An investigation into the feasibility of psychological interventions for managing the symptoms of trauma and insomnia for women in prison

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On a final note, the thesis is dedicated to the women of HMP who took part in the research project. I hope as promised your story has been told.
Abbreviations

ADHD - Attention Deficit Hyperactivity Disorder
ANS - Autonomic Nervous System
AP – Assistant Psychologist
APA - American Psychiatric Association
BDNF - Brain-Derived Neurotrophic Factor
CAPS - Clinician-Administered PTSD Scale
CBT - Cognitive Behavioural Therapy
CMHT – Community Mental Health Team
CMMI - Cognitive Model of the Maintenance of Insomnia
DSM - The Diagnostic and Statistical Manual of Mental Disorders
EAT - Exercise as Therapy
EMDR - Eye Movement Desensitization and Reprocessing
FFG – Facilitator Focus Group
F-SET - False Safety Behaviour Elimination Therapy
GHQ-28 - General Health Questionnaire-28
GP - General Practitioner
GFG – Generic Focus Group
HCA - Health Care Assistant
HMP - Her Majesty's Prison
IAM - An Introduction to Anxiety Management
IAPT - Increasing Access to Psychological Therapies
IES - Impact of Event Scale
IL - Infalimbic Region
ISI - Insomnia Severity Index
ITM - An Introduction to Mindfulness
IYS - Improving your Sleep
MBCT - Mindfulness Based Cognitive Therapy
MDT - A Multi-Disciplinary Team Meeting
MHT – Mental Health Trust
MOFC - Medial Orbitofrontal Cortex
NETSCC - National Institute for Health Research Evaluation, Trials and Studies
NHS - National Health Service
NOMS - National Offender Management Service
NTS - Nucleus Tractus Solitaries
OFC - Orbitofrontal Cortex
P- Page
Q- Quote
PSS-SR - Post-Traumatic Symptom Scale-Self Rated
PTSD - Post-Traumatic Stress Disorder
RACC - Rostral Anterior Cingulate Cortex
RCT - Randomized Control Trial
ROTL – Release on Temporary License
RMN - Registered Mental Health Nurse
RWR – Real World Research
SCOPE - Suicide Concerns for Offenders in Prison Environment
SMT - Stress Management Techniques
SNS - Sympathetic Nervous System
STFH - Specialist Trauma-Focused Hospital
TSP - Thinking Skills Program
US - United States
VO2 - Volume of Oxygen
VMPFC - Ventromedial Prefrontal Cortex
WT – Women’s Therapy
Prelude

The material in this thesis is the authors with the exception of third party material where appropriate permissions have been obtained and attributed. The author’s thesis forms a component part of the Professional Doctorate in Health Psychology and the data extraction was undertaken in a female prison, which will remain anonymous throughout the thesis and herein be known as HMP (Her Majesty’s Prison). The prison holds around 400 women that come from certain catchment areas of England and Wales. During the development of the thesis, the author worked as an assistant psychologist (AP) for the prison’s Community Mental Health Team (CMHT) that is ran by a NHS Mental Health Trust (MHT). The trust in this thesis will remain anonymous and herein known as MHT. The CMHT operates a seven-day a week service, 09:00 to 17:00hrs and provides a consultant psychiatrist, a clinical psychologist, an AP, mental health nurses and healthcare assistants (HCA’s). The author assisted the CMHT to develop the psychological group interventions, which were formulated to assist the women who access the service, who substantially present with symptoms of trauma and insomnia. The psychological groups under review in this study take place in the prison’s therapeutic setting, which for anonymity will be called ‘Women’s Therapy’.
Abstract

Background
Female prison populations, when compared to a general population, appear to contain higher prevalence’s of trauma histories with the majority of women in prison having experienced sexual or physical violence in childhood or during their adult lives (Moloney and Moller, 2009). Resultantly, many women in prison exhibit psychological difficulties as a consequence of past victimization including conditions such as Post-Traumatic Stress Disorder, Borderline Personality Disorder, emotional dysregulation, depression, insomnia and also physical morbidity (Zlotnick, 1997).

Objective
The objective of this investigation at an HMP was to recognise the experiences and mental health of women who access psychological support in prison and to provide a preliminary understanding of the effectiveness of group psychological intervention to improve symptoms of trauma and insomnia.

Design
This HMP investigation was a cohort feasibility study, which utilized a mixed-method approach to enhance the understanding of the participant’s experiences of accessing psychological support in prison (Sandelowski, 2000). The 71 women invited to participate in the study were designated into one of four psychological group interventions through a process of purposive sequential sampling. The psychometric evaluations of the Post-Traumatic Stress Disorder Symptom Scale (PSS-SR), the General Health Questionnaire – 28 (GHQ-28) and the Insomnia Severity Index (ISI) were administered to measure symptoms of trauma and insomnia before the commencement of the respective psychological group interventions, and three weeks subsequent at the participant’s attendance in the matching intervention focus group.

Results
Descriptive statistics were used to interpret the clinical effectiveness of the 4 group interventions; and at the 3-week follow-up points the group mean percentage outcomes indicated the ‘exercise as therapy’ (PSS-SR, -16%; GHQ-28, -14%; ISI, -12%) and the ‘improving your sleep’ (PSS-SR, -12%; GHQ-28, -12%; ISI, -36%) groups to be more effective at treating the patients symptoms of trauma and sleep than the ‘introduction to anxiety management’ (PSS-SR, -11%; GHQ-28, +8%; ISI, +4%) and the ‘introduction to mindfulness’ (PSS-SR, +1%; GHQ-28, +3%; ISI, +21%)
interventions. The quantitative approach also provided information about group intervention non-participation and this illustrated that 30% of women were released or transferred prior to their clinical appointment. Whereas, the qualitative findings from undertaking thematic analysis of the focus groups discourse provided the emergence of six themes that helped to explain the women’s experiences of accessing psychological treatment in prison. These themes were, ‘a pathway to care’, ‘stigma as a therapeutic barrier’, ‘the patient or prisoner paradox’, ‘the retraumatising nature of prison’, ‘the significance of sleep’ and ‘women as stakeholders’.

**Conclusion**

The findings of the HMP investigation indicate that prison is an unhelpful environment for women who have trauma histories, as prison can be a factor for the continuation or exacerbation of trauma symptoms and insomnia, even when the women have access to group psychological support. The HMP investigation recommends a series of interim interventions to address the prison culture unhelpful to the psychological wellbeing of detained women. The study’s ultimate recommendation proposes the transformation of HMP into a specialised trauma focused hospital to manage women detained within the criminal justice system who exhibit symptoms of trauma and insomnia.
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Chapter 1: Introduction and Thesis Overview

1. Introduction
The intent of the introduction section is to provide the reader with a succinct account to the subject matter of psychological trauma. The section provides a narrative explaining the recognition of psychological trauma as a psychiatric condition and a phenomenological perspective of psychological trauma to deliver an understanding into the impact situational experience can have for an individual’s psychological and emotional wellbeing. A discussion about the epidemiology of psychological trauma leads to theory that sets out to explain the biomechanics behind the condition and the implications trauma has for mental and physical health. The introduction section next discusses the necessity for prisons to provide an equality in care to match the care offered to people in the outside community and closes with the aims of the study.

1.1. An introduction to psychological trauma
1.1.1. A brief history of trauma
The original meaning of the word trauma taken from Greek denotes an injury to the body, although from the 1860’s through the occurrences of war and industrialization the meaning expanded to incorporate trauma as a ‘psychological rupture’ (Bourke, 2012). Perhaps, not until the work of Freud was the relationship between neurotic disorders of hysteria connected to situational experience (Lewis, 2012). This led to some psychoanalysts in the late 19th century attempting to treat psychological trauma articulated by Freud as “infantile sexual activity: repression, failure of repression and return of the depressed” (Freud, 1909a, p.233) with hypnosis in the hope of modifying upsetting traumatic memories. The interest in trauma from early psychoanalysts began to decline as the discipline of psychotherapy grew (Haaken, 1998); however, the major conflicts of the 20th century provided a renewed focus to psychological trauma that arose from the symptoms observed in soldiers involved in active duty (Courtois, 2004). World War I and World War II introduced labels like ‘shellshock’, ‘combat neuroses’, ‘war neuroses’ and ‘irritable heart’ to describe these conflict-related presentations (Seedat and Stein, 2001). Two decades later the Vietnam War of the 1960’s and 1970’s provided further interest in understanding the related symptoms of nightmares, flashbacks, emotional responses and somatic ailments seen in many of the returning veterans (Tseris, 2013). The American public’s attention to the veterans allowed feminist researchers like Anne Burgess to explicate a social
causation to the experience of trauma (Burgess and Holmstrom, 1974b). Burgess worked in a rape crisis centre and observed similarities in trauma symptomatology between the women subjected to sexual violence and the returning Vietnam veterans. Burgess argued that these women similarly interpreted their distressing incident(s) as life threatening and many of the women appeared to hold a belief that they too had evaded death (Burgess and Holmstrom, 1974b). Burgess labelled the symptoms observed in these women as a Rape Trauma Syndrome and described how sexual violence is comparable to other types of assault when the incident encompasses “power, control, anger and aggression” (Burgess, Watson and Holmstrom et al., 1988, p.38).

Ostensibly, as a consequence of the work of Burgess, the growing feminist movement, political and other social pressures associated to the returning Vietnam veterans there was an increasing demand to determine how events that are life threatening or extremely distressing could lead to the development of mental illness (Keane, 1993). Although, during this period the American Psychiatric Association (APA) early editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) did acknowledge the affects stressful stimuli can exhibit in the individual, the explanation of illness regarded the stressor as a “transient situation disturbance” (Yehuda and Bierer, 2009), which meant that the psychological symptoms should dissipate, unless a causal psychiatric condition was present and promoting the individual’s symptoms. In 1980 and in part to satisfy social pressures, the APA classified Posttraumatic Stress Disorder (PTSD) as an anxiety disorder for the first time in the DSM, 3rd Edition (DSM-III). The inclusion of PTSD in the DSM-III provided a significant step in directly correlating how events that are life threatening or extremely distressing could lead to the development of mental illness (Keane, 1993). The DSM-III was then more progressive than the previous DSM editions in defining trauma to be an occurrence “outside the range of usual human experience” (APA, 1980, P. 236). However, in 2013, the APA furthered the understanding of PTSD in the release of the DSM-V, which now classifies the disorder as being subjected to an actual or threatened death, severe injury, or sexual violence in one or more of four ways: (a) directly experiencing the event; (b) witnessing in person the event occurring to others; (c) learning that such an event happened to a close family member or friend; and (d) experiencing repeated or extreme exposure to aversive details of such events, like people who are first responders.

The DSM-V also defines the PTSD subtype of hyperarousal, which can essentially be
understood as an elevated form of physiological arousal (Weston, 2014) and includes symptoms of irritability, difficulties concentrating, hypervigilance and an exaggerated startle response (Friedman, Resick, and Bryant et al., 2011). Researchers have estimated that 70% of people with a PTSD diagnosis will experience hyperarousal and 30% of them dissociation, numbing, and physiological unresponsiveness (Lanius, Hopper and Menon, 2003; Laniun, Bluhm and Lanius, 2006; and Lanius, Vermetten and Loewenstein et al., 2010). It is believed that hyperarousal within PTSD becomes dysfunctional since the individual experiencing symptoms may find that there is an automatic and unwanted severe triggering of the hyperarousal subtypes to innocuous reminders (Weston, 2014). Weston (2014) argues that many of the symptoms of PTSD are related to hyperarousal-based responses that occurred during the time of the trauma. The brain mechanisms, which cause and maintain PTSD based hyperarousal, are delivered through the amygdala, which can be reactivated to produce hyperarousal symptoms when the individual comes across trauma-associated stimuli. This perspective appears to integrate with grounded cognition and proposes how recalling an unsettling past event can trigger reactions in diverse regions of the brain like the ‘brainstem, hippocampal function, the visual cortex, rostral anterior cingulate cortex (rACC) and the medial orbitofrontal cortex (mOFC)’ (Weston, 2014) that were also stimulated during the instigating traumatic event (Barsalou, 2008a, 2008b; and Weston, 2014).

Similarly, to Weston’s (2014) explanation to the aetiology and neurocircuitry of hyperarousal, fear extinction research argues that individuals with PTSD experience hyperactivity to the amygdala (Nutt and Malizia, 2004) and reduced hippocampal volume (Smith, 2005). It is proposed that the brain structures involved in the maintenance of PTSD are identical with the structures associated to the extinction of a conditioned fear (Powers, Medina, Burns et al., 2015). When an individual experiences PTSD or a fear there is a suppression to the inhibitory neurons located in the intercalated region of the amygdala, which is usually influenced from the ventromedial prefrontal cortex (vmPFC; Powers, et al., 2015). Quirk, Russo and Barron et al. (2000) demonstrate this theory in their research that examined the effect of lesions inflicted to the Infralimbic region (IL) and the vmPFC in the brains of rodents, which caused an impairment in the rodent’s brains to disconnect conditioned fears, and the IL in humans as in most animals helps facilitate the extinction of fear (LaBar, Gatenby, Gore, LeDoux and Phelps, 1998). The hippocampus plays an important role in the theory of fear extinction through having a gated function to the extinction of habituated stimuli, which prevents the fear being applied to various milieus (Ji and
Maren, 2005). In the hippocampal region of the brain in people who experience trauma related disorders there is a reduced level of Brain-derived neurotrophic factor (BDNF) than seen in healthy controls, which is essential for synaptic plasticity, necessary for experiencing healthy cognitions like learning, memory consolidation and the extinction of fears (Powers et al., 2015). Therefore, a reduction of BDNF inhibits an individual learning that a fear instigating stimuli out of the context of its instigation no longer requires the same physiological response, which can in part explain why people with PTSD experience hyperarousal (Powers, et al., 2015).

1.1.2. A Cognitive model of post-traumatic stress disorder

Ehlers and Clark’s (2000) cognitive model of PTSD (figure 1) can help explain why some people naturally recover from trauma and others appear to experience enduring symptoms that can last decades. The model explains that the maintenance of trauma symptoms could be from the interplay of how an individual appraises memories of the traumatic event with their appraisal of current threats. People who maintain PTSD symptoms might interpret their external world or their internal world as more threatening than is necessarily realistic. For example, a driver who was involved in a fatal car accident may now perceive the roads (external world) to be hazardous environments and hold a belief that “the roads these days are too dangerous to drive on”. This belief may connote ideas about the individual's ability to drive a car safely with thoughts like “I'll cause another accident and someone else will die”. Therefore, the driver is overestimating the external risk associated with their behaviour (driving) and minimizing their ability (reaching a destination safely) to achieve a realistic goal. The individual’s appraisal of their external environment may be further exacerbated through an assessment of their internal environment, which can also maintain and aggravate symptoms of trauma. The driver may misinterpret internal symptoms like flashbacks, irritability, emotional instability, poor concentration or emotional numbing as permanent psychological injuries or as threats to their health that may impair their ability to achieve everyday life events (Ehlers and Clark, 2000). Furthermore, people with persistent PTSD can undertake maladaptive coping strategies known as safety behaviours to control threats, which minimize the reminders of their trauma and its psychological or physiological discomfort (Salkovskis, 1996). However, although safety behaviours can increase the individual's feelings of safety they can prevent disconfirmation to the feared outcome, which preserves the individual's responsiveness to react to the perceived threats. For example, after being subjected to a violent attack, the victim may now find comfort by avoiding areas interpreted as dangerous or for added protection, they may only venture outdoors with a chaperon.
Thus, if the PTSD individual believes the reduction of threat is only achievable through such precautions they can maintain the anxiety associated with the external environment because the behaviour eliminates an ability to correctly appraise situational risk (Salkovskis, 1996).

Figure 1 - A cognitive model of PTSD (Ehlers and Clark, 2000)

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1.1.3. The phenomenology of trauma

Alongside the importance to continue to develop a medical classification and empirical understanding of trauma, there is a need to ensure that the phenomenology of trauma receives recognition within the professions of research, medicine and psychology. The phenomenology of trauma has been described as an unusual experience that is based on the individuals own “particularized world of experience” (Larrabee, 1995). The strength and meaning that individuals attach to such unusual events are based on their own internalized world perspective of experience, which in turn influences the perceptivity of emotional reaction (Behnke, 2008). The work of Gusich (2012) helps to provide further understanding of the phenomenology of traumatic experience and how the unexpected death of a loved one or being the victim of serious violence are likely to be traumatic for most; while say the loss of a job or the realization of a partner’s infidelity may pronounce differences in the degree of emotional reactivity. Gusich (2012) argues that for trauma to occur the initial interpretation of an unusual event causes a disbelief, whereby the individual’s appraisal is counterintuitive to their everyday perception of the world. The incident can leave the individual struggling to make sense of this new reality, one where they are aware of what is happening or has happened but one that leaves them struggling to comprehend how to interrelate the two separate narratives of belief and disbelief.
The trauma then affects the memory so that there is no lineal experience of time and the ‘past, present and future all seem to be painted in the same shade’ (Gusich, 2012). The memories of the unusual event can thus intermittently intertwine their way into the individual’s life without desire or warning, as detailed in the work of Price, MacDonald and Adair (2014) who examined the phenomenology of trauma in Vietnam Veterans. Price et al. (2014) argue that the relationship between trauma and memory can explain why those who are subjected to significantly unusual events like those who narrowly evaded death during the Vietnam conflict have expressed becoming overwhelmed with terrifying memories from the conflict intruding into their everyday lives. Veterans have reported hearing loud explosions when there has been no explosion and experiencing severe physiological responses that see them seeking shelter when no danger exists. The effects of trauma left many of the Veteran’s with a fearful perception toward their everyday life and this influenced their beliefs about themselves, others and their world. Price’s et al. (2014) analysis of the Veterans discourse also revealed a range of personal difficulties related to themes around safety, survival, trust and powerlessness. The veterans spoke about unwanted feelings of guilt, fear, regret, self-blame, low self-esteem, sadness and emotional numbing. These after effects of the trauma are said to have affected the quality of personal relationships with loved ones and the trauma is regarded as a contributory factor to the Veteran’s increased use of drugs and alcohol (Price, MacDonald and Adair, 2014).

“As far as safety I don’t care anymore, sometimes I wish it was over with."

“I have little trust in others as I feel that most people will get to know me and not like me and they will try to do something else bad to me.”

“Vietnam taught me that death is everywhere, instant and non-negotiable. Nam took away any chance of running away. In a very real sense I am much more vulnerable to attack now than before. Physically I cannot run, so psychically I cannot run either”

Traumatic events and the accompanying trauma symptomatology are not just confined to those who have experienced war. Qualitative research has examined the phenomenology of trauma in young women who have been subjected to sexual violence. In one qualitative study, San Diego (2011) interviewed adolescent women about their lived experience and worldview. San Diego (2014) divided the interview
data into the four trauma related themes of (1) ‘affect dysregulation’, (2) ‘cognitive and perceptual distortions’, (3) ‘sense of betrayal’ and (4) ‘self-degradation’. The first theme, ‘Affect dysregulation’ revealed how certain environments could remind the individual of the instigating trauma and induce an unwanted associated response of heightened vigilance and unpleasant feelings like fear, shock, emotional numbing and sadness. The women interviewed also experienced upsetting intrusive memories in the daytime, trauma related dreams at night-time, frequent suicidal ideations and a need to self-injure.

“I became more elusive, more sensitive. Most of the time, I would dream I am being raped whenever I sleep. I would always get shocked whenever I wake up, agitated, afraid, bothered in the dark, but before it was not like that.”

The theme ‘cognitive and perceptual distortions’ was said by San Diego (2011) to take into account the difficulties the women had concerning their mental processing following the trauma. The trauma caused some of the women to experience almost an ‘empty mind’ with no cognitive processing occurring, whereas other women talked about the difficulties with concentration and the frustration of having no control over the intrusive images that they are experiencing. The theme accounted for the challenges the participants had around trust, particularly when the victims knew the perpetrators of the trauma. This brought about feelings of fear, depression and a questioning to the incongruity of their associated thoughts, which led some of the participants to normalise or minimise the abuse and its personal implication.

“For me, what happened was not really a big deal, I can handle myself. If you are to ask me, I managed to forget what happened before, since those were not really important. I am okay now.”

The theme a ‘sense of betrayal’ was significantly related to the women’s perceptions towards the abusers in regards to an emotional and expressional context. For some of the women there remained concerns that if they were to continue to engage with the abusers in regular social activities that this would increase the likelihood for the abuse to happen again. The women like the Veterans also spoke about how the trauma has caused difficulties in relationships, reducing their ability to maintain relationships, especially sexual ones, which is perhaps brought about by feelings of ‘disgust’.
“He (perpetrator) is so evil, doing those things to me! I wish I will be the one to kill him because it feels like he killed me already, my entire being, I even treated him as a sibling, a brother who can defend me, but he is even the one who raped me!”

The fourth theme ‘Self-degradation’ details the self-loathing that the women experienced. San Diego (2011) argues that this internalization of self-blame and self-degradation observed in the victims of abuse could be an explanation for the severe traumatic response observed in many of these young women.

“I am so dirty! I feel so disgusted with myself! I can even compare myself to the prostitutes. I feel ashamed to others because my femininity is destroyed.”

“Others might even think that I am bad, share gossips about me. I am like a colourless picture because of the unfortunate event that happened to me.”

1.2. Trauma and female prison populations

In the United States (US), researchers have discussed the difficulties of carrying out studies examining the trauma histories of women who reside in prison due to an underreporting of traumatic experience (Browne, Miller and Maguin, 1999). Available literature appears to indicate that female prison populations when compared to a general population contain a higher prevalence of trauma history (Clements-Nolle, Wolden and Bargmam-Losche et al., 2009) and greater frequencies of PTSD (Moloney, van den Bergh and Moller, 2009). In a representative study carried out by Brown et al. (1999), involving 150 detained women the authors found that around 70% of participants had experienced severe physical violence from a parent and 59% of the women had endured childhood sexual violence. The majority of the women interviewed (75%) reported being subjected to violence from a sexual partner including being punched, kicked, bitten, objects being thrown at them, strangulation, being smothered, being threatened with an offensive weapon and marital rape. Furthermore, 77% of the interviewed participants revealed experiencing other sexual or physical violence excluding those incidences from childhood carers or intimate partners.

In England and Wales, the female prison population according to the Howard League for Penal Reform is estimated to be 3,866 (March, 2015). The majority of these women (81%) are detained for non-violent offences (Ministry of Justice, 2012); 15 % will be remand prisoners and the average length of stay for a detained woman is
between four to six weeks (Bradley, 2009). However, there is a dearth of research exploring the trauma histories of women in British prisons and of the available literature, the evidence appears to indicate similar trauma histories to women jailed in the US. In a British Home Office (1997) study involving 234 women prisoners, the research revealed about one-third of the women interviewed claimed to have been bullied in prison, one-third of the women disclosed being sexually abused as children and one-fifth of the women experienced abuse both as a child and as an adult. The high occurrences of childhood victimization and violence during adulthood can perhaps begin to indicate why women’s prisons contain elevated levels of mental and physical morbidity.

The high rates of mental health illness in female prison populations have been discussed in a systematic review carried out by Fazel and Danesh (2002). In the review, the authors analysed 5 studies involving 1208 female prisoners and discovered the condition of BPD to affect about 25% of women. However, the authors omitted any reference or discussion to studies that have examined the prevalence’s of PTSD with female prison populations. This omission contrasts the findings of a systematic literature review carried out by Goff, Rose, Rose and Purves (2007) who found PTSD rates in female prison populations in New Zealand surpassed that of the general population by a factor of 6, and in Australia the PTSD rates of women prisoners exceeded that of the general population by a factor of 10. Whereas, in the US it is estimated that 70% of women prisoners have PTSD, which is the second most prevalent condition after substance misuse, which itself has been related to the experience of childhood trauma (Teplin, Abram and McCeland, 1996). Furthermore, women in prison with PTSD are more likely to experience comorbidities than women in prison absent of PTSD, including conditions like major depression, emotional dysregulation and physical health difficulties (Zlotnick, 1997).

1.3. The relationship of trauma with health and sleep

The relationship of PTSD with some health difficulties could be explained from the effects that hyperarousal has on the sympathetic nervous system (SNS), which influences the functioning of the body’s immune system and thus increases an individual’s susceptibility to certain illnesses (Boscarino (2004). Studies that have specifically examined health conditions in women with a PTSD diagnosis reveal evidence of a greater frequency of medical complaints like arthritis, lower back pain, hypertension and weight gain, than women without a PTSD diagnosis (Bender, 2004). Studies examining PTSD comorbidities in men and women reveal higher rates of
certain health conditions than would be deemed expected, including difficulties with
the gastrointestinal system, the cardiopulmonary system, pain, fibromyalgia, chronic
fatigue syndrome, heart disease, asthma, angina and irritable bowel syndrome
(Green and Kimerling, 2004; Schnurr and Janowski, 1999 and Pacella, Hruska and
Delahanty, 2013). Other research highlights the relationship between PTSD and
somatic health conditions like dizziness, complaints of shortness in breath, nauseam,
constipation, lower backache, headaches and fatigue (Green and Kimerling, 2004; and
Pacella et al., 2013). However, several studies have shown that insomnia is the
predominant symptom of complaint for people who have experienced a traumatic
event (e.g. Kuch and Cox, 1992; and Kato, Asukai and Miyake et al., 1996). For
example, in a US study carried out by Ohayon and Shapiro (2000) of ‘an urban general
population’, the researchers found that around 70% of people with PTSD experience
a difficulty sleeping, with approximately 41% having poor sleep onset, 47% a trouble
maintaining sleep, and 43% of people waking too early.

The relationship between PTSD and sleep has been discussed in the work of Neylan,
Marmar and Metzler et al. (1998) in studying the sleep of Vietnam veterans. The
researchers discovered that 91% of the veterans diagnosed with PTSD had at times
a difficulty maintaining sleep, compared to 63% of the veterans absent of PTSD and
53% of civilians. Furthermore, research that was carried out by Zayfert and DeVivia
(2004) in examining sleep difficulties in people undertaking CBT for PTSD found that
at pre-treatment 88% of individuals were experiencing insomnia and 64% of these
people were categorized as experiencing severe insomnia. Understanding the
relationships between sleep and PTSD is important because people who have
difficulties sleeping are less likely to recover from initial traumatic symptomatic
responses than are people without sleep difficulties (Mellman and Hipolito, 2006;
Neylan et al., et al., 1998) and even when PTSD has been successfully treated
insomnia can remain a prevailing problem (Babson and Feldner, 2010). Insomnia, as
a standalone condition is a well researched field of clinical health and at present can
be understood from its classification in the DSM-V, which describes insomnia as a
difficulty initializing or maintaining sleep, or that sleep feels nonrestorative or non-
restful. The difficulty must be present in the individual for at least a three-month period;
otherwise, a period of 0-1 month is described as acute insomnia; and 1-3 months as
transitional/sub-acute insomnia. The individual experiencing insomnia must also
express a minimum of one item from a list of eight items that comprise a significant
impairment in daytime functioning; (i.e.) ‘fatigue, daytime sleepiness, cognitive
impairment, mood disturbance, behaviour changes, impaired occupational
functioning, impaired social functioning or experiencing a negative impact on family/caregiving functioning’ (APA, 2015; and Di Bonaventura, Richard, and Kumar et al., 2015).

Bonnet and Arrand (1997) in an article for the Sleep Medicine review explain how patients diagnosed with insomnia can experience a disorder of physiological hyperarousal, a process that has also been associated to PTSD based sleep disturbances. Germain, Buysse and Nofzinger (2008) propose that PTSD related insomnia occurs from hyperactivity to the amygdala, which stimulates the brainstem sub-regions that induce wakefulness, while also dissuading the stimulation of the brainstem sub-regions that promote and maintain sleep (Weston, 2014; and Germain et al., 2008). Similarly, Weston (2014) in the examination of PTSD-based hyperarousal details sleep and wake to be a process between the interlinks of the autonomic nervous system (ANS) of the midbrain reticular formation, the nucleus tractus solitaries (NTS), the anterior hypothalamus, the preoptic area, the nucleus basol of Meynert and the orbitofrontal cortex (OFC). When there are changes to these physiological regions, it can leave the individual who experiences insomnia with increased levels of emotional and physical arousal (Nofzinger, Buysse and Germain et al., 2004; Nofzinger et al., 2006, Weston, 2014). However, the scale of sleep difficulties to the experience of trauma has led some researchers to think away from a conceptualization of sleep as a secondary symptom of PTSD (Hefez, Metz and Lavie, 1987) to an understanding that sleep difficulties are its “hallmark” (Ross, Ball and Sullivan et al.,1989) and the principal component to the maintenance of the condition (Spoormaker and Montgomery, 2008). Nevertheless, the relationship between trauma and sleep has been the focus of much research (Luyester, Strollo and Patrick et al., 2012) the complexities in the relationship between PTSD and sleep are still insufficiently understood (Harvey, Jones and Schmidt, 2003).

1.3.1. The cognitive model to the maintenance of insomnia

In addition to an aetiological explanation of sleep and wake (e.g. Weston’s, 2014), Harvey (2002) has proposed (figure 2) a cognitive model of the maintenance of insomnia (CMMI) to help explain how difficulties sleeping are perpetuated through cognitive and behavioural relationships. Harvey (2002) believes ‘worry’ activates the sympathetic nervous system, this causes a process of arousal and distress, which is counterintuitive for sleep (Harvey, 2002; Corren, 1998; Borkovec, Ray and Stober, 1998, Tang and Nicole, 2004). When the individual enters a phase of arousal and distress, they can begin to undertake a process of ‘selective attention and monitoring’.
Harvey (2002) explains this stage as being in a state of heightened arousal, which sees the individual scan externally (their environment) and internally (bodily sensations) for sleep threats. As the monitoring for such perceived threats increases the more threats that are detected, which intensifies the individual’s anxiety and arousal levels (Clark, 1999). Harvey (2002) argues that the phenomenon of ‘misperception’ plays a significant role within the CMMI and typically for the insomniac they can overestimate the duration of sleep onset, the length or frequencies of awakenings and the perception that sleep quality was somehow inadequate (Harvey, 2002).

