The Evaluation of Carousel:
A Therapeutic Programme for Prisoners who Self-Harm

Julia Margaret Scott Rose

(BSc (Hons), MSc, MSc-Post-Dip, C.Psychol, AFBPsS)

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Research Supervisors: Professor Ken Manktelow
& Dr. Nicky Hart

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Signature:…….

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Abstract

"Prison self-injury rate accelerates at four times the rise in population"

(The Howard League for Penal Reform; 2008a)

The rise in self-harm figures in forensic settings in 2003 may largely be due to the improvement in the reporting of self-harm levels in prisons in December 2002. However it does not account for the continued rise in self-harm figures during the years that followed. Despite the increase, there have been few interventions to support prisoners who self-harm, particularly in remand settings. For this purpose the Carousel programme was designed by a counselling psychologist specifically to meet the demands of the female remand population. The aim of this study was to evaluate the effectiveness of Carousel. Forty women who had a history of deliberate self-harm entered and completed the programme through means of self-referral. The study employed both a quantitative and qualitative methodology to evaluate the programme. Participants were interviewed and assessed both at the start and completion of Carousel. This included monitoring levels of self-harm incidents, levels of anxiety and depression using the 14-item Hospital Anxiety and Depression Scale (HADS) (Zigmond & Snaith, 1983), and coping levels using the 60-item Coping Styles Questionnaire (CSQ) (Roger, Jarvis & Najarian, 1993). Results showed a significant decrease in depression and anxiety, a reduction in self-harm levels and a change of coping styles in the desired direction. Qualitative methodology using content analysis was employed to ascertain the components of the programme

which were deemed most helpful or unhelpful to the participants. Findings suggest that the most useful components within the programme are coping strategies, management of self-harm behaviours, antecedent, behaviour and consequence (ABC) sessions and the understanding of the brain and associated emotions with self-harm behaviours. Implications for counselling psychology and clinical practice are highlighted and limitations of the current study and directions for future research suggested within the report.

The great art of life is sensation,

to feel that we exist,

even in pain.

Lord Byron

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Summary – Introduction

This thesis consists of three main sections: a literature review, research report, and a critical appraisal of the research process. Regardless of the continuous debate in the literature regarding the definition and concept of 'self-harm', it remains *"poorly understood despite it being a powerful emotional trigger"* (Tantum & Huband, 2009:1). Snow (2002) highlights the importance of contextualising self-harm research within the continuum whilst recognising the extent of the problem within the prison service (Royal College of Psychiatrists, 2009).

The literature review commences with an exploration of the varied and widely contested definition and to what this encompasses, whilst setting it in a historical context. This was with a view of attempting to understand the concept whilst appreciating the function of the behaviour, with parallels relating to forensic and community settings. In addition, it discusses the importance of recognising the link between abuse, self-harm and suicide. Many female prisoners may have experienced a multitude of abuse of a physical, sexual, emotional, ritual or cultural nature. As a result of such experiences, the victims can enter into a circuitous lifestyle, encompassing maladaptive coping strategies of self-harm.

The aim of the research project was to evaluate Carousel, a self-harm programme specifically designed to meet the needs of a busy female remand population with high levels of self-harm. Current programmes do not target the remand population, which has a high turnover of prisoners, and incidents of self-harm and suicidal

behaviour. Therefore, with the increase in self-harm HM Prisons have identified the need to improve services for females who self-harm including the provision of therapeutic programmes. The research reported in Section 2 consists of the programme evaluation using quantitative and qualitative analysis. It explores the relevance and implications to counselling psychology and discusses the limitations to the study with recommendations for future research.

The final section is the researcher's critical appraisal of the research process based on her personal research diary. It is a reflexive piece examining the impact of the research on the researcher (and vice versa) and critical events in the research process.

Many people include many things under the umbrella term of self-harm including cosmetic surgery and eating disorders; however, this will not be covered in this report. The research will be examining the more obvious self-harm including culture healing, religion and body piercing due to relevance and parallels within forensic settings.

Search Strategy for Literature Review

Some Key Words: Self-Harm, Self-Injurious, Self-mutilation, self-poisoning, cutting, overdose, parasuicide, evaluation research, mental health, evaluation of prisons programmes, sexual abuse, suicide, prevention initiatives, childhood trauma, trauma, avoidant memory, Accident and Emergency, Dialectical

behavioural therapy, coping styles, attempted suicide, adolescent self-harm, developmental arrest/delay, disorder, prisoner coping, emotion focussed, suicidal behaviour, childhood sexual abuse, delinquent adolescents.

Examples of Databases used: Academic Search Complete, AGRICOLA, ASSISA, Cambridge Journals Online, Informaworld, IngentaConnect, JSTOR, MEDLINE, PAO, PsycARTICLES, PsycBOOKS, PsychINFO, ScienceDirect Journals, Scopus, Springerlink, Wiley InterScience Journals.

SECTION 1 – LITERATURE REVIEW

1.1 Self-Harm - Definition and Terminology

Deliberate self-harm behaviour is defined and highlighted in the literature as acts of self-directed violence, of a repetitious nature including self-cutting, self-scalding, and overdosing (Pattison & Kahan, 1995 cited in Kennerley, 2002; Rose, 2006; Turp, 2003). It includes behaviours such as abrading, hitting oneself, inserting sharp objects in the anus or vagina, pulling out body hair, other self-attacking behaviours idiosyncratic to the survivor and his or her abuse history (Connors, 1996a). Such behaviour is referred to as "scratching", "self-harm", "self-abuse", "cutting-up", "self-mutilation", "self-wounding" (Faye, 1995; Feldman, 1988; Snow & Paton, 2002), "self-battery" (Skegg, Nada-Raja, & Moffit, 2004), "suicidal behaviour", "suicide", "rational suicide", "parasuicide" (Kreitman, 1977; O'Connor, Sheehy & O'Connor, 1999; O'Connor, 2001), "self-injury" (Duffy & Ryan, 2004; Klonsky & Muehlenkamp, 2007; Tantum & Hubband, 2009), "self-injurious behaviour" (Kirkland, 2000) and "repetitive skin-cutting" (Marchetto, 2006).

What constitutes self-harm behaviour has been debated in the literature for decades, and professional texts continue to utilise various definitions and terminology for self-harm (Rose, 2004). Temple and Harris (2000) confirmed that 'the devil is in the detail' for researchers who aim to define and classify accounts of deliberate self-harm. They add that once a researcher has defined it one way, another researcher will re-define it another way. Anderson, Woodward and Armstrong (2004) highlighted that definitions of deliberate self-harm usually arise from medical, psychological and

sociological arenas. Towl, Snow and McHugh (2002) report of the diversity of terminology and definitions being similar in both the prison service and the community studies.

Farber (1983), an early pioneer in self-harm research, defined self-harm as a range of behaviours from life affirming to destructive, comprising adaptive or maladaptive properties. These include: excessive tattooing, nail and cuticle biting, hair pulling, skin picking, scratching, through to what was described as 'more bizarre actions' including: severe under/over-eating, purging, scarring, burning, cutting, self-ligature and asphyxiation. Arnold (1995) included over-work, over-exercising, abusing glue/solvents, suicide attempts, unnecessary and repeated risk-taking and excessive smoking. McAllister, Moyle, Billett and Zimmer-Gembeck (2009) classify self-harm behaviour as a *"wide range of things that people do to themselves in a deliberate and usually hidden way"* (p. 2838). Turp (2002) also refers to 'hidden self-harm' such as squeezing pimples, picking scabs off wounds, over/under eating, smoking, overworking, self-imposed sleep deprivation, the refusal to seek treatment for medical and dental care and reckless behaviour. As bizarre as some of the practices may appear, they are behaviours exhibited within forensic settings (Snow, 2002; Tantum & Huband, 2009; Towl et al., 2002). Tantum and Huband (2009) also note that self-harm remains poorly understood despite the fact that it is an emotional trigger. They highlight the importance of understanding self-injury within the historical and broader context and how self-harm acts are accepted within different cultures. They draw parallels of how types of self-harm that occur in a culturally sanctioned context also

become a ‘social norm’ within the prison service. They attempt to do this with a case study describing how a prisoner saw cutting as an accepted behaviour amongst his peers, as a method of coping against feelings of anger, giving temporary relief. He continued to engage in the behaviour, partly through fear of rejection and in turn was ‘accepted’ and earned the respect as a ‘tough man’ amongst his peers (p. 37). Arguably this is like a ‘rite of passage’ where there is very little difference between this type of behaviour and some of the ritualistic behaviours that Favazza (1989a, 1989b, 1996) and Arnold (1994) discuss below.

1.2 Self-Harm - Culture and Religion

Favazza (1989a, 1989b, 1996) was another of the early key researchers in self-harm, whose writing has played an important role in legitimising the study of self-harm (Turp, 2002), and drew attention to culturally accepted self-harm behaviours such as religious practices. Although the true extent of this is unknown, the psychologically damaging lasting effects are worth noting due to the culturally diverse arena of both community and forensic settings (McCafferty, Davies & Momoh 2005). Furthermore this also highlights two further points that some of these practices of extreme piercing and mutilation are parallel to self-harm acts that occur in the prisons (Rose, 2008). Practices embedded under this heading includes those that hold the ideation that self-mutilation is a process for the development of healing powers. This includes behaviours ranging from female circumcision, infibulation, walking over hot coals, torso piercing with hot rods, to the religious ritualistic elements of self-flagellation and walking barefoot for long distances over rough ground. Babiker and Arnold

(1997) argue that the inflictions of pain and injuries, as well as the drawing of blood, have a range of powerful meanings in different cultures, with beliefs that such acts, primarily self-mutilation, could lead to the development of healing and wisdom. Favazza (1996) noted that the Native American Plains Indians believed that when they are attached to a pole, dancing with skewers through their flesh, they received purity and a vision making clearer the 'meaning of life'. Whilst female 'self-harmers' in prisons are not necessarily looking for 'meaning of life' and 'wisdom' they do use similar extreme practices such as inserting sharp objects into their skin and orifices in addition to cutting as methods of healing their 'internal psyche of pain' (Gardner, 2001; Rose, 2008). Gardner (2001) reports that in Christianity, mortification of the flesh has also been used as a form of punishment and a means to the forgiveness of sins (p. 134). This includes extreme mutilations that were taken literally rather than symbolically. To illustrate, Gardner uses the example of a religious sect in Russia who *"practiced varying degrees of self-mutilation and castration as a way of reaching salvation"* (p. 134).

1.3 Self-Harm - Healing

Some traditions use a variety of self-harm behaviours as methods for healing. For example, in European countries up until the 1920s, blood-lettings (through the use of leeches or cutting of veins, to rid the body of disease) were commonplace (Babiker & Arnold, 1997). Favazza (1996) describes some of the more extreme practices that include fingertip removal, scarring of the flesh and male infibulations whereby the foreskin of the penis is pierced and a clasp attached to prevent erection and

ejaculation, which was thought to be a cure against epilepsy. Babiker and Arnold (1997) argue that although banned in Britain the mutilation of girls' genitals continues in many African Countries and remains legal in Somalia and Ethiopia. Originally in Britain during Victorian times, the practice of excising a woman's clitoris was considered a cure for medical problems caused by menstruation. However, infections and psychological problems can result from female circumcision. Nevertheless, despite being illegal in the UK, acts of this nature have been discovered in Britain recently: in March 2009, The Times newspaper reported:

> *"Despite having been outlawed in 1985, female circumcision is still practised in British African communities, in some cases on girls as young as 5. Police have been unable to bring a single prosecution even though they suspect that community elders are being flown from the Horn of Africa to carry out the procedures".*

It goes on to report of girls being *"brainwashed"* into believing circumcision is cultural, and in some cases, a religious obligation that should be *"kept secret"* (Times Newspaper, 2009). The level of concern over the prevalence of this practice and lasting psychological effects has led to the NHS offering to reverse female circumcisions due to there being 500 victims annually with no prosecutions (Kerbaj, 2009). A proportion of these women find themselves within the prison system, which further adds to the distress already experienced.

Turp (2002) questions, to what point can 'accepted behaviour' which differs between sub-cultures, cultures, individuals and generations go beyond what is perceived as acceptable? Turp refers to the "breaking of unspoken cultural rules" and "transgression of limits" and includes the behaviour of continuing to undertake extreme physical activities when pregnant or with terminal/severe medical conditions (p. 31). Connors (1996b) defines these most extreme forms of self-injury *"as direct actions that harm the body and that are outside the realms of social acceptability"* (p. 207). Whereas, Turner (2002) describes in more severe cases self-harm methods that include: the breaking of bones, amputation of fingers, limbs, or other bodily parts including eye removal. Klonsky and Meuhlenkamp (2007) refer to 'self-injury' collectively as 'non-suicidal self-injury', with the explanation that it is the *"intentional destruction of body tissue without suicide intent and for purposes not socially sanctioned"* (p. 1045). Gardner (2001) adds activities that are on the periphery of social acceptability and understanding, including variations of self-fashioning.

1.4 Self-Harm and Suicide

Where does deliberate self-harm sit in terms of suicidal behaviour? The World Health Organization (2009) predicted that by 2020 a suicide would occur every twenty seconds; the statistic currently stands at one suicide every forty seconds. Due to the behaviours discussed, it is not surprising that this remains a topic of debate. Turp (2002) argues the need for self-harm and suicidal behaviour (referred to as 'severe self-harm') to be on a continuum model of self-harm, suggesting five

categories: ‘good enough self-care’, ‘compromised self-care’, ‘mild self-harm’, ‘moderate self-harm’ and ‘severe self-harm’ (p. 29). Connors (1996a) also saw self-harm on a continuum but divided the ‘broad spectrum of self-harm’ into four categories: body altering, indirect self-harm, failure to care for ‘self’, and self-injury, (p.207). More recently Croyle, Fortune and Waltz (2007) added further support for self-harm to be viewed as a continuum ranging from mildly injurious sub-clinical behaviours to moderately and severely injurious clinical behaviours. Connors (1996a) adds that it is not just the behaviour alone that constitutes self-injury it is also “*the actor’s intent, the psychological state accompanying the act, and how the act affects not just the body but the self as well”* (p. 198). For some the range of self-harm goes further from mild behaviours to ‘completed suicide’. Furthermore, Liebling (1991) suggests that suicide and self-injury can be understood as a continuum along which the vulnerable may quickly progress.

It is perhaps the wide usage of different names given to self-harm behaviour that keeps the debate alive and adds confusion as to where self-harm and suicide sit in terms of risk and treatment. ‘Parasuicide’ was first coined by Kreitman (1969), who defined it as “*any non-fatal act in which an individual deliberately causes self-injury or ingests a substance in excess of any prescribed or generally recognised dosage”*. This was the most widely used term for all deliberate self-harm behaviour (whatever the explicit or implicit intention) whilst some clinicians use the terms “*deliberate self-harm*” and “*attempted suicide*” interchangeably (Kreitman, 1977). Towl, Snow and

McHugh (2002) adopted the term "*para-suicide"* to describe a wide range of self-harm behaviours.

Towl and Crighton (2000) acknowledge the use of the term deliberate self-harm (DSH) stating that as professionals we tend to use what appears in the text we are referring to, but argue that 'intentional self-injury (ISI)' should replace it. Sidley (1998) defines "parasuicide' as deliberate self-harm which is not lethal" (p. 272). However O'Connor et al. (1999) argue that deliberate self-harm can lead to suicide regardless of intent. Additionally, it is reported that approximately 40% of completed suicides involve a history of self-injury. This statistic is irrespective of whether the attempt included the intention to kill themselves (O'Connor, 2003; O'Connor & Sheehy, 2000). In addition, deliberate self-harm has also been identified as a key factor in suicide, coupled with a recent discharge from psychiatric hospital (Parker, Malhi, Mitchell, Kotze, Wilhelm & Parker, 2005).

Furthermore, Kapur and Gask (2003) report that follow-up studies of suicide following self-harm have shown rates of suicide to be 1% in the year after an episode of deliberate self-harm (100 times the general population rate), 3% at 5 years and around 7% for periods in excess of 10 years. Klonsky, Oltmanns and Turkheimer (2003) argue that suicide is not always the objective of self-harm; nevertheless it does occur, often inadvertently through deliberate self-harm. However, their study was based on a smaller sample of military recruits and therefore difficult to compare to the prison service and general population.

Winter, Sireling, Riley, Metcalfe, Quaite and Bhandari (2007) report that approximately 400 of every 100,000 people engage in deliberate self-harm in the United Kingdom every year. Klonsky and Muehlenkamp (2007) add that *"a sizable portion (50% community; 70% inpatients) of self-injurers do report having attempted suicide at least once"* (p. 1049). Whilst Hawton (2005) emphasises that *"deliberate self-harm (or attempted suicide) is the most important risk factor for eventual suicide" (p. 6).*

Kirkland (2000) argues that self-injurious behaviour (SIB), causing wounds and injuries to one's own body in the absence of suicidal intent, is of great concern as it may be an indicator of deeper psychological distress. This is often undertaken on a repetitive basis and correlates with an increased risk of future suicide.

1.5 Self-Harm within Prison Settings

Snow and Biggar (2006) and Crighton (2000) argue that the rate of suicide in prisons far exceeds that of the general population. Summers (2005) states that prison suicides increased by 40% during the 1990's. MacKenzie, Oram and Borrill (2003) also reported that there were 33 self-inflicted deaths between 1992 and 2001. In 2006 there were 67, 2007 there were 92 and 2008 there were 61 self-inflicted deaths (MOJ, 2009). The majority of fatalities were over twenty-one as noted in table 1.

Table 1. Self-inflicted deaths in prison custody (England and Wales) by age band as recorded by the HM Prison Service. [1]

Age Band

Date	Under 18s	18 - 20	21+	Total
1995	1	7	51	59
1996	1	11	53	65
1997	1	8	59	68
1998	3	11	69	83
1999	2	13	76	91
2000	3	13	65	81
2001	3	10	60	73
2002	2	12	81	95
2003	0	11	83	94
2004	0	6	89	95
2005	2	10	66	78
2006	0	2	65	67
2007	1	6	85	92
2008	0	4	57	61

Prisoners' 'self-inflicted deaths' include where it appears (it cannot always be proven, but enough evidence supports) that a prisoner has acted specifically to take their own

[1] The prison service regards all prisoners of 21 and over as adults, hence the wide classification in the above table of 21+. However, a further breakdown of age bands within the adult section would have been useful.

life. Approximately 80% of these deaths receive a suicide or open verdict at inquest (Spencer, 2009). The Royal College of Psychiatrists (2009) stated that:

> *"Although there has been a decrease in successful suicides, the rate of suicide for prisoners is still alarmingly high with 91 suicides per 100,000 in the prison population compared with 8.5 per 100,000 in the general population. This means that the risk of suicide is more than 10 times higher for a prisoner than for the general population" (p. 2).*

Therefore, it is not surprising that all self-harm injuries regardless of intent are treated as potential suicides within the prison service. In addition, the highest rates of self-injurious behaviour in Europe are found in the United Kingdom (Bowen & John, 2001a, 2001b); and some of the most extreme forms of self-injury can be found in forensic settings (Rayner & Shaw, 2003). The dramatic increase in the levels of deliberate self-harm in HM Prisons amongst female offenders has caused concern for the British Government and Prison officials (HMCIP, 1997) and has been an agenda item for the last two years (Milligan & Andrews, 2005). According to Towl et al. (2002), acts of 'self-injury' in prisons (primarily self-laceration and abrasion, i.e. 'cutting') are far more common than in community settings. Whereas acts of self-poisoning, especially using prescribed medication are much less frequent in prisons (p. 53), they suggest this would be largely due to the controlled access of prescribed medication in prisons.

Hawton (1990) reported that in the community there was a higher prevalence of self-poisoning than self-injury, with a smaller percentage involving both. Similar findings were reported by O'Connor, who also concluded that self-poisoning was a preferred method of deliberate self-harm by men (O'Connor, 2003). Hawton, Bergen, Casey, Simkin, Palmer, Cooper, Kapur, Horrocks, House, Lilley, Noble and Owens (2007) argue that self-poisoning was the preferred method of self-harm by females. However Arnold (1995) argues that the most common form of self-harm by women in the community was 'cutting'. These conclusions were based on the findings of Arnold's research known as 'The Bristol Survey' (Arnold, 1995) where 90 % of women had used 'cutting' as their most common type of self-injury. Women used implements such as knives, razor blades and broken glass. The area most commonly cut were arms and/or hands, while a proportion cut their legs and some incorporated the stomach, face, breasts and genitals. Some women reported *"cutting several areas of their bodies"* or *"all over"* (Arnold 1995:6). A study conducted by Warm, Murray, and Fox (2002) found similar findings, reporting that cutting was the most prevalent form of self-harm; along with a high percentage of 'self-harmers' having experienced sexual abuse.

1.6 Self-Harm – Antecedent from Sexual Abuse

Comparable results were found in other studies suggesting that there is a strong correlation between self-harm and sexual abuse (Briere, 1992; Briere & Gil, 1998; Coll, Law, Tobias & Hawton, 1998; Connors, 1996a; Everett & Gallop, 2001; Faye, 1995; Gardner, 2001; Tantum & Huband, 2009; Low, Jones, MacLeod, Power &

Duggan, 2000; Marchetto, 2006; O'Connor & Sheehy, 2000; Parker et al., 2005; Snow, 1997; Turner, 2002; Turp, 2003; Warm et al., 2002; Zlotnick, Shea, Pearlstein, Simpson, Costello & Begin, 1996).

Connors (1996a) stated that throughout the history of self-harm there has been an evident correlation between one or more "childhood trauma and loss experiences" (p. 200). Everett and Gallop state:

> "*Research shows that rates of self-harm among clinical samples of patients with histories of childhood sexual abuse are at least twice that of non-abused comparison groups"* (2001:61).

Turp (2003) argues that 50 – 60% of women who self-harm have suffered childhood physical and sexual abuse (SA). In addition, O'Connor and Sheehy (2000) urge the need for acknowledgment on the extent and severity of the problem of abuse and the lack of research in the area. They cite Law, Coll, Tobias and Hawton (1998) study who found a relationship between the severity of sexual, physical and psychological abuse and subsequent deliberate self-harm in a sample of 267 females admitted to a general hospital in England after taking an overdose (p. 40).

Coll et al. (1998) found that

> "*Grand repeaters (those who overdosed five or more times) tended to have been more severely abused on all three types of abuse, to have been abused for longer, at a younger age and re-abused in adulthood"*
>
> (Cited in O'Connor & Sheehy, 2000:41).

Due to the vast extent of the correlation between childhood abuse and self-harm within the general population, it has been suggested that clinicians "*routinely inquire about abuse experiences*" (O'Connor & Sheehy, 2000 p.41). This is even more pertinent in the prison settings where the rates exceed that of the general population (Snow, 2002). It could be argued that a rationale for enquiry is that 2 to 3 million infants and children are annually the victims of sexual abuse and/or physical abuse (Guthrie, 2000 cited in Stern 2003). This heightens the awareness of the difficulties faced by this proportion of the population (O'Connor & Sheehy, 2000 p.41). McCann, Ball and Ivanoff (2000) predict that this type of developmental history can lead to the onset of interconnected mental health problems in adulthood, and for a large percentage lead to maladaptive lifestyles resulting in imprisonment (Snow, 2002).

A recent Canadian Fact sheet in the American Academy of Child and Adolescent Psychiatry (2008) notes that there is a strong link between sexual abuse and low self-esteem. The paper states that the long-term emotional and psychological

damage of sexual abuse can be devastating to the child. Law et al. (1998) concurred that a link existed between the severities of childhood abuse, whether sexual, physical or psychological in nature, and subsequent self-harm. Other studies have also made the link (Briere & Elliott, 1994, 2003; Fisher, 1998; Newmann & Sallmann, 2004; Peleikis, Mykletun & Dahl, 2005).

Santa Mina and Gallop (1998) reported that empirical studies within community, clinical and forensic populations have suggested that there were more reports of self-harm within adults who reported sexual and or physical abuse than comparison groups. Furthermore, in a recent study Marchetto (2006) added that early traumatic experiences arise *prior* to first episodes of skin-cutting. Undoubtedly, there is a significant proportion of clinical research that suggests that there is a principal link between childhood sexual abuse and deliberate self-harm and argue that childhood experiences of sexual/physical abuse were important antecedents to skin-cutting (Favazza, 1996; Low et al., 2000; Zlotnick et al., 1996). However Favazza (1996) argues that although there is a link, it is also important to acknowledge that not all 'self-harmers' are victims of childhood sexual abuse (Frost, 2001). Jeffreys (2000) cites Favazza and Conterio's (1989) study in Favazza (1996) as evidence noting that 38% of female habitual 'self-harmers' did not report childhood sexual abuse, although 62% did. Coid, Wilkins, Coid and Everitt (1992) also add further evidence for a link between self-harm and childhood sexual abuse both in clinical and forensic populations.

1.7 Self-Harm - Consequences of Childhood Abuse

As a result of the severity of the childhood sexual abuse/child abuse, self-harm is seen as an 'escape inside' leaving the victim in an alternative and sometimes better world (Tantum & Huband, 2009). This depersonalisation or 'spacing out' is often theorised as being disrupted through the 'flow of blood' bringing them back to reality and making the world real again. Anna Freud referred to this as 'identification with the aggressor' (cited in Tantum & Huband, 2009:60) and it is in the control exerted through the trauma of abuse (by the abuser) that self-harm is seen (by the victim) as a way of regaining control over their own skin. Consequently, the attempts to regain control are often in conjunction with the thoughts that "*this time I'll be in charge of the pain and decide when it's too much*" (Connors, 1996a:202).

Similarly, Gardner reports of many survivors of sexual assault who turn the anger they feel inwards. Gardner (2001) notes that when *"childhood sexual abuse takes place, the child has been prematurely sexualised, forced to grow sexually but unable to grow emotionally*" (p. 46). Faidley (2003) also refers to this as 'developmental arrest'. Gardner goes on to state that the memory of the bodily pain leads to an inner tension deeply repressed or dissociated and remains in some corner of the mind, which she refers to as the "encaptive conflict" which can result in an *"unconscious compulsion to repeat the experience and masochistic, destructive attacks on the body partly fulfil that function"* (p. 46). Survivors also blame themselves for not stopping the abuse, believing that such awful things only happen to 'bad people'; thus reinforcing their belief that they must have done something very wrong and therefore

must be ‘bad’, so they cut themselves as a form of punishment or as a method to release their anger. Some have reported that they need to see the blood in order to release the ‘dirt’ and feel cleansed from the contamination, the aggression is internalised and exhibited through various acts of self-harm (Coll et al., 1998; Collins, 1996; Connors, 1996a; Gardner, 2001; Kennerley, 2002; Snow, 2002). Others describe a feeling of being dead inside, so they ‘cut’ to feel alive again. Some describe the need to be in control of their own bodies, maybe for the first time in their lives, so the act of cutting themselves, gives them control over how, why, where and when they feel the pain. Whilst others state they are just simply ‘out of control’ (Collins, 1996; Kennerley, 2002). These aggressive episodes often lead to a ‘temporary release’ of anger, frustration, anxiety and depression (Gardner, 2001).

1.8 Self-Harm – Depression

Parker et al. (2005) report that individuals who are depressed often admit to preoccupations about self-harm; in their three-sampled study of outpatients in Australia, they considered possible contributors to deliberate self-harm in depressed patients. Their findings however, did not support a strong link between depression severities and deliberate self-harm, other than 20% admitting to episodes of deliberate self-harm. Nevertheless, they did find evidence of higher rates of self-harm and depression in bipolar patients. Previous suicide attempts and ‘acting-out behaviours’ were evident, suggesting the relevance of externalising responses to stress and poor impulse control. Their conclusion highlighted a need to reduce acts of deliberate self-harm by addressing individual response to stress. Simms, McCormack, Anderson and

Mulholland (2007) compared acutely ill patients diagnosed with schizophrenia, with a history of self-harm. The study included measures of depression, suicide ideation and hopelessness. They found that their patients with a history of self-harm had significantly greater symptoms of depression, and greater suicidal thoughts. Similarly their sub-group patients, who experienced auditory hallucinations, also had significantly greater symptoms of depression and hopelessness (2007). Towl and Crighton (2000) state:

> *"Depression is the most common form of mental disorder and the one most closely associated with self-harm, suicide and attempted suicide" (p. 72).*

Kinnier, Hofsess, Pongratz and Lambert (2009) note that: *"Depression has been called the common cold of mental illness"* (p. 153). The Mental Health Foundation back in 1997 reported that 70% of recorded suicides are by people experiencing depression that is often undiagnosed. On average people with recurrent depression have a 15-20% increased risk of suicide, although this is likely to be underestimated as many have experienced undiagnosed depressive illnesses. Bebbington, Marsden and Brewin (1997) note that many who suffer with anxiety or depression do not seek professional help mainly due to a lack of awareness regarding the disorder and/or the stigma associated with mental illness.

1.9 Self-Harm and Coping Styles

In addition to depression, previous research has drawn attention to the apparent association between self-harm and deficits in coping (Slade & Gilchrist, 2005). Studies of coping styles have generally identified two broad strategies which people use for dealing with stress or threat: problem-focussed and emotion-focussed. Problem-focussed strategies refer to attempts to manage or change problems, including finding different ways of thinking about them. Whereas emotion-focussed strategies concentrate on trying to regulate the emotional distress, including avoidance. Problem-focussed coping is generally believed to be the most effective in reducing stress, although it may be less adaptive in situations that are not amenable to change (Lazarus & Folkman, 1984), where a more detached coping style may be helpful (Roger, Jarvis & Najarian, 1993). Avoidant coping has been related to higher levels of distress in adolescents and young adults (Wilkinson, Walford, & Espnes, 2000) and to suicide risk in young adults (Botsis, Soldatos, Liossi, Kokkevi & Stefanis, 1994).

1.10 Prisoners' Coping Styles

The dynamic interactions between the prison environment, offender psychopathology and individual coping styles further elevate the risk of suicide and self-harm (Eccleston & Sorbello, 2002). This is exacerbated by prisoners rebelling against the restricted prison regime leading to a deluge and maintenance of negative thoughts, emotions and behaviours. Eccleston and Sorbello (2002) recommend that an intervention to facilitate the learning of self-regulation skills combined with

additional skills is imperative for them to adjust to their new restricted environment. The most contested aspect of the regime is the utilisation and frequency of 'lock-up'[2] periods. It is during these times that women report heightened vulnerability resulting in difficulty in coping, and therefore resort to an emotional style of coping that leads to self-harm behaviour as a method of relieving stress. Coughlan (2006) reports:

> *"Night time is the most dangerous time in the prison when things are most likely to go wrong. Once the women are locked behind their doors they are less able to distract themselves from their problems. Whether it is worrying about their children or the mess they have made of their life or thinking about past abuse" (p. 12).*

There is further evidence that prisoners may have less adaptive styles of coping than the general population, and in particular are more likely to use emotion-focussed (as noted above) and avoidance-focussed styles of coping (Gullone, Jones & Cummings, 2000). Several studies have reported that prisoners who self-harm are particularly likely to use less adaptive coping strategies, in particular avoidance (Dear, Thomson, Hall & Howells 1998a; Livingston, 1994; Slade & Gilchrist, 2005). These avoidance-focussed strategies are particularly prevalent in victims of childhood trauma (Briere

[2] Lock up refers to when the prisoners are locked behind their door, usually at set times of the day and at night-time. Longer lock-up periods take place at the weekend. Lock-down refers to additional lock up periods, for example, prisoners may be locked 'behind their cell door' due to a number of reasons. This could range from a shortage of staff to a severe security breach or incident and prisoners need to be locked up for various reports/interviews, investigations to take place. This can happen at a moment's notice. Similarly with 'roll call': at different times of the day all prisoners have to be accounted for (counted). If there is a discrepancy then a search has to be carried out. For this all prisoners may have to return to their wing and be locked behind their cell door.

& Elliot, 1994; Hauer, Wessel, Geraerts, Merckelbach & Dalgleish, 2008). Fivush and McDermott-Sales (2003) note that how we remember stressful events of our lives has an impact on our ability to cope. The resultant dysfunctional behaviours exhibited are due to the individual seeking to avoid recalling specific details of their traumatic experience in order to reduce associated distress: avoidant memory (Hauer et al., 2008). They concluded that parasuicidal individuals were more likely to over-generalise responses in order to avoid memories of specific events. Friday (2002 cited in Munday, 2008) found that male prisoners who self-harmed scored significantly higher on emotional coping, but not on avoidance coping as measured by the Coping Styles Questionnaire (Roger et al., 1993). Whereas Gullone, Jones and Cummins (2000) noted that prisoners scored higher on emotion and avoidance coping. Friday also noted that the prisoners also scored significantly lower on rationale (problem-solving) and detached coping styles. Thus raising the question of whether interventions can be designed to increase the use of adaptive coping and problem-solving strategies, and whether such increases are associated with better self-management of self-harm.

1.11 Self-Harm - Why use Cutting Behaviour?

Snow (1997) conducted a pilot study interviewing women in prison who had self-injured, to establish why they engaged in 'cutting' behaviour. Ten women reported that they injure themselves as a means of relieving stress, tension, anger and frustration. Seven women said they also injured themselves specifically to draw blood; reasons offered included the feeling of 'calmness' when they see the blood.

Two women reported that they injure themselves specifically to inflict pain on themselves. Feldman (1988) argues that cutting the skin repeatedly and habitually is common in many young women, and is often used as a way of easing emotional suffering. Morton (2004) reports that deliberate self-harm incidents within the prison system are extremely common. During the last few years there has been a 78% increase in reported incidents of self-injury occurring in prisons in England and Wales.

Table 2. Reported Self-Harm Incidents in Prisons in England and Wales

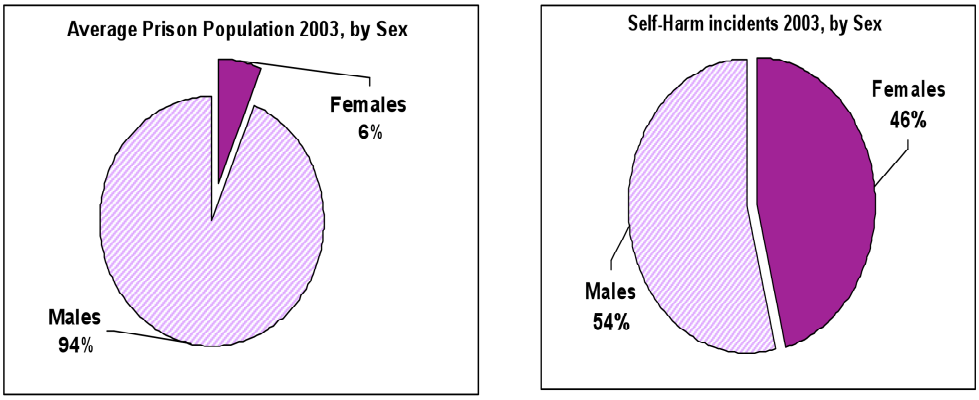
Year	No. of Incidents	No. of Prisoners	Percentage of Prisoners Self-Harming
2000	4,982	65,666	7.6%
2001	7,812	67,056	11.6%
2002	10,042	71,324	14.1%
2003	16,199	72,992	22.2%
2004	19,285	75,057	25.7%
2005	23,794	79,896	29.8%
2006	23,420	79,085	29.6%
2007	22,459	79,730	28.2%
2008	23,026	81,636	28.2%

(Safer Custody, 2009 and European Prison Statistics, 2007)

However, it is important to note that in December 2002, the Prison Service introduced a revised system for self-harm data collection that requires staff to complete documentation for every incident of self-harm known to occur within the establishment. The introduction of the new procedures has improved the validity and accuracy of the self-harm data collected although it is known that under-reporting still continues. Therefore it is important that comparisons of self-harm levels pre-2003 are read with caution, as the rise in self-harm figures may largely be due to the improvement of reporting and not just to the increase in self-harm. Nevertheless despite this the self-harm figures continued to rise after 2003 as noted by the Howard League for Penal Reform (2008a) who state that: "*rates of self-injury in prison have rocketed by almost 40% in the last five years.* This equates to approximately 800 self-harm incidents per month within female prison populations. Further analysis indicates that prolific 'self-harmers'[3] can engage in self-harm behaviour several hundred times per year (National Offender Management Service (NOMS), 2008). In addition it is estimated that deliberate self-harm occurs in up to 63% of sentenced or convicted women prisoners and up to 76% of women remand prisoners. In general, the prison population are 9-10 times more likely to engage in self-harm or to attempt suicide than the non-prison population (Sedenu, Safer Custody Group, 2004).

[3] The term prolific is still under review within the prison service. Currently any prisoner who consistently self-harms twenty times or more within one week is termed a 'prolific self-harmer'.

Figure 1. Average male and female prison population with comparison of self-harm incident percentages (Safer Custody Group, 2004).



As can be seen from the illustrations above, in 2003, 46% of self-harming incidents were from females held in custody, compared to 54% of self-harming incidents from males held in custody. *"Despite females making up just 6% of the prison population, they accounted for nearly half of all reported self-harm incidents"* as reported by the Safer Custody Group (Adeniji, 2004).

As a result of the significant increase in suicide, suicide attempts and deliberate self-harm incidents in custody, Her Majesty's Chief Inspector of Prisons carried out a review in 1990 (HMCIP, 1990a). This resulted in a policy for suicide and self-harm awareness in custody being drafted and a final one agreed in 1994, which is still in operation today. Features of the current prison service policy included encouraging the development of a prison-wide responsibility for caring for parasuicidal prisoners, with less reliance on healthcare staff and a multi-disciplinary emphasis on prevention. The rationale being to identify and target resources for those most at risk, to monitor and carry out risk assessments and care plans with the recommendation of regular cases review.

However a later HMCIP thematic review (1999), criticised the policy for failing to give sufficient attention to particular 'at-risk groups', such as women, young prisoners and those in overcrowded local prisons that offer short sentences only; these characteristically have a high turnover of prisoners (Shaw, Bayley & Turnball, 2003). Local prisons tend to serve other establishments as remand centres, accommodating female prisoners awaiting trial and sentencing. The length of time prisoners spent in these establishments was unpredictable, ranging from one night to two years (the latter less common), an average being around two to ten weeks.

1.12 Management of Self-Harm in Custody

Managing self-harm in the prison system has become increasingly difficult. Until recently the women deemed most at risk in some establishments were placed in a unit called the 'Care, Separation and Rehabilitation Unit'[4] (CSRU), along with women who are relocated for disciplinary reasons (Coughlan, 2006). However, the CSRU has since closed due to a series of deaths, and a special unit has since opened specifically for self-harm and suicidal prisoners.

Depending on the individual prison's facilities, some women were placed in segregation units, whilst others were managed in health care centres. All women who self-harm were placed on a 'watch'.[5] Women who are regarded most at risk, i.e.

[4]The CSRU was a separate building with ten cells: five for women held there for disciplinary reasons and five for women who needed crisis intervention to address their self-harming behaviour (p. 11).

[5]All clients who self-harmed or attempted suicide were placed on a 'suicide watch'. The documentation completed is called F2052SH (Self-harm at Risk Form) . The level of watch (how many times they are checked) is reviewed at regular intervals by a multidisciplinary team. This has since been replaced by the ACCT booklet (Assessment, Care in Custody and Teamwork).

constantly self-ligaturing or seriously cutting, are often placed on 'constant watch', consisting of twenty-four hour, one-to-one surveillance by prison and/or healthcare staff. Some women described being on suicide watch with *"someone sat outside their gated cell 24-hours a day .... as a form of extra punishment" (p. 11).* This includes surveillance when the prisoner 'goes to the toilet' with just privacy screens in place for 'dignity' and 'decency'. For example, in some female prisons the woman's torso would be concealed by what was commonly described by the staff as a 'stable door' (privacy screen) so the feet, head and shoulders could be observed by a staff member to ensure that no self-harm or suicidal behaviour occurred. For many women however, this was thought to be degrading additional punishment. One officer reported that they *"would like not to watch them when they go to the toilet but that would be an ideal time for them to put something around their neck"* (Coughlan 2006:11). Officers and women alike agreed that it *"took away any privacy or dignity"* (Coughlan, 2006:11). At times however, there was little alternative, as the women placed on constant watch were considered by staff to be a *"danger to themselves"* intent on serious deliberate self-harm with or without the intent of suicide.

