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VOICES FROM BEHIND BARS: A WORKING ALLIANCE?

by

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M.Ed. Community Counseling / Couples and Family Counseling, 2004

B.A. Psychology with a Trauma Studies Certificate, 2002

A DISSERTATION

Submitted to the Graduate School of the

UNIVERSITY OF MISSOURI-ST. LOUIS

In partial Fulfillment of the Requirements of the Degree

DOCTOR OF PHILOSOPHY

In

EDUCATION

November, 2012

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## ABSTRACT

Prisons have become a primary location for mental health services, yet little research has been done to investigate the clinical relationships experienced by a growing population of female inmates. This qualitative study was based upon intersectional theory and explored the experiences of 12 female inmates through in-depth interviews about receiving mental health services in prison and the quality of the working alliance with mental health professionals. Additionally, suggestions for improving mental health services in the prison system are documented. Through 12 semi-structured interviews the researcher listened to narratives of these participants and their mental health journeys. Using open and axial coding a codebook was developed to identify underlying emergent themes, as well as descriptors to characterize each person's perspective about therapeutic relationships and overall psychotherapeutic experience. This study reports on the qualities of a working alliance that inmates believe are central to an effective working relationship with a mental health professional. Although study participants reported an overall positive working alliance with their mental health professionals, they also disclosed divergent definitions of a working alliance in practice, including avoiding counseling because of fear of peer ridicule and isolation in 'the hole,' a solitary place. Candid sharing of previous trauma directly connected past oppressive experiences to present mental health challenges. The participants supported the use of counseling within the penal system and advocated for post release mental health services to ease their transition and mental health needs after release.

**KEYWORDS:** female inmates, mental health professionals, working alliance, penal system mental health needs.

## DEDICATION

My brother Javier spoke often of one's "journey" of life. I could not have completed this portion of my "journey" without the support, empowerment, and unconditional love of my family, dear friends (including my partner), mentors, colleagues, and last, my higher power. My familia has been my support system during my entire Ph.D. program and you have been my inspiration. I love you all so much.

My brother, Ernesto, has been my closest friend throughout life and constantly served as my support system throughout. His family, Jackie, Maria and Deanna, also made this journey more meaningful. Maria and Deanna are two strong Latinas, and my wish to them is to follow their own journeys and know I will support them as they supported me during the program. My other brother Javier introduced the counseling profession to me during a brief conversation many years ago. Our plan was to become counselors and open a clinic for children. He was the most passionate person I had ever known and he taught me to use my passion to get through the hard times and enhance the good times. He passed away in 2000, but lives within my heart and soul. His dream of receiving an education became my dream, therefore this is OUR degree.

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for your support and patience all these years. You are truly a beautiful soul and taught me the gift of resilience.

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Thank you.

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## CHAPTER ONE

## Voices from behind bars: A working alliance?

The number of inmates in prison who are mentally ill is three times the number of mentally ill patients in mental health agencies (Sodija, 2006). As a result, prisons have become the primary location to store the mentally ill in the United States. According to the Bureau of Justice Statistics (BJS; 2006), 64% of jail inmates, 56% of state prisoners, and 45% of federal prisoners have signs of severe mental illness. The criminal justice and mental health systems have moved slowly to keep up with the mental health needs of these populations (Gido & Dalley, 2009; Teplin, Abram, & McClelland, 1997). In addition, female offender populations with mental health illnesses are dramatically higher compared to men: 73% of female offenders have mental health problems compared to 55% of male offenders (BJS, 2006). Slowly, a growing body of literature addresses the mental health needs of prison inmates; however, very little research has examined mental health services among female inmates.

Moreover, there has been very little research which specifically examined issues of relationship power within the working alliance. There is a paradox in the prison system with its social control realities alongside the delivery of therapeutic services to female inmates by mental health professionals (Pollack & Brezina, 2006). Little consideration is given to the contradictive issues of developing egalitarian working alliances within the punitive nature of a prison system or how to empower clients while simultaneously helping them to conform to the oppressive nature of their environment (Pollack & Brezina, 2006). This qualitative study will explore these factors and whether

or not a working alliance between a female inmate and her therapist can be achieved in such an oppressive setting, and if so, what this dynamic looks like.

