

# **Women in Prison: Approaches in the Treatment of Our Most Invisible Population**

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## **Overview**

Some of the most neglected, misunderstood and unseen women in our society are those in our jails, prisons and community correctional facilities. While women's rate of incarceration has increased dramatically, tripling in the last decade, prisons have not kept pace with the growth of the number of women in prison; nor has the criminal justice system been redesigned to meet women's needs, which are often quite different from the needs of men.

There are many reasons for the growing numbers of women in the criminal justice system, but the primary one is the increase in drug-related convictions and the advent of mandatory sentences for these offenses. According to the Federal Bureau of Prisons, over 60% of the women in their custody are serving sentences for drug offenses. For many states the rate is even higher for alcohol and drug-related crimes.

In spite of this, the issues of addicted women are, for the most part, invisible in the criminal justice system. Historically, treatment, research and recovery have been based on the male experience, often neglecting women's needs. While this neglect has a serious impact on women and treatment programs in the free world, the problem is magnified for women in the criminal justice population.

Statistics indicate that for women there is a high correlation between drug abuse and incarceration and parole/probation violations, and yet our society provides no comprehensive continuum of care for these women. This paper will discuss a relational model of treatment that incorporates the multiple issues involved in women's recovery. Three theoretical perspectives --addiction, trauma, and women's psychological development -- are interwoven to provide the foundation for a model based on the concept of a woman's journey to recovery. This model can be adapted for both the prison population and community-based programs.

In summation, the objectives of this paper are:

1. To increase awareness of women's lives in the criminal justice system.
2. To discuss a comprehensive and integrated treatment model (theory of addiction, theory of

trauma, theory of women's psychological development).

3. To examine the four areas that women report as being both most challenging, and their major triggers to relapse: self, relationships, sexuality, and spirituality.
4. To discuss Twelve Step programs for women.

### **Rising Numbers of Women in the Criminal Justice System**

Since 1980, the number of women in United States prisons has tripled. During this time, the rate of incarceration for women has surpassed the male rate during every year but one; and in 1996, the number of women imprisoned nationally was 69,028 (LeBlanc, 1996).

The war on drugs has inadvertently become a war on women, clearly contributing to the explosive increase in the number of women who are incarcerated. The 1986 mandatory drug sentencing laws, with their "get tough on crime" philosophy specifying that anyone caught with possession of a drug should automatically be sentenced, were designed to rid society of drug dealers and major players in the illegal drug trade. Unfortunately, this law backfired in the case of women. The assumption that this law was only sending dangerous males to prison was a false one. Between 1986 and 1991, the number of women in state prisons for drug offenses increased by 433%, compared to a 283% increase for men (LeBlanc, 1996). Currently, 35.9% of women serving time for drug offenses were charged solely with "possession." "Instead of a policy of last resort, imprisonment has become the first-order response for a wide range of non-violent and petty offenses and women have been disproportionately swept up in this trend" (Bloom, Chesney-Lind, & Owen, 1994, p. 2).

To keep up with the high costs of incarceration -- it takes \$50,000 per cell to build a new prison and \$20,000 per person per year to house offenders -- many states have cut vitally needed social service, educational, and drug/alcohol programs (Raspberry, 1991). Since there is a high rate of recidivism among women who are convicted for possession or use of drugs, curtailing drug and alcohol recovery programs has proven to be an expensive and illogical move.

One of the questions we must ask ourselves when faced with the issues surrounding the growing number of women in the criminal justice system is whether or not there is always a need for incarceration. In a private conversation, a warden at one of the largest women's prisons in the U.S. stated that 75% of the women in her custodial care would be better treated in the community (personal communication, May 1995). Clearly, this would be a more humane and economical solution to the overcrowding of our prisons by women who have committed nonviolent, petty offenses.

