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Original Articles

Examination of a Violence Prevention Program for Female Offenders

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Abstract

Only a few interventions have been designed to address violence in women's lives, both as victims or as perpetrators. Moreover, women in prison are consistently reported to have more complex histories of exposure to violence, trauma, and abuse than their male counterparts. More than 6500 women currently reside in California's state prisons, with two-thirds serving lengthy sentences for violent crimes. Recent policy changes regarding violent crimes require changes in the type of programming and services offered to these incarcerated women. This study examines results from the intervention, *Beyond Violence*, a trauma-informed and gender-responsive approach to violence prevention that was provided to women serving sentences for violent crimes ($n = 91$) in two California prisons. *The curricula* were facilitated by 29 incarcerated peer educators to 62 women in the general population in the prison. The majority of the participants met the criteria for posttraumatic stress disorder at baseline (55% of the peer educators and 71% of the other participants). At the time of the study, women had been incarcerated for an average of 14 years. The intervention showed significantly positive outcomes, with moderate to high effect sizes for women incarcerated for long terms or life on reductions in post traumatic stress disorder, anxiety, anger and aggression, and symptoms of serious mental illness. Implementing *Beyond Violence* may result in reductions in violent behavior among longer term female inmates. Also, findings indicate that the curricula can be effectively facilitated by incarcerated peer educators. Further investigation regarding the potential cost-effectiveness of peer educators versus trained clinical staff is needed.

Keywords: corrections, criminal justice, violence, women

Introduction

The enactment of *California's Public Safety Realignment Legislation* (AB 109) in 2011 has created a shift in California prison populations. AB 109 altered both sentencing and postprison supervision for the newly statutorily classified ''nonserious, nonviolent, and nonsex'' offenders (Quan et al. 2014).

As a result, the California prison population now largely consists of men and women incarcerated for violent offenses (i.e., crimes against persons involving force, threat of force, or use of a weapon, and include offense types such as homicide, manslaughter, mayhem, robbery, assault, battery, and sex offenses).

Currently, more than 6500 women reside in California's state prisons, with two-thirds serving lengthy sentences for violent crimes. Data on assaults show that women are most likely to assault people close to them instead of strangers (Durose et al. 2005). Women's acts of violence are often an isolated event occurring within the context of family and intimate relationships (Kruttschnitt et al. 2002). A national profile of female-committed homicides, specifically, shows that 44% of them involved the women's intimate partners and 32% involved acquaintances (Bair-Merritt et al. 2010). Only 7% of homicides committed by women involve strangers, compared with 25% for men.

Moreover, a comprehensive review of the literature shows that female-perpetrated intimate partner violence (IPV) is at least as common as male-perpetrated abuse, with the same degree of severity and serious injury (Carney, et al. 2007). A more recent review of the literature indicates that primary and immediate motives of IPV for both men and women included power/control, self-defense, and violence as an expression of negative emotion (Langhinrichsen-Rohling et al. 2012).

Although women in prison constitute a small proportion of violent offenders in total (West et al. 2010), they are consistently reported to have more complex histories of exposure to violence, trauma, and abuse than their male counterparts (Battle et al. 2003; Messina et al. 2007). Existing literature outlines the complex and overlapping prevalence of

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victimization, household dysfunction, substance abuse, and mental health issues as potential precursors to violent and aggressive behavior by women in general (Bair-Merritt et al. 2010). For instance, Kruttschnitt et al. (2002) found that childhood violent victimization and trauma, specifically, were highly correlated with female-perpetrated violence. Other studies have demonstrated the mediating role of anger between victimization, mental health, and substance use disorders and the perpetration of violence among incarcerated women (Maneta et al. 2012).

There are a limited number of interventions designed to address violence in women's lives, both as victims or as perpetrators. Most available research on violence, anger, and aggression focuses on male offenders. Thus, programming and interventions addressing violence have been primarily based on models of male aggression (Bair-Merritt et al. 2010; Kubiak et al. 2014). Moreover, there are a limited number of interventions for women who are perpetrators of IPV, and these have mainly remained untested. Thus, more research is needed to determine effective interventions to reduce anger and violent behavior among women.

