

# **Addressing the Mental Health Needs of Women Offenders**

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## ***Women's Mental Health Issues Across the Criminal Justice System***

**Rosemary Gido and Lanette Dalley (2008)**

*Women in American society have life experiences that differ from men's in important ways. Many of these-- sexual assault, domestic violence, poverty and discrimination-- hurt women's mental and physical health (American Psychological Association)*

### **Introduction**

The number of women in jail, in prison, on probation, or on parole in the United States has increased dramatically over the past several decades and now exceeds one million. Women entering the correctional system represent a population at high risk for substance use disorders and mental health problems. According to the Bureau of Justice Statistics, 73% of female prisoners in state institutions and 47% in federal institutions used drugs regularly prior to incarceration (Mumola, 1999). Data from other studies suggest that as many as 80% of incarcerated women meet the criteria for at least one lifetime psychiatric disorder (Teplin et al., 1996; Jordan et al., 1996). Substance abuse or

dependence, post-traumatic stress disorder (PTSD) and depression appear to be some of the most common mental health problems for female prisoners.

There is a growing body of research on the mental health needs of women offenders. One major finding from this research is that incarcerated women are more likely than their male counterparts to report extensive histories of physical, sexual, and emotional abuse (Messina, Burdon, Hagopian, & Prendergast, 2006). Surveys conducted among incarcerated women have also shown a strong link between childhood abuse and adult mental health problems, particularly depression, post-traumatic stress, panic, and eating disorders (Messina & Grella, 2006). In a 2006 study of the impact of childhood traumatic events on a sample of drug-dependent female offenders, Messina and Grella found that greater exposure to childhood adverse events was associated with behavioral problems in adolescence and adulthood, as well as physical and mental health problems.

Although they are therapeutically linked, substance abuse, post-traumatic stress, and mental health problems have been treated separately. One of the most important developments in mental health care over the past several decades is the recognition that a substantial proportion of women offenders have experienced trauma and this plays a vital and often unrecognized role in the evolution of a woman's physical and mental health problems (Bloom, Owen, & Covington, 2003).

There are important mental health differences between incarcerated women and women in general. For example, 12% of females in the general population have symptoms of a mental disorder, compared to 73% of females in state prison, 61% in federal prison, and 75% in local jails (James and Glaze, 2006). Another study, comparing incarcerated women matched by age and ethnicity to those in the community,

found that incarcerated women have a significantly higher incidence of mental health disorders including schizophrenia, major depression, substance use disorders, psychosexual dysfunction, and antisocial personality disorder (Ross, Glaser, & Stiasny, 1998).

Women offenders characteristically are poor, women of color, unemployed and mothers of young children. They also have significant substance abuse issues and multiple physical and mental health problems (Bloom, Owen, & Covington, 2003). Incarcerated women have typically experienced some form of abuse in their lifetime, including sexual assault, domestic violence, and other physical and psychological abuse. Although a history of abuse and family-related problems are common issues among female inmates, many correctional systems do not screen for childhood or adult abuse when determining possible therapeutic interventions (Morash, Bynum, & Koons, 1998).

According to the Bureau of Justice Statistics, at midyear 2005, female prison and jail inmates had many more mental health problems than did male prisoners. Seventy-three percent of women in state prisons had mental health problems versus 55% of males, and 75% of women in local jails had mental health problems versus 63% of males. Twenty-three percent of females in state prisons and local jails said that they had been diagnosed with mental disorders by mental health professionals in the past year (James and Glaze, 2006). This is nearly three times the number of male inmates (8%) who had been told they had mental disorders.

Three-quarters of female inmates in state prisons who had a mental health problem met the criteria for substance dependence or abuse. Thirty-four percent had used powdered or crystalline (“crack”) cocaine, and 17% had used methamphetamines in the

month prior to arrest. Sixty-eight percent had experienced past physical or sexual abuse, 17% had been homeless in the year prior to arrest, and, 47% had a parent who abused alcohol or drugs (James and Glaze, 2006).

Teplin, Abram, and McClellan (1996) found that most incarcerated women with psychiatric disorders did not receive treatment. The findings of a study of lifetime use of mental health and substance abuse treatment services by incarcerated women by Jordan et al. (2002) suggest that:

There is a subgroup of troubled women whose impairments result not only in their receiving mental health and or substance abuse treatment services, or both, but also in their being repeatedly incarcerated (p. 324.)