### **Profile of Women in the Criminal Justice System**

Female prison populations differ from their male counterparts in several significant ways. First of all, they are less likely to have committed a violent offense and more likely to have been convicted of a crime involving alcohol, other drugs or property. It is important to point out that many property crimes are economically driven, often motivated by the abuse/addiction of alcohol and other drugs and/or poverty. A 1994 study done in California showed that 71.9% of women had been convicted on a drug or property charge versus 49.7% of men. Men also commit nearly twice the violent crimes that women do (Bloom, Chesney-Lind, & Owen, 1994). These statistics are consistent with national trends (LeBlanc, 1996). Women are significantly less violent than their male counterparts, and show more responsiveness to prison programs, although they have less opportunity to participate in them than male prisoners do. While men often deal with their anxiety by working their bodies constantly, women tend to fear the central yard, working out their anxieties with too much sleep, food and prescription pills (LeBlanc, 1996).

Most female prisoners are poor, undereducated, unskilled, single mothers, and a disproportionate number of them are women of color. In a study of California prisons, over half of the women were African American (35%) and Hispanic (16.6%). One-third were Caucasian and the remaining 13% were made up of other minorities. Of those who had been employed before incarceration, many were on the lower rungs of the economic ladder, with only 37% working at a legitimate job. Twenty-two percent were on some kind of public support, 16% made money from drug dealing and 15% were involved in prostitution, shoplifting or other illegal activities (Bloom, Chesney-Lind, & Owen, 1994). One of the things that these statistics clearly shows is that there are issues of race and class involved in the criminal justice system (Chesney-Lind & Bloom, 1997; Watterson, 1996). For example, there has been a law in the state of Minnesota (recently held unconstitutional) that says first-time users of crack cocaine will receive mandatory four-year sentences, but first-time users of cocaine in its powdered form will receive only probation. Since 92% of those arrested on charges for possession of crack in 1988 were African Americans and 85% of those arrested for possession of powdered cocaine were Caucasian, the law is clearly racist (Raspberry, 1991). When racial and economic factors drive the issue of who will be imprisoned, where is the "justice" in the criminal justice system (Belknap, 1996)?

One major health concern in prisons is AIDS. In a study done with 400 female volunteers in a Massachusetts's prison, 35% of the women tested were HIV positive, compared with 13% of the men. In one California prison, women who tested positive were placed in a segregated AIDS unit, whether they showed signs of the disease or not (Salholz & Wright, 1990).

Two-thirds of incarcerated women have children under the age of 18 (Smith, 1991). Many feel enormous guilt about being absent from their children's lives and worry about whether they will still have custody of their children when they get out (Bloom & Steinhart, 1993). These and other concerns, including unresolved issues of physical and sexual abuse, lead female inmates to make requests for psychological counseling that far exceed those made by men. Penal experts agree that women would benefit from additional services (Salholz & Wright, 1990).

Many incarcerated women either abuse or are addicted to alcohol and/or other drugs. In a study done in the Las Colinas Detention Facility in California, 37% of the women said that alcohol was their drug of choice, 21% said heroin, 24% crystal meth, and 18% cocaine (Covington, 1991c). Unfortunately, drugs are readily available in prisons, usually brought in and sold by prison guards (Salholz & Wright, 1990).

Along with their history of alcohol/drug use, many women in prison also have a history of physical and sexual abuse. In California prisons, nearly 80% have experienced some form of abuse. Twenty-nine percent report being physically abused as children, and 60% as adults, usually by their partners. Thirty-one percent experienced sexual abuse as a child and 23% as adults; and 40% reported emotional abuse as a child and 48% as an adult (Bloom, Chesney-Lind, & Owen, 1994). Women are also abused *within* the prison system. An ongoing investigation by the Human Rights Watch Women's Rights Project documented custodial misconduct in many forms including verbal degradation, rape, sexual assault, unwarranted visual supervision, denying goods and privileges, and use or threat of force. "Male correctional officers and staff contribute to a custodial environment in state prisons for women which is often highly sexualized and excessively hostile" (Human Rights Watch Women's Rights Project, 1996, p.2).