Preliminary Evidence for the Beyond Violence Intervention

Gender-responsive programs are designed to address the limitations of previous interventions delivered to women offenders by providing a secure environment for women offenders to safely discuss histories of trauma, abuse, and addiction without fear (Covington 2008). Trauma-informed services recognize the importance of trauma in women's psychological development by avoiding the triggering of trauma reactions of women, adjusting the behavior of staff to support women's capacity for coping, and allowing survivors to manage their symptoms (Harris and Fallot 2001). *Beyond Violence* utilizes a trauma-informed and gender-responsive approach, a theory-based framework for violence prevention endorsed by the World Health Organization, and a variety of techniques to address trauma, mental health, substance abuse, and anger. Short-term outcomes of a pilot study of women in prison found significant declines, with moderate to large effect sizes, in symptoms associated with depression, anxiety, and post traumatic stress disorder (PTSD), as well as a measure of serious mental illness (Kubiak et al. 2012).

Long-term studies of the pilot found that women involved in *Beyond Violence* were more likely to participate in community-based treatment after release, to stay longer in treatment, and to complete treatment, compared to women who had committed violent offenses who did not attend *Beyond Violence* (Kubiak et al. 2013). In a randomized controlled trial, Kubiak et al. (2015) compared the 20-session *Beyond Violence* intervention with a 44-session treatment as usual (TAU; Assaultive Offender Program), both delivered by trained clinicians within a prison. They found significant differences with robust effect sizes on measures of mental health for both interventions; however, between-group differences revealed that women in the *Beyond Violence* condition had greater declines in anxiety and state or current anger than those in TAU. Moreover, State-Trait Anger Expression Inventory (STAXI) subscales (Spielberger 1991, 1999) measuring anger found declines for women in *Beyond Violence*.

The primary goal of this study was to assess the effectiveness of the woman-focused *Beyond Violence* intervention in preventing and reducing violence in the lives of incarcerated women. In addition, this study ascertained the feasibility of using peer educators (i.e., incarcerated women serving life sentences) trained to facilitate the *Beyond Violence* program to other violent female offenders in prison.

Materials and Methods

This evaluation was reviewed and approved by the California Department of Corrections and Rehabilitation (CDCR), Office of Research, Research and Evaluation Branch, before all research activities. This sample consisted of incarcerated women serving a state-prison sentence for a violent crime in two California prisons ($n = 91$). Women serving time in one of these two prisons with a current or previous conviction for an assaultive offense (e.g., homicide, robbery, or assault) were eligible to participate in the study. In addition, women with any disciplinary action for serious violent misconduct (e.g., assault on an officer or on another inmate) within 6 months before study admission were also eligible. Women who had previously been remanded to the segregated housing unit (SHU) or administrative segregation were included in this study.

Beyond Violence: *a prevention program for criminal justice-involved women*

Beyond Violence is a manualized curriculum for women in criminal justice settings (jails, prisons, community corrections, etc.) with histories of violence (Covington 2013). It focuses on the violence they have experienced, as well as the violence they have perpetrated. This four-level model of violence prevention considers the complex interplay between individual, relationship, community, and societal factors. It addresses the factors that put people at risk for experiencing or perpetrating violence. This model is used by the Centers for Disease Control and Prevention (CDC) and World Health Organization (WHO), and was used in the Prison Rape Elimination Act (PREA) research on women in prison (Bloom et al. 2004). *Beyond Violence* is a 20-session intervention that consists of a facilitator guide, participant workbook, and DVD.

The author of *Beyond Violence,* Dr. Stephanie Covington conducted a 2-day training within the prisons. The selected peer educators and prison programming staff participated in the 2-day training. On completion of the training, the peer educators participated in the curricula facilitated by trained prison programming staff (i.e., retired annuitants with more than 40 years of experience in prison settings). After finishing the 20-session curricula, refresher training was conducted. Groups of volunteers from the general population were then facilitated by the peer educators with retired annuitant co-facilitation.

Peer educators

Twenty-nine of the women were selected to be peer educators and were trained to facilitate the *Beyond Violence* program to other women in the prison who were violent offenders. The peer educators were selected by the wardens and programming clinical supervisors. Peer educators had

previously held positions of peer mentors or had participated in orientation for newly incarcerated women. They went through an hour-long job interview before being picked as facilitators. The peer educators were typically women serving life without parole or long-term offenders serving more than 20 years. The majority of the peer educators were incarcerated for homicide.