Figure 2 – A cognitive model to the maintenance of insomnia (Harvey, 2002)

The distortions about sleep can lead to additional worry, which further contributes to the individual’s distresses and eventually this can lead to an actual sleep deficit. ‘Unhelpful beliefs’ about sleep and ‘safety behaviours’ are the two final components of the model. The unhelpful beliefs that people with sleep difficulties experience and their associated safety behaviours are likely to exacerbate anxiety and increase problems sleeping (Morin, 1993 and Harvey, 2002). For example, someone with a sleep complaint may misattribute difficulties sleeping to drinking too much caffeine in the day. The associated safety behaviours to manage this difficulty may be the cessation of caffeinated beverages a few hours before bed. However, the use of safety behaviour’s only serves to reinforce false beliefs about the causes of sleep difficulties and prevents the individual from learning the associated belief is dysfunctional and thus maintains or elevates the anxiety that is disturbing sleep.

1.3.2. The relationship of sleep with physical and mental health

The importance of sleep to human health has been recognized as far back as Hippocrates (Aphorism, LXXI) who believed that “disease exists, if either sleep or watchfulness be excessive”. This theory has in more recent times received veracity from epidemiological studies that indicate a reduced morbidity when sleep length is between 7 to 8 hours (Luyster et al., 2012). This includes for example, a reduced susceptibility to cardiovascular disease and the associated risk of death (Buxton and Marcelli, 2010; Cappucio, Cooper and D’Elia et al., 2011), a reduced risk of obesity and type-2 diabetes (Van Cauter and Knutson, 2008). When sleep is disturbed, or when the duration of sleep is too long or too short it can increase the risk of morbidity, which can be evidenced from looking at studies examining the health of shift workers (Blask, 2009). Unsociable occupational hours increase the risk of developing myocardial infarction, atherosclerosis (Haut, Alte, Dorr et al., 2008) and ischemic heart disease (Frost, Kolstad, Bonde, 2009). Shift work has also been shown to increase the risk for developing malignancy to the colon, breasts and endometrial cancer (Luyster et al., 2012). One theory that explains the increased risk of cancer in shift workers is that this type of occupation reduces an individual’s exposure to natural light and this suppression can inhibit the development of nocturnal melatonin, which then encourages cancer cell development (Blask, 2009).

Furthermore, in a systematic review carried out by Cappuccion, Cooper, and D’Elia et al. (2011) the authors discuss how short sleep durations can increase the risk of coronary heart disease, stroke and cancer (Thompson, Larkin and Patel, et al., 2010) to the breast (Wu, Wang, Koh et al., 2008). In reviews of epidemiological evidence of sleep duration and cardiometabolic risk, sleeping less than 6 hours is related to an increased risk for type-2 diabetes and reduced glucose tolerance (Knutson, 2010); sleep lengths less than 5 hours were shown to increase the risk of obesity by a factor of 1.5 (Cappuccio, Taggart and Kandala et al., 2008). Studies (Marshall, Glozier and Grunstein, 2008) including a systematic review (Patel and Hu, 2008) that have examined the relationship between sleep duration and health appear to indicate a greater morbidity for sleep lengths longer than 8 hours. This includes an increased risk of obesity, stroke, hypertension and heart disease (Cappuccion et al., 2011; Haupt, Alte, Dorr et al., 2008; and Qureshi, Giles, and Croft et al., 1997).

In addition to the relationship between poor sleep quality and physical morbidity, research also indicates that difficulties sleeping can increase the risk of mental illness
(Ohayon, 1997). However, the relationship between mental health and poor sleep quality may in circumstances be reciprocal and psychiatric disorders potentially a precursor or maintenance factor for insomnia (Sateia, 2009). Research in this field appears to indicate that individuals who have a sleep length fewer than 7 hours or sleep exceeding 9 hours are at an increased risk of experiencing poor concentration, irritability, memory problems, psychological distress, anxiety (Glozier, Martiniuk and Patton et al., 2010), difficulties experiencing positive emotions (Woodson, 2006) and are more likely to develop depression (Ford and Kamerow, 1989). In the work of Perlis, Smith and Lyness (2006) who examined the risk of depression in older adults with no previous history of psychiatric morbidity the authors found insomnia to be a significant risk factor for the development of major depression. In a British population study, Morphy, Dunn and Lewis et al. (2007) found insomnia to increase the likelihood for developing depression or anxiety. However, Neckelmann, Mykletun, and Dahl (2007) in an 11-year longitudinal Norwegian study concluded that insomnia did not increase the likelihood of developing depression, but depression was likely to be present with the development of symptom onset. The authors did though find a significant relationship between people who had insomnia and a susceptibility to the development of anxiety.

Mental health conditions such as anxiety and depression have also been associated as risk factors for the the development and persistence of insomnia in prison populations (Singleton, Meltzer and Gatward, 1998). In a study carried out by Elger and Sekera (2009) in examining the pre-detention risk factors for prison based insomnia the authors found that sleep disturbances were more likely if an individual had a previous history of insomnia (36% of prisoner’s report insomnia before detention), a history of mental health difficulties (particularly mild anxiety) and a previous use of opiates or benzodiazepines. Prison specific risk factors have also been reported to increase sleep disturbances. The prison regime can affect the normal daily patterns of functioning, such as an excessive time locked in cells, which can make people more acquiescent to daytime sleeping that thereby affects the sleep-wake regulations (Levin and Brown, 1975). In a review examining the factors affecting insomnia in people detained in prison, Dewa, Kyle and Hassan et al. (2015) discussed how sleep difficulties can be influenced by anxieties associated to violent victimisation (Liebling and Arnold, 2012), or from the perceived external environment like room temperatures (Royal College of General Practitioners, 2011), high noise levels (e.g. rattling of keys or the slamming of doors), poor lighting and an uncomfortable mattress (Morin and Espie, 2003). Nevertheless, certain environmental factors according to
Elger and Sekera (2009) played no role in the quality of sleep experienced for people residing in prison, this included the number of people sharing a cell, whether or not someone had a prison job, illicit drug use, drinking caffeinated beverages or eating chocolate.

### 1.4. Health care service provisions in prison establishments

In Dewa et al.’s (2015) review of the prevalence, associated factors and the management of insomnia in prison populations the authors request researchers to carry out qualitative reflective discussions with prison staff and inmates to help improve the management of sleep in prison. However, the need to improve sleep and the health of detained populations is not just a perquisite for researchers; it is since the introduction of the Care Act 2014 a legal requirement for healthcare providers to improve the standards of care delivered to people living in prison (Lee, Haggith and Mann et al., 2016). The Care Act 2014 encourages greater collaborative work between the local health care authorities and the local prison establishment to develop strategies that support prison populations to receive the same level of ‘wellbeing’ care as people in the outside community. The decision to address these imbalances is likely to have been driven from the work of the Prison Reform Trust, Her Majesty’s Chief Inspector of Prison and the Prison and Probation Ombudsman, who each respectively have detailed the inadequacy of health care services within prisons (Loucks, 2000; and Forrester, MacLennan and Slade, et al., 2013). To understand the care deemed necessary for people residing in jails the Bradley Report (Executive Summary, 2009) advocates that prisons undertake an audit to assess the health needs of their populations and to understand the ability of the local healthcare service providers to manage these identified needs. In regard to mental health services, detained populations should be receiving what was set out in the National Framework for Mental Health (Department of Health, 1999; cited in Forrester, 2014), which states, ‘any service user who contacts their primary health care team with a common mental health problem should have their mental health needs identified and assessed and be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it’.

The deficiencies in the level of mental health care provided to people living in prison has been highlighted in the work of Forrester et al. (2013) who also argue that there is a disparity in the level of mental health care between prisons, which for the patient means that the standard of care becomes a ‘postcode lottery’. The authors found that some prisons were operating on a CMHT model as opposed to a particular prison
model; 13% of prisons did not provide a CMHT; and that some prisons had an insufficient number of mental health nurses to cope with the number of people who have mental health difficulties. Forrester et al. (2014) further argue that the prison service places greater emphasis in the use of forensic psychologists to carry out psychological interventions to reduce the risk of suicide, self-injurious behaviours (Toch, 1992) and recidivism (McGuire, 2006); as opposed to using clinical psychologists to treat the mental health needs of the prison population. The consequence for the prison service in focusing greater attention to the profession of forensic psychology is the slow implementation of the Increasing Access to Psychological Therapies (IAPT) services within prisons (Gee and Bertrand-Godfrey, 2014; and Forrester et al., 2014). Therefore, people detained in prison are not receiving the same level of care as people living in the wider community for conditions like anxiety, depression, insomnia, and PTSD (Richards and Borglin, 2011).

The focus of the prison service in prioritizing psychological intervention towards risk-based behaviours can also help to explain why there is a dearth of available British prison research examining the efficacy of psychological interventions like IAPT for mental health conditions (Gee and Bertrand-Godfrey, 2014). The majority of prison based mental health research appears to examine programmes around substance dependency (e.g. Rouse, 1991), substance dependency with comorbidity (e.g. Zlotnick, Najavits, Rohsenow and Johnson, 2003), outreach clinics (Skipper et al., 2003) and therapeutic communities (e.g. Rawlings, 1999; and Hobson, Shine and Roberts, 2000). Ostensibly, Adamson, Gibbs and McLaglin (2015) carried out the only available study that has examined the implementation of the IAPT service in a prison establishment. The study formed part of a three-year service evaluation at HMP Lincoln and set out to examine the efficacy of the CMHT’s IAPT service to treat detained males, who were experiencing difficulties with anxiety and depression. The authors (Adamson et al., 2015) of the study revealed that 893 patients accessed the service and 455 completed their designated treatment. The IAPT provision provided the appropriate intervention to the men using the service, which included CBT based individual or group work, self-help guides, behavioural activation, cognitive restructuring, sleep management, exposure work, eye movement desensitization and reprocessing (EMDR) and person centred counselling. The results of their work revealed that the IAPT based approach provided similar clinical effect sizes comparable to findings from IAPT based community services.
1.5. The definition of a feasibility study

The definition of a feasibility study, which will be used for this research and its differentiation from a pilot study (cited in Tickle-Degnen, 2013) is based upon the demarcation provided by the United Kingdom’s National Institute for Health Research Evaluation, Trials and Studies (NETSCC, 2012). The NETSCC (2012) defines feasibility studies as “pieces of research done before a main study in order to answer the question ‘can this study be done?’...used to estimate important parameters that are needed to design the main study” (Research Methods section, para 3). The NETSCC (2012) definition argues that the feasibility studies test certain elements of the Randomized Control Trial (RCT). Whereas, a pilot study tests all pieces of the planned RCT that is to say “a version of the main study that is run in miniature to test whether the components of the main study can all work together... (and resembles) the main study in many respects including an assessment of the primary outcome” (Research Methods section, para. 6). Feasibility studies explicitly address the feasibility and validity of the RCT plan and do not necessarily have to provide or test the hypotheses of the potential larger RCT (Arain, Campbell, Cooper, and Lancaster, 2010; Thabane et al., 2010; Leon, Davis and Kraemer, 2011; Shanydine, Pickering and Weatherall et al, 2011; and Tickle-Degnen, 2013). Cohn and Orsmond (2015) argue that feasibility studies can be conducted with a less rigorous methodological approach than is seen in pilot studies and provide a preliminary investigation into the “research and intervention process” (Cohn and Orsmond, 2015) that can support the decision making processes about the suitability for the implementation of a future pilot study (Gitlin, 2013).

1.5.1. HMP feasibility study

In Baroness Corston’s review (Corston Report, 2007) of the treatment of vulnerable women detained within the criminal justice system, female prisons were found to neglect women specific service needs because female prisons are operated from the blueprints of male prison estates. Furthermore, the observed gender inequalities that affect much of the criminal justice system are also noticeable within the field of prison research as the majority of prison based study’s appearing to have been undertaken in male prison estates. While, ostensibly, little research has been commissioned to understand how the personal histories of violence and trauma influence the needs of women in prison (Garcia, Baker, and Fields et al., 1998; and Maloney, van den Bergh and Moller, 2009). To help address the gender imbalances of prison research the HMP feasibility study is exclusively delivered at HMP a female prison establishment.
The study investigates the needs of the women referred to its CMHT’s psychological service provision from undertaking a mixed-method approach to ascertain the feasibility, acceptability and efficacy of four psychological group interventions for improving symptoms of trauma and sleep.

The patient driven nature of the HMP feasibility study displays respect for the patient by readdressing the power imbalances that affects much research in health care (Abma, 2014) because health research needs to be “done with or by the public and not to, about or for them” (Dainty, Fox and Lewis et al, 2014). In particular, the study’s focus groups will support a platform for problem solving, self-determination and influence (Boog, 2003) within the women’s detaining establishment. The women’s collaboration is seen to empower a disadvantaged population to gain an aspect of control over the factors that are determining their lives (Hecker, 1997). Thus, this study helps to give a ‘voice to the voiceless’ (Madriz, 2000) in providing empowerment and a degree of emancipation to an oppressed population who are not regularly involved in the evaluation stages of prison service programs (Fetterman, 1994). Furthermore, the utilisation of the detained women as stakeholders in the research process will help support the CMHT in the redesigning of its psychological service provision, which can be evaluated in a future pilot study.

1.5.2. **The feasibility study aims**

The intention of the HMP feasibility study is to:

- use a quantitative research approach to begin to understand the clinical effectiveness of the four psychological group interventions for improving symptoms of trauma and insomnia; to examine participant recruitment and retention rates; and to provide and describe the range of data with relevant descriptive statistics
- use a qualitative research approach through the employment of focus groups to explore the experiences of the stakeholders who participate in the study’s psychological group interventions (i.e. patients and facilitators); and to examine why patients decline psychological treatment for their condition
- provide an understanding into the advantages and disadvantages to the implementation of group psychological interventions in a female prison
- empower patients as stakeholders in the research process
- assess the practicability of implementing a future pilot study
Chapter 2: Methods and Methodology

2. Introduction

The intention of this chapter is to describe the methodology and methods used in the feasibility study that enabled the examination of the experiences of the detained women and the staff group facilitators who attended the HMP group psychological interventions. The chapter provides explanation for the use a mix-method approach and offers validation to the methods integrated into the design of the feasibility study. In summary, the HMP feasibility study is a piece of ‘real world research’ (RWR) (Knottnerus and Tugwell, 2010), which means the study will attempt to replicate the clinical environment, protocols and procedures that are standard practice when treating women who have been referred to the HMP’s CMHT for group psychological treatment. The implementation of RWR, through incorporating the women as stakeholders will help inform about current practice, enhance an understanding about the effectiveness of the HMP group psychological interventions, support ideas for service improvements and evidence the potential need for prison policy reform (Freemantle and Strack, 2010).

2.1. Sampling and selection

A multi-disciplinary team meeting (MDT) was held at HMP to inform prison representatives about the intention of the HMP study. The representatives were reminded to complete referral forms for women that they deem appropriate for psychological group intervention. The referrals for psychological groups traditionally come from members of the teams represented in the meeting (i.e.) the healthcare team, the substance misuse team and the CMHT. Ideally, the referrer from a discussion with the patient would have an understanding about the patients preferred choice of intervention, which is then written on the referral form to support the intervention allocation procedure. The referrals are written in the CMHT referral book at point of receipt. A weekly meeting is held to allocate these referrals to group psychological interventions. If an inappropriate psychological referral (e.g., no indication of trauma symptomatology or the referred has a psychotic disorder) has been received the referral would be directed to the CMHT’s secondary care service or not included for group psychological treatment.

In November 2014, approximately two weeks following the MDT meeting the women currently on the CMHT caseload who were deemed appropriate for group intervention
and the women on the waiting list for psychological group interventions were met by representatives of the CMHT to be informed about the nature of the feasibility study. 71 women who expressed an interest in being research participants were provided with an information pack and consent form. During the recruitment process 3 (of the 71) women approached staff requesting support for psychological difficulties and were willing to be research participants. The provisional meeting with the 71 potential participants provided an opportunity for the women to discuss any concerns that they have about attending the group psychological interventions and matching focus groups. The meeting also provided the HCA’s an opportunity to gather information around risk (e.g. to ensure a victim is separated from a perpetrator), an understanding about cognitive or literacy issues that could affect an individual’s ability to provide participatory informed consent and the necessity for any remedial assistance. It was emphasised to all candidate participants during the recruitment stage that a decision of participation or nonparticipation in the study would not affect their care pathway or access to the psychological group interventions. The women who provisionally agreed to participation were informed that if involvement in the research caused the experience of psychological distress that they were to contact a member of the CMHT or seek an appointment with the prison General Practitioner (GP). The women who chose not to participate were also reminded to discuss any psychological difficulties that they might be experiencing with members of the Healthcare Team or the CMHT.

2.1.1. The process of participant intervention allocation

The feasibility study being a piece of RWR was required to replicate the same allocation to intervention procedures that take place during a weekly and specific CMHT meeting. The research participants were classified as a cluster sample, allocated to a group psychological intervention from the referral book waiting list, through a process of purposive sequential sampling (Teddle and Yu, 2009). A woman’s allocation to an intervention group (and thus intervention focus group) is dependent upon the outcome of a team discussion, which is influenced from (e.g.) information recorded on the referral form, prison based risk information, spaces available in the group, a pending release date and any known condition that may impede intervention attendance. There were two intervention groups assigned for each of the 4 psychological groups being evaluated. An intervention took place in the morning and this intervention was replicated with different participants in the afternoon. The feasibility study invited 71 women to participate in the research project, 9 women were assigned to 7 intervention groups meaning 1 intervention group (introduction to mindfulness) required 8 participants. However, due to HMP
psychological groups having a history of high attrition, it was important to increase the likelihood for participant access, therefore if a morning participant was unable to attend the session, the individual was offered an opportunity to join the afternoon intervention. When a participant did not attend for an intervention a member of the CMHT met with the individual to identify the reason for nonattendance. If a woman was absent for the re-invited intervention, a second follow up interview was deemed excessive and the reason for nonparticipation was unrecorded. Succeeding the initial allocation of women to group interventions a further convenience type of sampling was required in order to reallocate some women to different interventions groups due to mitigating factors. This included a suspicion of harassment between certain participants, which prohibited them from attending the same intervention group and clashes with scheduled prison appointments (i.e. a victim awareness course, a dental appointment, GP appointments and education classes).

2.1.2. The participants
The feasibility study inclusion criteria required being a prisoner at HMP; an adult (female) patient aged 18 years or older at the time of enrolment; a capability to understand and speak English; an ability to provide written informed consent; willing to commit to the intervention on offer; exhibit trauma symptomatology as measured by the PTSD Symptom Scale-Self Report Version (PSS-SR; Riggs, Dancu and Rothbaum, 1993) (i.e. the experience of 1 or more traumatic event, 1 re-experiencing item, 3 avoidance symptoms, 2 arousal symptoms, and a total score higher than 13); the presence of insomnia either at a sub-threshold level, a moderate level or a severe level as measured by the the Insomnia Severity Index (ISI; Morin, Belleville, Belanger and Ivers, 2011); and a score 23 or greater as measured with the the GHQ-28, (Goldberg, 1978). The exclusion criteria included; nonconformity to the inclusion criteria, patients with symptoms inconsistent with trauma symptomatology; and any individual receiving (other) psychological therapy for symptoms of trauma or sleep.

2.1.3. Participant background information
The feasibility study invited 71 women to participate in the research project, although only 31 of these women attended for the psychological group interventions all 31 met the study’s inclusion criteria. Table 1.0 provides the participant’s demographic information, legal status and pharmacological and psychological information.
Table 1.0 - Participant demographics

<table>
<thead>
<tr>
<th>Item</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>31 (100%)</td>
</tr>
<tr>
<td>Nationality</td>
<td></td>
</tr>
<tr>
<td>British</td>
<td>30 (97%)</td>
</tr>
<tr>
<td>Polish</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Country of birth</td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>15 (48%)</td>
</tr>
<tr>
<td>Wales</td>
<td>15 (48%)</td>
</tr>
<tr>
<td>Poland</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Race</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>31 (100%)</td>
</tr>
<tr>
<td>Age range</td>
<td></td>
</tr>
<tr>
<td>19-42</td>
<td></td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>25 (81%)</td>
</tr>
<tr>
<td>Married</td>
<td>6 (19%)</td>
</tr>
<tr>
<td>Have children</td>
<td>22 (71%)</td>
</tr>
<tr>
<td>Legal status</td>
<td></td>
</tr>
<tr>
<td>Sentenced</td>
<td>16 (52%)</td>
</tr>
<tr>
<td>Remand</td>
<td>15 (48%)</td>
</tr>
<tr>
<td>Medication</td>
<td></td>
</tr>
<tr>
<td>Psychiatric (e.g. anxiety, depression)</td>
<td>29 (94%)</td>
</tr>
<tr>
<td>For substance misuse</td>
<td>10 (32%)</td>
</tr>
<tr>
<td>Sleep specific</td>
<td>3 (10%)</td>
</tr>
<tr>
<td>Physical health</td>
<td>29 (94%)</td>
</tr>
<tr>
<td>Previous psychological intervention</td>
<td></td>
</tr>
<tr>
<td>Substance misuse</td>
<td>15 (48%)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (3%)</td>
</tr>
</tbody>
</table>

2.1.4. The focus group participants

The participants of the feasibility study’s focus groups were derived from an opportunity sampling method. The study delivered 6 focus groups i.e. 4 intervention specific focus groups, 1 generic stakeholder focus group (GFG) and 1 facilitator focus group (FFG). In total, the intervention focus groups were composed of 24 participants that were female, British (Welsh 58%, English 42%), Caucasian and 19-42 years in age range. The GFG contained 4 women purposively selected from the intervention focus groups and 2 women purposively selected from the CMHT’s patient caseload who did not attend a psychological group intervention forming a part of the research. The participants of the GFG were female, Caucasian, British (Welsh, 33%, English 67%) and with an age range of between 23-42 years. The facilitator focus group
contained 5 female participants that were British (Welsh 20%, English 80%), Caucasian and between 22-57 years in age range.

2.2. HMP psychological interventions

The feasibility study intervention groups were supplementary to the CMHT’s normal scheduled group work programme and took place in an allocated week in December 2014. All intervention participants were reminded about the nature of anonymity and confidentiality and informed that the CMHT staff are bound by local and national confidentiality policies and procedures of the NHS and prison service. The study’s participants were required to adhere to anonymity and confidentiality and their responsibilities were set out in a therapeutic contract. These are the processes and procedures that are routinely used in the CMHT service provision and are not stand alone for this feasibility study. The participants completed and returned their psychometric evaluations and consent forms, indicating a willingness to be involved in the research project. If the group facilitators observed any errors in the completion of the forms, the participant was asked to amend the error. The interventions were carried out in HMP within a comfortable environment dedicated for psychological group interventions. Each of the interventions was exclusively 1 session, 90 minutes in duration, with a 15-minute break at an appropriate midway point, where the participants were provided with light refreshments.

The intervention groups are designed to receive a heterogeneous population and support people experiencing symptoms of trauma and difficulties sleeping. The four psychological group interventions under investigation in the feasibility study were ‘an introduction to anxiety management’ (IAM), ‘an introduction to mindfulness (ITM), ‘improving your sleep’ (IYS) and ‘exercise as therapy’ (EAT). The groups utilise psychological techniques to reduce the experience of hyperarousal, which is argued to be the catalyst for symptoms of trauma and its related insomnia (e.g. Van der Kolk and Bassel, 1985; Harvey, 2002; Bonnet and Arand, 2010; Friedman et al., 2011; and Weston, 2014). The groups are psychoeducational; delivered in a didactic and Socratic presentation style. The interventions each contain sections where the group members can contribute through discussions and participatory tasks. The groups utilise techniques that can be found in CBT; however, the IAM and the IYS groups are founded upon False Safety Behaviour Elimination Therapy (F-SET; Schmidt, Buckner, and Pusser, et al., 2012) and Stress Management Techniques (SMT). The EAT group is based upon the incorporation of physical exercise with interoceptive exposure (IE); and the ITM group utilises constituents of Mindfulness Based Cognitive
Therapy (MBCT). The participants in each group receive an accompanying workbook to provide a summary of the attended intervention and homework tasks to be completed outside of the group session.

2.2.1. Intervention facilitators
The IAM group was facilitated by the study’s principal researcher, educated to master’s level and a Registered Mental Health Nurse (RMN) educated to degree level. The study’s principal researcher is an AP, with two years’ experience facilitating the intervention, and the RMN has nine months’ experience delivering the group. Two Health Care Assistant’s (HCA’s) each with approximately two years’ experience of facilitating the group neither educated to degree level delivered the ITM. The EAT intervention was co-facilitated by the principal researcher and the RMN who both have delivered the intervention for a twelve-month period. The principal researcher and a HCA who is educated to degree level delivered the IYS intervention and both have facilitated the intervention for two years.

2.3. Mixed-method approach
The aims of this feasibility study, which was a cohort study were tested through a mixed method design, through analysing patient feedback from quantitative (psychometric evaluations) data pre (December, 2014) and 3 weeks post intervention attendance (January, 2015); and from qualitative (i.e. focus groups) data taken at the same three week follow up point (January, 2015). The use of a mixed-method approach was considered after consultation with the project supervisors; and from reading the work of Sandelowski (2000) who describes mixed-method research as having the ‘potential to dramatize the artfulness and versatility of research design’. In other words, mixed-method research is able to increase the scope of the work and enhance the analytical command of studies than perhaps quantitative or qualitative research could alone (Sandelowski, 2000). The quantitative approach, being RWR was required to examine the clinical effectiveness of the group psychological interventions for treating trauma symptomatology including insomnia as measured with the psychometric evaluations of the PSS-SR, GHQ-28 and the ISI taken at the pre and 3-week post intervention measurement points. The quantitative approach also examined the phenomenon of attrition that effects the prison’s psychological groups and this provided essential information about participant recruitment and retention rates. The qualitative approach from using semi-structured focus groups, which were analysed with thematic analysis provided an understanding about why patients declined psychological treatment for their conditions and supported an
exploration of the experiences of the stakeholders who participated in the study’s psychological interventions (i.e. patients and facilitators). The undertaking of a mixed-method approach helped evidence an understanding into the advantages and disadvantages of delivering psychological interventions within a prison environment, principally through recognising patients as important stakeholders in the research process, which dually facilitated an opportunity for patient orientated service improvements. Furthermore, the decision to use a mixed method was supported from its successful application in research areas similar to this study. Cramer, Salisbury, Conrad et al. (2011) used a mixed-method approach in a pilot and feasibility study examining the use of CBT based interventions in treating women with depression; Colbert, Sekula, Zoucha et al. (2013) used a mixed-method approach when investigating the health care needs of women who have recently been released from prison.

2.3.1. Interpretative quantitative research
The field of psychology has many proponents that regard measurement as a paramount means to extract essential knowledge, described by Michell (2003) as the “quantitative imperative”. However, the use of measurement in interpretive psychological research is shrouded in the debate about how to define interpretative quantitative psychological research (Westerman and Yanchar, 2011). This study is unable to add to this discussion but will as recommended in the work of Westerman and Yanchar (2011) take an uncomplicated approach and define interpretive quantitative psychological research as a measurement approach that places ‘numbers to observations’. This allows the feasibility study through psychometric evaluations to measure meaning from constructs and understand more about the ‘quantification and analysis of human differences’ (Browne, 2000).

2.3.2. Psychometric evaluation
There appears a shortage of interpretive quantitative research that has used psychometric scales to evaluate trauma symptomatology, including difficulties sleeping in British female prisons. However, there is a plethora of research that has incorporated psychometric evaluation toward the fields of mental health and physical health within secure settings. Perry and Olason (2009) developed and used psychometric assessments called SCOPE (i.e. Suicide Concerns for Offenders in Prison Environment) to examine the susceptibility to suicide and self-injurious risk in young men and women in medium-secure psychiatric hospitals. Gobbett and Sellen (2014) used psychometric evaluations to assess the effectiveness of a CBT based
prison intervention called the Thinking Skills Program (TSP). In another study, Long, Hall and Dolley et al., (2010) incorporated psychometric evaluation to measure women's substance misuse issues in a psychiatric hospital including dependency to substances, difficulties associated with substance misuse, a motivation for behavioural change, self-efficacy, cravings and coping strategies.

2.3.3. Quantitative data analysis
The quantitative data in the form of descriptive statistics were incorporated to denote intervention attendance and nonattendance rates. The HMP study also wanted to understand the clinical effectiveness of the interventions provided by the CMHT in helping improve the symptoms of trauma and insomnia of the patients under psychological treatment. The psychometrics used to assess intervention efficacy in this feasibility study were the PSS-SR (Foa, Riggs, Dancu and Rothbaum, 1993); the GHQ-28, (Goldberg, 1978) and the ISI (Morin, Belleville, Belanger and Ivers, 2011); and each was administered to the patients at the pre-intervention and 3 weeks’ post-intervention stage of the feasibility study and deduced using average ratings, median scores, standard deviations, ranges and percentages.

2.3.4. Post-traumatic stress disorder symptom scale (PSS-SR)
The PSS-SR (Foa, Riggs, Dancu, & Rothbaum, 1993) is a self-report psychometric instrument based upon the DSM-IV classification of PTSD. The 17 items of the PSS-SR help clinicians and researchers quickly evaluate the likelihood that an individual under assessment meets the DSM-IV PTSD criteria (Hoge, Castro, Messer et al., 2004; and Engelhard, Arntz, van den Hout, 2007). The PSS-SR begins by ascertaining the traumatic event or situation that an individual has experienced. Next, the PSS-SR requests the individual rate (0-3 on a Likert scale) from a list of 17 items the problems experienced following trauma exposure, on how much or often these problems have arisen during the past two weeks (Foa et al., 1993). The 17 items relate to symptoms of re-experiencing, avoidance and arousal. The PSS-SR allows a total score severity of 51 and a PTSD diagnosis can be made when the individual experiences a minimum of 1 re-experiencing item, 3 avoidance symptoms and 2 arousal symptoms, and a total score higher than 13 (Sin, Abdin and Lee 2012).