### **What Kind of Addiction Treatment Are Women Receiving in Prisons?**

With nearly 60% of women in prison for a drug-related crime, and with the number of addiction and abuse issues that women bring with them, it would not be unreasonable to expect prisons to invest some resources in alcohol/drug recovery programs, support groups, and psychological counseling.

Unfortunately, although the current programs we have in men's prisons are few and inadequate, there are even fewer for women (Salholz & Wright, 1990). Health care, especially pre-natal care, education, job training and treatment for alcohol/other drug abuse are all missing from the women's prison system. Only 3% of California prisoners have any alcohol and/or drug treatment programs available to them, even if such voluntary programs as Alcoholics and Narcotics Anonymous are included (Bloom, Chesney-Lind, & Owen, 1994). In light of these facts, the term "correctional institutions" becomes a sad euphemism in a system that provides no programs to help redress the most basic needs and concerns that are shared by many women.

The lack of proper substance abuse treatment programs was recently confirmed by the National Criminal Justice Association. In a nationwide survey done under the U.S. Department of Justice, they found "Virtually every survey respondent reported that there is too little funding for treatment services, that there are not enough drug treatment facilities or appropriate placements for drug dependent clients, and there is a lack of qualified personnel to staff treatment programs" (Zawistowski, 1991, p.9).

There is also a wide gap between what our judicial system actually believes about the availability of health care and alcohol/drug recovery programs in prison, and the existence of such programs. In recent years, shrinking tax dollars for community based programs have led judges to believe that the best chance that pregnant, addicted women have for treatment is through sentencing and incarceration. Unfortunately, this belief is a myth, because the programs simply do not exist, often with tragic consequences for the high number of these women who enter the penal system. Although detoxification of pregnant, substance-dependent women can be accomplished safely, successfully and at low cost, many prisons force these women to go "cold turkey." Many times this results in the death of the fetus or serious damage to it. Nor do pregnant, addicted women in many prisons receive even the most basic of gynecological or maternity care. In addition, illegal drugs are often more readily available in prisons than they are on the street (Barry, 1991).

If we are to develop effective programs for women in prison and community corrections, we need to develop a theoretical approach to addiction treatment that is gender sensitive, addressing itself to the realities of women's lives.

### **Developing an Integrated Model of Addiction**

To develop an integrated model for the treatment of addiction, it is important first to develop a sound theoretical framework, asking ourselves to what theory of addiction we are subscribing. The next step is to utilize a theory of women's psychological development, which refers to what is known about how women learn, grow and heal. Lastly, it is important to incorporate a theory of trauma since the majority of women who are chemically dependent, especially those in the criminal justice system, have experienced emotional, physical and sexual abuse in their childhood and/or adulthood. The definition of victimization and trauma also needs to be expanded to include racial prejudice, witnessing violence, and the stigma, stress, and abusiveness of incarceration.

### **Theory of Addiction**

Traditionally, addiction treatment has been based on a medical model, which views addiction as a disease. The most commonly used analogy is that addiction is like diabetes, a physical disease that carries no moral or social stigma. This analogy is often useful because neither diabetes nor addiction can be managed by will power. They both require adherence to a lifestyle regimen for physical and emotional stability.

However, this analogy sees the disease/disorder rooted solely in the individual. As we move into the twenty-first century, health professionals in many disciplines are revising their concept of disease in general. Based on a holistic health model, we are now acknowledging not only the physical aspects of disease, but also the emotional, psychological, and spiritual aspects (Northrup, 1994).

I believe we can best understand addiction as a disease/disorder if we understand it holistically and include cancer as an analogy. The diabetes model is useful, but too individualistic and simplistic to adequately explain addiction.