The authors go on to state that they do not know why, despite having been in treatment, the women continued to exhibit serious mental health problems and to engage in behaviors that led to incarceration. One hypothesis suggested by the high prevalence of exposure to trauma among the women inmates is that their disorders may be trauma related and previous treatment may not have addressed traumatic experiences.

A study by Green, Miranda, Daroowalla, and Siddique (2005) that explored exposure to trauma, mental health functioning, and treatment-program needs of women in jails found high levels of exposure to trauma (98%) – especially interpersonal trauma (90%) – and domestic violence (71%) among incarcerated women, along with high rates of PTSD, substance abuse problems, and depression. Thirty-six percent of the women had mental disorders. These findings suggest that many incarcerated women are unlikely to meet goals of economic and social independence, family reunification, and reduced involvement in criminal activities without adequate attention to their PTSD and other mental health problems (p. 145). The authors emphasize that, unless traumatic

victimization experiences, functional difficulties, and other mental health needs are taken into account in program development, incarcerated women are unlikely to benefit from in-custody and post-release programs.

### **Understanding Trauma**

The terms *violence*, *trauma*, *abuse*, and *post-traumatic stress disorder (PTSD)* often are used interchangeably. One way to clarify these terms is to think of trauma as a response to violence or some other overwhelmingly negative experience. Trauma is both an event and a particular response to an event. *The Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994) (also known as the *DSM-IV*), used by mental health providers, defines *trauma* as follows:

...involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. The person's response to the event must involve intense fear, helplessness or horror (or in children, the response must involve disorganized or agitated behavior). (p. 424)

PTSD is one type of disorder that results from trauma. The *DSM IV* lists the following symptoms of PTSD (pp. 427-429):

- Re-experiencing the event through nightmares and flashbacks.
- Avoidance of stimuli associated with the event (e.g., if a woman was assaulted by a blonde man, she may fear and want to avoid men with blonde hair).
- Estrangement (the inability to be emotionally close to anyone).
- Numbing of general responsiveness (feeling nothing most of the time).
- Hypervigilance (constantly scanning one's environment for danger, whether physical or emotional).

- Exaggerated startle response (a tendency to jump at loud noises or unexpected touch).

There are two types of PTSD: simple and complex. A single traumatic incident in adulthood (such as a flood or accident) may result in simple PTSD. Complex PTSD usually results from multiple incidents of abuse and/or violence (such as childhood sexual abuse and domestic violence).

A review of studies that examined the combined effects of post-traumatic stress disorder and substance abuse found more co-occurring mental disorders, medical problems, psychological symptoms, in-patient admissions, interpersonal problems, lower levels of functioning, poor compliance with aftercare and motivation for treatment, and other significant life problems (such as homelessness, HIV, domestic violence, and loss of custody of children) in women with both disorders than in women with PTSD or substance abuse alone (Najavits, Weiss, & Shaw, 1997).

Although PTSD is a common diagnosis associated with abuse and trauma, the most common mental health problem for women who are trauma survivors is depression.

When working in the criminal justice system, it is important to know that the vast majority of female offenders have been physically and/or sexually abused, both as children and as adults. Women often have their first encounters with the law as juveniles who have run away from home to escape violence and physical or sexual abuse.

Prostitution, property crime, and drug use can then become ways of life.

There is a difference between women and men in terms of their risk for physical and sexual abuse. Both female and male children are at risk in their childhood, from family members and people known to them. However, there are significant gender

differences over a life span. In adolescence, boys are at risk if they are gay, young men of color, or gang members. Their risk is from people who dislike or hate them. For a young woman, the risk is in her primary relationship from the person(s) to whom she is saying, "I love you." For an adult man, the risk for abuse comes from being in combat or being a victim of crime, and the perpetrator is usually a stranger. For an adult woman, the risk is again in her relationship with the person to whom she says, "I love you." Clinically, we think that this may account for the increase in mental health problems for women. It is more confusing and distressing to have the person who is supposed to love and care for you do harm to you than it is to be harmed by someone who dislikes you or is a stranger (Covington, 2007b).

Of course, different women have different responses to violence and abuse. Some may respond without trauma, because they have coping skills that are effective for a specific event. Sometimes trauma occurs but is not recognized immediately, because the violent event is perceived as normal.