The validity and reliability of the PSS-SR as a psychometric tool has been evaluated in several studies (e.g. Foa and Tolin, 2000; Coffey, Gudmundsdottir, Beck, et al., 2006; Naifeh, Elhai, and Kashdan, et al., 2008; Sin, et al., 2012; Paquin, Kivlghan, and Drogosz, 2013; and Engelhard, Arntz and van den Hout, 2007) and according to
Foa and Tolin (2000) the PSS-SR has an internal consistency (Cronbach’s α) of between 0.65 to 0.71, a test-retest reliability of 0.66 and 0.77; that correlates at 0.87 with the Clinician-Administered PTSD Scale (CAPS; Blake, Weathers, Kaloupek et al., 1995) and a diagnostic sensitivity of 0.88 and specificity of 0.96 (Naifeh, et al., 2008). These findings have in part been substantiated in a study carried out by Coffey (2006) when comparing the CAPS to the Impact of Event Scale (IES; Horowitz, Wilner and Alvarez, 1979) and the PSS-SR in assessing 229 people who survived motor vehicle accidents. The CAPS tool found that 43% of the motor vehicle survivors met the DSM-IV PTSD diagnostic criteria. The results of the study revealed the PSS-SR correctly identified 91% of people diagnosed with PTSD (90 from 99 people a sensitivity rate of 0.91). In specific regard to female participants, the PSS-SR correctly assigned 64 of the 72 people diagnosed through CAPS with PTSD. Coffey (2006) concluded that the PSS-SR is a valid instrument for assessing treatment seeking individuals at risk for a PTSD diagnosis.

2.3.5. General health questionnaire - 28 (GHQ-28)

The GHQ-28 (Goldberg, 1972) is a psychometric tool, which can be used to assess the likelihood that an individual has evidence of or is at risk of developing a psychiatric disorder (Sterling, 2001). The GHQ-28 is a self-administered tool, which can be completed by the individual in as quickly as 5 minutes and it is commonly used in research and clinical settings (Willmott, Boardman, Henshaw and Jones, 2004). The GHQ-28 consists of 28 items, separated into 4 subscales, to assess the individual’s somatic symptoms (items 1 to 7), anxiety and insomnia (items 8 to 14), social dysfunctioning (items 15 to 21) and depression severity (items 22 to 28; Goldberg, 1972; and Sterling, 2011). The GHQ-28 allows different scoring methods to ascertain the presence of distress within the individual; however, studies have shown minimal variation in determining distress between the various methods of scoring available (Bland, Newman and Orn, 1988). In this HMP feasibility study, the items are scored from 0 to 3, which allows a total scoring of 0 to 84. A score of 23/24 is regarded as the marker to detect a presence of distress within the individual (Goldberg, 1972; and Sterling, 2011). The validity and reliability of the GHQ-28 has been assessed in many clinical studies (e.g. Robinson and Price, 1982; Goldberg, Gater and Sartorius et al., 1997; Richard, Lussier, Gagnon and Lamarche, 2004; and Ormel, Koeter, van den Brink and Giel et al., 1989). In a study by Hurley and Dunne (1991), investigating psychiatric morbidity within female prisoners located in New Zealand and Australia the researchers found high levels of psychiatric distress within female prisoners, including depressive symptoms that appeared high upon intake and remained high
throughout the period of detention. In one investigation, Robinson and Price (1982) examining post-stroke depressive disorders found the GHQ-28 to have high test-retest reliability (i.e. Cronbach alpha coefficient 0.78 to 0.90) and the interrater and intrarater reliability has been regarded as excellent (Cronbach alpha coefficient 0.90–0.95) in the work of Sterling (2001).

### 2.3.6. Insomnia severity index (ISI)

The ISI is a self-report measurement tool to help researchers and clinicians understand the severity of the sleep complaint, and the distress the sleep difficulty is having upon the individual. The ISI is based on the DSM-IV diagnostic criteria for insomnia (Bastien, Vallieres and Morin, 2001) and comprises 10 items; the first three items measure the difficulties the individual experiences attempting to go to sleep, staying asleep or waking too early. The remaining items examine the satisfaction the individual has about their sleep, their opinion about the impact their sleep difficulty has upon quality of life, how noticeable they believe their difficulty sleeping is to others, how worried they are about this sleep problem and the extent it interferes with their daily functioning (e.g. concentration or memory). A score ranging between 0-7 indicates ‘no clinically significant insomnia’, 8-14 is ‘sub-threshold insomnia’, 15-21 is ‘clinical insomnia (moderate severity)’, and 22-28 is ‘clinical insomnia (severe)’ (Bastien, Vallieres and Morin, 2001).

Studies (i.e. Morin, Colecchi, Stone et al., 1999; and Mimeault and Morin, 1999) examining the ISI appear to demonstrate validity when the ISI has been compared to sleep diaries, with results showing that the ISI appears able to observe changes that are related to the treatment of insomnia. In a study that looked at the validation of the ISI as an outcome measure for insomnia research, Bastien, Vallieres and Morin (2001) examined the ‘internal consistency and concurrent validity of the ISI from carrying out two studies’. The first study compared the results of the ISI from 145 patients at a sleep disorders clinic to sleep diary measurements. The authors concluded that the ISI appears to be a reliable tool for the evaluation of insomnia within clinical populations, achieving internal consistency from Cronbach alpha coefficient, measured at 0.74. In the second study, the authors investigated the concurrent validity of the ISI from evaluating 78 older adults who participated in a study looking at the effects behavioural and pharmacological interventions had for insomnia. The ISI totals were measured for internal consistency with the Cronbach's coefficient alpha with a mean of 0.56 at pre-treatment, 0.69 at post-treatment and 0.72 at follow-up. When the sleep diaries were compared to the correlations between the
ISI subtypes, the results showed that the scores at baseline were between 0.32 to 0.55 and 0.50 to 0.91 at post-treatment; the authors concluded that the study showed internal consistency and concurrent validity as observed in their previous study.

2.4. Qualitative approach

Qualitative research has been described as a ‘fuzzy set’, often containing an overlap between its multiplicity of diverse methods and theoretical approaches, where typology is not necessarily absolute (Madill and Gough, 2008) and is “not quantitative” because statistical analysis is seldom required (Kidd, 2002). Qualitative research principally lays its attention to studying individuals or small groups and usually operates without a hypothesis or “predefined response categories” (Kidd, 2002). This stance leaves qualitative research open for reproach from its critics about issues regarding subjectivity, bias and criticism about the absence of a hypothetico-deductive approach (Archer, 2004). This can help to explain why Kidd (2002) found that in 15 journals published and distributed by the American Psychological Association that only 1% of content was solely qualitative and five journals had never published any qualitative work. However, over recent years, the field of psychology appears more amenable towards qualitative psychological research, which has been represented through growth in the number of qualitative based journals and textbooks; and in 2005, the ‘British Psychological Society Qualitative Methods in Psychology Section’ was introduced (Madill and Todd, 2002; and Madill and Gough, 2008).

2.4.1. Focus groups

Qualitative research data collection has five main types of approach, which are collaborative, interviews, naturally-occurring, observation and structured (Kidd, 2002; and Madill and Gough, 2008). For the feasibility study, semi-structured interviews within focus groups were regarded the most appropriate method of approach for data collection. Semi-structured interviews are an especially common means to generate data in British qualitative psychological research (Madill, 2007). Focus groups as a research method appeared to begin from work in the 1940’s at Columbia University (Mertons and Kendall, 1946) and enable the researcher to understand the phenomena in question, from detailing how a participant’s personal perspective connects and develops from the group interaction (Barbour and Kitzinger, 1999). Semi-structured interviews within the confines of the focus groups provided the opportunity to understand the relationships between the women’s experience (Madill and Gough, 2008) of living in prison with attending group psychological interventions. The focus groups also afforded the principal researcher an opportunity to generate an
opinion about certain constructs or phenomena (Madill and Gough, 2008) through the incorporation of a greater number of participants than could be practicably individually interviewed, thus providing for richer data.

It has been suggested (Wilkinson, 1999) that it is best practice for the members of the focus group to be unfamiliar with each other. In certain situations, this is hard to construct and alternatively it has been argued (Morgan and Kruger, 1993) that focus groups are better delivered in the setting where the members naturally befall (Brown, Long and Weitz et al., 2000, 2001). The focus groups in the feasibility study were carried out in a familiar setting to the participants because they took place at HMP and in the vicinity where the interventions were delivered. Therefore, due to the mix of attendees in the focus groups the women were only familiar with the individuals who attended their particular intervention group. Unless they knew the other member outside of the therapeutic setting (e.g. living on the same wing). The varying degree of familiarity between the feasibility study’s participants is argued to have enhanced the focus groups discourse. Unfamiliarity provides conversations that are less shorthand in nature because people reduce the quantity of assumed knowledge that the unfamiliar person holds (Agar and MacDonald, 1995); and unfamiliarity can also increase the information that people feel comfortable sharing because it lessens perceived judgements (Wilkinson, 1999). A focus group where there is a familiarity between group members, can aid normal day-to-day talk because ‘friends tell stories about their experiences’, which provides a richer data set (Wilkinson, 1998a). The varying degree of familiarity between the focus group members provided the women with an environment that supported stakeholder empowerment and emancipation because the women voiced their experiences about accessing HMP group psychological interventions and problem solved to propose ideas for improving the CMHT’s psychological service provisions.

The HMP feasibility study assigned a focus group for each of the four psychological group interventions, which took place three weeks after the respective intervention. The focus groups contained a heterogeneous composition of intervention participants, observed through the varying presentation of trauma symptomatology. The focus groups were semi-structured, with similar questions asked in each group (appendix 3,4 and 5). The process was iterative, where the principal researcher and focus group co-facilitator’s dialogue would have been influenced by knowledge gained in the previous groups. An additional semi-structured focus group took place to expand upon content discussed in the intervention focus groups and to provide the detained women
an opportunity to talk about matters relating to the CMHT psychological service provision. This focus group included four participants who were purposively selected from the intervention focus groups and two other women that were not involved in the psychological interventions phase of the research but expressed a willingness to be a part of the research process. The principal researcher and a CMHT HCA delivered these focus groups. The sixth focus group, delivered by the principal researcher, was semi-structured and exclusively for CMHT group facilitators. This group contained four participants and was used to gain an opinion about the facilitator’s experiences of delivering psychological group interventions within HMP. All the focus groups took place within the CMHT area of HMP, were between 60 to 90 minutes in length and provided a 15-minute interval for refreshments.

2.4.2. Qualitative data analysis

Madill and Gough (2008) propose 4 main procedural categorization methods of analysing qualitative data (i.e.) discursive, thematic, structured and instrumental. Each categorization contains several qualitative methods that can be incorporated, the list though is too exhaustive to discuss in this feasibility study. However, the first categorization is discursive, which places attention to detail upon the text, elucidating understanding into how phenomena come into existence through the use of ‘linguistic resources’, and the approach relies upon discourse theory (Madill and Gough, 2008). The next categorization is thematic (analysis), which is regarded as an appropriate and clear methodology. Thematic analysis aims to explicate the explored phenomena through the coding of qualitative data to form groups of text with comparable meaning. The structured method allows the researcher to choose an area of interest for which the researcher will have already developed coded schemes, and have a prior theory to deduce the data, and can convert aspects of the qualitative data into numbers (Madill and Gough, 2008). The final categorization is the instrumental method, which draws upon adherence to a particular ‘research ethos, a philosophical perspective, or research aim’ from within the boundaries of an encompassing theoretical or ethical commitment (Madill and Gough, 2008).

The method of qualitative data analysis applied to the discourse of the HMP focus groups was thematic analysis. The decision to use thematic analysis was decided from consultation with the principal researcher’s supervisors and from the guidance of Braun and Clarke (2006) in their paper ‘using thematic analysis in psychology’. In the paper, Braun and Clarke (2006) argue that thematic analysis is a ‘foundational method and is the first qualitative method of analysis that researchers should learn’
because other qualitative methodologies, which can be shrouded by pre-existing theoretical frameworks (Rillota, Kirby and Shearer, 2010) can present complexities for the inexperienced qualitative analyst (Holloway and Todres, 2003). This is the first time the principal researcher has carried out qualitative research and due to the noted intricacies of other qualitative methodologies, it was felt that thematic analysis with the aid of the analytical procedural guide offered by Braun and Clarke (2006) was the most practicable qualitative methodology for the study.

Braun and Clarke (2006) state that thematic analysis allows examination from varying theoretical frameworks, stating that thematic analysis has the choice to be either an ‘essentialist or realist method’, a ‘constructionist method’ or a ‘contextualist method’. Braun and Clarke (2006) argue that this flexibility in methodology means that thematic analysis can present the reality of the phenomena or the elucidation of the subtexts driving the phenomena. The principal researcher when carrying out the qualitative work wanted to recognize the meaning of the discourse from a perspective to the women’s trauma histories and the situational experience of imprisonment. Thus, during the principal researcher’s participation in the focus groups, and during the transcription process and analysis, the discourse of the women was considered from an essentialist/realist, constructionist and contextualist perspective. It was felt this method would provide a richer understanding of the phenomena in question (McLeod, 2001). Furthermore, the identification of the themes from the discourse of the focus groups was influenced by the principal researcher’s theoretical interest in the area and the themes developed from a theoretical thematic analysis approach (Braun and Clarke, 2006). However, the emergence of themes was also influenced from an inductive means, where some of the themes bore little connection to the topic or area of the focus group (Braun and Clarke, 2006), which is likely related to the semi-structured interview approach, which allowed the discourse at times to meander away from the constraint of set questions to newer areas of interest. The openness of the principal research to consider essentialist/realist, constructionist and contextualist methods, alongside the development of themes from a theoretical and inductive perspective, resulted in the analysis of some themes that were influenced from a theoretical thematic perspective being analysed in a semantic approach and the themes that were influenced from an inductive approach were examined at a more latent level.

2.4.3. Thematic analysis

Audio recording equipment is a prohibited item at HMP and special permission to
record the focus groups was granted from the head of the prison security. The quality and rigour in the process of the thematic analysis came from utilising Braun and Clarke’s (2006) fifteen-point guide to thematic analysis and the analytical process being overseen and reviewed by the principal researcher’s two project supervisors. The focus groups were transcribed verbatim and checked twice with the audio recordings to ensure transcription accuracy. The principal researcher became further familiarised with the discourse of the focus groups from the reading and rereading of the transcriptions on an electronic Microsoft word document. During the process of familiarisation, observations were noted on the document about initial ideas or thoughts emerging from the data. This process of note taking allowed a further familiarity with the data that helped generate initial codes, which were keywords and phrases that allowed a preliminary organisation of the data (appendix 6). The codes that were similar in nature were highlighted with a particular colour, for example, codes that related to sentiments of anger were highlighted blue. Often, the data had more than one code, which meant that the data had more than one colour applied. When this part of the coding process was complete, the next objective was to commence the process of developing themes.

The initial codes derived from the focus group data were grouped together to allow a more detailed analysis and to provide more meaningful themes. The data, which appeared miscellaneous or was insufficient to be considered as a meaningful theme at that moment in time, were grouped together. The codes that were similar and appeared to have a richness in detail developed into more encompassing codes, which became candidate themes. At this stage, a narrative started to emerge in the data that provided meaning to the discourse of the focus groups. Further analytical processes enabled the discarding of candidate themes that appeared weak and unsuited to the narrative that was evolving. The data that was acquainted with the themes were reread to ensure the data represented the essence of the theme. The data, which appeared less relevant, was removed. The concluding stages of the analytic process looked at the remaining themes and examined their worth to the narrative of the discourse, with the final removal of the themes that were felt to be less emblematic. The data extracts were re-examined for accuracy in transcription and to ensure that those included were the most pertinent and descriptive to the chosen themes, which then enabled the audio recordings of the focus groups to be destroyed. The completion of this process allowed for the write-up of the qualitative report; however, due to the difficulties in differentiating participant voices and participant over talk, quotes were unidentifiable to specific participants.
2.5. Research approval

The Deputy Governor of the prison granted a request for permission to conduct the research at HMP, in October 2013. Approval was required and subsequently granted at a local level from the National Health Service (NHS), MHT research committee in August 2014. Ethical approval was sought from the ethics committee of the University of the West of England (UWE) and sanctioned in September 2014. A research proposal had also been completed for the National Offender Management Service (NOMS) to seek permission for the research to be carried out within the HMP prison, which was granted in November, 2014. In early December 2014, the NOMS approval was subsequently revoked as an outcome of the newly Acting Deputy Governor stating that the research would place constraint upon the HMP prison service. The principal researcher communicated with the Acting Deputy Governor to discuss the matter of perceived constraint and it transpired that miscommunication within the prison service caused the feasibility study to be confused with another research application. The Acting Deputy Governor informed the NOMS research department about the error in communication. Accordingly, NOMS retracted the research application denial and granted permission for the continuation of the feasibility study. However, the HMP Acting Deputy Governor precluded the use of prison staff in the research process, therefore prison staff are unable to be represented as stakeholders in the feasibility study.

2.6. Ethical issues

There was no physical, psychological, social, legal or economic risk for a participant or member of staff taking part in this study. However, it was possible that the group environment may involve talking about subjects of a personal and sensitive nature. Therefore, participants were made aware that if attendance to the intervention highlights a psychological difficulty and they are not already under the care of the CMHT they will be referred for further support (e.g. medical intervention or psychological intervention). The participants involved in the study were also informed that a disclosure to an experience of harm/danger/risk to herself or another individual might initiate a reporting procedure where other relevant agencies (e.g. the HMP safeguarding team) are informed about the disclosure. All women who were invited to participate in the research process were advised to speak to the prison GP or a member of the mental health team if they required more immediate support for mental health issues. All prospective participants were informed that a decision of non-participation or participation in the research would not interfere with their expected
care pathway or access to group psychological treatment.

### 2.7. Data management plan

The data management was in compliance to the policies of the NHS, MHT and those of the prison authority at HMP. This included the author's attendance and successful completion of information governance awareness training. The feasibility study obtained informed consent to use information gathered from the participants. The data was stored in locked cabinets and electronic information secured through encryption and a password setting that could only be accessed by the principal researcher. All the data collected as a result of this study was managed in accordance to the eight principles of the Data Protection Act 1998.

### 2.8. Reflexivity

Berger (2015) argues reflexivity is an important process for researchers, where they can pay attention to their own ‘biases, beliefs and personal experiences’ and ‘emotional responses to participants’, factors that can influence the research process and findings. This research was carried out in a female prison where I worked as an AP. During my tenure at HMP, I became increasingly aware to the trauma histories that many of the women who entered the prison had endured. The traumas were all too often similar, detailing the women’s victimisation by men often from within their own families. The repeated hearing of the women’s distressing accounts was vicariously upsetting and created an anger and frustration at the inability of society to protect its most vulnerable. Even during my time working in HMP I felt a dissatisfaction about how women who have experienced trauma are managed within the criminal justice system and that criminalising the women who have been past victims of violence appears to further dislocate this vulnerable population from suitable support (Arnold, 1995). Therefore, on reflection it could be argued that the emotional impact of working with this particular client population and an opinion that many women who are detained in the criminal justice system are managed inappropriately could have influenced the discourse of the focus groups that I facilitated and influenced how I analysed and interpreted the data. However, Pillow (2003) when discussing reflexivity in qualitative work encourages the researcher as a partaker in the research process because the researcher can help address the power imbalances that can occur in research. In the criminal justice system, power imbalances are explicit in the relationship between the detained and the castigator, while the quantity of research in the criminal justice system appears more focused to male prison estates. Thus, an emphasis of the HMP feasibility study was to recognise the women as the important
stakeholders within the research process and contribute to a process of “principled reform”, where researchers are attentive to empowering women in prison (Hannah-Moffatt, 1995, 2001). The feasibility study was thus also emancipatory for the women because it provided focus groups for the participants to talk openly, without the fear of reprisal about their experiences of living in prison and accessing group psychological support. Thus, it is hoped that my personal biases have helped to provide a platform to illuminate the difficulties confronting imprisoned women and evidence the need for women specific service improvements.

However, it is also imperative in this reflexive account to recognise my male gender and the potential implications of working with a female traumatised population, when other men have overwhelmingly been responsible for the women’s traumas. When I started my position at HMP, the implications of me being a man delivering therapy to a traumatised female population were deliberated in my clinical supervision sessions. It was agreed that women who feel uncomfortable working with a male therapist can decline the opportunity for treatment and alternatively be provided with individual support from a female worker. Furthermore, to manage specific issues that may arise within a group, where the women may feel more comfortable talking to another woman, all groups have a female co-facilitator. However, during my clinical supervision we discussed the importance for women in prison to develop working alliances with positive male role models, which would be beneficial in helping the women manage their psychological difficulties. Therefore, the CMHT worked hard to develop a group setting that could aid the successful development of therapeutic alliances and pivotal to this objective was creating an environment that contrasts the stricter feel of the wider prison. The group facilitators (and particularly myself as a male) took particular care to provide an empathetic, attentive and compassionate approach when working with the women, one that emphasises mutual respect and limits where possible the unhealthy power imbalances that occur within secure settings. The facilitator and patient relationships were carefully managed because we were aware that any less considered approach to working with a female prison population might unwittingly replicate innocuous reminders to the women’s previous traumas and therefore confound the treatment processes. Furthermore, in my subjective experience of working in HMP, I feel the approach that the team and I have developed when working with our patients has been of benefit to the women who have accessed our service. For example, on one occasion during the interval of a group intervention a woman approached me to request if I could offer her individual support for symptoms related to childhood traumas. This woman’s request for help from me,
as a man perhaps signifies that for some women in prison the gender of the therapist is less significant and what is important is a therapist that they feel they can trust. After all, although men have commonly perpetrated the majority of the abuse the detained women have endured, perhaps significant females in the women’s lives have been implicit in the processes of abuse or unsupportive when hearing the women recount their trauma.
Chapter 3: Results and Findings

3. Introduction

This chapter details the results of the mixed-method approach examining the feasibility of running group psychological interventions for the HMP women experiencing symptoms of trauma and sleep difficulties. The outcomes of the study’s pre and post intervention psychometric questionnaires utilize descriptive statistics to provide indicative analysis into the clinical effectiveness of running the psychological group interventions in HMP. The use of quantitative data also provides information about the number of patients needed to screen in relation to the numbers who successfully participate in HMP psychological group interventions. The qualitative data incorporates thematic themes, to provide an understanding why some detained women might decline psychological treatment. *Nota bene*, the bracketed information included after participant quotes denote the focus group that the extract was taken from and the sequential numbering has been included to provide evidential reference to matters raised in chapter 4: the discussion.

3.1. Incidence of adverse effects

There was no evidence to indicate that participation in the feasibility study caused the participants any adverse effect. One woman in the focus group stated that she felt “worse” after attending an intervention. When the woman was offered further psychological support, the distress she was experiencing was associated to a pending trial and not connected to her attendance to a psychological group.

3.2. Quantitative data

3.2.1. A summary of the quantitative findings

The quantitative findings of the study, as measured with the psychometric evaluations (PSS-SR, GHQ-28 and ISI) indicated that at the 3-week follow-up point the ‘exercise as therapy’ (PSS-SR, -16%; GHQ-28, -14%; ISI, -12%) and the ‘improving your sleep’ (PSS-SR, -12%; GHQ-28, -12%; ISI -36%) groups to be more effective at improving the participant’s symptoms of trauma and sleep than the ‘introduction to anxiety management’ (PSS-SR, -11%; GHQ-28, +8%; ISI, +4%) and the ‘introduction to mindfulness’ (PSS-SR, +1%; GHQ-28, +3%; ISI, +21%) group interventions. The quantitative data also provided information about the women’s reasons for non-participation and this revealed that 30% of the women referred to group treatments were either released (17%) or transferred (13%) before their scheduled appointment.
Whereas, the women detained in HMP who did not attend for their scheduled appointment alternatively attended for education classes (19%), medical appointments (13%) or work (4%). The remainder of women withdrew from the study (13%), forgot to attend (6%) or provided ‘other’ (15%) reasons for their nonattendances.

3.2.2. Participant involvement
Invitation appointments to participate in the psychological group interventions forming the feasibility study were issued to \( n=71 \) women; and \( n=31 \) (44%) women attended the prescribed intervention (table 2.0). The morning treatment groups in total invited \( n=35 \) women, with \( n=17 \) (49%) attending the interventions. To increase participant access to the interventions, \( n=18 \) women who did not attend for their allocated morning intervention, were offered an appointment to join the same afternoon intervention. The afternoon interventions invited \( n=54 \) participants and \( n=14 \) (26%) participated in the intervention. There was \( n= 89 \) total participant invites (including afternoon re-invites) to the psychological group interventions and a total of \( n=31 \) (35%) women accessed the group treatment. Proceeding the participant’s intervention attendance, the women were invited to an intervention focus group, held 3-weeks post-treatment to collect follow-up psychometric evaluations and qualitative data. A total of \( n=31 \) women were invited to the intervention focus groups and \( n=24 \) women attended, which denoted a 77% participant retention rate and a total participant retention rate of 34% from the initial \( n=71 \) (excluding afternoon re-invites) women invited to participate in the research.

### Table 2.0 Breakdown of group invitations to group attendances

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<tr>
<th>Intervention and Focus Group Invitations with Attendance Rates</th>
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<tr>
<td>35</td>
</tr>
</tbody>
</table>

### Table 3.0 Group participation completion rates

<table>
<thead>
<tr>
<th>Invitation to Completion Rates (excluding re-invites)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agreed Participation</td>
</tr>
<tr>
<td>71</td>
</tr>
</tbody>
</table>
3.2.3. Reasons for nonparticipation

There were $n=47$ women who initially agreed participation in the feasibility study who did not participate in the intervention group or the intervention focus group. The women who were still detained in HMP following their nonattendance to their first missed group were asked about the reason for their absenteeism, which is a standard protocol for the CMHT. The outcomes revealed that almost a third of the women who were invited to participate in the feasibility study were detained an insufficient amount of time at HMP to complete their participation, due to being released (17%) or transferred to another prison establishment (13%). The women that remained in prison throughout the period of the feasibility study, 19% attended an education class as opposed to the intervention group or focus groups. Medical appointments (13%) and withdrawal (13%) from the study were further reasons for the women’s nonattendances. The women who attended for a medical appointment explained that nonattendance to this appointment can result in the prison issuing of a “warning”; and the absence of punitive action from the CMHT for missing a scheduled psychology appointment allayed their decision for absenteeism. Whereas, other women explained that they were attending an impromptu appointment in healthcare for an illness and that the illness would have also prevented their attendance to the psychological group intervention. The women who withdrew from the study prior to any participation explained that they no longer felt comfortable receiving therapy within a group environment or that attendance “seems pointless” when their release was impending. There was $n=3$ (6%) women who explained their reason for nonattendance was because they forgot, of which $n=2$ were due to attend the intervention focus group. Work was also a reason why 4% of the women did not attend to a group intervention; $n=1$ of the women stated that work required precedence due to staff shortages, and the other $n=1$ woman believed that she would earn more money by working, than for participating in the intervention. Lastly, 15% of the women questioned provided several further explanations for their nonattendances, which was grouped into the category ‘other’. These ‘other’ reasons included going to church, being “too tired”, a legal visit, a meeting with the prison governor, feeling unwell, going to the gymnasium and missing “free-flow” (a period of movement in prison to allow access to service provisions).
3.2.4. Sample size

The feasibility study invited $n=71$ participants and $n=24$ participants completed the study, which denoted an attrition rate of 66%. Therefore, for any future research, which intends to employ inferential statistical analysis it was estimated that the study would require $n=192$ participant invitations to achieve an end retention of $n=65$ participants.

<table>
<thead>
<tr>
<th>Table 4.0 - Sample size calculation for the potential pilot study</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population Size</strong></td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td>71</td>
</tr>
</tbody>
</table>

3.2.5. Psychometric evaluation

The participant’s psychometric evaluation (i.e., PSS-SR, GHQ-28; and ISI) scores were taken at the pre-intervention stage and then 3-weeks post-intervention at the matching intervention focus groups. The individual participant’s outcomes for each respective intervention group were combined to provide 4 total intervention group outcomes scores that are presented as descriptive statistics (i.e. mean scores,
standard deviations, medians, ranges and percentages).

3.2.6. Introduction to anxiety management

The following tables show the descriptive statistics for the IAM psychometric evaluation (PSS-SR, GHQ-28 and ISI) scores at the pre (table 5.0) and 3-weeks’ post (table 6.0) intervention group measurement points. Table 7.0 denotes the likely clinical effectiveness of the IAM group psychological intervention from comparing the IAM group pre and post intervention psychometric measurements.

Table 5.0 - IAM group psychometric outcomes pre-intervention attendance

<table>
<thead>
<tr>
<th>IAM Group Pre-intervention Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychometric</td>
</tr>
<tr>
<td>---------------</td>
</tr>
<tr>
<td>PSS-SR</td>
</tr>
<tr>
<td>GHQ-28</td>
</tr>
<tr>
<td>ISI</td>
</tr>
</tbody>
</table>

The IAM pre-intervention group psychometric outcomes of the PSS-SR (M=38.22, SD=7.95, Median=40, Range=26-48) denote a mean group score classifiable for the presence of PTSD. The GHQ-28 (M=50.67, SD=18.85, Median= 46, Range= 25-84) group mean score denotes a classification of psychological distress; and the ISI (M= 19.78, SD= 5.07, Median= 18, Range= 12-26) group mean score denotes clinical insomnia (moderate severity).

Table 6.0 - IAM group psychometric outcomes post-intervention attendance

<table>
<thead>
<tr>
<th>IAM Post-intervention Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychometric</td>
</tr>
<tr>
<td>---------------</td>
</tr>
<tr>
<td>PSS-SR</td>
</tr>
<tr>
<td>GHQ-28</td>
</tr>
<tr>
<td>ISI</td>
</tr>
</tbody>
</table>

The IAM post-intervention group mean outcome of the PSS-SR (M=34.14, SD=8.88, Median= 34, Range=20-44) indicates the continued presence of PTSD. The GHQ-28 (M= 54.57, SD= 17.29, Median= 55, Range= 34-82) group mean score shows the continuation of psychological distress; and the ISI (M= 20.57, SD= 7.72, Median= 23,
Range= 6-27) group mean scores indicates the persistence of insomnia at the moderate severity classification level.

