

Meilleures pratiques en matière de recherche

Effectuer une étude auprès des femmes criminalisées en milieu carcéral : le point de vue des chercheurs

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Bien que d'importantes menaces pèsent sur la santé des femmes incarcérées par le système de justice pénale, il n'existe que très peu de travaux de recherche qui portent sur leur hygiène de vie. Afin d'apporter leur contribution aux projets de recherche sur la condition de santé des femmes criminalisées, les auteures ont mené une recherche multiméthode dans le cadre d'un programme de recherche visant à étudier la promotion de la santé et les compétences des femmes ayant des démêlés avec la justice sur le plan de la santé. Les travaux de recherche effectués en milieu carcéral présentent des difficultés uniques et soulèvent des dilemmes éthiques qui ont problématisé chaque phase de la collecte de données. Les auteures font part de leur expérience en tant que chercheuses en santé menant une recherche en milieu carcéral auprès des femmes criminalisées. Elles décrivent certaines des difficultés, des réussites et des précieuses leçons apprises durant le processus de recherche dans l'espoir qu'en transmettant leurs connaissances à d'autres chercheurs en santé, elles inspireront de futures études auprès de femmes criminalisées.

Mots clés : méthodes de recherche en collaboration, promotion de la santé, populations mal desservies, santé des femmes

Best Practices for Research

Conducting Research With Criminalized Women in an Incarcerated Setting: The Researcher's Perspective

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Although women incarcerated by the criminal justice system encounter significant challenges to their health, there has been little research focusing on their health practices. To contribute to the research literature on the health experiences of criminalized women, the authors conducted a multi-method study as part of a program of research exploring the health promotion and health-literacy skills of women in conflict with the law. Conducting research in an incarcerated setting posed unique challenges and ethical dilemmas that problematized each phase of data collection. The authors share their experiences as health researchers conducting research in an incarcerated setting and with criminalized women. They document some of the challenges, successes, and valuable lessons learned during the research process in the hope that by sharing their knowledge with other health researchers they will support future studies with criminalized women.

Keywords: collaborative research methods, health promotion, under-served populations, women's health

Introduction

Conducting research in incarcerated settings entails special and specific considerations for researchers (Pollack, 2004; Quina et al., 2011; Roberts, 2011; Woods-Bryne, 2005). While researchers in the United States and the United Kingdom have begun to share their unique experiences of data collection in incarcerated settings, relatively little attention has been paid to research conducted in incarcerated settings overall, and particularly amongst health researchers in Canada (Hall & Donelle, 2009). The purpose of this article is to share our experiences as health researchers that were unique to conducting research in a detention centre and to consider the personal and professional implications of research with criminalized women.

Researchers' experiences were documented during a multi-method program of research to examine perceived strengths and deficits in health knowledge, access to information, services, social support, and advocacy skills related to participant-identified health promotion issues for criminalized women. Throughout the 2 years of data collection and analysis, members of the research team took field notes, met both formally and informally to debrief, and dialogued in person and via e-mail around emerging findings. During these team meetings, reflections by researchers revealed the theme that conducting research in an incarcerated setting poses unique challenges and ethical dilemmas that problematize each phase of data collection for both participants and researchers. In this article we report on some of the challenges, successes, and valuable lessons we documented in field notes, minutes of meetings, and e-mail dialogue throughout the research process. Our hope is that by sharing our knowledge with other health researchers we will support future studies in incarcerated settings generally and with incarcerated women in particular.

Background

The impact of women's incarceration reverberates beyond the individual; it also impacts their children (O'Brien & Bates, 2003). In addition to the unique realities of women's lives, women's experiences of reproductive health, menstruation, and gynecological conditions demonstrate that their biological health-care needs are different from those of incarcerated men (Acoca, 1998; Flanagan, 1995). While for some women the health care received during incarceration may provide an avenue of access that would not exist otherwise (Peternej-Taylor, 2008), health-care access is generally limited and inconsistent for incarcerated individuals (Stoller, 2003). Although research has shown that experiences tend to vary based on gender (Ammar & Weaver, 2005), "the needs and challenges of these women [female offenders] have been overlooked in favour of those of men, who far outnumber women in the criminal justice system" (O'Brien & Bates, 2003, p. 210). Consequently, nationally there is limited knowledge regarding health promotion issues and services at Canadian correctional facilities (Moloughney, 2004), particularly as related to women (Hall & Donelle, 2009).