Many women who used to be considered "treatment failures" because they relapsed can now be understood as trauma survivors who returned to alcohol or other drugs in order to medicate the pain of trauma. By integrating trauma treatment with addiction treatment, we reduce the risk of trauma-based relapse.

Although services designed for women that acknowledge their typical victimization experiences are becoming more widespread, and a variety of approaches targeting gender-responsive needs have been proposed (Bloom, Owen, & Covington, 2003; Covington, 1998, 1999, 2003, 2007b; Zlotnick, Najavits, Rohsenow, & Johnson, 2003), such specialized services tend to be the exceptions rather than the rule. Gaps in

substance abuse treatment, physical and mental health care exist during incarceration and upon reentry into the community. While in the correctional system, women have little access to gender-responsive substance abuse and mental health services. After completing their prison sentences, they are released back into their communities with little transitional support or integrated services that address their substance abuse, trauma, and mental health needs.

In conceptualizing treatment programs for women, it is essential that providers combine theory and practice from a multidisciplinary perspective. Increased sensitivity to women's needs is necessary in order to design effective programs.

### **Theoretical Perspectives**

In order to develop gender-responsive substance abuse and mental health services for women, it is essential to have a theoretical framework. This is the knowledge base that also creates the foundation upon which programs are developed. Four fundamental theories for creating women's services include: pathways theory, theory of women's psychological development, trauma theory, and addiction theory.

#### ***Pathways Theory***

Research on women's pathways into crime indicates that gender matters. Steffensmeier and Allen (1998) note how the "profound differences" between the lives of women and men shape their patterns of criminal offense. Many women on the social and economic margins of society struggle to survive outside of legitimate enterprises, which brings them into contact with the criminal justice system. As was previously mentioned, because of their gender, women are also at greater risk for experiences such as sexual abuse, sexual assault, and domestic violence. The most common pathways to crime are

based on survival (of abuse and poverty) and substance abuse. Pollock (1998) asserts that female offenders have histories of sexual and/or physical abuse that appear to be major roots of subsequent delinquency, addiction, and criminality.

In summary, pathway research has identified such key issues in producing and sustaining female criminality as histories of personal abuse, mental illness tied to early life experiences, substance abuse and addiction, economic and social marginality, homelessness, and relationships.

### ***Theory of Women's Psychological Development***

Theories that focus on female development, such as the relational model, posit that the primary motivation for women throughout life is the establishment of a strong sense of connection with others. Relational-Cultural Theory (RTC) developed from an increased understanding of gender differences and, specifically, of the different ways in which women and men develop psychologically (Miller, 1986, 1990). According to RCT, females develop a sense of self and self-worth when their actions arise out of, and lead back into, connections with others. Connection, not separation, is thus the guiding principle of growth for girls and women.

The importance of understanding Relational-Cultural Theory is reflected in the recurring themes of relationship and family seen in the lives of female offenders. Disconnection and violation rather than growth-fostering relationships characterize the childhood experiences of most women in the criminal justice system. Females are far more likely than males to be motivated by relational concerns. For example, women offenders who cite drug abuse as self-medication often discuss personal relationships as the cause of their pain. The relational aspects of addiction are also evident in the research

that indicates that women are more likely than men to turn to drugs in the context of relationships with drug-abusing partners in order to feel connected. A relational context is critical to successfully addressing the reasons why women commit crimes, the motivations behind their behaviors, the ways they can change their behavior, and their reintegration into the community (Covington, 2007a).

### ***Trauma and Addiction Theories***

Trauma and addiction are interrelated issues in the lives of women offenders. Although they are therapeutically linked, these issues have historically been treated separately. Trauma and addiction theories provide a critical element in the integration of and foundation for gender-responsive services in the criminal justice system (Covington, 2007b).

*Trauma Theory:* As the understanding of traumatic experiences has increased, mental health conceptualizations and practice need to be changed accordingly. It is now considered necessary for all service providers to become “trauma informed” if they want to be effective. Trauma-informed services are services that are provided for problems other than trauma but require knowledge concerning the impact of violence against women other traumatic experiences. According to Harris and Falot (2001), trauma-informed services:

- Take the trauma into account.
- Avoid triggering trauma reactions and/or retraumatizing the individual.
- Adjust the behavior of counselors, other staff, and the organization to support the individual’s coping capacity.
- Allow survivors to manage their trauma symptoms successfully so that they are able to access, retain, and benefit from these services.