Table 7.0 - A comparison of the IAM psychometric outcomes pre and post intervention

<table>
<thead>
<tr>
<th>IAM Group Psychometric Outcome Comparisons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychometric</td>
</tr>
<tr>
<td>-----------------------------</td>
</tr>
<tr>
<td>PSS-SR</td>
</tr>
<tr>
<td>GHQ-28</td>
</tr>
<tr>
<td>ISI</td>
</tr>
</tbody>
</table>

The IAM mean group scores for the PSS-SR were -11% lower at the 3-week follow up point (M= 34.14, SD= 8.88, Median= 34, Range= 20-44), than they were at the pre-intervention stage (M= 38.22, SD =7.95, Median= 40, Range= 26-48). However, the mean (M=54.57, SD= 17.29, Median= 55, Range= 34-82) 3-week follow-up scores for the GHQ-28 were +8% higher than the mean (M= 50.67, SD= 18.85, Median= 46, Range= 25-84) pre-intervention scores; while, the ISI pre-intervention mean marginally increased (M= 19.78, SD= 5.07, Median= 18, Range= 12-26) by +4% following attendance to the IAM intervention (M= 20.57, SD= 7.72, Median= 23, Range= 6-27).

### 3.2.7. Introduction to mindfulness

The proceeding tables illustrate the descriptive statistics for the ITM psychometric evaluation (PSS-SR, GHQ-28 and ISI) scores at the pre (table 8.0) and 3-weeks’ post (table 9.0) intervention group measurement points. Table 10.0 denotes the likely clinical effectiveness of the ITM group psychological intervention from examining the group's pre and post group psychometric evaluation measurements.

Table 8.0 - ITM group psychometric outcomes pre-intervention attendance

<table>
<thead>
<tr>
<th>ITM Group Pre-intervention Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychometric</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>PSS-SR</td>
</tr>
<tr>
<td>GHQ-28</td>
</tr>
<tr>
<td>ISI</td>
</tr>
</tbody>
</table>
The ITM pre-intervention PSS-SR (M=32.40, SD=5.03, Median=32, Range=25-38) mean score indicates a group classification of PTSD. The GHQ-28 (M=39.20, SD=4.76, Median=41, Range=32-44) group mean score denotes the presence of psychological distress; and the ISI (M=17.20, SD=5.07, Median=16, Range=13-26) group mean score indicates clinical insomnia at a moderate severity.

Table 9.0 - ITM group psychometric outcomes post-intervention attendance

<table>
<thead>
<tr>
<th>Psychometric</th>
<th>Mean</th>
<th>Stnd.Dev</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSS-SR</td>
<td>32.60</td>
<td>4.83</td>
<td>34</td>
<td>27-37</td>
</tr>
<tr>
<td>GHQ-28</td>
<td>40.20</td>
<td>11.82</td>
<td>37</td>
<td>32-61</td>
</tr>
<tr>
<td>ISI</td>
<td>20.80</td>
<td>4.82</td>
<td>21</td>
<td>15-26</td>
</tr>
</tbody>
</table>

The ITM post-intervention outcomes of the PSS-SR (M=32.60, SD=4.83, Median=34, Range=27-37) illustrate that the group remained classifiable with PTSD. The GHQ-28 (M=40.20, SD=11.82, Median=37, Range=32-61) group mean scores showed that collectively the women remain classifiable as psychologically distressed; and the ISI (M=20.80, SD=4.82, Median=21, Range=15-26) group mean score indicates the continued experience of clinical insomnia at the moderate severity rating.

Table 10.0 - A comparison of the ITM psychometric outcomes pre and post intervention

<table>
<thead>
<tr>
<th>Psychometric</th>
<th>Pre-intervention Mean</th>
<th>Post-intervention Mean</th>
<th>Outcome % (+/-)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSS-SR</td>
<td>32.40</td>
<td>32.60</td>
<td>+1%</td>
</tr>
<tr>
<td>GHQ-28</td>
<td>39.20</td>
<td>40.20</td>
<td>+3%</td>
</tr>
<tr>
<td>ISI</td>
<td>17.20</td>
<td>20.80</td>
<td>+21%</td>
</tr>
</tbody>
</table>

The ITM post-intervention mean scores showed an increase for all 3 psychometric (PSS-SR, GHQ-28, ISI) evaluation outcome measures when compared to the pre-intervention scores. The PSS-SR post-intervention group mean (M=32.60, SD=4.83, Median=34, Range=27-37) increased marginally by +1%; the GHQ-28 post-intervention group mean (M=40.20, SD=11.82, Median=37, Range=32-61)
observed a marginal increase at +3%. However, the ISI pre-intervention group mean ($M=17.20$, $SD= 5.07$, $Median= 16$, $Range= 13-26$) increased +21% ($M=20.80$, $SD= 4.82$, $Median= 21$, $Range= 15-26$) at the 3-week follow up.

### 3.2.8. Improving your sleep

The following tables reveal the descriptive statistics for the IYS psychometric evaluation (PSS-SR, GHQ-28 and ISI) scores at the pre (table 11.0) and 3-weeks’ post (table 12.0) intervention group measurement points. Table 13.0 provides an indicative examination of the clinical effectiveness of the IYS group psychological intervention from comparing the group pre and post intervention psychometric measurements.

#### Table 11.0 - IYS group psychometric outcomes pre-intervention attendance

<table>
<thead>
<tr>
<th>Psychometric</th>
<th>Mean</th>
<th>Stnd.Dev</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSS-SR</td>
<td>38.71</td>
<td>6.42</td>
<td>37</td>
<td>29-49</td>
</tr>
<tr>
<td>GHQ28</td>
<td>51.29</td>
<td>13.72</td>
<td>48</td>
<td>42-69</td>
</tr>
<tr>
<td>ISI</td>
<td>19.71</td>
<td>4.68</td>
<td>18</td>
<td>14-28</td>
</tr>
</tbody>
</table>

The IYS pre-intervention group outcomes of the PSS-SR ($M= 38.71$, $SD= 6.42$, $Median= 37$, $Range= 29-49$) reveal the presence of PTSD. The GHQ-28 ($M= 51.29$, $SD= 13.72$, $Median= 48$, $Range= 42-69$) denotes a group mean score classifiable as experiencing psychological distress; and the ISI ($M= 19.71$, $SD= 4.68$, $Median= 18$, $Range= 14-28$) group mean score indicates the presence of clinical insomnia (moderate severity).

#### Table 12.0 - IYS group psychometric outcomes post-intervention attendance

<table>
<thead>
<tr>
<th>Psychometric</th>
<th>Mean</th>
<th>Stnd.Dev</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSS-SR</td>
<td>34.17</td>
<td>8.18</td>
<td>35</td>
<td>21-46</td>
</tr>
<tr>
<td>GHQ-28</td>
<td>45.00</td>
<td>15.89</td>
<td>40</td>
<td>25-67</td>
</tr>
<tr>
<td>ISI</td>
<td>12.67</td>
<td>3.44</td>
<td>12</td>
<td>9-19</td>
</tr>
</tbody>
</table>

Table 12.0 reveals the post-intervention psychometric outcomes of the IYS group and
the PSS-SR (M= 34.17, SD= 8.18, Median= 35, Range= 21-46) group mean score illustrates the women’s PTSD persistence three weeks after attending for the intervention. The GHQ-28 (M= 45.00, SD= 15.89, Median= 40, Range= 25-67) group mean score also evidences the women’s continuation of psychological distress. However, the ISI (M= 12.67, SD= 3.44, Median= 12, Range= 9-19) group mean score indicated that at post-intervention measurement the women’s insomnia improved to a level classifiable as sub-threshold insomnia.

**Table 13.0 - A comparison of the IYS psychometric outcomes pre and post intervention**

<table>
<thead>
<tr>
<th>Psychometric</th>
<th>Pre-intervention Mean</th>
<th>Post-intervention Mean</th>
<th>Outcome % (-/+)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSS-SR</td>
<td>38.71</td>
<td>34.17</td>
<td>-12%</td>
</tr>
<tr>
<td>GHQ-28</td>
<td>51.29</td>
<td>45.00</td>
<td>-12%</td>
</tr>
<tr>
<td>ISI</td>
<td>19.71</td>
<td>12.67</td>
<td>-36%</td>
</tr>
</tbody>
</table>

The 3-week post-intervention psychometric means for the IYS group revealed a decrease in all 3 of the psychometric (PSS-SR, GHQ-28, and ISI) outcomes when compared to the respective pre-intervention means. The descriptive statistics showed a -12% lowered group mean for the PSS-SR (M= 34.17, SD= 8.18, Median= 35, Range= 21-46) and GHQ-28 (M=45.00, SD= 15.89, Median= 40, Range= 25-67) at the post-intervention point. While, the ISI post-intervention group mean (M= 12.67, SD= 3.44, Median= 12, Range= 9-19) was measured -36% lower than the pre-intervention point (M=19.71, SD= 4.68, Median= 18, range= 14-28).

**3.2.9. Exercise as therapy**

The proceeding tables illustrates the descriptive statistics for the EAT psychometric evaluation (PSS-SR, GHQ-28 and ISI) scores at the pre (table 14.0) and 3-weeks’ post (table 15.0) intervention group measurement points. Table 16.0 denotes the likely clinical effectiveness of the EAT group psychological intervention for supporting the women to manage their trauma symptomatology from comparing the psychometric evaluation data at the pre and post treatment points.
Table 14.0 - EAT group psychometric outcomes pre-intervention attendance

<table>
<thead>
<tr>
<th>Psychometric</th>
<th>Mean</th>
<th>Std.Dev</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSS-SR</td>
<td>33.70</td>
<td>7.78</td>
<td>35</td>
<td>22-38</td>
</tr>
<tr>
<td>GHQ-28</td>
<td>42.00</td>
<td>8.33</td>
<td>40</td>
<td>36-60</td>
</tr>
<tr>
<td>ISI</td>
<td>17.90</td>
<td>3.73</td>
<td>18</td>
<td>13-23</td>
</tr>
</tbody>
</table>

The EAT pre-intervention group mean scores of the PSS-SR ($M= 33.70$, $SD= 7.78$, $Median= 35$, $Range= 22-38$) signify a collective score classifiable for PTSD. The GHQ-28 psychometric ($M= 42.00$, $SD= 8.33$, $Median= 40$, $Range= 36-60$) group mean score indicates the presence of psychological distress; and the ISI ($M= 17.90$, $SD= 3.73$, $Median= 18$, $Range= 13-23$) group mean score suggests that collectively the women are classifiable as experiencing clinical insomnia (moderate severity).

Table 15.0 - EAT group psychometric outcomes post-intervention attendance

<table>
<thead>
<tr>
<th>Psychometric</th>
<th>Mean</th>
<th>Std.Dev</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSS-SR</td>
<td>28.17</td>
<td>9.52</td>
<td>31</td>
<td>12-39</td>
</tr>
<tr>
<td>GHQ-28</td>
<td>36.33</td>
<td>17.31</td>
<td>31</td>
<td>16-57</td>
</tr>
<tr>
<td>ISI</td>
<td>15.83</td>
<td>4.58</td>
<td>16</td>
<td>9-22</td>
</tr>
</tbody>
</table>

In table 15.0 the EAT post-intervention group mean score for the PSS-SR ($M= 28.17$, $SD= 9.52$, $Median= 31$, $Range= 12-39$) indicate the persistence of PTSD in the detained women. The GHQ-28 ($M= 36.33$, $SD= 17.31$, $Median= 31$, $Range= 16-57$) group mean score denotes the continuation of psychological distress. However, the group mean scores for the ISI ($M= 15.83$, $SD= 4.58$, $Median= 16$, $Range= 9-22$) suggests an improvement of sleep, which is now classifiable as sub-threshold insomnia.
Table 16.0 - A comparison of the EAT psychometric outcomes pre and post intervention

<table>
<thead>
<tr>
<th>Psychometric</th>
<th>Pre-intervention Mean</th>
<th>Post-intervention Mean</th>
<th>Outcome % (+/-)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSS-SR</td>
<td>33.70</td>
<td>28.17</td>
<td>-16%</td>
</tr>
<tr>
<td>GHQ-28</td>
<td>42.00</td>
<td>36.33</td>
<td>-14%</td>
</tr>
<tr>
<td>ISI</td>
<td>17.90</td>
<td>15.83</td>
<td>-12%</td>
</tr>
</tbody>
</table>

The EAT post-intervention psychometric outcomes (PSS-SR, GHQ-28, and ISI) revealed all the measurements to be lower than the mean scores recorded at the pre-intervention stage. The PSS-SR pre-intervention group mean (\(M=33.70\), \(SD= 7.78\), \(Median=35\), \(range= 22-38\)) declined -16% when taken at the 3-week follow-up point (\(M=28.17\), \(SD= 9.52\), \(Median=31\), \(Range= 12-39\)). The GHQ-28 post-intervention group mean (\(M=36.33\), \(SD= 17.31\), \(Median=31\), \(Range= 16-57\)) reduced by -14%; and the ISI pre-intervention group means (\(M=17.90\), \(SD= 3.73\), \(M= 18\), \(Range= 13-23\)) lowered -12% (\(M=15.83\), \(SD= 4.58\), \(Median= 16\), \(Range= 9-22\)) 3 weeks post treatment.

3.3. Qualitative data

3.3.1. A summary of the qualitative findings

The qualitative work derived from the thematic analysis of the discourse of the study’s six focus groups delivered the development of six themes that illuminated the experiences of the detained women who accessed the HMP’s group psychological interventions and the CMHT staff who facilitated the groups. The theme ‘a pathway to care’, described how inadequate communication is impeding the efficient employment of women into group psychological interventions. The ‘prisoner or patient paradox’, denotes how healthcare professionals who work in the prison can unhelpfully perceive the women as prisoners before patients and query the women’s motivation for requesting medication, which leaves some women with the drive to self-injure to validate the authenticity of their pain. The theme ‘stigma as a therapeutic barrier’, revealed the prejudices towards mental health in the prison, which can result in some women minimalizing their psychological distress and affect their treatment intentions. The theme, ‘the retraumatising nature of prison’ offered an understanding of how the castigatory nature of prison can for the detained women bring reminders of past episodes of victimisation, which can cause a process of retraumatisation. The theme, ‘the
significance of sleep’, substantiated the wider literature (Singleton et al., 1998; and Dewa et al., 2011) that proposes the difficulties that women in prison have in achieving a good sleep quality. The theme provided evidence to support a relationship between hyperarousal with insomnia and an indication that poor sleep education could innocuously be maintaining the women’s sleep difficulties. The final theme ‘women as stakeholders’ explicitly recognised the women as important stakeholders in the research process. The women disclosed information about their mental health referrals, information about their pathway to the group interventions and patient led ideas for service improvements.

3.3.2. A pathway to care

The focus groups provided an opportunity for the women to talk about their experiences of accessing the prisons CMHT and the Women’s Therapy service that provides group psychological interventions. Collectively the women in the focus group were aware of the referral procedures to access the CMHT and Women’s Therapy, but individually the women were unsure about the various ways a referral could be made to the CMHT. The women were able to explain that they can access the CMHT from submitting a self-referral, or a referral can be made on their behalf by a member of the healthcare team, the substance misuse team or another member of staff working with the women in the prison. The women in the focus group were unanimous in their agreement about the importance of being able to access a CMHT in prison due to the high number of detained women who require the support of mental health services. However, the women highlighted an intrinsic failing at the early stages of the referral process in that many women on arrival to HMP are unaware of the provision of the prison’s CMHT and the psychological groups.

“One of the biggest things about mental health is people not being supported and I think that there is a lot of people, who need it like, but they don’t know how to access it, they don’t know how to get referred.” (GFG, 1)

“People are asking me… When you go to Women’s Therapy give my name, so there are people which want to come but they don’t know how to access it.” (GFC, 2)

Several of those who attended the focus groups were of the opinion that increasing knowledge about the CMHT and the Women’s Therapy service is the responsibility of the prison’s NHS service provisions. Primarily, their reasoning was that without knowledge of the service it is difficult to seek a referral for the appropriate support; “/
think that you need to learn about your service, there isn’t much information, I haven’t
seen any, only what you posted me, I didn’t see any information leaflets or anything
on Women’s Therapy…” (IYS, 3). The lack of communication to detained women
about the CMHT service operating from within the prison provided an avenue for the
women to talk critically about the referral procedures for the CMHT. The majority of
women explained that they received insufficient communication from NHS staff about
the referral made on their behalf to access the Women’s Therapy service. Some
women spoke about only becoming aware that a referral had been made for them to
receive group psychological support when they received the CMHT letter inviting them
to attend a Women’s Therapy group; “I didn’t know anything. It wasn’t until the letter
did I know about it and that I was referred to some session” (IYS, 4). Although the
majority of women were referred to the CMHT through the healthcare team, these
women appeared to receive minimal information from the referrer about the nature of
the group that they were being referred; “I had no clue what it was about. I didn’t know
if I was coming for my anxiety or sleep.” (IAM, 5). The problems in the communication
of the staff member to the detained woman about the referral process can be evident
in the women’s difficulties recalling which staff member was responsible for their
referral because it would suggest that their inability to remember means that there
was a lack of discussion about the process. This dearth of communication from the
staff member may indicate that the referrers themselves have insufficient knowledge
about the groups, as indicated by one woman; “She was alright actually, but it did take
a long time, but when I first come in she referred me, she didn’t know a lot about it but
she knew these groups.” (EAT, 6); or it may also be that the referrer is unaware about
the importance of delivering information to the service user about the psychological
groups.

“I think mine was through the GP because of sleep. I was getting referred for sleep
and somehow it must be something to do with you all.” (ITM, 7)

“I can’t actually remember…it was either an officer or a nurse who referred me.” (IAM,
8)

The women also brought attention to the encountered difficulties with NHS provisions,
when they were trying to secure the referral to receive psychological group
intervention. Several women who were working concurrently with staff from
healthcare and the substance misuse team experienced a disorganization in the
referral process that could be related to a lack of communication between the
individuals involved in their care. It appears that a weakness in the referral process is that the member of staff, either in healthcare or substance misuse, who has the first contact with the woman, can overlook completing a referral for the psychological groups. Therefore, it may be that there is a judgment from staff involved in the woman’s care that another member of staff would make the referral for psychological support, which means there will be a delay in the referral process and treatment from disorganization. However, no matter the staff inefficiency in communication, a fundamental flaw in the referral process is the lack of communication with the woman concerned. An occurrence that can put responsibility on the woman being the initiator for chasing the progress of her own referral, which could contribute to her confusion about the referral process, her distress and dissatisfaction with services.

“Well, when I was having my appointments to see a doctor and substance misuse I just kept on asking and I was saying that nobody has come to see me and what do I do about it? And they say, well you’ll have to have an appointment with someone first then well you’ll get referred. But like I said it took 4 people to see before the last one then, who did finally refer me and that took a couple of months that did, just to get that far.” (IAM, 9)

“…she referred me to them, but I had to see a doctor in-between that and I had to see a doctor before that, then I had to see three people before I got my name down, it was my carrot worker and my nurse, then a doctor and then the misuse worker and then when I saw I had my appointment for substance misuse with the doctor or whoever he is, then I got referred to this place then.” (ITM, 10)

The inadequacies in communication from some healthcare and substance misuse staff to the service users during the referral process to Women’s Therapy can also be seen in some staff working for the CMHT, who can refer the women for psychological groups without providing them with a meaningful discussion about the referral; “I never asked for the anxiety group, I was just told by mental health that there was groups, I didn’t ask for anything and I wasn’t told I was put on this…I didn’t even know if I was anxious, I knew I was anxious, but I didn’t know it was as bad to need a group.” (IAM, 11). Several of the women were dissatisfied with the interaction provided by the CMHT staff during the referral process, and one dissatisfaction was in the quantity of time allocated to them during assessments as detailed by two women in the focus groups; “…I think there should have been a lot more support that could have been given. Like five minutes doesn’t get you far.” (EAT, 12); and “Yeah, literally a five-minute conversation.” (EAT, 13). The time the CMHT allocated to these women left them
feeling unsupported and confused about the referral process; “… you’re just not understanding anything, as it’s just been chucked at you.” (ITM, 14); which led another woman to say; “You know what gets me angry? I was put on mental health. They came over to assess me and then they said they’ll come back to assess me later on and when they came back they didn’t ask me anymore questions, they just dismissed me.” (ITM, 15). Other women appeared to agree with these sentiments of dissatisfaction in elements of the CMHT service during the referral process to psychological groups. The women indicated that the referral process, which can take several weeks provides just one session for group support. The women, needs dependent can be referred to further psychological support after attending the introductory group; however, for the women the whole process can leave them feeling unsupported before, during and after the referral has been processed; “…and after a few months you get a letter through your door saying you’ll get a little bit of therapy and you think that’s that for another 5 months.” (ITM, 16).

3.3.3. The patient or prisoner paradox

The identity awareness of the detained woman as both a patient and prisoner appears apparent on her arrival to prison. The women are greeted at the prison reception, a location where many women begin to assume that certain ‘wings’ can cater for specific health needs, like drug or alcohol dependencies or mental health difficulties. Thus, there seems a common misconception in many women that reception acts as the first step on the women’s care pathway to accessing patient service provisions for psychological or medical rehabilitation.

“Yeah, I think everyone gets to see the nurse when they come in and then it’s kind of like they’re deciding where to put you and what place to put you in when you get in and they ask if you’ve got any addictions, and if you haven’t you go on the induction wing and they ask you about your mental health and I said how bad it is, so they’ll send you to certain places.” (GFG, 17)

“I think they watch and see how you are like, if your mental health is that bad, usually they’ll put people on res 4, which is known as like the wing, like for the worst off people like.” (GFG, 18)

“I reckon that they’ll watch some people and start to put any kind of people with mental health issues on E wing.” (GFG, 19)
These quotes above indicate that some women have a lesser focus of prison as an establishment for criminal rehabilitation, which minimizes their identity as a prisoner. Whereas, the prison system appears catered to reinforcing the women's identities as prisoners with less overt emphasis upon establishing a pluralism in the women's identity where they can be both prisoner and patient. This notion appears propagated through prison staff, who can freely remind the women to their perceived interpretations about the purpose of prison and the women's identity within the prison as prisoners.

“They say that a lot don't they? ‘Remember where you are’, like.” (EAT, 20)

“We’re acting like princesses, we should remember where we are, we’re here for a reason.” (EAT, 21)

“You’re in prison, you deserve to be punished.” (ITM, 22)

“…ok we might have made mistakes and we’ve been punished, we’re in prison but we need supporting in here as well, whatever people have, issues or problems we still need support.” (ITM, 23)

There appears a challenge for prison staff to keep hold of the woman's identity as a prisoner when the woman perceives herself as a patient. This can make prison staff seem unsympathetic or punitive to the care needs of the women, contributing to her feelings of frustration. Perhaps from the perspective of the prison staff, this is a welcomed reciprocal transference and countertransference to such emotions because it allows the prison an opportunity to demonstrate to both parties that its staff's role is to manage security as opposed to supplying empathetic care. This conflict between the staff and the detained woman reinforces perceived prisoner identities and this vindicates the identity of the prison system within society.

“…and I’ll do everything I can do to not come back. I’ve got my head sorted, well not sorted but I’ve got a plan for when I’m out and it’s not yeah get off me face and do this and carry on how I was before I came in; but then they just put you down again saying “yeah, you’ll be back”. (IAM, 24)

“When I was ill they told me I had to go into group and I said I wasn’t very well. They told me I had to get a sick note and then I got a sick note and they told me that I still
had to go in…and then a conversation I had with one of them was that I don’t like the way I was being spoken to like a child… and basically… she said we’re in here and we’re treated like this because we couldn’t look after our own children on the out … They knew my only trigger is my kids, saying I can’t look after my kids to me, I’m surprised I didn’t punch her in the face to be honest.” (IAM, 25)

Several of the women interviewed appeared mindful to the struggles that staff working in prison can have in understanding and managing the woman who is presenting as the patient, this was particularly notable for many women who were expressing psychological distress. This staff quandary then becomes a predicament for the woman wanting access to the prison’s health care services because it can leave her with the belief that she needs to substantiate her morbidity and patient identity in order to receive appropriate patient intervention.

“A lot of the people you come across have talked to officers, reception or doctors or nurses and they look at you and think that you are lying. A lot of the stuff that you say or try explaining, they think that you are lying, don’t they? And that you’re just saying that cause you want something like”. (EAT, 26)

“They don’t see mental health as a priority. As far as they are concerned your attention seeking or copying behaviours or yeah are just a difficult person.” (EAT, 27)

“You’ll have to prove to them in here that you’ve got mental health issues and wait for your doctor’s record and then they’ll give you your medication. They don’t believe you from word of mouth, they don’t believe you cause you’re a prisoner.” (IAM, 28)

Many women in the focus groups spoke about how the prisons health care system similarly perceives them as the prisoner who has an ulterior motive for seeking medical or psychological intervention. The perception that you can be disbelieved for wanting support with a genuine health condition means that the woman can be left feeling that she needs the identity of someone who is perceived as a genuine patient. This can leave her with a difficult conundrum because many trauma symptoms are concealed within her own body and mind. Therefore, the patient needs sagacity in how to represent their personal distress to staff to increase the prospect of accessing their desired health care intervention. However, perhaps when the prison principally perceives and treats the women as prisoners it creates a paradoxical outcome, whereby the women feel that in order to be perceived as a patient they need to project
their internal psychological distress in a fashion that relinquishes her prisoner identity.

“And yeah what I’ve seen to be taken seriously you need to go to massive extremes like cut yourself, overdose, slit your wrist, or do something really serious to be taken serious by an officer, otherwise its mental health ‘get over it’. They tar everyone with the same brush and presume you’re ok unless something like that happens”. (GFG, 29)

“Yeah I was having a breakdown on the wing so the officer got the mental health worker to see me…” (ITM, 30)

The difficulties for the prison in recognising a pluralism in an identity of the woman between the patient and the prisoner is not exclusive to just the areas principally controlled by prison staff. Healthcare workers who are operating within the prison can also have difficulties in how they perceive and thus manage their patients. The accounts of some women in the focus groups reveal that health care staff may foremost view the woman as the prisoner and negate the fact that for them she is principally the patient. In the focus group, there appeared agreement to an opinion that women are frequently viewed as a malingering prisoner, seeking prescription medication for recreational purposes. Many women in the focus group sympathised to the difficulties that can be present for health care staff when working with women in prison; however, collectively there was an importance placed upon first being viewed as the genuine patient.

“In jail, it’s about medication, I can obviously see where they are coming from, they don’t want to give to those who palm it, but they shouldn’t tar us all with the same brush.” (IYS, 31)

The discourse of the focus groups also appeared to reveal that for many women their identity as either a patient or prisoner is frequently related to situations around the need for medication. During these periods, the woman’s identity becomes a malleable construct ostensibly related to its convenience to the health care worker. One woman spoke about the difficulties she experienced when wanting to discuss a medication query with a nurse and for the detained woman the most convenient time for her to discuss this matter was during the dispensing of her medication. However, her ability to engage with the health care staff during this time was hindered because of the short time frame allocated to the medication round. Therefore, to manage her query it
appeared easier for the staff members to treat the woman as a prisoner through reduced engagement, which ensures a more efficient running of their service.

“And when you try and speak to staff, you’ve got loads of other people speaking as well. Even when you go to the hatch at two, it’s the same; they’re like” hurry up, hurry up.” (IAM, 32)

The women in the focus groups appeared to agree that prison requires a greater direction in establishing its provision of service to accommodate the specific psychological and health needs of women, as opposed to focusing its priority as a means to detain. For some of the women, who had experienced periods of time living in a mental health hospital, they appeared effortless to hold themselves to the patient identity. These women provided a sensibility about the obviousness that prison staff working in women’s prisons should be able to provide appropriate psychological support and engage with the women as patients.

“They need support workers, they need to be like them, obviously if 90% of women have mental health then surely the staff should be trained for mental health needs, you can’t work in mental health hospitals if you haven’t got any qualifications or no understanding about the support you have to give”. (GFG, 33)

Although the women in prison in some context can talk to prison staff about ongoing concerns or utilise the ‘listener service’, the women appear more comfortable to discuss personal concerns with their peers. However, this means the women need to think about issues related to confidentiality and they are aware that the disclosure of emotional content, which is a cathartic process could for the recipient become an emotional burden for someone who is likely to have her own personal difficulties. Alternatively, the women would prefer to be the patient, where they can receive support from workers who understand their emotional and psychological needs, who are bound by the nature of confidentiality. It appears that many of the women in the focus groups perceive prison as an unsupportive environment for helping them manage their psychological distress, which for many women triggers feelings of loneliness and isolation.

“In my mental health hospital, I found I had people I can talk to anytime I wanted and they were a great support, positive people, but in here I’ve got nobody, I feel isolated… I’ve no credit on my phone to phone anybody, you don’t want to talk to people to other
prisoners about our personal problems, they've got enough to deal with themselves”. (GFG, 34)

“There is more freedom in prison than a mental health hospital, I was in a medium secure so its lock down all the time, but being here I feel more lonely. I know I’m surrounded by people, but I’m alone. I ain’t gunna just go to an officer and say I feel like you know what I mean? I felt like self-harming”. (GFG, 35)

“It adds extra pressures you don’t need, you’re already cut off from friends and family, there’s no support there and then if you haven’t got friends in here, what are you supposed to do? The prison doesn’t really provide any support, you’ve got the listening services but they don’t care about that now, they’re shipping them out, they suspended it.” (GFG, 36)

3.3.4. The retraumatising nature of prison

Participants in the focus groups talked about the difficulties that the institution of prison can provide, which ostensibly stems from the inherent power imbalances operating between prison staff and the detained women. The basis to these imbalances in power may be unwitting and relate to the prison’s need to operate from a security based-model as opposed a framework that considers psychological trauma. Issues around disempowerment became an emotive subject for the women, particularly when conversation centred on the prison staff’s use of force and search of the person, which from the discourse could be argued to be procedures that are inappropriate for women because the experience of powerlessness appears a catalyst for retraumatisation. The emotive data of this theme predominantly emerged from the IAM focus group and the analysis required more than the intended contextualist approach. Thus, an integrative qualitative approach was used to elucidate the phenomenon of prison based retraumatisation. The ability to integrate other qualitative methods from within a thematic analytical approach is reasoned from the work of Braun and Clark (2006), who explain thematic analysis to be a ‘flexible’ and ‘useful research tool’ that provides ‘theoretical freedom’ to enable ‘a rich and detailed, account of the data’. Therefore, to acknowledge the women’s trauma histories and how such experiences can affect the interpretation of the women’s prison life, a two level narrative analysis was provided to chronicle the women’s reality (Wengraf, 2006). However, deeper examination of the IAM focus group data indicated an intertextuality, which appeared amenable to the use of discourse analysis. Intertextuality, according to Fairclough (1992c) is the processes of how language
draws upon past events, which can change an individual’s discourse and the construction of their social reality. The assimilation of discourse analysis within a thematic analytical approach enables a richer understanding into how a past traumatic experience can influence the detained women’s cognitive appraisals of prison life.