The Prison Service and other providers of custodial care have a duty of care for all prisoners and staff, and improvements are constantly being made to reduce the level of risk to prisoners. Improvements include: a revised Prison Service Order (PSO) 2700, Suicide Prevention and Self-harm Management (HM Prison Service, 2007). Implementation was completed in April 2008, building on several years of learning

from the experience of prisoners, staff, investigators, inspectors and other professionals, it incorporates developments such as the introduction of the Assessment Care in Custody and Teamwork (ACCT), improved cross-agency communication and integrated local Safer Custody Teams, pursuing a continuous improvement plan in each prison. Also reflected are longstanding areas of safer custody work such as peer supporters (Listeners[6] and Insiders)[7] and work with outside organisations such as the Samaritans and Childline (Spencer, 2009). ACCT is the care planning system for prisoners at risk of suicide or self-harm, introduced across the 'prison estate' in partnership with the Department of Health during 2005-2007. ACCT aims to improve the quality of care by introducing individual/flexible care-planning, supported by improved staff training in case management and in assessing and understanding at risk prisoners.

The Prison Service Order 2700[8] (PSO 2700) provides instructions on identifying prisoners at risk of suicide and self-harm, on providing the subsequent care and support for such prisoners, and support for the staff who care for them. These instructions include the different levels of 'watch' (surveillance). However, even on 'constant watch' some women manage to find methods of self-harming, for example: whilst concealed under the covers they use items such as underwear in order to self-

[6] Listeners– Prisoners trained by Samaritans who listen in confidence to other prisoners who feel they need emotional support for whatever reason (HM Prison Service).

[7] Insiders - Scheme involving the training of selected prisoner/trainee volunteers to provide basic information and reassurance to prisoners new to prison shortly after their arrival in prison. (HM Prison Service).

[8] Prison Service Order (PSO) is long-term mandatory instructions, which are intended to last for an indefinite period. (HM Prison Service).

ligature. As a result, such high-risk prisoners were often required to wear 'safer clothing' and sleep in 'safer bedding', considered un-tearable. High-risk prisoners were also relocated in to 'safer cells'[9]; these were first introduced in prison establishments in 1997 and replaced the previous 'isolation cells' otherwise known as 'strip cells'. The replacement was due to increased levels of isolation, frustration and depression along with a 'loss of control' reportedly felt by prisoners (Summers, 2005). Strip cells ceased operation throughout the prison service in 2000 and were regarded as a 'sterile artificial line of prevention' (Stern, 1998:133) with intrusive practices that are degrading, dehumanising and of dubious benefit, even in the short term (Dexter & Towl, 1995). It could be argued that these were contradictory to the ethical guideline of the British Psychological Society's Division of Counselling Psychology (2001).

The new 'safer-cells' had the advantage of having reduced ligature points. However, prisoners often switched methods when thwarted and have been known to attempt self-strangulation with their own hands or torn clothing. Therefore, 'safer-cells' are not guaranteed to eliminate the risk of suicide completely (Safer Custody Group, 2002); and are recommended not to be the only intervention utilised and additional strategies to be employed, such as psychology, comprehensive risk assessments and good staff-prisoner relationships. The level of stigmatisation associated with prisoners being relocated to safer cells is prevalent in young offender institutions.

[9] Safer cells are designed with rounded corners, with no exposed pipes, modified light fittings, safe ventilators instead of windows. In addition, stronger materials are used that cannot be broken and used for cutting (Safer Custody Group, 2002).

Summers (2005) recommends a counter measure for this is to also allocate 'non at risk prisoners' 'safer cells' when available, in order to reduce the associated stigmatisation as the majority of these are usually located within normal location (residential wings).

1.13 Self-Harm - Reactions and Stigmatisation

'Deliberate self-harmers' are judged for their self-cutting behaviour within different settings, including: the Community, National Health Services (NHS), Mental Health Settings and within the HM Prisons and Secure Settings. Various studies report of a poor response from nursing staff and other professionals towards 'self-harmers' (Warm et al., 2002). For example, in Harris's study (1999 cited in Gardner 2001), women claimed that medical and nursing professionals viewed their self-harm as irrational and illogical. Their response was perceived as that of impatience, frustration, and hostile care, including the 'stitching' of self-inflicted wounds being carried out without anaesthesia. This supports other findings where medical personnel were reported as providing the most unsatisfactory support (Warm et al., 2002). Such practices of maintaining inferior subject positions of 'self-harmers' and control by the medical professionals are also evident in the prison environment where stigmatising and passing judgements are considered part of the 'natural culture' (Foucault, 1972), and custom (Yates, 1986). Deliberate self-harm is often perceived by professionals as manipulative and attention seeking and 'self-harmers' are labelled as such (Feldman, 1988; Walsh & Rosen, 1988). It is argued that deliberate self-harm and suicidal behaviour is powerfully embedded in the literature as being stigmatised and firmly

rooted in the domain of 'abnormal' behaviour. Research has focussed on suicide behaviour as a disease, reinforcing the notion that mental illness is a precursor to all deliberate self-harm/suicidal behaviour. As a result, many do not contact healthcare facilities in fear of stigmatisation (Arnold, 1995; Favazza, 1989a, 1989b cited in Turp, 2003, McAllister et al., 2009, O'Connor et al., 2000). Such moral judgments intensify the levels of distress being experienced and hinder the effectiveness of therapeutic interventions (Dear, Thompson, Hills, 2000; Dvoskin, 2002; Haycock, 1989; Howells et al., 1999; Pollock, 1998). These negative attitudes often prevent the women getting the help they need for their self-harm behaviour, as they are seen as "attention seekers" and "time wasters" and are thought of as "abusing the system" (Farrington, Morris & Gelsthorpe, 1981), therefore "deserve to be punished". Prison staff has also referred to these as "acting out" and "manipulative" behaviours (Dear et al., 2000; Dvoskin, 2002; Haycock, 1989; Howells et al., 1999; Pollock, 1998); and such prisoners are considered by some as "non-conformists", "deviants" and "misfits" (Farrington, Morris & Gelsthorpe, 1981). These thoughts and beliefs are juxtaposed with the current service policy to encourage therapeutic interventions with prisoners who are 'parasucidal' (HMCIP, 1990b; HMCIP, 2009; van wormer, 2001). Such socially constructed discourses often carry destructive implications (Shaw, 2002; van Wormer, 2001). Welldon (1988) argues that there are professionals who contend that deliberate self-harm is essentially sexualised behaviour. However, Collins (1996) argues that this would only reflect the minority:

"I would like to reflect on this notion of sadomasochism in relation to self-harm. Few people who self-harm talk of

> *enjoyment of the physical pain they inflict on themselves. They talk more in terms of the tension it relieves or the pride they feel in being able to withstand the pain"* (pp. 465-466).

Turp (2002) argues that not all professionals react in a negative manner to 'self-harmers' and noted that some professionals do respond to 'self-harmers' with empathy and compassion, whereas Arnold (1995) and Leibenluft, Gardner and Chowdry (1987) argue that others are prone to attribute primarily hostile or manipulative intent to the behaviour, and they pay insufficient attention to the internal experience of the client. McAllister et al. (2009) state that these dehumanising approaches are due to clinicians not seeing the wider context; instead viewing them through a 'narrow bio-medical lens'. In response to some of the negative reports by 'self-harmers' at Accident and Emergency departments, (refer to page 122), NICE Guidelines (2004) (National Institute for Clinical Excellence) for procedures have been implemented as an example of good practice[10]**.** One of these guidelines recommends that anaesthesia and/or analgesia is always used if the treatment that is about to be given could be painful. However, anecdotal evidence from prisoners suggests that this is not always practised both within forensic and community settings (Rose, 2006). This invalidation exacerbates the often underlying psychological issues and reinforces the 'attention seeking' misrepresentations, rather than addressing 'attention needing' aetiology of the dysfunctional behaviour. All of which have psychological repercussions for the self-harmer's sense of 'self' (Rose,

[10] NICE Guidelines are recommended good practice based on the clinical experience of the Guidelines Development Group.

2006). Self-harm and suicidal behaviour is not individually recognised as a psychiatric disorder, but is included as part of the diagnostic criteria for disorders such as Borderline Personality Disorder.

1.14 Self-Harm – Mental Health

The Department of Health reports that there is an increase in mental illness in prison with 70% of female sentenced prisoners suffering from two or more mental health disorders (Bromley Briefing, 2009). In addition 70% of self-harm episodes are precipitated by a personal problem, often linked with past and present traumas. Shaw (2002) argues that not all women and girls fit neatly into diagnostic categories, with their aetiology being more complex (Hawton & Catalan, 1987: Herpertez, 1995; Shaw, 2002); and argue that it is essential to understand the aetiology and function of deliberate self-harm to provide effective therapeutic care and treatment.

However, many do not seek treatment and help due to the stigma associated with mental illness. In addition there are 'overarching assumptions' that mental illnesses are not real or are of less importance, and that people with a mental illness are accountable for their own actions (Munday, 2008). Therefore, it is not surprising that some 'self-harmers' with mental health problems are reluctant to contact healthcare facilities. Consequently, there is an underlying assumption that if one exhibits behaviour outside of "society's expectations" then the behaviour is perceived as 'wrong' or 'bad', resulting in discipline and punishment.

> "*Foucault treats the space of the body as the irreducible elements in our social scheme of things, for it is upon that space that the forces of repression, socialisation, disciplining, and punishing are inflicted"*
>
> (Cited in Harvey, 1989:213).

Foucault (1979) suggests that the concept of health has itself become 'disciplinary'. We are driven by an un-stated ideal of perfection and urged towards constant self-criticism and self-surveillance, along with criticism and surveillance of others. The way in which medicine is practised together with the language of medicine and psychiatry are highly influential factors resulting in setting the parameters within which most of us think about health and illness and what is considered as 'normal' and 'abnormal' behaviour.

Favazza (1989a, 1989b cited in Turp, 2003) attempted to challenge the assumption that all deliberate self-harm behaviour is 'abnormal'. He does this by considering cross-cultural studies and the acceptance of various forms of behaviour, including 'particular acts' practiced on others that would be considered acceptable (normal) in another culture but considered abnormal in others, e.g. the practice of tattooing and body piercing and female mutilation (p.32). Gardner (2001) proposes that there is an underlying assumption that all deliberate self-harm is 'bad'. However, many women turn to deliberate self-harm in a desperate bid to cope and keep going. Gardner writes:

> *"Attacking the body is essentially a paradoxical gesture in that the apparently destructive act reflects a desire to continue to live and get on with life. Cutting can function as a way of cutting off from internal pain providing a distraction"* (Gardner 2001:25).

Therefore, despite the stigmatisation, and the way that society has imbedded self-harm behaviour into 'abnormal behaviour', for copious 'self-harmers' it is their method of survival; and many, as noted by Gardner above, use the method of 'cutting' as a distraction from the internal pain and chaos to keep alive. These methods of coping often continue due to the fear of seeking help based on stigmatisation and poor reactions from health professionals. However for some people who self-harm, therapy has been a means of finding alternative methods to cope with their chaotic histories (Rose, 2004, 2008).

1.15 Self-Harm – Therapeutic Interventions within Female Prisons and Community Settings

Many researchers quote Arnold's (1995) study as a key influential factor in self-harm behaviour, in relation to reactions from professionals and the effectiveness of therapy within community settings. Arnold (1995) notes from the 'Bristol Survey' that some women who reported engaging with counselling had finally been able to turn their lives around after many years of distress and self-injury, and in some cases, repeated hospital admissions (p. 20). In spite of this, it emerged that counselling and psychotherapy were very seldom offered. Some women were told that it would be

'dangerous' for them to uncover their feelings and experiences, which underlay their self-injury behaviour (Arnold 1995:19).

In addition to previous encounters with healthcare professionals within community settings, the prison context presents particular challenges for the women, and for any kind of therapeutic intervention in response to self-harm and suicide prevention. The majority of women enter into prison on short sentences. In 2001, 39% of women received a sentence of less than three months and 63% less than six months (Hooper, 2003). Furthermore, many women are held in custody on remand, prior to sentencing, and may be released or transferred after a few weeks. Much of their attention may initially be adapting to their immediate environment, particularly for the "first timers" in custody, who often experience "incarceration shock". This situation is exacerbated when women are arrested and not given time to make adequate arrangements for their children and family members. Many have difficulty adapting to the stressors of arrest, remand and trial which are magnified by experiences, such as bullying, violence, intimidation, disempowerment, social isolation and segregation units[11], further elevating the risk of dysfunctional behaviours (Howells et al., 1999; McCann et al., 2000), resulting in many not wanting to seek help for sensitive personal issues in an environment where fears about loss of privacy and confidentiality are abundant (Morris & Wilkinson, 1995). However, for those who do seek help, a trusting

[11] Segregation units are still functioning in some prison establishments, mainly for disciplinary purposes. The purpose of segregation is to maintain safety, order and discipline and the respect for human dignity. Segregation is sometimes necessary to help prisoners address negative aspects of their behaviour and return to normal location as soon as possible. They can be used for disciplinary purposes, incidents of disruptive behaviour and for a prisoners own safety (HM Prison Service Website).

relationship[12] may be difficult to establish. Furthermore, the learning and acquisition of personal development skills are hampered when the individuals' immediate environment is hostile towards such learning (Linehan**,** 1993a) impacts of trauma and/or to empower women to make changes in their lives may be continually hampered due to the re-traumatising and disempowering nature of the wider environment.

The risk of re-traumatisation while in prison and the potential benefits for the women's reintegration into the community later require specialised and tailored attention to their needs. A range of approaches is likely to be necessary to meet a wide variety of different needs and preferences. Hence there is a pivotal role for Counselling Psychologists, whose training includes a range of key therapeutic approaches, and also take into consideration the whole context of the client (Clarkson, 1998; Mayer, 2005; Pugh & Coyle, 2000). The prison service has been employing counselling psychologists for several years; specifically to provide therapeutic interventions designed to address the mental health needs of women (Mayer, 2005).

1.16 Counselling Psychologists

Various personnel including counselling psychologists, forensic psychologists, therapists, counsellors and prison staff offer a degree of support in some prison establishments. However, very little is offered in terms of group work, particularly

[12] Trust is a key issue for women who have been abused. According to Huband and Tantum (1999) and De Young (1982) 95% of 'self-harmers' have suffered childhood sexual abuse.

for remand prisoners.[13] The informal support which often develops with such programmes has been described as being *"at the heart of what is best in women's prisons"* (HMCIP, 1997:132) and may play an important role in prisoners' well being. Staff members in different roles have varying levels of knowledge and skill, and many also have an authority/disciplinary role with prisoners, which may impede openness and trust (Snow, 2002).

Therapists, psychologists and psychotherapists who are highly trained in the area of self-harm and histories of abuse, and are relatively independent of the disciplinary structure, offer an important resource for all women offenders and to date most establishments have relied upon voluntary organisations to fill this gap (Armstrong & Joy, 2001; Devlin, 1999; HMCIP, 1997; Pollock, 1998). However, there appears to be no literature evaluating their effectiveness, which is a consideration for future research.

More recently, Mayer (2005) reports that there is:

> *"Qualitative evidence of the greater involvement of psychologists in working with acutely suicidal prisoners, and in the greater provision of specialist support to other staff undertaking such challenging and stressful work"*
> (p. 38).

[13] Remand prisoners are people who have not been tried or sentenced yet; rather they have been placed on remand pending a court appearance.

Nevertheless, there are conflicting views regarding 'therapeutic interventions' with vulnerable prisoners (Nelson, 2001). Kendall (1998) found in a Canadian study that prison staff were positive about the role of such services in crisis intervention and management within the prison, but concerned about 'opening Pandora's box' (i.e. painful memories about abuse) whilst in a volatile environment. However, according to Kendall's research (1998) the same views were not shared by women prisoners, who were positive about therapeutic service, but not about the prison environment. Likewise, such fears of 'lifting the lid' or 'opening a can of worms' on abuse issues are shared by professionals in many contexts in the United Kingdom (Nelson 2001).

In addition to community reports, including Accident and Emergency departments (as noted earlier in this report), it appears that negative attitudes from prison staff towards female prisoners are so embedded into the culture of the institution that therapeutic intervention is treated cautiously by many of the officers. Many believe that the women are "deviant", "manipulative" and "time wasters" who have strayed from the "normal" path of stereotypical acceptable gender roles and therefore deserved to be punished and are not deserving of " therapy and group work" (Hinshelwood, 1993; Leonard, 1982 & Smith, 1998). Coughlan (2006) states:

> *"Prisons have always been repositories for the 'poor copers' in society, previously referred to as 'social inadequates', and there have always been the 'self-harmers' and the 'suicidal'" (p. 11).*

1.17 Self-Harm Awareness Training

Arguably, poor attitudes are mainly down to staff's lack of knowledge and awareness of the antecedents towards self-harm and suicidal behaviour along with their confidence and ability in how to manage the situations effectively. Bailey, McHugh, Chisnall and Forbes (2002) highlight the need for good quality training for effective delivery of a suicide prevention programme. They also cite the HM Chief Inspector of Prisons' thematic review, that suicide is everyone's concern (1999) and recommended more training for staff. Borrill, Snow, Medlicott, Teers and Paton (2005) highlighted the need for more resources to implement the training that the prison service was developing. Many of the developments that were proposed by the HMCIP review have taken place. Changes included specific training on the use of care document (F2052SH); this has since been replaced by the ACCT (Assessment, Care in Custody and Teamwork) document.[14] The prisoner is encouraged to attend these reviews.

More recently, extensive self-harm awareness training to all staff including healthcare, takes place in one of the female establishments, and has been well received by staff (HMCIP, 2008). The training is divided into three modules (full day training in each module). Module 1 looks at the antecedents of self-harm including possible past experiences of rape, sexual abuse and domestic violence. Modules 2 and 3 are theoretical and skills based focusing on how to treat and manage prisoners who

[14] Anyone who self-harms has an ACCT document opened and an Assessor assesses the client need, and a case manager is assigned to the individual, levels, and types of support are offered and a multidisciplinary team meet regularly to assess the clients' needs.

self-harm. Evaluations are taken after each module as part of prison policy. However a formal evaluation for research purposes would be beneficial, particularly to maximise its effectiveness. The training was an initiative to develop the 'whole prison' approach to 'Safer Custody' (HMCIP, 2008).

Bailey et al. (2002) also recommend the need for 'good quality supervision and management', noting that it must not be overlooked (p. 134). Borrill et al. (2005) also emphasised the need for supervision to prevent staff 'burnout' and noted that *"staff were praised for their efforts"* (p. 67). Furthermore, as the statistics currently indicate, deliberate self-harm levels are much greater than ever before. Thus without the necessary support, staff can be left feeling disempowered and less equipped to deal with the increasing demands, which Bailey et al. (2002) suggest can be damaging to both prisoners and staff. It is these important factors that assist and equip the staff to cope effectively with the demanding population and assist in the reduction of suicide and self-harm levels. Positive regimes are recommended in The Prison Service Order (PSO) 2700 5.1.1 (2007):

> *"Positive regimes are those which enable prisoners to engage in activities which reduce distress and potentially reduce rates of suicide or self-harm, for example through improving mood and increase coping skills and self-esteem. Potentially helpful activities include work, education, structured programmes, art and exercise".*

Nevertheless, the value of group work is recognised by many, as well as the extra hazards of being in a prison environment (Pollock, 1998). Few prison establishments offer deliberate self-harm intervention group work programmes, which are aimed at long term sentenced prisoners, and do not cater for the "remand population"; moreover, they are also considered to be expensive to run (Safer Custody, 2004). Prisons that run support groups have found mixed responses from those attending such groups. Some of the women benefited from the mutual support in sharing their feelings and experiences with others, whilst others found talking in a group setting difficult.

Morton (2004) states that interventions targeted at reducing self-harm in prisons tend to fall into three categories: specialised individual or group therapy, informal support groups and structured programmes. Research in non-prison settings suggests that structured programmes, teaching problem-solving techniques can be useful in helping people reduce self-harm (Hawton, Arensman, Townsend, Bremner, Feldman & Goldney, 1998). These programmes focus on helping the individual to learn new ways of thinking (cognitive restructuring) (Kaplan, Asnis, Lipschitz, & Chorney, 1995; Kaplan, Yaryura-Tobias & Neziroglu, 1995; Stallard 2002:1; Scott & Dryden, 1996) and develop alternative coping strategies. However, Winter et al. (2007) stated that evidence for the effectiveness of psychological therapies for people who self-harm are limited. Winter et al. (2007) ran a controlled trial of personal construct psychotherapy for 'deliberate self-harmers', results showed evidence of lower self-harm frequency. The programme draws on Kelly's (1955) construct theory, how the

person views the world and others in it. They proposed that personal construct theory could provide various techniques that will be tailored to the individual 'self-harmer's' view of the world. It was concluded that brief personal construct psychotherapy may be effective for people who self-harm therefore meriting further exploration.

Guthrie (2003) conducted a review of psychological treatment for deliberate self-harm and argues that the type of therapy offered (if any) may depend on local circumstances and availability. Guthrie reported that whilst there is evidence that psychological interventions of the problem-solving type lead to an improvement in psychosocial status, the evidence to support a reduction in repetitive self-harm is less robust. Guthrie categorises the research into two main types of study groups within which sub-groups of therapeutic approaches exist. The first study focuses on routine attendees with self-harm to general hospital services or referrals to psychiatric services (i.e. first-episode and repeaters) including 'problem solving' (Gibbons, Butler, Urwin & Gibbons, 1978; Hawton, Bancroft, Catalan, Kingston, Stedeford & Welsch 1981; Hawton, McKeown, Day, Martin, O'Connor & Yule, 1987; McLeavy, Daly, Ludgate & Murray, 1994), psychodynamic interpersonal therapy (Guthrie, Kapur, Mackway-Jones, Chew-Graham, Moorey, Mendel, Marion-Francis, Sanderson, Turpin, Boddy, & Tomenson, 2001), and the same therapist vs. referral to a different centre (Torhorst, Moller, Burk & Kurz, 1987). The second study types were on patients who repeatedly self-harm focussing on Dialectical Behaviour Therapy (DBT) (Linehan, Armstrong, Suarez, Allmari & Heard, 1991), cognitive-behaviour problem solving (Salkovskis, Atha, & Storer, 1990), manualised brief

cognitively orientated psychotherapy (Evans, Tyra, Catalan, Schmidt, Davidson, Dent, Tata, Thorton, Barber & Thompson, 1999a), and in-patient behaviour therapy vs. in-patient insight-orientated therapy (Liberman & Eckman, 1981). Guthrie (2003) argued that DBT was impractical and probably unsuitable as a treatment for the majority of patients who present with deliberate self-harm (p. 16). However, Guthrie (2003) concludes that there is no evidence from available research that any one therapeutic approach has greater benefit than any other, albeit the best evidence available regarding psychological treatments supports a problem-solving approach. Guthrie argues that as with all psychotherapies, the effectiveness of the treatment is largely dependent on the skill of the therapist (p. 17).

1.18 Structured Programmes in the Prison Service

Examples of structured self-harm programmes in prisons include the brief "Alternatives to Self-harm" programme, and the ACCESS programme developed for young men. To date the evaluation of structured programmes within the prison context has been limited, albeit promising (Mitchell, Trotter & Donlon, 2002). Stewart (2009) in a recent report of 'Therapeutic Interventions in Female Establishments' highlights the need for the evaluation of such programmes. The DBT self-harm programme a structured programme devised by Linehan (1993a) was adapted and previously piloted in three prisons (Borrill, 2002). This was a one-year treatment course written and developed for people diagnosed with borderline personality disorder (BPD) (refer to appendix 18) who self-harm. The programme is regarded as an intensive treatment combining individual and group therapy, and little

is known about its effectiveness with men. Studies of women with BPD have shown that it can be effective in reducing self-harm (Borrill, 2002). However, due to the lack of funding, the pilots were stopped.

1.19 'Brookland' a Female Remand Prison

The DBT programme was considered for the prison establishment 'Brookland',[15] but despite the reported effectiveness with females, the area Manager and Senior Management Team (SMT) felt that it did not meet the demands of a remand population. This was primarily due to the DBT criteria being for sentenced prisoners who were in custody for a minimum of twelve months and had the diagnosis of BPD. This excluded a large number of women who were 'self-harmers' but did not meet BPD diagnosis criteria. In addition, implementation of the current DBT programme would be inherently difficult due to the vast array of differences between prisoners and clinical DBT practices. Such differences include educational attainment levels, limitations within the prison environment to exercise the range of DBT skills, along with the fiscal restraints of lengthy therapeutic programmes (Eccleston & Sorbello, 2002). The current criticisms of implementing Dialectical Behaviour Therapy in a variety of settings are that in every instance the original programme has had to undergo approved adaptations to maximise the effectiveness for the respective client groups. Therefore, despite the reported effectiveness of a proportion of Dialectical Behavioural Therapy programmes, none has been a true reflection of the original

[15] In accordance with the British Psychological Society's Code of Ethics (1993, 2006) the appropriate confidentiality measures have been taken; any personal identifiable information (i.e. names, places and so on) have been changed; therefore a pseudonym of 'Brookland' has been given to the establishment.

Linehan programme. Many of the criticisms have included the complicated nature of the programmes acronyms and their translatability into the clients' 'real-life' settings along with the format which requires the skills trainer to teach aspects of the programme prior to the skills acquisition session (Munday, 2008).

Although a four-month version of DBT was being piloted in another female establishment, which increased the accessibility for women, most of the women in 'Brookland', whose average stay in the establishment was between six to ten weeks at any one time, were still unable to access the course. Furthermore, participants were also required to have a specified level of intellectual functioning that would enable them to understand the programme. This again would further limit the number of suitable participants in 'Brookland'.

The Carousel programme differs from Dialectical Behavioural Therapy in that it is inclusive of 'self-harmers' regardless of diagnosis and/or intellectual ability. Participants can join the programme at any time due to its circuitous nature, unlike DBT where participants can only join once an entire cycle has been completed which can take up to 12 months. Carousel necessitates that the participants are engaged with the programme. In addition to individual and group therapy sessions and holistic elements such as the construction of 'happy boxes' and therapeutic art they are encouraged to undertake regular exercise in the gymnasium and complete a journal daily. These aspects are regularly verified by the facilitators, whereas DBT consists of weekly homework and rehearsal of techniques taught, with definitive

compulsory aspects (Munday, 2008). More importantly, DBT fundamentally believes that any trauma experienced and/or the underpinnings to their self-harm behaviour should not be explored until the second cycle, which Munday (2008) argues can take up to 12 months to reach. Therefore, within the majority of settings this time-scale is impractical.

1.20 Current Self-Harm Programmes in the Prison Service

The National Institute for Clinical Excellence (NICE) Guidelines (2004) recommend interventions for the treatment of self-harm such as DBT amongst additional psychological interventions (Stewart, 2009). DBT has recently been adapted for the prison service and is currently running for 32 weeks. It is divided in to 4 modules, each module lasting 8 weeks under the name of 'HOST'[16] in a London female prison. Nevertheless this still excludes the remand population. In Australia, the 'Rush' (Real understanding of self-harm) programme, which is an approved adaptation of Linehan's DBT model, has been utilised with both male and female offenders within a variety of forensic settings. Rush aims to validate an offender's past and current emotional, cognitive and behavioural responses to stressful situations and life experiences.

Stewart highlights an additional three programmes currently being run in female prison establishments:

[16] The Full name of HOST has deliberately not been given, as the establishment's name appears is the name; as in accordance with the British Psychological Society's Code of Ethics (1993, 2006) the appropriate confidentiality measures have been taken; any personal identifiable information (i.e. names, places and so on) have been omitted or changed.

1. The Alternatives to self-harm programme (ASH) consists of six sessions running over two or three weeks, targeting the general prison population with a medium to low risk of self-harm. This programme is run by officers with sporadic involvement from nursing and psychology staff. Stewart (2009) criticises the programme for lack of evaluation and lack of uptake by prisoners (it had only run twice in the last twelve months). 2. Carousel, an 8-week rolling CBT based programme of structured activities and weekly one to one sessions, targeting women who are known to be at high and medium risk of self-harm. The Carousel Programme was devised by a Counselling psychologist and designed to be run by Counselling psychologists. It is described in both the Corston report (2007) and CSIP (Care Services Improvement Partnership) as an example of good practice (2007). This has also been highlighted in the HMCIP report (2008) for its effectiveness and good practice. Stewart (2009) criticises the lack of formal evaluation for Carousel. 3. The Safe programme, a 3 day (unstructured) programme is run on consecutive days, targeting women who are known to have self-harmed in prison or before coming into custody, running in two establishments. Officers run this with no input from psychology or nursing staff. Stewart criticises the lack of evaluation for the Safe programme also.

Stewart (2009) reports that good feedback had been received on the programme's effectiveness, however these reports were mainly from 'practitioners' and the prison service are waiting for further evaluation. This current study sets out to formally evaluate the Carousel Self-Harm Treatment programme (referred to as Carousel)

using quantitative analysis to measure outcomes, and qualitative analysis to establish from the participants what components of Carousel was effective.

SECTION 2 – RESPEARCH REPORT

2.1 Introduction

The highest rates of self-injurious behaviour in Europe are found in the UK (Bowen & John, 2001a, 2001b), with some of the most extreme forms being found within forensic settings (Rayner & Shaw, 2003). It is reported that:

> *"Between 2004 and 2008 incidents of self-harm in prisons increased by 25 per cent. In female prisons the increase was 42 per cent in the same period. The total number of self-harm cases in 2008 was 10,466 for men and 12,560 for women – a total of 23,026"*
>
> (The Howard League for Penal Reform, 2008a).

Increases in the levels of deliberate self-harm amongst female offenders in HM Prisons have been a cause for concern for the British Government and Prison officials (HMCIP, 1997, 2008; Milligan & Andrews, 2005). This continues to be a high priority for the Home Office and the Ministry of Justice (HMCIP, 2008). However, it is important to note that in December 2002, the Prison Service introduced a revised system for self-harm data collection that requires staff to complete documentation for every incident of self-harm known to occur within the establishment. The introduction of the new procedures has improved the validity and accuracy of the self-harm data collected although it is known that under-reporting still continues.

Therefore it is important that comparisons of self-harm levels pre-2003 are read with caution, as the rise in self-harm figures may largely be due to the improvement of reporting and not just to the increase in self-harm. Nevertheless despite this the self-harm figures continued to rise after 2003 as noted by the Howard League for Penal Reform (2008a) who state that: "*rates of self-injury in prison have rocketed by almost 40% in the last five years.*

According to Towl, Snow and McHugh (2000) acts of 'self-injury' in prisons (primarily self-laceration and abrasion, i.e. 'cutting') are far more common than in community settings. Whereas acts of self-poisoning, especially through the medium of prescription medication are significantly less frequent in prisons. Research suggests that there is a strong link between self-harm behaviour and suicide in prisons (Backett, 1987; Bogue & Power, 1995; Dooley, 1990; Livingston, 1997; Lloyd, 1990; Singleton, Meltzer, Galward, Coid & Deasy, 1998). Liebling (1992) reported that approximately half of those who die by suicide in prison have had a history of previous attempts and self-harm. Crighton (2000) and Snow and Biggar (2006) state that the rate of suicide in prisons far exceeds that of the general population. This continues to be the same today as noted by the Royal College of Psychiatrists: *"The risk of suicide is more than 10 times higher for a prisoner than for the general population"* (2009:2). Therefore it is not surprising that all self-harm injuries regardless of intent are treated as potential suicides within the prison service and regarded as part of the same continuum.

Nevertheless, there has been considerable research debating the concept of continuum models of self-harm/suicidal ideation that include a variety of behaviours ranging from mild self-harm to eventual suicide (Bailey, 1994; Croyle, Fortune & Waltz, 2007; Liebling, 1991; Turp, 2002). However, Wichmann, Serin and Abracen (2002) argue that although suicide, self-mutilation and self-injury are intertwined, there needs to be an expansion of future research focusing on a conceptual distinction between attempts to self-injure and authentic suicide attempts. Stevenson and Skett (1995) add to the debate by stating that despite inflicting superficial and non-life-threatening injuries a proportion of 'self-harmers' reported that they expected to die as a result. Nevertheless, regardless of expectations the Medical Research Council (1995) reports that self-injurious behaviour, causing wounds and injuries to one's own body in the absence of suicidal intent, is of great concern since it may be an indicator of deeper psychological distress. Similarly Collins (1996) refers to this as a 'metaphor for psychic distress'. It is argued that this is largely due to the repetitive nature of deliberate self-harm together with its relationship to increased risks of future suicide, particularly within the remand population (Rose, 2008). Within the prison service deliberate self-harm behaviour is regarded as a 'suicide risk' and necessary precautions are taken to keep the prisoner safe. Kilty (2006) argues that in relation to the individual, self-harm is a possible coping mechanism in a debilitating environment. Gardner (2001) further argues that for many, self-harm is a coping strategy in order to stay alive rather than to take one's own life. However, for many self-harming prisoners the prospect of seeking help or commencing therapy is not an

option (Rose, 2008). This is based on experiences of stigmatisation from prison staff (Coughlan, 2006).

Moreover stigmatisation and poor reactions from health professionals within forensic and community settings have been a significant deciding factor in relation to seeking professional help with suicidal and self-harm behaviours (Arnold, 1995; Favazza, 1989a, 1989b cited in Turp 2003; McAllister, et al., 2009, O'Connor et al., 2000). In addition, women were advised not to seek therapy for fear of uncovering negative feelings and experiences, underpinning their self-harm behaviour (Arnold, 1995). However, these thoughts and beliefs are juxtaposed with the current Prison Service Policy, which encourages therapeutic interventions with "parasuicidal" prisoners (HMCIP, 1990; HMCIP, 2009; van Wormer, 2001). In addition, Turp (2002) believes that not all professionals react in a negative manner towards 'self-harmers' but respond with empathy and compassion. Paradoxically, prior research found that other professionals were prone to attribute primarily hostile or manipulative intent to the behaviour, therefore paying insufficient attention to the internal experience of the client (Arnold, 1995; Leibenluft et al., 1987).

2.2 Complex Histories

Past histories of abuse have an enormous impact on the internal world of a client with many using self-harm as a method to survive rather than what is perceived as a method to manipulate a system (Gardner, 2001). Morris, Wilkinson, Tisi, Woodrow and Rockly (1995) noted that all women who had admitted to self-harming before or after their prison sentence had experienced abuse in their past, with a large proportion

having experienced both physical and sexual victimisation. Moreover, there has been overwhelming evidence from studies supporting the suggestion of a link between self-harm behaviour and sexual abuse, whilst arguing that childhood experiences of sexual/physical abuse were recognised as salient antecedents to skin-cutting (Borrill et al., 2005; Briere, 1992; Briere & Elliot, 2003; Briere & Gil, 1998; Coll et al., 1998; Connors, 1996a; Everett & Gallop, 2001; Faye, 1995; Favazza, 1996; Feldman, 1988; Gardner, 2001; Law et al., 1998; Low et al., 2000; Marchetto, 2006; O'Connor & Sheehy, 2000; Parker et al., 2005; Snow, 1997; Tantum & Huband, 2009; Turner, 2002; Turp, 2003; Warm et al., 2002; Zlotnick et al., 1996).

However, Frost (2001) argues that not all 'self-harmers' are victims of childhood sexual abuse. In addition, Jeffreys (2001) cites Favazza and Conterio's (1996) study as evidence to this noting that 38% of female habitual 'self-harmers' did not report childhood sexual abuse, but Jeffreys fails to highlight that 62% did. Paradoxically, Huband and Tantum (1999) and De Young (1982) reported that 95% of 'self-harmers' suffered childhood sexual abuse. In addition, Coid, Wilkins, Coid and Everitt (1992) add further evidence for the 'link' between forensic and clinical populations. Moreover, Short, Cooper, Shaw, Kenning, Abel and Chew-Graham (2008) highlight the disturbingly high levels of abuse and violence that women in prison have experienced, thus heightening the awareness of the difficulties faced by this proportion of the population (O'Connor & Sheehy, 2000 p. 41). As a result, many of the women have difficulties with emotional regulation, and use self-harm as their means of managing overwhelming emotional distress. Freud (1932) and Joseph

(1999) suggest that repeated harmful reactions are often a trace of the repressed and traumatic experiences of childhood. This material is re-enacted or re-experienced through symptoms, behaviours, dreams, hallucinations or flashbacks including guilt, shame, self-blame, loss of trust, and stigmatisation, which are regularly experienced and reported by female prisoners (Rose, 2008). Linehan (1993a) and Yule, Perrin and Smith (1999) add that sexual abuse affects cognitive functioning in respect to self-perceptions with victims often perceiving themselves as different from their peers.

2.3 Self-Harm and Coping

In response, research has drawn attention to the apparent association between self-harm and deficits in coping (Slade & Gilchrist, 2005). Studies of coping styles have generally identified two broad strategies which people use for dealing with stress or threat: problem-focused and emotion-focused. Problem-focused strategies refer to attempts to manage or change problems including finding different ways of thinking about them (cognitive restructuring) (Kaplan et al., 1995 cited in Stallard 2002:1; Scott & Dryden, 1996). In contrast, emotion-focused strategies concentrate on trying to regulate emotional distress, including avoidance. Problem-focused coping is generally believed to be the most effective in reducing stress, although it may be less adaptive in situations not amenable to change (Lazarus & Folkman, 1984). In such circumstances a detached coping style may be helpful (Roger, et al., 1993). Avoidant coping has been related to a higher level of distress in adolescents and young adults (Wilkinson et al., 2000) and to suicide risk in young adults (Botsis et al., 1994).

There is some evidence to suggest that prisoners in general may have less adaptive styles of coping than the general population, and in particular are more likely to use emotion-focused and avoidance-focused styles of coping (Gullone et al., 2000). In addition, several studies have reported that prisoners who self-harm are also likely to use less adaptive coping strategies, in particular avoidance (Livingston, 1994; 1998; Slade & Gilchrist, 2002). One of the aims of the Carousel programme was to be an intervention for 'self-harmers' aiming to reduce maladaptive coping styles (self-harm) whilst increasing problem solving skills and adaptive coping styles (Rose, 2004, 2006).

Research in non-prison settings suggest that structured programmes focussing on problem solving techniques can be beneficial in assisting people to reduce their self-harming behaviours (Hawton, et al., 1998). To date the evaluation of structured programmes in the prison service for long-term prisoners has been limited albeit promising (Mitchelle et al., 2002). Carousel is an example of a structured programme and was the first of its kind specifically targeting short-term remand female prisoners who self-harmed. Furthermore, it is unique in that it combines cognitive behavioural therapy with personal construct psychotherapy, with underpinnings of humanistic therapy. This combination was tailored to meet the needs of female remand prisoners who have experienced multiple problems resulting in complex histories (Rose, 2008). Important factors that need to be taken into account when designing a programme is the inclusion of psycho-education. This assists the women to achieve emotional regulation, self-regulation and effective interpersonal skills, which in turn helps them

to deal with issues resulting from incarceration such as the loss of direct family support (Corston, 2007), trauma, loss, abuse and Mental health problems (Borrill et al., 2005) and their maladaptive self-harm coping strategies (Livingston, 1994, 1998; Slade & Gilchrist, 2005). Many 'self-harmers' report the need to engage in such acts as a way of purging themselves of negative internal attributions felt and/or experienced. In addition, acts of self-harm can serve multiple functions such as those of feeling cleansed, temporary release and the experiencing of pain and/or numbness in order to regain control over their body (Connors, 1996a; Gardner, 2001; Strong, 2005; Sutton, 2005). Linehan (1993a) cautions that learning of new coping strategies can be detrimental if others are not in place and explored for their function/purpose.