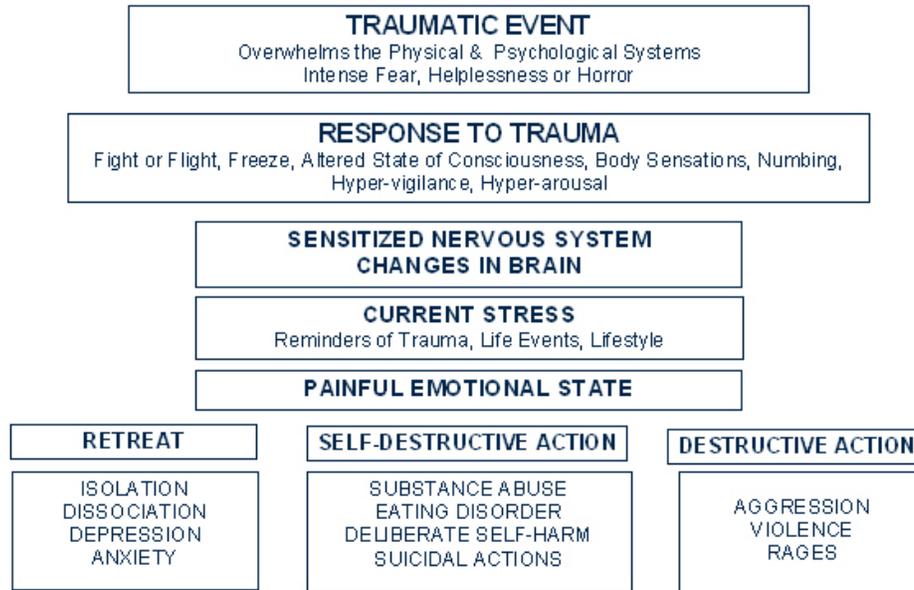
Becoming trauma-informed is particularly important for the criminal justice system. The standard operating practices (searches, seclusion, and restraint) may traumatize/retraumatize women. There is also the inherent cultural conflict in the criminal justice system: corrections is based on a culture of control, whereas treatment is based on a culture of change. The high rates of severe childhood maltreatment, as well as the high rates of physical and sexual abuse in adolescent and adult lives, underscore the importance of understanding the process of trauma. This is a critical step in the rehabilitation of women (Covington, 2003).

Figure 9.1 helps to explain the process of trauma and its interrelationships with substance abuse and mental health disorders.

Trauma begins with an event or experience that overwhelms a woman's normal coping mechanisms. There are physical and psychological reactions in response to the event: these are normal reactions to an abnormal or extreme situation. This creates a painful emotional state and subsequent behavior. These behaviors can be placed into three categories: retreat, self-destructive action, and destructive action. Women are more likely to retreat or be self-destructive, while men are more likely to engage in destructive behavior (Covington, 2003).

**FIGURE 9.1**

# Process of Trauma



*Addiction Theory:* Historically, addiction research and treatment have been focused on men, even though women’s addictions span a wide range, from alcohol and other types of drug dependence to smoking, gambling, sex, eating, and shopping (Straussner & Brown, 2002).

The holistic health model of addiction, with the inclusion of the environmental and sociopolitical aspects of disease, is the theoretical framework recommended for the development of women’s services (Covington, 1999; 2007b). This is consistent with information from the National Institute on Drug Abuse (NIDA) and the Center for Substance Abuse Treatment (CSAT):

- The reality, based on twenty-five years of research, is that drug addiction is a brain disease, one that disrupts the mechanisms responsible for generating, modulating, and controlling cognitive, emotional, and social behavior (NIDA, 1998).

- Alcohol and drug use disorder, or addiction, is a progressive disease, with increasing severity of biological, psychological, and social problems over time. (CSAT, 1994)

Although the addiction treatment field considers addiction a “chronic, progressive disease,” its treatment methods are more closely aligned to those of the emergency-medicine specialist than the chronic-disease specialist (White, Boyle, & Loveland, 2002). Recent articles assert that treating severe and chronic substance use disorders through screening, assessment, admission, and brief treatment, followed by discharge and minimal aftercare, is ineffective and results in shaming and punishing clients for failing to respond to an intervention design that is inherently flawed.

