one.* **Focus Group 1 Lines 45-50** *thank you, erm, i was a bit scared of what the future held, because obviously this is something) I'm stuck with. If it was a mental health problem it probably get treated, but Aspergers you're stuck with. ok, is that something about this being lifelong? Yeah, erm but I was relieved to know what was wrong because I had always known there was something*	If given a label want it to be by someone qualified in that particular area. Relief to get confirmation and a diagnosis which explains things which have not felt ''right' or normal in the social/ cultural context in which they are found Differences between opinions
Emotions associated with diagnoses	**Focus Group 1 Page 3** "Don't like term personality disorder, it feels defective" 1 **Focus Group 1 Page 3** When explaining her full diagnosis. 1 stated she felt embarrassed of the term EUPD with characteristics of MPD.	Only negative emotions were reported when a diagnosis of PD was

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		given.
	Focus Group 2 Lines 16-17 *Today say you're not diagnosed with something and tomorrow you get a report saying you have been diagnoses you with something how does that feel? Shit, weird*	Relief reported with ASD diagnosis as it aided understanding of concerns
	Focus Group 2 Lines 31-33 *Ok, what does it feel like to be labelled? Horrible, it's like, oh you've got a personality disorder. It's like (0.5) it's like we are a freak.*	
	Focus Group 2 Lines 37-43 *It depends what illness (.) cause like when I was diagnosed with my Aspergers syndrome that was a very different feeling to when I was diagnosed with anorexia nervosa. Let's think about the two feelings you have had and your diagnoses. Being diagnosed with ASD, and you have had a diagnosis of anorexia nervosa. What were your feelings? ASD I was relieved.*	
	Focus Group 2 Lines 50-51 *erm but I was relieved to know what was wrong because I had always known there was something.*	
	Focus Group 2 Lines 64-68 *These are all linking together aren't they. So we have got relieved in two columns. But K doesn't really like this. No I think when w(.) with PD as well (.) what were you feeling? Disbelief.*	
	Focus Group 2 Lines 70-79 *I haven't actually been diagnosed with a PD yet but they are assessing me for one. They are assessing you for a PD? Yeah, they have done an IP (.) DE?. [yeah] whatever its bloody called, erm, n(.) I am very (0.5) negative about it. I don't want (the) label of PD. Why? What's wrong with having a PD diagnosis? What's right with it? I just don't like (trails off)*	
	Focus Group 2 Lines 88-91 *Both. Anorexia and bulimia nervosa? I switch between the two. Feelings around this, when you first saw that?*	

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	Denial. Both denial	
Meaning of words	**Focus Group 1 Page 3** "Don't like term personality disorder, it feels defective" 1 **Focus Group 2 Lines 19-30** *We have just gone back to what we were talking about. K said that she didn't like the eating disorder term that was used in her report. Or personality disorder I don't like disorder. No. it's that word. I think it (0.5) its saying something (1) something is wrong, not work(...). (wrong). And you can't help when something not () not (...). Makes you feel guilty and that doesn't it. Yeah. So it makes you feel guilty. Yeah, thinking you have done something wrong 'cause you get labelled.* **Focus Group 2 Lines 80-81** *I*t's like saying you're wrong as a person and that you have a bad personality and (...)	The word used for some mental health issues have negative connotations. There is also media stigma and lack of understanding around the meanings of the diagnoses.

APPENDIX U.

Qualitative Evaluation Checklist (Patton (2003)

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QUALITATIVE EVALUATION CHECKLIST **Michael Quinn Patton** **September 2003**	

The purposes of this checklist are to guide evaluators in determining when qualitative methods are
appropriate for an evaluative inquiry and factors to consider

(1) to select qualitative approaches that are particularly appropriate for a given evaluation's expected uses and answer the evaluation's questions,

(2) to collect high quality and credible qualitative evaluation data, and

(3) to analyze and report qualitative evaluation findings.