2.4 The Programme: Outline of Carousel

Carousel is an eight week rolling group-treatment programme catering for female remand prisoners who self-harm. Ideally the participants complete the entire course. However, in order to accommodate the "prison system" with frequent discharges and transfers, each week was designed to be self-contained, enabling participants to enter or leave the programme at any stage. Group therapy is combined with individual counselling, physical exercise, relaxation, psycho-education and therapeutic art. The development of alternative coping skills and problem solving techniques are key elements running throughout the programme. Carousel is a psychotherapeutic approach that combines a range of research based methods. Similar to dialectical behaviour therapy (DBT), it follows the principles of cognitive-behavioural methodology, with the addition of personal construct methodology. It is partly based

on the transactional biosocial theory of the aetiology of the affect regulations of 'self-harmers'. Due to predisposing factors of abuse/dysfunctional backgrounds, precipitated by invalidating environments, prisoners who self-harm lack the ability to develop the skills and capacity to manage their emotions. Topics within the programme include the management of impulsivity, behavioural regulation, alternative constructs of self-harm, world views, development and awareness of pro-social skills, personal protective factors, as well as education around drug and substance abuse. Psycho-education offers opportunities of learning and insight from the shared experience of group members. The use of cognitive behavioural and personal construct theories enables an appreciation of the 'self' in relation to others, increasing emotional intelligence and pro-social skills thus encouraging behaviour regulation and contingency management. The programme provides mutual support within a motivating environment to foster a willingness to work and learn together. In total the participants spend two to three hours per day in programme related activities. All completers of Carousel received a certificate (refer to appendix 20).

2.5 Rationale for using Cognitive Behaviour Therapy (CBT) and Humanistic Theory (Person Centred)

There is a growing amount of research about the effectiveness of CBT, although limited evidence is available regarding self-harm programmes. However, within this small sample Connors (1996b), O'Connor et al. (1999), O'Connor and Sheehy (2000) and Yule et al. (1999) highlight that CBT approaches for deliberate self-harm produce significant improvements. CBT encourages working collaboratively with clients to

help them challenge their own beliefs, experiment with alternatives and discover for themselves the emotional and behavioural consequences of following a different set of guiding assumptions. This is in keeping with the educational goal of CBT, which teaches clients problem solving techniques to help them in different situations. The programme emphasises the effectiveness of building up a 'tool-box' of skills for life, to be used within the prison and community. The aim is to reduce psychological distress and maladaptive behaviour by attending to cognitive processes; this is often referred to as 'cognitive restructuring' (Kaplan et al., 1995 cited in Stallard 2002:1; Scott & Dryden, 1996). However, Waddington (2002) argues that CBT alone is insufficient for therapeutic change. Therefore by using Rogers' (1957) core conditions combined with CBT and personal construct psychotherapy, a more collaborative therapeutic relationship can be facilitated which is necessary for 'getting alongside' the client (Beck, Rush, Shaw & Emery, 1979) and optimising therapeutic outcomes (Waddington, 2002). This is particularly pertinent with women who have suffered childhood sexual abuse and as a result, trust is more difficult to establish. Mearns and Thorne (2001) suggest that it is only when trust is established within a therapeutic relationship and the person feels safe and un-judged that work at a deeper level can be accomplished. Working in a collaborative manner through psycho-education aims to empower the client to participate in developing coping strategies alternative to self-harm behaviour (Linehan, 1993a, 1993b; Ferenczi, 1933 in Balint, 1968; Rose, 2008).

2.6 Personal Construct Therapy (PCT)

Little is known about the effectiveness of personal construct psychotherapy for deliberate self-harm. Personal construct theory (Kelly, 1955) views "*the actions of the self-harmer as 'validating acts'* (Kelly, 1961; Stefan & Von, 1985) *directed towards the better anticipation of their world"* cited in Winter et al. (2007:24). A recent study conducted by Winter, et al. (2007), noted evidence of a lower frequency of repetition of self-harm incidents in the psychotherapy group intervention, compared to the control group of regular clinical practice. However, there were significant weaknesses to this study, firstly a randomised sample from an accident and emergency department where participants lacked motivation and failed to turn up to all sessions. All the members that formed the control group failed to meet the second assessment, therefore a true comparison could not be made. In addition a follow up study five years later revealed that the participants were still self-harming. Winter et al. (2007) concluded that personal construct therapy may be effective for people who self-harm and merits further exploration.

Carousel utilises personal construct therapy as an approach allowing deliberate self-harm to be understood from the perspective of the individual. The therapy challenges how the self-harmer construes the world, with cognitive restructuring (Kaplan et al., 1995 cited in Stallard 2002:1; Scott & Dryden, 1996) aiding them to change their worldview whilst increasing protective factors, often lacking in this proportion of the female prison population.

2.7 Evidence of Effectiveness and Current Study

The National Institute for Clinical Excellence (NICE) (2004) noted that there is limited evidence on effective interventions for self-harm. Similarly, Stewart (2009) highlighted in a recent report of therapeutic interventions in female establishments, the need for the evaluation of self-harm programmes. Stewart states that good feedback had been received on their effectiveness, however these reports were mainly from 'practitioners', and the prison service is awaiting further evaluation. In addition, Carousel received good reports regarding its effectiveness (Corston, 2007; CSIP, 2007 & HMCIP, 2008, Stewart, 2009), however to-date no formal evaluation has been carried out (Stewart, 2009). The aim of the current study was to evaluate the Carousel programme (refer to appendix 19 for copy of Carousel manual), which was designed specifically for 'Brookland'[17] a local prison predominantly housing a female remand population. The original concept of Carousel was born out of the need to meet the challenge of increasing levels and severity of self-harm within 'Brookland'. It was designed and written by Rose (2004, author of the current study), and assisted by Pope (co-author of the programme). This was at the request of the governing governor and area manager due to no suitable alternatives. The Carousel programme ran for two years in the establishment and ceased due to 'Brookland' being 'rerolled' (became a male establishment). Carousel is currently running in another establishment.

[17] In accordance with the British Psychological Society's Code of Ethics (1993, 2006) the appropriate confidentiality measures have been taken; any personal identifiable information (i.e. names, places and so on) have been changed; therefore a pseudonym of 'Brookland' has been given to the establishment.

2.8 Training

Self-harm awareness training incorporating Carousel was provided for staff and officers prior to implementation of the programme. This training was circular in nature to incorporate new and transferring staff into the establishment. In addition the facilitators continually liaised with the prison staff who were directly involved in the participants' care.

2.9 Research Question and Hypotheses

The study sought to measure the effectiveness of Carousel a self-harm programme designed for female prisoners. This was conducted using quantitative and qualitative data. It was hypothesised that there would be a reduction in the levels of depression, anxiety and self-harm incidents, and a change in the level of coping styles in the desired direction, i.e. emotional and avoidance coping styles would decrease, and rational and detached coping styles would increase. The first stage of the analysis used a repeated measures design to investigate differences in levels of self-harm, anxiety and depression, and coping styles between time one and time two.

A second stage analysis was carried out using qualitative interviews to generate constructive data about the effectiveness of the Carousel programme (Dale, Allen & Measor, 1998; Kuhnlein, 1999; McKenna & Todd, 1997; McLeod, 2001). For this purpose a content analysis was used. The rationale for this method will be described in Section 2 Part B.

Method

2.10 Participants - Recruitment to the Programme

Posters were displayed around the prison advertising the Carousel programme (refer to appendix 7) and referral forms placed on the residential wings (refer to appendix 8 & 9). The participants were interviewed by the two facilitators[18] of the programme and selected by fulfilling the following criteria: have a history of self-harm behaviour and motivation to change (i.e. to either reduce or stop their self-harming behaviour).[19] Forty-six participants were recruited by method of self-referral over a two-year period and forty women completed the programme (n = 40 women, 38 remand, 1 lifer[20] and 1 sentenced; age range from 19 to 44 years, mean age 28). Six participants did not complete the programme for various reasons: two (P41 & P44) were released from prison after completing one week, another (P45) after completing two weeks, the fourth (P46) was transferred to a different prison. Two participants, who said they were motivated to change at the interview, later retracted this. One of these (P42) dropped out after the first session stating that "self-harming was part of [her], been with [her] all of [her] life and [she] wasn't ready to replace it". The other (P43) dropped out after two weeks stating that she "did not feel ready to engage". Thirty-

[18] Two facilitators were required to run the programme as recommended by the prison service, partly due to the 'self-harmers' symptomatology and complex underlying issues, which is often exacerbated within a prison population. Thereby the support of a co-facilitator in addition to ongoing supervision is necessary to prevent staff burnout.

[19] The Governing Governor and the Area Psychologist had expressed from the onset that the criteria for programme entry should be as inclusive as possible to include as many 'self-harmers' as viable to keep exclusion to a minimum.

[20] Lifer is a term given to those serving a life sentence. Though sentenced to life imprisonment or an indeterminate sentence of Imprisonment for Public Protection (IPP) they have no automatic right to be released. They do have a minimum sentence imposed, which is to meet the needs of retribution and deterrence (HM Prison Service Website).

nine of the forty participants who completed the programme reported to have experienced sexual abuse, some disclosed experiences of multiple trauma.[21]

2.11 Participant: Temporary Exclusion

Part of the process of recruitment was to liaise with the security department regarding eligible referrals mixing with other participants. This process highlighted one participant (of the forty completers) who at the time of application was a 'known bully' and therefore temporarily excluded from entering the Carousel programme, (refer to exclusion criteria on page 65 in footnote 24; refer also to page 64 of this report under heading "Ethical Considerations: Criteria for exclusion from the Programme"). As a result the participant undertook five sessions of individual psychological intervention, which included bullying awareness and anger management. Upon completion of these sessions it was agreed by the multidisciplinary team to release her from the 'bully watch programme' and allow participation in Carousel. Due to the length of her remand status, she was able to enter the programme and complete the entire course.

2.12 Ethical Considerations

The programme was devised and implemented at the request of the Governing Governor[22], the Area Manager and Senior Management Team of 'Brookland'. The programme was approved through the Prison Service Effective Regimes protocol

[21] Many experienced multiple sexual abuse, physical abuse, domestic violence, family disruption, divorce, rape and bullying.

[22] There are several Governors working within the prison, the Governing Governor is the main Governor in charge of the establishment.

(PSO 4350) (refer to appendix 5 for certificate). The Governing Governor and Wolverhampton University Ethics Committee approved the study data to be used for the purpose of this research (refer to appendix 2, 3, 4 & 6). The British Psychological Society's ethical codes and principles (2003, 2006) [23] were adhered to throughout. An underpinning of all ethical codes is that participants' welfare must be considered when conducting any psychological research, particularly when working with vulnerable client groups. All of the women who entered the Carousel programme were considered vulnerable. Therefore prior to commencement of the group work, participants received at least two individual therapy sessions, depending on individual needs. Individual therapy continued during and after completion of the programme.

2.13 Ethical Considerations: Criteria for Exclusion from the Programme

Part of the ethical considerations for the programme was to consider the inclusion and exclusion criteria: in keeping with the request to be as inclusive as possible (see footnote 25 below), exclusion was kept to a minimum. However, given the nature of the setting it was predicted that there might be circumstances when it would be necessary to exclude, either on a temporary or permanent basis. Prospective participants who are 'actively psychotic' or a 'known' and 'proven' bully[24] at the time of application would come under these criteria. However, excluded participants could still receive individual therapy sessions by a member of the psychology team

[23] The programme commenced prior to the 2006 BPS Guidelines; nevertheless are still in keeping with the 2006 guidelines.

[24] "Bullies" are placed on a "Bully watch", stage 1, 2 or 3; this is a procedure that it carried out by the Anti-bullying coordinator and a multidisciplinary team within the establishment. To exclude them from the programme is to protect vulnerable members of the group.

and once deemed appropriate would be eligible to join the programme. A multidisciplinary team meets to make such decisions in order to protect vulnerable clients and prevent discrimination.

2.14 Ethical Considerations: Control Group

A control group was considered for this study; however, due to the high turnover of prisoners within the remand population of 'Brookland' it was not considered ethical. Before reaching this conclusion, two options were considered and evaluated: Option 1, to delay a group of prisoners from entering the programme to form a control group. Option 2, to exclude women from taking part in the programme (with their prior agreement) to form the control group. However, due to the nature of the prison it could not be guaranteed that the delayed group (option 1) would still be in the establishment to take part in the programme. Moreover, to exclude women from a service that they would benefit from, either by total exclusion (option 2), or delaying them (option 1) with no guarantee they would be able to complete part or the whole of the programme, would not be acting in the best interests of the women (beneficence). For these reasons the researcher, area psychologist and governing governor decided a control group would not be used for the purpose of this study. Previous studies have come to the same conclusion and therefore not used a control group (Milligan & Andrews, 2005). Nevertheless, it was recognised by the researcher that this would be a limitation to the study (refer to limitations and future research, page 112)

2.15 Ethical Considerations: Informed Consent

Acting in accordance with the Professional Guidelines of the British Psychological Society (BPS) for the Division of Counselling Psychology 1.5.1 (2001), participants completed consent forms (refer to appendix 10) to take part in the programme and for the data to be used for research and publication purposes. The forms outlined that if they chose for their data not to be used for the purposes stated, it would not affect their eligibility to take part in the programme. The participants were also verbally informed as to the rationale of data collection, along with their right to withdraw at any time. Consent forms were stored in a locked cabinet within the prison establishment (refer to appendix 10 for copy of consent form). Participants were also informed that as part of the programme, individual therapy and support would be given prior, during, and at the end of the programme. Following the BPS Code of Ethics (1994, 2006) the appropriate confidentiality measures were taken: any personal identifiable information (i.e. names, places) were changed; and for research purposes, all participants were identified by a number, i.e. 'Participant 1, 2 or 3 etc'.

2.16 Materials

The Participants were interviewed and assessed at the start and completion of the programme. Tests were administered to assess their levels of anxiety and depression using the 14-item Hospital Anxiety and Depression Scale (HADS) (Zigmond & Snaith, 1983); and coping levels using the 60-item Coping Styles Questionnaire (CSQ) (Roger, Jarvis & Najarian, 1993).

2.17 HADS

The 14-item HADS consists of two subscales of anxiety and depression. The HADS has internal consistency and construct validity (Spiegel, Morrow, Classen, Raubertas, Stott, Mudaliar, Pierce, Flynn, Heard & Rigg, 1999). Review of the literature on the validity of the HADS scale (747) papers identified discriminate validity and internal consistency. Findings concluded that the HADS was found to perform well in assessing the "symptom severity and caseness of disorders and depression in somatic, psychiatric and primary care patients and in the general population" (Lewin, Thompson, Martin, Stuckey, Devlen, Michaelson & Maguire, 2002: p. 201). Validity, reliability and predictive values for HADS have been evaluated in populations through systemic interviews (Barczak, Kane, Congdon, Clay & Betts, 1998; Bramley, Easton, Morley & Snaith, 1988; Schaaber, Smari & Oskarsson, 1990; Zigmond & Snaith, 1983). Moreover, the HADS has been shown to be comparable with other self-report scales (General Health Questionnaire, GHQ, Lewin, et al., 2002; Centre for Epidemiologic Studies Depression Scale, CES-D; Beck Depression Inventory, BDI, Bramley, et al., 1998; Schaaber, et al., 1990).

2.18 CSQ

The 60-item Coping Styles Questionnaire (CSQ) (Roger, Jarvis & Najarian, 1993) comprises of four subscales rational coping styles, detached coping styles, emotional coping styles and avoidance coping styles. The CSQ has internal consistency and construct validity (Roger et al., 1993). The re-test reliability coefficients for the CSQ factors were all substantial and the scales were internally consistent. The re-test alpha

coefficients for all four subscales; rational coping styles, detached coping styles, emotional coping styles and avoidance coping styles were 0.801, 0.794, 0.766 and 0.701 respectively. The Internal reliability coefficients for the sub-scales, rational coping styles, detached coping styles, emotional coping styles and avoidance coping styles were 0.801, 0.794, 0.766 and 0.701 respectively. Moreover the CSQ has been shown to be comparable with other self-report scales (Chapman, Gratz, & Brown, 2006). Other items were administered but not used for the purpose of this report[25].

2.19 Self-Harm

The monitoring of the levels of self-harm incidents took place in two stages referred to as time 1 and time 2.

Time 1: consisted of the recording of the number of self-harm incidents over the eight-week period leading up to and immediately prior to the commencement of the programme. The number of incidents was taken from the prison records (IRS monitoring system).

Time 2: The number of self-harm incidents were monitored and recorded throughout the 8-week programme from the commencement (first day) to end of the programme (last day).

[25] Psychometric tests and measurement tools administered but not used for the purpose of this report were: The Firestone Assessment of Self-destructive Thoughts (FAST) (Robert Firestone & Lisa Firestone 1996), the Repertory Grid (Kelly, 1955).

However, occasions arose when the documentary evidence (either all or part of) for time 1 was unavailable due to the prisoner not being at the establishment for an eight-week period prior to the programme. In these instances self-report was used to gain a base line for the data (P3, P9, P10, P24, P33, P37, P38). Participant 34's pre data was collected from the establishment that she was transferred from.

PART ONE: QUANTITATIVE ANALYSIS

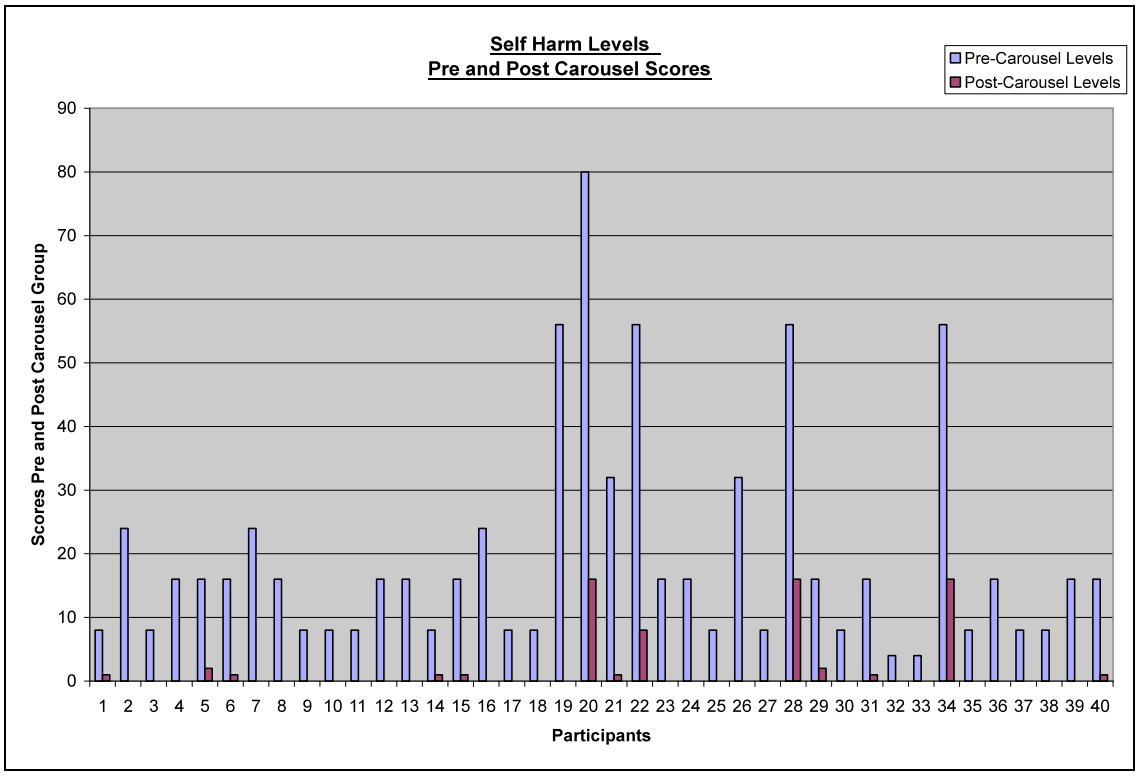
A repeated measures design was used to investigate differences in levels of self-harm between time one and time two. Statistical analysis using a paired *t*-test indicates that from pre- to post-programme the women showed a highly significant reduction in self-harm levels as illustrated in Table 3 below.

Table 3. Descriptive statistics for total recorded pre- and post-Carousel scores of self-harm levels.

	Pre-mean (st dev)	Post- mean (st dev)	*t*	*df*	*P* value
Self-harm Levels	19.60 (17.44)	1.67 (4.34)	$t = 7.998$	39	$p<.001$

However, despite the significant levels of self-harm reduction, some participants remained self-harming during and at the end of the programme as indicated in Figure 2 below (refer to appendix 15 for raw data).

Figure 2. Self-Harm levels pre and post Carousel Programme



As illustrated in Figure 2, all forty participants showed a marked reduction in self-harm levels by the end of the programme. In twenty-seven out of forty cases the self-harm levels were reduced to zero, with each participant reporting that they did not self-harm during or immediately after completion of the Carousel Programme. However four of the thirteen who continued to self-harm throughout the programme did so with frequency albeit at a reduced rate (P20 eighty to sixteen, P22 fifty-six to eight, P28 fifty-six to sixteen, P34 fifty-six to sixteen) as shown in table 4. Two of the remaining participants self-harmed twice during the programme but had stopped by the end of the programme, participant 5 self-harmed once in the first and third week, and participant 29 self-harmed once in the first week and second week as shown in table 4. The remaining seven participants self-harmed once during the programme:

three in the first week (P1, P14 & P21), three in the second week (P6, P31 & P40) and one participant self-harmed in the fifth week (P15).

Table 4. Continuation of self-harm levels during the programme per week

Participant	Wk 1	Wk 2	Wk 3	Wk 4	Wk 5	Wk 6	Wk 7	Wk 8
P1	1							
P5	1		1					
P6		1						
P14	1							
P15					1			
P20	3	2	3	4	0	1	2	1
P21	1							
P22	1	2	1	2	1	0	0	1
P28	3	2	4	2	0	3	1	1
P29	1	1						
P31		1						
P34	2	2	4	2	1	3	1	1
P40		1						
TOTAL	**15**	**12**	**13**	**9**	**3**	**7**	**4**	**4**

Participant 22 was free of self-harming for just two weeks, Participants 28 and 20 each had one week of no self-harm incidents. Whereas Participant 34 self-harmed every week during the programme but had reduced to just one incident in each of the last two weeks of the programme. Interesting to note from table 4 above there is a definite trend in reduction of self-harm incidents per week during the programme, commencing at 15 reducing to 4 incidents by the end if the programme, with weeks 5, 7 and 8 having the least number of self-harm incidents of 4 each.

2.20 Measures: Hospital Anxiety and Depression Scale (HADS)

(Zigmond & Snaith, 1983).

The desired direction of change from pre-programme to post-programme is for depression and anxiety scores to decrease (refer to appendix 16 for raw data). A repeated measures design was used to investigate the differences in the levels of anxiety and depression, between time 1 and time 2. Paired *t*-tests indicate that from pre- to post-programme the women showed a highly significant reduction in their depression and anxiety levels as displayed in the Table 5.

Time 1: HADS scale administered 1 day prior to the commencement of the programme.

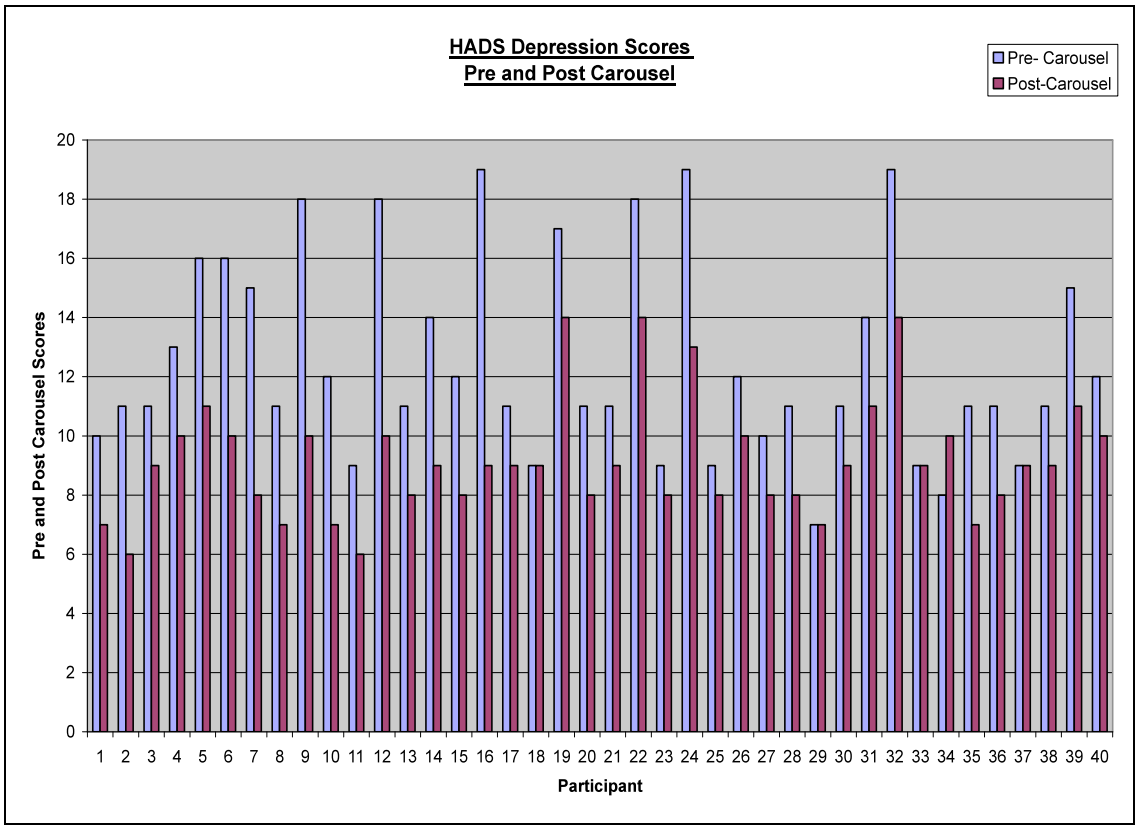
Time 2: HADS scale administered on the final day of the programme.

Table 5. Descriptive statistics for total pre- and post-recorded Carousel scores of Depression and Anxiety levels.

HADS	Pre-mean (st dev)	Post-mean (st dev)	*t*	*df*	*P* value
Depression	12.50 (3.37)	9.17 (1.99)	$t = 8.64$	39	$p<.001$
Anxiety	13.17 (3.50)	8.22 (1.44)	$t = 11.03$	39	$p<.001$

However despite the highly significant results as shown in table 5, not all participants reduced their depression levels as illustrated in Figure 3.

Figure 3. Pre- and Post-programme HADS Depression Scores



For both anxiety and depression scales scores of zero-seven in respective subscales are considered normal, with eight-ten borderline abnormal and eleven to twenty-one abnormal, indicating clinical significance (Zigmond & Snaith, 1983). For the purpose of this study, the abnormal range will be referred to as 'clinical significance' to add more clarity in the analysis.

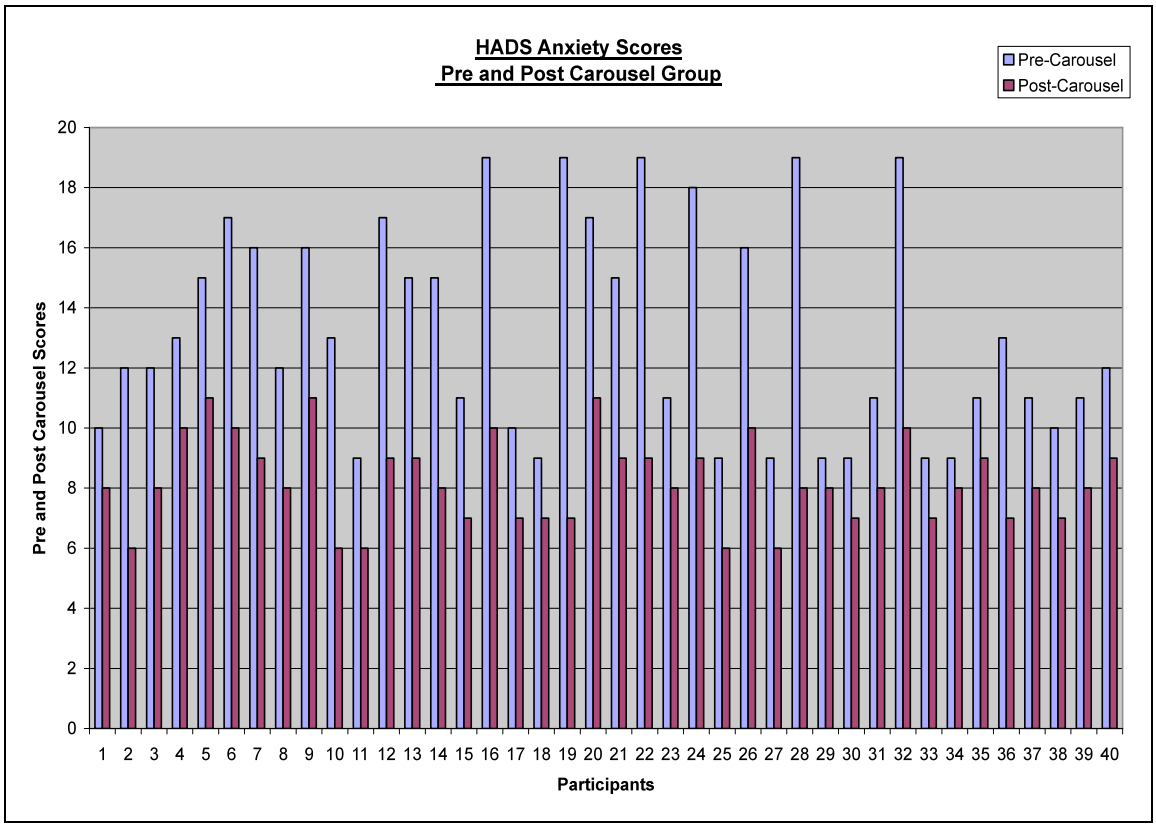
As can be seen from the Figure 3 the depression levels in the pre-testing are high adding further support to Snow's (2002) study, suggesting a link between self-harming and depression in prisoners. However, this is a tentative observation as there is no comparative data of a prisoner no-self-harm group in the current study. In addition, a previous study by Towl and Crighton (2000) reported that depression is

the most common form of mental disorder and the most closely associated with self-harm, suicide and attempted suicide.

As illustrated in Figure 3 there were significant decreases in post-depression scores. However, there were only six participants at the end of the programme with scores that were within the normal range (P1- seven, P2- seven, P8- seven, P10- seven, P11- six, P35- seven). One commenced the Carousel Programme with a score within the normal range of depression (P29- seven) and completed the programme with the same score. Nine participants commenced the programme with scores in the borderline abnormal range (P1- ten, P11- nine, P18- nine, P23- nine, P25- nine, P27- ten, P33- nine, P34- eight, P37- nine), two of whom reduced their depression level to within the normal range (P1- seven, P11- six). Three of the remaining six completed with the same score (P18- nine, P33- nine, P37- nine), two scored one point less than their initial score (P23- eight, P25- eight) and the one remaining had increased the level by two points (P34- eight-ten), both pre- and post-scores being in the borderline abnormal range. The remaining twenty-eight were within the clinical significance range pre-score (P3- eleven, P4- thirteen, P5- sixteen, P6- sixteen, P7- fifteen, P8- eleven, P10- twelve, P12- eighteen, P13- eleven, P14- fourteen, P15- twelve, P16- nineteen, P17- eleven, P19- seventeen, P20- eleven, P21- eleven, P22- eighteen, P24- nineteen, P26- twelve, P28- eleven, P30- eleven, P31- fourteen, P32- nineteen, P35- eleven, P36- eleven, P38- eleven, P39- fifteen, P40- twelve), nine of whom had high scores ranging from sixteen to nineteen. Of the eight high scores, three participants had reduced to the borderline abnormal range (P6- ten, P12- ten, P16- nine), the other

five remained in the clinical significance range, albeit a significant reduction from the pre-scores.

Figure 4. Pre- and Post- HADS Anxiety Scores



Scores of zero-seven in respective subscales are considered normal, with eight-ten borderline abnormal and eleven to twenty-one abnormal, indicating clinical significance (Zigmond & Snaith, 1983). As illustrated in Figure 4, pre-tests of the anxiety sub-scale illustrate that eleven participants commenced the programme with scores in the borderline abnormal range, whilst the remaining twenty-nine were within the clinical significance range, adding further support to Coid, Wilkins, Coid and Everitt, (1992) who found links between anxiety and depression and self-harming incidents among female prisoners (although as previously stated, this is a tentative

observation as there is no comparative data of a prisoner no-self-harm group in the current study). Of these twenty-nine, twelve participants had particularly high scores ranging between sixteen and nineteen. All twelve showed a reduction in anxiety and eight were in the borderline abnormal range (P6- ten, P7- nine, P8- eight, P16- ten, P22- nine, P24- nine, P26- ten, P32- ten), whilst only one was in the normal range (P19- seven). In total, thirteen participants reduced their anxiety levels to the normal range (P2- six, P10- six, P11- six, P15- seven, P18- seven, P19- seven, P25- six, P27- six, P30- seven, P33- seven, P36- seven, P38- seven). There was no increase in levels of anxiety post-testing.

On both depression and anxiety sub-scales, thirty-five participants showed a marked change in the desired directions as shown in Figures 3 and 4. In thirty cases there were changes in the desired direction on both sub-scales. In four of the remaining cases there were changes in the desired direction on one sub-scale (anxiety) and no change on the depression sub-scale (P18- nine to nine, P29- seven to seven, P33- nine to nine, P37- nine to nine). Three of these were within the borderline abnormal range, whilst participant 29 scored within the normal range. Remarkably, only one participant (P34) recorded a score in the non-desired direction on the depression sub-scale, by two points, albeit both pre- and post-scores fell within the borderline abnormal range. Only one participant recorded in the normal range on pre-test in the depression scale (P29- seven to seven) and retained this level in the post-test. However, her scores were slightly higher in the pre-anxiety levels (P29- nine to eight) and reduced by one point in the post-test, both just inside the borderline abnormal

range. Whilst there were significant changes of reduction in the anxiety subscale overall, only nine were reduced to the normal range, leaving twenty in the borderline abnormal range and three just inside the clinical significance range.

On further examination of the results comparing the differences between the pre- and post-scores for each participant in both subscales, the scores appear to be comparable. For example: four participants showed no change in pre- and post-depression sub-scale and only a slight change in anxiety subscale scores (P18- difference two, P29- difference one, P33- difference two, P37 difference three, and P12- difference eight). Similarly, 26 participants scored in the clinical significance range in both sub-scales pre-programme.

2.21 Measures: Coping Skills Questionnaire (CSQ) (Roger, Jarvis & Najarian, 1993)

The desired direction of change for pre-programme is for scores on rational and detached coping to increase, and scores on emotional and avoidance coping to decrease. A repeated measures design was used to investigate differences of coping skills between time 1 and time 2.

Time 1: CSQ scale administered 1 day prior to the commencement of the programme.

Time 2: CSQ scale administered on the final day of the programme.

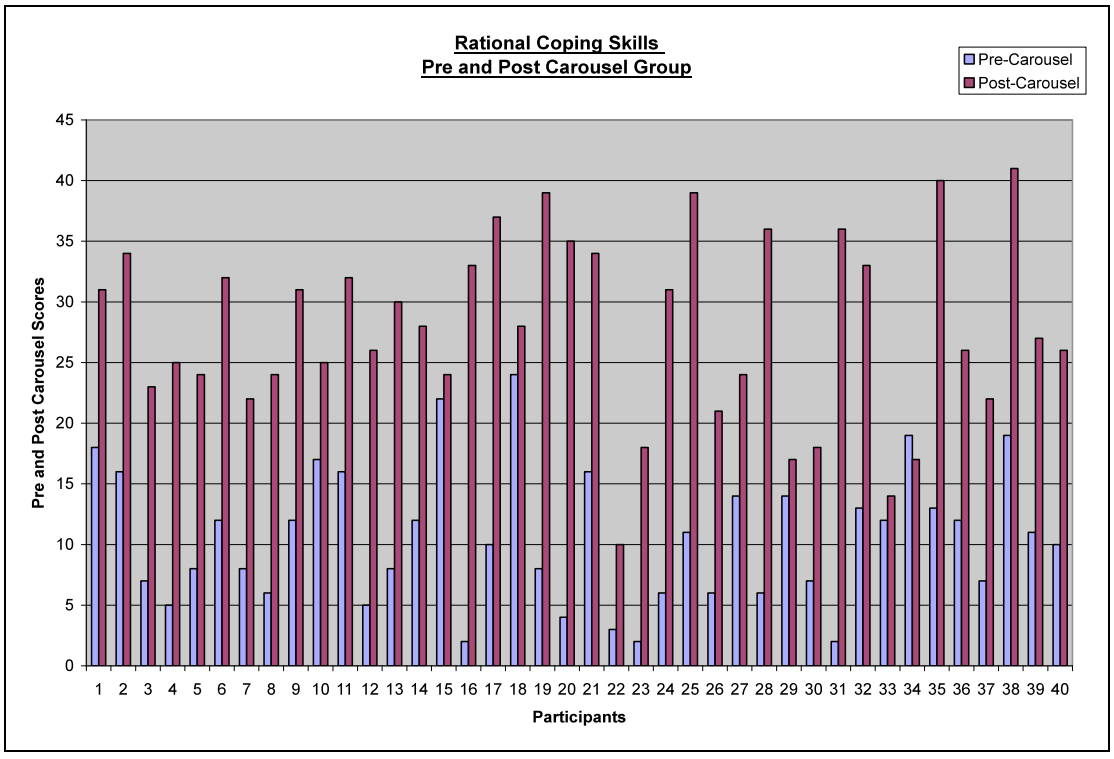
Paired *t*-tests show that from pre- to post-programme the women showed highly significant changes in coping style in the desired direction, as displayed in Table 6.

Table 6. Pre-post scores on CSQ

Coping Style	Pre- mean (st dev)	Post- mean (st dev)	*t*	*df*	*P* value
Rational	10.57 (5.58)	27.82 (7.51)	$t = 12.39$	39	$p<.001$
Detached	10.67 (4.74)	21.90 (6.36)	$t = 10.49$	39	$p<.001$
Emotional	33.05 (7.80)	14.95 (5.74)	$t = 11.50$	39	$p<.001$
Avoidance	21.32 (4.52)	15.25 (4.03)	$t = 7.31$	39	$p<.001$

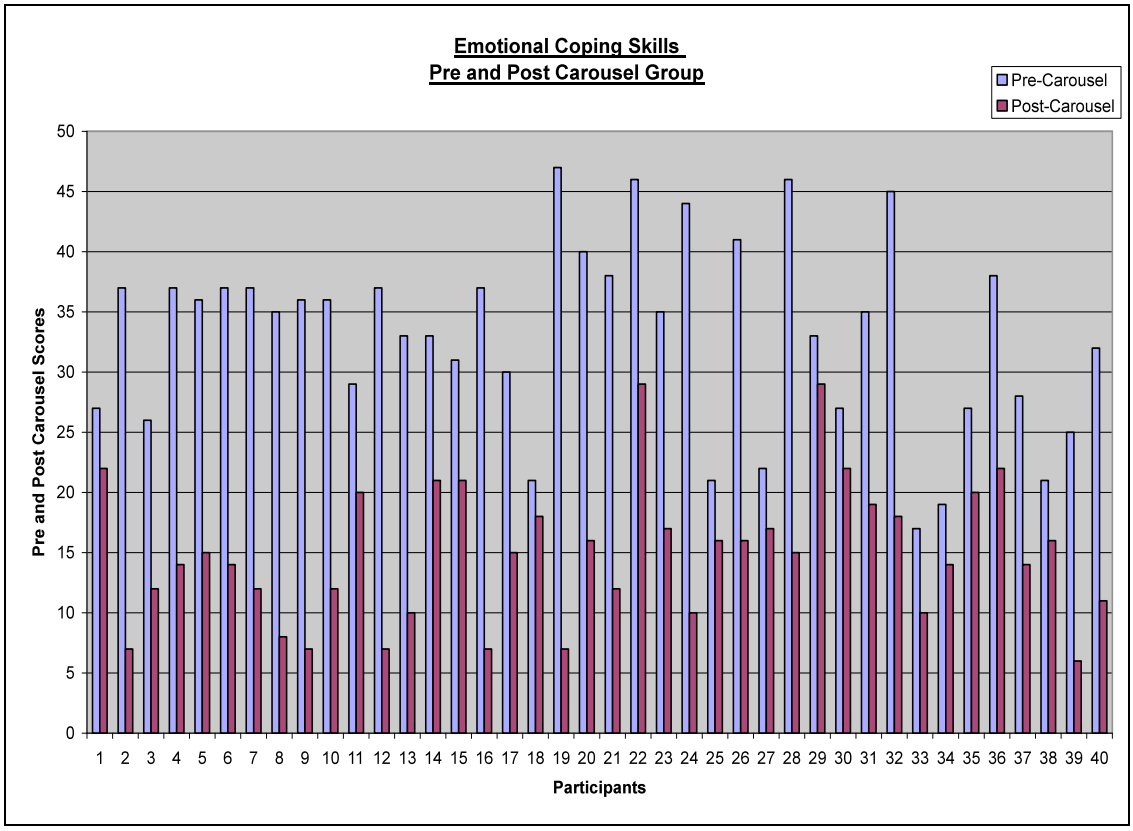
The results of the paired *t*-test show that, from pre- to post-programme, there were highly significant changes in reported coping styles in the desired direction, i.e. increases in the reported use of rational and detached coping methods, and decreases in reported use of emotion-focused and avoidance coping styles.