With the criminal justice system housing an increasing number of female inmates with mental illnesses, it has become essential for the mental health and criminal justice systems to enhance their partnerships and working relationships. In order for therapeutic relationships between the mental health professional and inmates to be effective, mental health professionals must understand the criminal justice system's challenges and the limitations of establishing a healthy working alliance, setting realistic goals with clients, exploring new therapeutic approaches, and identifying systemic program gaps that might diminish client success (Bloom, Owen & Covington, 2003; Mc Corkel, 2003). Once imprisoned, female inmates with mental health illnesses face several challenges in receiving proper treatment due to the harsh prison environment itself, a decline in mental health due to imprisonment. Other challenges include failures in diagnosis and in deliverance of mental health services, failures in assessment of complex levels of trauma or drug use, and a lack of cultural sensitivity (Bloom, Owen & Covington, 2003; Mc Corkel, 2003). With the challenges female inmates face and the systemic gaps between the criminal justice system and mental health system, more and more females are being caught in a broken system which sets them up for failure and an increase in the recidivism rate (Bloom & Covington, 2009).

The population of females in the United States prison system has more than tripled within the last two decades (BJS; 2009), equaling over one million females currently in the criminal justice system (Evens, 2006). Within the last five years, the female inmate population has risen 5.9% as compared to the 3.8% rate increase in the

male inmate population (Green, Mirana, Daroowalla, & Siddique, 2005). The increasing female inmate population is comprised mostly of minority females, single mothers, females living in poverty, survivors or victims of physical/sexual abuse, and females living with mental illnesses, addictions, or both (Evens, 2007). Policy makers have responded by instituting gender specific programs for those in the population who are court mandated to receive counseling services, but others in the inmate population who have mental health problems have been largely ignored and are more likely to be repeat offenders because of the lack of effective therapeutic interventions (Gido & Dalley, 2009; Worell & Remer, 2003). Strong links have been found between receiving mental health treatment and a decrease in recidivism among female inmates (Gido & Dalley, 2009; Leeder & Wimmer, 2006). Some of these studies used different forms of therapy to help clients find connections from their past trauma and social lifestyle influences to shape their current situations and beliefs (Leeder & Wimmer, 2006). With awareness and understanding, clients feel empowered and in control of some factors in their lives, so they are able to make decisions that would better themselves. Examples of therapeutic interventions included support groups, personal counseling, educational sessions, and strong working relationships with the mental health professionals providing services. By not implementing more effective treatments, at least a quarter of inmates with mental health illnesses have been found to reoffend three times more than those without mental health illnesses (BJS, 2006).

The prevalence of mental health issues differs by female ethnic and racial groups, age and economic status. Although African American and Latina women make up approximately 63-67% of the female population in state and federal prison systems

(Evens, 2007), 62% of white inmates in prison, as compared to 55% of African American and 46% of Latinos, have mental health problems (BJS, 2006). Among all races and ethnicities, female inmates 24 years or younger have higher rates of mental health problems such as depression, anxiety, and post traumatic stress disorder (PTSD); rates are higher among those who have been in the foster care system, who have been homeless, or who are from low economic status backgrounds (BJS, 2006). The strongest predictor of mental health problems among females of all walks of life is the prevalence of past or current abuse (Belknap & Holsinger, 2006; Bloom et al., 2003; Blume, 1997; English, Widon, & Branford, 2002).

Approximately 90% of females who are incarcerated have experienced trauma in their lives, usually related to sexual, physical, and/or emotional abuse, as well as neglect issues (Belknap & Holsinger, 2006; Bloom et al., 2003; Blume, 1997). A study by English et al. (2001) examined the relationship between past abuse and criminal behavior. The results indicated that females who were neglected and abused during childhood were four times more likely to end up in the juvenile justice system than males who were abused and neglected. Neglect and abuse also doubled the chances of females being arrested in their adult years as compared to adult males who had suffered neglect and abuse in their younger years (Belknap & Holsinger, 2006; Bloom et al., 2003). In addition to increases in arrest, abuse can also result in psychological problems such as depression, anxiety, PTSD, eating disorders, self-harm, addictions and co-occurring disorders (Belknap & Holsinger, 2006; Bloom et al., 2003; Blume, 1997).