The five-member research team was made up of a principal investigator and four graduate students with combined expertise in the areas of community-based nursing, women's health, trauma, and mental health. Our multi-method program of research was intended to address a gap in the literature related to health promotion, specifically issues of health literacy among criminalized women. Our approach focused on exploring

political, social, and economic inequities that construct women's "choices" related to surviving as criminalized behaviour (Pollack, 2004).

The projects within this program of research incorporated diverse data-collection strategies, including arts-based body-mapping (Soloman, 2007), individual semi-structured interviews, social network analysis (Vera & Schupp, 2006), structured survey assessments (health literacy survey assessment), and content analysis of institutional medical charts. The research team spent approximately 2 years and 200 collective research hours inside the detention centre. While the purpose of the research program was to investigate health promotion and health literacy among incarcerated women, what emerged throughout data collection and analysis was the significance of the experience of conducting research in an incarcerated setting. Thematic analysis of field notes, minutes of meetings, and e-mail dialogue was conducted to document and report on our experiences. Trustworthiness of the data was attended to through the reflective memoing that researchers engaged in throughout data collection and analysis, data confirmability by members of the research team, and researcher consensus on similarities and differences of data coding through open dialogue (Graneheim & Lundman, 2004).

Challenges

Through our review process, we identified three overarching themes related to the challenges of conducting research in the incarcerated setting: *the process of (re)gaining entry, conducting research within the space of an incarcerated setting, and leaving the space behind.*

The Process of (Re)gaining Entry

Gaining entry to the detention centre required the approval of two separate ethics review boards, the principal investigator's university ethics review board and the provincial Ministry of Community Safety and Correctional Services. As with conducting research in other institutional settings, gaining approval from more than one review board delayed initiation of the project. While the ethics forms for the two boards were not substantially different in focus, reconciling discrepant recommendations from each board extended the preparatory period of the study. For instance, offering participants an honorarium, a common practice in research, is forbidden in most incarcerated settings (Brewer-Smyth, 2008) and was authorized by one ethics review board but not the other. A compromise was reached by offering refreshments (juice or coffee and muffins). While an honorarium is always a moral and ethical issue, no matter the setting, there were additional considerations and regulations, and the potential for coercion was heightened due to the restrictive envi-

ronment unique to an incarcerated setting (Woods–Bryne, 2005). Safety is also a consideration in this setting, such that any honorarium had to meet institutional standards of what the women could have access to.

Fostering relationships. Similar to research in many institutional health-care settings, research in the incarcerated setting was outside of normative institutional practices. Therefore, fostering trusting and professional relationships within the institution was integral to the successful initiation and completion of the study, although this strategy never fully eradicated barriers to accessing the women. With the support of health-services administration, a registered nurse working at the facility was assigned to partner with the research team and acted as a liaison between staff and researchers during our time there. This RN helped us to understand the cultural norms, brokered a relationship between the research team and correctional staff, and facilitated participant recruitment. Data collection was predicated on the RN's scheduled shifts. Day-to-day data-collection plans remained tentative until we confirmed with the RN by telephone and/or text whether we would be allowed to collect data on any given day. Our alliance with the health-care staff, particularly the RN assigned to our study, and our own identities as health professionals and nursing researchers seemed to facilitate relationship development with the participants.