Figure 5. Illustrating the individual scores pre- and post-rational coping skills



As illustrated in Figure 5 thirty-nine participants showed a marked change (increase) in the desired direction on the rational coping scale, whilst only one showed a decrease (non-desired direction) in rational coping scale, by two points (P34- nineteen to seventeen). Remarkably only four participants showed slight improvements of 'difference' in scores of two points, four points, three points and two points respectively (P15- difference two, P18- difference four, P29- difference three, P33- difference two). Seven participants in total scored a 'difference' under ten points (P10- difference eight, P15- difference two, P18- difference four, P22- difference seven, P29- difference three, P33- difference two, P34- difference two). The more dramatic changes were from the remaining thirty-five participants. Nine of whom scored a difference of between twenty-five and thirty-one points (P16- difference thirty-one; P17- difference twenty-seven; P19- difference thirty-one; P20- difference thirty-one; P24- difference twenty-five; P25- difference twenty-eight; P28- difference thirty; P31- difference thirty-four; P35- difference twenty-seven).

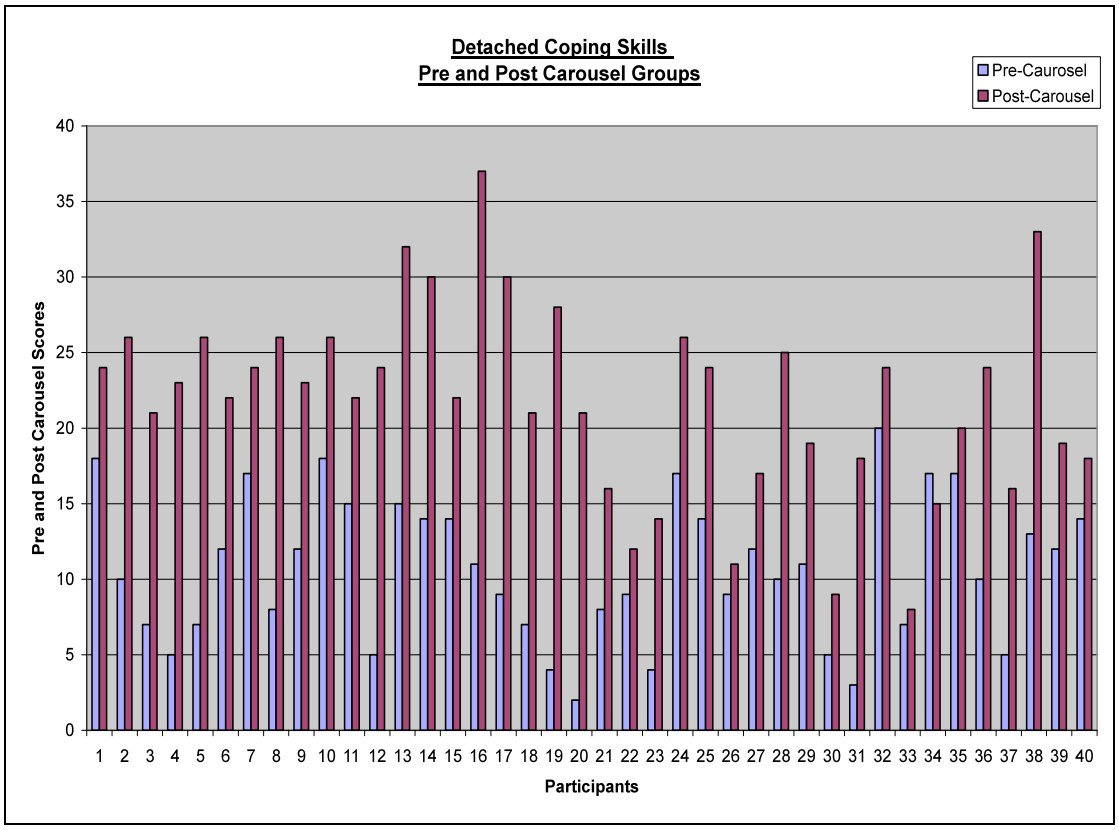
Figure 6. Illustrating the individual scores pre- and post-Emotional Coping Skills



As illustrated in Figure 6 all forty participants showed a marked change in the desired direction of emotional coping styles, i.e. showing a reduction. Only eleven participants had a difference of scores below ten (P1- difference five, P11- difference nine, P18- difference three, P25- difference five, P22- difference five, P29- difference four, P30- difference five, P33- difference seven, P35- difference seven, P34- difference five and P38- difference five). Whereas eleven participants scored a difference of between twenty-five and forty (P2- difference thirty, P7- difference twenty-five, P8- difference twenty-seven, P12- difference thirty, P16- difference thirty, P19- difference forty, P21- difference twenty-six, P24- difference thirty-four,

P26- difference twenty-five, P28- difference thirty-one and P32- difference twenty-seven).

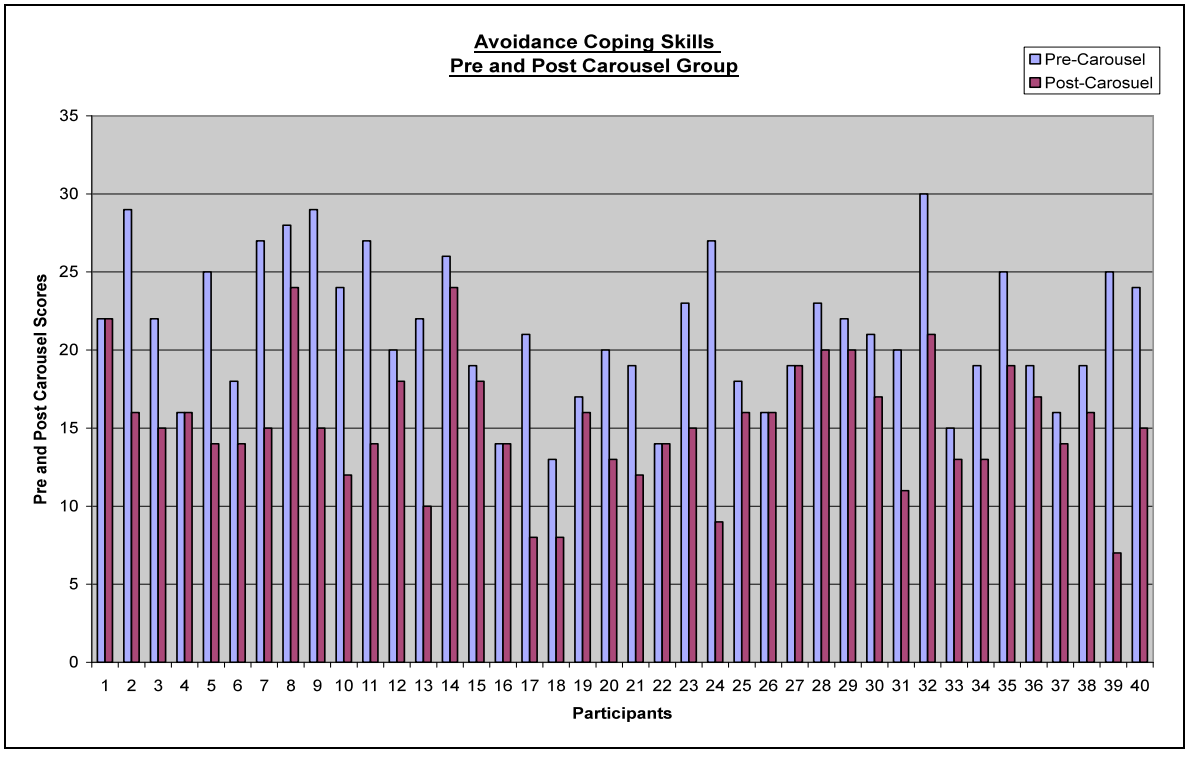
Figure 7. Illustrating the individual scores pre- and post-detached coping skills



As illustrated in Figure 7 thirty-nine participants showed a marked change in the desired direction (increase) of detached coping styles. Remarkably only one participant had a decrease in score in the opposite direction (P34- seventeen to fifteen difference two). It is interesting that participant 34 also scored in the opposite direction on the rational sub-scale, both sub-scales showing a difference of two points. There was only one participant that scored a difference of above twenty-five in this sub-scale which was participant 16 with a difference in scores of twenty-six points. (P16- eleven to thirty-seven, difference of twenty-six). However there were a

higher number of participants with a lower number of differences in the detached coping compared to the previous two sub-scales, showing 18 participants with a difference of below 10 points (P1- difference six, P7- difference seven, P10- difference eight, P11- difference seven, P15- difference eight, P21- difference eight, P22- difference three, P24- difference nine, P26- difference two, P27- difference five, P29- difference eight, P30- difference four, P32- difference four, P33- difference one, P34- difference two, P35- difference three, P39- difference seven and P40- difference four). On further examination of Figure 7 it is evident that in addition to smaller differences in pre- and post-scores there were some very low scores, suggesting that several participants had more difficulty in using a detached coping style. Thus, adding further support for prisoners finding difficulty in using a detached coping style (Gullone et al., 2000).

Figure 8. Illustrating the individual scores pre- and post-avoidance coping skills.



As illustrated in Figure 8 thirty-four participants showed a change in the desired direction of avoidance coping styles (decrease), albeit with narrower margins than the other three sub-sets; refer to Figures 5.1, 5.2. 5.3. Six of the participants made no change in either direction (P1- twenty-two and twenty-two, P4- sixteen and sixteen, P16- fourteen and fourteen, P22- fourteen and fourteen, P26- sixteen and sixteen and P-27 sixteen and sixteen). No participants scored a difference of over twenty-five in this subset.

Thirty participants showed a marked change in the desired directions of all four sub-scales. In thirty-three cases there were changes in the desired direction on all four sub-scales. In six of the remaining cases there were changes in the desired direction on three sub-scales (rational, emotional and detached) and no change on the avoidance sub-scale. Remarkably, only one participant (P34) recorded a score in the non-desired direction on two sub-scales: the rational sub-scale and the detached sub-scale both by a difference of two points (refer to Figures 5 and 7).

It is interesting that the same participant as illustrated in Figure 3 (depression sub-scale) (P34) recorded a score in the non-desired direction on the depression sub-scale by two points. Both her anxiety levels pre- and post- were just inside the borderline abnormal range (P34- nine and eight), and so was her depression scores (P34- eight and ten). It is important to note that participant 34 was a 'lifer' who had been transferred from another establishment specifically to take part in the Carousel programme for remand prisoners. She had already completed the DBT one-year programme. Participant 34 had a chaotic lifestyle, arguably more than others, which

supported her diagnosis of Borderline Personality Disorder with prolific self-harm tendencies. These self-harm behaviours included an attempt to gouge out one of her eyes for which no explanation was offered. In addition, participant 34 was one of seven participants with a diagnosis of Borderline Personality Disorder (These participants were P1, P2, P8, P21, P28, P34 & P39).

2.22 Summary of Results

The evaluation of Carousel scores show that, from pre- to post-programme, there were highly significant changes in the psychometric testing. All participants had a significant decrease in self-harm behaviour including some that stopped altogether. This had an impact on levels of self-harm figures within the establishment for the two years the programme was in operation. Whilst national figures continued to rise, 'Brookland's' figures decreased (refer to Table 7 below). 'Brookland' was 're-rolled' in 2006 (i.e. changed from being a female remand establishment to a male prison) consequently, for the purpose of this study the figures below solely reflect the time that Carousel was in operation at 'Brookland'.

Table 7. National Annual Self-Harm incidents for the Prison Service and for 'Brookland' (Safer Custody Group, Home Office, 2007).

Year	National	'Brookland'
2003	16,199	674
2004	19,285	475 *programme commenced July
2005	21,391	257
2006	23,355	252

The HADS testing showed a significant decrease in the anxiety and depression sub-scales. The CSQ testing showed a significant increase in the use of rational and

detached coping methods and decreases in the use of emotion-focused and avoidance coping styles. On close examination of the results there are exceptions that six participants made no change in either direction, whilst one made changes in the non-desired direction. A discussion will take place after the qualitative analysis.

PART TWO: QUALITATIVE ANALYSIS

2.23 Rationale for qualitative analysis data using Content Analysis (CA)

The National Institute for Clinical Excellence (NICE) guidelines (2004) on the short-term management of patients who self-harm, noted the limited evidence of effective self-harm interventions, and recommends qualitative research to explore patients' experiences of services. Glachen (1996) argues that there is a place for both qualitative and quantitative approaches in the endeavour to gain insight into human experience. In addition, qualitative interview data can be used to generate useful information about the effectiveness of therapy (Dale, Allen & Measor, 1998; Kuhnlein, 1999; McKenna & Todd, 1997; McLeod, 2001), and the effectiveness of interventions have been used for some time. McLeod (2001) states:

> "*As therapists, we do our best to help our clients to express their feelings, accept their desires and their agency ... mainstream of research-based writing about therapy is unreflexive, distanced, permeated by a scientific ideology that is neither appropriate nor satisfying"* (p 172).

Glachan (1996) argued that empirical work largely deals with that which is directly observable and fails to get below the surface to the actual human experience. Moreover Burman and Parker (1993) suggest that when using statistics to emphasise a "standpoint", it is important to be aware of "selective accountancy" being carried out to strengthen an argument (p. 28). Statistics can be used out of context, or be relative to other statistics but not necessarily portray a true reflection. They also argue that "facts" are not innocent, but are loaded with various meanings: *"they are like lenses through which things are seen"* (p. 28). They further advise that the analyst needs to be aware of the broader contextual concerns such as cultural trends and political and social issues to which the text alludes. Furthermore, McLeod (2001) suggests that quantitative analysis alone would not include accounts of how participants feel about the kind of therapy they have received, or what they have learned from participating in the study. Glachan (1996) argues that the qualitative argument is essential: *"don't let pre-selected measures determine the outcome, let individuals speak for themselves"* (p. 6). Glachan suggests that there is a case for both methods stating: *"Quantitative methodologies as well as qualitative approaches offer us a way of gaining insight into shared meanings and shared experiences"* (p.7). The discipline of counselling psychology encourages multiple viewpoints along with ways of understanding the human psyche and its ailments, focusing on both the objective in terms of theoretical approaches and the subjective with regards to individual perceptions and experiences.

Qualitative analysis has therefore been used in conjunction with quantitative analysis

within this study to not only provide an objective measurement of the effectiveness of the programme; but also to gain insight into the most helpful/unhelpful components from the view point of the participants.

2.24 Content Analysis

Wilson (1995) suggests that the first step in dealing with qualitative data is to establish a classification scheme. Content analysis is a method that is extremely flexible in its application. Krippendorff (1980) suggests that this is a *"technique that allows the researcher to utilise data without imposing too much structure on the subject"* (p.18). The aim is to *"extract units of meaning from the verbal data in a manner which permits the quantification of the material in terms of frequency of occurrence of certain categories"* (Pauli & Bray, 1996:19). There is no set recipe to carry out this analysis and Pauli and Bray suggest that it is the researcher who decides how to divide up the material in the manner most appropriate to the research question (1996). Content analysis is a coherent way of reading and organising the interview material in relation to specific research questions. These readings are organised under thematic headings in ways, which attempt to do justice both to the element of the research question and to the preoccupation of the interviewees (Banister, Burman, Parker, Taylor & Tindall, 1994).

2.25 Participants and Coding

The semi-structured interviews administered by the researcher lasted approximately thirty minutes using an open-ended question format (refer to appendix 13). Reliability

was enhanced by following a consistent line of questioning with all participants and a process of reiteration.[26] The data was subjected to qualitative content analysis as described by Breakwell, Hammond and Fife-Schaw (1998, 2000). Content analysis involves 'a mechanical and interpretative component'. The mechanical component involves physically organising the data into categories or themes. The interpretative aspect involves determining which categories are meaningful to the research topic and therefore which should be retained. The author initially coded recurring themes, which was followed by second level analysis to elicit further information on the categories and the relationships between them. A third stage involved an independent assessor who was experienced in working with self-harm in a clinical setting reviewed the allocation of data to theme headings. Following discussions between the researcher and assessor on two separate occasions, accordance was reached regarding the allocation of data to theme headings. This was to ensure that the data was not entirely subjective, and open to interpretation (Wilson, 1995). The questions used for analysis were the ones from cluster one below[27]. Due to the word length restriction, only the salient questions that were pertinent to the research question were used for analysis (full set of questions refer to appendix 13).

[26] Tape recordings were prohibited due to prison regulations; therefore the researcher manually transcribed participant responses.

[27] For the purpose of this study the first three questions were used from cluster one to be more meaningful to the research question (Pauli & Bray, 1996).

Table 8. Cluster One: Observations and benefits about the group and individual sessions and topics.

Questions
Do you feel that you benefited from the Carousel Programme?
Are there any sessions or topics covered by the programme, which you found particularly helpful? If so what were they?
Are there any sessions or topics covered by the programme, which you did not find particularly helpful? If so what were they?

2.26 Results

As stated above all participants who completed the Carousel programme (n – 40) expressed that they had benefited from the programme with forty positive responses to sessions and ten negative responses to the sessions as shown in Table 9 below.

Table 9. Observing Benefits. The Number of participants who reported that they had benefited from the programme and the frequency of positive/negative responses that emerged from the data.

Category	Frequency
Benefited from group	40
Positive responses to sessions.	40
Negative/responses to the sessions	10

The content analysis revealed sixteen primary categories of helpful sessions and topics as illustrated in Table 10.

Table 10. Primary Categories that emerged from Cluster one, question 2: Are there any sessions or topics covered by the group, which you found particularly helpful, if so what are they?

Primary Categories **Helpful Sessions/Topics**	**Frequency**
Coping strategies	40
Management of self-harm including drugs and alcohol	32
Antecedent, Behaviour and Consequences session	32
The brain/understanding the emotion	32
Gym	30
Support	25
Achievements	22
'Core beliefs'	10
Protective Factors	10
Therapeutic art	18
Networks/support outside	12
Group discussion	10
Facilitators as a factor	10
Being believed/acceptance	4
Freedom of expression	2
Offending behaviour	2

The Second stage analysis explores the content within these themes.

Table 11. Breakdown of Most Common Themes (most participants entered more than one category).

Primary Categories/themes	Frequency	Percentage of Primary Category (Coping Strategies)
Coping Strategies	**40**	
Journal: reading, writing & drawing	40	100
Happy box	34	85
Exercise	34	85
ABC	31	77.5
7/11 Breathing	32	80
Individual therapy	27	67.5
Cleaning	24	60
Listened to Music	23	57.5
Dance	2	5
Relaxation	21	52.5
Punched Pillow	21	52.5
Elastic Band	12	30
Wrote letter	7	17.5
Plucked hair	6	15
Walked away	5	12.5
Competition	7	17.5
Karaoke	2	5
Cartoon face	3	7.5
Budgie	1	2.5
Bath and/or shower	25	62.5
Crying	1	2.5
Prescribed Medication	7	17.5
Help seeking and treatment	**40**	
Positive attitudes towards therapy	40	100
Asking for help	4	10
Disclosure	2	5
Support	**37**	

Talked to friend	36	97.3
Talked to Officers	29	78.4
Individual therapy	25	67.6
Group therapy	24	64.9
From each other	21	56.8
Management of Self-harm	**32**	
Drugs & Alcohol Awareness	26	81.3
GYM - Exercise	**30**	
Gym - exercise	29	96.7
Exercise in cell	8	26.7
Basketball	8	26.7
Netball	3	10
Football	7	23.3
Long Walks	1	3.3
Categories/themes	**Frequency**	**Percentage of Primary Category**
Facilitators	**29**	
Believed	22	75.9
They motivated me/us	19	65.5
Enthusiasm	18	62.1
Safe-Freedom of Expression	17	58.6
Express emotion anger	17	58.6
Not Judged	6	20.7
Chocolate cake	4	13.8
Therapeutic art	**18**	
Happy Box	16	88.9
Colouring	12	66.7
Making photo-frames for photos	5	27.8
Making cards	2	11.1
Core-beliefs	**14**	
Reminded myself that I'm not a bad person	6	42.9
I'm not to blame/its not my fault	4	28.6
I'm unlovable	2	14.3
Rotten through and through	1	7.1
I'm bad	1	7.1

Protective Factors	**10**	
I can protect myself from him	5	50
How to protect myself from me – know my trigger points	5	50
Networks	**9**	
What to do on the 'out'	4	44.4
Offending behaviour	9	100

Table 12. From cluster one, the question: Are there any sessions or topics covered by the group which you did not find particularly helpful?

Primary Categories	Frequency
Gym - Exercise	8
Therapeutic art	2

Table 13. Breakdown of Most Common Themes regarded as unhelpful (one participant entered more than one category).

Categories/themes	Frequency	Percentage of Primary Category
Gym - Exercise	**8**	
Netball	2	25.5
Lifting weights	6	75
Football	1	37.5
Therapeutic art	**2**	
Painting	1	50
Making things	1	50

2.27 Discussion of Key Themes

A strong emphasis on the perceived benefits of identifying and developing alternative ways of coping was the highest key theme that emerged from the post-interviews: *"I go through my 100 coping strategies; one of them is bound to work"* (P1). Night-time during lock-up periods was a key time when the women found the coping strategies most useful: *"I have 128 coping strategies the first few are the ones that work the most, but if I have a really bad night then I will work through them all if I have to. I haven't cut up since the second week of the group"* (P17). Another stated: *"I felt so bad so I tried the coping strategies. I went through about a dozen in an hour but at least it got me through"* (P26). One participant had 8 coping strategies and said *"One night I felt so bad and I wrote my coping strategies on a piece of paper and stuck them to my door, they worked; I didn't cut up!"* (P2). Treen's happy boxes were also a key coping strategy that emerged for thirty-four of the clients all noting variations of *"When I was down and nothing else worked, particularly when the lights are out, I would open the happy box and get everything out that makes me feel good"* (P17). *"I keep my photos in my box, when I feel like self-harming I get them out"* (P26).

Strategies included drawing or colouring, listening to music, writing thoughts and feelings down in a journal or notebook: *"I've had the idea of a happy book, like a scrapbook, you put in poems, memories and pictures. When I feel down I can pick something out of the book"* (P27). One participant reported using dance as a coping strategy: *"I dance to cope, if you can call it dancing. I used to hate f**king*

*dancing, but now it is number two on my list of coping strategies. The screws thought I was f**king mad bopping up and down in my room, but do you know what? I don't give a 'monkeys arse'; I would rather do that than cut up!"* (P13). Another reported initial mixed feelings about coping strategies, *"I used to think this coping strategy lark was stupid, but I now have 110 that I use if I have to, and you know what? One of them will work"* (P23).

The journal proved to be an important element to the programme. Participant (P14) noted *"Writing down my reasons for wanting to self-harm helped me reflect my thoughts and feelings and it 'got rid' of the urge to self-harm".* Whilst participant 37 noted *"It helped to get rid of my anger, I reflected on how I would feel later after I had cut. I based this on how I have felt in the past".* Participant 16 stated *"I always write down how I feel, it's my first port of call when the lights go out".* Similarly participant 36 noted, *"Night time was the worst, it's when everything at once seems to go through my mind. The journal really helps, I can get it all down on paper and it helps me to think straight. What's more, I can't get into trouble about what I write".* Participant 15 saw it as a method of problem solving: *"I write down how I feel, what I think I should do, and then how I would feel afterward".*

The competition element to the programme was also considered useful: Participant 20 noted *"I won the competition one week for having the most coping strategies; I have never won anything ever in my life before. It sort of gave me a reason to go on and I felt that I had achieved something. I got given a box of*

'Maltesers'. I could have eaten them all to myself, but shared them with the rest of the group, I felt so good! This may sound daft but I kept the box as a souvenir. I decorated it in our art group and I now put my pens and crayons in it". Participant 7 won the competition for the most original coping strategy for the week and stated *"I hated the fact that we are locked in our rooms whenever the officers feel like it. So I now tell them when I want to be locked in my room, usually five minutes before lock up time. I won the competition for asking the officers to lock me in my room, as my coping method, it was great".*

Perceived improvements in their ability to manage both self-harm and aggression towards others: *"I haven't hurt myself or beaten anyone up as I did before"* (P21). *"I used to switch on a self-destruct button – now I can switch it off"* (P22). *"Before I would have sworn, cut up, lost my temper. Now I can let it go over my head"* (P18). *"I was always in trouble and locked behind my door, I have spent a life time down the block![28] But now I think before my mouth gets me into trouble, and I haven't kicked off for weeks"* (P2). *"Last time I was in, I hit one of the 'screws' - but he did wind me up, now I don't let them get to me, well not so much. It's normally them or me, but I haven't self-harmed since I came on this group"* (P26).

Reports of increased readiness to talk, disclosed feelings, and asking for help: *"I've never asked for help before, find it so much easier now"* (P30). *"Before,*

[28] Block is a term often used by prisoners to describe the Segregation Unit in the Prisons. This is a special unit used to house prisoners that cause disruptive behaviour, violence and at times used as an overflow for prisoners needing extra support due to their challenging and/or self-injurious/parasuicidal behaviour.

whenever I spoke about feelings it just came out as anger or aggression. Now I've learned to open up, walk away from the situation, think about nice things instead" (P39). *"I was always afraid to talk about things before, as it was always a secret, I was afraid that something bad would happen to me or my family, but I was more worried about my mum and dad, oh and my little sister. But for the first time in my life I know that not all people are bad, and I feel safe"* (P24).

For some women disclosure brought benefits in terms of increased acceptance and reduced self-blame: *"I've realised that things are not my fault … they don't judge me, don't push me…it's clever how they got me to talk"* (P34). *"I used to think I was a really bad person, and no-one would ever want me: I was unlovable, now I know that I am OK and 'I'm not to blame"* (P33). Another participant said, *"I was always told I was a bad girl and I believed it. I may have done some bad things in my life, but I have also done some good, I look on life so differently now"* (P40). *"I don't need to punish myself anymore"* (P4). *"I thought I was the bad one, but I'm not". "When I think of all the years wasted, thinking it was my fault* – (pause) *it makes me sick!"* (P10). *"The past is the past and I can't change it, but I don't have to hurt myself any more". "When I realised that he can't hurt me no more, was when I stopped cutting"* (P3).

The perceived importance of support from staff and group members: *"Staff help – I knew she* (tutor) *would be there if I need her"* (P1). *"The teacher talked to you as well. She's a good listener, doesn't judge you"* (P23). *"It was good listening to others*

and what they do to try and stop hurting themselves. During association, we try and get together and that has really helped, we understand each other" (P5). *"Even the 'Screws'*[29] *are better in this jail – Miss* (officer) *has been very helpful, I like it when she's on, 'cos' I can talk to her and she doesn't look down on me"* (P31). *"I used to think that Mr. *** was a bag of sh*t but he's really helped me"* (P8). *"People really care here, even the governor does"* (P20). *"Knowing I'm not the only ones that's been through crap helps, we all help each other"* (P32).

Positive responses to the art and music sessions, both for the 'fun' involved, and as an opportunity to express emotions, particularly anger: *"We did karaoke – it was brilliant, funny; we always come out smiling"* (P12). *"Sculpting faces ... gets your aggression out"* (P35). Whereas participant 3 stated *"I like making the happy boxes, and I always open mine when I feel like cutting; it's the third thing on my list of coping strategies. The first is breathing; doing the 7/11*[30]*, the next is punching my pillow"*. For participant 6, Art brought mixed emotions, on the one hand she looked forward to the art, and on the other, it was followed by a weekend of fewer activities, more lock-up time, and more time to think*: "Therapeutic art was the best it was fun. I can't wait for Fridays for art, then dread the weekend, too much 'lock up', I hate it. When I am behind my door I have too much time to think of the past"*.

[29] 'Screw' is a term prisoners sometimes used to describe a 'Prison Officer'.

[30] This involves breathing in slowly for a count of 7 and breathing out for a count of 11. It does two things, firstly slows the heart rate down to assist relaxation and secondly, acts as a distraction. This is also particularly good with panic attacks. All participants referred to this as the 7/11 technique.

Attitudes to gym and exercise were more mixed, although some realized the benefits: *"It helps with my aggression, doing weights ... I do press-ups in my cell".* (P24). *"When we played basket ball I ran into a wall ... so I stayed away! I've got certificates from the gym ... It's given me insight into options"* (P9). *"I hated exercise in the past, you could say I was lazy – I suppose I was, but now I can't get enough of it, it's like a drug, you know you get hooked, but unlike drugs, it doesn't cost money!"* (P29). Participant 36 referred to the benefits of the exercise in the gym and noted *"Look at me! I have lost loads of weight and feel so much better about myself".*

Several women reported changes in their attitudes to others and to themselves: *"I found I learnt to pick up on things from other people – I learnt not to write them off"* (P19). *"A couple of others say they see me as a tower of strength in the group ... that's nice"* (P5). *"I used to be one of the nastiest people in jail but now I've been told by Miss ****[31] that I have mellowed, and I have ... I've changed so much"* (P26). *"I actually like myself now"* (P10). *"I know I had a bad attitude and used to blame others for everything I did, I think I still have things to learn but I don't kick off like I used to"* (P11). For one participant she saw Carousel as having changed her life, partly from her own attitude to the world and stated: *"Thank God for Carousel!"* (P27).

[31] In accordance with the British Psychological Society's Code of Ethics (1993, 2006) the appropriate confidentiality measures have been taken; any personal identifiable information (i.e. names, places and so on) have been changed; therefore a pseudonym of 'Brookland' has been given to the establishment.

Some of these women attributed the change to protective factors. *"I now think before I go into anything, I never even thought about protecting myself from myself, let alone him"* (P22). Whilst another said: *"'Protect' has become my buzz word".*

Positive responses to offending behaviour were a consistent theme with several of the women. *"That's it! I have decided that this time I am not coming back into prison. I now know that my drug habits got me into trouble; I get a better high after one hour in the gym than I did on 'Crack', and it lasts longer! I believe I can cope on the outside"* (P29). Peer pressure was a problem for many women: *"I am going to live in Brighton with my grandmother; she could not believe how I have changed. If I'm not around my old friends I won't be tempted!"* (P38). *"I always said I was not coming back to prison, now I know I won't. I know it's not going to be easy, but I am really going to try"* (P25). *"It was the pain that got me into trouble. Now I cope better and I am clean. I will try to keep away from drugs"* (P22). *"Alcohol was my thing: I only ever stole when I was drunk, now I don't need to drink anymore"* (P21). Another reported (P29), *"It was the drugs that got me into trouble, I took crack, then I stole for me next shot. Why should I waste my life in jail, sod my friends, I am going to live with my mum in Kent, no one knows me there, I will have a fresh start, even my old fag of a boyfriend can't get me there".*

Core-beliefs also emerged as a theme, with 'unlovable', 'bad' person with self-blame, linked to sexual abuse being prominent throughout. One participant stated she had believed that it was her *"fault"* that she was abused, and saying: *"I always*

believed that I was a bad person, now I know that I'm not, and I did not deserve that treatment" (P26). Participant (25) said it *"... was a big thing realising that it's not my fault".* Another stated (P4) that she believed that she was *"... rotten through and through and deserved to be punished"* because she "*was very bad."* Another said she *"was unlovable"* (P10). Whilst participant 32 said, *"I'm to blame, it's all my fault".*

Providing informal support to each other was one of the main messages listed in the questionnaire. Comments such as: "*it was so good to be amongst others who self-harmed, who supported us when we were new to the group"* (P15). Another (P32) reported, "*I was worried about coming in to the group but meeting others that were in the same boat and who were able to help me, made me feel better. I realised that I was not alone, and for once in my life I was able to express how I felt in a safe environment without feeling that I was stupid and alone*" (P33).

Some women reported aspects of the programme, which they found unhelpful: One participant (16) rejected participation in both exercise and therapeutic art stating that she was *"unable to concentrate for long-periods".* Another (P8) claimed to be *"uncreative"* and that therapeutic art was *"not my thing".* Participants also reported disliking having to access the gym *"I would go if I could say when I wanted to go, what I wanted to do and for how long"* (P11).

Discussion

2.28 Quantitative and Qualitative Data

The current findings suggest that Carousel is an effective programme assisting females who self-harm in a remand setting, to reduce their self-harming behaviour. The repeated measures design was used to investigate differences in levels of self-harm, levels of depression and anxiety and the changes of coping styles between time one and time two. Statistical analysis using a paired *t*-test indicates that from pre- to post- programme the women showed a highly significant reduction in self-harm levels, depression and anxiety levels and the changes of coping styles in the desired direction. The findings in the pre-testing also support previous research that prisoners who self-harm are more likely to use emotion-focused and avoidance-focused styles of coping (Gullone, Jones, & Cummins, 2000; Livingston, 1994; 1998; Slade & Gilchrist, 2005).

However, as noted in the results section participant 34 stated that she had benefited from the programme, but remarkably was the only participant to have recorded a score in the non-desired direction on three sub-scales: the detached and rational coping style sub-scales and the depression sub-scale (difference of two points on each). However, the anxiety sub-scale did reduce albeit by one point, and remained within the borderline abnormal range. Nevertheless the emotional coping style sub-scale showed a more positive outcome with a reduction of five points. Similarly, her self-harming levels reduced dramatically from fifty-seven to sixteen incidents. This could be due to a number of factors, for example a significant realisation for

Participant 34 was the insight that the experiences she had encountered in the past *"were not [her] fault"*. She had felt that she was *"to blame and deserved to be punished,"* which is a typical response from 'abuse sufferers' (Rose, 2008). This included core beliefs of *"being bad"* and *"unlovable"*. Thirty-nine of the participants were all survivors of singular or multiple abuse with many reporting similar responses. Carousel had provided a platform and *"safe place"* from which they could 'explore' without feelings of *"being judged"* or *"pushed"*. This resulted in an increased readiness to talk, including personal disclosures, asking for help and a willingness to explore.

This is a strength of Carousel, using the humanistic paradigm as part of the theoretical framework to get alongside the client (Beck et al., 1979), using Rogers' (1957) core conditions; being non-judgmental and using a person centred approach to enable the participant to feel comfortable to begin trust and work at a deeper level (Mearns & Thorne, 2001); thus Participant 34 (among others) was able to 'open up' ... *"it's clever how they got me to talk"*. Also stating it *"takes time to trust"*. Once this had occurred participants felt more able to tolerate and accept change, which prepared the way for cognitive behaviour therapy. Consequently it became more effective in assisting the exploration on how to accept what has happened. This included learning to understand the processes – how and where they are in 'the moment' – and learn skills to bring about change in thoughts, emotions and behaviours, all of which help to reduce stress (Eccleston & Scorbello, 2002; Linehan, 1993a, 1993b). This included

learning how to respond to negative responses from 'self' and 'others' that had arisen from various factors including stigmatisation (refer to introduction).

These techniques are similar to DBT in focussing on the interrelatedness of skills deficits learning and using multi-skills simultaneously that Eccleston and Scorbello (2002) noted are particularly important with offenders who are also learning to adapt to a restricted environment. This includes losses, which in many cases involved taking away their main coping strategy of 'self-harm'. Therefore self-regulation skills together with skills to manage the environment for these participants have shown to be beneficial. Each participant in post interview reported changes in their thinking and behaviour, which included better management of their self-harm, as evidenced in the significant results. They attribute these changes to the participation and completion of the Carousel programme therefore adding support to the research of Connors (1996a,b), O'Connor et al. (1999), O'Connor, Sheehy (2000) and Yule, Williams and Joseph (1999) who promote CBT as an effective treatment for self-harm. In addition it is a tool to aid reduction of depression and anxiety levels (Borkovec, Ruscio, Ballenger, Wittchen, Nutt, Stein & Lecrubier, 2001). This is also effective with those diagnosed with Borderline Personality Disorder (BPD) or traits of BPD, who characteristically lead a chaotic lifestyle. This includes negative self-perceptions and a prolonged history of para-suicidal and suicidal ideation behaviours. According to the Diagnostic Statistical Manual (DSM-IV-TR) (American Psychiatric Association, 1994), a diagnosis of BPD entails fulfilling five out of the nine criteria (refer to appendix 18 for full diagnostic criteria). Disproportionately many 'self-

harmers' receive this diagnosis without full exploration as to the rationale of their self-harm behaviour and lived experiences (Munday, 2008).

It is interesting to note that only seven participants were diagnosed with BPD prior to commencing the programme. Nevertheless, with the exception of participant 34, there were no significant differences in their test results worthy of a separate note. It is interesting to note that participant 34 had stated in the post-testing interview that Carousel had reinforced some of the learning that she had done in the DBT group, but felt that it was *"less aggressive and more practical"*.

However, as already noted CBT has not worked in isolation during this programme and its strength derives from the multifaceted approach using humanistic (as noted above) and personal construct psychotherapy. In addition to therapeutic art, regular exercise and individual counselling sessions (refer to appendix 22 for timetable).

The personal construct psychotherapy element provides some support for Winter et al's. (2007) study showing a reduction in self-harm and depression levels. Protective factors were a component that was found particularly helpful by participants of both studies. This is imperative for survivors of sexual abuse who do not intrinsically have the ability to 'protect' and have rarely been taught the skills due to inadequate parenting (thirty-nine Carousel participants disclosed abuse). Therefore learning how to protect themselves from the world, from themselves and others was a vital ingredient to the 'tool box' of skills that the Carousel programme was assisting them

to build. This also involved exploring their constructions of the world, which for 'self-harmers', constantly shift (otherwise known as loose construing) (Kelly, 1955; Winter et al., 2007). For many participants 'cutting' previously brought some stability into an otherwise anxious life construed as unpredictable (Fransella, 1970; Winter et al., 2007).

Women remand prisoners have numerous factors exacerbating the unpredictability including unknown quantities such as a possible prison sentence. For example, first timers in prison experience unfamiliarity that amplifies anxiety;[32] their only knowledge of prisons may be through media coverage via television programmes such as 'Bad Girls.' Whereas, for prisoners who have experienced previous incarcerations, their unpredictability relates to the unfamiliarity of different establishments, officers, and prejudice together with the knowledge that self-harming is discouraged in HM Prisons. All of these factors intensify their already anxious state supported by the view of personal construct theory that correlates anxiety with unpredictability. These indicators can lead to potential increases in self-harming forming a vicious cycle that is extremely difficult to break and change. Therefore, exploration of their personal constructs (how they see the world, how the world sees them and their protective factors) assisted the participants to make the appropriate and well-informed adjustments to their construing. This collectively with other learnt skills (using multi-skills simultaneously together with self-regulation skills) had a

[32] Moreover, the most crucial factors with regards to suicide risk for prisoners are: first time in prison, first week on remand, plus a history of self-harm/suicidal ideation (Towl, Snow & McHugh, 2000).

major impact on the results, it helped to stabilise the perception of 'self' and their environment.