Data collection measurements

Mental health. Assessing change in mental health functioning was determined by assessing change in depression, anxiety, PTSD, and other serious mental illness. These constructs were measured at intake to the *Beyond Violence* intervention and again at the end of the 20 sessions using two subscales of the self-report Patient Health Questionnaire (Spitzer et al. 1999). The Patient Health Questionnaire 9-item depression subscale measures current depressive symptomatology, and the anxiety subscale is a 7-item subscale that measures anxiety symptoms felt over the previous 4 weeks. The Short Screening Scale for *DSM-IV* Posttraumatic Stress Disorder-modified version (Breslau et al. 1999) was administered to assess current PTSD. The K6, a 6-item brief mental health screening tool (Kessler et al. 2002, 2003), was used to assess participants' overall mental health. Responses, based on a Likert-type scale, ranging from 0 (*None of the time*) to 4 (*All of the time*), were summed into an overall scale with scores ranging from 0 to 24.

Anger and aggression. The Buss-Warren Aggression Questionnaire (AQ) is a 34-item instrument that was used to assess anger and aggression (Buss and Warren 2000). The Buss-Warren includes five scales: Physical Aggression (PHY), Verbal Aggression (VER), Anger (ANG), Hostility (HOS), and Indirect Aggression (IND). Instrumental and expressive anger were assessed through the Revised Instrumental and Expressive Representation Scales (Campbell et al. 1999). The State-Trait Anger Expression Inventory-2 (STAXI-2) is a 57-item instrument used to measure the experience and intensity of anger as an emotional state (State Anger) and as an emotional trait (Trait Anger). The State Anger scale assesses the intensity of anger at a particular time and the Trait Anger scale measures how anger is expressed over time.

Perpetration and victimization. A modified index of perpetration and victimization history was developed based on several of the items from the Conflict Tactics Scales (Straus 1979; Straus et al. 1996) and the Abuse Behavior Inventory (Shepard and Campbell 1992). The Adverse Childhood Experiences (ACE) indicators also were included as a measure of childhood trauma (Messina and Grella 2006).

Risk and need. The Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) is a fourth-generation (4G) ''recidivism risk model'' assessment tool that tracks offenders from intake to case closure, including placement decisions, offender management, and treatment planning (Brennan et al. 1998). COMPAS is based on several criminological theories, including low self-control, strain, social control, routine activities, and subcultural theory. Also included are the eight critical criminogenic predictive factors identified by Andrews et al. (2006) and measures of strength and protective factors that have empirical support for risk reduction, including job skills, employment history, family bonds, emotional support, and noncriminal associations. Finally, COMPAS was developed using gender-specific calibrations of all risk and need factors and evaluated using separate samples of male and female offenders.*

Statistical analysis

Paired-sample *t*-tests were conducted to examine differences for all participants across time (baseline to follow-up) for depression, anxiety, PTSD, serious mental illness, anger, hostility, and aggression. Cohen's *d* scores were calculated to estimate effect sizes for significant paired differences. McNemar's test was utilized to analyze marginal frequencies between PTSD diagnoses as a binary measure (*yes*/*no*) over time.

Results

Table 1 displays the demographic characteristics, including drug use and criminal history information, of the 29 peer educators and 62 general prison population participants. The demographic and self-reported histories of the peer educators and general population participants were initially analyzed by prison; however, the findings did not differ significantly on most of the measures by prison. Therefore, between-prison differences are not reported but are available upon request.

Peer educators

The majority of the peer educators' had never been married (38%) and identified as black/African American (38%) or white (28%). On average, women were 43 years of age (SD = 8.7) at time of enrollment in the intervention and had been incarcerated for an average of 17.5 years (SD = 7.2). Many women had achieved their General Educational Diploma (GED) or some higher education during incarceration (42%). Women were about 22 years old at the time of their first arrest. The majority of women had histories of alcohol and drug abuse, with 52% of them engaging in alcohol abuse and 62% engaging in some form of drug abuse 12 months before their admission to CDCR.