The majority of women in one focus group spoke about witnessing prison staff force towards a detained woman and the group’s reflection about this incident provided insight into the women’s opinions about the use of controlled restraint techniques. The focus group appeared unanimous in their disapproval of force against women and the contextual inferences of such force for women can be seen in the following data extract; “they caused things, they slammed her hand, they suffocated her, and they slammed her down.” (IAM, 37) A narrative analysis of this statement can allow the telling of two experiences, in the first level the narrative explains the woman’s recount of the restraint. In the second level, the narrative indicates the woman’s own previous traumatic experience, which was derived from analysis of the woman’s hermeneutical syntax in the language used to describe the first narrative. The second narrative relies on interpretative suppositions about the woman’s traumatic past, but this was confirmed from the scrutiny of her PSS-SR psychometric, which indicates a past subjugation of sexual violence. The second narrative can be explained as follows, “they caused things”, which can denote the part others played in her personal trauma; the focusing of “they slammed her hand”, is a weapon focused appraisal that views the perpetrators disabling of her hand as a means to inhibit her protective riposte, “they suffocated her” may be a parallel to the perpetrator attempting to asphyxiate her, or breathlessness from an autonomous fear response; and “they slammed her down”, could allude to her position where she experienced the forced sexual violence. Therefore, this analysis would indicate that when women witness the use of force from prison staff, for women who have experienced trauma, the prison procedures and protocol could unwittingly become a trigger for retraumatisation.

“No man should lay their hands on a woman; they’re a fucking officer they shouldn’t. They shouldn’t put their hands on you.” (IAM, 38)

In contention to the previous narrative analysis, even women who at a realist level support the use of restraint within the prison, may make judgments in support of restraint because of their own traumatic past. The one woman in the focus group who provided support to the use of prison restraint believed that at times, “it can be your own fault because you caused it” (IAM, 39); which was a difficult perspective for the
other women to accept. The PSS-SR psychometric for this woman would indicate past sexual trauma from a known person and could provide an explanation for how she interpreted the witnessed restraint and perceives the narrative of her own traumatic past. In the first level narrative, the woman justifies the use of restraint to control a situation around risk; in the second level of the narrative, the woman may be conceding acceptance and justification of force to her personal experiences of a violent past. This can leave the woman in a quandary when an institution (e.g. family system or prison system) provides both sanctuary and harm. The predicament for the woman is if she challenges the care provider would this impede the sanctuary that is being offered. Further, the direct use of force for someone who has experienced violence may also denote that if she was in a situation of harm, she is now overtly aware that protection can be provided, a counterintuitive dilemma that can provide a perception of safety.

“If you consider a lot of people in here have gone through traumatic things in the past, the worst thing that can happen is being restrained by a man.” (IAM, 40)

The majority of the women in the focus group were unable to defend the use of force from prison staff, especially when the restraints involved men, which is a pertinent consideration when women have traumatic histories. The emotiveness about the use of prison force appears to release unwelcome feelings in the women, ones that may be similar to the feelings experienced at the time of their instigating trauma(s). This could also indicate a process of retraumatisation, observed in the use of language like “fear” (IAM, 41), “intimidated” (IAM, 42), “disgusting” (IAM, 43) and the anger seen in their swearing when expressing a personal opinion. This retraumatisation is further evidenced when some of the women detailed an inescapable sense of susceptibility to prison initiated force. One woman explained that knowing she can be restrained at any moment felt “quite scary” (IAM, 44), it made another woman “feel anxious” (IAM, 45) and there was a general agreement within the focus group that restraint causes the women to repetitively “worry about what you’re doing” (IAM, 46). At the first level narrative, these accounts seem to indicate a retraumatisation and at the second level narrative there is elucidation about the women’s own personal experiences of trauma. Evidentially, from the perspective of the detained women, this could indicate that prison restraint is the potential to be retraumatised, which is seemingly confirmed when the women talk about feeling “vulnerable” (IAM, 47); and how “in here you’re so powerless, you’re puppets on a string and anything, anything can be done to you, pretty much” (IAM, 48).
Besides the distress, that restraint can cause women who are detained in prison; other security procedures can also induce traumatic feelings, ones particularly distressing for the individual who has been exposed to sexual violence. Some of the women in the focus group explained that if the prison has ‘intelligence’, it could be required for the woman’s cell and person to be searched. On occasion, the search of the woman, which is carried out by a female member of staff can include the removal of clothing. The first level narrative of the women describing the protocol of personal searches indicates the distaste in the procedure. The women referred to the protocol as a “strip search” (IAM, 49) and explained the search in a way to indicate that there is an almost insidious sexual undertone. The women appeared to assume that a search of the person would more likely be carried out by a gay female staff member and that staff would willingly neglect to inform the woman of her rights when a search is being carried out, meaning that she could needlessly remove her underwear. At a second level narrative, the “strip search” appears to allow the woman’s indignity to become an opportunity for the staff member to receive sexual gratification. Thus for women with a trauma history, how she perceives the prison search will influence if the search becomes a mechanism for retraumatisation.

“You feel vulnerable cause you’ve got no control over nothing, there’s not a thing you can do if they say strip search”. (IAM, 50)

“I don’t think it’s right as well, where you’ve got to be stripped searched from intelligence for whatever. We’ve got to be stripped searched by an officer that’s a lesbian; I think that’s out of order.” (IAM, 51)

“Defenceless.” (IAM, 52)

“You haven’t got to squat or take your knickers off, but they don’t tell you that.” (IAM, 53)

Empathizing that the women have a history of experiencing sexual violence permits a compassionate understanding into why searches of person would provide the women with sexualized connotations. For example, the women imply that the intelligence behind protocols like searches can appear conspicuous; “…with the intelligence you can’t challenge it, it’s really dangerous, cause literally someone can say something about you and that’s on your file and it stays there and you often don’t
know about it until something comes up and it’s mentioned to you, and you’re like what the hell?” (GFG, 54); a statement that at the first level narrative denotes an awareness about power imbalances between the women and the prison staff. At the second level narrative in the discourse that took place within the focus groups about searches and prison intelligence, there were connotations that searches are unwitting reminders to the women’s past traumatic experiences. The women’s sexual traumas have often been carried out through coercion or force, with potential perceived punitive actions if they are not willing participants. Therefore, retraumatisation can occur in prison when the women are experiencing an unwanted removal of clothing because previously for the woman this may have been the trigger for sexual violence. The perception that searches have sexualized connotations is supported when one of the women held an opinion that imprisoned men are not exposed to the same indignities; “They wouldn’t do that in a men’s jail.” (GFG, 55). This indicates that for this member of the focus groups, she felt women are more likely than men to be compelled into sexual acts for the pleasure of others. It seems that for the women in the focus groups the search of the person can seem a manipulation of power that is subjecting them to a sexualized indignity. Therefore, due to the power imbalances operating within prison establishments, when a woman is requested for a search of the person the woman knows that being uncooperative could for her result in a punitive outcome. Thus, prison protocols and procedures are conceivably contributing to a woman’s retraumatisation because the prison establishment is unwittingly operating in a way that draws reminders to the women’s past experiences of violence.

3.3.5. Stigma as a therapeutic barrier
Several women in the focus groups had experience of being prison residents from previous sentences. These women acknowledged that the therapeutic environment of ‘Women’s Therapy, ran by the CMHT has for many years been associated with misunderstandings. One woman explained that she believed people in prison “think we just come over here and I don’t know make cards and stuff.” (ITM, 56). Similar and unhelpful opinion that has been attached to Women’s Therapy were discussed within the facilitator focus group. Those who were long-term staff acknowledged that the “old Women’s Therapy” (FFG, 57), was a facility “purely for colouring, card making and playing games.” (FFG, 58). The facilitators acknowledged that the Women’s Therapy today is contrastingly different in being a psychologically informed environment; however, unhelpful perceptions about the previous service can still resonate with prison staff. The facilitator focus group brought disconcerting attention to the prejudices prison staff can hold about the women under the care of the CMHT and
Women’s Therapy. The extent of the prejudice was sufficient for one facilitator to say, “I think that some of the girls that do have problems are not necessarily coming here because of the name Women’s Therapy.” (FFG, 59). There seemed a consensus from the facilitators that certain prison staff propagate a view that the women who use the Women’s Therapy service have cognitive disabilities and that these women can be discussed in a way without any consideration for their respect or dignity.

“I think they still have the old view of Women’s Therapy… “Scribble and dribble”, seriously…I don’t know, it’s just discrimination isn’t it?” (FFG, 60)

“They talk about Women’s Therapy in a different tone of voice…connotations perhaps that the girls are quite vulnerable or not quite as intelligent to be very honest. It was for the most vulnerable when I first started here…it did have that reputation that they are a ‘bit thick’…and there are stigmas attached that people who have learning difficulties are regarded as being not at all bright.” (FFG, 61)

The women in the service user focus group were also aware that prison staff could hold disparaging and prejudiced opinion towards mental health and the Women’s Therapy service. The women talked from personal experiences of receiving prejudiced prison staff attitudes, which for them was an uncomfortable experience. The way the women spoke left a feeling that sometimes the remarks from prison staff were intentionally deprived of covertness and contentedly delivered without any consideration to the impact such comments can have for the recipient.

“They look you up and down if you go here; they say it’s only Women’s Therapy. They don’t give a shit what you feel. I don’t think they realize what goes on here.” (EAT, 62)

“They laugh at me at the gate and grin at me weirdly; I say shut up …Where are you going Women’s Therapy?” (Said in a prejudicial tone of voice) (EAT, 63)

“…It was a sly remark about me coming up this way. He didn’t have the balls to tell me.” (EAT, 64)

“All the time they do it.” (EAT, 65)

“A woman in the kitchen, one of the caterers, said to me, what do you want to go there for?” (ITM, 66)
Several women in the focus group related concerns about how prison staff hold stigmas towards mental health and how such prejudice can influence a woman’s decision to access psychological support; “…they don’t want to talk to officers as they don’t want to be referred by officers, they don’t want that stigma attached, I think there’s a lot of work needing to be done on that.” (EAT, 67). The women in the focus groups felt that in part these views about mental health and Women’s Therapy were perhaps derived from the earlier functioning of Women’s Therapy, which was more arts and crafts based. One woman who had experienced detrimental staff remarks felt that the prison staff needed to visit Women’s Therapy in order to change their opinions; “Let them in here, they’ll be able to see what it’s like then; they’ll see it’s not a googledy gonk wing.” (EAT, 68). However, the same woman, went on to discuss how prison prejudices towards mental health are not exclusive to staff and that her prison peers can similarly hold unhelpful judgements towards mental health. An opinion that was discussed by other women who attended the focus groups.

“I’ve been in and out of jail for 6 years, even when I was here first, I heard stuff about it. I heard it’s for nutters.” (GFG, 69)

“I don’t like it. Everyone is like, if you’re going to Women’s Therapy there is definitely something wrong with you.” (GFG, 70)

“There’s a stigma with it. In healthcare just now, I said I want to go to Women’s Therapy and some of the girls started laughing and I was like fuck you”. (EAT, 71)

“I was offered a lot from mental health, I don’t know why I didn’t come, I think it was what people say, how people judge you in here with mental health issues” (ITM, 72)

The discussion around the stigmas attached to Women’s Therapy allowed for the uncovering of how far reaching stigma and prejudicial opinion can be for women who live in prisons. It appears that for many of the women in the focus groups, being aware of the stigma attached to mental health and Women’s Therapy left them feeling that the prison system is conceding their anonymity. A common first awareness for the women about the potential compromising of their anonymity was upon receipt of the appointment letter to attend a Women’s Therapy intervention. The women explained that when you are new to the prison you are unfamiliar with the locations of various services and that they believe for security reasons there is little directional signage.
that can help them arrive at their intended destination. For some of the women this meant that they were presented with the dilemma of wanting to attend for their appointment but an acknowledgement that in order to find Women’s Therapy they will need to ask either a member of staff or a peer for directions. This compromising of her confidentiality in attending a psychological intervention opens up the possibility that the woman will receive the stigma associated with mental health.

“Well the letter has mental health on top and you don’t want people to judge you so you don’t want to show them the letter for directions to Women’s Therapy. I’ve only ever heard it’s for mental health and people who go there are… look I’ve got issues myself to be honest.” (IAM, 73)

The women in the focus groups also brought attention to experiencing a loss of anonymity on the due day of attendance to their respective psychological intervention at Women’s Therapy, which may unwittingly be related to prison security procedures. It was explained that when a woman leaves her wing the prison would place her name on a board that is observable to all who are present on the wing, a function designed to denote the woman's next place of locality. The women revealed that besides placing their name next to the words Women’s Therapy, the signage at times also states the name of the group that the person is due to attend, something which appeared less relevant for prison security. This lack of anonymity was something that the women found unsettling and a factor that could be further increasing the women’s likelihood to experience stigma from attending a psychological intervention.

“Sometimes the officers have it up” (EAT, 74)

“It says Women’s Therapy and which group it’s to be, it says what’s it’s for.” (EAT, 75)

“We have it on the wing on a big board and the list is there and everyone has to go there every day” (ITM, 76)

A few of the women in the focus groups discussed how anonymity about their need to attend Women’s Therapy has been challenged when group facilitators have needed to make cell visits. “Yeah when you come down our wing they say there’s that Women’s Therapy man, see what he wants, they all know you’re coming for me.” (IAM, 77). The women explained how such visits, which are made with good intent, mean that those who observe have an opportunity to form a prejudicial opinion or
make an overt comment about the woman’s mental health. This was highlighted by one focus group member who said, "When you came to my door, they were saying check her out having to go to Women’s Therapy …making out that I might need help… that there’s something wrong… I went on one then.” (IAM, 78). The experiences of the women who spoke about receiving cell visits and the judgments that this can bring, provided insight into the conflict that some women must have when recognizing that they need CMHT support. For example, the woman experiencing psychological difficulties may need to weigh up if the support of Women’s Therapy will be outweighed by the burden of the stigma attached to receiving the support.

There was an opinion held from some of the women that the stigma associated with mental health in prison was strong enough for women who need the services of Women’s Therapy to refuse consideration of the service; “People aren’t coming to Women’s Therapy… They think coming here makes you googledy bonk.” (GFG, 79). Perhaps conflicts like these can be seen in the following data extract from one of the focus group participants when she recounted a discussion with a peer about accessing psychological services; “Can’t we talk to Gavin? I’m not fucking mental though”. “And I said neither am I fucking mental, I’m just having some support while I’m here and you can have it too, doesn’t mean you’re mental though.” (IAM, 80). The word “mental” (IAM, GFG, 81) appears to many of the women in the focus group discussions to have unhelpful connotation and at times this was evident in the focus group discussions. Even benign discourse, without prejudice when the women are interacting with healthcare staff, can for the woman concerned be personalized into a stigma. “They ask you if you want to be referred for anxiety management, they say something along the lines…Do you want help with your anxiety? But I hesitated a bit, cause they said mental health, cause the word mental makes you seem crazy. You know what I mean?” (IAM, 82). For this woman, her personal stigmas about mental health appeared to be a confounding factor in her initial hesitation to accept treatment. Therefore, women’s prejudices towards mental health, which may be influenced by their lived prison environment or lives in the wider the community appear to cause implications for her own understanding about her identity, which could further her personal distress.

“Like you get anxiety, when you hear the words mental health.” (GFG, 83)

The focus groups appear to indicate that the women can struggle with such quandaries, about the necessity of receiving support at Women’s Therapy and the
implication that this has upon her own stigmas towards mental health. At times, the discourse of the women appeared contradictory around their views of mental health and Women’s Therapy. The women in the focus groups were often articulate in discussing dissatisfaction about the stigmas of mental health within the prison; yet the women themselves often appeared naive in recognizing that they too may hold stigmas and prejudicial opinion about other women who use the Women’s Therapy service. It could be argued that the focus groups indicated that women were able to recognize mental health prejudice when they were the recipient; however, the women had difficulty recognizing how their own attitudes towards mental health could influence the phenomenon of stigmatization; “everyone thinks there is a stigma attached to Women’s Therapy …I know two people that come here and they’re creepy.” (IAM, 84).

3.3.6. The significance of sleep
The discourse of the focus groups provided insight into the significance sleep has for women who enter prison. For some of the women who attended the IYS focus group, there appeared a gratefulness to discuss their sleep problems, which can demonstrate the importance improving sleep for women is in prison. There was a shared opinion from these women that sleep difficulties in prison were undervalued and that perhaps this is a reflection of the attitudes wider society has towards sleep. The seeming lack of societal awareness of sleep could provide reasoning as to why many women who enter prison have unhelpful pre-sleep routines because society in general has insufficient behavioural sleep knowledge; “No one really talks about sleep on the out do they? It’s like I’ve had a shit night and that’s it and this is why I like these groups cause you learn more about yourself and new strategies to cope.” (IYS, 85). It also appears that for many of the women interviewed there has been a difficulty with sleep prior their detainment, which suggests women who enter the criminal justice system may have inherent difficulties with sleeping, as was succinctly articulated by one woman; “falling asleep for me has always been a problem.” (ITM, 86). For women like her sleep difficulties that occur in the wider community can be continued in jail, while for other women prison brings an unwanted change in their sleep pattern. However, no matter the differences between the women’s sleep quality before detention, there was a sense in the focus groups that within prison the majority of women experience sleep dissatisfaction; “I think people don’t realize how bad their sleep is until you’re in these types of environments, cause you’re more focused on yourself in these environments than you are on the out.” (IYS, 87).
The women in the focus groups appeared to recognize a relationship between unhelpful night-time worrying and anxiety with the influence this can have upon decreasing their ability to initiate or maintain the desired sleep. The women indicated that although they experienced a variety of psychological difficulties in the wider community, things like worry would exacerbate in jail; “When you come inside, when you come in jail everything is increased like. They say you have more time to think, so it’s just you, yourself and your own thoughts.” (IYS, 88). Therefore, the prison may be unhelpfully centring the women’s attention to their preoccupations, which “intensifies” (IAM, 89) their anxiety and affects their sleep because; “If you’ve got anxiety and worry you’re not going to sleep are you? Cause you’ll be thinking and thinking.” (ITM, 90). The struggle for the women is that in prison many of them have multiple worries and consequently sleep complaints can become an accepted part of prison life, meaning that although poor sleep quality is undesirable, women can place greater significance in the management of other concerns; “Obviously it affects me, obviously you need to sleep to function, but I think personally myself I am going through a lot at the moment with different things in my life, to be honest.” (ITM, 91). The situational affect to worry from detainment may also be influencing some women to acquire unhelpful metacognitive processes, where attention is also applied to worrying about the thoughts that are causing the worry; “Everyone has difficulty sleeping in jail, we’ve all got our worries to worry about and that causes anxiety then, in it? So we’re more focused upon ourselves in the night-times.” (ITM, 92). The paradox can be that an increase in worrying is furthering the likelihood for women in prison to endure sleep disturbances. As seen in the following data extract where one woman is applying unhelpful labelling about the types of thoughts that she is receiving in the evenings; “It was even hard dropping off to sleep, and then when I was gone to sleep I was waking all the time, I was thinking, I still do it now sometimes, I have really stupid random thoughts when trying to get to sleep.” (ITM, 93)

The hardship many women in prison face towards the management of their difficulties with sleep could be related to the commonality of trauma exposure and an apparent dearth of support for their trauma symptomatology, which is also likely affecting their night-time wellbeing. It was the discussion of sleep that allowed an opportunity for further insight into the women’s experiences of mental health, which showed how many women are struggling with trauma-based symptoms like insomnia, anxiety, low mood, irritability, emotional numbing, startle responses and flashbacks. The conversations about sleep showed that for many of the focus group members the evening time is a period when the women are more overtly aware of increased arousal.
levels that they associate to anxiety. These women may be experiencing a hyperarousal based sleep disturbance and this is contributing to racing thoughts, which at night-time are frequently worry based; “I’ve just got a problem with sleeping I have and switching off to stop my brain from doing over time…” (ITM, 94). While, anecdotally from the content of the women’s conversations it would seem that those who were complaining of more severe sleep dissatisfaction, appeared to also be the women that were expressing greater difficulties with their mental health and trauma-related symptomatology.

“…I can’t get to sleep and when I do get to sleep I wake up every 20 minutes or so and it’s horrible and I’ve got my anxiety back and I don’t want to go to sleep anymore because the visions and flashbacks have come back so it’s made it 10 times worse, it’s really bad.” (ITM, 95)

“I don’t know when I’m in a low mood or a high mood it’s so rare; it changes a lot so I can’t really take notice but I am aware I am more moody and bitchy and snappy at people cause of the loss of sleep.” (IAM, 96)

Discussions around sleep in the focus groups allowed for the women to explain how the prison establishment could be contributing to their sleep difficulties. However, care may need to be applied to some of the women’s perceived causes of their sleep difficulties because their symptoms of insomnia are more likely attributable to trauma-based hyperarousal than innocuous environmental triggers. For example, the women attributed a difficulty to sleep with the night-time operations within the prison. Many of the women believed that environmental factors were causing them to experience problems sleeping, including being disturbed by prison staff, which carry out night-time welfare checks.

“Then when you do go to sleep they are dragging tables and chairs and scraping along the floors and you wake back up.” (ITM, 97)

“Shining a torch in your eyes”” (ITM, 98)

“Keys, blots. It’s inconsiderate” (ITM, 99)

The women spoke about how at certain times in the day they are required to be locked in their cells and for those individuals who are experiencing difficulties sleeping in the evenings, the ability to fall asleep during these daytime periods is more easily
achieved; “... I can sleep in the day, but I definitely can't at night, you know what I mean?” (IAM, 100). The women accepted that when they do sleep in the day this is decreasing their sleep drive in the evening; “… you’re in your cell and all you’re doing is sleeping, so come the night you don’t want no sleep. It's boredom ain’t it, constantly sleeping in the day.” (IYS, 101)

The focus group discourse also allowed attention to the opinion that some healthcare staff are unhelpful in the treatment of insomnia. There appeared a consensus that sleep problems in prison are so commonplace that staff are overwhelmed and “it’s almost like they don’t know how to help, so they therefore say we’ll pass you off on someone else…” (GFG, 102). However, some women felt that there was a degree of cynicism from some healthcare staff towards the psychological treatment of insomnia. This appeared to make some of the focus group members frustrated, perhaps because the attitudes of healthcare staff could imply that the treatment of insomnia is difficult, which provides connotations to the women that the sleep problem was almost untreatable. “The GP was dismissive, they offered the group, which I didn’t ask for cause I didn’t know about it. But the way in which they said it was dismissive and abrupt and you can give that a go if you like, as though it wasn’t a particularly important thing, it was just something I could do cause they didn’t want to give out meds...” (IYS, 103). The belief the women have that healthcare staff are also unwilling to provide medication for sleep difficulties is further compounding their frustration around sleep. The women felt that GPs could be cynical to the detained women’s sleep complaint, interpreting her request for sleep medication as an opportunity for her to receive sedatives that would be used for recreational purposes. In summary, there were connotations from the women that if the prison as an institution placed greater importance to healthcare providing the support they need for their insomnia that this would support the women in their psychological recovery.

### 3.3.7. Women as stakeholders

The holding of the focus groups provided the women with an opportunity to be stakeholders in the research process, which allowed them to discuss the difficulties accessing psychological groups in the prison and the ideas that they have for increasing the acceptability of the Women’s Therapy service. The women raised concerns about a “fear of the unknown” (IAM, 104), which related to worries about their peers and the facilitators who would be present in the group, with specific apprehensions around the nature of confidentiality. The women were concerned that even though group members sign a therapeutic contract related to patient conduct,
which includes a discussion about the expectations of confidentiality, there remained the potential that women in the group would disregard the confidentiality outside of Women’s Therapy. The major concern for the women was that the breaking of confidentiality could result in rumour where an individual is wrongfully accused of committing a crime that the prison population views with disgust, which would lead to concerns over their safety in prison. The consequence for the psychological groups is that women may choose not to attend Women’s Therapy due to the associated fears around confidentiality.

“My massive concern is that everything that I said within group would be taken back around the wings and you kind of worry then that it could cause you issues and these things in here get twisted like Chinese whispers so something you’re saying is completely different and taken completely out of context and you get picked on and bullied or whatever... so you are concerned about that sort of thing...” (GFG, 105)

“Yes, I get exactly what you are saying. I agree completely with that, you feel like that if you are open and honest with someone it’s going to bite you right back on the backside.” (GFG, 106)

The women in the focus groups discussed the nature of the trust needed from the facilitators of the psychological groups in order for them to feel more comfortable attending. An interest the women raised was worries that the groups facilitators may neglect the nature of confidentiality and discuss some of the sensitive content of the psychological group with prison staff; “... I found as well that it was really hard to trust you guys, the mental health workers because you are likely saying to officers that anything you say goes back to them and you will get judged and I wouldn’t feel comfortable opening up because of the environment...” (ITM, 107). The women emphasised that there is a need for the Women’s Therapy group facilitators to present themselves as trustworthy and sincere in wanting to support the women who attend the groups; “... I do think that you need that level of trust and that there is that genuine want to help as opposed to sitting in another class or group to listen and not get anything out of it...” (EAT, 108). Several of the women felt that a useful way for the group facilitators to demonstrate trust and sincerity in the support being offered to the women was for them to disclose their own experiences of psychological difficulties. This disclosure perhaps helps break down the power imbalances that can occur within prison, where the women express that they “...wouldn’t open up to just anybody...” (GFG, 109). It was felt that such disclosure from Women’s Therapy facilitators can act
as a powerful example to provide the women with the hope that mental illnesses can be successfully managed. Some of the women in the focus group suggested that knowing the group facilitators had experienced their own psychological difficulties would help the women feel more relaxed within the group environment because they would feel less likely to be unsympathetically judged by a facilitator who has had a similar life experience.

“…all of you are really relaxed and we’ll have a laugh as well, you don’t judge anybody neither about what they say, or what somebody says and nobody judges you for anything.” (EAT, 110)

“Cause the workers were giving their point of views and how they’ve suffered with anxiety, it makes us feel more at ease and they understand it more and officers don’t understand about anxiety unless they’ve suffered it…” (EAT, 111)

“Cause you’ve been through it, you can relate to it.” (EAT, 112)

“In order to encourage the women to attend the psychological groups, the focus group attendees felt that it was important that the facilitators of these groups had contact with the women prior to the date of their appointment. The women feel that this would help diffuse some of the concerns other women may have, which could affect their attendance. One woman explained that she would not have attended the group therapy without first participating in individual work with one of group facilitators; “Well I wouldn’t have gone to any group without say having worked with you first because me getting to know you and you understanding my mental health and my anxiety issues gave me the confidence to come to a group. But if I was just put down for a group I wouldn’t have wanted to come….so I think it’s really important that you get to work with someone first, to trust somebody so that you’re getting somewhere with that person before you’re thrown into a group.” (GFG, 114). The impracticality for all women referred to a Women’s Therapy group to receive individual psychological support prior to the commencement of the group was recognised by others in the focus group. Alternatively, the women suggested it would be beneficial for the prospective women to personally receive appointment letters from the intended group facilitators. It was explained that receiving an invite to a group from an appointment letter sent in the internal post appears less welcoming and that this could be having
an effect upon attendance rates. Whereas, the gesture of visiting the women at their cell can help to represent the sincerity of the staff member in wanting to support the women with their psychological and emotional needs. The women felt that this early opportunity to meet the Women’s Therapy staff would allow other women to have a discussion about the group that they have been referred and help allay any fears the women may have about attending.

“If you explain what it’s about a bit more to people they will know about it rather than just give the letter, in it?” (IAM, 115)

“But that would take more time out of your day, but you’ll have fuller sessions, so more than 3 people will turn up.” (IAM, 116)

“Cause you’re making the effort to go and find the person it does make a difference. Yeah, it does because they’ll have more belief in you knowing that you come out of your own way to come and see them rather than just slip a letter under the door.” (IAM, 117)

The women in the focus group indicated that the more information people in prison receive about the psychological groups on offer in Women’s Therapy, the more amenable they will be in attending. There was widespread opinion within the focus groups that the CMHT need to increase the advertising of their Women’s Therapy service to make women aware of the potential to receive psychological support and how best to access this support. The popular means to achieve this was to place posters and leaflets around the prison providing details about the Women’s Therapy service, but also to ensure that the literature incorporates advice in how to manage “stress” (GFG, 118). The women indicated the importance for future literature to provide detailed information about the groups on offer as this would encourage a greater collaborative discussion with the referrer about their preferred choice of group. The current deficiencies in collaborative communication between the referrer and patient about psychological groups can denote to the patient an absence of personal control over the direction of their care, which can reinforce a sense of powerlessness within the prison.