Post interviews with participants suggest that they benefited from the combination of approaches within the programme: group therapy, peer group support, one-to-one counselling (to deal with underlying problems and traumatic memories) and activities (to facilitate emotional expression, enhance well being and increase self-esteem). Although some participants found the exercise less helpful the majority found they had benefited from the 'feel good factor', which many referred to as the release of 'happy hormones'. Exploration using psycho-education as a tool in the programme was a key factor to the success of Carousel. The participants increased understanding and knowledge of themselves, including their biological make-up and effects of past events helped to empower them to make changes. Then by teaching how to adapt and utilise different skills (matching appropriately) in different situations, including how to deal with intense emotions deriving from flashbacks, triggers, nightmares and negative responses, which are exacerbated further by imprisonment, brings about the necessary change with the aid of cognitive restructuring and contingency management (Kaplan et al., 1995 cited in Stallard 2002:1; Scott & Dryden, 1996).

In addition, through skills training the participants viewed 'others' (wing officers and staff) differently from their previous perceptions. Moreover, feedback from participants emphasised the value of having access to support from tutors, wing staff and peers between sessions and in moments of crisis. Utilising some of these methods

including the 'happy boxes' at lock-up time helped to reduce the stress at what is considered a particularly vulnerable time when self-harm incidents normally increase (Coughlan, 2006). The programme also appeared to have had a positive impact on the participants' attitude towards future offending behaviour, several commented during the interviews, on how they were going to do things differently as a result of the strategies they had been taught on Carousel.

Furthermore participants demonstrated continuous and significant improvements in coping styles throughout and upon completion of the programme. This is consistent with the findings of the qualitative data, where emergent key themes of benefit with the sessions focussing on coping skills. All participants reported this component as being beneficial with each making reference to it at least once. On reflection these findings are not surprising as 'coping skills' were discussed and reinforced in each group and individual therapy session. For many 'self-harmers', cutting is either their primary or only coping strategy used to overcome emotional distress (Arnold, 1995; Ross & McKay, 1979; Walsh & Rosen, 1988). This is a maladaptive coping style, often developed as a result of trauma, involving intense emotion. Fivush et al. (2003) cite Lazarus and Folkman (1984) who argue:

> *"It is the perception of whether and to what extent an event is stressful that is critical for coping and well-being. For an event that has already occurred, how it is remembered will not only reflect back upon prior coping and influence future coping with that specific stress event…" (p.190).*

Fivush and McDermott-Sales (2006) add that as a result they are providing a template for the future. Through the Carousel programme the participants learnt adaptive problem-solving coping styles, which were reinforced at every opportunity. Lazarus and Folkman (1991) state: "*Problem solving is employed as an aim to alter the situation or factor that is causing the stress or demand and emotion focused strategies are employed in order to affect the individual's response to the stressor or demand"* (p.190). Thus it becomes *"realistic and flexible thoughts and acts that solve problems and thereby reduce stress" (p.190).*

It would be difficult; in fact impossible to highlight any individual factor of the programme that would have contributed more to its success. It appears that the combination of many elements including the three theoretical approaches, each play an important role as succinctly quoted in the Gestalt theory (originally stated by Aristotle) (cited in WikiAnswers, 2010):

"*The whole is the sum of many parts"*

2.29 Counselling Psychology and Clinical implications

Counselling psychology has played a major role in the innovative programme and shown to be effective in reducing self-harm in one of the busy female remand prisons. The Carousel programme was originally designed by Rose (Chartered Counselling Psychologist) authored by Rose and Pope (Rose, 2004) who also implemented and co-facilitated the programme. Counselling psychologists within the prison service have increased in numbers in the last three years bringing with them

the type of therapeutic skills that recognise the contextual embeddedness of human lives (McLeod, 2001). Counselling psychology is in the unique position to be able to view the therapy in the whole context of the client (Duffy, 1990), a need that is pertinent to the chaotic life of the female self-harmer (Rose, 2008). In addition, the counselling psychology training includes a variety of different therapies, enabling the psychologist to effectively utilise the evidence based methodological approaches in the Carousel programme.

The findings of this study have implications for the assessment and treatment of those who self-harm. In terms of assessment, coping styles deficits and increased depression and anxiety may be useful in assessing the risk for self-harm and suicide attempts, however coping skills ability may not be useful in assessing lethality or intent. With regard to treatment, coping skills training together with problem solving would be beneficial for 'self-harmers' and suicide attempters both in forensic settings and in psychiatric hospitals. Problem solving-skills training have proved to be an effective intervention with depressed adults (Nezu, 1986) in addition to 'self-harmers' (Linehan, 1993b).

Implementing Carousel has reinforced the researcher's belief that specialised multi-component programmes are advantageous since they allow vulnerable prisoners time to consolidate concepts, initiate behaviour change, and gain life long skills and coping strategies. This is particularly relevant to prisoners who self-harm in remand settings, many of whom have chaotic family histories which is pertinent to their current chaotic life styles of self-harming and imprisonment. The findings of the

Carousel programme have highlighted a further need for counselling psychology within the prison system (Rose, 2008) where counselling psychologists are able to utilise the depth of skills acquired in their training. In addition to working at multi-levels with complex client groups, within group and individual sessions, it would include evidence-based research. The advancement of self-harm research as a counselling psychologist is an area that is important for further development of counselling psychology.

2.30 Limitations and Recommendations for Future Research

There are several limitations to this study. A control group was not used as previously discussed (refer to page 63 ethical guidelines for a detailed explanation). It was recognised by the researcher that this would be a limitation to the study. Moreover, Goldstein and Ford (2002) argued that a control group should be used to *"eliminate the possibility of other explanations for the changes between pre-test and post-test scores"* (p. 182). Furthermore, a control group assists in the process of determining if the content of the programme is responsible for the changes or other factors (Goldstein & Ford, 2002). However, for the purpose of the current research it is argued that the ethical reasons for not having a control group far outweighs the reasons above. For example, it would have been necessary to either exclude a group of women completely from taking part in the programme to form a control group, or to delay them from entering the programme in the hope that they would not be moved prior to commencing the programme. Furthermore, to exclude women from a service that they would benefit from would not be acting in the best interests of the women

(beneficence). For these reasons a control group was not used for the purpose of this study. Previous studies have also not used a control group (Eccleston & Sorbello, 2002; Milligan & Andrews, 2005).

However, to strengthen the credibility of the Carousel programme, a comparative evaluation using a waiting list control group in a more static environment (sentenced prisoners) could be utilised to determine how much of the improvement in coping and self-harm, can be attributed to Carousel and how much to other static or dynamic factors. Further research in a larger establishment is recommended to include a controlled trial where the remand population was not under such a rapid change. Nevertheless, this would still need to be considered with great care due to the risk of severe self-harm and suicide. This would be in addition to the ethical issues involving someone needing treatment whilst in a control group, particularly if there was a serious incident whilst someone was on a waiting list. In addition there needs to be some assessment of whether there was a kind of 'Hawthorne' effect, where it might be the mere fact of 'being attended to' that brought about the changes, not the nature of the intervention itself.

A further limitation was the recording of self-harm incidents in the pre-testing. Primarily they were taken from the prison service Incident Reporting System[33] (IRS) when possible (as outlined earlier in this report); and some of this data relied on self-report. Anastai and Urbina (1997) argue that self-report inventories are especially

[33] Self-harm is recognised as a high volume incident with all information on the frequency and nature of the occurrences being supplied by the prison service Incident Reporting System (IRS).

subject to the possibility of deliberate misrepresentation. The IRS system and accuracy is sometimes subject to technical and recording problems. This system was only introduced in 1999 (HMP PSO 1500), but nevertheless does provide a reasonable indication of the scale of self-harm, although numbers should be regarded with a degree of caution and not treated as definitive. It is also important to be mindful that despite reporting methods improving, a proportion of incidents remain unreported. This was evident in the current study, for example participant 4 was known to engage in self-harm although the true extent was undetermined. Through accessing the Carousel Programme she disclosed that she had habitually 'cut' her genital area almost on a daily basis. This is in direct contrast to the sixteen reports (approximately two per week) of visible abrasions on her arms that were recorded on the IRS during the eight-week period prior to commencing Carousel.

Reliability was enhanced by following a consistent line of questioning with all participants and a process of reiteration. However, this does not prevent the possible demand characteristics that may arise from an end-of-therapy questionnaire, which invites particular answers. It could therefore be argued that the interviews conducted at the end of the programme could produce a bias, which would contaminate the results in favour of the researcher's perceived expectations (Munday, 2008).

The researcher was also co-author of the Carousel Programme as well as a facilitator; therefore it could be a limiting factor in such research where the process of evaluation may be subjective and therefore vulnerable to a certain level of bias regardless of

carefully implemented precautions. Furthermore, coding procedures within the content analysis: despite the careful and consistent procedures including a second assessor, are likely to be subject to a certain amount of inevitable bias in the coding process. However, combining qualitative and quantitative methods within the current study strengthens the research design resulting in more valid and reliable findings (Burman & Parker, 1993; Glachan, 1996; Perone & Tucker, 2003). In addition, Sells, Smith and Sprenkle (1995) note *"qualitative and quantitative methods build upon each other offering information that neither could provide alone"* (p. 203).

The women in this study had long histories of self-harm and many had complex personal and social problems. Therefore the consistency of change in coping styles in the desired direction is impressive, but in the absence of follow-up data it is not possible to interpret this as indicating lasting cognitive change. Further research is required to address this. Follow-up monitoring was attempted on transfer, however due to sudden release and multi-transfers, in addition to the monitoring differences within establishments, it proved impossible to manage. Anecdotal evidence was received from prisoners who had heard good reports from previous participants who had left the establishment. In addition to a few prisoners who had returned to the establishment, and had reduced or stopped self-harming post programme; however this was not reliable or robust and difficult to record.

Additionally, in the post interview, participants attributed current reductions in self-harm directly to the skills acquired on the programme in particular identifying new

strategies for coping and describing change in their perceived ability to 'manage' their feelings. In order to demonstrate a more meaningful association between improved coping styles and reduction or severity of self-harm, future research to include a detailed monitoring of all self-harm incidents to include episodic severity is recommended.[34]

There were several factors in the Carousel programme that have been highlighted and contributed to the process of change. Coping strategies (behavioural approach) was a key factor to the process throughout the programme, which was reinforced weekly during the group and individual sessions and as part of their homework tasks. Competitions took place each week, including: a prize for the *most* coping strategies, the most *unique* coping strategies or be willing to talk to the group about the coping strategy that worked best for them. Due to the different levels of ability in the group, each week introduced a new competition task to enable a different group member to win. Recognising achievements was also an important element throughout and one that had been highlighted in this research, along with self-esteem.

In essence the group programme through psycho-education offered opportunities of learning from the shared experience of group members. It offered learning and insight and allowed a greater awareness of self-harm behaviour, drug and alcohol abuse and encourages reduction of such. The use of cognitive behavioural and personal construct theories enabled an appreciation of 'self' in relation to others, increasing

[34] The degree of individual change in coping style could be matched against the pattern of self-harm incidents; this could also include a method of categorising the severity of self-harming incidents in addition to measuring the time taken between such occurrences.

emotional intelligence and pro-social skills thus encouraging behavioural regulation and contingency management. Also through the same methodology it offered awareness and development of personal protective factors (how to protect themselves from others and themselves). The group programme provided mutual support within a motivating environment, which fostered a willingness to work and learn together.

Therapeutic art was another element of the group programme, which was a favourite amongst the women and contributed to the process of change. It is relatively new to the range of therapeutic practices and can provide a means of communication that is highly beneficial. Within these sessions the emphasis was on the person and the process rather than the finished goal of a completed painting or piece of work. It provided a concrete rather than verbal medium through which the women could achieve both conscious and unconscious expression, and be used as a valuable agent for therapeutic change (Dalley, 1984). In addition, the construction of 'happy boxes' helped the women when they were alone in their rooms at night; a time when most self-harm incidents occurred (refer to manual appendix 19). The process of looking through their 'happy box' for items that helped them to 'feel good', brought about a change in mood, and reduced the temptation to self-harm (refer to discussion). Regular exercise in the gym was another group activity that contributed to change; although some participants found the exercise less helpful the majority found they had benefited from the 'feel good factor', which many referred to as the release of 'happy hormones'.

Behavioural and emotional regulation were also useful elements to the programme. The women found that by identifying, understanding and managing their emotions, provided insight into how they respond at an emotional level to situational factors. This resulted in an improvement in their interpersonal behaviour with the immediate environment. Future research may also include measures of emotional control – the tendency to either inhibit or express emotion, including measures of rumination about emotional distress, inhibition and anger control (Clarbour & Roger, 2004; Harris, Moore, Clarbour & McDougall et al., 2002. Roger & Nesshover, 1987).

The participants were overwhelmingly positive in their programme evaluations thus providing social/face validity data on the programme's need and usefulness. In addition the statistical data analysis provided more robust evidence to the effectiveness of the programme, thus evidencing that Carousel had a positive impact on females who self-harm in remand prisons. It also had a positive impact on a longer-term prisoner (P1) who had a diagnosis of schizophrenia and BPD who became a mentor on the programme and was waiting for hospital transfer. It also impacted on the prisoner serving life imprisonment (P34) with regards to emotional regulation and decreased self-harm incidents although there were some contrasting results in her data. This programme cries out for implementation and follow-up research in different settings to include males, longer-term prisoners, lifers, and in-patient settings to test the adaptability of Carousel.

2.31 Conclusion

The findings suggest that the Carousel programme is a viable intervention benefiting prisoners who self-harm within a remand population. Although 'Brookland' may not be representative of all who self-harm, it does provide a snapshot of remand female prisoners who self-harm. While participants did not reflect the gender breakdown of self-injurious behaviour in the general population (Whitlock, Eckenrode & Silverman, 2006) and in prisons generally, they may reflect the tendency for females to seek more informal and formal help and social support compared with males (Fuhrer, Stansfield, Chemali & Shipley, 1999; Saunders, Resnick, Hoberman, & Blum, 1994). The statistical analysis was highly significant showing a dramatic decrease in self-harming, anxiety and depression, and maladaptive coping styles with an increase in adaptive coping styles.

The treatment outcome suggests that using a multi-disciplinary and multi-component intervention of therapies, has been an effective treatment for this complex client group. The CBT component supports previous literature demonstrating effective outcomes with 'self-harmers'. In addition it provides further support to the previously limited, personal construct psychotherapy literature (Winter et al., 2007). The humanistic addition facilitated a more collaborative therapeutic relationship, which was necessary for 'getting alongside' the client (Beck et al., 1979), and optimising therapeutic outcomes (Waddington, 2002) particularly with this complex client group. This helped to foster an atmosphere of trust and safety that was reported by the participants in post-programme interview.

The qualitative approach using content analysis added a further dimension to the current study by evidencing the participants' views of the effectiveness of the programme as recommended by NICE guidelines (NICE, 2004) and Dale, Allen and Measor (1998), Kuhnlein (1999); McKenna and Todd (1997) and McLeod (2001). The insight gained (Glachen, 1996) identified coping skills as one of the main components that the women found helpful; this added further support for a problem-solving approach (Fivush et al., 2003; Guthrie, 2003; Lazurus & Folkman, 1991).

In summary, the results were highly significant and are supported by 'rich data' from the perspective of the participants. This has strong implications for future interventions and research, particularly for counselling psychology. The most rewarding outcome were the reduced levels of self-harm along with the adaptive coping styles accepted and utilised by the women that can be applied in a variety of settings both now and in the future. One participant (P27) stated that *"Carousel had changed her life",* partly from her own attitude to the world and added: *"Thank God for Carousel".*

SECTION 3 – CRITICAL APPRAISAL OF THE RESEARCH PROCESS

3.1 Introduction

The current study is an evaluation of the effectiveness of the Carousel intervention programme for females who self-harm, using quantitative and qualitative analysis. It involved the evaluation of a programme that I had designed, co-authored, implemented and co-facilitated with the assistance of Pope who co-authored and initially co-facilitated. With these multiple roles emerged some hurdles and ethical dilemmas, which will be evaluated in this section. Conversely, the strengths of these roles also placed me in a fortunate position where I was able to generate and nurture the development of the programme and within the study stimulate the depth and quality of the data without influencing the results, thus remaining objective.

Reflexivity takes an important stance within this section of the report. It involves personal reflexivity and epistemological reflexivity that has guided me through my research process. Therefore, in the spirit of 'action research' (see Bond & Hart, 1996; 1998), the desire to change things for the better, I have integrated reflexivity throughout this section.

3.2 The Researcher

Bannister et al. (1994) recommend that qualitative research reports have a separate subsection detailing the researcher's position to enable them to be located in the construction of the findings. Etherington (2004:180) also states:

> "*Our personal history, when it is known to us and processed in ways that allow us to remain in contact emotionally and bodily, with others whose stories remind us of our wound, can enrich our role as researcher".*

I will therefore outline how I, as a researcher, was positioned within the process. The original concept of Carousel was born out of the need to meet the challenge of increase in self-harm and suicide levels within 'Brookland'. At the time I was providing one-to-one therapy to prisoners who self-harmed. The governing governor and area manager requested me to research what programmes were currently running in the prison service and their suitability for 'Brookland'. I presented the Dialectical Behaviour Therapy (DBT) programme as a possibility; as it was being run as a pilot in three establishments and was the only self-harm programme being delivered at the time. However they turned it down due to several factors: firstly, it was a twelve-month duration programme that wouldn't meet the needs of the remand prisoners; secondly, there was a lack of data as to its effectiveness; and finally, the area manager felt that for 'Brookland' it would be too expensive and resource intensive to run. As a result, I was asked to write a group programme for females who self-harm that would fulfil the needs of a busy remand population.

Through working with an extensive range of self-harm and suicide ideation for fifteen years, I have fostered a genuine interest in counselling psychology service development within forensic settings with particular emphasis on this complex client

group. This has resulted in a belief that with the right approach and methodologies, female prisoners can be empowered to make changes in their psychological thinking, and their world view whilst learning life skills that they can take forward into 'new beginnings'.

Reflecting back, I feel that it is important not to lose sight of the aim of counselling psychology research, which is to extend the knowledge base with reliable and useable information (Corrie, 2003; Heppner, Kivlighan & Wampold, 1992). The prison also takes a strong stance on the importance of using evidence-based practice in the writing and delivery of therapeutic programmes to groups of prisoners (Hooper, 2003). This was the emphasis placed on my co-author (Pope) and myself during the writing of the Carousel programme. As Corrie suggests:

> *"Evidence based practice with its link between research and practice, challenges us to reflect on what we offer our clients in a systematic way which is morally imperative"*
>
> (Corrie, 2003:6).

Furthermore, working with women who self-harm have highlighted the need for the development of the appropriate interventions, which take into account the individual within the whole context of presenting problems. This places counselling psychologists in a good position to undertake this work, as counselling psychology is distinctive in its competence, in the psychological therapies being firmly rooted in the

discipline of psychology, whilst emphasising the importance of the therapeutic relationship and process (Pugh & Coyle, 2000).

However, at the time of writing Carousel I was aware of the responsibility that was bestowed on me to design and implement a programme that would benefit a population of vulnerable women with complex histories. Reflexivity played a major role throughout this process and I was continually mindful of the ethical principles and guidelines (BPS, 1994, 1998, 2001, 2003 & 2006). Therefore I needed to ensure they were adhered to particularly as I was working as a practitioner and co-author, which developed into being co-facilitator and researcher. It was important that I maintained professional boundaries at all times. The process of researching and writing took approximately one year, involving consultation and meetings with the area manager, governing governor, senior management and other key personnel from head office and the area team. The recruitment of a co-author after my initial design assisted in the writing process. He was working at the establishment at the time and also had experience with this client group and had a keen interest in group therapy. This was followed by another year of proceedings for the programme to receive approval through the Effective Regimes Prison Service Order (PSO)[35] (necessary for any programme to be implemented into the prison service, as previously discussed within the report).

[35] Refer to appendix for certificate.

3.3 Opposing Discourses and Ethics

I was aware that introducing a new intervention for women who self-harm into the 'prison culture' required careful deliberation and forethought. Historically, attempting to implement any group work in 'Brookland' encountered difficulties primarily due to the excessive turnover of female prisoners. Consequently the prisoners were not in the establishment long enough to complete a course of group therapy. Additionally, the embedded attitudes within the political discourse of the prison culture also contributed to the unsuccessfulness of programmes. Nevertheless, I was also aware of the responsibilities of the staff, who took on many roles in relation to the prisoners, i.e., care givers, educators and discipline staff – a practice that has remained relatively the same for years. I was also aware that the Carousel programme was located in opposing discourses; an authoritarian and therapeutic discourse. It is not uncommon for opposing discourses to work in practice, but in this situation it raised various ethical concerns, particularly relating to therapeutic practice. The years that I had worked within the environment helped me realise that it is paramount to be aware of this throughout the process, as Jenkins (2003) reports:

> *"Ethical practice goes beyond events in therapy and is to an extent, grounded within structures of our work practices*" (p. 19).

These structures in the workplace can also impact on the therapeutic relationship as the context in which we work can shape our practice (Farthy & Milton, 1998).

Therefore as well as being bound by the Division's code of ethics, (BPS, 2001) I, as a counselling psychologist, am also bound by the institutional codes which can raise various dilemmas. This can result in enforced decisions being made that are based on a psychologist's own values and clinical judgement, the law, professional codes, and rules of the organisation, which is evident when working with this particular client group. So embedded are the dominant discourses that legitimise the existing power relationships in the prison system, that it is not surprising that female prisoners are positioned as 'deviant women who have strayed from the normal path of womanhood and therefore deserve to be punished' (Farringdon, et al., 1981). In many cases they are punished more severely than men (Reddish, 1994), impacting negatively on their already fragile mental state due to previous trauma exacerbating the risk of self-harm behaviour and suicide.

Upon reflection my experience and knowledge base compelled me to proceed with caution. Self-harm, suicide, dissociation and re-victimisation are critical areas of observable impact that we need to understand, both from the perspective of their origins in the survivor's past (abuse, assault and other factors) and from the many present-day purposes they serve (Everett & Gallop, 2001). The 'self-harmer' often becomes re-abused in a system that fails to see the injury as a communication of the trauma, but views it instead as manipulative. For a young person crying out for help to be regarded as attention seeking carries maladaptive connotations, and this just provokes more of the same (e.g., silence, ignoring the injury, punitive responses) (Collins, 1996:464). While such terms may be used sometimes out of a frustration

with what can be difficult work, such language may serve to increase the risk of an individual completing suicide (Dexter & Towl, 1995; Towl et al., 2000:100). For example Towl et al. (2000) state that some prisoners, who report feelings of suicide, or a desire to self-harm, have on occasions been successful in their attempt either deliberately or as an accident. Thus providing enough evidence to support a therapeutic approach that will empower the women to alter their maladaptive coping styles and replace them with alternatives. The language used by professionals and institutions in relation to self-harm can have a significant impact upon the effectiveness of our therapeutic interventions and thus impact the therapeutic relationship as Crandall and Allen (1982) state:

> *"To fully understand the development of a therapeutic relationship one must pay attention to the organisational context within which helping occurs"* (p.86).

As I had expected, the programme was met with mixed reactions. Some discipline staff presented with an attitude of not wanting the programme to work. Paradoxically, other staff in the same roles had a genuine desire to see a much-needed intervention survive and have a positive impact. Borrill, Snow, Medlicott, Teers and Paton (2005) recommended *"training for the prison staff together with encouragement to engage proactively with prisoners, particularly as women who self-harm may initially reject help"* (p.67). This was often born out of the stigma reactions discussed above. Indeed women in the group discussed being on the receiving end of poor reactions from both

prison staff and nursing staff. One woman noted that she had been 'stitched' without anaesthetic on her last visit to the hospital; so despite the NICE (2004) guidelines it appears that such practices are still current.

Therefore it was of paramount importance to raise awareness about Carousel and to embed its principles into the establishment. This was achieved by regular awareness and skills training (refer to 1.18 of this report) so that the staff felt included from the onset and understood more about why people self-harm, and how Carousel would support them to make lasting change. I imparted vital knowledge to staff on how to respond to self-harm situations with appropriate language and intervention. Liaison with wing staff, gym and education staff helped to deliver a whole prison approach. This helped to break down some of the traditional attitudes discussed above. I knew that if Carousel was to be effective, a multi-disciplinary or 'whole prison approach' which the governing governor had directed would be imperative. The aim therefore, was to make Carousel 'everyone's responsibility' to help to dispel negative responses.

It was through reflection during the writing of this research, that I went through a change and realised that I may have inadvertently added to the stigma that promotes 'negative responses'. I became uneasy with part of the title that I had originally chosen for this research: *"The Evaluation of Carousel: A Therapeutic Programme for Self-harmers in Prison"*. I realised that the term 'self-harmers' although widely used throughout self-harm literature, was in fact a 'label', and through the title I could be adding to the 'stigma' that was already embedded within the prison culture. Although

this did not appear to affect the recruitment of the women to the programme, it could be argued that it still reinforces the self-criticism and self-surveillance along with criticism and surveillance of others, together with the influence of the language of medicine and psychiatry (Foucault, 1979). I realised that I too, inadvertently had been caught up with the use of 'accepted language' without realising the connotations of the usage. Although I cannot change the term used in all the past posters and referral forms, I am able to change the current title of the research and all future literature connected to the Carousel Programme.

3.4 Methodological Issues

Part of the research process was to decide on psychometrics as a measurement tool, which can be a dilemma from the viewpoint of counselling psychology. Nevertheless, psychometric testing has traditionally played a significant role in satisfying the demand for 'rigorous empirical enquiry' in psychology. However, I was aware that this has also been a contentious issue throughout the history of counselling psychology in the UK (Sequeira & Van Scoyoc, 2004). This is especially so in clinical practice, where some counselling psychologists believe that psychological testing can seriously interfere with the therapeutic relationship (Vogel, 2004). My standpoint as noted in more detail in section 2 of this report is that qualitative and quantitative data together provide a more meaningful discovery from the client base which is in keeping with the spirit of counselling psychology (Pugh & Coyle, 2000). Pillay (2004) agrees that on the one hand psychometrics is an essential element for counselling psychologists but on the other hand argues that there should be a shift

from working within a medical model, where problems, needs and deficiencies are accentuated (Eloff & Ebersohn, 2002; Lockett, 2000; Sharpe & Greany, 2000).

Furthermore, I was also aware of the importance of using the correct evaluation tools for the purpose as well as benefiting the client. I was satisfied with using the coping styles questionnaire (Roger et al., 1993) which is used in forensic settings, but had some reservations with regards to which scale to use to measure anxiety and depression. The Hospital Anxiety and Depression Scale (HADS) (Zigmond & Snaith, 1983) was my initial instinct as it fitted all the boxes for the purpose. I also considered The Beck Depression Inventory (BDI) (Beck, Steer, & Brown, 1996). Both scales are used more widely in clinical and forensic settings to measure progress (Van Scoyoc, 2004). Nevertheless, despite the HADS being a widely used and recognised scale, Bjelland, Dahl, Haug and Neckelmann (2002) criticised it for being too simplistic with the opportunity for the results to be manipulated. However, after they extensively reviewed the literature (747 identified papers) pertaining to the HADS with an emphasis on its validity, they concluded that it performs well in assessing symptom severity and clinical significance of anxiety disorders and depression in somatic, psychiatric, primary care patients, and the general population. This scale was used due to the validity and the evidence to suggest that there are higher rates of depression found in deliberate 'self-harmers' (Nezu, 1985; Parker et al., 2005; Simms, et al., 2007;). Consultation and psychometric test approval was sought from the area team and head office prior to administration.

The main purpose of the psychometrics was to measure the effectiveness of treatment, but can also be used in treatment planning. Individual sessions were often tailored collaboratively to focus on the participant's needs, which were corroborated with the test results. Finn and Tonsanger (1997) refer to this as an 'information-gathering paradigm', as the focus is on collecting data that will aid in communication and decision-making about clients, and determining psychotherapeutic interventions that would help them reach their goals in life. They contrast this with the 'therapeutic model' of assessment, in which the focus is on producing positive change in clients. Van Scoyoc (2004) argues that tests can provide information to support, or add objective weight to and also provide another entry point into the client's phenomenal world. When used creatively they can help build an effective alliance where the therapist can work with the client to move towards agreed outcomes (Grimley, 2004), and be thought of, or regarded as, a co-creation between researcher and participants (Giorgi, 1989; Reason & Rowan, 1981; Van Scoyoc, 2004). This forces a shift from diagnosis and classification of psychological problems to recognising the potential within clients to manage their own changed life (Pillay, 2004).

Another issue arose that could potentially have affected the study and the results, in addition to ethical concerns, was a proposal put forward by an officer to include a 'No-harm agreement' as part of a contract. Reflecting back I recall being really concerned that this took away the 'choice' for the women. As much as I wanted them to stop self-harming, I felt that it was important that they reduced or stopped because they were psychologically ready to do so and not due to a 'set of rules'. In addition, a

'No-harm agreement' would affect the accuracy of the results and ecological validity. Therefore, bringing into the question whether the results could be attributed to the effectiveness of the programme or to the lack of choice with a 'No-harm agreement'? Warm, Murray and Fox (2002) note that this is an area of controversy, taking the view of Arnold (1995) and Spandler (1996) that *"it is likely to be unproductive and even detrimental to the self-harmer as it enforces constraints on their self-harming behaviour"* (p. 127). There were three further reasons for the rejection. Firstly, there had been a 'near death' in custody at another establishment after a young woman had signed an agreement, and although that wasn't the actual reason for the suicide attempt, there were major concerns that the agreement had been a contributory factor in her increased stress levels; secondly, it was against the principles of therapy; and thirdly, the area psychologist expressed that it was 'setting the participants up to fail' as it would be virtually impossible for someone to agree not to self-harm, highlighting various ethical concerns. I was relieved when it was agreed by area and head office to reject the proposal.

Of further concern were the dual roles that I undertook, as co-author of Carousel, facilitator and the researcher: I was aware of the subjectivity that may be involved with the qualitative analysis. Less so with the quantitative analysis, although I was aware of the criticisms around selective accountancy as discussed in more detail in the methods section of this report (Burnman & Parker, 1993; McLeod, 2001). However I had a genuine desire to see the effect of the programme 'as it was'. I was quite overwhelmed by the significance of the results, and was really keen through

content analysis to discover from the women's viewpoint what components of the programme they found more helpful and unhelpful. This would have implications for the current running of the programme and for the future. It was useful for me on three counts: firstly, as co-author, I could change or adapt the programme if necessary; secondly, as the practitioner/co-facilitator I was able to monitor the delivery and reception of the programme and finally, as a researcher, I had an enquiring mind and a genuine interest in the discovery (Glachen, 1996; McLeod, 2001).

However, it was difficult at times to bracket off some prior conceptions (Ponterotto, 2002) of what I perceived may have worked well, particularly as being co-author and co-facilitator. I was aware that I could influence the direction of the analysis interpretation. I was mindful of the process and kept firm boundaries, including keeping to the questions. Moreover, having an independent second assessor helped this process for objectivity. Within the two meetings we reached accordance, and with the two that I was slightly hesitant about, I chose the theme in favour of the assessor. In addition the use of a reflexive journal together with supervision was paramount in assisting me to remain objective. On reflecting back, I recall keeping the words 'in the best interests of my clients' (beneficence) at the forefront of my mind.

3.5 Clinical and Research Supervision

Supervision provided another 'forum' for the reflexive process and played an important part in the development of the research. From the literature review it was apparent that to introduce an intervention programme into the prison system would

need careful consideration, largely due to the beliefs, attitudes and prejudices that were so embedded in the political arena of the institution (Foucault, 1979). For Carousel to be effective, it was important to explore all components that would be considered vital to the programme's success.

Supervision was also useful throughout the process from the conceptualisation of Carousel and through to completion of the research process. I was aware of the importance of the client feeling safe to bestow trust in me as the facilitator and the researcher. With the help of supervision, and being reflective in my practice, I was able to question my reactions and the possible impact they have on my therapeutic relationship and research. Schon (1983) argues that in professional practice, as in everyday life, our 'knowing' is embedded in our 'action'. It is when something unusual happens that we step back and reflect on what we are doing, and identify, criticise and restructure our understanding. Schon (1983) states that the process of reflection-in-action provides the framework for competent practitioners to cope with the uncertainty, instability, uniqueness, and value conflicts, which occur in daily practice.

> *"Practice must be sensitive, relevant and responsive to the needs of individual clients and have the capacity to adjust, where and when appropriate to changing circumstances"* (UKCC, 1992).

Similar to Kelly (1988) whose study involved interviewing women about their experiences of sexual violence, I found facilitating the programme and interviewing at times quite emotionally draining. Following the intensive periods of this work, my perspectives regarding the 'safety of the world and my safety in relation to others' were temporarily challenged. Brady, Healy, Norcross and Guy (1995) and Jensen (1995) found that counselling itself could be stressful and demanding for the counsellor. Supervision became a vital tool, and I was very aware of the possibilities of Vicarious Trauma (Everett & Gallop, 2001). I was grateful to have two really good clinical supervisors to prevent this process, as well as two really good research supervisors. In addition Jenkins (2003) highlights that when working with suicide ideation regular supervision should be taken.

Initially self-harm data was collected by method of self-report, this changed due to the need for scientific rigour and accuracy about the effectiveness of the programme. This arose from my reflexive journal and explored during supervision and thus approved by the governing governor. The suicide and self-harm coordinator and I went back through the IRS records and extracted the self-harm levels for each participant. Where possible the data for eight weeks prior to commencing Carousel was used for the pre-test results. However, it was not possible for the participants who were in the establishment for less than eight weeks. In those circumstances, the data for the 'absent 'weeks was by self-report together with the actual figures (as described in the method section). This was not ideal, but gave more accuracy than relying completely on self-report. It was interesting to note that the women were

fairly accurate in their estimates with just one or two exceptions. However, although partly overcome, this was still a limitation for the study.

3.6 Paradigm Shift

Reflecting back to the 'beginning' of the research process, it was amazing to see such a shift in the attitude of the discipline staff that was originally against the Carousel programme. This was largely due to the dramatic reduction in self-harm levels on an individual basis and in the establishment as a whole. Also it was partly because the staff were kept involved in the process; some directly, through the various components of the Carousel, such as the gym staff (gym and exercise) and education staff (therapeutic art) and others through regular liaison. The facilitators regularly met with wing staff, personal officers and key people around the establishment. This was to measure how the women were doing on the wings, and to assist staff with any concerns. This became an *"establishment in action"* that was fully utilising the '*Whole Prison Approach'* towards suicide and self-harm, which is now under the umbrella of 'Safer Custody' (Rose, 2008). I recall writing in my journal that these reactions were not surprising. Once the officers had received awareness training, understood the underlying factors of self-harming behaviour, together with the purpose of Carousel, and witnessed the change in self-harm levels, this resulted in the paradigm shift which enabled them to respond to the women in a more positive way. This in turn provoked a positive response by the women, which began to break down the cycle of negativity, and contributed to an environment that could foster change. On reflection this is quite a simple recipe, as Jewkes (2002) states:

> *"If you are positioning prisoners in a particular way, they will behave in such a way, similarly if you point them in another way they will behave that way also"* (p.87).

In summary, the results are conclusive that Carousel is a programme that brings about change. If this level of result can be achieved within a short space of time on a small sample of women with complex histories, the implications would be phenomenal on a national level. In real terms, the highly significant results have made a difference to forty lives. This journey has been amazing, to see before my very own eyes, such a change in women has been a true privilege. To see them believe in themselves, stop, or reduce their self-harming, feel less anxious and depressed and have the skills to take themselves forward, is the best reward I could ask for.

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Appendices

Appendix 1: Copy of Notes to Contributors

CLINICAL PSYCHOLOGY REVIEW

Guide for Authors

SUBMISSION REQUIREMENTS: Authors should submit their articles electronically via the Elsevier Editorial System (EES) page of this journal (http://ees.elsevier.com/cpr). The system automatically converts source files to a single Adobe Acrobat PDF version of the article, which is used in the peer-review process. Please note that even though manuscript source files are converted to PDF at submission for the review process, these source files are needed for further processing after acceptance. All correspondence, including notification of the Editor's decision and requests for revision, takes places by e-mails and via the Authors homepage, removing the need for a hard-copy paper trail. Questions about the appropriateness of a manuscript should be directed (prior to submission) to the Editorial Office, details at URL above. Papers should not exceed 50 pages (including references).

Submission of an article implies that the work described has not been published previously (except in the form of an abstract or as part of a published lecture or academic thesis), that it is not under consideration for publication elsewhere, that its publication is approved by all authors and tacitly or explicitly by the responsible authorities where the work was carried out, and that, if accepted, it will not be published elsewhere in the same form, in English or in any other language without written consent of the Publisher.

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Please provide the following data on the title page (in the order given)

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Abstract. A concise and factual abstract is required (not exceeding 200 words). This should be typed on a separate page following the title page. The abstract should state briefly the purpose of the research, the principal results and major conclusions. An abstract is often presented separate from the article, so it must be able to stand alone. References should therefore be avoided, but if essential they must be cited in full, without reference to the reference list.

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For Books: Hersen, M. (Ed.),. (2005). Comprehensive handbook of behavioural assessment (2 volumes). New York: Academic Press (Elsevier Scientific)

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Appendix 2: RES20

UNIVERSITY OF WOLVERHAMPTON

RES 20A
(February 2002)

Ethics Committee: submission of project for approval

To be completed by SEC:
Date Received:
Project No:

Title of Project:	**RES 20 submitted to the Psychology Ethics Committee and subsequently passed under Chair's Action: The evaluation of Carousel – a therapeutic programme for self-harmers in prison.**
Name of Supervisor: (for all student projects)	**K. Manktelow, N. Hart**
Name of Investigator(s):	**Julia Rose**
Date Division Ethical Approval Given:	
Level of Research: (U/G, P/G, MSc, DCounsPsych, MPhil/PhD, Staff)	**D. Couns. Psych.**
.	

FOR USE BY THE SCHOOL ETHICS COMMITTEE

Conditional Approval Granted: K. Manktelow Date: 31.10.05
(Chair of Psychology Ethics Committee)

Minute Ref No: _____

Approval Granted: Neil Mackay Date 2/11/05
(Chair of School Ethics Committee)

*delete as appropriate

Appendix 3: RES01

THE UNIVERSITY OF WOLVERHAMPTON

FORM RES 1P – July 2004

Graduate School

FOR RI/RDU USE
Date Received:

PRELIMINARY NOTIFICATION OF INTENTION TO UNDERTAKE THE RESEARCH PROJECT PHASE OF A DOCTOR OF PROFESSIONAL PRACTICE PROGRAMME

The information requested below is required for Research Institute/School records; the formal registration of your research project takes place via the RES 2P form and is subject to scrutiny by the Student Management Board of the relevant Research Institute (RI) or Research Degree Unit (RDU). Failure to submit the Res 2P within 3 months of this notification may result in your progress being deemed unsatisfactory.

THIS FORM MUST BE USED ONLY BY STUDENTS CURRENTLY REGISTERED ON A PROFESSIONAL DOCTORATE PROGRAMME AND APPROACHING THE FINAL RESEARCH PROJECT PHASE.

SECTION A. PLEASE COMPLETE SECTION A ONLY AND RETURN THE ENTIRE FORM TO THE RELEVANT RI/RDU SECRETARY.
1. Name: Julia Rose
2. Address (for correspondence): Bethany, 17 Hewell Road, Barnt Green, Birmingham. B45 8NG
3. Name and Address of person or organisation paying fees: *(please specify if you are a member of staff at the University. If so, an authorised Pathways agreement should be attached).* Julia Rose, 'Bethany', 17 Hewell Road, Barnt Green, Birmingham B45 8NG A member of staff (visiting lecturer/module leader).
4. Name your Doctor of Professional Practice Programme: Top Up Doctorate in

Counselling Psychology

5. Mode of Study (i.e. Full-time or Part-time): Part-time

6. Proposed title of the investigation:

   The Evaluation of Carousel - an Innovative Therapeutic Programme for Deliberate 'self-harmers' in a Female Remand Prison Population

7. Indicative rationale for and summary of the proposed project. The summary should contain some indication of the **research question/problem** the project aims to address, and outline the **contex**t of the proposed work and of the **methodology** to be employed.