1	**Determine the extent to which qualitative methods are appropriate given the evaluation's purposes and intended uses.**
2	**Determine which general strategic themes of qualitative inquiry will guide the evaluation. Determine qualitative design strategies, data collection options, and analysis approaches based on the evaluation's purpose.**
3	**Determine which qualitative evaluation applications are especially appropriate given the evaluation's purpose and priorities.**
4	**Make major design decisions so that the design answers important evaluation questions for intended users. Consider design options and choose those most appropriate for the evaluation's purposes.**
5	**Where fieldwork is part of the evaluation, determine how to approach the fieldwork.**
6	**Where open-ended interviewing is part of the evaluation, determine how to approach the interviews.**
7	**Design the evaluation with careful attention to ethical issues.**
8	**Anticipate analysis—design the evaluation data collection to facilitate analysis.**
9	**Analyze the data so that the qualitative findings are clear, credible, and address the relevant and priority evaluation questions and issues.**
10	**Focus the qualitative evaluation report.**

APPENDIX V.

Overview of three specific themes explores under the umbrella of communication with correlating codes

Individual	Environment	Others
• **Ideas about what people need to be ok-** Explore their belief system about what it means to be OK? Well and unwell? • **Negative associations about self-** do they hold negative associations about self? Stemming from own beliefs or others? • **Having to prove myself-** Do they feel as though they have to prove themselves? Are they trying to achieve a certain level/ goal?	• **Teaching and learning-** What are their views on being taught? Do they feel they have nothing left to learn? • **Feeling safe-** Do they feel safe around others? Is there anytime they don't feel safe? What things do they feel important when trying to feel safe in regards to social aspects?	• **Caring/ protecting others-** What type of person are they? Are they deemed to be a carer? Do they worry about upsetting others? Do they feel the need to protect others? Or do they seem to want protection? • **Influence of others-** Are they easily influenced by others? • **Interactions with others-** Do they lead interactions? Do they avoid social interaction? • **Relating to others-** Do they relate to the other individuals in the environment? Are they given a forum in which they can attempt to relate to others? • **Perceptions of others-**What are their perceptions of the staff? Do they hold judgements/ assumptions? • **Perception by others-** How do they think people see them? Is there a large area of dissonance or is it fairly accurate? • **People making judgements/ assumptions-** Do they think people have made judgements or assumptions before? Have they got any assumptions or judgements which they hold about themselves or others?

APPENDIX W.

Cope of ESSEN CES psychometric

APPENDIX X.

Semi structured focus group topics and prompts

Patient Focus Group

1) Prior to ward relocation when were you informed of the move?

2) Do you think this was long enough?   Why?

3) How did you feel before moving wards?

4) Can you remember what your thoughts were prior to moving wards?

5) On the day of the ward move did you feel informed and supported during the move?

6) What were your initial thoughts about the new ward?

7) Now you have been here for some time what are your thoughts about the new ward?

8) Is there anything you would change about the ward? What?

Staff Focus Group

1) Prior to ward relocation when were you informed of the move?

2) Did you feel informed about the ward move prior to the day of the move?

3) If you were on shift on the day of the move how do you think it went?

4) What were your initial impressions of the new ward?

5) Would you change anything about the new ward? What?

6) Is there any differences in how you feel about this ward to the previous one?

7) Have you any thoughts about the new ward and the direction it is moving?

APPENDIX Y.

An example of the intervention plan for women's MSU ward following Essen CES assessment of ward climate.