Psychological distress, resulting from trauma exposure such as abuse, needs to be recognized and respected when implementing mental health services and responding

appropriately to females in the criminal justice system. A mounting body of literature supports the need for gender responsive practice to acknowledge the realities of female inmates' lives, especially with regard to histories of abuse. To help females with mental health needs associated with trauma, Bloom and Covington (2009) described gender responsive approaches as multidimensional theoretical approaches that recognize female pathways into the criminal justice system and cultural and social factors important for therapeutic interventions. Research has shown that gender responsive practice often has been ignored by mental health professionals and staff who work with females in the criminal justice system (Bloom & Covington, 2009). Training protocols and interventions have neglected the theoretical understanding and interventions needed for female inmates in order to insure change or growth and instead have focused on traditional therapeutic interventions and staff training that have been borrowed from the male inmate population (Bloom et al., 2003).

Theoretically-based support from an array of mental health practices and disciplines suggests that acknowledging the variety of realities of female inmates' lives using gender responsive policy and treatment programs is essential to enhanced mental health outcomes (Owen & Covington, 2003). The National Institute of Corrections report called *Gender-Responsive Strategies: Research, Practice and Guiding Principles for Women Offenders* (Bloom et al., 2003) illuminated how important it is for the criminal justice system to consider specific implications for gender-responsive approaches in mental health services, programs, and practices. Gender responsive approaches toward female inmates include: focusing on personal strengths, considering issues of social oppression and individual factors that affect females in the criminal justice system;

enhancing emotional and social support; providing consistent treatment and recovery; creating a safe, dignifying, and respectful environment for treatment; and addressing mental health issues, trauma, and addictions using integrated and culturally sensitive services (Bloom & Covington, 2009; Bloom et al., 2003).

Gender responsive therapy should begin early in a woman's prison term to help provide her with the tools and encouragement to deal with the oppressive and contradictory nature of the criminal justice system and to emotionally help prepare her for post prison life (Leeder & Wimmer, 2006). Mental health services addressing these issues have been shown to be important for lower rates of recidivism (Twaddle, 2006). Acknowledging the paradox of counseling clients who are inmates can address the contradictory hierarchical relationship in which mental health professionals find themselves when working in the correctional culture (Beck, 2006; Evens, 2006). The use of interpersonal skills between client and professional can help build a healthy therapeutic relationship which can, in turn, assist clients to talk about the dynamics of the therapeutic working alliance and the culture of the prison environment.

Feminist therapy encourages the professional and client to talk about gender specific techniques and strategies for understanding the experiences of the client all through her life (Worell & Remer, 1996). Feminist theory integrates multicultural issues and theories that provide the knowledge base in which mental health program/treatments are developed for female inmates (Bloom & Covington, 2009). A specific feminist theory used for this study will be intersectional theory developed by Kimberle Crenshaw.

Intersectional theory acknowledges the existence of oppression, and examines the relationship of the intersection of different forms of oppression, such as race intersected

with class, and gender (Collins, 2000; Ritzer, 2007; Tong 1998). Intersectional theory also explores how social and cultural meanings interact on different levels of societal inequalities throughout the woman's life (Collins, 2000; Tong, 1998). This approach has relevance for female inmates because it recognizes the impact of oppression and social constructs in the criminal justice system.

Many of the female inmates who have been victimized have high rates of PTSD and the corrections culture can trigger or cue PTSD behaviors (Bloom, Owen, & Covington, 2003). Such behaviors and thoughts can be perceived as defiant or self provoking (Pollack & Brezina, 2006) and the inmate can be punished for her behavior. The need to understand PTSD and environmental triggers in prison life is often neglected in the correctional system, potentially harming the mental health of this population (Evens, 2006; Pollack & Brezina, 2006). Mental health professionals should be educated and aware of the importance of creating a therapy relationship that is based on safety, dignity, and respect, in order for positive behavioral changes for the client to occur (Bloom et al., 2003). Research has shown that the working alliance between professional and client is more powerful than common treatment techniques, such as behavioral modification, for long term change and that this relationship should be reinforced in practice (Bush-Baskette, 2004).