Introduction

The Role of Counselling Psychology

Since the programme was set up, further advancements have included: the presentation of the 'Development of Carousel' at the 62nd Annual Convention of the International Council of Psychologists (ICP) in Jinan, China, August, 2004; Further Developments of Carousel' at the 63rd Annual Convention of the International Council of Psychologists (ICP) in Brazil, 2005; the acceptance of publication of the 'Development of Carousel' in the ICP Journal (Rose in press); the BBC recording of 'Carousel extracts', highlighted as an innovative programme on BBC News Night (September 2004); and Her Majesty's Prisons' official accreditation in March 2005, of the 'Carousel Programme' (refer to appendix 2 of the original doctorate submission for copy of certificate). As a result, 'Carousel' is being considered as a group programme for Counselling Psychologists to run in other HM Prisons (male and female establishments).

Counselling Psychologists within the HM Prison service have increased in numbers in the last three years with the type of therapeutic skills that recognise the contextual

embeddedness of human lives (McLeod, 2001). The 'Carousel programme' has highlighted a further need of Counselling Psychology within the prison system (CoPIFS, 2005) where Counselling Psychologists are able to utilise the depth of skills acquired in their training, for research skills, group programmes, audits and evaluation and the range of therapeutic interventions.

Relevance to Counselling Psychology

A formal evaluation showing a difference (decrease) in self-harm behaviour pre- and post- Carousel will enable the Carousel Programme to move forward as an effective intervention designed and delivered by Counselling Psychologists. The advancement of Deliberate Self-harm research as a Counselling Psychologist is an area that is important for Counselling Psychology. The programme is new and novel in terms of therapeutic intervention, because of the uniqueness of the programme described earlier and the prevalence of Para-suicidal behaviour causing concern for the British Government.

British Government Concern with DSH levels

Public awareness has increased since self-injury has attracted a wider audience through media coverage (Shaw, 2002; Todd, 1996; Egan, 1997). The highest rates of self-injurious behaviour in Europe are found in the UK (Bowen & John, 2001); and some of the most extreme forms of self-injury may be found in forensic settings (Rayner and Shaw, 2003) The dramatic increase in the levels of Deliberate Self-Harm (DSH) in HM Prisons amongst female offenders has caused concern for the British Government and Prison officials (HMCIP, 1997) and has been an agenda item for the last two years (Milligan & Andrews, 2005). During 2001, there were 7,486 reported incidents of self-injury occurring in prisons across England and Wales (Safer Custody Group (SCG), 2002 cited in Morton, 2004). In 2002 the numbers rose to 9,500; in 2003 there was a further increase to 16,214 (SCG, 2004); with an additional increase to 18,722 in 2004 (SCG, 2005). It is estimated that DSH occurs in up to 63 percent of sentenced or convicted women prisoners and up to 76 percent of women remand prisoners.

Intervention Programmes

Research in non-prison settings suggests that structured programmes teaching problem-solving techniques can be useful in helping people reduce self-harm behaviour (Hawton, Arensman & Townsend, 1998). To date the evaluation of structured programmes in the prison context for long-term prisoners has been limited but promising (e.g. Mitchell, Trotter, Donlon, 2002). Carousel is an example of a structured programme and is the first of its kind that specifically targets short-term remand female prisoners, a 'rolling programme' that enables participants to enter and leave at different stages [36] (Rose in press).

Research Question and Hypothesis.

The study seeks to measure the effectiveness of the programme Carousel - a Deliberate Self-Harm Programme. It is hypothesised that there will be a significant increase in the level of coping skills and a reduction in self-harm incidents for the women who took part in the programme.

Proposed Methodological Approach and Rationale

Participants and ethical implications

The participants were 40 remand female prisoners awaiting trial/sentence in a prison. All participants were 'self-harmers' and were selected after self-referral to take part in the Pilot studies of the 'Carousel Programme'; (groups 1, 2, 3 & 4). The criteria was a history of self-harm, being on a 'suicide/self-harm watch', and a motivation of

[36] Carousel consists of a combination of individual therapy, group therapy, and physical exercise/relaxation activities in the gym and art therapy. The programme draws on cognitive behavioural therapy (CBT) and personal construct therapy (PCT). Topics covered in the group sessions include: psychological education; drug & substance awareness; management of anger and impulsivity; behaviour regulation; development of pro-social skills and personal protective factors; alternative constructs of self-harm and development of pro-social skills (refer to appendix 3 of original submission for the programme manual).

change i.e. acquiring alternative coping strategies to their severe and repetitive parasuicide behaviour, including 'cutting' and previous suicide attempts.

It was a requirement of the HM prison service to carry out pre- and post- psychometric tests and interviews to measure the effectiveness of group programmes, as part of the Effective Regimes Policy (HMSO). It is proposed that this study will utilise quantitative and qualitative methods using existing data that was collected pre- and post- each Carousel Group. As a further requirement of the HMP establishment, consent was received from each participant to use the data collected for research and publication. Permission was also granted from the Governing Governor (No 1 Governor) to use the data (letter submitted separately). The Participants were fully informed of the purpose of the data collected pre- and post- 'programme'; and their right to withdraw from the programme at any time. Consent forms were signed and stored in a locked cabinet in the prison establishment (available on request), following the Professional guidelines of the BPS for the Division of Counselling Psychology 1.5.1: 2001. The participants were also informed that a preference for their data not to be used in the study would not effect their right to take part in the programme. Therapy/support was given pre, post and throughout the programme.
Existing data will be used to evaluate the effectiveness of the Carousel programme as outlined above. Res 20a has been submitted.

The 40 women who completed 'Carousel' during 2004 and 2005 complete a semi-structured interview, pre- and post- programme. The psychometric tests were carried out to measure the severity of difficulties and provides evidence for base line and post treatment of effectiveness. The tests carried out were:

1. Firestone Self-destructiveness thought questionnaire (FAST) – a self-report 84 item scale to identify the level at which the client is experiencing the highest frequency (intensity) of self-destructive thoughts.
2. Hospital Anxiety and Depression Questionnaire (HADS) a self report questionnaire to identify levels of anxiety and depression.

3. Coping Skills Questionnaire (CSQ) a self-report 60 item scale to establish change in coping skills

4. Repertory grids to establish changes in how the group members view their progress thinking and behaviour.

5. The number of self-harm incidents and the frequency of 'watches' were also recorded.

6. The post semi-structured interview asked questions about the group members' perceptions of the programme, its impact on self-harm and other behaviour; the aspects of the programme that they enjoyed the most and least and changes they could recommend to be made.

Participants also submitted extracts from their journals, i.e. poems and prose on their 'experience' of Carousel.

An internal evaluation has taken place using only the data collected from the recorded incidents of self-harm pre- and post- programme and frequency of watches (suicide watch). Preliminary findings of Carousel show a dramatic reduction in self-harm behaviour (SASH, 2004, SCG, 2004).

Due to the restriction of word length, for the purpose of this research, it is proposed to use the raw data collected from the CSQ, FAST and HADS questionnaires. It is also proposed to use information collected from the semi structured interviews and extracts from the journals. This will involve a quantitative and qualitative analysis.

Rationale for CSQ

Studies of coping style have identified two broad strategies, which people use for dealing with stress or threat. *Problem-focussed* strategies refer to attempts to manage or change problems, including finding different ways of thinking about them, whereas *emotion-focussed* strategies concentrate on trying to regulate the emotional distress, including avoidance. Problem-focussed coping is generally believed to be

most effective in reducing stress, although it may be less adaptive in situations that are not amenable to change (Lazarus & Folkman) where a more detached coping style may be helpful (Roger, Jarvis & Najarian 1993).

There is some evidence to suggest that prisoners may have less adaptive styles of coping than the general population, and in particular are more likely to use emotion-focussed and avoidance-focussed styles of coping (Gullone et al 2000). Several studies have reported that prisoners who self-harm are particularly likely to use less adaptive coping strategies, particularly avoidance (Livingston 1994; 1998; Slade & Gilchrist 2002).

Rationale for FAST and HADS

The FAST scale provides information directly relevant to treatment for practitioners from divergent orientations. The aspect of this scale is particularly important in the case of self-harm and suicide, for which immediate, appropriate intervention may be life saving. In addition, with the FAST, the clinician can identify and address less extreme types of self-destructive thoughts before they lead to or precipitate a suicidal crisis. By administering the test pre- and post- the 'programme' the participants change or progress and be monitored. The HADS scale provides indication of the range of depression and anxiety (normal to clinical range).

Rational for qualitative data Content Analysis (CA)

The content analysis is a method that is extremely flexible in its application. Krippendorff (1980) suggest that this is a "technique that allows the researcher to utilise data without imposing too much structure on the subject" (p.18). The aim is to 'extract units of meaning from the verbal data in a manner which permits the quantification of the material in terms of frequency of occurrence of certain categories.' There is no set recipe to carry out this analysis and Pauli & Bray suggest that it is the researcher who decides how to divide up the material in the manner most appropriate to the research question (1996). Content analysis is a coherent way of

rating and organising the interview material in relation to specific research questions. These readings are organised under thematic headings in ways, which attempt to do justice both to the element of the research question and to the preoccupation of the interviewees (Banister, Burnman, Parker, Taylor & Tindall, 1994). It is proposed that CA will and give further insight into the effectiveness of the Programme within a forensic setting.

Proposed Method of Data Analysis

Stage 1 Quantitative.

For the purpose of this study, paired *t*-tests will be carried out for each of the psychometric tests, to assess the statistical significance of the pre-post scores i.e. between time one and time two. It is predicted that there will be an increase in detached and rational coping skills between time one and two and a decease in the emotional and avoidance coping skills between time one and two.

Dependant variable is the 'Self-harm' behaviour
Independent variable is the 'Programme Carousel'

Stage 2.

Repeat of the above using the scores from the FAST scale

Stage 3. Repeat of the above using the scores from the HADS scale. It is predicted that there will be a decrease in the anxiety and depression scores between time one and two (post programme).

Stage 4.

Repeat of the above using the scores from the number of self-harm incidents (i.e. weekly) pre- and post- programme.

It is predicted that there will be a decrease in the number of self-harm incidents post programme.

Stage 5.

It is proposed that a qualitative analysis will also be carried out on the answers from the post interview questionnaire and the extracts from journals, e.g. poems, thoughts on carousel using content analysis.

SECTION B: TO BE COMPLETED BY PROPOSED DIRECTOR OF STUDIES ***(please note that a candidate for a research or other doctoral degree - whether registered at the University of Wolverhampton or elsewhere - is ineligible to act as a member of a supervisory team for another research degree candidate)***

8. Name of Director of Studies: Dr Yvette Lewis/Dr Nicky Hart School:

No. of current supervisions:	MPhil:	PD:	No. of successfully completed supervisions:	MPhil:	PD:
	PhD:			PhD:	

9. Other proposed members of the supervisory team:

Name of Second Supervisor (1): Dr Nicky Hart School:

No. of current supervisions:	MPhil:	PD:	No. of successfully completed supervisions:	MPhil:	PD:
	PhD:			PhD:	

Name of Second Supervisor (2): Professor Ken Manktelow School:

No. of current supervisions:	MPhil:	PD:	No. of successfully completed supervisions:	MPhil:	PD:
	PhD:			PhD:	

Please note that in the case of a candidate proposing to work outside the UK, the proposed research project must be supported by an existing academic link between the University and an appropriate institution in the applicant's country of residence.

10. If any of the proposed members of the supervisory team already have what is considered by their RI/RDU to be the maximum acceptable number of current MPhil/PhD or other doctoral thesis supervisions, a short justification of this additional proposed supervision should be supplied here:

11. Resource Implications – please specify full requirements, funding sources and responsibility

12. SITS RESEARCH COURSES Please ✓ the most appropriate course from the list below

- ❑ Research in Built Environment
- ❑ Research in Engineering
- ❑ Research in Computing and Mathematics
- ❑ Research in Education
- ❑ Research in Humanities
- ❑ Research in Social Sciences
- ❑ Research in Media & Communications
- ❑ Research in Languages & Related Subjects
- ❑ Research in Law
- ❑ Research in Business
- ❑ Research in Art & Design
- ❑ Research in Performing Arts
- ❑ Research in Sports & Recreation
- ❑ Research in Psychology
- ❑ Research in Health
- ❑ Research in Nursing
- ❑ Research in Biomedical Sciences
- ❑ Research in Environmental & Analytical Science
- ❑ Research in Biological Sciences

13. SITS RESEARCH SUBJECTS *Please ✓ the most closely linked subject from the list below (one subject only)*

- ❑ Physiology (B9)/10/7 **(RS/PH)**
- ❑ Pharmacology (B2)/10/11 **(RS/PM)**
- ❑ Biomedical Science (B9)/10/11 **(RS/BM)**
- ❑ Immunology (B9)/10/11 **(RS/IMM)**
- ❑ Diabetes Research (B9)/10/11 **(RS/DIA)**
- ❑ Epidemiology (B9)/10/11 **(RS/EPID)**
- ❑ Human Biology (B1)/10/11 **(RS/HB)**
- ❑ Nursing (B7)/5/11 **(RS/NUR)**
- ❑ Nutrition/Dietetics (B4)/6/11 **(RS/DIN)**
- ❑ Oncology (B9)/10/11 **(RS/ONC)**
- ❑ Primary care (B7)/10/11 **(RS/PRC)**
- ❑ Exercise Physiology (X2)/38/11 **(RS/EXPH)**
- ❑ Molecular Biology (C1)/10/11 **(RS/MOB)**
- ❑ Psychology (L7)/7/13 **(RS/PS)**
- ❑ Agriculture (D2)/14/15 **(RS/AG)**
- ❑ Biosciences (C1)/10/15 **(RS/BL)**
- ❑ Computer Science (G5)/25/25 **(RS/CS)**
- ❑ General Engineering (H1)/21/26 **(RS/GEN)**
- ❑ Built Environment (K2)/23/33 **(RS/BE)**
- ❑ Law (M3)/29/36 **(RS/LA)**
- ❑ Politics (M1)/32/39 **(RS/PO)**
- ❑ Social Policy & Administration (L4)/32/39 **(RS/SCAD)**
- ❑ Social Work (L5)/6/41 **(RS/SO)**
- ❑ Sociology (L3/6/41 **(RS/SO)**
- ❑ Business & Mngmt Studies (N1)/27/43 **(RS/BSM)**
- ❑ Marketing (N5)/27/43**(RS/MK)**
- ❑ Operational Research (N2)/27/43 **(RS/OR)**
- ❑ Quality Management (N1)/27/43 **(RS/EQ)**
- ❑ European Studies (T2)/31/48 **(RS/EPS)**
- ❑ Latin American Studies (R6)/31/55 **(RS/LAS)**
- ❑ Linguistics (Q1)/31/56 **(RS/LN)**
- ❑ English Language & Literature (Q3)/32/50 **(RS/EGLL)**
- ❑ History (V1)/32/59 **(RS/HI)**
- ❑ Library & Information Management (-)/-/61 **(RS/LIM)**
- ❑ Religious Studies (V8)/32/63 **(RS/RL)**
- ❑ Art & Design (W9)/33/64 **(RS/ART)**
- ❑ Communication Studies (P3)/30/65 **RS/CU)**
- ❑ Drama (W4)/-/66 **(RS/DR)**
- ❑ Music (-)/-/67 **(RS/MU)**
- ❑ Education (X3)/34/67 **(RS/ED)**
- ❑ Sports Science (X2)/38/69 **(RS/SR**

14. Starting date of research project: 1st October 2005 20

SECTIONS C to F : SIGNATURES (To be completed at or after the interview stage)

SECTION C. TO BE COMPLETED BY THE CANDIDATE

I confirm that I accept and am in agreement with the broad terms of the research project as outlined, and that I shall undertake any programme of work and training as required. I also confirm that I have read and will observe the Regulations for the Doctoral Award for which I am registered and that I have read and will observe University policy as outlined in the papers "Intellectual Property and Copyright" and "Code of Good Research Practice".

SIGNATURE OF CANDIDATE: *Julia Rose* **DATE: 03/09/05**

SECTION D. TO BE COMPLETED BY THE DIRECTOR OF STUDIES

I confirm that the proposed investigation is feasible, has a sound academic foundation and is capable of leading to scholarly research. I have read and will observe the Regulations for the Award of Professional Doctorates; I have also read and will observe University policy as outlined in the papers "Intellectual Property and Copyright" and "Code of Good Research Practice".

Any investigation involving ethical considerations will be forwarded to the appropriate School Committee for clearance before registration is confirmed at RES 2 stage. This has been done.

SIGNATURE: **DATE:**

SECTION E. TO BE COMPLETED BY THE PROFESSIONAL DOCTORATE AWARD LEADER (OR DELEGATE) ON BEHALF OF THE AWARD COMMITTEE

I approve the preliminary research proposal outlined above

SIGNATURE: **DATE:**

SECTION F. TO BE COMPLETED BY THE CHAIR OF RI/RDU STUDENT MANAGEMENT BOARD

I approve the preliminary research proposal outlined above, including any resource implications (facilities, teaching and administrative duties). I confirm that this proposal has been discussed at SMB, that account has been taken of the present supervisory load of the members of the proposed supervisory team, and that the proposal has been approved.

SIGNATURE: **DATE:**

AFTER COMPLETION BY ALL PARTIES INVOLVED, THIS FORM SHOULD BE FORWARDED TO THE RELEVANT RI/RDU RESEARCH SECRETARY.

Appendix 4: University Confirmation

UNIVERSITY OF
WOLVERHAMPTON
School of Applied Sciences

Dean of School: Professor Patrick W J Robotham BSc PhD

Psychology Division
University of Wolverhampton
Wulfruna Street
Wolverhampton
WV1 1SB
United Kingdom

Telephone Codes
UK: 01902 Abroad: 0 (+44) 1902

Direct Line: 321379
Switchboard: 321000

Fax: 321380

E-mail: psychology@wlv.ac.uk

24 October 2005

Julia Rose
'Bethany'
17 Hewell Road
Barnt Green
Birmingham
B45 8NG

Dear Julia

Research Institute in Healthcare Science – Special Student Management Board Meeting held on 26th September 2005

As promised in our letter of 29th September 2005, we give below detailed feedback from the above meeting.

Practitioner Doctorate in Counselling Psychology
KIM advised the Board he has spoken to the student concerning her data analysis. She has now provided clearer articulation of what she has collected and how she is going to analyse it. Her ethics application has been processed through the Psychology Ethics Committee.

The Board approved the application.

Kind regards

Yours sincerely

pp **Dr Nicola Hart**
Subject Group Leader
Psychology
School of Applied Sciences

Appendix 5: Area Manager- Effective Regimes Certificate

HM PRISON SERVICE
WEST MIDLANDS

Certificate of Area Manager Approval

is hereby granted to:

HMP [redacted]

Carousel

Deliberate Self-Harm Therapy/Support Group

Granted: 22 March 2005

[redacted]

[redacted] *Area Manager*

Appendix 6 : Ethical Approval

UNIVERSITY OF WOLVERHAMPTON

RES 20A
(February 2002)

Ethics Committee: submission of project for approval

To be completed by SEC:
Date Received:
Project No:

Title of Project:	**RES 20 submitted to the Psychology Ethics Committee and subsequently passed under Chair's Action: The evaluation of Carousel – a therapeutic programme for self-harmers in prison.**
Name of Supervisor: (for all student projects)	**K. Manktelow, N. Hart**
Name of Investigator(s):	**Julia Rose**
Date Division Ethical Approval Given:	
Level of Research: (U/G, P/G, MSc, DCounsPsych, MPhil/PhD, Staff)	**D. Couns. Psych.**
.	

FOR USE BY THE SCHOOL ETHICS COMMITTEE

Conditional Approval Granted: K. Manktelow Date: 31.10.05
(Chair of Psychology Ethics Committee)

Minute Ref No: _____

Approval Granted: Neil Moore Date 2/11/05
(Chair of School Ethics Committee)

*delete as appropriate

Appendix 7: Carousel Poster

Carousel
Deliberate Self-harm (DSH)
Therapy/support group

Carousel

Carousel

(DSH) Support /therapy group

Dedicated to reduce Self-harm

New beginnings. Find out how you can learn to help yourself.

Interested ? Information leaflets can be obtained from the wings.

Appendix 8: Referral Form (front)

Carousel

DSH support/therapy group

New beginnings. Find out how you can learn to help yourself.

Carousel is a support/therapy group designed to explore alternatives coping strategies for those who 'self-harm.' This will be done through: individual assessment, therapy group, providing psychoeducation; identify anger management problems and its manifestation; appropriate behavioural regulation; focus on prosocial skill development; increase self esteem/ confidence.

New beginnings—alternatives to self-harm. Find out how you can learn to help yourself.

Carousel

Deliberate self-harm (DSH)

support/therapy group

Individual Assessment.
One to one counselling
Group work.

Group work: Therapy, Support, Art , Music, Education, Gym.

Gym: relaxation, life skills, physical skills.

Carousel

Deliberate self-harm (DSH)

support/therapy group

Carousel

PROVIDING ALTERNATIVE COPING STRATEGIES

This may be for you.
Interested? then read on

What do self-harmers say about their DSH behaviour?

"I self-harm because I hate myself"

"It's all my fault"

"I hate myself"

Appendix 9: Referral Form (back)

Some of the beliefs that 'self-harmers' have:

"I deserve to be punished"

"I have to be perfect to be loved"

"No-one loves me"

"I'm unlovable"

"Bad things happen to me because I am bad"

"I'm a bad person"

Carousel will challenge these beliefs in a 'safe environment' and through assisted 'self discovery,' the group will learn new alternatives to DSH and new healthy life skills.

Programme

Monday
Therapy Group
One-to-one counselling/support

Tuesday
Relaxation, physical skills, life skills in the gym

Wednesday
Relaxation, physical skills, life skills, in the gym

Thursday
One to One counselling

Friday
Relaxation, physical skills, life skills in the gym.
Education/music /art/therapy

Programme is subject to change

REFERRAL

If you would like to be considered for the group, please ask the wing officer to enter your name into the carousel book on the wing or fill in the slip below and place in 'APP' box in wing or hand to wing officer.

.....

Name .....

Number .....

Wing .....

Carousel

Deliberate self-harm (DSH)

support/therapy group

Individual Assessment.
One to one counselling
Group work.

Group work: Therapy, Support, Art , Music, Education, Gym.

Appendix 10: Information and Consent Form

Carousel Self-Harm Group: Research

Information

You are about to take part in the Carousel Self-harm Group Programme. In order to evaluate the effectiveness of the programme we will carry out a series of pre- and post- psychometric assessments that will measure any change that takes place from when you commenced and completed the programme. We will also ask a series of questions that will take approximately thirty minutes. This will help us to know how the programme is doing, and what topics you found helpful, to assist us to find ways of improving it.

We also want to talk to as many people as possible who take part in Carousel, to explore questions such as:

- **Do you feel that you benefited from the Carousel programme?**
- **Are there any sessions or topics covered by the programme, which you found particularly helpful? If so what were they?**
- **Are there any sessions or topics covered in the programme which you did not find helpful? If so what are they?**
- **Should the group be changed in any way?**
- **Does the group have any impact on patterns of self-harm?**
- **Has attending the group helped people cope better with prison life**
- **Do prisoners feel differently about themselves after attending the group?**

If we find that the group is helpful we will try to get the prison to continue to run the group. If we find that the groups need to be run in a different way or are not helpful we can make sure that changes are made.

You are being invited to take part in this study because you are about to join a group and we would like to hear your views. However you do not have to take part in the study in order to get a place on the self-harm group.

If you agree to take part in the study you will be interviewed twice by the facilitator or researcher: once before you start the group and again at the end or after the group stops. On each occasion you will also be asked to complete some questionnaires. If you agree to take part and then change your mind you can stop the interview **at any time.** This will not have any effect on your taking part in the group, or on any aspect of your life in the prison.

At some point it is likely that research will be carried out and used for publication. **The information you give to the interviewer and the answers you give to the questions will be kept confidential**. When the study is written up no names will be given and all the answers will be put together so that you cannot be identified or linked with particular answers. You will be referred to as a number such as 'Participant' 1. The only exception is that if you indicate that you are about to hurt

yourself, hurt someone else, or cause a breach of security we are legally bound to tell prison staff. If this happened we would speak to the Suicide Prevention Coordinator.

Thank you for reading this.
If you are happy to take part in the study please read and sign the Consent Form

Julia Rose
Chartered Counselling Psychologist.

Consent Form **Participant Code ∀∀∀**

Please read the statements and tick each box

I have read the Information given above and I am willing to take part in the study. ∀

I understand that if I change my mind I can withdraw from the study at any time and this will not prevent me attending the group. ∀

I understand that if I indicate that I am about to hurt myself, hurt anyone else, or cause a breach of security at the prison, this information will be passed on to the Suicide Prevention Coordinator. ∀

If I feel distressed or concerned at any time during the study I will tell the interviewer. ∀

I understand that if I feel upset or distressed at any time after the interview I can talk to …….. about it. ∀

Signed …… (Participant)

Print Name……..

Signed ……. (Researcher)

Date ……..

Appendix 11: Measures – Hospital Anxiety and Depression Scale

HOSPITAL ANXIETY & DEPRESSION SCALE (HADS)

Name: _____

Date: _____

Please read each item, and then indicate the frequency you have felt like this in the last 7 days.

1A. I feel tense or 'wound up'?

Most of the time	3
A lot of the time	2
From time to time	1
Not at all	0

2D. I still enjoy things I used to?

Definitely as much	0
Not quite so much	1
Only a little	2
Hardly at all	3

3A. I get a sort of frightened feeling as if something awful is about to happen?

Very definitely and quite badly	3
Yes, but not too badly	2
A little, but it doesn't worry me	1
Not at all	0

4D. I can laugh & see the funny side of things?

As much as I always could	0
Not quite as much now	1
Definitely not so much	2
Not at all	3

8D. I feel as if I am slowed down?

Nearly all the time	3
Very often	2
Sometimes	1
Not at all	0

9A. I get a sort of frightened feeling like 'butterflies' in the stomach?

Not at all	0
Occasionally	1
Quite often	2
Very often	3

10D. I have lost interest in my appearance?

Definitely	3
I don't take as much care as I should	2
I may not take quite as much care	1
I take just as much care as ever	0

11A. I feel restless as if I have to be on the move?

Very much indeed	3
Quite a lot	2
Not very much	1
Not at all	0

5A. Worrying thoughts go through my mind?

A great deal of the time	3
A lot of the time	2
Not too often	1
Very little	0

6D. I feel cheerful?

Never	3
Not often	2
Sometimes	1
Most of the time	0

7A. I can sit at ease & feel relaxed?

Definitely	0
Usually	1
Not often	2
Not at all	3

12D. I look forward with enjoyment to things?

As much as I ever did	0
Rather less than I used to	1
Definitely less than I used to	2
Hardly at all	3

13A. I get sudden feelings of panic?

Very often indeed	3
Quite often	2
Not very often	1
Not at all	0

14D. I can enjoy a good book, radio or TV programme?

Often	0
Sometimes	1
Not often	2
Very Seldom	3

Appendix 12: Measures – Coping Style Questionnaire

Coping Styles Questionnaire

Although people may react in different ways to different situations, we all tend to have a characteristic way of dealing with things which upset us. How would you describe the way you typically react to stress?

Circle **A**lways (A), **O**ften (O), **S**ometimes (S) or **N**ever (N) for each item below

1. Feel overpowered and at the mercy of the situation	A	O	S	N
2. Work out a plan for dealing with what has happened	A	O	S	N
3. See the situation for what it actually is and nothing more	A	O	S	N
4. See the problem as something separate from myself so I can deal with it.	A	O	S	N
5. Become miserable or distressed	A	O	S	N
6. Feel that no-one understands	A	O	S	N
7. Stop doing hobbies or interests	A	O	S	N
8. Do not see the problem or situation as a threat	A	O	S	N
9. Try to find the positive side to the situation	A	O	S	N
10. Become lonely or isolated	A	O	S	N
11. Daydream about times in the past when things were better	A	O	S	N
12. Take action to change things	A	O	S	N
13. Have presence of mind when dealing with the problem or circumstances	A	O	S	N
14. Avoid family or friends in general	A	O	S	N
15. Feel helpless – there's nothing you can do about it	A	O	S	N
16. Try to find more information to help make a decision about things	A	O	S	N
17. Keep things to myself and not let others know how bad things are for me	A	O	S	N
18. Think how about someone I respect would handle the situation and try to do the same	A	O	S	N
19. Feel independent of the circumstances	A	O	S	N
20. Sit tight and hope it all goes away	A	O	S	N

21. Take my frustrations out on the people closest to me	A	O	S	N
22. 'Distance' myself so I don't have to make any decision about the situation	A	O	S	N
23. Resolve the issue by not becoming identified with it	A	O	S	N
24. Assess myself or the problem without getting emotional	A	O	S	N
25. Cry, or feel like crying	A	O	S	N
26. Try to see things from the other persons point of view	A	O	S	N
27. Respond neutrally to the problem	A	O	S	N
28. Pretend there is nothing the matter even if people ask what's bothering me	A	O	S	N
29. Get things into proportion – nothing is really that important	A	O	S	N
30. Keep reminding myself about the good things about myself	A	O	S	N
31. Feel that time will sort things out	A	O	S	N
32. Feel completely clear-headed about the whole thing	A	O	S	N
33. Try to keep a sense of humour – laugh at myself or the situation	A	O	S	N
34. Keep thinking it over in the hope it will go away	A	O	S	N
35. Believe that I can cope with most things with the minimum of fuss	A	O	S	N
36. Try not to let my heart rule my head	A	O	S	N
37. Eat more (or less) than usual	A	O	S	N
38. Daydream about things getting better in the future	A	O	S	N
39. Try to find a logical way of explaining the problem	A	O	S	N
40. Decide it's useless to get upset and just get on with things	A	O	S	N
41. Feel worthless and unimportant	A	O	S	N
42. Trust in fate – that things have a way of	A	O	S	N

working out for the best				
43. Use my past experiences to try to deal with the situation	A	O	S	N
44. Try to forget the whole thing	A	O	S	N
45. Just take nothing personally	A	O	S	N
46. Become irritable or angry	A	O	S	N
47. Just give the situation my full attention	A	O	S	N
48. Just take one step at a time	A	O	S	N
49. Criticise or blame myself	A	O	S	N
50. Simply & quickly disregard all irrelevant information	A	O	S	N
51. Pray that all things will just change	A	O	S	N
52. Think or talk about the problem as if it did not belong to me	A	O	S	N
53. Talk about it as little as possible	A	O	S	N
54. Prepare myself for the worst possible outcome	A	O	S	N
55. Feel completely calm in the face of any adversity	A	O	S	N
56. Look for sympathy and understanding from people	A	O	S	N
57. See the thing as a challenge that must be met	A	O	S	N
58. Be realistic in my approach to the situation	A	O	S	N
59. Try to think about or do something else	A	O	S	N
60. Do something that will make me feel better	A	O	S	N

Appendix 13: Post-Group Interview

Post-Group Interview **Date: -_____**

Participant Code Number:

1. **Did you feel that you benefited from the Carousel Programme?**

1b. Are there any sessions or topics covered by the Programme, which you found particularly helpful? If so, what were they?

1c. Are there any sessions or topics covered by the Programme, which you did not find particularly helpful? If so, what were they?

2. **How many sessions of the group did you attend?**

2b. Did you complete the course/group?

[Reasons for non-attendance or non-completion:]

3. **Did you ever feel distressed during the group or after attending the group?**

Yes/No

3.a If Yes. Explain:

4. **Do you have any suggestions for changing or improving the group?**

5. Self-Harm - (Cross check with pre-interview if available)

5a. How often were you harming yourself before you started the group?

5b. Since starting the group how often have you thought about harming yourself? (week/month)

5c. Since starting the group have you actually harmed yourself? If yes, how many times (week/month)

Give dates, details, and reasons:

6. Has there been any occasion since starting the group when you felt like harming yourself but didn't? Yes/No

6a. If yes, what happened?

6b. What did you do instead of harming yourself?

6c. Did you think about anything discussed at the group?

6d. If yes, was it helpful or not?

7. Since starting the group, has there been any occasion when you tried to avoid self-harming but couldn't?

Yes/No

7a. If yes, what happened?

7b. What made it difficult to avoid self-harming?

7c. Did you think about anything discussed at the group?

7d. If yes, was it helpful or not?

Appendix 14: Raw Data – Qualitative Responses

Qualitative Raw Data - Participants Responses in Discussion of Key Themes

P1	*"I go through my 100 coping strategies – one of them is bound to work".* *"Staff help – I knew she (tutor) would be there if I need her".*
P2	*"One night I felt so bad and I wrote my coping strategies on a piece of paper and stuck them to my door, they worked: I didn't cut up!"* *"I was always in trouble and locked behind my door, I have spent a lifetime down the block! But now I think before my mouth gets me into trouble, and I haven't kicked off for weeks".*
P3	*"The past is the past and I can't change it, but I don't have to hurt myself any more". "When I realised that he can't hurt me no more, was when I stopped cutting".* *"I like making the happy boxes, and I always open mine when I feel like cutting; it's the third thing on my list of coping strategies. The first is breathing; doing the 7/11, the next is punching my pillow".*
P4	*"I don't need to punish myself anymore*". *"…rotten through and through and deserved to be punished"* because she "*…was very bad".*
P5	*"A couple of others say they see me as a tower of strength in the group … that's nice".* *"It was good listening to others and what they do to try and stop hurting themselves. During association, we try and get together and that has really helped, we understand each other".*
P6	*"Therapeutic art was the best it was fun. I can't wait for Fridays for art, then dread the weekend, too much 'lock up', I hate it. When I am behind my door I have to much time to think of the past".*
P7	*"I hated the fact that we are locked in our rooms whenever the officers feel like it. So I now tell them when I want to be locked in my room, usually five minutes before lock up time. I won the competition for asking the officers to lock me in my room, as my coping method, it was great".*
P8	*"I used to think that Mr. *** was a bag of sh*t but he's really helped me*". *"Uncreative"* and *"Not my thing".*
P9	*"When we played basket ball I ran into a wall... so I stayed away!" "I've got certificates from the gym … It's given me insight into options".*
P10	*"I thought I was the bad one, but I'm not". "When I think of all the years wasted, thinking it was my fault – (pause) it makes me sick!"* *"I actually like myself now".* *"was unlovable".*
P11	*"I know I had a bad attitude and used to blame others for everything I did, I think I still have things to learn but I don't kick off like I used to".*

P11	*"I know I had a bad attitude and used to blame others for everything I did, I think I still have things to learn but I don't kick off like I used to".* *"'Protect' has become my buzzword".* *"I would go if I could say when I wanted to go, what I wanted to do and for how long".*
P12	*"We did karaoke – it was brilliant, funny; we always come out smiling"*
P13	*"I dance to cope, if you can call it dancing. I used to hate f**king dancing, but now it is number two on my list of coping strategies. The screws thought I was f**king mad bopping up and down in my room, but do you know what? I don't give a 'monkeys arse'; I would rather do that than cut up!"*
P14	*"Writing down my reasons for wanting to self-harm helped me reflect my thoughts feelings and it 'got rid' of the urge to self-harm".*
P15	*"I write down how I feel, what I think I should do and then how I would feel afterward".* "*It was so good to be amongst others who self-harmed, who supported us when we were new to the group".*
P16	*"I always write down how I feel, its my first port of call when the lights go out".* *"unable to concentrate for long-periods".*
P17	*"I have 128 coping strategies the first few are the ones that work the most, but if I have a really bad night then I will work through them all if I have to. I haven't cut up since the second week of the group".* *"When I was down and nothing else worked, particularly when the lights are out, I would open the happy box and get everything out that makes me feel good".*
P18	*"Before I would have sworn, cut up, lost my temper. Now I can let it go over my head".*
P19	*"I found I learnt to pick up on things from other people – I learnt not to write them off"* *"I've never liked sport or exercise".*
P20	*"I won the competition one week for having the most coping strategies; I have never won anything ever in my life before. It sort of gave me a reason to go on and I felt that I had achieved something. I got given a box of 'Maltesers'. I could have eaten them all to myself, but shared them with the rest of the group, I felt so good! This may sound daft but I kept the box as a souvenir. I decorated it in our art group and I now put my pens and crayons in it".* *"People really care here, even the governor does".*
P21	*"I haven't hurt myself or beaten anyone up as I did before".* *"Alcohol was my thing. I only ever stole when I was drunk; now I don't need to drink anymore".*
P22	*"I used to switch on a self-destruct button – now I can switch it off"* *"I now think before I go into anything; I never even thought about protecting myself from myself, let alone him".*

P23	*"I used to think this coping strategy lark was stupid, but I now have 110 that I use if I have to, and you know what? One of them will work".* *"The teacher talked to you as well. She's a good listener, doesn't judge you".*
P24	*"I was always afraid to talk about things before, as it was always a secret, I was afraid that something bad would happen to me or my family, but I was more worried about my mum and dad, oh and my little sister. But for the first time in my life I know that not all people are bad, and I feel safe".* *"It helps with my aggression, doing weights... I do press-ups in my cell".*
P25	*"Was a big thing realising that it's not my fault".* *"I always said I was not coming back to prison, now I know I won't. I know it's not going to be easy, but I am really going to try".*
P26	*"I felt so bad so I tried the coping strategies. I went through about a dozen in an hour but at least it got me through".* *"I used to be one of the nastiest people in jail but now I've been told by Miss **** that I have mellowed, and I have ... I've changed so much".* *"I always believed that I was a bad person, now I know that I'm not, and I did not deserve that treatment".* *"Last time I was in, I hit one of the 'screws' – but he did wind me up, now I don't let them get to me, well not so much. It's normally them or me, but I haven't self-harmed since I came on this group".* *"I know it's not going to be easy, but I am really going to try".* *"I keep my photos in my box, when I feel like self-harming I get them out".*
P27	*"I've had the idea of a happy book, like a scrapbook, you put in poems, memories and pictures. When I feel down I can pick something out of the book".* *"Thank God for Carousel".*
P28	*"I was always in trouble and locked behind my door, I have spent a life time down the block. But now I think before my mouth gets me into trouble, and I haven't kicked off for weeks".*
P29	*"I hated exercise in the past, you could say I was lazy – I suppose I was, but now I can't get enough of it, it's like a drug, you know you get hooked, but unlike drugs, it doesn't cost money!"* *"That's it! I have decided that this time I am not coming back into prison. I now know that my drug habits got me into trouble. I get a better high after one hour in the gym than I did on Crack, and it lasts longer! I believe I can cope on the outside".* *"It was the drugs that got me into trouble, I took crack, then I stole for me next shot".*

P29	*"I hated exercise in the past, you could say I was lazy – I suppose I was, but now I can't get enough of it, it's like a drug, you know you get hooked, but unlike drugs, it doesn't cost money!"* *"That's it! I have decided that this time I am not coming back into prison. I now know that my drug habits got me into trouble. I get a better high after one hour in the gym than I did on Crack, and it lasts longer! I believe I can cope on the outside".* *"It was the drugs that got me into trouble, I took crack, then I stole for me next shot". "Why should I waste my life in jail, sod my friends, I am going to live with my mum in Kent, no one knows me there, I will have a fresh start, even my old fag of a boyfriend can't get me there".*
P30	*"I've never asked for help before, find it so much easier now".*
P31	*"Even the 'Screws'[37] are better in this jail – Miss (officer) has been very helpful, I like it when she's on, 'cos' I can talk to her and she doesn't look down on me".*
P32	*"Knowing I'm not the only one that's been through crap helps, we all help each other".* *"I'm to blame, it's all my fault".* "*I was worried about coming in to the group but meeting others that were in the same boat and who were able to help me, made me feel better*".
P33	*"I used to think I was a really bad person, and no-one would ever want me: I was unlovable, now I know that I am OK and 'I'm not to blame".* "*I realised that I was not alone, and for once in my life I was able to express how I felt in a safe environment without feeling that I was stupid and alone*".
P34	*"I've realised that things are not my fault … they don't judge me, don't push me…it's clever how they got me to talk".*
P35	*"Sculpting faces …gets your aggression out".*
P36	*"Night time was the worst, it's when everything at once seems to go through my mind. The journal really helps, I can get it all down on paper and it helps me to think straight. What's more, I can't get into trouble about what I write".* *"Look at me! I have lost loads of weight and feel so much better about myself".*
P37	*"It helped to get rid of my anger, I reflected on how I would feel later after I had cut. I*

[37] 'Screw' is a term prisoners sometimes used to describe a 'Prison Officer'.