Conducting Research Within the Space of an Incarcerated Setting

Unlike in other institutional settings, in this setting it was not uncommon for women to be in “lock down” because cells were being searched or because of staff shortages. Inmates were not permitted to take part in research, or any other activity, during lock down. Additionally, scheduled programming during the data-collection “window” competed with recruitment and data collection. At times women had to choose between participating in our study and attending a group program that was running simultaneously. Some days we were permitted to enter the facility and the female unit, while other days we would be questioned, left waiting, and/or refused access/entry, despite having adhered to the conditions for entry. Conducting research in an incarcerated setting also resulted in a lack of (safe) spaces to meet with the women, which resulted in our meeting in locked rooms without monitoring, or at times not being able to meet at all. Therefore, despite our established relationships and the approval of the research, each time we entered the detention centre we were faced with new and unique challenges.

As we were not employees of the detention centre, we were fully dependent on the generosity, flexibility, and regulation of the staff to gain entry to the institution and access to potential participants each time we arrived for data collection. The willingness of staff to support our project,

and therefore our entry, fluctuated and was reflective of a number of complex contextual situations. As a consequence, data collection took considerably longer and was more tenuous than anticipated. While women readily volunteered to take part in our study, most days a wait list of potential participants was drawn up because of the 1-to-2-hour hour restriction placed on our data-collection window. The high rate of turnover at the centre meant that many of the women were released or transferred to another facility before they could take part in our study.

Enacting contradictory alliances. Within the incarcerated space we had to continuously negotiate our roles. This system of control and power created contradictory alliances, regardless of intent, with the participants and correctional staff. Engaging in such polarizing alliances was not something we had anticipated prior to entering the detention centre, and it is not a topic widely discussed in the health literature. In enacting an alliance with the correctional staff, we were expected to support the power differential between us as “outsiders” and the inmates while simultaneously holding a position of less power than the staff. There was an expectation on the part of correctional staff that we would be vigilant in monitoring and regulating women’s access to such items as drinking straws and writing devices. A comment by a research assistant captures the challenge of attempting to ensure safety while conducting an interview:

The first [part of working within the space] is in relation to negotiating my own abilities to be vigilant and give the attention required to maintain “control,” “safety,” “order,” while at the same time trying to be present with the women in the interview.

This was a difficult balancing act, since we sought to be authentically present with the women during each interview. The level of vigilance that was required of us during our time with the women became a focus of the data-collection process; we were constantly counting the number of pens being distributed and returned and ensuring that the women’s drinking straws were handed in to us after interviews. This was an aspect of the research that we had not considered in advance.

In alliance with the participants, we were locked in a small room and our mutual ability to exit was controlled and authorized by the correctional staff, as “order” within the facility was maintained through restricted movement. Like our participants, we were perpetually locked in or out and needed permission to exit each room, hallway, and the building itself. At times the women observed how the staff used their power and control over the researchers. For instance, there was a delay between the time when we notified staff that we were ready to leave a room and the time when they arrived to let us out. Further, in building

relationships with the participants we were cognizant of the privilege that we held and made decisions that were mindful of their lack of access to many commodities. While privilege is acknowledged in the research literature mainly in terms of the socio-economic differences between researcher and participant (McCorkel & Mayers, 2003), in the case of incarcerated women privilege needs to be further conceptualized in terms of access — what is available to those outside versus those inside. For example, participants commented on the soap and shampoo we had access to “on the outside” when they smelled a particular soap that they were denied “on the inside.” While we were able to adjust our presentation in this regard, there were many aspects of our privilege that we could not minimize. For instance, our clothing stood out from the ministry jumpsuit and footwear that incarcerated women are required to wear.

Given our alliance with the women, we were conflicted when acting as “situational correctional officers” while trying to build a collaborative research environment. We were neither insiders nor outsiders. This suggests the broader issue of the unavoidable ways in which incarcerated settings enforce and reproduce hierarchical systems of power, control, and compliance. Conducting research in an institution designed to “punish, regulate, control, and produce law-abiding citizens” (Pollack, 2004, p. 701) challenged our role as “health researcher,” which is guided by the values of respect, empowerment, and social justice.