PTSD and negative reactions to prison life are not the only presenting situations in which behavioral interventions or punishments are often misused. Due to the high rate of drug offenses in this country for both genders, mental health services are provided to those suffering from drug addictions (Bush-Baskette, 200; Ross & Lawrence, 2009). These mental health services are primarily behavior modification programs, which stress



psychoeducation as the primary intervention (Bush-Baskette, 2004; Ross & Lawrence, 2009). Behavior modification may not be culturally appropriate for certain clients. In addition, behavior modification typically does not address cultural differences in treatment and it may minimize the experience of minority females and their worldviews. This is very problematic, considering that a majority of women in the criminal justice system are Latinas or African American females (Evens, 2006). As a result, the intersection of gender, race/ethnicity, drug offenses and the criminal justice system has become a focus of research among feminist criminologists (Bush-Baskette, 2004). These concepts should also be of interest for mental health professionals to accurately understand the complexity of their clients' lives in the criminal justice system (Bloom et al., 2003).

Numerous studies have reported a strong relationship between a history of physical or sexual abuse and drug use in incarcerated women (Ross & Lawrence, 2009). Drug use may be a coping mechanism for handling unresolved issues associated with being victimized (Ross & Lawrence, 2009). In addition to the abuse, most females in prison have not finished high school or live near or below the poverty level, so drugs may be sold as a means of economic survival (Bush-Baskette, 2004). Hence, a majority of female inmates are incarcerated for committing drug related crimes, often for different reasons, and prison evaluations are not culturally sensitive to detect these complexities. Therefore, there is a need to stress the importance of the working alliance with ethical cultural competencies to help mental health professionals understand the complexities of their clients' lives.

Research illustrates that the mental health needs of female inmates are often determined based upon results from prison assessments. Van Voorhis, Salisbury, Buaman, Holsinger, and Wright (2004) indicated that correctional assessments provided to female inmates often lack an accurate procedure for identifying mental illnesses. These assessments focus on the behaviors which influenced the crime itself, rather than the underlying social or psychological issues which influenced the criminal behaviors. Mental health as a risk factor often tends to be underestimated among female inmates for several reasons. One reason is that most female inmates are never properly diagnosed and treated for presenting problems (Blanchette & Brown, 2006). Second, women are more likely to be grouped into common diagnoses. An example is a client who was seeking chemical dependency treatment but was not treated for her depression or PTSD (Van Voorhis et al., 2004). Treating only the behaviors of these women and not their underlying issues can lessen the effectiveness of the treatment the women receive and prolong their mental health illnesses. Last, cultural differences often are not covered on the evaluations; ignoring race, ethnicity, age and other social factors can be problematic in understanding the underlying contextual framework of female inmates.

The benefit of the working alliance is that the relationship between professional and client can allow the professional to explore all the realities of the client's life, including cultural differences (Lambert & Barley, 2002). Also, the working alliance allows for therapist personal attributes to surface and to be used as part of the therapeutic exchange between client and professional. Research has indicated that consistent positive therapeutic results are predicted by the client's perception of her relationship with her mental health professional (Lambert & Barley, 2002). Emphasizing the relationship and

other cultural factors in practice is more effective for results than specific behavioral techniques, although this is not the norm in the correctional environment (Bloom et al., 2003; Covington & Bloom, 2006).

Little research has been conducted with female inmates in general, and especially in terms of mental health needs and services (Bloom et al., 2009; Mc Corkel, 2003). Most research focuses on male inmates and the correctional facilities that retain them. Therefore, there is a need for more in-depth research to close the gap in the literature regarding female inmates (Bloom et al., 2009; Mc Corkel, 2003). Additionally, there has been even less research conducted with the mental health professionals who work with female incarcerated populations (Bloom, 2003).