Like cancer, addiction has a physical component as well as emotional, psychological, and spiritual dimensions. I would argue that two other components of disease must also be added to a fully holistic model: the environmental and the sociopolitical dimensions. It's interesting that few people question that cancer is a disease even though some experts estimate that 80% of doctors link cancer to lifestyle choices (diet and exercise) and the environment (pesticides, emissions, nuclear waste, etc.) (Siegel, 1996). There are also sociopolitical aspects of cancer, especially when we realize the huge profits carcinogenic products make for powerful business interests. The same is true of addictive substances, both legal and illegal. For example, medical doctors prescribe 80% of the amphetamines, 60% of the psychoactive drugs and 71% of the antidepressants to women (Galbraith, 1991). Companies that produce and sell alcohol are indirectly responsible for over 23,000 deaths and three quarter of a million injuries each year -- and these are only the figures reported to insurance companies (Zawistowski, 1991). Even though some women may have a strong genetic predisposition to addiction, an important treatment issue is acknowledging that many of them have grown up in an environment where drug dealing and addiction are a way of life.

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

The next important element for developing a treatment model is having a theory of women's psychological development. Traditional developmental psychology is based on a separation/individuation model. The Relational Model, developed by the Stone Center in Wellesley, Massachusetts, posits that the primary motivation for women throughout life is not separation, but establishing a strong sense of connection. When a woman is disconnected from others, or involved in abusive relationships, she experiences disempowerment, confusion, and diminished zest, vitality and self-worth -- fertile ground for addiction. Healthy, growth-fostering relationships create increased zest and vitality, empowerment, self-knowledge, self-worth and a desire for more connection. In growth-fostering relationship, a woman develops a sense of mutuality that is "creative, energy-releasing and empowering for all participants," and fundamental to her psychological well-being (Covington & Surrey, 1997).

If we are trying to create treatment for women to help them to change, grow and heal from addictions, it is critical that we place them in programs and environments where relationship and mutuality are core elements. The system needs to provide a setting where women can experience healthy relationships with their counselors and each other. Unfortunately, the criminal justice system is designed to discourage women from coming together, trusting, speaking about personal issues or forming bonds of relationship. Women who leave prison are often discouraged from associating with other women who have been incarcerated.

If women are to be successfully reintegrated back into the community after serving their sentences, there must be a *continuum of care* that can connect them in a community after they've been released. Ideally, these community programs should have a relational basis.

### **Theory of Trauma**

The last element we need in order to create a model for treatment is a theory of trauma. A vast majority

of chemically dependent women have been physically, sexually and emotionally abused for much of their lives, and these numbers are even greater within the criminal justice population. Traditional addiction treatment often does not deal with abuse issues in early recovery, even though they are a primary trigger for relapse among women (Covington & Surrey, 1997). Therefore, we need a theory of trauma that is appropriate for women in early recovery.

Psychiatrist Judith Herman (1992) writes that there are three stages in the process of healing from trauma: safety, remembrance and mourning, and reconnection. “Survivors feel unsafe in their bodies. Their emotions and their thinking feel out of control. They also feel unsafe in relation to other people” (Herman, 1992, p. 160). Stage One (safety) addresses the woman’s safety concerns in all of these domains. In the second stage of recovery (remembrance and mourning) the survivor tells the story of the trauma and mourns the old self that the trauma destroyed. In Stage Three (reconnection) the survivor faces the task of creating a future; now she develops a new self. As we have seen above, the difficulty is that many women are *not* safe in our criminal justice system where they are vulnerable to abuse and harassment from correctional staff.

Stage One recovery from trauma, safety, is the appropriate level of intervention for women in early recovery from addiction. If we want women to heal from addiction, we must set up a safe environment in which the healing process can begin to take place. Dr. Herman uses Twelve Step groups as an example of the type of group appropriate for Stage One (safety) recovery because of their focus on present-tense issues of self-care, in a supportive, homogeneous environment.