Appendix 15: Raw Data – Self-Harm Levels

Raw Data: Self-harm levels

Participants	Self-harm Levels	
Number	Pre	Post
1	8	1
2	24	0
3	8	0
4	16	0
5	16	2
6	16	1
7	24	0
8	16	0
9	8	0
10	8	0
11	8	0
12	16	0
13	16	0
14	8	1
15	16	1
16	24	0
17	8	0
18	8	0
19	56	0
20	80	16
21	32	1
22	56	8
23	16	0
24	16	0
25	8	0
26	32	0
27	8	0
28	56	16
29	16	2
30	8	0
31	16	1
32	4	0
33	4	0
34	56	16
35	8	0
36	16	0
37	8	0
38	8	0
39	16	0
40	16	1

Appendix 16: Raw Data – HADS Levels

Raw Data. HADS

Participants	Depression		Anxiety	
Number	pre	post	pre	post
1	10	7	10	8
2	11	6	12	6
3	11	9	12	8
4	13	10	13	10
5	16	11	15	11
6	16	10	17	10
7	15	8	16	9
8	11	7	12	8
9	18	10	16	11
10	12	7	13	6
11	9	6	9	6
12	18	10	17	9
13	11	8	15	9
14	14	9	15	8
15	12	8	11	7
16	19	9	19	10
17	11	9	10	7
18	9	9	9	7
19	17	14	19	7
20	11	8	17	11
21	11	9	15	9
22	18	14	19	9
23	9	8	11	8
24	19	13	18	9
25	9	8	9	6
26	12	10	16	10
27	10	8	9	6
28	11	8	19	8
29	7	7	9	8
30	11	9	9	7
31	14	11	11	8
32	19	14	19	10
33	9	9	9	7
34	8	10	9	8
35	11	7	11	9
36	11	8	13	7
37	9	9	11	8
38	11	9	10	7
39	15	11	11	8
40	12	10	12	9

Appendix 17: Raw Data – CSQ Levels

Raw Data. CSQ

Participants	Rational Coping RATCOP		Detached Coping DETCOP		Emotional Coping EMCOP		Avoidance Coping AVCOP	
	pre	post	pre	post	pre	post	pre	Post
1	18	31	18	24	27	22	22	22
2	16	34	10	26	37	7	29	16
3	7	23	7	21	26	12	22	15
4	5	25	5	23	37	14	16	16
5	8	24	7	26	36	15	25	14
6	12	32	12	22	37	14	18	14
7	8	22	17	24	37	12	27	15
8	6	24	8	26	35	8	28	24
9	12	31	12	23	36	7	29	15
10	17	25	18	26	36	12	24	12
11	16	32	15	22	29	20	27	14
12	5	26	5	24	37	7	20	18
13	8	30	15	32	33	10	22	10
14	12	28	14	30	33	21	26	24
15	22	24	14	22	31	21	19	18
16	2	33	11	37	37	7	14	14
17	10	37	9	30	30	15	21	8
18	24	28	7	21	21	18	13	8
19	8	39	4	28	47	7	17	16
20	4	35	2	21	40	16	20	13
21	16	34	8	16	38	12	19	12
22	3	10	9	12	46	29	14	14
23	2	18	4	14	35	17	23	15
24	6	31	17	26	44	10	27	9
25	11	39	14	24	21	16	18	16
26	6	21	9	11	41	16	16	16
27	14	24	12	17	22	17	19	19
28	6	36	10	25	46	15	23	20
29	14	17	11	19	33	29	22	20
30	7	18	5	9	27	22	21	17
31	2	36	3	18	35	19	20	11
32	13	33	20	24	45	18	30	21
33	12	14	7	8	17	10	15	13
34	19	17	17	15	19	14	19	13
35	13	40	17	20	27	20	25	19
36	12	26	10	24	38	22	19	17
37	7	22	5	16	28	14	16	14
38	19	41	13	33	21	16	19	16
39	11	27	12	19	25	6	25	7
40	10	26	14	18	32	11	24	15

Appendix 18: Diagnostic Criteria for Borderline Personality Disorder

Diagnostic Criteria for Borderline Personality Disorder -

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts as indicated by five (or more) of the following:

1) Frantic efforts to avoid real or imagined abandonment's
2) A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation an devaluation
3) Identify disturbance: markedly and persistently unstable self-image or sense of self
4) Impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating)
5) Recurrent suicidal behaviour, gestures or threats or self-mutilating behaviour
6) Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability or anxiety usually lasting a few hours and only rarely more than a few days)
7) Chronic feelings of emptiness
8) Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays if temper, constant anger, recurrent physical fights)
9) Transient, stress-related paranoid ideation or severe dissociative symptoms.

Appendix 19: Carousel Manual

CAROUSEL GROUP WORK PROGRAMME

PSYCHOLOGICAL MANAGEMENT

OF

DELIBERATE SELF-HARM

(DSH)

HMP [redacted]

Devised by Julia Rose and

Authored by Julia Rose and Barry Pope, 2004

This programme has been revised and implemented with support and consultation from Dr. Louisa Snow, Claire Russ, Dr. Dennis Trent, Niall Clifford and Barbara Treen. Special thanks to all of the above.

All methods and exercises described in the manual have been successfully used and evaluated in the Carousel groups. Following the three initial pilot studies, the programme is fully implemented at HMP [redacted].

The Carousel Programme is an eight-session programme comprising: - individual therapy, therapeutic art, physical exercise (gym) and group therapy. Each session deals with a particular aspect of the whole programme and ideally the client completes the 'Carousel cycle'. One of the strengths of the programme is that the clients can join at any stage and leave at any stage (with the exception of week 5), within the eight week cycle. Due to the process of the remand and prison movements each element of the programme has the potential to be of benefit to clients, whether or not they complete the whole 'Carousel cycle'.

Individual Therapy (One to One)

Prior to Group Programme each client undergoes a 1-hour session of individual therapy.

During the session, psychometric tests are administered including: the Firestone Assessment of Self-Destructive Thoughts Questionnaire (FAST), Hospital Anxiety/Depression Scale (HADS), Coping Skills Questionnaire (CSQ) and Repertory Grids.

Individual Therapy continues throughout the programme, one hour per week.

Therapy Group

Group members attend therapy/treatment group one morning per week for a two-hour session.

Therapeutic Art

Group members attend art therapy once a week for two-hour session.

Gymnasium

Group members attend gym three mornings per week for 1 ½ hours.

Entry Criteria is a recent/past history of 'self-destructive behaviour'. Either self-referral or staff referral is required with a willingness to engage in psychotherapy.

CAROUSEL GROUP WORK PROGRAMME PSYCHOLOGICAL MANAGEMENT OF DELIBERATE SELF-HARM

HMP [redacted]

Carousel Session 1

Title of the session:	**Introduction to the course**
Aims of the session:	To establish the group and orientation to the Carousel group-work programme. Establish joint group aims and objectives. Establish group rules. To discuss and elaborate the reasons for deliberate self-harm for women within the group. Describe and provide the group participants with their weekly journal. Introduce the notion of coping strategies and provide tasks for the following week.
Facilities:	Programmes Room, HMP [redacted] with comfortable seating, cushions and audio equipment.
Materials:	Flip chart, drawing materials, journal and refreshments.
Length of session:	2 hours.

1.1: Introduction to the Course

Welcome and ice breaker exercise of a non-threatening nature in order to help people feel part of the group, for example:

EXERCISE 1	Ask the group to turn to the person next to them and take turns in telling each other the positive things about themselves. Then pick three positive points about each other and feed it back to the group. Facilitators also take part in this exercise.
LEARNING POINTS	To break the ice, help members to feel more comfortable and orientated to the group scenario. To establish early ideas of positive describing and thinking.

1:2: Orientation to the Carousel Group-Work Programme

Facilitators need to describe the purpose of the Carousel group and the emphasis on a collaborative approach between the facilitators and group members. State clearly how long the group will last and the components of the group; for example, the physical education (GYM), one to one individual therapy and therapeutic art. Ensure that all leaflets and timetables are handed out and the personal journals. Ensure that all group members understand the philosophy of the Carousel programme and where necessary ask them to repeat back what the aims of the group are.

1:3: Joint aims and objectives

Facilitators state clearly that the group is an alternative to intentional self-injury or deliberate self-harm. Discuss the need for each participant to develop appropriate life-skills and link this to the eight weeks of the Carousel programme. At this point, it is

important to allow participants to have a dialogue in the aims and objectives by asking them what aims and objectives they would like to see or expect from the programme. The facilitators need to ensure that the emphasis is on coping strategies and future objectives rather than the exploration of individual past difficulties. Reiterate that the individual therapy is the ideal setting for exploration of these difficulties.

1:4: Group Rules

Through brainstorming, establish a group set of rules and these should number no more than six as a maximum.

EXERCISE 1.2	Ask the group what group rules they would like to include for the programme, and write them on the flip chart.
LEARNING POINTS	To assist the members to 'own' and value the group rules, and understand the purpose of the implementation.

Facilitators should ensure that individual respect, autonomy and confidentiality are at the centre of the rule process. For example, confidentiality both within the group and in the wider establishment. Facilitators should state clearly where confidentiality meets its boundary and ceases. For example, where information is revealed regarding security issues, violence to either self or others and any issue that is thought serious enough to require disclosure outside of the group. It is important for facilitators to state these points very clearly, as confidentiality is always an issue within groups, particularly in a population who are frequently suffering from mental health problems and traumatic childhoods.

Discussion and Elaboration of Deliberate Self-Harm

EXERCISE 1.3	Brainstorm definitions of deliberate self-harm for example self-injury, self-sabotage, cutting, etc.
LEARNING POINTS	Focus upon individual and group ways that DSH features in the clients' coping systems.

Therapists should be aware that self-injury takes many forms and not necessarily behaviours that could be observed by others. Some of the ways people self-harm are by ingestion of drugs or foreign objects, eating disorders, self-neglect, personal sabotage and hostility to others provoking a violent response.

Issues Arising

It is important that the facilitators' record issues arising on a flip chart, as these will need to be addressed at some point in the Carousel programme. For example, themes generally emerge when discussing deliberate self-harm or self-injury and it is inappropriate to deal with them in this session. Nevertheless, these themes will be consistent throughout the person's life and it is important for facilitators to contain this information and validate the individual's experience of coping whilst usually feeling seriously disturbed. Practical issues arise regarding methods people use around the performance of deliberate self-harm and these will need to be addressed or contained. At this point facilitators ***should not*** jump in with solutions to deliberate self-harm.

Introduction to the weekly journal

Facilitators should ensure that each participant has their personal copy of their journal and it is important to note that this is a private document. Facilitators will not have access to this journal unless the client requests or gives their permission. It is

important that this journal is kept safe and wing staff should be aware that information in the journal is private. Facilitators need to liaise with wing staff, and explain the purpose of the weekly journal and that it will contain the client's 'psychological experiments'. The facilitators will need to reiterate that the Carousel group work programme will give each client an opportunity to experiment with their own conduct and that there are no right or wrong answers. Therefore, the facilitators should encourage people to be able to discuss their views and experiments openly even where the client feels that things have not gone to plan.

BREAK FOR REFRESHMENTS

EXERCISE 1.4	**<u>Coping strategies and alternatives to substance use</u>** Therapists should use a brainstorm technique and will invite everyone within the group to provide ideas of coping strategies and substance use. At this point in the programme, it is important to put down all coping strategies even if many of them are socially unacceptable or maladaptive.
LEARNING POINTS	Identifying positive and negative coping strategies used by group members. Clients begin to understand that DSH is perhaps more common than they thought.

	Once all the ideas are written on the flip chart, separate the group into clusters of three and ask the groups to sort in to categories, the coping strategies (including 'substances') that they consider to be 'more' to 'less' sociable. This can be achieved by drawing a dividing line in the middle of the flip chart and putting

	acceptable strategies one side and the rest on the other side.
FEEDBACK DISCUSSION	Display sheets on the wall/board and facilitators to lead the discussion drawing the points from each one. Facilitators should be aware that many issues will arise and therefore the facilitators should note themes and commonalities as these usually come out in further sessions and will often inform the one-to-one therapy that the clients receive in the other part of the programme. Highlight the coping strategies that are socially acceptable within the Prison and ones that they feel will be useful to them for the following week.
LEARNING POINTS	Reinforcing and validating positive coping strategies.
EXERCISE 1.5	**<u>ACHIEVEMENTS</u>** Facilitators' explain that we rarely congratulate ourselves for the things that we do 'right'. We tend to be too hard and critical of ourselves. For example, we may remember the negatives i.e. things that are considered wrong, 'or the things that we don't do'. Ask the group as a quick brainstorm exercise to think of two actions each that are positive. Facilitator to give examples, such as helping someone, by listening to them, helping with the cleaning, etc. It is important to highlight that for someone who is feeling low, getting out of bed, or going to education, or doing a 'duty' can also be achievement. The facilitators' can highlight and reinforce these points, encouraging them to think positively.
LEARNING POINTS	To assist the group to recognise achievements, and learn to give themselves some praise. To build self-esteem and self-efficacy.

Tasking **LEARNING POINTS**	To develop a critical appraisal of over generalised thinking. **<u>Set task for work outside the session</u>** To record their achievements in their journal. This can be done through either listing the achievements or drawing a flower, using each petal to name the achievement (this can be described in one word for each petal). Facilitator to draw example on flip chart (refer to sheet 2 in appendices for example). N.B. In previous groups, the more artistic group members have drawn a flower for every achievement. There are no right or wrong ways of doing this exercise; it is important to encourage their natural abilities, thus increasing their self-awareness and self-esteem. Continuation and reinforcing positive thinking, building self-esteem and self-worth.
EXERCISE 1:6 **<u>GROUNDING</u>** **LEARNING POINTS**	Facilitators ask group members to name the most positive things that they have gained from the session, which they feel they can take with them. Ask each client in turn; if they can only think of one then its ok, however if they are unsure then to go back to them. N.B. On previous groups, members have helped and encouraged each other at this juncture. To ensure that each member is grounded and in a positive state, before returning to the wing.

Task for the Following Week

1) Keep a journal of coping strategies used throughout the week.
2) Attend the other parts of the Carousel programme (gym, individual therapy and therapeutic art).
3) Facilitators remind clients to use the journal as a coping strategy in ways that are appropriate for them i.e. through art, poetry, thoughts and feelings or other writing, magazine articles, etc. Facilitators also to suggest that the group members take their journal to therapeutic art to decorate the front cover.
4) Remind them to list or/and draw in their journals their achievements for the week.

Once group members return to the wings the facilitators evaluate the group session.

Post group evaluation/discussion

1) If a trainee has been present in the session, the facilitators should attend to their learning process and supervision.
2) Evaluate the week by discussing the group response to the topics and issues that may have arisen within the group.
3) There may be action points arising from the discussions or the whole group work process. A list of these should be made with action points.
4) For clients on F2052SH/ACCT watches, files should be completed within the sessions in accordance to the correct policy and procedures.
5) Where facilitators have concerns about particular clients, appropriate referrals should be sought, e.g. medical, psychiatric, probation etc.
6) Facilitators should liaise with Wing Staff (This is vital as the wing staff manage the clients on a day-to-day basis).

CAROUSEL GROUP WORK PROGRAMME PSYCHOLOGICAL MANAGEMENT OF DELIBERATE SELF-HARM

HMP [redacted]

Carousel Session 2

Title of the session: The exploration of clients' similarities and differences of experience (theories of causality).

Aims of the session: To establish within a group setting, peoples experiences of deliberate self-harm and common factors between the members of the group that may be involved with both coping strategies and episodes of self-harm.

The development of positive coping strategies.

A review of the journal and issues arising.

Introduce the notion of coping strategies and provide task for the following week.

Facilities: Programmes Room, HMP [redacted] with comfortable seating, cushions and audio equipment.

Materials: Flip chart, drawing materials, journal and refreshments.

Length of session: 2 hours.

EXERCISE 2:1	**Welcome and icebreaker** Prior to commencing this exercise, display the ground rules on the flip chart and reiterate the ground rules.
ICEBREAKER	Facilitators to prepare and deliver a task in order to help the group settle together. Make the task non-threatening and

	achievable by all members of the group. This task need only take three to five minutes in duration. Where you feel the group is capable of developing their own ice-breaker, this should be encouraged.

Introduction to the Session

EXERCISE 2:2	Facilitators should introduce the topic of the week emphasising that there are many similarities and differences between people. Explain that we all make sense of our experience in an individual way; therefore no two people see and feel things in exactly the same way.
REVIEW **Coping Strategies**	Facilitators should review the past week in terms of coping strategies. List these on a flipchart by either a facilitator or a confident member of the group. It is important to list all the strategies used that would be considered both socially acceptable and less acceptable. No attempt should be made to limit this list and each member should be encouraged to contribute to the brainstorming. Clients should also be encouraged to share the coping strategies that they have recorded over the past week. Facilitators should help the group members to explain the areas of coping that were most useful and 'how' they were useful. Thereby reinforcing the coping mechanisms people are using. This type of cognitive restructuring should be emphasised in a positive way and group members encouraged to look at the differences in their own coping strategies as well as the coping strategies of others. Experience tells us that people learn from these exercises, from

	within the peer group as well as from the facilitators. The constructs arising from this should be well noted by the facilitators, as they are frequently prone to areas of deficit in coping styles for each group member. The constructs can be used later in this session when looking at commonality of experience and coping mechanisms.
LEARNING POINTS	Differences in coping styles and peoples understanding of each others experiences. Identification of coping styles that perpetuate difficulties. Emphasis on positive coping strategies.

Issues Arising

Facilitators should be aware that issues of coping and not coping arise at this point from within the session. It is important to emphasise that anything that the group member does in order to cope is a coping mechanism. Introduce the idea that there is very seldom a way of not coping.

Facilitators will need to be sure of their own strength in being able to discuss issues of deliberate self-harm when people are using strategies that may be abhorrent to them. It is important that facilitators keep the session moving and not allow more time than is reasonable, on the discussion about issues that have arisen in relation to coping strategies. Experience tells us that the superficial development of coping strategies is often peripheral and in many cases, it is not internalised, but more of a discussion of what is acceptable rather than an internalisation of true coping styles. Facilitators need to reinforce the positive aspects of coping in a way that does not harm ‘self’ or ‘others’.

EXERCISE 2.3 Similarities and differences	Introduce the topic of similarity and difference and brainstorm how people think they are similar or different to each other. Here the facilitators should allow each person to be able to describe their own type of personality. The questions facilitators should ask and then record on the flipchart is 'Tell me three important things about yourself", this should be done for each group member and the others should listen without interruption to what the person says. The facilitators should also participate in this exercise (often helpful to go first). For example, I am a good friend". A person may reply 'I am a kind trusting person, I take drugs and shop lift', (they may at this stage consider their offending behaviour as positive, especially when they haven't been caught for their crime; this would be challenged later). At this point use group discussion to draw out themes of commonality between the descriptions, each has provided (including facilitators), and allow free dialogue. At this point, it is useful to keep the dialogue around personality factors emphasising commonality. Facilitators should be aware that even the most closed 'psychologically minded' clients will have areas of commonality with others and this should be treated by affirming the positive statements. For example, where a group member finds it difficult to interact within the group and prefers to remain silent, the facilitators can include this person by asking them to agree or disagree with some of the descriptions that people make about themselves. For example, the facilitator can ask 'Are you also a kind

	person?' etc.
LEARNING POINTS	Learning to feel safe within the group through cooperative discussion. Developing an awareness of common experience.

BREAK FOR REFRESHMENTS

2.4 Coping Strategies

EXERCISE 2.4 RELAXATION	Introduce relaxation as a coping strategy. Emphasising the importance of relaxation as a means of self-control of negative emotions, such as anger, fear and depression. Ask group members to sit comfortably and close their eyes. Talk through the technique of relaxation by using the tensing and relaxing of different parts of the body commencing with the feet, moving on to the legs, knees, stomach, chest, hands, arms, shoulders, neck, face and the mouth. It's helpful to play some soothing music at this juncture as an extra stimuli to aid in relaxation. Ask them to check each part of their body to ensure that there is no tension remaining and then to imagine they are relaxing in a field of flowers and the sun is warming them up … (keep silent for a few minutes). **N.B. this exercise needs to be administered very carefully and be aware of any adverse reactions in clients due to memories or traumatic incidents'. Some clients may need to**

	sit quietly to relax with their eyes open. This had proved to be a popular exercise in all groups and can be practiced in private.
LEARNING POINTS	Increase coping strategies, building up a 'toolbox for life'. Learning to relax.

Task for the Following Week

Facilitator to go through and explain the homework tasks ensuring that they are listed within their journals.

2.5 Task for the week	To practice the relaxation exercise at least twice daily. To record all coping strategies in the journal. Attend the other parts of the Carousel programme (gym, individual therapy and therapeutic art). Where a mentor is in place encourage each group member to use the mentor as appropriate, encouraging support from each other. Remind the group to list or/and draw in their journals their achievements for the week. Record in the journal at least three personality attributes of characters they see on the television or in real life. Describe at least three people. For example, the television soap 'Coronation Street' may be a favourite TV programme and three characters could be described from that. Alternatively, the soap 'Eastenders' could be used for people to draw their sample from. Ask the clients to note down the three personality attributes for each TV character. The facilitators should phrase

	the question 'What is 'X' like?' The facilitators' can give an example from their own experience i.e. 'X' is a kind person who sometimes gets very frustrated, a person who comes across all bubbly but is quite moody underneath, a person who appears to be a good friend. It is important for the facilitator to describe 'personality attributes' to get the example across otherwise people might simply write down that 'X is a woman' or 'Y is a prison officer'.
LEARNING POINTS	Learning to think about personality characteristics and differentiate at a conscious level. Helps the client to focus adjectives that are used to describe people. This is fundamental in the development of empathy and the process of sociality, i.e., 'putting yourself in another's shoes'.

Summary

Summarise the week and pull together positive experiences and remind people of the tasks to be undertaken as well as the journal. It is important that people leave the group ready and feeling able to conduct their experiments on observations, as they were grounded on the previous week.

2.6 GROUNDING

EXERCISE 2.6 GROUNDING	Facilitators ask group members to name the most positive things that they have gained from today that they can take with them. Ask each one in turn; if there is only one then it is ok, if they are unsure then to go back to them. On previous groups, members have helped and encouraged each other at this juncture.

LEARNING POINTS	To ensure that each member is grounded and in a positive state, before returning to the wing.

Once group members return to the wings the facilitators evaluate the group session.

Post group evaluation/discussion

1) If a trainee has been present in the session, the facilitators should attend to their learning process and supervision.
2) Evaluate the week by discussing the group response to the topics and issues that may have arisen within the group.
3) There may be action points arising from the discussions or the whole group work process. A list of these should be made with action points.
4) For clients on F2052SH/ACCT watches, files should be completed within the sessions in accordance to the correct policy and procedures.
5) Where facilitators have concerns about particular clients, appropriate referral should be sought, e.g. medical, psychiatric, probation etc.
6) Facilitators should liaise with Wing Staff (This is vital as the wing staff manage the clients on a day-to-day basis).

CAROUSEL GROUP WORK PROGRAMME PSYCHOLOGICAL MANAGEMENT OF DELIBERATE SELF-HARM

HMP [redacted]

Carousel Session 3

Title of the session: **Life experiences and pain**

Aims of the session: Explain that the aim of the session is to look at people's life experiences focused on the causes of pain.

Introduce the concepts of conscious and automatic construal/ thinking.

Introduce 'Seven-eleven' 7/11 breathing technique for emotional control and slow down rapid breathing.

The exploration of alternatives to substance abuse.
The development of further coping strategies.

Facilities Programme run at HMP [redacted] with comfortable seating, cushions and audiovisual equipment including flip chart, drawing materials and refreshments.

Length of the session: 2 hours.

Materials needed: Flip chart, personal journal and refreshments.

EXERCISE 3:1	**Welcome and icebreaker** Prior to commencing this exercise, display the ground rules on the flip chart and reiterate the ground rules.
ICEBREAKER	Facilitators to prepare and deliver a task in order to help the

	group settle together. Make the task non-threatening and achievable by all members of the group. This task need only take three to five minutes in duration. Where you feel the group is capable of developing their own ice-breaker, this should be encouraged.

Introduction to the session

Exercise 3.2	**Facilitators introduce the concepts of conscious and automatic construal/ thinking, giving an example from their own experience.** **Inform the group that will return to this after the review.** **Review of the Past Week and Issues Arising from the Journal** Here it is important that the facilitators' time limit this discussion particularly where people have had a difficult week. Where difficult issues arise, remind clients that they can bring these issues up in their individual one-to-one therapy. From our experience it is important to keep the discussion flowing and certain group members may be particularly disturbed during every weekly programme and there is a tendency to monopolise the group if allowed to do so. As many people who can identify with the group members as on the Carousel programme they will have multiple problems so it is easy for them to monopolise the time in the group. Facilitators need to keep the boundaries and focus of the session clear.

Exercise 3.3	**<u>Topics, Life Experience and Manifestation of Pain</u>** Facilitators should introduce the idea that some of our experiences can be painful and give an example where this is possible. For example, 'When people have been nasty to us we sometimes feel the pain in our bodies and this may come out as anger, disappointment or other emotional states etc.' Facilitators should remain vigilant of the responses of group members at this particular time as most of them will have very painful memories that may be triggered by this simple discussion. Introduce the link between psychological pain and somatic manifestation. For example, 'In the first world war some of the men in the trenches were paralysed when the order was given to go over the top, they knew they were travelling to certain death. Although they would want to obey the orders, their physical bodies simply became paralysed and disabled. These men were actually treated at the Northfield Hospitals in Birmingham, well away from the trauma of the war and they gradually began to improve and regain their mobility. This example can be used as an extreme example of psychological problems causing physical disablement or physical symptoms. Give another example of where a prisoner is 'banged up behind the door' and they feel this is unjust as they have behaved appropriately, how these actions can cause an emotional response i.e. anger, depression, nausea etc. N.B. in previous groups all the clients could relate to the latter example, even if it hasn't happen to them, they know of others that it has. Ask the group members, what experiences or examples they would like to share with the group?

LEARNING POINTS	Continuously record on the flip chart the types of experiences/ examples and manifestations of pain experienced by the group members. For example write down the key word of what someone says, their experiences and then when in doubt ask them 'How they experienced the pain.' Be sure to write down what the client says rather than provide an interpretation. It is important to establish a link between the experience and the manifestation of internal pain. You can use examples of adrenaline rushes or heaviness in the chest, however, always link the experience to that of pain. Facilitators should not dwell too much on the pain angle after it has been established. It is also appropriate to gauge the feeling within the group and experience will tell you that too much discussion of negative aspects of life will in fact lead the client to spiral in to an emotional tunnel. Facilitators will need to be very attentive to the whole group situation as well as individuals within the group. If the discussion becomes very painful for group members, introduce examples of present experiences and ask people to describe instances where they have felt joy and happiness. Facilitators need to be aware that not all people within your group will have experienced joy or happiness therefore you need to establish an experience that is positive even if only slightly in that direction. Experience of your previous training by the Carousel facilitators will have been invaluable in the management of these situations. The physiological manifestation of psychological pain using the examples from history and current day experience.

	Learning that there is often a link between negative experiences and internal pain.

BREAK FOR REFRESHMENTS

EXERCISE 3.4	**Introduction of Automatic Thoughts** At this point facilitators introduce the concept of automatic thinking and automatic feeling. At this time there is no need to elaborate these notions, however the group should be encouraged to discuss for the last part of the session, instances where they have 'thought' automatically and 'felt' automatically. The group discussion should be a dialogue between group members including facilitators and you can use your skills to highlight where people think or feel automatically. For example, the facilitator can tell a short story where someone is provoked and automatically lashes out, swears and eventually gets in conflict with the prison regime.
The Brain	Use the brain as an illustration of automatic thinking/feeling. Facilitators draw the brain on the flip chart and label the main parts. Explain/illustrate what happens when we experience pain, both emotional and physically. Pointing to the different parts on the drawing of the brain. Include emotions such as anger, fear etc. Highlight automatic thinking and conscious thinking. Explain fight/flight response. N.B. previous group members have really enjoyed this section. It is important to keep it 'light and jargon free.'
LEARNING POINTS	The development and awareness of automatic thinking and feeling. Introducing the idea that there are different systems

	working within us all where we can respond to events at an automatic level rather than at an overtly conscious level. Further insight into emotions.

EXERCISE 3.5	**Breathing control** Introduce the 7/11 breathing technique. Ask the clients to practice breathing in slowly to the count of 7, then exhale to a steady count of 11. Explain that this technique can be very effective in calming our emotions and with practice will help them to gain more self-control. This is also an excellent technique to regain the control of rapid breathing during an onset of a panic attack, thus reducing the risk if hyperventilation (Rose, 2004).
LEARNING POINTS	Learning to control breathing in a positive way when under emotional pressure, angry or when needing to focus the mind.

Summary

Summarise the week and pull together positive experiences and remind people of the tasks to be undertaken. It is important that people leave the group ready and feeling prepared and equipped, thus able to conduct their experiments on observations, as they were grounded on the previous week.

3.6 GROUNDING

EXERCISE 3.6 GROUNDING	Facilitators ask group members to name what are the most positive things that they have gained from this session that they can take with them? Ask each one in turn; if there is only one then it is ok, if they are unsure then to go back to them. On previous groups, members have helped and encouraged each other at this juncture.

LEARNING POINTS	To ensure that each member is grounded and in a reasonably positive state, before returning to the wing.

Once group members return to the wings the facilitators evaluate the group session.

Post group evaluation/discussion

1) If a trainee has been present in the session, the facilitators should attend to their learning process and supervision.
2) Evaluate the week by discussing the group response to the topics and issues that may have arisen within the group.
3) There may be action points arising from the discussions or the whole group work process. A list of these should be made with action points.
4) For clients on F2052SH/ACCT watches, files should be completed within the sessions in accordance to the correct policy and procedures.
5) Where facilitators have concerns about particular clients, appropriate referral should be sought, e.g. medical, psychiatric, probation etc.
6) Facilitators should liaise with Wing Staff (This is vital as the wing staff manage the clients on a day-to-day basis).

CAROUSEL GROUP WORK PROGRAMME PSYCHOLOGICAL MANAGEMENT OF DELIBERATE SELF-HARM

HMP [redacted]

Carousel Session 4

Title of the session:	**Ways of getting better**
Aims of session:	To introduce a model of conscious and automatic construal (thinking and feeling).
Joint aims and objectives:	Making life style choices through discussion of automatic construal. Develop new coping strategies through building on previous techniques and session based techniques. A review of previous homework set and through group work, the discussion of issues arising so far.
Facilities:	Programmes room HMP [redacted] with comfortable seating, cushions and audiovisual equipment.
Materials:	Flip chart, drawing materials, journal and refreshments.
Length of session:	2 hours.

EXERCISE 4:1	**Welcome and icebreaker** Prior to commencing this exercise, display the ground rules on the flip chart and reiterate the ground rules to the group.
ICEBREAKER	Facilitators to prepare and deliver a task in order to help the group settle together. Make the task non-threatening and achievable by all members of the group. This task need only take three to five minutes in duration. Where you feel the group is capable of developing their own ice-breaker, this should be encouraged.

Introduction to the session

EXERCISE 4.2	**Facilitators introduce the notion of conscious and unconscious automatic thinking and behaviour** To achieve this give examples of how people can react to a situation before they think. At this point move on to the review of the previous week through group discussion and issues arising, that may have been written in a client's personal journal or brought to the room. Refer back to the 'brain'. If there are new members in the group, it is good to go back over the 'brain' in detail. It is also good reinforcement learning for all group members. Facilitators should keep the group members on task and spend no more than fifteen minutes on this activity.
LEARNING POINTS	Exploration of thinking and feeling as systems within us that are not necessarily working together in a balanced way. Helping clients develop ideas of thinking and feeling as separate entities, e.g. gut reactions sometimes different from thoughts.

EXERCISE 4.3	**Coping Strategies** Either a facilitator or group member write on the flip chart the coping strategies that have been used by each group member during the week. Be sure to have all group members participate in this activity even where there have been instances of self-harm during the week. It is important to emphasise that even instances of self-harm are still coping strategies; this will encourage the clients to feel safe about discussing their ways of dealing with difficulties. Also important to emphasise that we are aiming to help them use alternative coping strategies to self-harming. Facilitators need to pick out as many coping strategies as possible and record them on the flip chart. This process helps the client focus on the positive aspects of problem resolution. The group may help each other develop coping strategies and this should be fully encouraged.
LEARNING POINTS	Reinforcement learning of using coping strategies as an alternative to self-harm and substance abuse.

Ways of Getting Better

EXERCISE 4.4	**Ways of Getting Better Using A B C** Introduce the A,B,C and give the hand out (Sheet 2) with the three main areas blank. Here facilitators need to provide simple examples of the A,B,C process and these should be worked on

	the flip chart for all to see. It is important to encourage some discussion about an example and help clients come up with their own A,B,C process the style of delivery for this should be Socratic and it is important for the facilitators to try and keep the whole process as simple and clear as possible. Facilitators give an example of an A,B,C in action and record it on the flip chart. Example: divide the chart so that there are three columns and write A in the first, B in the second and C in the last. In column A, suggest that the trigger event may be getting some good news in a letter you have been waiting for (write this in column A). Then in column B, write the thought associated with getting the letter, e.g. "Yes, that is good news at last". Finally, in column C, write down the associated feeling, e.g. "feel good, relieved, more positive". Example 2. Explain how this example shows that one single event can affect two different people in different ways, by the way we think. It's good to ask one of the client's, suppose you have just won the lottery what would you be thinking? It usually follows a pattern similar to the words below (follow through to include column C): Lottery: column A, **Event**, someone wins the lottery; Column B, **Thoughts:** the person thinks wow, that is fantastic, I can do what I want, it will change my life, etc.; Column C, **Emotions**, feels happy, excited, dizzy, elated. Then explain how one person felt vary different to that and didn't want to win, and was given a ticket as a present. When she heard that she had won, she was thinking, (write in column B) *oh no, it can't be. I*

	don't want to win, it will change my life for the worse. Then ask the group, as a result what do you think she was feeling, (write in column C the answers). They usually suggest the following emotions, upset, tearful, anxious, dizzy, sick, and very upset. N.B. sometimes it's useful to use 'thought bubbles' to illustrate this exercise as well as or instead of columns, examples in appendices. Move on to:- Discussions about automatic thoughts and feelings should not focus solely on negative cycles and where some people in the group may find the process upsetting, it is important to stay on task and help people understand its nature. Where facilitators feel the group are exceptionally traumatised the process can be undertaken by using the A,B,C with figures from favourite television programmes, soap operas etc. The main learning point is the A,B,C process and helping clients to learn more about the way they construe and make sense of their worlds and how thoughts can affect their feelings. Facilitators should attempt to make sure that all members have as clear as possible an understanding of the A,B,C process.

BREAK FOR REFRESHMENTS

EXERCISE 4.5	Making lifestyle choices and the introduction of life worlds (Habermass). Facilitators should introduce the topic of life worlds and making life style choices. Start by explaining that a 'life world' is the total of a person's experience. It is important that this concept is

	understood. At this point it may be useful for the facilitator to say that a life world is everything you think, feel and have experienced in your life so far. Where this concept may be difficult to grasp, the facilitator may simply explain that the life world is the view from behind the eyes looking out on the rest of the world and this is individual. Essentially you are asking the clients to view themselves as a very powerful video camera that also feels, thinks and behaves that is actually pointing out to the world. Most clients will be able to grasp this concept. It is worth noting that there may be people within the group who appear to be stuck in the concrete operational stage of development and unable to 'put themselves in another's shoes'. Others may have complex psychiatric character or personality difficulties and may find this task difficult. Therefore, the facilitators should progress slowly giving clear examples along the way and encouraging group discussion.
EXERCISE 4.6	**Making life style choices** Using the flip chart ask the group to brainstorm and write down choices that people feel they have made automatically. Move to a clean sheet on the flip chart and write up the A,B,C grid and select a choice that was made automatically from the exercise. The facilitators should be careful not to isolate any one client in this process and seek permission to use their examples. Establish the A,B,C clearly on the chart and encourage discussion by other group members about their A,B,C's. Facilitators should help the client s clearly define the A,B,C's but also ask how the automatic thought or action is influenced

	by past experience. N.B. It goes without saying, that this process may trigger strong memories and emotions and many of the clients will have seriously disturbed histories. The incidents of flashbacks and panic reactions amongst the prison population are significantly higher than those in the normal population; therefore, it is important to be very sensitive in all these processes. Where a particular client may become distressed to the point of being unable to continue with the process, the facilitator will have to decide whether to adjourn for some moments or ask the co-facilitator or mentor to take the client aside until they feel they can return to the group.
LEARNING POINTS	Learning and elaboration of the automatic nature of thoughts and feelings by exploration of ideas within the group. Association of learning and automatic thoughts and feelings in both positive, negative circumstances.

EXERCISE 4.7	**Coping Strategies** Through brainstorming, list the coping strategies that the group members feel they can try through the week. It is important to link the coping strategies to actual stressor points or triggers and each client should have at least three strategies that they feel they can try.
Task for the Week	**Competition** The facilitators introduce the competition for the development of coping strategies. Explain that there is a prize for the client who lists the most positive coping strategies and makes use of the most positive (pro-social) coping strategies (box of chocolates); check with governor and security for approval for

	the type of prize as it is important that the 'packaging is not a security issue'). N.B. Every encouragement should be given to the winner to share their prize with the group members and acknowledge their support. Facilitators should make sure that they all get an opportunity to win a prize; sheer volume of ideas should not be the main criteria for winning the competition, as it is the process that is more beneficial to them.

Review the Session

Outline the positive activity of identification of automatic construal and behaviour and the power of making life style choices. The message should be given to the clients in a form of a question, 'How do you think you can use what you have learnt today?' Remind the group of their coping strategies and set the task for the following week.

4.8 GROUNDING

EXERCISE 4.8 GROUNDING	Facilitators ask group members to name the most positive things that they have gained from today that they can take with them. Ask each one in turn; if there is only one then it's ok, if they are unsure then to go back to them. On previous groups, members have helped and encouraged each other at this juncture.
LEARNING POINTS	To ensure that each member is grounded and in a reasonably positive state, before returning to the wing.

Once group members return to the wings the facilitators evaluate the group session.

Post group evaluation/discussion

1) If a trainee has been present in the session, the facilitators should attend to their learning process and supervision.
2) Evaluate the week by discussing the group response to the topics and issues that may have arisen within the group.
3) There may be action points arising from the discussions or the whole group work process. A list of these should be made with action points.
4) For clients on F2052SH/ACCT watches, files should be complete within the sessions in accordance to the correct policy and procedures.
5) Where facilitators have concerns about particular clients, appropriate referral should be sought, e.g. medical, psychiatric, probation etc.
6) Facilitators should liaise with Wing Staff (This is vital as the wing staff manage the clients on a day-to-day basis).

CAROUSEL GROUP WORK PROGRAMME PSYCHOLOGICAL MANAGEMENT OF DELIBERATE SELF-HARM

HMP [redacted]

Carousel Session 5

Do not introduce new clients into session 5.

Title of the session: **Making lifestyle choices (2), experience and life worlds. Breaking with history, and developing self-esteem and efficacy.**

Aims of session: To help clients develop new life style choices and understand the process of self- efficacy.

Through discussion and tasks to help clients develop a greater self-esteem and further coping strategies.

Facilities: Programmes room HMP [redacted] with comfortable seating, cushions and audio equipment.

Materials: Flip chart, drawing materials, journal and refreshments.

Length of session: 2 hours.