Research has indicated that four common factors account for effective psychotherapy: (1) extra therapeutic change (client factors), (2) therapeutic relationship factors, (3) expectancy (hope and expectation), and (4) techniques (Asay & Lambert, 1999; Horvath, 2002, Lambert, 2001; Lambert & Barley, 2002; Lutz et al., 2006). Of these four factors, a substantial amount of research indicates that about 30% of client improvement within the mental health journey is due to the client-therapist relationship (Asay & Lambert, 1999; Lambert, 2001; Lutz et al., 2006).

With the alarming increase in females with mental health issues being imprisoned in this country, the ability to understand inmates' perceptions of the working alliance would benefit a population that has been ignored for too long. Research into the interactions between the mental health professional and the female inmate could aid in developing more effective treatments, and ultimately, lower the rates of recidivism (Baugh, Bill, & Cohen, 1998, Bradley, 1998).

### **Significance of the Study**

The therapeutic relationship is an important agent of change for the client within the counseling process (Asay & Lambert, 1999). Carl Rogers, a humanistic theorist, believed that the relationship dynamic could be used as an agent to create change for the client. His humanist movement for client-centered therapy focused on the working alliance as an agent to create lasting therapeutic change. Rogers (1961) emphasized that an authentic and genuine bond between therapist and client could create positive change as long as the therapist demonstrated unconditional positive regard, empathy, genuine congruence, and warmth. Rogers' ensuing humanistic theory posited that, regardless of technique and theoretical orientation, these core conditions were essential for long lasting and profound therapeutic change and progress (Asay & Lambert, 1999).

The term *alliance* has been used in research literature as any of the following: therapeutic alliance, working alliance, or helping alliance. For this study, the researcher will use the term working alliance. The definition of working alliance is the collaboration or bond between the client and the therapist that empowers the client to help with goal setting and consensus about tasks in therapy (Bordin, 1994; Horvath & Bedi, 2002).

### **Purpose of Study**

Many researchers argue that the therapeutic working alliance is an important factor contributing to the successful outcome of therapy (Bordin, 1994; Horvath & Bedi, 2002). The working alliance, if carefully nurtured by mental health professionals, can positively impact therapeutic outcomes. The purpose of this study was to explore to what extent there is a perceived therapeutic working alliance between female inmates and

mental health professionals and what the dynamics of the relationship are in order to identify ways to improve the quality of the alliance.

The Research Questions explored in this qualitative study included the following:

1. How do female inmates feel about the working alliance with mental health professionals within a correctional facility?
2. What is the overall quality of experiences for incarcerated women receiving mental health services in a correctional facility?
3. What are suggested improvements for mental health services in the prison system and beyond identified by the clients?

Using a basic qualitative design with grounded theory tenets, this study focused on the relationship between female inmates who receive mental health services and the mental health professionals who provide these services. Studies have shown that the dynamic between client and therapist can shape the overall counseling experience and outcome for both client and therapist. The researcher examined how these dynamics and perceptions influenced the overall counseling experience for the female inmate by using semi-structured interviews to gather information from female inmates at one prison.

#### Intersections with my Personal Life History

I began my path in counseling after my brother Javier suggested it during a thoughtful and insightful conversation when I was 20 years of age. We both wanted to go into a helping profession after living through a fairly tough upbringing, and my brother and I were determined to move forward and not become stuck in our past. We wanted to learn from our parents, their strengths and their growth needs, and use these qualities to form our own futures. With time and patience, I eventually made it through college and

became a counselor. My brother Javier became a social worker helping children and teens from abusive homes. We both had internalized our pain from our past into our careers and focused on working with marginalized populations. Sadly Javier died in a car wreck at age 27; he was a wonderful social worker and advocate for many victims and survivors of abuse.

In my undergraduate study, I began researching the criminal justice system. My family and I had had run-ins with the law over the years, so I wanted to learn more about a system that scared me. Education turned my fear of the penal system into mixed feelings of concern and sadness. Concern stemmed from the oppressive nature of the penal system and sadness for those who ended up there from a hard or unfair path. I also used education as an equalizer to allow me to help others. I counseled females who had experienced trauma or had been in prison.