### **Addiction Recovery for Women**

The Center for Substance Abuse Treatment (1994, p.178) has developed the following list of issues that should be reflected in a comprehensive treatment model for women:

- The etiology of addiction, especially gender-specific issues related to addiction (including social, physiological, and psychological consequences of addiction and factors related to onset of addiction)
- Low self-esteem
- Race, ethnicity and cultural issues
- Gender discrimination and harassment
- Disability-related issues, where relevant
- Relationships with family 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
- Grief related to the loss of alcohol or other drugs, children, family members, or partners
- Work
- 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
- Child care and child custody

When I interviewed women around the country who had recovered in Twelve Step programs and asked them to describe both the things that had changed the most for them in their journey from using to recovery and the issues that contributed to relapse, they listed the self, relationships, sexuality and spirituality. It is interesting to note that these four issues incorporate the issues listed above. If we are going to create recovery programs for women in correctional settings, these four issues need to be understood and addressed. (For additional information, see *A Woman's Way Through the Twelve Steps*, Covington, 1994.)

*The Self.* The generic definition of addiction I use is "the chronic neglect of self in favor of something or someone else." Addiction can be conceptualized as a self-disorder. One of the first questions women in recovery need to begin to address is "Who am I?" Women in our culture are taught to identify themselves according to role: mother, professional, wife, daughter. One of the first tasks for women in recovery is to find words to describe who they are from a deep, inner place. In addiction, one loses the sense of oneself and, with it, the ability to have a real connection with others. Recovery is about expansion and growth of the self, both the inner and the outer self.

Many women enter the prison system with a poor self-image and a history of trauma and abuse. As we have seen, prisons actively discourage relationship. Creating the kinds of programs that help incarcerated women to develop a strong sense of self, an identification that goes beyond who they are in the criminal justice system, is vital to their recovery.

*Relationship.* Some women use addictive substances to maintain relationships with using partners, some use them to fill up the void of what is missing in relationship, and some use alcohol/other drugs to deal with the pain of being abused (Covington & Surrey, 1997). One of the tasks of any recovery program is to teach women self-soothing techniques in order to deal with the myriad of feelings that surface when abstinent.

Women in the prison system often have unhealthy, illusory or unequal relationships with spouses, partners, friends and family members. For that reason, it is important for recovery programs to model healthy relationships, among both staff and participants, providing a safe place and a container for healing (Covington & Beckett, 1988). Our greatest challenge is to overcome the alienation that is fostered within prison walls, and replace it with a greater sense of relationship in community.

*Sexuality.* Sexuality is one of the most neglected areas in the treatment of addiction, and one of the major causes for relapse. Healthy sexuality is integral to one's sense of self-worth. It represents the integration of the biological, emotional, social, and spiritual aspects of who one is and how one relates to others (Covington, 1991a; Covington, in press; Kaplan, 1981; Schnarch, 1991). Addiction is often defined as a

physical, emotional, social, and spiritual disease. Since healthy sexuality is defined as the integration of all these aspects of the self, we can see that addiction can have an impact on every area of sexuality. Therefore, addressing and healing all aspects of the sexual self is critical to a woman's recovery process (Covington, 1991a; Covington, in press).

Creating healthy sexuality is a developmental process that occurs over time. This normal developmental process is often interrupted by addiction. In addition, many women entering the early stages of recovery report the following sexual concerns: sexual dysfunction, shame and guilt, sexual identity, prostitution, sexual abuse, and the fear of sex clean and sober. These issues need to be addressed if we expect women to maintain their recovery (Covington, 1991a; Covington, 1993).

Few women in prisons have a positive view of sex. Some have been prostitutes, many have been abused and most connect sex with shame and guilt. Even those who have been the most sexually active have little accurate information about sex. Developing programs that can work with this part of a women's recovery can help to create a positive sense of self and a healthier image of relationship.

*Spirituality.* The root of the word psychology is "psyche," which means "the knowledge and the understanding of the soul." Although we live in a secular culture where traditional psychology does not focus on the spiritual, helping women to reconnect to their own definition of the spiritual is critical to their recovery process. Religion and spirituality are not the same -- they may or may not be connected. Religion is about form, dogma and structure, and is institutionally based. Spirituality is about transformation, connection, wholeness, meaning and depth.