An alternative to the acute intervention model is behavioral health recovery management (BHRM). This concept grew out of and shares much in common with “disease management” approaches to other chronic health problems, but BHRM focuses on quality-of-life outcomes as defined by the individual and family. It also offers a broader range of services earlier and extends treatment well beyond traditional treatment services. BHRM models extend the current continuum of care for addiction by including: (a) pretreatment (recovery-priming) services, (b) recovery mentoring through primary treatment, and (c) sustained post-treatment recovery-support services (White, Boyle, & Loveland, 2002).

This updated and expanded perspective of disease offers a more helpful approach to the treatment of addiction for women because it is comprehensive and multidimensional. The holistic health model allows service providers to treat the primary problem of addiction while simultaneously addressing the many issues that women bring to treatment, such as genetic predisposition, health consequences, shame, isolation, and a

history of abuse, or a combination of these. For example, although some women may have a genetic predisposition to addiction, it is important in treatment to acknowledge that many have grown up in environments in which drug dealing, substance abuse, and addiction are ways of life. When addiction has been a core part of the multiple aspects of a woman's life, the treatment process requires a holistic, multidimensional approach.

### **Woman-Centered Treatment**

Specific elements are needed to create gender-responsive programs for women. For women, recovery is a process of transformational change. This type of profound change is not linear and simple, nor does it occur in isolation. The process of recovery and healing for women occurs in deep connection with self and others. In addition to the four theories discussed previously—pathways, women's psychological development, trauma, and addiction – as foundations on which to design mental health services, other important elements are: the clinical issues that create the content of the program, therapeutic approaches, and the structure of the program, its context and environment (Covington, 2007b).

### **Program Content**

The Center for Substance Abuse Treatment (CSAT) operates within the U.S. Public Health Service, an agency of the Department of Health and Human Services. CSAT funds ongoing studies of women's addiction and treatment, establishes minimum standards for treatment, and provides demonstration models for treatment in programs around the country. It recognizes the need for gender-responsive treatment for women that takes into account physical, psychological, emotional, spiritual, and sociopolitical

issues. CSAT identifies the following clinical issues as essential to a comprehensive treatment program (1999):

- The process of addiction, especially gender-specific issues related to addiction (including social, physiological, and psychological consequences of addiction and factors related to the onset of addiction).
- Low self-esteem.
- Race, ethnicity, and cultural issues.
- Gender discrimination and harassment.
- Disability-related issues, where relevant.
- Relationships with family members and significant others.
- Attachments to unhealthy interpersonal relationships.
- Interpersonal violence, including incest, rape, battering, and other abuse.
- Eating disorders.
- Sexuality, including sexual functioning and sexual orientation.
- Parenting, child care, and child custody.
- Grief related to the loss of alcohol or other drugs, children, family members, or partners.
- Employment.
- Appearance and overall health and hygiene.
- Isolation related to a lack of support systems (which may or may not include family members and/or partners) and other resources.
- Life-plan development.

This list indicates that therapeutic addiction and mental health programs for women need to assess all domains of a woman's life in order to obtain an accurate picture of her life. Many women's programs do not have the resources to address all the issues listed above, so providing referrals when they cannot provide services themselves is essential.

The following sections discuss in more depth some of the clinical issues that are essential to address.

### ***Trauma***

Judith Herman's work offers a three-stage model for providing trauma services (1997). *Safety* is the first stage of work with trauma survivors. Women in the criminal justice system often feel unsafe in this environment and unable to participate when services are provided. Trauma can skew a woman's relational experiences and hinder her psychological development. Because it can affect the way a woman relates to staff members, her peers, and the therapeutic environment, it is helpful to ask, "Is this person's behavior linked to her trauma history?" However, traditional addiction, and/or mental health treatment, often does not deal with trauma issues in early recovery, even though it is a primary trigger for relapse among women and may be underlying their mental health disorder. Many treatment providers lack the knowledge and understanding of what is needed in order to do this work.

Here are three important things that you can do in treatment:

1. Educate women as to what abuse and trauma are. Women often do not know that they have been abused. Nor do they have an understanding of PTSD.