General prison population participants

Almost half of the general prison population participants had never been married (49%) and identified as Hispanic/Latina (44%). On average, these inmates were 36 years of age (SD = 7.3) at the time of enrollment in the intervention and had been incarcerated for an average of 11.3 years (SD = 7.7). Thirty percent of the general prison population participants

*At the time of the study, CDCR administered the COMPAS instrument for risk and need. However, a modified version for incarcerated women has been created. (1) Women's Risk/Needs Assessment (WRNA), which assesses both gender-neutral and gender-responsive factors and affords separate forms for probation, prison, and prerelease; and (2) the Women's Risk/Needs Assessment–Trailer (WRNA-T), which is designed to supplement existing risk/needs assessments such as the Level of Service Inventory–Revised or the Northpointe COMPAS.

Table 1. Demographics and Background History: Peer Educators and Other Participants

Demographic and background history	*Peer educators* (n = 29)	*Other participants* (n = 62)	*Total* (n = 91)
Race/ethnicity			
Latina/Hispanic	17%	44%	35%
White	28%	21%	23%
Black	38%	23%	28%
Multiracial	14%	7%	9%
Other	3%	5%	5%
Marital status (at time of incarceration)			
Married/living together as married	31%	33%	33%
Never married	38%	49%	45%
Divorced/separated/widowed	31%	18%	22%
Current age	43.3 (SD = 8.7)	36.1 (SD = 11.8)	37.3 (SD = 12.7)
Education			
Obtained GED in prison	42%	30%	34%
Obtained higher degree in prison	68%	18%	33%
Criminal justice history			
Age of first arrest	21.6 (SD = 7.5)	18.9 (SD = 7.3)	19.8 (SD = 7.4)
Is your current conviction for murder?	57%	40%	46%
Are you serving life without possibility of parole?	35%	78%	51%
Number of years in prison?	17.5 (SD = 7.2)	11.3 (SD = 7.7)	13.6 (SD = 8.0)
Substance use			
Using alcohol during the 12 months before your arrest?	52%	56%	55%
Using drugs during the 12 months before your arrest?	62%	76%	71%

GED, General Education Diploma.

had achieved their GED or some higher education during incarceration. Women in this group were about 19 years of age at the time of their first arrest, and the majority had histories of both alcohol abuse and drug abuse (with 56% of women engaging in alcohol use and 76% in some form of drug abuse 12 months before their admission to CDCR).

Table 2 displays the frequency of Adverse Childhood Experiences (ACEs). Collectively, the peer educators reported an average of 6.5 ACEs (SD = 2.2) before the age of 18, a substantial number. Common ACEs included humiliation by a parent (83%), physical abuse by a parent (83%), and sexual abuse by an adult 5 years or older than the victim (83%). The general prison population participants reported significantly fewer ACEs than the peer educators, with an average of 5.05 ACEs (SD = 2.8). Common ACEs among the general prison population inmates were similar to that of peer educators, including having an alcoholic or drug user in the home while growing up (67%), humiliation by a parent (66%), and physical abuse by a parent (65%).

Table 3 shows the decreases in PTSD diagnoses from pre- to postintervention for the peer educators. A general decrease was found for peer educators over time (55.2% positive at intake vs. 18.5% at follow-up). More specifically, 11 women who were positive for PTSD at intake were negative at follow-up. Four women who were positive at intake remained positive at follow-up, whereas 11 women who were negative at intake remained negative at follow-up. McNemar's test revealed a significant difference in diagnosis rates from pre- to post-assessment ($p < 0.01$).Of the 29 peer educators who completed the pretest, two declined to continue in the study and one did not complete the follow-up interview, leaving 26 women who completed the intervention, as well as the posttest. Table 4

Table 2. Adverse Childhood Experiences

Adverse childhood events/before 18…	*Peer educators* (n = 29), %	*Other participants* (n = 62), %	*Total* (n = 91), %
Parent/adult swear at you, put you down, humiliate you?	83	66	71
Parent/adult touch, fondle, in sexual way, or attempt any form of sexual contact?	83	65	71
Parent/adult push, grab, slap, throw, hit hard?	83	60	67
Did you often feel no one in family loved you?	76	61	66
Did you feel you did not have enough to eat, had dirty clothes, no protection, no doctor?	28	26	27
Were your parents separated or divorced?	82	63	69
Was your mother being pushed, slapped, grabbed, had things thrown at her, or hit?	52	35	41
Alcoholic in home or drug user?	76	67	70
Someone mentally ill in house or attempt/commit suicide?	36	25	29
Household member go to prison?	48	39	42