I felt deeply rooted in my soul and conscience with a commitment to social equality and the right for all to receive mental health services during my work. As someone who has had the privilege to conduct qualitative research in a women's correctional facility, I fell in love with listening to the stories of the brave and strong women living behind these tall walls. Although mental health services were provided to inmates, I knew very little about the complexities of the relationship between a client and a therapist within the correctional system. I suddenly reflected back on my own professional training and academic experience, and realized that this culture was foreign to me and wondered how other counselors or mental health professionals connected with their clients. Did they notice communication style differences? How did they empower a client that has no power within the system? I wondered about what the clients thought of

their mental health professional? Did they like him/her? What did they think of counseling? What does counseling mean to them? Do they think the experience is benefiting them? What do they think about possible improvements to the therapy process?

I felt that the meanings of these complexities such as the client-therapist dynamic could best be explored by listening to the stories of both the women (clients) and mental health professionals working in the criminal justice world. It is my responsibility as an academic, educator and counselor, who recognizes the ways in which oppression and inequality can cripple humanity and erode peace, to echo their voices through this study. My personal and professional goals are to advocate through education, mental health, and community service the importance of identifying and breaking down the systemic barriers to gender equality. Since I am openly passionate about understanding the often oppressive nature of the criminal justice system, I understood that I needed to work to remain objective within this study, and be careful to use reflexivity to address the subjective nature of my research. I was also aware of my desire to fight for human rights and to galvanize the voices of inequality in the movement toward national and international social justice. This personal goal can also impact the lens through which I look when conducting my study. I used reflections, logs, dialogue with my mentor, and other forms of internal processing to work through my feelings and thoughts, so I can represent all voices as fairly and accurately as possible.

#### Document overview

In Chapter Two I focus on the rationale of my study within a feminist framework constructed from two different paradigms: criminal justice and counseling. Key concepts

will be defined, theories will be examined, and intersections between the criminal justice world and the mental health world will be analyzed. Chapter Three explains the step-by-step methodical process of this qualitative study, including the hypothesis, the research design, the sample design, and limitations of the research design and sample design. Chapter Four focuses on the summary of the results, salient characteristics, preliminary analytical issues, self-reflections, and data collection procedures that impacted the results. Last, Chapter Five examines methodological and theoretical implications and limitations, contributions my study makes, and recommendations for future research.



## CHAPTER TWO: REVIEW OF RELATED LITERATURE

The literature on the working alliance with female inmates was systematically reviewed from 1997 to fall 2012. The review that follows resulted from: word searches of the databases PsycINFO, ERIC/Ovid, and the National Criminal Justice Reference Service (NCJRS); manual searches within topic-related peer reviewed journals; manual searches within topic-related criminal justice websites; reviews of various topic related texts; and examination of nonpublished papers. The keywords utilized in database searches included: working alliance, therapeutic relationship, therapeutic alliance, counseling, psychotherapy, female inmate, female offender, incarcerated female, imprisoned women, criminal justice, prison, feminism, feminism theory, gender responsive needs, gender responsive treatment, recidivism, addiction, substance abuse treatment, abuse, and Post Traumatic Stress Disorder. For the purpose of this review, the following terms will be used interchangeably: working alliance and therapeutic alliance; female inmates and female offender.

This review focuses on professional knowledge about the nature of female offending and the nature of a gendered paradigm of criminology, including studies on crime and mental health. The review expounds on the underlying mental health issues for understanding the treatment rationale and the nature and context of the working alliance with female offenders. A special focus throughout this review includes elements of effective treatment and recommendations of best practices for female offenders and mental health professionals. The ultimate goal of this study is to understand the most effective mental health practices, including therapeutic qualities for the working alliance

that may have a positive impact on rehabilitation and allow female offenders to reenter society as mentally healthy and productive citizens.