2. Validate their reactions. It is important that women learn that their responses are normal, given their experiences. The DSM has stated that trauma responses are normal reactions to abnormal situations.
3. Provide coping skills. There are grounding and self-soothing techniques (i.e., breathing exercises) that women can learn to help themselves cope with their traumatic experiences. (See Covington, 2003, for specific techniques to use in individual and group therapy).

#### *Avoid Revictimization and Retraumatization*

A woman who has experienced a traumatic event also experiences increased vulnerability. She may have difficulty tolerating, expressing, and/or modulating her emotions. This results in what is called emotional dysregulation. An example of this is when she over responds to neutral cues and under responds to danger cues. Therefore, traumatized women are at increased risk of similar, repeated revictimization.

“Retraumatization” refers to the psychological and/or physiological experience of being “triggered.” A single environmental cue related to the trauma – such as the time of year, a smell, or a sound – can trigger a full fight-or-flight response. Because women are often triggered in criminal justice settings, some jurisdictions are being trained through the use of a new curriculum designed to reduce seclusion and restraint (Center for Mental Health Services, 2005). The traditional belief is that seclusion and restraint need to be used in mental health settings for safety reasons. However, both patients and staff are reporting an increased sense of safety and security when seclusion and restraint are reduced. Trauma survivors are used to having their boundaries ignored and their protests dismissed. A crucial element of successful treatment involves attention to these

components of a woman's experience. Again, safety is critical for women who are trauma survivors.

### *Co-occurring Disorders*

Co-occurring disorders (CODs) are complex, and the historic division in the mental health and substance abuse fields often has resulted in contradictory treatment. As mentioned earlier, one study revealed that 75% of the women in state prisons who had mental health disorders also had substance abuse problems (James and Glaze, 2006). It is often difficult to know whether a psychiatric disorder existed for a woman before she began to abuse alcohol or other drugs or whether the psychiatric problem emerged after the onset of substance abuse. Women in early recovery often show symptoms of mood disorders, but these can be temporary conditions associated with withdrawal from drugs. Also, women may be more likely to seek help from the mental or physical health-care system than from specialized addiction services. Therefore, their mental health problems may be identified sooner than their addictive disorders.

As noted earlier, one of the most important developments in health care since the 1980's is the recognition that serious traumatic experiences often play an unrecognized role in a woman's physical and mental health problems. For many women a co-occurring disorder is trauma related. The Adverse Childhood Experiences Study (Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, Koss, & Marks, 1998), which shows a strong link between childhood trauma and adult physical and mental health problems, was the model for a study with female offenders. Eight types of childhood traumatic events were assessed: emotional abuse and neglect, physical neglect, physical abuse, sexual abuse, family violence, parental separation/divorce, incarcerated family member, out-of-home

placement. A score of 5 or more increased the risk of both mental and physical health problems in a person's adult life. For women who scored 7 or more, the risk of a mental health problem was increased by 980% (Messina and Grella, 2006).

Addicted women are more likely to experience the following co-occurring disorders: depression, dissociation, post-traumatic stress disorder, other anxiety disorders, eating disorders, and personality disorders. Mood disorders and anxiety disorders are the most common. Women are commonly diagnosed as having "borderline personality disorder" (BPD) more often than men are. Many of the descriptors of BPD can be viewed differently when one considers a history of childhood and adult abuse. The American Psychiatric Association is considering adding the diagnosis of "complex PTSD" in the next edition of the DSM (Herman, 1997).

Research suggests that preexisting psychiatric disorders improve more slowly for recovering substance abusers and need to be addressed directly in treatment. However, the presence of a psychiatric disorder can adversely influence the course of addiction treatment, and vice versa. Problems often become magnified, and co-occurring mental disorders often result in poor psychosocial functioning, health problems, medication noncompliance, relapse, homelessness, and suicidal behavior (Drake, 2006).

In order to work with women with mental health and substance abuse issues, the treatment team needs to understand the symptoms and diagnoses of mental illnesses, the roles of medications, the process and symptoms of addiction, the needed credentials of mental health providers, and have a treatment philosophy. All of this needs to be filtered through the lens of trauma.

Integrated treatment for women with co-occurring disorders means concurrent, not sequential, treatment. Dual recovery strategies are needed that employ effective treatment strategies from both the mental health and substance abuse treatment fields.