Table 3. Peer Educator Change in Posttraumatic Stress Disorder ($N=29$)

PTSD change over time	*Positive at admission to beyond violence*	*Positive at graduation from beyond violence*	*McNemar's chi square*
Peer educators	55.2%	18.5%	8.33**

**$p<0.01$.
PTSD, post traumatic stress disorder.

Table 5. Change in Posttraumatic Stress Disorder ($N=61$)

PTSD change over time	*Positive at admission to beyond violence*	*Positive at graduation from beyond violence*	*McNemar's chi square*
Other participants	72.1%	42.3%	7.35*

*$p<0.05$.
**$p<0.01$.

describes the average changes in pre- and posttest measures of mental health, anger, and aggression/hostility issues among those that completed the intervention. Mean scores for anxiety (4.2 vs. 2.6) and other serious mental illness (4.5 to 1.8) decreased significantly at follow-up, with moderate ($d=0.45$) and high ($d=0.85$) effect sizes, respectively. Mean scores for expressive anger (24.1 vs. 20.4) significantly decreased, with a moderate effect size ($d=0.53$), whereas there was no significant decrease in instrumental anger. PTSD levels also significantly declined (5.1 vs. 2.3), with a moderate effect size ($d=0.55$). All indicators of aggression/hostility yielded significant reductions from pre- to- postassessment with moderate to high effect sizes ($d=0.54$–0.89), save verbal aggression/hostility, which was not significantly reduced.

Table 5 shows the decreases in PTSD diagnoses from pre- to postintervention for the general prison population inmates. A general decrease was found for these inmates over time (72.1% positive at intake vs. 42.3% at follow-up). More specifically, 18 of these women, who were positive for PTSD at intake, were negative at follow-up. Seventeen women who were positive at intake remained positive at follow-up, whereas 11 women who were negative at intake remained negative at follow-up. McNemar's test revealed a significant difference in diagnosis rates from pre- to postassessment ($p<0.05$). A total of 51 of the general prison population inmates completed the intervention and the posttest.

Table 6 describes the average changes in pre- and posttest measures of mental health, anger, and aggression/hostility issues among those who completed the intervention. Mean scores for depression (8.5 vs. 5.0), anxiety (6.0 vs. 23.1), and other serious mental illness (7.3 to 5.0) decreased significantly at postintervention, with moderate ($d=0.44$, $d=0.49$, and $d=0.39$) effect sizes, respectively. Mean scores for instrumental anger (19.7 vs. 14.8) decreased significantly, with a moderate effect size ($d=0.57$), whereas expressive anger did significantly decrease. PTSD levels (7.3 vs. 4.0) also significantly declined, with a moderate effect size ($d=0.44$). All indicators of aggression/hostility yielded significant reductions from pre- to postassessment, with low to moderate effect sizes ($d=0.26$–0.42).

Conclusion and Recommendations

A review of the literature underscores the importance of studying in-depth data from diverse samples of women offenders to better describe their pathways to substance use and crime, to predict the complex, dynamic nature, and course of substance use, crime, and violence, and to determine the types of interventions that alter those trajectories. The existing literature on pathways is often limited by reliance on official records, case studies, or single cohorts. In addition, very few longitudinal studies of patterns of offending in girls and women follow them further than young adulthood. These limitations directly affect the design and direction of treatment and supervision of women offenders.

Given the aggregate impact of trauma and violence in the lives of women offenders, the field will benefit from research that identifies effective services that moderate the

Table 4. Peer Educator Pre- to Postintervention Change on Outcome Measures

	Pretest mean	*Posttest mean*	*t, df(25)*	*Cohen's* d
Depression	4.5	3.2	1.58	—
Anxiety	4.2	2.6	2.32*	0.45
Serious mental illness	4.5	1.8	4.34**	0.85
Anger (composite score)	16.7	14.4	2.20*	0.43
Instrumental anger	12.2	10.9	1.24	—
Expressive anger	24.1	20.4	2.70**	0.53
Posttraumatic stress disorder	5.1	2.3	2.82**	0.55
Aggression/hostility total	63.4	52.0	5.29**	1.04
Physical aggression	12.7	9.5	4.43**	0.87
Verbal aggression	11.3	10.3	1.35	—
Anger	12.6	10.2	4.54**	0.89
Hostility	16.3	12.9	3.67**	0.72
Indirect aggression	10.6	9.1	2.73**	0.54

*$p<0.05$.
**$p<0.01$.