“I think rather than give people slips saying come to this session. I think you should be able to apply and choose which one they want to go to and put Women’s Therapy on it and apply for it so if they’re choosing to come out of their own free will.” (GFG, 119)
“You can put leaflets around and little posters like, you can put like feeling stressed do this, little tips and do this all around the prison and put on it like something about how you can get help…” (GFG, 120)

“Put posters in education, the library, pathways and just encourage people who are going to the groups to spread the word, like I will when I get back to the mother and baby unit, cause our voice is important in here, isn’t it?” (GFG, 121)

Alongside the availability of literature explaining the psychological groups, the women discussed the encountered difficulties accessing the support of Women’s Therapy. The women indicated that they would prefer to make direct self-referrals for psychological support and bypass referrals through say healthcare in order to speed up the referral process; “Healthcare is just the same, you get an appointment for the nurses and then they say you’ve got to wait for the doctor and then the doctor says I’m referring you.” (ITM, 122). This was problematic for women because the decision to attend a group for some was a worrisome period with any delays in the process adding to their anxiety, which the women argued could reduce the likelihood of attendance; “… women are not here for a long time anyway, so if they’re caught at the beginning of it, if you can deal with it quicker, then the better… because the time it takes to get into these sessions you dispersed yourself not to go anyway.” (ITM, 123). That said, even though the women can make self-referrals it is evident that relatively few women understood this process. Therefore, the women recommended the placement of specific ‘app boxes’ around the prison wings where the women can access and confidentially post mental health referral forms, which could be directly collected from members of the CMHT.

“You can always put a poster up and an app box and if you’d like to join Women’s Therapy then put your name in and we’ll talk to you about it.” (GFG, 124)

“You should have your own boxes for apps.” (GFG, 125)

However, besides the importance of increasing the access to the Women’s Therapy service the women discussed how one group session can seem insignificant to supporting their needs when they have many distressful personal issues to manage when detained in prison; “One session is a very short time like I found that really useful and it gave me loads of things I can apply but probably just the one session I don’t know if that’s really enough to be sure … yeah with everything going on.” (IAM, 126).
A confounding factor to the success of therapy according to some of the women in the focus group was the effect that being detained in prison has upon the relationships with loved ones. This was an issue for many of the women in the focus groups and there appeared a sense from the women that being detained reduced the professional social support that they needed to deal with matters related to their families. This was a factor that was causing the women distress in so far as the lack of support from the prison for social issues was having a negative impact upon the women’s psychological wellbeing, as detailed in the two vignettes beneath that describe the difficulties the women encounter when trying to maintain relationships with loved ones.

“There’s not enough support in here for women. It’s a simple thing like I’ve tried to get in contact with my children and there’s only one lady in here that deals with 312 women who have kids in here, something ridiculous like that. I’ve seen her once. I’ve tracked her down maybe twice in prison and that’s in 6 months and she has done a few updates but she can’t physically do it on her own. If you think of all the different agencies involved with the kids on the out and she’s trying to chase everyone, it’s impossible for one person to do that and that just draws on your anxiety cause you’re waiting to hear something and she hasn’t got the time to do it, so you know you’re not going to get the answers. But I really want to speak to my kids or see them or get an address to write to them, just simple little things like that, there are just not enough people to help.” (IAM, 127)

My mother is elderly and she’s got no support on the outside and I was like her carer and I find it really difficult cause she got rushed into hospital and I couldn’t do anything and I couldn’t get hold of an offender supervisor so I can get ROTL (Release On Temporary License) to be with her and support her. But they won’t do it because at the moment it’s basically for kids. You can get an emergency one for kids but not for elderly relatives, but again there is no support there, so I couldn’t find out how she was. I couldn’t speak to the hospital, I couldn’t do anything, I was literally sat in limbo for a couple of days until I got an update that she was fine and well, you know? Things like that obviously raise your anxiety.” (GFG, 128)
Chapter 4: Discussion

4. Introduction

The HMP study provided a preliminary understanding about the feasibility of delivering psychological group interventions for managing symptoms of trauma and insomnia within a female prison population and the factors influencing the women’s nonattendances to the group provisions. It was not an aim of the feasibility study to synthesise its quantitative and qualitative data, instead the aim of the quantitative approach was to examine the clinical effectiveness of the group psychological interventions and to provide information about group nonattendances. The quantitative findings indicated that the ‘exercise as therapy’ and the ‘improving your sleep’ groups to be more effective at improving symptoms of trauma and sleep than were the group interventions of ‘introduction to anxiety management’ and the ‘introduction to mindfulness’. In respects to group nonattendances, the results indicated that around 30% of women who were invited to a group psychological intervention were released or transferred before their scheduled appointment.

The qualitative approach from the undertaking of thematic analysis of the focus groups data provided the emergence of six meaningful themes; ‘a pathway to care’ that details the prisons institutional and organizational inefficiencies that hinder the women’s access to the psychological group interventions. ‘Stigma as a therapeutic barrier’, which explains how a prison culture of mental health prejudice can adversely affect the women’s attitudes towards psychological group treatments. The theme ‘the patient or prisoner paradox’ elucidates the difficulties HMP staff have in managing the women as either patients or prisoners within an establishment where the majority of women require access to NHS service provisions. The theme ‘the retraumatising nature of prison’ shows how prison procedures and protocols such as invasive searches or restraints can trigger reminders of the women’s past experiences of violence or disempowerment. The ‘significance of sleep’ provided evidence to indicate the high prevalence of insomnia within prison and the need for effective education to help the women improve their sleep. The final theme, ‘women as stakeholders’ delivered information about the women’s experiences of accessing psychological therapy within prison and ideas for patient led service improvements. In consideration to the research findings, the feasibility study provides recommendation to support a
two-stage intervention of systemic change to improve the psychological wellbeing of the women HMP detains.

4.1. Interpreting the findings of the HMP study

4.1.1. Quantitative interpretation

4.1.2. Psychometric evaluations

The feasibility study in replicating the standard protocols and procedures of the HMP group psychological interventions utilised its normal psychometric evaluation tools of the PSS-SR, GHQ-28 and ISI to assess the women's symptoms of trauma and difficulties sleeping. The validity and reliability of the psychometric evaluations were discussed in the method and methodology section (p35-38) and considered acceptable instruments to measure observable changes in symptoms following intervention attendance.

4.1.3. False-safety behaviour elimination therapy: IAM and IYS

The principals of the IAM and IYS group are each founded upon F-SET a treatment for a range of anxiety-based conditions (Schmidt, et al., 2012). F-SET was deemed an appropriate intervention to improve sleep for the detained women because Harvey’s (2002) cognitive model of insomnia confers how safety behaviours maintain the sleep complaint. Harvey (2002a) encourages professionals in healthcare to develop interventions to specifically target the use of safety behaviours involved in poor sleep as opposed to the encouragement for people to undertake sleep hygiene practices, which as reported in a systematic review (Hellstrom, 2011) examining sleep promotion interventions are argued to have minimal efficacy. It is important to note that there is an advancement to Harvey’s (2002) understanding of safety behaviours in the more recent work of Schmidt et al. (2012) who differentiate safety behaviours from false safety behaviours. Schmidt et al. (2012) propose false safety behaviours to be the actions used to manage an unwanted fear associated with a false belief. The intended efficacy in treatment of the IAM and the IYS group is in enabling the women to identify their own false safety behaviours and eliminate them as the habit contributing to or maintaining the hyperarousal associated to trauma or insomnia (Harvey, 2002; Schmidt et al., 2012; Bonnet and Arrand, 1997; Ehlers and Clark, 2008; and Weston, 2014).

There appears no research that specifically examines the use of F-SET to manage symptoms of trauma or insomnia, therefore the HMP feasibility study appears to be
the first example to offer findings of the efficacy of F-SET for improving symptoms of trauma and insomnia. The application of F-SET in the IAM group for treating trauma symptoms appeared to provide the women with a small improvement in symptoms when measured with the PSS-SR but there were slight increases in symptoms as measured with the GHQ-28 and the ISI. It is believed that the minimal change in symptoms may be due to the intervention being of insufficient duration to support the women to eliminate the ostensible high frequency of false safety behaviours used to manage their daytime distresses. In respect to the IYS group, F-SET seemed to be beneficial for helping women improve their sleep and the women’s observed sleep improvements may have been responsible for the decreased trauma symptoms as measured with the PSS-SR and the GHQ-28 without the IYS intervention specifically targeting these trauma symptoms. Whereas in the IAM group the use of F-SET to treat daytime symptoms of trauma provided the women with no consequential improvement to their sleep. It is acknowledged that the feasibility study findings are based on small samples; nonetheless, the IAM and the IYS results may possibly imply a stronger directional relationship to the symptoms of trauma being driven from hyperarousal based insomnia. This could demonstrate hyperarousal based insomnia to be the catalyst for the experience of trauma-based hyperarousal. There is retrospective evidence that indicates sleep disturbance occurs before the experience of trauma symptoms (e.g. Mellman, Kulick-Bell, and Hebding et al., 1995; and Bryand, Creamer, and O’Donnell, et al., 2010) and Liempt (2012) argues that this process is caused from trauma related nightmares disturbing sleep and as sleep becomes fragmented the ability for the brain to achieve fear extinction weakens during the REM stages of sleep. Therefore, sleep disturbance is triggering and maintaining PTSD symptoms and creating a cyclical condition (Liempt, 2012).

The IYS intervention appears to encourage sleep from the management of hyperarousal through the removal of sleep associated behaviours (Harvey, 2002) that may be integrated with cognitions that are innocuous reminders to past trauma or are trauma-associated stimuli (Weston, 2014). In the development of the IYS intervention, the principal researcher theorised a relationship between insomnia and a fight or flight self-preservation hypothesis. In the animal kingdom when prey is evident, the susceptible animal will remain awake and therefore vulnerability can be said to increase awakening (Abrams, 2002). In humans, false safety behaviours like attempting to sleep in a protective foetal position, keeping the lights on or frequent awakening are unwittingly employed to increase a sense of safety or self-preservation, although counterintuitively these actions stimulate fear based
hyperarousal and sleep disturbances because they inhibit an individual’s ability to disconfirm the feared outcome (Ehlers and Clarke, 2000; Harvey, 2002 and Schmidt et al., 2012). The elimination of the self-preservation behaviours or false safety behaviours (Harvey, 2002; and Schmidt et al., 2012) should reduce the processes of hyperarousal that have been influencing the sleep complaint (Mellman, Kulick-Bell, and Hebding et al., 1995) because the individual is able to disconfirm the fear based belief (Schmidt et al., 2012). The IYS intervention argues that for trauma associated hyperarousal a person’s sleep can be improved in creating an environment connoting ostensible vulnerability. The paradoxical intention is to reduce hyperarousal through representing to the brain that a confidence to present oneself as vulnerable before sleep signifies reduced environmental threats to self-preservation during sleep. The participants are encouraged to identify and remove behaviours that may have innocently been employed for self-preservation, for example, the new behaviour of turning lights off before sleep and laying in a position of postural vulnerability (e.g. breathing slowly, laying on their backs with eyes closed at all times). The encouraging findings of the IYS intervention for supporting improvements to the women’s sleep and the supplementary improvement to their symptoms of trauma would indicate an ethicalness for all women who enter HMP to be offered education in the techniques employed in the IYS intervention.

4.1.4. Introduction to mindfulness
The ITM group teaches the participant’s basic mindfulness exercises to direct cognitions to the present moment and away from stressful thoughts about past concerns or anticipating worrisome future happenings (Fries, Dettenborn and Kirschbaum, 2009; and Adam, Hawkley and Kudielka, 2006). Garland and Roberts-Lewis (2013) found mindfulness could reduce thought suppressions linked to trauma, which consequently allows for greater stress symptom improvement. The efficacy of mindfulness is believed to be from meditation altering regions within the hippocampus (the area of the brain that plays a role in modulating cortical arousal and emotional regulation) (Bergen-Cico and Cheon, 2014) through engaging the prefrontal cortex and taking attention away from an unconscious activation of the amygdala (Segal, Williams, and Teasdale, 2013, Bergen-Cico and Cheon, 2014; and Banks, Tartar and Welhaf, 2015). The HMP mindfulness techniques encourage participants to sit in comfortable positions and apply awareness to different parts of the body, the skills support greater environmental awareness, and greater attention to the engagement in occupational activity and deliver meditational guided breathing.
The ITM intervention appeared to marginally increase trauma symptoms as measured with the PSS-SR and the GHQ-28, and possibly aggravated the participant’s symptoms (ISI) of insomnia. The reduced effectiveness of the ITM intervention to manage symptoms of trauma and sleep in the study’s participants could indicate the application of mindfulness as a one-session intervention to be insufficient for the women’s needs. In a study by Murrell, Lester and Sandoz (2015) examining the application of mindfulness as a means to treat attention deficit hyperactivity disorder (ADHD) the authors noted that 71% of participants in the early stages of the intervention experienced increased distress, although the authors argue that the distress reduced with the longevity of the intervention. This could indicate that the application of mindfulness in HMP may be more effective if participants are provided with further sessions and thus the treatment may be more suited to women with longer detentions. The unsuccessful ability of the ITM group to improve trauma symptoms of the study’s participants provides a contrasting understanding of the application of mindfulness than that provided from Garland and Roberts-Lewis (2013) who argue the efficacy of mindfulness lays in its ability to inhibit thought suppression. Alternatively, when rationalising the findings of the HMP mindfulness intervention in relation to its component parts the taught techniques could be encouraging the women to use the techniques as a means for thought suppression. Mindfulness as an intervention to manage psychological distress thus becomes a false safety behaviour, meaning the distressful cognitions remain as perceived threats and contribute to the preservation of hyperarousal. Mindfulness as thought suppression may provide further explanation to the qualitative work of Lomas, Cartwright and Edington et al. (2015) who in their study of 30 male meditators discussed the potential for mindfulness to have increased the men’s symptoms of anxiety and depression.

However, although there were no reports of any participants in the HMP feasibility study experiencing harm as a consequence of attending the mindfulness intervention it is important to acknowledge that attendance to the mindfulness group may have exacerbated symptoms of insomnia and disturbed sleep with time may exacerbate the women’s other trauma symptoms (Bryant, Creamer, and O'Donnell et al, 2010). Mindfulness affecting sleep has been discussed in the work of Peck, Lester and Bootzin et al. (2012), who evaluated their participants, sleep quality with polysomnography measurements. The authors (Peck et al., 2012) revealed that mindfulness interventions may be disturbing sleep from observations of the participant’s increased length and frequency of night-time awakening’s. In relation to the ITM group, the women’s continued insomnia could again be attributed to
mindfulness producing thought suppression, which is increasing the state of hyperarousal that is unconducive for sleep (Garland and Roberts-Lewis, 2013). Therefore, due to the effect the mindfulness intervention may have had upon sleep the CMHT needs to further assess its substance as a one-session intervention before it can be considered a part of any future pilot study.

4.1.5. Exercise as therapy
The EAT group is a non-invasive intervention, which has little risk of exacerbating mental health symptoms in people with psychiatric conditions (Trivedi, Greer and Church et al., 2011) and is suitable for those less acquiescent to psychopharmacology (Asmundson, Fetzner and DeBoer, et al., 2013). The EAT intervention provided the women with a moderate reduction in symptoms of trauma (PSS-SR) and distress (GHQ-28) and feasibly helped the women improve the quality of their sleep (ISI). The EAT intervention utilises IE a technique that has typically been incorporated within CBT interventions to reduce anxiety sensitivity in patients with panic disorders (Telch, Schmidt, and Jaimez, et al., 1995). It appears restructuring the detained women’s cognitive and affective interpretation of distress can reduce fear-based interpretations (Sabourin et al., 2015). The extinction of a conditioned fear response to physiological arousal is believed to arrive through the repeated IE technique, which enables habituation from teaching the individual that the feared symptom is actually benign (Bouton, 2002). This explanation of IE receives support from the Sabourin, Sherry, and Sherry’s et al. (2008) incorporation of IE with physical exercise, who showed that only 10 minutes of running over 10 occasions was sufficient treatment to improve their participant’s cognitive, affective and somatic symptoms.

The HMP feasibility study was unable to achieve a true understanding into the efficacy of EAT as an intervention within a prison environment due to impediments from the prison regime, like staff shortages affecting gym access. Therefore, the EAT findings provide an understanding of the effectiveness of the psychoeducational component of the intervention and less about repeated IE (Bouton, 2002) during physical exercise. However, the psychoeducational component of IE that explains the similarities between the physiological arousal of exercise and (e.g.) anxiety may have helped support a cognitive retrospective reappraisal of the women’s interpretation of an anxiety aroused state as nonthreatening. This assumption is evidenced from the women who attended the intervention appearing to be able to recall experiences of physical activity that induced physiological arousal, which at the time were not interpreted as threatening symptoms. Therefore, the participant’s newer perspective
of hyperarousal-based symptoms (e.g. anxiety) reduces the fear associated with experiencing these symptoms, which in turn reduces the experience of hyperarousal and psychological distress. The preliminary findings of the EAT intervention are encouraging and with gym based IE the psychological group could receive further efficacy. However, until the women receive the intervention as intended it would be unfeasible to incorporate the EAT intervention into any future pilot study because researchers will be measuring an unreliable treatment.

4.2. Participant recruitment and retention rates

4.2.1. Recruitment of participants
Research investigating the experience of trauma within female prison populations (e.g. Browne, Miller and Aguin, 1999; and Home Office, 1997) provides insight into the extent women who enter the criminal justice system have been past victims of sexual and physical violence. The feasibility study further contributes to an understanding of the high prevalence’s of trauma histories of detained women because all participants who returned the completed PSS-SR psychometrics met the PSS-SR case criteria. Therefore, HMP provides researchers an opportunity to work with a female prison population that contains high prevalence’s of trauma histories and trauma symptomatology. However, any future pilot study, which aims to further the feasibility study and employ inferential statistical analysis, would require around 192 participants to retain at least 65 participants.

4.2.2. Retention of participants
The HMP feasibility study invited 71 detained women to participate in the research project and only 24 women attended both the intervention and the matching focus group, indicating that approximately two thirds of women were unable to meet the study’s retention criteria. The main reasons for the nonattendance of groups were the women attending for education (19%), being released (17%), a participants transfer to another establishment (13%), attending for a medical appointment (13%) and withdrawing from the study (13%). However, besides the associated attrition to withdrawing from the study and releases, there appears an opportunity for the prison service with the CMHT to invoke an organisational and cultural change to increase attendance to psychological service provisions. In HMP, significant attrition was due to the women choosing to attend an education class or a medical appointment running concurrently with the intervention groups. The focus groups revealed that the women could receive a ‘warning’ for their nonattendance to an education or medical appointment and ostensibly many women in HMP are unaware that attendance to a
psychological group does not activate the warning system. Thus, inadequate communication to the women about the policies and procedures of psychological intervention attendance is affecting the ability for women to make an informed decision about their attendance to service provisions.

The degree of attrition observed in the HMP study and the known reasons for the participant’s nonattendances appear to draw similarities to other prison-based research that discusses the phenomenon of attrition. Breese, Maunder and Gray et al. (2012) in an audit of psychological interventions in prison for stress management found attrition to be 60%, which was attributed to prison transfers, work commitments and disinterest. In, Olver, Stockdale and Wormith (2011) review of attrition rates in offender management interventions the authors suggested that shorter sentence durations, single marital status, a younger age, lower levels of income and lower educational attainment were each risk factors for increasing intervention nonattendances. In the HMP study, the majority of the participants were young, of single marital status and subject to short detention durations of less than 5 weeks. Although, it was not recorded as a part of the HMP study, from personal observation of working within HMP it could be argued that the women who use the psychological service are academically underachievers and from households with low incomes. Furthermore, in a meta-analysis carried out by Swift and Greenberg (2012) greater attrition was associated to interventions where the facilitators were not educated to at least degree level. These findings (Swift and Greenberg, 2012) contrast the outcomes of the HMP study, which showed that the only group (ITM) where neither facilitator was educated to a degree level of education provided the only example where all the participants of the intervention group attended the corresponding focus group. This could indicate that for the women in HMP a degree level facilitator has lesser meaning for participant retention and factors encompassing affability and intervention acceptability, which were discussed by the women in the focus groups, are perhaps a more influential factor in attendance decision making. However, it is difficult to make a like for like comparison of attrition rates between this study and other studies due to methodological differences because the HMP study appears unique in evaluating brief, one session psychological group interventions designed to manage symptoms of trauma and sleep within a female prison population. A similar observation about methodological differences between prison studies was made in the work of Kroner, Power and Harris (2014) who found several studies excluded the people who had been released or transferred from their attrition rates, thus inflating group attendance figures.
4.3. Qualitative interpretation

The Bradley Report (Executive Summary, 2009) advocates that prisons undertake an audit to evaluate the needs of the people it detains and to collaborate with local health care service providers to manage the assessed needs of the detained population. The Care Act 2014 reaffirms the need for improved services for people in prison and a strong working alliance between healthcare authorities and the prison service is crucial in this process (Loucks, 2000; and Forrester et al., 2013). The HMP feasibility study helps to address the requirements of the Bradley report (2009) and the Care Act 2014 in exploring the experiences of the stakeholders involved in the CMHT’s psychological groups with particular anticipation that a collaborative working relationship with the detained women will empower patient driven improvements to its psychological service. The HMP study enabled a preliminary understanding into the reasons why patients can decline psychological treatment and the implications living in prison can have upon the psychological wellbeing of the women it detains. The thematic themes (i.e. the stigma as a therapeutic barrier, a pathway to care, the patient or prisoner paradox, the retraumatising nature of prison, the significance of sleep, and women as stakeholders) provide a narrative to the struggles women living in HMP face during their detention and are difficulties that could be confounding factors to the efficacy of the psychological group interventions. HMP as an institution from inefficiencies in the women’s care pathways, its prejudicial attitudes towards mental health and its retraumatising protocols and procedures evidences an archaic prison establishment that requires modernisation.

4.3.1. Understanding the experiences of patients who access psychological services

4.3.2. A pathway to care

The emergence of the theme ‘a pathway to care’, which was examined from within a realist perspective, provided a narrative for the patient experience in accessing the HMP’s mental health and psychological service provisions. The first opportunity a woman receives to be referred for mental health services is at the prison reception where she undergoes a health screening. A health screening is a protocol in operation throughout many UK prison establishments (Brown, Cullen, Kooymen et al., 2014) and at HMP it is carried out by a member of the healthcare team from a set questionnaire. The screening provides an early opportunity for the healthcare team to become aware of the women’s health needs and directly liaise with the relevant service provision to address any concerns. However, the focus groups revealed that
none of the participants recalled being referred to psychological groups during the health screening nor did the screening provide them with information about the care pathway to access psychological groups (page (p) 53-54; quote (q) 1, 3). Pocock and Sutton (2015) from their work in HMP have also identified how the prison system overlooks an individual’s mental health difficulties on entry into prison. It is difficult to ascertain the reasons why the screening process is failing to identify potential cases for the CMHT without specifically interviewing healthcare, which was outside the parameters of this feasibility study. The lack of referrals at this stage could indicate a prison culture that places greater importance on identifying physical health matters or the high prevalence’s of women entering prison who exhibit trauma symptomatology creates a desensitisation (Redgewell, 2010) that biases the screeners to physical health complaints. However, it is imperative that the prison service, the healthcare team and the CMHT remedy this shortcoming as the national framework for mental health (Department of Health, 1999; cited in Forrester, 2014) stipulates that a patient in contact with primary health care who is exhibiting mental health difficulties have the right to be offered further mental health assessment and treatment.

A culture of inadequate communication about mental health services from the prison establishment and its NHS service provisions is impeding the women’s access to psychological support. Inadequate communication can minimise the women’s mental health difficulties and reduce treatment engagement with mental health services. The women in the focus groups spoke about “not being supported“ or having knowledge of how to access the CMHT psychological groups and revealed that some women in HMP only became aware of the psychological groups from peer recommendations (p53-54; q1-5). The lack of prison communiqué can also explain why several women in the focus groups were unsure about the mental health referral procedures (p53-54; q1, 3, 4, 7, 8). It also became apparent that women could be invited to psychological groups without the referrer informing the patient about the pending referral or even discussing with them the basis of the referral (p53-56; q2, 4, 7, 8, 11). It appears women can be overlooked during the referral process and this provides connotations about an absence of patient-focused care, which could affect the women’s subsequent decision to engage with mental health services.

The women in the focus groups also discussed dissatisfaction in the time delay between the known point of referral to the receipt of treatment and the limited time they are afforded during assessments (p54-56; q8-10,15), which are similar experiences to women in other prison establishments when accessing primary care.
services (Plugge, Douglas and Fitzpatrick (2008). The implication for delays in the referral process increases the likelihood that the patient will disengage with psychological service provisions (Hoffman, Ford and Tillotson et al., 2011, and Walsh and Brinker, 2015). In HMP during the waiting periods for group psychological treatment, the patients received little information from staff about the progress of their referral. It appears that for many women who wanted an update about their position in the waiting list that they were the ones who initiated the conversations with staff (p55; q9, 10). Instead, healthcare staff should be regularly liaising with the women about the progress of the referral because they have unrestricted access to the women but the women have restricted communicational access to staff. Deficiencies in communication during the patient’s care pathway appeared to be contributing to the stakeholder’s general dissatisfaction in the HMP’s NHS service provisions, which is an essential observation as good communication has been shown to be an important facet for continuing patient engagement within healthcare services (Carroll, Yancey and Spring et al., 2011; and Bower, Brueton and Gamble et al., 2014). Therefore, until inefficiencies around communication in the care pathway are appropriately managed the psychological group interventions may continue to experience unnecessary attrition that will reduce the feasibility of procuring a future pilot study or a RCT that requires higher participant attendance rates.

4.3.3. The patient or prisoner paradox
The theme “the patient or prisoner paradox” embodies the detained women’s identity instability when they access the prisons healthcare service provisions and this theme appears to be the first example of a female prison based study that discusses the paradox of the prisoner or patient identity. The theme, from incorporating a contextualist perspective detailed how institutional suppression can develop from the prisons difficulties in recognising the detained women as patients within the prison system. Institutional suppression for women is a common experience and for many it begins early through a process of ‘structural dislocation’ from the primary socializing agents of their families and schools (Arnold, 1995). The degenerative effects for some women can result in a life that increases the risk of entering the criminal justice system (Dirks, 2004). In prison, the institutional suppression of women continues and ‘the patient or prisoner paradox’ describes the prison systems requirement to reinforce the woman’s identity as a prisoner and this for the detained individual is often an unwanted identity. The academic Mika ’il De Veauxl (2013) himself a former detainee discusses the struggles individuals in prison have in maintaining an identity away from one of a prisoner recalling that, “I was in prison, but being a "prisoner" was neither
who I was nor who I wanted to be."

The confusion in the identity of the HMP women between that of prisoners or patients appears to begin at the prisons reception where the women are dually greeted by prison and healthcare staff (p56-57; q17-19). This protocol appears to mimic several of the prison’s wings where officers manage prisoner security and nursing staff manage the patient’s health. In female prisons, it is estimated that 90% of individuals have mental health difficulties, 60% a significant medical problem and 70% a substance misuse issue (Hales, Somers and Reeves et al., 2015; and Greenfeld and Snell, 1999). Therefore, the woman’s perceived identity as a patient can derive from her own sense of morbidity and the observed prevalence’s of ill health amongst her peers. Thus, HMP appears to be an institution to both detain and treat women (p57-58; q23-25) and consequently it has been argued that people who are detained in prisons can view their stay as an opportunity to ‘catch up on healthcare and to make use of the services offered’ (Condon, Hek, and Harris et al., 2006). This appears a plausible observation when institutions like HMP offer healthcare provisions for patients to access (e.g.) nursing staff, GP’s, dentists and mental health workers.

The seeming unwillingness of a prison culture to identify women as patients may be due to fears that any surrender of the prisoner construct would challenge the prison’s power dynamics designed to create situational suppression. The prison staff are employed to manage security but for the women requiring access to the NHS service provisions, the officers are the gatekeepers of their care (Plugge, Douglas and Fitzpatrick, 2008). Thus, the officers are presented with the prisoner or patient paradox that arguably creates contentions of ambivalences around the morality of morbidity, empathy, security and suppression. The issues of morality are managed through the officer’s reinforcement of the prisoner identity and their choice of language seems pivotal to the processes. The women spoke of being told, “remember where you are”; and the use of language like this is essential for the suppression of the detained women. In essence, the statement could be perceived reciprocal to remind the women that their identity is dictated through the prison(er) environment and to confirm to the officers that their role is to manage prisoners and not patients. The women also recalled being told to not act like “princesses.” The regal connotations appear to insinuate an officer’s perception that the women have privilege, which requires suppression through sarcastic syntax. The officers may feel that an empathetically directed discourse is inappropriate (p57-58; q20-25) as empathy is the “favouring of one who is more closely like one’s self” and the use of withholding
empathy has been said to reduce the other person's sense of self (Brown, 2012). Therefore, a lack of empathy is pivotal to suppress women self-identifying as patients and a process for psychological detachment is achieved. Psychological detachment could prevent women expressing emotional content to prison staff that would require their compassionate response and be a form of engagement counterintuitive to the officer's role of castigation.