### ***Societal Realities***

A gender-responsive treatment program is based on an understanding of the role of socialization in women's lives. It acknowledges the social and political structures that support inequality, which leads to low self-esteem among women, lower pay for women, and high rates of violence against women.

Being able to acknowledge the impact of socialization and its implicit messages allows women to put their own individual issues into the larger social context. Many women understand their issues only as individual pathologies, rather than as the risks and consequences of being born female.

### **Therapeutic Approaches**

A number of approaches and modalities have been found to be effective with women. Some are more research based than others, as rigorous research studies are still lacking on many women-specific treatment approaches. In fact, the term "evidence-based," which is currently considered a criterion for interventions to be used, has no universal definition. A 2005 Presidential Task Force of the American Psychological Association said, "Evidence-based practice (EBP) is defined as the integration of the best available research and clinical expertise within the context of patient characteristics, culture, values, and preferences" (Goodheart, Kazdin, & Sternberg, 2006). The research clearly indicates that, regardless of the therapeutic approach used, the central factors that influence whether or not a modality is effective appear to be related to the characteristics

of the treatment *alliance*. Therapeutic alliance refers to the relationship between the clinician and the client. In order to fully address the needs of women, therapeutic programs need to use a variety of interventions with behavioral, cognitive, affective/dynamic, and systems perspectives.

### **Structure of the Program (Context and Environment)**

While the clinical issues create the program content, the structure creates the context and environment. How a program is designed and implemented impacts a woman's treatment experience. When the structural element is integrated with the theoretical foundation and the clinical issues, the framework for gender-responsive treatment is established. The following are the structural elements of gender-responsive programming (Covington and Bloom, 2007).

#### ***Individualized Treatment***

Woman-centered treatment regards each client as unique, with individual life circumstances, goals, priorities, patterns of recovery, and treatment needs. Treatment needs to be individualized in order to be effective.

#### ***Women-Only Groups***

Women tend to engage in group therapy more often than men. This phenomenon may be linked to gender norms that support the suppositions of the relational model. Groups encourage the development of a sense of belonging and connection to others, which helps to motivate women to stay in the process. However, most groups in correctional settings are not group therapy. Often it is just a group of people sitting in a circle doing individual work with a facilitator.

Many researchers and practitioners believe that the treatment needs of women with substance use and mental health disorders are best met in women-only groups (facilitated by women). Women's complex histories of sexual and physical abuse, the greater tendency toward social isolation, and the stronger stigma attached to women's substance abuse all call for treatment that could not take place in mixed-gender groups. Yet many community-based programs continue to provide only co-ed services. Experience shows that many women do not talk as freely when men are present. They may be uncomfortable discussing their addiction, mental health, sexual histories, relationships, childcare issues, and other personal topics with males present. In addition, many women believe that only women can understand how they feel and react to things. This is especially true of women who have been dominated by or abused by men in some way. Experience also shows that men tend to dominate in mixed-gender groups.

Finally, women-only groups afford women an opportunity to compare their attitudes about parents, partners, and children, and their feelings about things that have happened to them. The group members can suggest new possibilities for feeling, perceiving, and behaving.

### ***The Physical Environment***

Women recover best in an atmosphere that is warm and welcoming for them and their children. The environment needs to reflect the diverse cultures of the staff members and clients. To emphasize women's strengths, female role models from many cultures can be highlighted. A connection to women's history and heroines can play an important role in bolstering self-esteem for women.

A child-friendly space dedicated to childcare and age-appropriate equipment and activities for children are essential when children are included in a community program or when they visit a jail or prison. There need to be games and other learning opportunities that engage children in developing communication skills, relationships, and healthy forms of expression.

### ***The Psychological Environment***

Any teaching and/or rehabilitation process would be unsuccessful if its environment were to mimic the dysfunctional systems that women already have experienced. Therefore, program and treatment strategies should be designed to undo some of the prior damage. This can be particularly challenging in criminal justice settings. Therapeutic community norms need to be consciously designed to be different: safety with oneself and with others is paramount.

Work with trauma survivors has shown that social support is critical for recovery and has encouraged practitioners to take a new look at the “therapeutic milieu.” This refers to a carefully arranged environment designed to reverse the effects of exposure to interpersonal violence. A therapeutic culture contains the following five elements, all fundamental in both institutional settings and the community:

- *Attachment*: a culture of belonging.
- *Containment*: a culture of safety.
- *Communication*: a culture of openness.
- *Involvement*: a culture of participation and citizenship.
- *Agency*: a culture of empowerment.