Different worldviews. While differences in worldviews in conducting research in incarcerated settings have been explored (Arditti, Joest, Lambert-Shute, & Walker, 2010; O’Brien & Bates, 2003), ideological differences related to health-professional identities are not thoroughly discussed in the literature. Our personal and professional understandings of health as an asset contrasted with the focus on physical and psychiatric dysfunction that predominates in the incarcerated setting. The disconnect between the health promotion perspectives of the researchers and the medical care offered at the institution created ethical and professional turmoil for the researchers, as the services being provided were less than comprehensive and did little to address the multifaceted and complicated influences on health. Although the facility had a health-services department, we observed and perceived limited ability to promote health in an institution whose mandate is punishment.

Personal safety. Ensuring the safety of participants and the environment was emphasized in the conduct of all our work; however, safety considerations were a distinctive element of conducting research in this setting. During the interviews we were locked in a room with anywhere from one to nine women, some of whom had a record of violent behaviour. A research assistant recounts her personal feelings about safety:

After banging on the door a few times [to be let out, as instructed by staff], and realizing no one was coming, the potential safety risk of being locked in a room came to mind. I felt safe, especially with this particular woman, but the process did not feel safe. At one point the woman stated, "It's a good thing I'm not trying to kill you," and I responded, "I appreciate that." We were both laughing but there was truth to her statement . . . Correctional officers did pass [by] but did not open the door . . . Finally, someone came.

Learning to feel safe in situations of inherent instability and constant flux required us to adopt both personal and professional ways of negotiating. It was exhausting to constantly shift our way of being within the setting in order to form an alliance with whoever was present. Tensions mounted as we learned to perform roles with the participants that were neither familiar nor comfortable to us. This exacted a toll on our emotional well-being.

Anonymity and confidentiality. There were limits to maintaining participant confidentiality and anonymity as a direct result of the incarcerated environment, particularly during the recruitment process. Because of the limited space and restricted movement, we were able to recruit women only during specific times of the day — primarily when they were “on the range,” a locked common room. Through a barred “cage,” we proceeded to collect the names of women interested in participating, and had to give these names to the correctional staff so they could unlock the cage and escort the women to another locked room that would serve as the interview space. Since the only way to access the women was through correctional staff, the staff were aware of who had chosen to participate in the study. However, once the women were in the “research room” the correctional officers were not privy to any information being shared.

Leaving the Space Behind

We had to not only learn ways of negotiating the space while collecting data, but also grapple with the feelings that lingered each time we left the correctional facility. For us, feeling was a way of knowing (Ferrell, 2005), as we believed that the research process was strengthened by the emotions that emerged (e.g., sorrow, powerlessness, guilt, anger, and frustration) (Arditti et al., 2010; Brewer-Smyth, 2008). The emotions grounded us and were sources of insight into the experience of conducting research with criminalized women. The culture of power and compliance deeply impacted us, particularly in relation to the attitudes displayed towards the women and ourselves (as outsiders and researchers) by certain correctional officers. It was difficult to make sense of this in terms of our role

as health researchers without the authority to intervene. Witnessing such behaviour and mistreatment did not negatively influence our ability to collect data, but, rather, reified our commitment to conduct research with criminalized women and to use our relative position of power to leverage their voices, issues, and health needs.

The professional backgrounds of the research team influenced the emotional toll on us:

One would think that being locked in a room with someone convicted of murder would be terrifying, that it would feel unsafe. I thought it would. I was wrong. What is terrifying and leaves me feeling empty is the feeling that I should be able to help. We should all be able to help. These lives, these stories, these women — they are not safe. They have never been safe. Do I play a role in that? That is what hurts.

Our experiences as community health nurses, mental health nurse, and trauma counsellor made us sensitive to the unique health needs of this population, which were simply not being met.