The theme the prisoner or patient paradox provides a unique perspective about the hardships women in prison can have in attempting to access group psychological support. The theme connotes a prison culture unsympathetic to women specific service needs, which are arguably exacerbated from the female prison being operated from the blueprints of male prison estates (Corston, 2007). The inappropriate and unsympathetic treatment of women in British prisons can be further substantiated from the work of Redgewell (2010), who discusses how prison based healthcare staff can experience a process of “desensitization”, which similarly appears to be a difficulty affecting staff at HMP. The qualitative analysis of the focus groups would indicate that the desensitization (p58-60; q25-29, 31, 32) process of healthcare workers is actually through a prison culture that suppresses empathetic inclinations towards women as patients. The healthcare professional’s perception of detained women as prisoners unknowingly fashions a paradoxical affect, which requires the women to prove to the gatekeepers and healthcare workers the genuineness of their unheeded distress. Therefore, when the majority of women in this study and in female prison institutions are experiencing physical and mental morbidity (e.g. Fazel and Danesh, 2002; Moloney et al., 2009; and Ministry of Justice, 2012) the identity of a patient provides an acknowledgement to the difficulties they are experiencing. The viewing of women as prisoners or malingerer's implies deceitfulness and repudiation to their symptoms of trauma (p58-59; q25-31). A failure to acknowledge the distress the women are experiencing could insinuate a disbelief in the root cause of their difficulties when being believed is so important for women who have experienced sexual violence (Torrey, 1991). Heath, Lynch, Frith et al. (2011) argue that disbelief makes victims stay silent, which will hinder trauma-focused psychological work and reduce the potential for convicting the perpetrator. Therefore, the institution of prison requires addressing its perception of the women it contains because the unhelpful engagement women experience could directly be increasing their distress. The ramification for the group psychological interventions is that the prisoner-patient paradox is feasibly a confounding factor that affects the ability of the intervention to suitably support the women referred.
4.3.4. Stigma as a therapeutic barrier

The theme stigma as a therapeutic barrier, approached through a realist paradigm brought recognition to the phenomenon of mental health stigmatization occurring at HMP. Ostensibly, at present, there is no research that has examined the phenomenon of mental health stigmatization in British female prisons; and this is somewhat surprising when the high prevalence of stigma affecting the criminal justice system has been recognised for many years (Jemelka et al., 1989). The HMP study offers awareness to the struggles faced by women with mental health difficulties living in prison and is believed to be the first study to examine the issues of mental health stigmatization and prejudice within British prisons. The HMP stakeholder focus groups revealed mental health stigma to be an unhelpful phenomenon occurring within the prison and how such stigmatization can affect the women’s treatment intentions in accessing mental health service provisions. The patients and facilitators spoke strongly about stigma in recalling how certain prison staff can overtly hold prejudicial attitudes (p65-66; q58-66). The facilitators and patients have observed prison staff mocking the speech and presentation of detained women with learning disabilities who access group mental health services and two facilitators have also heard prison staff discussing the psychological group interventions as “colouring, card making and playing games”, labelling the interventions as “scribble and dribble”. The facilitators felt the prison institution to be naive to psychological group interventions for supporting women in prison and ignorant to the mental health issues affecting detained women.

The majority of British prison research investigating stigma within prison establishments is concentrated to issues around race (Illingworth, 2009) and the seeming absence of literature from NOMS discussing mental health stigmatization, particularly in female prisons, can help explain the deficiency in organisational structure to challenge mental health prejudices and the ominous culture occurring within HMP. In one qualitative study, examining health care practices within a male prison a nurse unwittingly informed about the overt acceptability of stigmatizing and stereotyping detained prison populations when describing her prejudicial opinions of patients as “human nature” (Crampton and Turner, 2014). Perhaps, “human nature” describes a prison environment that enables a prejudicial opinion to be propagated from deficiencies of the organisational structure to challenge derogatory attitudes. The stigma towards mental health within HMP is sufficient for the women to deliberate about seeking the support of prison staff concerning their mental health needs as one member of the patient focus group explained, “…they don’t want to talk to officers as
they don’t want to be referred by officers, they don’t want that stigma attached”. Beck (1967) discusses how negative self-schemas like stigma inferable to the judgments of others can influence an individual’s depressive symptoms; and when judgments are hierarchical, the subservient recipient (e.g. staff to inmates) is at greater risk for the development of depression because an incapability to fight back increases a sense of disempowerment (Cox, Abramson and Devine et al., 2012). The prison environment through its disempowerment of women is intensifying issues around trust and safety; likely relatable to how the women consider memories of their trauma to the appraisal of their current environment (Ehlers and Clark, 2002). Innocuous environmental reminders to past incidents of violence have in other research (Gusich, 2012; Price et al., 2014; and San Diego, 2011) been shown to retraumatise people in increasing the frequency of upsetting intrusive thoughts, unsettling emotions, sleep disturbances and a want to self-injure. This is problematic for the welfare of the prospective patient because prison staff are the profession with the closest working relationship with the detained women. Prison staff as discussed in the work of Plugge, Douglas and Fitzpatrick (2008) can be the main gatekeepers for the women’s access to healthcare; and in HMP, they have the capacity to contact the mental health team directly, discuss with the women their options for seeking mental health support and can also complete mental health referral forms. The unhelpful and overt opinions prison staff can express towards mental health is thus influencing a woman’s thinking and choice about engaging with mental health interventions (p66-69; q63, 66, 69-71, 73, 77, 79, 80, 82).

The phenomenon of stigma has been investigated in community mental health settings (Shrivatava, Johnston and Bureau, 2012) and has been said to be an associative cause for patient treatment refusal and nonattendances. The idea that stigma can affect mental health engagement has also been discussed in a community study (Kessler, Berglund and Bruce et al., 2001), which revealed that a quarter of participants who required mental health treatment chose not to attend for their intervention due to apprehensions about how others may negatively perceive their engagement with mental health services. In the HMP focus groups, the participants talked about how their perceptions of received negative feedback from prison staff and peers about their attendance to mental health service provisions influenced their thinking. The women’s experience of mental health stigma could give rise to connotations that an attendance to a psychological intervention brings with it feelings of embarrassment or shame (p66-69; q65-79). Research (Corrigan, Watson, and Barr, 2006; and Eisenberg, Downs and Golberstein et al., 2009) that sets out to
explain how stigma influences attrition in mental health indicates that stigma derives from an individual’s awareness of public stigmas, which comprises negative stereotypes and bigotries. This influences the individual’s own perceived stigmas towards mental health and its service provisions thereby reducing attendance and completion rates (Sirey, Bruce and Alexopoulos, et al., 2001). A concern would be that in HMP an individual’s interpretation of their own psychological distress might be minimised, as these symptoms may be inconsistent to the exaggerated connotations contained within the perceived stigma of say being “doolally” as one patient described. Thus, nonattendance may be a product of the individual viewing their symptoms as insufficient for treatment or that psychological group absenteeism becomes a means to avoid an unwelcome stigmatisation.

4.3.5. The retraumatising nature of prison

The processes of "adjusting" to prison life are challenging for anyone (King, 1941) and from the thematic analysis of the focus group’s discourse there emerged the theme ‘the retraumatising nature of prison’. Research over the years explains how prison can facilitate a process where life goals dissipate, which affects a person’s self-esteem and their personal security (e.g. Sykes, 1958). A similar observation has been reported by The Sainsbury Centre for Mental Health, a charity which sets out to improve the lives of people with mental health difficulties, who suggest prison detention may deteriorate further an individual’s mental and physical wellbeing (2008). A prison sentence for the women who have children invokes a separation that can bring about feelings of guilt, anxiety and depression, stemming from reminders about their own experiences of childhood neglect (Hooper, 2003). Prison procedures, protocols and mistreatment often in the name of security for women with trauma histories can provoke reminders of abuse through the dynamics of revictimisation and retraumatisation (Dirks, 2004). Women in prison lose a sense of empowerment over their own bodies from the unequal power dynamics of physical restraints, reduced privacy and invasive searches (Girshick, 1999; and Dirks, 2004). Therefore, to enhance the HMP feasibility study’s understanding into how such prison factors could be affecting its women’s appraisal and recounts of prison life, an integrated qualitative method was undertaken through assimilating a contextualist approach with discourse and narrative analysis.

The unsettling nature of HMP life was described as making the women feel “so powerless, you’re puppets on a string and anything, anything can be done to you, pretty much.” The statement stemmed from the women’s knowledge that prison
intelligence can mean the subjugation of a “strip search” and for people who have endured past sexual violence it can denote the institution’s disconcerting power dynamics (p62-64; q37-54). The distress a potential invasive search creates for the women left some with beliefs that the searches are carried out for the sexual gratification of the prison officers (p64, q51). When the women talked about the potential of enduring a physical restraint in prison many felt reminded to the parallels of past trauma, especially knowing that men can be involved in the restraint (p62-64; q37-52). Invasive searches or restraints create cognitive appraisals where the women deduce the prison power dynamics to be suggestive of situations where abuse will take place (p62-65; q37, 38, 40, 48, 50, 53, 54, 56). Thus, the institutional culture of the prison creates a process of retraumatisation (e.g. Dirks, 2004, et al.) or in other words, an activation of trauma related hyperarousal (e.g., Weston, 2014, et al.). Even when the women themselves have not been subjected to an invasive search or restraint, the potential for prison victimization is psychologically unsettling. The retraumatising nature of prison indicates the institution of prison to be a confounding effect to the efficacy of the delivered psychological interventions as the received benefit of psychological group therapy appears mitigated from living within an environment that can trigger reminders of past abuse. The retraumatising nature of prison could explain increases in symptom frequency and severity, or account for the number of women who received minimal change in reported symptoms after attendance to the psychological groups. Therefore, only when the detained women at HMP are supported in an institutional environment compassionate to their trauma histories that mitigate the effect of retraumatisation would it be feasible to carry out a pilot study.

4.3.6. The significance of sleep
The theme ‘the significance of sleep’, indicated the difficulties women in HMP experienced in terms of sleep quality and how poorer sleep may be exacerbating other trauma symptoms. The theme was approached from a realist perspective and supported from qualitative feedback of the focus groups and the pre-intervention ISI measurements that classified all the study’s participants to be experiencing insomnia. In a recent review of study’s that have examined insomnia in prison populations, carried out by Dewa, Kyle and Hassan et al., (2015) there appeared a dearth of research exploring the sleep experiences of women. However, in the available studies that have examined women’s sleep in prison (Singleton, Meltzer and Gatward, 1998; and O’Brien, Mortimer and Singleton et al., 2001) it appears that insomnia is more prevalent in female prison populations than in male prison populations, with
estimations that 81% of detained women experience the sleep difficulty (Dewa, et al., 2015). The HMP findings indicate that poor sleep quality has been a problem for many women throughout their lives (p70; q85-88) or that detainment in prison has increased the women’s awareness of their difficulties sleeping (p70-72; q87-92, 97-101). Either way, a commonality was that prison “intensifies” the women’s distress from having “more time to think” about their ongoing preoccupations, which at night-time appeared to affect sleep. The relationship between worry in the evenings to difficulties sleeping in prison populations has also been identified in other studies (e.g. Elger, 2009; Elger and Sekera, 2009; and Harner and Budescu, 2013). In the HMP study, it appeared that some of the women’s worries related to the welfare of their children, the criminal justice system (e.g. sentencing), their health and frustrations associated with the physiological experience of hyperarousal, which exacerbated the sleep difficulty (e.g. hot, sweating, heart palpitations). It also seemed from the focus groups that the women who articulated more severe sleep disturbances were expressing greater distress attributable to symptoms of trauma (Weston, 2014) like “feeling tense”, “irritable”, “low” mood, “anxiety”, and “flashbacks”, than women who stated less severe sleep disturbances, which could tentatively support the argument that sleep difficulties are the “hallmark” of PTSD (Ross, Ball and Sullivan et al., 1989).

However, the majority of the women in the focus groups did not attend the IYS intervention and it was discovered that many of these women misattributed their difficulties sleeping to innocuous environmental causes, which would substantiate the applicability of Harvey’s (2002) CMMI to a prison population. Harvey (2002) argues that an individual’s incorrect beliefs about the causes of their sleep complaint encourages a process of excessive negatively toned cognitive activity. In prison, the women’s arousal and distress may lead to the selective attention and monitoring of innocuous stimuli, which increases their arousal and maintains or exacerbates their insomnia. For example, several women held the belief that background noise disturbance was a reason of their inability to sleep, which related to the prison’s night staff making noise when “dragging tables and chairs”, the noise of the officer’s key “chains” and from the sounds of the “bolts” turning when the officers are opening and locking doors. Some of the women believed that the “light” of staff torches disturbed their sleep during observational checks. The women interpreted the actions of the night staff as “inconsiderate” and this appeared to be a further causative factor to their frustrations around sleep. In their review of sleep within prisons, Dewa, et al. (2015) found that many detained individuals believed the environmental factors of light (Elger, 2003; Elger, 2009 and Elger and Sekera, 2009) or noise (Elger, 2009) from
officers “shaking their keys during security rounds” to be causative factors of their sleep difficulties (Harner and Budescu, 2014). However, until HMP implement institutional changes to create an environment more conducive to supporting women with trauma symptomatology, it is imperative that the CMHT develops innovative interventions to further support women manage their sleep.

4.3.7. **Women as stakeholders**

The theme women as stakeholders provided a realist account of patient experiences of living in prison and issues associated with accessing the CMHT service provisions. Important for the women in the focus groups was trusting relationships and confidentiality played a role in this matter. In the work of Condon, Harris and Powell et al. (2006) examining patient views of health services across 12 prisons in England, the study revealed the importance detained populations place upon confidentiality within healthcare. The women in HMP place equal importance to confidentiality and hold concerns that the breaking of group confidentiality from their peers could generate rumourmongering (p74; q105-109). The women were also concerned that group facilitators may disclose personal group discourse to prison staff. The women appeared to confuse the nature of disclosure being aware of the group facilitator’s responsibilities to disclose risk-based information (e.g. suicidal intent) but incorrectly deemed non-risk information to be freely divulged to officers. The women offered a remedy for improving concerns about confidentiality, this was a greater effort for the facilitators to represent themselves as trustworthy, and this can be achieved from the facilitators detailing their own experiences of psychological difficulties. The women appeared to receive a cathartic relief in knowing the ‘professionals’ who facilitate their groups had overcome psychological difficulties and perhaps this type of disclosure presumably evidences to the women that they too can be liberated from their own psychological distress (p74-75; q109-114).

A facilitator’s lack of personal disclosure could connote a risk for mistrust, as there is the potential that episodes of the women’s victimisation in prison (e.g. invasive searches) or the community (e.g. violence) in part occurred from a disentitlement of knowledge. Levenson (1996) argues that disclosure is the ‘act to make known an occurrence that has been under consideration, but for valid reasons, has been kept under wraps’. The group facilitators need to consider the issues of patient trust and gauge a personal comfortableness in what constitutes the appropriateness of disclosure within the therapeutic boundaries of their role within the prison. However, the women also discussed that trust can come from the psychological group
environment being relaxed and light-hearted. The group facilitator's presentation style is playful and incorporates self-deprecating humour to help reduce power imbalances that can occur in prison dynamics, which was recognised and appreciated by many of the women in the focus groups (p74-75; q108, 110). The building of trusting relationships between the facilitators and patient’s the women felt could be enhanced through earlier contact to help diffuse concerns the women may have about attending group therapy. The stakeholders also requested the group facilitators deliver in person the intervention invitation letters to allow both parties to meet and this will provide the patients the opportunity to discuss any issues concerning their attendance. In essence the women are requesting greater collaborative work and communication is pivotal to these processes, which echoes other research that discussed the role communication plays in patient engagement within healthcare service provisions (e.g., Carroll, Yancey and Spring et al., 2011; Donovan, Wade and Hamdy et al.; Neal, and Lane, 2011; and Bower, Brueton, and Gamble, et al., 2014). The women explained the more information they receive about the psychological groups the more they can make an informed decision about attending with inferences that enhancing communication will lead to improved participant attendances (p75-77; q114-117,119,123). The stakeholders also advocated communicating directly with the CMHT so that they can bypass the usual gatekeepers of their care whom they view with suspicion. The women requested for specific ‘app boxes’ (a post box for internal mail) on each prison wing where they can send information directly to the CMHT, which is a system used successfully in other prison establishments (Condon et al., 2007).

4.4. Contribution to new knowledge

The HMP feasibility study is the first example of RWR that has addressed the requirements of the Care Act 2014 and the Bradley Report (2009) in undertaking an investigation of the needs of detained women who access a prison’s psychological service provision. The HMP study is also believed to be the first illustration of prison based mental health research that has specifically regarded detained women as important stakeholders in the research process. The patient driven approach was regarded as an emancipatory process in uniquely empowering a disadvantaged female prison population with the capability for self-determination, problem solving and influence within their detaining establishment (Boog, 2003; and Hecker, 1997). The detained women’s feedback was essential to help addresses the gender inequalities that are synonymous to female prison services because women’s prisons are guided from the blueprints of male prison estates (Corston Report, 2007).
Furthermore, the study’s utilisation of a mixed method approach has contributed to new knowledge in the field of prison research. The quantitative data (derived from the psychometric evaluations of the PSS-SR, GHQ-28 and ISI) indicated prison to be a factor for the persistence or exacerbation of the women's trauma symptomatology and enumerated the phenomenon of attrition affecting the prison-based groups. Whereas, the qualitative data explicated the women’s experiences of accessing group psychological interventions and provided an understanding about group nonparticipation. In summary, the feasibility study reveals HMP to be an institution experiencing difficulty in its management of women who present with trauma symptomatology from evidencing how the prison culture, its protocols and procedures play a role in the persistence of the women’s psychological distress.

It is accepted that the HMP feasibility study’s findings are based upon a small sample size and therefore to illustrate how the prison service could be influencing the women’s trauma symptomatology a retrospective analysis of the study’s findings with the Ehlers and Clark (2000) cognitive model of PTSD is discussed. Ehlers and Clark (2000) argue that trauma symptomatology can persist through an interplay between traumatic memories, individual sequelae and how people appraise and act towards their perceived internal and environmental threats. However, due to this analysis being retrospective it is not possible to explore the participant’s sequelae prior experiences or their cognitive processing during the trauma, as these discussions did not occur in the focus groups. Nevertheless, the retrospective analysis can provide a preliminary understanding into how trauma symptomatology can be precipitated in prison from examining the variables of ‘current threat’ (intrusions, arousal symptoms and strong emotions) and the women’s ‘strategies intended to control threats/symptoms’ (Ehlers and Clark, 2000). For example, the quantitative data taken from the administration of the PSS-SR psychometric scale at the pre-intervention and three weeks’ post-intervention (IAM, ITM, IYS and EAT) time points, each denoted a mean group score classifiable for PTSD. Furthermore, the study’s qualitative data derived from its focus groups indicated the probable persistence of PTSD from the insensitive power imbalances operating in prison and an inability of the prison to understand women specific service needs. It is argued that the persistence of the women’s trauma symptomatology is likely factored from the prison’s use of controlled restraints, a preference to perceive the women as prisoners instead of patients, staff disparagement or cynicism towards the women’s psychological distress, systemic bullying, mental health prejudices and the women’s separation from loved ones. Thus, the detained women could have unknowingly perceived these unhelpful prison factors.
as ‘current threats’ from being reminders to the ‘nature of their trauma memory’ (Ehers and Clark, 2000).

In the PTSD model, Ehlers and Clark (2000) explain that a reminder to the ‘memory of trauma’ is likely to lead to the variables of ‘intrusions’, ‘arousal symptoms’ and ‘strong emotions’, which are managed with ‘coping strategies’ (Ehlers and Clark, 2000). The ‘coping strategies’ are commonly actions designed to increase an individual’s sense of safety from avoiding a feared outcome and can include the use of distraction or thought suppression to escape unwanted cognitions. The women’s use of coping strategies to manage their distress was demonstrated in the IYS focus group when a participant stated that in “jail, it’s about medication”, and this was an important remark because the majority of the women who participated in the study were medicated for either mental or physical health conditions. Ostensibly, medication in prison can be used as a ‘coping strategy’ to reduce the unwanted cognitions associated to prison life or the uncomfortableness of ‘intrusions’, ‘arousal symptoms’ and ‘strong emotions’ (Ehlers and Clark, 2000). Therefore, coping strategies like medication can unwittingly prevent the disconfirmation of beliefs associated to the perceived threat (Schmidt et al., 2014; and Stallard, 2003) and are thus a potential explanation for the persistence of the women’s PTSD (as measured with the PSS-SR) three weeks’ post-intervention attendance.

However, similarly to the use of medication as a coping strategy, there is the potential that some women may have unhelpfully used psychological interventions as a means to prevent exposure to feared outcomes. For example, the quantitative and qualitative feedback of the participants who attended the ITM focus group would indicate this intervention to have been the least successful in helping the women manage their trauma symptomatology. The ITM post-intervention psychometric data revealed increases in trauma symptomatology, while the qualitative data described “worrying”, “anxiety”, “irritability”, physiological arousal, “flashbacks” and sleep dissatisfaction. Therefore, an explanation for the exacerbation of the women’s trauma symptoms could be from the participants using the taught mindfulness techniques as a means to distract from the uncomfortableness of their distress. Thus, the coping strategy of mindfulness prevented a change in the nature of the women’s ‘trauma memory’ (Ehlers and Clark, 2000) and increased the women’s use of ex-consequentia reasoning (Amtz, Rauner and Van den Hout, 1995), meaning that the variables of ‘intrusions’, ‘arousal symptoms’ and ‘strong emotions’ were interpreted as threats and likely exacerbated.
The significance in the relationship of the variable ‘coping strategies’ (Ehlers and Clark, 2000) to PTSD can be observed from examining the quantitative and qualitative data of the participants who attended the EAT intervention. The quantitative data revealed that at the post-intervention time point the PSS-SR group mean scores maintained a classification of PTSD; however, collectively the EAT group psychometric scores (PSS-SR, GHQ-28 and the ISI) declined after receiving psychological treatment. The potential effectiveness of the EAT group treatment would appear to be from an incorporation of IE, which enabled the women to disconfirm beliefs associated to their ex-consequentia reasoning. The IE likely reduced the women’s need for unhelpful coping strategies because (e.g.) the arousal symptoms were reappraised and perceived in a more benevolent context (Schmidt et al., 2012; and Ehlers and Clark, 2000). The EAT intervention also encouraged the facilitators to discuss their own instances of anxiety in comparison to their experiences of undertaking rigorous physical exercise. The qualitative data from the EAT focus group revealed that the women appreciated the facilitators delivering their personal experiences of anxiety in a relaxed and humorous approach. The facilitator examples appeared to have been motivational in encouraging the women to reappraise their ex-consequentia reasoning and to perceive ‘current threats’ as benign, which reduced ‘arousal symptoms’ and ‘strong emotions’. Therefore, and overall the retrospective analysis appears to indicate the significance in the role of the variables ‘current threat’ (intrusions, arousal symptoms and strong emotions) and the ‘strategies intended to control threats/symptoms’ in the persistence of PTSD (Ehlers and Clark, 2000) in female prison populations. The findings of the retrospective analysis substantiate and explain how the institution of prison is an unhelpful environment to manage women who exhibit trauma symptomatology.

4.5. Recommendations: an overview

The participation of the detained women as stakeholders in the feasibility study successfully enabled the women to contribute knowledge about their experiences of accessing and participating in group psychological interventions. The focus groups provided the women with a stage to critically evaluate their experiences of accessing group psychological support and deliver recommendations for mental health service improvements. Therefore, as a consequence of the findings of the HMP feasibility study and in relation to the Bradley report (2009) and the Care Act 2014, it is recommended that the HMP prison service enhance its working relationship with the CMHT to better support the women assigned to its care. At present, the psychological group interventions appear of insufficient intervention to provide the needed support
for women in HMP who are exhibiting difficulties with psychological trauma and sleep. In addition, the prison can be argued to be a factor that is maintaining or exacerbating the detained women’s psychological distress. This definition of psychological distress is problematical for the prison because it has been regarded as a form of corporal punishment and outlawed for over forty years in the United Kingdom since the conception of Section 65 of the Criminal Justice Act 1967 (Scarre, 2003). There is the argument that interpreting psychological distress as a form of corporal punishment is in its broader sense (Scarre, 2003); however, whether the psychological distress that has been inflicted upon detained women is institutionally intentional or inadvertent the prison service requires direct action to remedy its institutional dereliction. Therefore, the overarching recommendation of the feasibility study is the commissioning of systemic change to reduce or diminish the institutional factors that may be contributing to the detained women’s symptoms of trauma and insomnia, which could be inhibiting the effectiveness of psychological interventions. However, the HMP research investigation proposes two stages of recommendations to facilitate systemic and cultural change to better manage the detained women’s psychological wellbeing. The first stage of recommendation is preliminary and focus attention on realistically achievable improvements to the prison culture, its protocols and procedures that are unhelpfully affecting the women’s mental health. The stage two recommendation are comprehensive and call for a service redesign that directly supports the prison as a systemic intervention for the treatment of detained women with symptoms of trauma and insomnia.

4.5.1. Recommendations: stage one

4.5.2. Managing restraints and invasive searches

The overt security driven environmental factors of invasive searches and restraints, which are discernibly traumatic for women who have experienced violence are unethical and it is recommended that these practices are minimalized and the development of other non-traumatizing measures examined. It is accepted that prison life will impose occasions when the use of restraint is essential to reduce risk and in these exceptional circumstances, it is fundamental the concerned individual is provided with subsequent qualified psychological support. It is similarly recommended in learning how detained women who are observers to restraints can experience an emotionally upsetting response for them to likewise be afforded the opportunity for psychological support. The occurrence of invasive searches of rooms and persons based upon “intelligence” also requires revision. The frequency of searches could reduce if the prison service proportioned greater commitment to the development of
preventative measures to minimalize the opportunity for contraband to enter the women’s possession and thus a wider review of prison security is essential. When an invasive search is necessary, the woman should be provided the choice of staff members present, including non-uniformed staff working in healthcare or mental health. The woman concerned should also be offered psychological support before and after a search in order to reduce the negative affect experiences of indignity can provoke in people who have been subjected to abuse.

4.5.3. Managing institutional prejudice
The focus groups brought attention to the offensive phenomenon of prejudice arising from prison staff’s attitudes towards mental health and how healthcare can perceive women as malingering prisoners as opposed to genuine patients. Staff working in prisons may interpret their prejudicial attitudes as inoffensive but maladroit engagement can adversely influence the women’s psychological distress and increase their intent to self-injure, which is a disconcerting outcome when evidence indicates that 42% of people who have attempted suicide in prison have previously self-injured (Liebling, 1992). The changing of institutional prejudice may be challenging but it is recommended that as an intervention the CMHT collaborate with the prison service to develop and run a mental health training package that all staff who work in HMP are mandated to attend. The programme can educate staff about the failings of the prison service identified in the HMP study and encourage a more thoughtful and psychologically informed way to work with women who have mental health difficulties.

4.5.4. Increasing access to mental health services: the essence of communication
The focus groups indicate insufficient communication to detained women about the mental health services available in prison and communication deficiencies during the assessment and referral procedures are reducing their access to psychological support. The absence of mental health referrals cascading from the prison’s reception health screenings indicates the necessity for the process to include a mental health care professional who can undertake a brief mental state examination. The CMHT’s earlier engagement with the women in reception would provide an opportunity to communicate information about the CMHT’s services and enable the women quicker access to psychological groups. Additionally, the CMHT needs to develop a mental health reception welcoming pack, which contains information about the CMHT service provision, provides communication forms to enhance direct communication through
the internal ‘app’ post system and literature signposting the women to outside community mental health support for when they are released. The welcome packs must also include self-help guides to initiate support for the women’s management of symptoms of trauma and insomnia. In other prison research (Maunder, Cameron and et al., 2009), self-help guides have been shown to be of therapeutic benefit and in HMP they can act as a brief psychological intervention for the women on the group psychological intervention waiting lists and for those less acquiescent to group work.

4.5.5. Improving symptoms of trauma and sleep
In relation to the findings of the HMP study it seems feasible to provide the women who enter HMP with increased access to the psychological groups (EAT and IYS) which appeared helpful for supporting symptoms of trauma and sleep. The CMHT must discuss with women upon their entry to reception their want to engage with psychological therapies. Women interested in exercise and a want to improve their mental wellbeing can be offered the EAT group, which with improved prison cooperation can facilitate the IE component. However, it is recommended that the CMHT undertake further evaluation of this intervention to ensure that IE is for the women acceptable and efficacious. In awareness to the high frequency of insomnia within female prison establishments and the relationship between poor sleep and the potential for exacerbation of other trauma symptomatology (e.g., Kato, Asukai and Miyake et al., 1996) there needs to be increased education about techniques to improve sleep. It is recommended in light of the encouraging findings of the IYS group that all women who enter HMP at reception should be offered an opportunity to attend the IYS group or where feasible be provided with individual support.

4.5.6. Improving the attendance to psychological groups
In regards to the phenomenon of attrition within the provision of the HMP psychological group interventions, it is recommended that the CMHT take accountability for developing innovative new measures to increase psychological group attendances. The CMHT currently operates on a 09:00 to 17:00 hour, seven days a week service and the psychological groups are only offered on weekdays during these hours. It is recommended that the CMHT increases access to its therapeutic groups in providing a service that operates after 17:00 hours or during weekends when there is reduced competition from the HMP factors shown to reduce psychological group attendances (e.g. education, other (church, gym, missing free-flow and prison appointments), medical appointments and work 4%). The adhering to this recommendation is critical when consideration is given to the Care Act 2014,
which directs health care service providers to deliver equality in care for people detainted in prison with those people living in the wider community (Forrester et al., 2013), where psychological services like IAPT offer support during early evenings and Saturday’s. The benefit for the CMHT in initiating a change to its service provision alongside the likely increase in group attendance rates is an overt demonstration of flexibility to generate a patient focused service, which is an important declaration of intent to the outside organisations (e.g. the Care Quality Commission, The HM Inspectorate of Prisons and the Independent Monitoring Board) that monitor prison healthcare service provisions.

4.6. Recommendations: stage two

4.6.1. A specialist trauma-focused hospital

It is anticipated that the stage one recommendations are considered and implemented with speed and for these changes to be assessed from the undertaking of further focus groups using the detained women as important stakeholders in the prison healthcare service redesign. However, the stage one recommendations are proposed as a transitory measure until the stage two recommendations for a service redesign are implemented. Stage two advocates HMP to become a specialist trauma-focused hospital (STFH) providing a trauma-focused service for females detained within the criminal justice system. The change in the identity of the prison to a STFH it is hoped will help render obsolete the archaic treatment of women as prisoners and empower a supportive culture amenable to women with trauma histories. There are several prisons in the UK (including HMP) that provide therapeutic wings to support women who have substance misuse issues or personality disorders (Stevens, 2012). The only prison in the UK that facilitates a therapeutic community throughout all prison wings is Grendon a male estate that has successfully become a psychologically informed environment (Genders and Player, 2010; and Stevens, 2012), which places emphasis upon trauma-focused group work (Rhodes, 2013). The challenges for the prison service in assigning HMP to a STFH are outside the remit of this feasibility study but it is imperative that the redesign encompass the women as stakeholders. All the stakeholders assigned to the service redesign will need to implement a series of new protocols and procedures to safeguard the detained women’s psychological wellbeing. For example, previously the prison has transferred women engaging with the CMHT to other establishments without liaising with the CMHT about the ability for the next prison to provide care continuity as different prisons offer differing levels of CMHT support (Forrester et. al, 2013). In the STFH, a woman should be provided the opportunity to finish her psychological work before being transferred to another prison.
locality. When it is fundamental that a woman requires a transfer or when a woman is released it is paramount that the STFH liaise with the woman’s next CMHT care provider to ensure that she has an appropriate and continued package of care.