### **Females in the Criminal Justice System**

Females represent the fastest growing prison population (Bloom, et al. 2003; McCorkel, 2003; Staton, Leukefeld, & Webster, 2003; Twaddle et al., 2006; Youman et al., 2010). Furthermore, the population of females in the United States prison system has more than tripled within the last two decades (Bureau of Justice Statistics, 2009) due to mandatory sentencing practices, gender biases inherent in the criminal justice system, social attitudes, gendered crime, and drug-related convictions (Green, Mirana, Daroowalla, & Siddique, 2005). Many of the women who have been incarcerated have high rates of substance abuse and mental disorders. Most research focuses on male inmates and the correctional facilities that retain them; therefore, there is a need for more in-depth research to help fill in the gaps in the literature regarding female inmates (Bloom et al., 2003; McCorkel, 2003).

African Americans make up about 13% of the U.S. population but make up about 40% of the criminal justice prison system (Youman et al., 2010). In comparison, Whites make up about 75% of the U.S. population and represent 40% of the criminal justice prison system (Bureau of Justice Statistics, 2004; Youman et al., 2010). African American men have the highest risk of being imprisoned, followed by Hispanic men, and then White men (Bureau of Justice Statistics, 2004; Youman et al., 2010). Approximately 67% of the female inmate population is ethnic minority; African American women make up 48% of the women imprisoned; Hispanic women make up 15%; and other ethnicities make up 4% (Twaddle et al., 2006; Youman et al., 2010).

The prevalence of mental health problems also varies by racial or ethnic groups. Among state inmates, 62% of Caucasians were found to have at least one mental health problem, compared to 55% of African Americans and 46% of Latinos (Bureau of Justice Statistics, 2004). The rate of mental health problems also varies by an inmate's age. The highest rate of mental health problems are found among inmates age 24 or younger and the lowest rates are found in those 55 or older (Bureau of Justice Statistics, 2006). In federal prisons, 61% of females were found to have a mental health disorder compared to 44% of males; the percentage of inmates who had been diagnosed within 12 months of incarceration was 23% for females compared to 8% for males (Bureau of Justice Statistics, 2006).

According to the Bureau of Justice Statistics (2006), 74% of women inmates in state prisons who have mental health problems also meet the criteria for substance abuse or dependence. Drug use rates of women who used in the month of arrest were 33.9% for cocaine or crack and 17.1% for methamphetmines. As a result of the drug arrests and the mishandling of those with mental health symptoms, prisons have become the new mental health location for many displaced women. Mothers of children under the age of 18 represent two-thirds of the women in prison and most of these mothers were primary caregivers prior to their incarceration. Women are imprisoned mostly for non-violent offenses (72%); this percentage is made up of drug related offenses (34%), property offenses (27%) and public order offenses (11%). These percentages represent the marginalized combination and intersections of race, ethnicity, class, and gender (Twaddle et al., 2006).

Messer, Maughan, Quinton, and Taylor (2004) conducted a longitudinal study of women in their thirties looking at precursors of criminal behavior. The researchers used two comparison groups: 86 “high-risk” women and 97 comparison group women. To determine precursors, questionnaires were used measuring childhood, adolescence and adult behavioral factors. Factors found to be precursors of criminal behavior in “high-risk” women included: mental health issues, drug use, parenting problems, and intimate partner problems. Factors which were criminal predictors which appeared throughout childhood and adolescence included: hanging out with deviant peers, quitting school without a high school diploma, displaying adolescent conduct problems or antisocial behaviors, and hyperactivity.

Reckdenwald and Parker (2008) studied the 2001 Uniform Crime report data to examine the relationship of gender and economic marginalization to female offending. The researchers hypothesized that women living below the poverty line or women who were jobless compared to women living at medium income levels, were more likely to offend due to limited economic resources and opportunities (Reckdenwald et al., 2008). Results supported the hypothesis, as female drug sales and female robbery were the two most reported offenses due to combined economical marginalization and gender inequality. These were options for poor women to make money. These offenses can be seen in the percentages of arrest in the Midwest.