EXERCISE 5:1	**Welcome and icebreaker** Prior to commencing this exercise, display the ground rules on the flip chart and reiterate the ground rules.
ICEBREAKER	Facilitators to prepare and deliver a task in order to help the group settle together. Make the task non-threatening and achievable by all members of the group. This task need only

	take three to five minutes in duration. Where you feel the group is capable of developing their own ice-breaker, this should be encouraged.

Introduction

Facilitators should introduce the session as part 2 of what was undertaken in the week before.

EXERCISE 5.2	**Review of the Previous Week, Journals and Issues Arising** Here the facilitator should focus on the positives of the past week where people have coped with their difficulties. Where clients may have had a difficult week or feel that nothing has been positive, it is important to keep the discussion in a positive frame, however small, emphasise the positive aspect of coping.

EXERCISE 5.3	**COMPETITION** **Coping Strategies** Use the flip chart to list all the coping strategies used in the past week particularly those coping strategies that people highlighted that they were going to try at the end of week 4. Evaluate these coping strategies by group work discussion and allow group members to express where the coping strategies have failed and where they have succeeded. The client who has listed and used the most coping strategies wins the prize e.g. box of chocolates. Facilitators should highlight the main learning points and group achievements over the course. The emphasis on coping strategies ***MUST*** always remain positive. Facilitators should gauge the mood of the group and pace the discussions accordingly. Nevertheless, it is important that any coping strategies are listed and seen in a positive way. Where people are using inappropriate coping

	strategies, ask the group to discuss these and support each other in the development of more appropriate ways of coping. Where there is an excess of projection and blaming of others, this should be handled by the facilitators using normal group work principles.

EXERCISE 5.4	**<u>Self-Esteem</u>** Facilitators should brain storm the group for a definition of self-esteem. Make sure that all group members participate in this activity even if by non-verbal agreement. Here, the facilitators' job is to bring out positive aspects of self-esteem whilst introducing experience in to the equation. For example where a client may say that self esteem is built on being treated fairly as a child, the facilitator can say that not all people have been encouraged as a child however, have gone on to build self-esteem. Using Socratic method can ask how can this be achieved? The message that the facilitator is giving across to clients is that some other people do not positively encourage others, therefore, we have to encourage ourselves and develop friend ships that are good for us. Encourage the group to speak about the positive development of self-esteem and ways that this can be achieved. Again, keep these ideas written on the flip chart and refer to them frequently.
LEARNING POINTS	The learning point here is about self-efficacy and self-esteem. By encouraging clients to develop a view that it is important to break with some history in order to develop self-esteem. This task is always difficult with people who have had serious dysfunctional histories; however, the majority of group members from previous groups have said that they would hope

	not to treat others as they have been treated.

BREAK FOR REFRESHMENTS

EXERCISE 5.5	**<u>Coping Strategies</u>** List the coping strategies that people want to refine for the next week and ground the group by re-stating the importance of working together. It is also important to review the session about making life style choices emphasising that previous experience does not automatically have to dictate how we behave and conduct ourselves. Use stories if necessary and refer to television programmes if this helps to get the point across.
LEARNING POINTS	The overall aim must be to help people make choices that are not necessarily based on previous negative experience or pain. The focus should be on the development of self-esteem however, small the steps may be.

EXERCISE 5.6	**<u>Task for the Following Week</u>** 1) Record in the journal the coping strategies – competition. 2) Observe and note instances where others have developed self- esteem (this can be from television or in real life).

<u>5.7 GROUNDING</u>

EXERCISE 5.7 GROUNDING	Facilitators ask group members to name what are the most positive things that they have gained from today that they can take with them? Ask each one in turn; if there is only one then

	it's ok, if they are unsure then to go back to them. On previous groups, members have helped and encouraged each other at this juncture.
LEARNING POINTS	To ensure that each member is grounded and in a happy positive state, before returning to the wing.

Once group members return to the wings the facilitators evaluate the group session.

Post group evaluation/discussion

1) If a trainee has been present in the session, the facilitators should attend to their learning process and supervision.
2) Evaluate the week by discussing the group response to the topics and issues that may have arisen within the group.
3) There may be action points arising from the discussions or the whole group work process. A list of these should be made with action points.
4) For clients on F2052SH/ACCT watches, files should be completed within the sessions in accordance to the correct policy and procedures.
5) Where facilitators have concerns about particular clients, appropriate referral should be sought, e.g. medical, psychiatric, probation etc.
6) Facilitators should liaise with Wing Staff (This is vital as the wing staff manage the clients on a day-to-day basis).

CAROUSEL GROUP WORK PROGRAMME PSYCHOLOGICAL MANAGEMENT OF DELIBERATE SELF-HARM

HMP [redacted]

Carousel Session 6

Title of the session:	**Trust and Mistrust**
Aims of session:	To explore trust, mistrust and internalised parenting within the clients.
Joint aims and objectives:	An exploration of loving and self-worth, anger, blame and guilt. Using the above concepts to explore issues of sociality and attachment by looking at 'How I want to be seen by others'. Through to discussion of different role models developing recognition of levels of trust and mistrust. The development of appropriate coping strategies.
Facilities:	Programmes room HMP [redacted] with comfortable seating, cushions and audio equipment.
Materials:	Flip chart, drawing materials, journal and refreshments.
Length of session:	2 hours.

EXERCISE 6:1 **ICEBREAKER**	**<u>Welcome and icebreaker</u>** Prior to commencing this exercise, display the ground rules on the flip chart and reiterate the ground rules. Facilitators' to prepare and deliver a task in order to help the group settle together. Make the task non-threatening and achievable by all member of the group. This task need only take three to five minutes in duration. Where you feel the group is capable of developing their own ice-breaker, this should be encouraged.

<u>Introduction to the session</u>	Facilitators should introduce this session as 'a time when we are going to look at trusting people, developing self-esteem and self-worth and how we get angry, blame and feel guilty'. The facilitator should introduce the idea that we sometimes want to be seen by different people in different ways. For example, there are some people you know you can and cannot trust with certain things. When we are let down by people we can lose trust in them. Sometimes people lose trust in us and we can come across as untrustworthy. What effect does this have on us if we think we are trustworthy? How do we react when people let us down, or hurt, or treat us really well? Does this lift us up in our self-esteem or knock us down? Facilitators explain that we will be exploring this later.

EXERCISE 6.2	**Review of the Past Week** Facilitators should review the past week looking at issues arisen from experience and in the journals. This task should take no longer than fifteen minutes. Write down on the flip chart all the coping strategies people have used in the past week with particular reference to the specific coping strategies people have developed in week 5. The emphasis should be on positive coping strategies and the reduction of deliberate self-harm (DSH). **COMPETITION** **Coping Strategies** Use the flip chart to list all the coping strategies used in the past week particularly those coping strategies that people highlighted that they were going to try at the end of week 4. Evaluate these coping strategies by group work discussion and allow group members to express where the coping strategies have failed and where they have succeeded. The client who has listed and used the most coping strategies wins the prize e.g. box of chocolates. Facilitators should highlight the main learning points and group achievements over the course. The emphasis on coping strategies ***MUST*** always remain positive. Facilitators should gauge the mood of the group and pace the discussions accordingly. Nevertheless, it is important that any coping strategies are listed and seen in a positive way. Where people are using inappropriate coping strategies, ask the group to discuss these and support each other in the development of more appropriate ways of coping. Where there is an excess of projection and blaming of others,

LEARNING POINTS	this should be handled by the facilitators using normal group work principles. Positive reinforcement of adaptive coping strategies. Vicarious learning within the group

EXERCISE 6. 3	**<u>Trust, Mistrust and the Parent Within</u>** Facilitated discussion on different people we feel we can trust and mistrust. Ask the group to discuss this from their own experience. The facilitators should keep the discussion going around the areas of trust and mistrust and this may involve people that are considered peers or staff. Confidentiality should be maintained throughout. The facilitator should pace the discussions and intervene at times where they feel they can make a link between the clients level of self worth, blame or guilt and how this relates to trust and mistrust. Clients may bring up issues to do with their own parenting (this is highly likely) and it is important that the client is helped to focus on making positive life style choices and focussing on the future rather than dwelling on negative thoughts and emotions. N.B. It is worth noting that discussions vary from week to week and group to group and there will be no two groups that are the same. The facilitator needs to pace the discussions and use their experience and knowledge to help clients look at positive ways of coping in the future with the development of appropriate coping strategies but also recognise that people have used destructive coping strategies in order to deal with their negative emotions and experience.

	Within the group process highlight where different members of the group may have varying views about one of their peers or a member of staff. It is important to look at the views rather than the member of staff, nevertheless, focus on ways that the client can deal with their level of mistrust if it is difficult for them.
LEARNING POINTS	Learning to take an observer perspective and through the group process, gain insight into different ways of seeing and feeling about others. To engage in open dialogue and discuss relationships within a safe group setting.

BREAK FOR REFRESHMENTS

EXERCISE 6.4	On the flip chart brainstorm with the group and list 'What makes people have a positive self-worth?' then on a new sheet 'What makes people angry?' then on a separate sheet brainstorm the different ways we deal with anger, blame and guilt. Following on in the session start on a clean sheet of the flip chart and write 'How I want to be seen by others?' Brainstorm with the group about how they would like to be seen by different people. It is important to get a whole group discussion on this and the discussion should focus on 'How people would like to come across to various others'. It is worth noting that there will be many varied responses to this and people's defences are likely to manifest themselves.

LEARNING POINTS	It is important to validate the clients view however, challenge where necessary and help the clients their to see and express their views in a more positive way. For example, if a client says that they want to come across as 'in control of themselves to a particular member of staff when normally they react poorly to discipline' the facilitator should explore how this could be achieved. Using the self-worth and anger flipchart sheets; encourage the group to discuss issues about the role of anger, self-worth and how people who manifest these qualities are seen by different people including their peers. The facilitators could role-play a brief example of what the client has highlighted. One facilitator can be the member of staff and the other can be the client. Ask the group to imagine that they were the member of staff. The other facilitator (the client) can role play being in control and the group as a large can comment on how this is seen by the member of staff. There are many variations on this the important issue is that the facilitators help the group explore the views of 'others'. Encourages the group to discuss various situations where they feel they have come across to other people well or have been pleased with themselves and this has been recognised by others. Exploration of sociality and developing a critical approach to pro-social and other behaviours, i.e., anger, frustration etc.

EXERCISE 6.5	On a new sheet from the flip chart write on their role-models, brainstorm with the group about different role models and introduce particular 'types' of role. For example, 'Someone I respect', 'Someone I get on with', 'Someone I look up to', 'A good friend of the same sex', 'A good friend of the opposite sex', 'Someone older than me', 'Someone younger than me'. Make all the role models positive. On a new sheet at the top, write role models and brainstorm with the group on people who are bad role models. Again the facilitator may have to prompt in terms of 'People who have got me into trouble', 'People who have treated me badly', 'People who treat other people badly', 'People who treat animals badly'. Generally, bad role models within society. It is important for the facilitators to look at what the role models actually do rather than the person himself or herself; so, it is distinguishing the behaviour of the role model rather than the name of the role model. For example, a person may be described as a bad person and the client focuses on the person rather than what the person does: John is an evil man who should be put in prison for life. He hates everyone and causes people a lot of grief. The important factor for the facilitator is to establish what this person actually does what the client categorises. For example, 'he sells drugs, he beats people up, etc'.
LEARNING POINTS	Differentiation of poor role models by raising insight. Exploration of behaviour as a functional entity where the conduct is differentiated from a personality trait.

EXERCISE 6.6	**<u>Coping Strategies</u>** Establish at least three coping strategies for each member of the group that they will try for the following week. Emphasise the need to record these in the journal.
6.6b	**<u>Task for the Week</u>** Set the task for the following week including attending the other components of the Carousel programme. **<u>Competition</u>** The facilitators re-introduce the competition for the development of coping strategies. Explain that there is a prize for the client who lists the most positive coping strategies and makes use of the most positive (pro-social) coping strategies (box of chocolates). N.B. Every encouragement should be given to the winner to share their prize with the group members and acknowledge their support. Facilitators should make sure that they all get an opportunity to win a prize; sheer volume of ideas should not be the main criteria for winning the competition, as it is the process that is more beneficial to them.

<u>Summary</u>

Summarise the discussions of week 6 and make links between **ALL** of the 6 sessions that have been undertaken so far. Where clients have been unable to attend all the weeks, it is still important to summarise the 6 weeks and make the links between the

topics relevant for each member of the group. Where there is doubt ask the group to brainstorm the main content of what has been covered so far.

6.7 GROUNDING

EXERCISE 6.7 GROUNDING	Facilitators ask group members to name what are the most positive things that they have gained from today that they can take with them? Ask each one in turn; if there is only one then it's ok, if they are unsure then to go back to them. On previous groups, members have helped and encouraged each other at this juncture.
LEARNING POINTS	To ensure that each member is grounded and in a happy positive state, before returning to the wing.

Once group members return to the wings the facilitators evaluate the group session.

Post group evaluation/discussion

1) If a trainee has been present in the session, the facilitators should attend to their learning process and supervision.
2) Evaluate the week by discussing the group response to the topics and issues that may have arisen within the group.
3) There may be action points arising from the discussions or the whole group work process. A list of these should be made with action points.
4) For clients on F2052SH/ACCT watches, files should be complete within the sessions in accordance to the correct policy and procedures.
5) Where facilitators have concerns about particular clients, appropriate referral should be sought, e.g. medical, psychiatric, probation etc.
6) Facilitators should liaise with Wing Staff (This is vital as the wing staff manage the clients on a day-to-day basis).

CAROUSEL GROUP WORK PROGRAMME PSYCHOLOGICAL MANAGEMENT OF DELIBERATE SELF-HARM

HMP [redacted]

Carousel Session 7

Title of the session: **Life choices and Support Networks**

Aims of session: To explore life-style choices and positive strategies to cope with difficulties in everyday life.

To develop insight into negative life-choices, offending behaviour, maladaptive thoughts, feelings and DSH.

To explore existing and anticipated support systems within the HM Prisons, secure accommodation and community.

To explore dependency issues (appropriate and inappropriate relationships, often resulting from insecure attachment styles).

Facilities: Programmes room HMP [redacted] with comfortable seating, cushions and audio equipment.

Materials: Flip chart, drawing materials, journal and refreshments.

Length of session: 2 hours.

EXERCISE 7:1	**Welcome and icebreaker** Prior to commencing this exercise, display the ground rules on the flip chart and reiterate the ground rules.
ICEBREAKER	Facilitators to prepare and deliver a task in order to help the group settle together. Make the task non-threatening and achievable by all members of the group. This task need only take three to five minutes in duration. Where you feel the group is capable of developing their own icebreaker, this should be encouraged.

Introduction

Introduce the topic of the session 'Life choices and Support Networks'. The facilitator should say a few words linking previous weeks and the development of making choices in life and the need to have supportive networks to help us.

EXERCISE 7.2	**Review of the Previous Week, Journals and Issues Arising** Here the facilitator should review the previous week with the group and deal with any issues arising. Allow fifteen minutes for this exercise.

EXERCISE 7:3	**Coping Strategies** Brainstorm with the group on flip chart for coping strategies, particularly those highlighted in week 6. The facilitators should encourage discussion about the specific coping strategies identified by each client at the end of week six that they were going to practice in the following week.

	Here it is important for the facilitators to help the client to identify trigger mechanisms, thoughts, feelings and actions.

EXERCISE 7:4	**<u>Life Choices</u>** On a clean sheet of flip chart paper write in the top left hand side 'Life Choices' and explain to the group that we are going to look at the life choices we would like to make. Brainstorm with the group and encourage discussion about making positive choices in life. Record the information on the flip chart. Here the facilitator should use the group work process to facilitate dialogue about positive life choices however, it is important to allow some discussion about where these choices have gone wrong in the past. Nevertheless, focus on the positive aspects of the life choices. These can be future based, particularly life choices that are made through the duration of their sentence or current situation and then anticipated for their release into the community. Where there are members of the group who are serving longer sentences it is important to validate certain choices no matter how small they are. For example, if someone is making a life choice to undertake some reading or a course of study as part of a life or longer sentence; the emphasis should be on the quality of achieving their study aim and its importance to them. Spend fifteen minutes on this task.

LEARNING POINTS	Introduction of a "life-choice" principle and orientation to different aspects of making choices. Vicarious learning from within the group on different ranges of choice both positive and negative

BREAK FOR REFRESHMENTS

EXERCISE 7:5	**<u>Life Choices part 2</u>** On a new flip chart sheet write 'Life Choices' and brainstorm with the group on poor life choices they have made. **NB:** Depending on your assessment of the group this can be an exercise where group members could discuss poor life choices made by people on television, e.g., soap stars etc. The important aspect of the exercise is to encourage the concept of life choices, no matter if it is positive or negative. Sensitivity on the part of the facilitators is crucial, as many of the clients' life choices will have been negative and disturbing. Therefore, focus on simply listing the negative life choices rather than having elaborative discussions about them. On a new sheet of flip chart paper at the top left hand side, write 'Life Choices' and explain to the group that you want to brainstorm the choices that the group would like to make about the future. List these and allow discussion on the benefits of making such choices. Where people become stuck, help them to identify smaller and achievable life choices. Therefore, these are more manageable and within easier reach. It is important to recognise that even the smallest of choice in a positive direction will have

LEARNING POINTS	the effect of building self-esteem. For example, some clients wish to make major changes to their personality and personal histories. Their aims are too extensive to be managed, and are setting themselves up for failure. Many have experienced serial invalidation, and are therefore used to failing. The facilitator should ensure that clients set targets for themselves that have a high probability of achievement. The facilitators along with the other group members can help a client focus on a small step and provide social encouragement and reinforcement when this step is achieved (see exercise 1.5 session one).

EXERCISE 7:6	**<u>Support Networks</u>** On a new sheet of flip chart paper write at the top left hand side, 'Support Network' ask the group to brainstorm **ALL** the support networks they can imagine. This should be written down as a list. N.B. It is common for clients to have problems in this particular area as many of the protective support systems enjoyed by people are severely lacking in this population. There may be a high instance of reliance on one particular system by a client, for example, they might say that their only support system is a parent or alternative caregiver. This caregiver may also be a seriously damaged person who in fact provides very little appropriate support. Other clients may

	also rely on a probation officer, or social worker as their only means of support. Other clients may cite one of the group members as their main support system even though they have only known this person for the duration of their recent remand or sentence. Once the list is exhausted turn to a blank sheet on the flip chart and ask the group to devise a support network for a person who is in a similar position to themselves. In the centre of the flip chart write the word 'ME' and draw a small circle around it. Ask people to comment on support systems they think should be on the page. For each of the support systems, draw a line radiating from the centre to a point where you can write down the support idea. For example, if someone says 'somewhere to live', then draw a line from the centre to a point on the flip chart and write 'somewhere to live'. Then ask the group 'Who might provide that?' the answers can be written underneath the response 'Somewhere to live'. Continue this procedure until there are many support networks listed. At the end of the exercise, summarise the discussions and invite further discussion on how people can use the support networks that have been identified.
LEARNING POINTS	Ask people to copy these ideas into their personal journal. Insight provoking discussion establishing the ranges of support networks. Developing thoughts about spreading dependencies .

	Preparation for resettlement into the community.

COMPETITION	**Coping Strategies** Use the flip chart to list all the coping strategies used in the past week particularly those coping strategies that people highlighted that they were going to try at the end of week 4. Evaluate these coping strategies by group work discussion and allow group members to express where the coping strategies have failed and where they have succeeded. The client who has listed and used the most coping strategies wins the prize e.g. box of chocolates. (The emphasis on coping strategies ***MUST*** always remain positive. Facilitators should gauge the mood of the group and pace the discussions accordingly. Nevertheless, it is important that any coping strategies are listed and seen in a positive way. Where people are using inappropriate coping strategies, ask the group to discuss these and support each other in the development of more appropriate ways of coping. Where there is an excess of projection and blaming of others, this should be handled by the facilitators using normal group work principles.

Summary

Summarise the learning week 1-7 and topics covered. Invite clients to comment on aspects that they have found most useful and keep the discussion positive and emphasise the coping strategies, development of choice and self-esteem and protection of themselves.

EXERCISE 7.7 **GROUNDING**	Facilitators ask group members to name what are the most positive things that they have gained from today that they can take with them? Ask each one in turn; if there is only one then

	it's ok, if they are unsure then to go back to them. On previous groups, members have helped and encouraged each other at this juncture.
LEARNING POINTS	To ensure that each member is grounded and in a reasonably positive state, before returning to the wing.

Once group members return to the wings the facilitators evaluate the group session.

Post group evaluation/discussion

1) If a trainee has been present in the session, the facilitators should attend to their learning process and supervision.
2) Evaluate the week by discussing the group response to the topics and issues that may have arisen within the group.
3) There may be action points arising from the discussions or the whole group work process. A list of these should be made with action points.
4) For clients on F2052SH/ACCT watches, files should be completed within the sessions in accordance to the correct policy and procedures.
5) Where facilitators have concerns about particular clients, appropriate referral should be sought, e.g. medical, psychiatric, probation etc.
6) Facilitators should liaise with Wing Staff (This is vital as the wing staff manage the clients on a day-to-day basis).

CAROUSEL GROUP WORK PROGRAMME PSYCHOLOGICAL MANAGEMENT OF DELIBERATE SELF-HARM

HMP [redacted]

Carousel Session 8

Title of the session:	**Coping Strategies and Evaluation**
Aims of session:	To build on coping strategies identified in previous weeks.
Joint aims and objectives:	To summarise the learning objectives of the course and identify the benefits of attending the Carousel programme. To evaluate the course from the participants point of view. The completion of any evaluation instruments
Facilities:	Programmes room HMP [redacted] with comfortable seating, cushions and audio equipment.
Materials:	Flip chart, drawing materials, journal and refreshments.
Length of session:	2 hours.

EXERCISE 8:1	**Welcome and icebreaker** Prior to commencing this exercise, display the ground rules on the flip chart and reiterate the ground rules.
ICEBREAKER	Facilitators to prepare and deliver a task in order to help the group settle together. Make the task non-threatening and achievable by all member of the group. This task need only take three to five minutes in duration. Where you feel the group is capable of developing their own ice-breaker, this should be encouraged.

Introduction to the session

The facilitators should introduce the session as an 'Evaluation' and a 'Bringing together Session'. Link together all the previous sessions and topics covered.

EXERCISE 8:2	**Review of the Previous Week, Journal and Issues Arising** Review the previous week in relation to coping strategies and allow a fifteen-minute discussion of issues arising from the journals.

EXERCISE 8. 3	**Coping Strategies** On a clean flip chart sheet write at the top left hand side, 'Coping Strategies' and list all the coping strategies people have used in all the previous sessions, with particular emphasis on the coping strategies set out in week 7. The facilitators should encourage the group to look at individual coping strategies and comment on each others coping

	mechanisms. It is important to validate the appropriate strategies and gains made in the group. It is also important for the facilitators to help group members elaborate the coping strategies to situations that are likely to arise in the future. The emphasis on protective as well as reactive strategies is important and the facilitator should keep this a priority in the procedure. Facilitators should highlight the main learning points and group achievements over the course. The emphasis on coping strategies ***MUST*** always remain positive.
Competition	As this is the last session, there should be shared prizes for the competition (box of 'Maltesers' for each group member), explaining that they are all winners as they have completed the programme.
LEARNING POINTS	Reinforcement of positive coping strategies. Use of coping strategies for life in various settings.

EXERCISE 8:4	Using the group processes encourage further discussion on relating the learning points to each individual. Facilitators should encourage clients to describe the benefits of attending the group with particular reference to elements of the course that have helped and will help in the future.
LEARNING POINTS	Facilitators should also look at any disadvantages with the newly developed coping strategies and help clients evaluate their range and usefulness of the methods that they are anticipating in the future in order to deal with difficult situations

	that may arise. N.B. The development of protective factors is a complex process; therefore, it is important to help clients identify the 'pros and cons' of their coping mechanisms. This serves to help the client elaborate their personal choices in a more comprehensive and balanced way. For example, some clients may have used wrist cutting as a coping mechanism for internalised psychological pain. Whilst this coping strategy may have been disruptive and maladaptive, it was, nevertheless, the clients' best efforts at adapting to the precipitating events (internal or external). By examining the perceived positive aspects of their cutting, the facilitators' maintain rapport. This validation is critical to the development of more positive coping strategies for the individual. The process can help the client develop a more Socratic approach to the future implementation of coping strategies, thereby enhancing self-efficacy and self-esteem.

8.5 Evaluation

The facilitator should brainstorm with the group on an evaluation of the programme. Note down all the main points raised. Ask the group members how the positive aspects of the course have helped them and encourage discussion within the group in this area.

On a clean sheet of flip chart paper write on the left hand side 'Evaluation' and ask the group members what changes they would make to the Carousel programme and recommendations for the future? From a facilitator's point of view it is worth asking the group to comment on a situation whereby, if they were running the group, how would they do it?

Ask participants to rate the value of the Carousel programme on a scale of 0 - 100 with 100 being the highest and 0 being the lowest. Facilitators should draw a line on a clean sheet of flip chart paper with 0 on the extreme left and 100 on extreme right. Draw a line between the 0 and 100 and mark off 50 in the middle. Ask each group member to give your score out of a 100 and write that score on the line.

Completion of Evaluation Instruments

Ensure that all group members have completed the repertory grid, coping styles questionnaire and HADS Scale.

After the completion of evaluation instruments ground the group and summarise the Carousel programme this far. Ask people to continue using their journals and support each other through the programme. Encourage group participants to support each other and review their journals with particular reference to the coping strategies group members have used over the weeks.

EXERCISE 8.6 GROUNDING	Facilitators ask group members to name what are the most positive things that they have gained from today that they can take with them? Ask each one in turn; if there is only one then it's ok, if they are unsure then to go back to them. On previous groups, members have helped and encouraged each other at this juncture.
LEARNING POINTS	To ensure that each member is grounded and in a reasonably positive state, before returning to the wing.

Close the group in a positive way.

Once group members' return to the wings, the facilitators' evaluate the group session.

Post Group Discussion

1) If a trainee has been present in the session, the facilitators should attend to their learning process and supervision.
2) Evaluate the whole of the course by discussing the group response to the topics and issues that may have arisen within the group.
3) There may be action points arising from the discussions or the whole group work process. A list of these should be made with action points.
4) For clients on F2052SH/ACCT watches, files should be completed within the sessions in accordance to the correct policy and procedures.
5) Where facilitators have concerns about particular clients, appropriate referral should be sought, e.g. medical, psychiatric, probation etc.
6) Facilitators should liaise with Wing Staff (This is vital as the wing staff manage the clients on a day-to-day basis).

THERAPEUTIC ART

During the duration of the Carousel programme, clients attend therapeutic art and take part in the following exercises:-

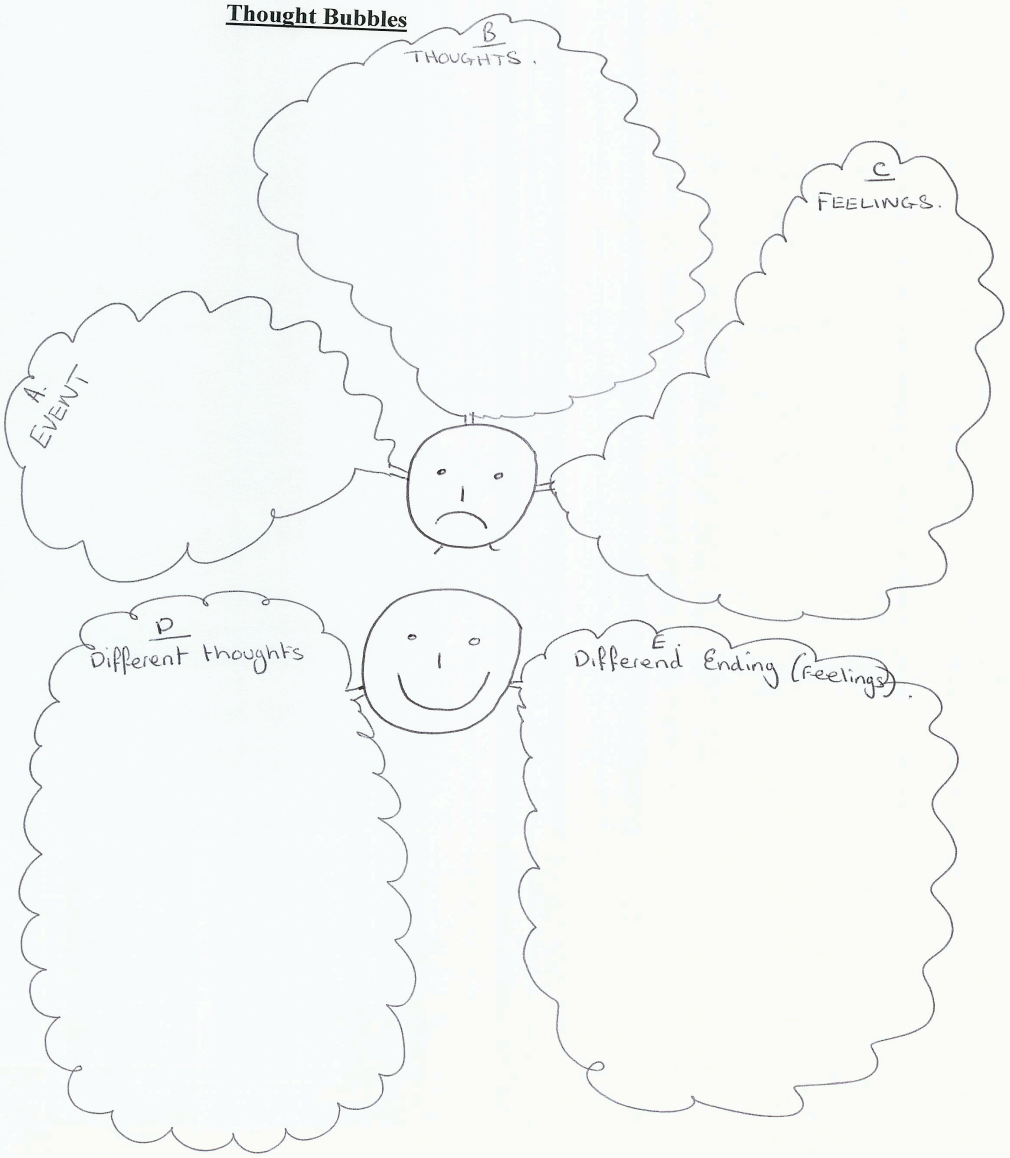
Decorate outside cover of Journal	Decorate the journals covers, with stickers, drawings, pictures from magazines. This helps the clients to personalise and own their journals.
Treen's Happy boxes	'Treen's Happy Boxes': based on Foston Hall's concept. Carousel group named [redacted]'s version after Governor Barbara Treen asked the 'Carousel' group to pilot them out as an 'additional coping strategy'. N.B. These have been very popular with the group members. Decorate shoe boxes bright coloured tissue paper, stickers, bows etc. The clients place items in the box that make them feel 'good/happy'. For example, poetry, drawings, cards, photographs, happy letter. When the client feels sad/down/depressed, and feel like self-harming they look through their happy box at all the items that make them feel good.
Photo frames	Clients bring to the session photographs. Cardboard frames are made and decorated for their photographs.
Painting and or drawing	Clients are encouraged to paint/draw pictures. This is therapeutic in itself. It is also a good self-esteem enhancer as it is an achievement and develops abilities.

Clay modelling	Modelling masks and objects. N. B check with governor and security to ensure that clay is permitted. Papier mache is an alternative.
Colouring	Colouring in pictures.
Self-esteem chart's	Making feel good charts helps to promote self-esteem.

N.B this session is run by one of the main facilitators from Carousel (the group therapy group), the art teacher, (an art therapist can be used), and a trainee counselling psychologist. Continuity is vital as 'art' is a coping strategy that is therapeutic, however, the process can churn up various issues. It is important that someone suitably qualified is present who understands the process and can deal with any situation appropriately, rather than leave a client feeling 'emotionally exposed'.

Appendix 19a. (sheet 1)

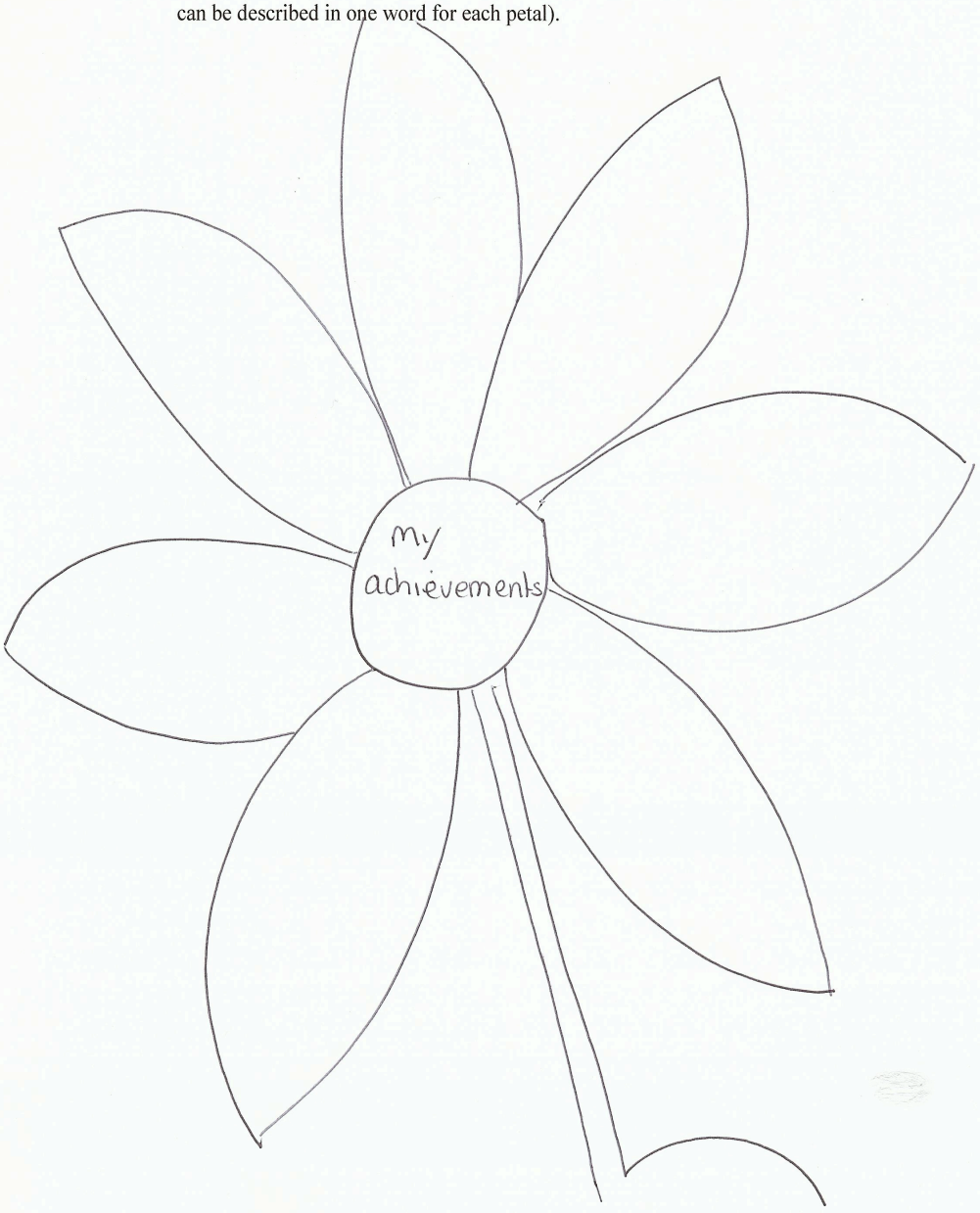
Thought Bubbles



Appendix 19b. (sheet 2)

Achievements

To record their achievements in their journal. This can be done through either listing the achievements or drawing a flower, using each petal to name the achievement (this can be described in one word for each petal).



Appendix 19c. (sheet 3)

A	B	C

Appendix 20: Certificate upon completion of Carousel

Certificate of Achievement

This certificate is presented to

For Successful Completion of the Carousel Programme
(Deliberate Self-harm)
at
HMP [redacted]

Signature _____ Date _____

Signature _____ Date _____

Carousel

Appendix 21: Carousel Weekly Programme Format

Carousel Group work Programme
Psychological Management of Deliberate Self Harm (DSH), C Wing HMP/ YOI Brockhill

Weekly Programme Format

The following weekly programme for the Carousel group is systematically structured though flexible in overall approach to the client. In this way we anticipate that clients will engage more readily if within group variations and experiences can be incorporated into the overall design of this programme. Nevertheless, clients attending the programme should experience the entire course in order to address their specific difficulties and benefit from the interventions. The term deliberate self-harm includes any intentional method of harming oneself. Many clients will present with multiple methods of harming including the use of substances; drugs, alcohol etc or devices.

WEEK 1

- Introduction to the course.
- Orientation.
- Joint aims and objectives.
- Group rules.
- Discussion and elaboration of deliberate self harm.
- Issues arising.
- Administration of initial repertory grid
- Introduction to the weekly journal (client experiments)
- Coping Strategies alternative to substances (drugs, alcohol)
- Task for the following week.

WEEK 2

- Introduction to the session.
- Review of previous week, journal and issues arising.
- Theories of causality (group views and experience).
- Exploration of similarities and differences of experience relating to group members and their experience.
- Drawing out themes and commonality of experience and coping mechanisms.
- Coping Strategies.
- Task for following week

WEEK 3

- Introduction to the session.
- Review of previous week, journal and issues arising.
- Exploration of DSH precipitating factors.
- Life experiences and the manifestation of pain (exploring psycho-social experience and conversion symptoms including somatic manifestation of psychological pain).
- Introduction to conscious and automatic construal. Part A. The elaboration of choice using the experience cycle (Kelly 1955).
- Alternatives to Substance abuse
- Coping Strategies
- Task for following week.

WEEK 4

- Introduction to the session.
- Review of previous week, journal and issues arising.
- Conscious and automatic construal. Part B. Ways of getting better.
- Introduce experience and lifeworlds. Making lifestyle choices.
- Coping Strategies
- Task for following week.

WEEK 5

- Introduction to the session.
- Review of previous week, journal and issues arising.
- Experience and lifeworlds. Making lifestyle choices.
- Personal psychology. Breaking with history and developing self-esteem and efficacy.
- Coping Strategies
- Task for the following week

WEEK 6

- Introduction to the session.
- Review of previous week, journal and issues arising.
- Exploring trust, mistrust and the parent within. Exploring loving, self worth, anger, blame and guilt.
- Stepping out of the personal view and exploration of "how I want to be seen by various others" Exploring issues of sociality and attachment.
- Role models.
- Coping Strategies
- Task for the following week.

WEEK 7

- Introduction to the session.
- Review of previous week, journal and issues arising.
- Coping Strategies.
- Life choices.
- Support network..
- Administration of repertory grids and evaluation instruments.
- Close.

WEEK 8

- Introduction to the session.
- Review of previous week, journal and issues arising.
- Coping Strategies
- Evaluation.
- Completion of evaluation instruments.
- Close.

Appendix 22: Carousel Timetable

Carousel

	MON	TUE	WED	THUR	FRI
09.00 – 10.30	**Therapy – Group** **9.00 – 11.00 Programmes Room**	**Gym Physical skills Life skills**	**Gym Physical skills Life skills**	**Gym Physical skills Life skills**	**Education/ Art/Music/ Therapy** **9.00 – 11.00 Programmes Room**
10.30 – 12.00	Normal Regime (from 11.00 on Mondays)	Normal Regime	Normal Regime (Visits Jobs etc Education)	One-to-One Counselling	Normal Regime
	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH
14.00-15.00 15.00-17.00	Normal Regime (Visits Jobs etc Education)	Normal Lock - up	**One-to-One Counselling**	**One-to-One Counselling** Normal Regime (Visits Jobs etc Education)	Normal Regime (Visits Jobs etc Education)

Green	All group Members
Light blue	Individual Members one session per week
Royal Blue	Individual Members one session per week (alternative time)

Orange	Individual Members one session per week (alternative time)

Normal Regime: Wing Duties
Visits
Education
Library

Legal visits (AM)