Problem	Action
Threatening situations can occur on the ward	• **Violence and aggression is monitored by use of IR1 forms.** • **Patient and staff debriefs are given after incidents on a 1:1 basis.** • **Patients are taken away from the area of the incident, and either go to their rooms or engage in activities in another room with staff.** • **Daily reflective meeting is held to voice issues and concerns.**
There are some really aggressive patients on the ward	• **Violence and aggression to be monitored** • **Aggression is managed by taught techniques** • **Individual care plans are in place for each individual patient to reduce violence and aggression.** • **Regular staff members are used on the ward wherever possible.** • **Patient behaviour is recorded on the electronic recording system and taken to the weekly MDT.** • **Patients participate in anger management groups and PSST Training.**
Some patients are afraid of other patients	• **1:1 offered on a daily basis.** • **Day area and general observations.** • **Staff and patients are respectful and take others into consideration.** • **Loud and boisterous behaviour is kept to a minimum** • **A suggestion box will be displayed on the ward for patients and staff to voice concerns. These will be discussed in patient experience meetings and reflection group.**
At times members of staff are afraid of some patients	• **1:1 support is given to staff and monthly planned supervision will be utilised** • **Staff work as a supportive team to reduce risk.**
Some patients are so excitable that one deals very cautiously with them.	• **Individual care plans are in place to deal with behaviour.** • **Staff work as a team to de-escalate situations.** • **Staff support will be given to reduce any aggression or violence.** • **Patient behaviour is recorded on the electronic recording system and taken to the weekly MDT.**

APPENDIX Z.

Factors identified to inform future directions

Patients	Factor	Explanation
Client 3, Client 2 and Client 1	Buddy system or allocated person.	Some participants felt this would be of benefit especially during the adjustment phase. Client 1 felt it would be more helpful to have a fellow patient as a buddy as they are in same situation and also the new patient may feel they are more able to ask questions to another patient instead of a staff member who might go and write everything down in the clinical notes. Also it gives an opportunity to have rules and guidelines explained. Client 1 had previously acted as a buddy as said she sat and spoke to the new admission and helped to introduce them to the ward. [Client 1, Session Notes pg 2, Week 6]
Client 3, Client 2 and Client 5	Emergency visits and phone calls	Able to have a visit and/or phone calls within the initial period of adjustment. Especially if the woman had children or had been placed out of home area. Client 3 stated that family and friends are *"very important when in hospital"* [Client 3, Session Notes pg 1, Week 6]
Client 3, Client 4 and Client 1	Leave	The importance of leave was highlighted even if the woman does not have local escorted or unescorted. Something in a group may be beneficial for a woman. As Client 3 stated you can begin to feel like a caged animal if you never go outside the hospital it is hard and will help the woman feel less like she is *"trapped"*. Client 3 further stated that *"things like this can change people"* [Client 3, Session Notes pg 5, Week 6]
Client 3, Client 2 and Client 1	Welcome Pack	Most participants indicated the benefits of a welcome pack for new admissions. They thought the welcome pack could be written by patients for patients and would help to relay important things about the ward such as the ward routine, ward rules and procedures for example pat down search which was reported to be a distressing situation for most of the patients as they were unfamiliar to this prior to admission. Client 1 stated that *"they didn't explain to me before doing it, I felt violate but I didn't resist because I was ill"* [Client 1 Session Notes pg 1, Week 6]
Client 2, Client 4 and Client 1	Less punitive, reactive measures after incidents of self harm.	Most participants stated that they felt punished after an incidence of self harm. This led to feeling guilty and not feeling able to talk to staff about urges to self harm. Client 2 stated *"when you tell them you get a negative response like no leave and increase in obs"* [Client 2, Flip Chart pg 16, Week 3]. So being truthful about it felt like it was punished however she also knew it was necessary to take the risk items but she felt there might be a more open way to do it. She further stated that it was important to sit with someone to discuss what had triggered the incident *"because there is always an underlying reason"* [Client 2 Session Notes pg 4, Week 6]
Client 3 and Client 5	Maintain skills	Some of the participants spoke of feeling as though they were becoming deskilled in the environment as they were not able to do their own cooking and depending on risk
Client 1 and Client 2	Visit unit before admission	Some participants spoke about how seeing the new ward and environment prior to admission would have helped. Although they both acknowledged this cannot always be the case a meeting on admission between old care team and new care team in order to discuss and complete a thorough hand over was important yet rarely happened in practice. Client 1 stated that *"it is very hard to leave old staff who you had built relationships with, instead I was brought straight on to the ward and I was very scared"* [Client 1, Session Notes pg1, Week 6]

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