Women connect with their spirituality in many different ways. Some have rejected the religion of their childhood, and must find a new path for themselves. Some return to the religion of their youth. In recovery groups I have facilitated, I often find it useful to give women art history books to look at how, for thousands of years before the Patriarchy, the female was revered. Since the feminine has been so denigrated in our culture, it is often helpful to show women that they are a part of a long history of birthers, growers and caregivers, helping them to reconnect with the energy of the great goddess.

The design of the criminal justice system is antithetical to spiritual values, and it is essential that any recovery program designed for women in this system find a way to help each woman find her own definition of a "higher power."

### **Twelve Step Programs**

In recent years, Twelve Step programs have been critiqued in various ways and, as some feminists have pointed out, the language used is simplistic, sexist and reductionist (Bepko, 1991; Berenson, 1991; Kasl, 1992; Rapping, 1996). Feminists are particularly concerned about the Twelve Steps' emphasis upon powerlessness as liberating. In contrasting the recovery movement with the women's movement, Marianne Walters (1990) points out that "one movement encourages individuals to surrender to a spiritual higher power, where the other encourages people to join together to challenge and restructure power arrangements in the larger society" (p. 55). What is often missed in feminist analysis is the masculine "power over" is what is being relinquished in order to experience the feminine "power with", "power to be able", i.e. a sense of empowerment (Miller, 1982). "The process of recovery from addiction is a process of recovering a different, more feminine, sense of power and will" (Berenson, 1991, p. 74). There is also a confusion between surrender and submission. "When we submit, we give in to a force that's trying to control us. When we surrender, we let go of our need to control" (Covington, 1994, p.48). Recovery encourages surrender and giving up the illusion of control. Feminist writer Marilyn French (1985) describes "...life is the highest value for 'feminine' people; whereas control is the highest value for 'masculine' people" (p. 93).

If we look at the underpinnings of Alcoholics Anonymous we can see that it was actually very radical for the 1930s, the time it was founded, and that this continues to be true even today. Twelve Step programs are free, a radical concept in a capitalistic society; they are non-hierarchical, a radical idea in a patriarchal society; and they are spiritual, a radical stance in a non-spiritual society. As previously stated, women grow and develop in relationship, and Twelve Step programs can provide a growth-fostering relational context, and offer their members social support through the creation of a caring community (Covington, 1991b; Covington & Surrey, 1997). These programs can also create a safe environment, which is an essential element for recovery from trauma (Herman, 1992). Although some critics have focused on the sexist language in which the Twelve Steps are couched, I have found that women are able to interpret the Steps in ways that are distinctly personal, meaningful and useful to themselves (Covington, 1994).

Since we know that women grow and develop in relationship and connection, and that these programs are free and available in our communities, it would make sense to enable women to have access to them both while they are incarcerated and while they are making the transition back into community. The Twelve Step programs also need to be incorporated into community correctional settings. These programs offer us an already existing "continuity of care" that we cannot afford to ignore.

### Conclusion

With women being incarcerated for drug related offenses at an alarming rate, it is imperative that treatment services be designed to reflect the realities of their lives. This means comprehensive, integrated programs that understand and address the intersection of race, class, gender, and addiction. Even though most professionals believe addiction is a disease / disorder, societally we still respond to it chiefly as a crime. We can also no longer think only of individual addicts but must acknowledge that society fosters addiction.

On one level our task is to provide better services for the invisible women caught in our criminal justice system. Women whose lives represent all women's issues – *magnified*. On a deeper level, we must question whether therapeutic, healing care can be provided in the ultimate system of oppression and domination.

Our criminal justice system is in desperate need of repair and revision. What changes would make a difference? The Human Kindness Foundation (1995) has suggested "Seven Ways to Fix the Criminal Justice System":

- Learn to recognize the influence of socially sanctioned hatred.
- Make drugs a public health problem instead of a criminal justice problem.
- Separate violent and nonviolent offenders right from the start.
- Regain compassion and respect for those who wrong us.
- Allow for transformation, not merely rehabilitation.
- Join and support the restorative justice movement.
- Take the issue of crime and punishment personally

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