In the design stages of the STFH it is recommended that, the relevant stakeholders consider how female forensic medium secure mental health hospitals manage the care of their patients. It is accepted that HMP as a STFH would require security staff to manage the safekeeping of the unit but as with forensic mental health hospitals, the NHS could effectively manage the running of the sites. In the stakeholder focus groups, some of the women who have lived in secure mental health hospitals recommended that HMP be operated in a similar fashion. These women felt that it was important for women in prison to receive daily care from staff who are appropriately trained and qualified in mental health due to the majority of women in HMP exhibiting mental health difficulties. A prison managed from appropriately qualified staff means that the women have an opportunity to receive appropriate engagement and support for their needs. At any time in the day, if a woman is in psychological distress there will be a psychologically minded member of staff available to support the woman’s needs. The recommendation for HMP to be operated in a similar fashion to female secure mental health hospitals would be supported by evidence that indicates secure female units to be of therapeutic benefit for women exhibiting psychological distress (Parkes and Freshwater, 2012). In relation to the investigative work of Parkes and Freshwater (2012) who examined approaches to work with women who have experienced psychological distress the STFH will provide onsite access to general practitioners, psychiatrists, mental health nurses, psychologists, occupational therapists and social workers. The STFH cannot permit the locking of women in their cells and will allow unrestricted access to the hospital’s communal areas. In the daytimes, the women will be provided with individual therapy and enrolment to trauma-focused group work programmes. In regards to the type of psychological services to be delivered and in adherence to the Care Act 2014 (Gee and Bertrand-Godfrey, 2014; and Forrester et al., 2014) it is recommended the STFH incorporate the IAPT service to manage the psychological service provision. It will be the responsibility of IAPT to safeguard that the hospital culture and environment is psychologically informed and this will necessitate a close working relationship between IAPT and their patients during the development of their service.

The team managing the STFH cannot neglect the findings of the feasibility study and
how psychological distress is for many women related to matters around sentencing, rehousing and the impediment detention has upon familial relationships (p66; q127,128). Issues like these have been discussed in prison research for over the past decade (Braman, 2002; and Travis and Waul, 2003) with growing calls for female specific prison service redevelopments (Codd, 2007). In recognition of the impact that being in prison has for women, Harris (2014) argues the importance for women to access social work teams to help facilitate the amenities often minimalized or prohibited in prison. Harris (2014) recommends that social workers supervise the women to have access to skype, emails, telephones and to provide letter writing assistance, recommendations that are endorsed for the STFH. It is also recommended that in the STFH the social work team increase the amenability of families from less financially comfortable backgrounds to visit relatives from securing subsidies for travel and overnight accommodation costs (Harris, 2014) because many women’s families come from areas where the locality of the STFH creates access difficulties (Sutton and Pocock, 2015).

4.7. The implication of change for the management of health

There is evidence to indicate that hyperarousal based trauma affects the working of the body’s immune system and this can increase people’s susceptibility to certain health conditions (Boscarino, 2004; Schnurr and Jankowski, 1999; and Dirkzwager, Van der Valden and Yzermans, 2007) like arthritis, fibromyalgia, chronic fatigue syndrome, heart disease, angina, asthma and irritable bowel syndrome (Green and Kimerling, 2004; Schnurr and Janowski, 1999 and pacella et al., 2013). Trauma associated hyperarousal is also a factor for sleep disturbance, which is related to an increased risk of morbidity (Blask, 2009) including cardiovascular disease (Buxton and Marcelli, 2010; Cappucio, Cooper and D’Elia et al., 2011), strokes (Cappuccion et al., 2011), obesity, type-2 diabetes (Knutson and Van Cauter, 2008), cancer (e.g. colon and breast) (Faith, 2012) and psychiatric difficulties (Glozier, Martiniuk and Patton at al., 2010) (Ford and Kamerow, 1989). However, although physical health has not been the central focus of the HMP investigation it is important to acknowledge how the prison factors that are having a detrimental influence on the women’s symptoms of trauma and insomnia could have ramifications for the women’s physical health. Therefore, implementing the recommendations set out in the HMP study for improving the women’s trauma symptoms and sleep could dualistically provide an element of intervention to trauma associated health conditions.
4.8. HMP study: methodological limitations

The carrying out of the HMP investigation presented the principal researcher with certain difficulties that contributed to research limitations. An intention of the research was to incorporate patients, group facilitators and prison staff as the three main stakeholders in the research process in order to understand the phenomenon of running psychological group interventions within a prison setting. The incapacity of the prison to provide participation in the research process omitted the capability of the HMP study to excerpt an understanding about prison staff thinking towards the provision of psychological intervention within HMP. It also diminished the opportunity for a representative of HMP to discuss contentions of institutional prejudices that became evident from the discourse of the patient and facilitator focus groups. The intention to include the CMHT staff facilitators as stakeholders in the research process was important to understand their opinion about delivering the group psychological interventions within the prison setting. However, during the facilitator focus groups, facilitators provided succinct responses, with little group discussion occurring. Interviewer prompting was unsuccessful in elucidating any further meaningful elaboration on areas of interest. There was the consideration to run further facilitator focus groups to produce more evocative data, but this was impracticable due to CMHT time constraints. Therefore, the facilitator focus group was felt to be unsuccessful in delivering sufficient data for more meaningful inclusion within the feasibility study write up.

A further constraint to the study also related to the recruitment of participants, although the participant sample sizes were adequate to use for descriptive statistics (Dainty et al., 2014; and Tickle-Degnen, 2013); it was anticipated that there would have been greater participant numbers to enable interpretive statistical analysis and increase the generalizability of the study’s quantitative findings. In addition, the HMP study, in examining the effects of psychological group interventions for improving symptoms of trauma and sleep for women in prison acknowledges that almost all of the participants were receiving psychopharmacological treatment. In a review carried out by Wurz and Sungur (2009), the authors provided evidence that combining pharmacological and psychological intervention improves treatment efficacies for conditions neurologically within the fear network from targeting prefrontal activation that can help reduce amygdala activity. The nature of the HMP study through purposive sampling reduced the study’s ability to understand the effectiveness of group psychological therapy as a standalone treatment because medication
(prescribed or non-prescribed) was not controlled as a part of the study’s design. Instead, the feasibility study’s quantitative findings provide a preliminary understanding of the effectiveness of psychological and pharmacological combination treatment for managing trauma and insomnia. However, the high frequency of women in HMP prescribed medication for trauma symptoms indicates the difficulty any future (e.g. a pilot study or larger RCT) study intending to deduce the efficacy of standalone psychological treatments may have in recruiting sufficient numbers of non-medicated participant’s.

4.9. Future work

The findings of the HMP study indicate the current unfeasibility for the commencement of a pilot study; nevertheless, there is an opportunity for qualitative researchers to continue to explore the relationship of living in HMP with the women’s experiences of trauma and sleep. If HMP implement change as recommended in this HMP investigation, researchers have the potential to understand how improved psychological environments influence self-injury, suicidal ideation, substance misuse, medication consumption and recidivism. Furthermore, longitudinal research could also examine how improving psychologically informed environments for women in prison influences health behaviours and trauma related physical health morbidities.
Chapter 5: Conclusion

5. Conclusion

It has been argued that prison research biases its attention to male prison estates (Rafter, 1992) and there is an insufficient emphasis for researchers to investigate how trauma histories of women relate to their needs within prison (e.g. Garcia et al., 1998, Maloney et al., 2009). The HMP feasibility study has played a role in confronting the inherent biases of prison research in taking an important step of empowering women as stakeholders within the processes of healthcare research. In addition, the HMP study supports the requirements of the Bradley Report (Executive Summary, 2009) and the Care Act 2014 in undertaking an investigation of a prison mental health service provision to specifically address the needs of the population (Forrester et al., 2013). The women’s participation in the research project allowed a preliminary understanding about the clinical effectiveness of the prisons group psychological interventions; valued information about the factors contributing to the women’s nonattendances of group interventions; and an exploration of the experiences of the women who participated in the research. The HMP study utilised descriptive statistics to preliminarily understand the effectiveness of the four group psychological interventions (IAM, ITM, IYS and EAT) for helping women manage symptoms of trauma and insomnia. The descriptive statistics albeit indicative implied the IYS group and the EAT group to be the more effective interventions for improving the women’s symptoms of trauma and sleep; and the IAM and the ITM less successful in their ability to manage the women’s trauma symptomatology.

The qualitative work derived from the thematic analysis of the focus group discourse provided the emergence of themes that explicated the experiences of the women who accessed the psychological group interventions. The theme ‘a pathway to care’, detailed how a culture of defective communication is obstructing an earlier recruitment of women into psychological groups. The ‘prisoner or patient paradox’, illuminated the unsupportiveness of identifying women who have mental health difficulties as prisoners and how a castigatory management of these women from the gatekeepers of their care can affect the women’s treatment intentions. The theme also revealed how healthcare staff can view the women with suspicion and question their motivation for seeking medication, which leaves some women with intentions to self-injure to demonstrate the genuineness of their distress. The theme ‘stigma as a therapeutic
barrier’, symbolized the prejudices towards mental health within the prison establishment. The stigmatization of mental health can minimalize a person’s perception of their own psychological health or affect attendances to group support from apprehensions about being stigmatised. The ‘retraumatising nature of prison’ provided understanding in how protocols and procedures like restraints and invasive searches for women who have a history of violence can bring reminders of past episodes of victimisation and this appears to be a phenomenon that is maintaining or exacerbating the women’s distress. ‘The significance of sleep’, brought confirmation to the wider literature (Singleton et al., 1998; and Dewa et al., 2011) that suggests the high frequency of women in prison who experience insomnia. The theme provided evidence to support the relationship between hyperarousal and insomnia and an indication that poor sleep education could innocuously be maintaining the sleep difficulty. The final theme ‘women as stakeholders’ utilised the women as important participants in the field of healthcare research. The women provided details about the experiences of their care pathway to mental health groups and offered patient led ideas for service improvements.

In summary, the HMP investigation indicates that imprisonment, for women who have experienced past incidences of violence and victimisation, can become a factor for the continuation or exacerbation of their psychological distress. Female prisons like HMP can be said to be unethical in their management of women because the institution of prison is failing to support the women under its care and is potentially confounding the efficacy of group psychological interventions. The outcomes of the HMP study provided two stages of recommendations to manage the prisons deficiencies outlined in the investigation. The first stage is preliminary and addresses institutional protocols, procedures and cultures unsupportive to the women in prison. The stage two recommendations are more extensive and argue the transformation of HMP into a STFH. The institutional transformation is intended to ensure that women detained within the criminal justice system, who exhibit trauma symptomatology’s are now cared for in an ethical and psychologically informed manner.
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7. Appendices
Appendix 1: Consent form

Consent Form

A Service Evaluation: Understanding the clinical effectiveness of interventions designed to treat psychological distress within a female prison population

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason

3. I agree to take part in the above study

4. I agree to the focus group being audio recorded

5. I agree to the use of anonymised quotes in publications

6. I agree to the use of my anonymised data being used to form a part of this service evaluation study

Name of participant

Date

Signature

Name of researcher

Date

Signature
Appendix 2: Information sheet

Information sheet

A service evaluation: Understanding the clinical effectiveness of interventions designed to treat psychological distress within a female prison population

Service Evaluation

[NHS] provides the Community Mental Health Team that runs the [Service in Location]. The service is to help women in prison who are experiencing mental health difficulties.

As someone who is or may use [Service], we would like your ideas about the service we are providing. To do this, we would like to invite you to take part in a service evaluation. A service evaluation is a study that looks at how useful people find a service and how good it is at helping people with their own particular needs.

However, before you agree to take part in this service evaluation, we would like you to take some time to read the following information carefully. You can talk to others about the study if you wish. But please ask someone from the Community Mental Health Team or someone in [Location] if anything is not clear and you need more information. You can either talk to the person who gave you this form; put in an 'app' to speak to us or ask a 'wing officer' to contact us so we can come and see you.

Groups

You have been referred to a group in [Location] because you are experiencing difficulties with anxiety (e.g. feeling nervous, a little shaky), depression (e.g. feeling sad or low), sleep difficulties (e.g. taking ages to get to sleep or wake up a lot), physical health problems (e.g. aches and pains), or day to day difficulties with your life (everything seems like an effort).

We run various groups that can help people with each of these difficulties and
we would like you to attend one of the groups beneath, which is being evaluated.

**Introduction to Anxiety Management:**
This is a 90 minute group that can help you deal with feelings of anxiety, nervousness or worry and the uncomfortable feelings this can bring about. It can even help you to improve your sleep.

**Introduction to Mindfulness:** This is a 90 minute group that can teach you how to relax and become more aware of the present moment. Mindfulness can help improve feelings of low mood, anxiety and help improve your sleep.

**Exercise as Therapy:** This is a 90 minute group that can show you how exercise with understanding your thoughts and feelings can help improve feelings low low mood, anxiety, sleep difficulties and general distress.

**Improving your Sleep:** This group is ran over 1 session, of 90 minutes. The group is designed to improve sleep difficulties, which can then improve symptoms of low mood, anxiety and general distress.

**Agreeing to Take Part**
As discussed earlier, we would like your help to find out more about the people who use our service, so we can continue to improve our care. What this will mean for you if you decide to be a part of this service evaluation is completing some forms before you start the group and the same forms a few weeks after attending the group. These forms will look at your experience of anxiety, low mood, general functioning, physical illness and sleep difficulties. We will also ask you to fill out a form that looks at difficulties in your life, which may have been traumatic. We want to know this information because we are aware that many women who come through HMP [blank], have been through very upsetting experiences. Understanding these upsetting experiences will help us provide a service that can help people manage the difficulties these upsetting experiences can bring.
We would also like you to attend a focus group. A focus group is an opportunity for you to talk to us about what you thought of the group you attended and how it has or hasn’t helped you with your personal difficulties.

The focus group will be run by a member of the Community Mental Health Team leading the Service Evaluation and attended by other people who have volunteered to take part. The focus group will be audio recorded so that we can take time after the group to really understand what was discussed and to start making the changes that people recommended.

Taking part in the service evaluation is voluntary. If you do not want to take part in the service evaluation you do not have to and you will still be offered a place on one of our groups.

If you do decide to take part in the service evaluation, you are free to withdraw your participation whenever you want. What we will ask for those of you who decide to take part is that we use the information we gather to understand how effective our groups are in helping people. Understanding your experiences will really help us provide groups that help you deal with your past and current experiences.

So, if you would like us to help improve our service for women like you who enter HMP [Redacted]. Please complete the Conset form that is attached with this information pack.

And most of all, thank you for taking the time to consider taking part in this service evaluation.

Contact Details:

If you would like further information, please ask a member of your residential staff to contact us and we will come and see you.

We are:

Community Mental Health Team: Gavin Jones, Assistant Psychologist or [Redacted] Team Leader. Or alternatively you can speak to a member of the HMP [Redacted].
Appendix 3: Focus group topic guide (intervention focus group)

1. Ground Rules (5 mins)
   Ask the group to suggest some ground rules. After they brainstorm, make sure the following are on the list.
   - Everyone can participate.
   - Information provided in the focus group must be kept confidential
   - Stay with the group and please don’t have side conversations
   - Have fun
2. Questions 70 mins (e.g.):
   - **Experiences before attending the group:**
     - What mental images came to your mind when thinking about your ‘phenomenon’?
     - What feelings come to mind?
     - What did you experience in terms of your ‘phenomenon’?
     - What contexts or situations typically influenced or affected your experience of the ‘phenomenon’?
   - **Experiences after attending the group:**
     - What have you recently experienced in terms of your phenomenon?
     - What contexts or situations have typically influenced or affected this current experience of the ‘phenomenon’?
     - What mental images come to mind when you think about your ‘phenomenon’ now?
     - What feelings come to mind?
3. Conclusion (5 mins)
   That concludes our focus group. Thank you so much for coming and sharing your thoughts and opinions with us.
Focus Group Topic Guide

Research Focus Group: Introduction (10 mins)
Thank you for agreeing to participate in this study. We are very interested to hear your experiences of the research study that you have been involved in. This is because we may undertake a much larger study in the future and would like your opinions about being involved in research.

- The information you give us is confidential and we will not associate your name with anything you say in the focus group.
- We would like to tape the focus groups so that we can make sure to capture the thoughts, opinions, and ideas we hear from the group. No names will be attached to the focus groups and the tapes will be destroyed as soon as they are transcribed.
- You may refuse to answer any question or withdraw from the study at anytime.
- We understand how important it is that this information is kept private and confidential. We will ask participants to respect each other’s confidentiality and remind people of the stepping stones contract that was signed.

If you have any questions now or after you have completed the questionnaires, please feel free to ask during the group. Or please feel free to contact either myself or ............... after the group; or you can contact us through completing a prison application form.

- What will be done with this information
- Focus group will last about one and a half hours
- Feel free to move around
- Where is the bathroom? Exit?
- Help yourself to refreshments
- Questions

4. Ground Rules (5 mins)
Ask the group to suggest some ground rules. After they brainstorm, make sure the following are on the list.

- Everyone can participate.
- Information provided in the focus group must be kept confidential
- Stay with the group and please don’t have side conversations
- Have fun
5. Questions 70 mins (e.g.):
   - Introduce yourselves and the intervention that you attended?
   - What mental images came to your mind when agreeing to take part in this study?
   - What feelings come to mind?
   - What contexts or situations influenced your decision to participate in the study?
   - What was your experience of taking part in the study?
   - What meaning does this study have for you?
     - Explain allocation process (10mins) for intervention in an RCT/as it is at the moment for CMHT referrals
   - What mental images came into your mind when this was explained?
   - What feelings come to mind about these allocation processes?
   - What would your experience be if you were allocated for an intervention that way?

6. Conclusion (5 mins)
   That concludes our focus group. Thank you so much for coming and sharing your thoughts and opinions with us.
Appendix 5: Focus group topic guide (group facilitators)

Focus Group Topic Guide

Group Facilitator Focus Group:
Introduction (10 mins)
Thank you for agreeing to participate in this study. We are very interested to hear your experiences of the research study that you have been involved in. This is because we may undertake a much larger study in the future and would like your opinions about being someone involved in research.

- The information you give us is confidential and we will not associate your name with anything you say in the focus group.
- We would like to tape the focus groups so that we can make sure to capture the thoughts, opinions, and ideas we hear from the group. No names will be attached to the focus groups and the tapes will be destroyed as soon as they are transcribed.
- You may refuse to answer any question or withdraw from the study at anytime.
- We understand how important it is that this information is kept private and confidential. We will ask participants to respect each other’s confidentiality and remind people of the stepping stones contract that was signed.

If you have any questions now or after you have completed the questionnaires, please feel free to ask during the group. Or please feel free to contact either myself or ................ after the group; or you can contact us through completing a prison application form.

- What will be done with this information
- Focus group will last about one and a half hours
- Feel free to move around
- Where is the bathroom? Exit?
- Help yourself to refreshments
- Questions

7. Ground Rules (5 mins)
Ask the group to suggest some ground rules. After they brainstorm, make sure the following are on the list.
- Everyone can participate.
- Information provided in the focus group must be kept confidential
- Stay with the group and please don’t have side conversations
- Have fun
8. Questions 70 mins (e.g.):
   - Introduce yourselves and the intervention that you facilitated?
   - What mental images come into your mind when thinking about your ‘group’?
   - What feelings come to mind?
   - What was your experience of this ‘group’?
   - What contexts or situations typically influenced or affected your experience of the ‘group’?
   - What meaning does this group have for you in your life?

9. Conclusion (5 mins)
That concludes our focus group. Thank you so much for coming and sharing your thoughts and opinions with us.
Appendix 6: Example of thematic analysis workings

A pathway to care
The text beneath are example extracts of discourse and notes used to develop the theme 'the retraumatising nature of prison. The highlighted text is words or phrases that were felt to be meaningful. The text in right column is an example of initial notes sourced during examination of the qualitative data.

Data extracts
"...One of the biggest things about mental health is people not being supported and I think that there is a lot of people, who need it like, but they don’t know how to access it, they don’t know how to get referred.”

"People are asking me... When you go to Women’s Therapy give my name, so there are people which want to come but they don’t know how to book it.”

"Well, when I was having my appointments to see a doctor and substance misuse [staff kept on asking] and I was saying that nobody has come to see me and what do I do about it? And they say, well you’ll have to have an appointment with someone first then well you’ll get referred. But like I said it took 4 people to see before the last one then, who did finally refer me and that took a couple of months not at just to get that far.”

"...I think there should have been a lot more support that could have been given. Like five minutes doesn’t get you far.”

"...you’re just not understanding anything, so it’s just been checked off you.”

An example of initial codes, keywords and phrases that led to the development of the final theme from the discourse text and notes taken
Unsupported, compassion, unknowledgable, want for help, back, frustration, don’t know, isolation, segregation from well and unwell, power dynamics, treatment, which is the care pathway, a lot of transference (checked is the negative energy being countertransferred? Blaming, you, then, who

Candidate themes
The struggle for compassion; understanding how to care; isolation from care; unseen and unheard; time to care; the access to care; prison care without compassion, ‘a pathway to care.’

Final theme: a pathway to care
The final theme plays upon the usage of the term ‘care pathway’, the theme tells an account of the women’s treatment journey narrative. Its challenges and directs meaning to supportive treatment without apportioning culpability.
The patient or prisoner paradox

The text beneath are example extracts of discourse used to develop the theme 'the patient or prisoner paradox. The highlighted text is words or phrases that were felt to be meaningful. The text in right column is an example of initial notes scribed during examination of the qualitative data.

Data extracts

"I reckon that they'll watch some people and start to put any kind of people with mental health issues on E wing"

"We're acting like princesses, we should remember where we are, we're here for a reason."

"You're in prison, you deserve to be punished."

"...ok we might have made mistakes and we've been punished, we're in prison but we need supporting in here as well, whatever people have issues or problems we still need support."

"You'll have to prove to them in here that you've got mental health issues and wait for your doctor's record and then they'll give you your medication. They don't believe you from word of mouth, they don't believe you cause you're a prisoner."

"There is more freedom in prison than a mental health hospital. I was in a medium secure so its lock down all the time, but being here I feel more safe. I know I'm surrounded by people, but I'm alone. I ain't gunna just go to an officer and say I feel like you know what I mean? I felt like self harming."

An example of initial codes, keywords and phrases that led to the development of the final theme from the discourse text and notes taken

You're a prisoner, remember where we are, transferences, acting like princesses, deserve to be punished, they don't believe you, clear pluralism in identity that is causing social conflict, patient and prisoner identity.

Candidate themes

It was clear from the discourse that candidate themes related to punishment and treatment of someone detained within the criminal justice system; themes were (e.g.) treating prisoners, patients as prisoners, prisoners as patients, prisoners and mental health, hospitals or prisons? the pluralism of prisoners as patients, the patient or prisoner paradox.

Final theme: the patient or prisoner paradox

The final theme succinctly denotes the difficulties in recognising NHS patients within a prison and the patients right to be treated as a patient and the conflict this causes the women and the staff working within prisons.
The retraumatising nature of prison

The text beneath are example extracts of discourse and notes used to develop the theme ‘the retraumatising nature of prison’. The highlighted text is words or phrases that were felt to be meaningful. The text in right column is an example of initial notes scrawled during examination of the qualitative data.

Data extracts

“They caused things, they slammed her hand, they suffocated her, and they slammed her down.”

“If you consider a lot of people in here have gone through traumatic things in the past, the worst thing that can happen is being restrained by a带有...”

“In here you’re so powerless, you’re hanged on a string and anything, anything can be done to you, pretty much.”

“I don’t think it’s right as well, where you’ve got to be stripped searched from intelligence for whatever. We’ve got to be stripped searched by an officer that’s a relation I think that’s out of order.”

An example of initial codes, keywords and phrases that led to the development of the final theme from the discourse text and notes taken

Trauma, powerlessness, restraint, strip searching, comments of restraint and strip search are significant for victims of trauma, traumatic vulnerability, power dynamics, abuse, exploitation, sexual gratification, privilege, hidden agenda.

Candidate themes

The trauma of prison, the unsettling nature of prison, the continuation of fear, the powerlessness of prison, prison the hidden fears, prison and trauma, the retraumatising nature of prison.

Final theme: the retraumatising nature of prison

The final theme encapsulates how living in prison can bring reminders of past victimisation and abuses of power, which can trigger, continue current trauma. Awareness placed to the possibility that one cannot be retraumatised and it’s an exacerbation of lower levels of trauma presentation that are retraumatising which is perhaps posttraumatic. However, retraumatisation a term used frequently in HMP from team to discuss exacerbation of symptoms.
Sigla as a therapeutic barrier

The text beneath are example extracts of discourse and notes used to develop the theme 'the retraumatising nature of prison.' The highlighted text is words or phrases that were felt to be meaningful. The text in right column is an example of initial notes scribbled during examination of the qualitative data.

Delta extracts

“think we just come over here and I don’t know make cards and stuff”

“I think that some of the girls that do have problems are not necessarily coming here because of the name Women’s Therapy”

“I think they still have the old view of Women’s Therapy... “scabbing and dibbling”, seriously... I don’t know. It’s just [disrupting] isn’t it?”

“...they don’t want to talk to officers as they don’t want to be referred by officers, they don’t want that stigma attached. I think there’s a lot of work needing to be done on that.”

“I’ve been in and out of jail for 6 years, even when I was here first, I heard stuff about it, I heard it’s far tougher.”

“I was offered a lot from mental health. I don’t know why I didn’t come. I think it was just what people say, how people judge you in here with mental health issues.”

An example of initial codes, keywords and phrases that led to the development of the final theme from the discourse text and notes taken

Rumormongering, stigma, prejudice, negative attitudes, unhelpful opinions, nonattendances, attrition, stereotyping, discrimination, prejudice, abuse, verbal aggression, containment, mental punishment, preventing or contributing to psychological therapy, cognitive appraisal of mental health, old views and new views, discrepancy

Candidate themes

Unhelpful nature of stigma, no pride in prejudice, stereotyping support, prison prejudices, the discriminatory perceptions of group support, stigma the barrier to groups, the guard to treatment, stigma as a therapeutic barrier

Final theme: stigma as a therapeutic barrier

Particularly succinct in providing narratives to the decision-making women must experience when deciding to seek and attend for psychological support. Recognises the unhelpful opinion being a social barrier for seeking appropriate means to manage difficulties.
The significance of sleep

The text beneath are example extracts of discourse and notes used to develop the theme 'the retremonising nature of prison.' The highlighted text is words or phrases that were felt to be meaningful. The text in right column is an example of initial notes crde during examination of the qualitative data.

Data extracts

“Everyone has difficulty sleeping in [a], we've all got our own way of doing it, and that causes anxiety then, in it? So we're more focused upon ourselves in the night time..."

“I’ve got a problem with sleeping. I have and switching off to stop my brain from doing over time...”

“...I can't get to sleep and when I do get to sleep I wake up every 20 minutes or so and it's horrible and I've got my anxiety back and I don't want to go to sleep anymore because the visions and flashbacks have come back so it's made it 10 times worse. It's really just"

“...The GP was dismissive, they offered the group, which I didn't ask for cause I didn't know about it. But the way in which they said it was dismissive and abrupt, you can give that a go if you like, as though it wasn't a particularly important thing, it was just something I could do cause they didn't want to give out much."

“...you're in your cell and if you're doing it crying, so come the night you don't want to go to sleep. It's boredom ain't it, constantly sleeping in the day...”

An example of initial codes, keywords and phrases that led to the development of the final theme from the discourse text and notes taken

Difficulty sleeping, worry, metacognitive, catastrophize, cognitive appraisal, flashbacks, visions, ptss, sleep deprived, relationship between sleep and trauma and mental health, professionalism towards sleep, institutional difficulties hindering sleep, lack of education, requirement to increase importance of sleep.

Candidate themes

Understanding the importance of sleep, sleep and mental health, prison preventing sleep.

Final theme: The significance of sleep

The clear theme that developed was the importance the women placed upon sleep and how perhaps this importance is overlooked from the prison establishment, which may result from a lack of sleep education. The significance of sleep tells its importance for the individual and also its wider consequence for an inability to sleep, theme reveals professional attitude and health consequences. And need for appropriate behavioural sleep education in prisons to improve sleep and health.
Women as stakeholders

The text beneath are example extracts of discourse and notes used to develop the theme the retraumatising nature of prison. The highlighted text is words or phrases that were felt to be meaningful. The text in right column is an example of initial notes scribbled during examination of the qualitative data.

Data extracts

“Yes, I got exactly what you are saying. I agree completely with that, you feel like that if you are open and honest with someone it’s going to bite you right back on the backside. “... I found as well that it was really hard to trust you guys, the mental health workers because you are likely saying to officers that anything you say goes back to them and you will get judged and I wouldn’t feel comfortable opening up because of the environment...” “Cause you’ve been through it you can relate to it...” “... women are not here for a long time anyway, so if they’re caught at the beginning of it, if you can deal with it quicker, then the better... because the time it takes to get into these sessions you persuade yourself not to go anyway.”

An example of initial codes, keywords and phrases that led to the development of the final theme from the discourse text and notes taken

Openness, honesty, confidentiality, prison as an environment for therapy, time delays, earlier intervention is required, relating to workers, trust is a major factor – and for engagement

Candidate themes

The challenges of prison, women specific treatment, trusting the need for therapy, understanding the need for gender specific treatment, a voice to the voiceless, empowering patients as stakeholders, women as stakeholders

Final theme: women as stakeholders

The theme needed to take into consideration one of the purposes for the study and that is to incorporate women as stakeholders in research and this ended up being a more generic in some respect theme but advocates the voice of the women, as stakeholders in research.