Women need both psychological-emotional and physical space. In both in-prison/

jail programs and community programs, the physical layout needs to provide some sense of privacy and space where women can be quiet and meditative. Some treatment programs are so focused on schedules that each day is totally activity driven. However, women need some unscheduled time for contemplation and reflection.

### ***Strength-based Treatment***

In a traditional treatment model, the clinician typically approaches assessment with a problem focus: *What is missing in the client? What is wrong with the client?* A woman entering mental health services probably is already struggling with a poor sense of self because of the stigma attached to her mental health issues, her addiction, her parenting history, her trauma, or her criminal record. It may be non-therapeutic to add another problem to the woman's list of perceived failures.

Strength-based (asset) treatment shifts the focus from targeting problems to identifying the multiple issues a woman must contend with and the strategies she has adopted to cope. This is referred to as assessing a woman's "level of burden." (Brown, Melchior, & Huba, 1999). Burdens are conditions such as psychological problems, homelessness, HIV/AIDS, other health issues, addiction, and physical and sexual abuse. The focus is on support, rather than on confrontation to break down her defenses.

In using a strength-based/asset model, a counselor helps a client to see the strengths and skills she already has that will help her to manage symptoms, and become sober and drug-free. The counselor looks for the seeds of health and strength, even in a woman's symptoms. For example, she may portray a client's relational difficulties as efforts to connect, rather than as failures to separate or disconnect.

## **Challenges**

Providing quality mental health services for women in criminal justice settings involves confronting a variety of systemic barriers. First, the criminal justice is based on “care, custody, and control.” It was not designed for the provision of mental health services. Many of the standard practices traumatize and retraumatize women. This exacerbates their symptoms of mental distress.

The mental health field has its own set of challenges:

***History of the DSM:*** It is ironic that with the current insistence on the use of evidence-based practices, the DSM itself is not being discussed nor challenged. When one reviews the history of the development of this manual, it becomes clear why Robert Spitzer, the veteran editor of the DSM, laments that unreliability in psychiatric diagnosis is “still a real problem, and it’s not clear how to solve the problem” (Spiegel, 2005).

***DSM and the Pharmaceutical Industry:*** A recent article (Cosgrove, Krimsky, Vijayaraghavan, & Schneider, 2006) examined the degree and type of financial ties to the pharmaceutical industry of panel members responsible for revisions of the DSM. Of the 170 DSM panel members 95 (56%) had one or more financial associations with companies in the pharmaceutical industry. One hundred percent of the members of the panels on ‘Mood Disorders’ and ‘Schizophrenia and Other Psychotic Disorders’ had financial ties to drug companies. This can result in care that unduly emphasizes drug treatments; while adverse effects of drugs are downplayed (Moncrieff, Hopker, & Thomas, 2005).

***Bias and the DSM:*** Unfortunately, research on mental illness is exceedingly complicated, and little is known about causes and cures. Virtually none of the standard

diagnostic categories has been empirically validated (Caplan & Cosgrove, 2004). In addition, members of marginalized groups suffer when we base our conceptions of normalcy on the behavior and worldview of dominant social groups, and the consequences of sexism, racism, homophobia, and the “struggle with poverty are misinterpreted as evidence of individual psychopathology” (Bullock, 2004). For example, in 1987 the Women and Mental Health Committee of the Canadian Mental Health Association recommended dispensing with unvalidated systems of diagnostic labels, instead naming many of the known and proven causes of women’s suffering, including poverty, violence, and lack of social and political power and resources.

## **Conclusion**

Addressing the mental health needs of women offenders involves a gender-responsive approach that includes comprehensive services that take into account the content and context of women’s lives. Programs need to consider the fact that a woman cannot be treated successfully in isolation from her social support network. Coordinating systems that link a broad range of services will promote a continuity-of-care model that integrates substance abuse, trauma, and mental health. As the fields of substance abuse and mental health begin to work with women offenders in a more integrated and comprehensive way and use the lens of trauma as a way to understand women’s lives, the criminalization of women’s survival behaviors may ultimately be reduced.

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