Grappling with the privilege of freedom. In the physical and emotional transition out of the incarcerated setting, there was often a sad silence as we moved from cell bars, locked doors, and bulletproof glass into the fresh air, bright sunshine, and occasional snowy day — a pleasure denied the women we had just interviewed. This invoked a bittersweet feeling of freedom while at the same time causing us to grapple with our position of privilege. In reflecting on the experience of collecting data in a detention setting, one research assistant used poetry to capture the tensions:

these cinderblock walls that steal my words
swallow them whole . . . leave sentences incomplete
I talk louder so she can hear me
so much noise — not decipherable noise, but noise
but there is no breeze because we're sealed in tight
the smooth feel of a pen gliding on paper
“oh, a pen . . .” (she exclaims) compared to the resistance of a pencil
clanging guards' keys that mark time . . . the only marker of time.
“they don't care because we're inmates — just because I'm in here
doesn't mean I shouldn't get health care”
“they treat us better because you are here,” she says to me
they gotta catch the woman having a seizure
“ah, she's fine, she's already on the floor,” says the women's keepers
'cuz according to them they're: fakers, manipulators, track marks/
markers.

Recognizing the potential and purpose of this research as a vehicle for change was foundational in our ability to overcome feelings of privilege, frustration, anger, sorrow, powerlessness, guilt, and hopelessness.

Recommendations and Conclusions

It is important to acknowledge outright that there are significant and numerous challenges and barriers to initiating and completing research in incarcerated settings. These are inevitable, and expectations, preparation, and timelines need to be adjusted accordingly. However, in spite of all the challenges, data collection with the women provided insightful lessons regarding the research process, and was rewarding, meaningful, and important.

Based on our research experiences, we have developed four recommendations for health researchers as to the challenges and opportunities of conducting research in incarcerated settings in general and with criminalized women in particular: (1) develop strong research relationships, (2) draw up a thorough safety and debriefing plan, (3) place oneself external to the system, and (4) use data-collection methods that provide opportunities for participants' voices to be heard.

Developing strong relationships and liaisons is critical to conducting research in any institutional environment. It takes on special significance in an incarcerated setting, as the researcher is unable to enter and move about the building without making prior arrangements. It is important to partner with insiders and include their insights about which research methods might be appropriate and likely to be approved. We found that taking the time to repeatedly explain ourselves to staff and describe the purpose of the research was particularly important when conducting research in a space where policing the whereabouts and activities of outsiders is an integral aspect of correctional officers' role. Helping staff to understand how the processes of recruitment and data collection were challenged by the incarcerated setting enhanced their willingness to continue supporting our study when deadlines for data collection were exceeded.

To process the challenging circumstances we witnessed, we found it necessary to have a thorough debriefing process in place for the research team. Our team meetings served several functions. They became a formal dialogic space to make sense out of what we were engaged and implicated in. Debriefing, with the aid of field notes that captured the immediate thoughts and feelings of a researcher after a data-collection session, was useful for contextualizing and giving deeper meaning to research findings, processes, and experiences (Arditti et al., 2010).

In addition to a debriefing process, there is a need to place oneself as the researcher, external to the correctional system (Roberts, 2011). This strategy meant emphasizing to the participants (and to ourselves) our connection to the university rather than to the detention centre. Because we foregrounded our identities as female health professionals and university-based researchers during the recruitment and consent process, the incarcerated women appeared eager to participate. We expressed genuine interest in what they had to say and conveyed an unwavering belief in the value of their opinions — a position that stood in direct contrast to their experience within the correctional system.

Lastly, the data-collection methods adopted should provide opportunities for participants' voices to be heard. We learned that the data-collection method mattered to both the participants and ourselves. The methods that required longer periods of engagement both enhanced the research-participant relationship and fostered a type of reciprocity unique to the incarcerated population. The demographic questionnaire and the quantitative assessment tool required much less time (20 minutes) than the individual semi-structured interviews (60 minutes) and were completed in a group setting (at the request of the correctional officers, due to time and space limitations) rather than in a one-on-one scenario. Participants' comments suggest that the time spent taking part in an individual semi-structured interview versus the briefer group health assessment served as an honorarium in and of itself.

Conducting research with criminalized women has, in retrospect, proved to be enriching, moving, and deeply impactful. We feel honoured and privileged to have worked with these participants. We hope that by sharing our challenges and successes with other health researchers, we will continue to carry the women's stories forward.

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