Table 6. Other Participant Pre- to Postintervention Change on Outcome Measures

	Pretest mean	*Posttest mean*	*t, df(50)*	*Cohen's* d
Depression	8.5	5.0	3.16**	0.44
Anxiety	6.0	3.1	3.47**	0.49
Serious mental illness	7.3	5.0	2.51**	0.35
Anger (composite score)	18.5	15.8	3.25**	0.46
Instrumental anger	19.7	14.8	4.06**	0.57
Expressive anger	24.3	23.4	0.78	—
Posttraumatic stress disorder	7.3	4.0	3.13**	0.44
Aggression/hostility total	78.1	68.1	2.97**	0.42
Physical aggression	18.2	15.1	2.96**	0.42
Verbal aggression	12.2	11.1	1.83*	0.26
Anger	16.1	14.1	2.39**	0.33
Hostility	18.2	16.0	2.25**	0.32
Indirect aggression	13.4	11.8	2.21*	0.31

*$p<0.05$.
**$p<0.01$.

negative impact of such histories. Moreover, the literature demonstrates the prevalence of violence and aggression perpetrated by women and indicates the need for interventions focusing on the prevention of IPV for women, in addition to interventions focused on male aggression.

The present study findings add to this body of literature by demonstrating the preliminary effectiveness of a violence prevention program designed specifically for violent women offenders. *Beyond Violence* showed significantly positive outcomes, with moderate to high effect sizes, for women incarcerated for long terms or life on reductions in PTSD, anxiety, anger and aggression, and symptoms of serious mental illness. In addition, the study demonstrated the feasibility of using incarcerated peer educators to facilitate programs delivered to other incarcerated women. This model of program delivery was successful across both prisons for this intervention. Future studies should compare facilitation by professionals versus peer educators and the potential impact on outcomes and cost-effectiveness.

The conclusions of the current study should be interpreted with caution, however. The study design (single group pretest–posttest) did not employ a comparison group of incarcerated women who did not participate in *Beyond Violence*. Therefore, it is difficult to judge whether improvements in posttest measures were indeed a product of participation in the curriculum. A future study that includes an equivalent matched control group of women who did not participate in *Beyond Violence* would provide stronger results. In addition, the sample size for the pilot study was small; however, significant and positive results were found for these populations (i.e., violent offenders, those previously assigned to SHUs, and those who refuse to participate in programs), which have been found to be difficult to treat.

Implementing *Beyond Violence* may result in reductions in violent behavior among longer term female inmates. A previous feasibility study also found that *Beyond Violence* was successfully implemented with therapists and corrections officers who are trained in the therapeutic milieu within a women's prison in Michigan (Kubiak et al. 2014) and that women convicted of violent offenses had significant declines in PTSD, depression, and anxiety-related symptoms (Kubiak et al. 2012). A second study in Michigan (a randomized control trial; Kubiak et al., unpublished data) found similar declines in mental health symptoms, as well as reductions in anger and hostility. Moreover, the 20 sessions of *Beyond Violence* in that study were superior in reducing mental health and anger symptoms, when compared to 44 sessions of the prison's TAU.

With current policies and practices focused on evidence-based practices, it is vital to understand that rigorous designs, and replications of these designs, are needed to create a history of evidence for an intervention. Because female offenders, relative to their male counterparts, report greater exposure to childhood trauma and abuse and have more extensive histories of mental health problems and substance use disorders (Messina et al. 2003), multimodal interventions that address the critical factors associated with violent behavior are suggested for reductions in and prevention of violence. Future studies are further needed to retrospectively examine the precipitating events leading to violent behavior among women in prison (e.g., the relationship between childhood trauma, household dysfunction, substance abuse, crime, mental health, and subsequent IPV).

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