According to the Missouri Department of Correction (2009), there has been a 10.9% increase in the female institutional population over the last five years, compared to a much smaller 1.1% increase in the male institutional population over that same period. Missouri is rank 12<sup>th</sup> in the nation for female state prison and incarceration rates per

100,000 population (Missouri Department of Correction, 2009). Currently, female inmates are serving sentences under five major classifications: 35% are serving time for non-violent crimes (property offenses, public order offenses, weapons offenses and traffic offenses); 27.8% are serving time for drug-related offenses, 3.6% are serving time for driving while intoxicated, 5.3% are serving time for sex offenses (includes child abuse offenses) and 28.4% are serving sentences for violent offenses (robbery, homicide, assault, kidnapping, arson 1<sup>st</sup>, armed criminal action and serious weapon felony offenses). On average, female inmates are sentenced to 8-10 years incarceration for these crimes (Missouri Department of Correction, 2009).

Over the past 15 years, both juvenile and adult female offender populations in the United States have increased dramatically, about 40% nationally for nonviolent and drug related offenses (Bureau of Justice Statistics, 2006; Richie, 2001). Prisons have more men and women with mental health disorders compared to the rates of such disorders in the general population (Steadman, Coczza, & Veysey, 1999). Mental health systems in the prison have moved slowly to keep up with the demands of those populations (Ross & Lawrance, 2009; Teplin, Abram, & McClelland, 1997). Policy makers have begun development of gender-specific programs for those incarcerated in the criminal justice system, but the mental health services are limited (Ross & Lawrence, 2009). Although gender-specific interventions are being promoted, those who suffer from mental illnesses are still being neglected in the following ways: lack of financial funding by the state for mental health programs; lack of gender focused treatments; lack of follow-up information on those who receive mental health treatment while incarcerated; power imbalances in

the therapeutic relationships; and inaccurate negative stereotypes such as being violent, antisocial, and being guilty (Ross & Lawrence, 2009; Worell & Remer, 2003).

More female inmates than ever are being treated for a dual diagnosis, such as drug addiction with depression or anxiety. In 2008, the Missouri State Department of Corrections reported that the state's male inmate population was 14,000 larger than their female inmate population, yet, 36% of the female admissions were considered mentally ill as compared to 13.8% of the male admissions. The alarming disparity between female and male mental health populations emphasizes the importance of examining female inmate populations and the mental health services they are receiving. Additionally, the lack of empirical research on female inmate populations calls for further investigation regarding the impact of the relationship dynamics of female inmates towards each other, the relationship dynamics of the female inmates towards the mental health professionals treating them, the potential biases of mental health professionals toward females inmates, and the overall perception of female inmates towards the counseling experience within correctional facilities. The majority of female inmates have had a history of not being heard; therefore, participants desire to voice their personal opinions about their experiences in order to educate those on the "other side" about their counseling experience (Gido & Dalley, 2009; O'Brian, 2001).

### **Feminist Theory**

One of the most gendered institutions in the United States is the prison system (Silberman, 2007). Research supports a gender-related approach for counseling female inmates because this approach encourages looking at the meaningful context of the organization of gender and female crime in relationship to mental health (Belknap, 2007;

Bloom, Owen & Covington, 2003; Covington & Bloom, 2006; Van Voorhis, Wright, Salisbury, & Bauman, 2007). Feminist theory draws on a wide range of philosophies and approaches and holds diverse perspectives about the focus and outcome of gender-related counseling and psychotherapy. Although there are many schools of thought regarding feminism, such as liberal, radical, Marxist and socialist, psychoanalytic, existential, and ecofeminism (Tong, 1998), the school of thought used in this study to illuminate the experiences of women with mental health issues in the criminal justice system will be intersectional theory.

Intersectional theory is a postmodern theory that explores how social and cultural meanings interact on different levels of societal inequalities (Collins, 2000).

Intersectional theory acknowledges the existence of oppression, but unlike other feminist schools of thought, intersectional theory examines the relationship of the intersection of different forms of oppression, such as race intersected with class, or sexual orientation intersected with religion (Collins, 2000; Ritzer, 2007; Tong 1998). The approach of examining intersections create a paradigmatic shift of thinking solely about each oppression, such as race, sexual orientation, age, or class, to focus on the interlocking systems of oppressions. This matrix of overlapping oppressions allows for privilege and oppression to be defined in relation to other privileges and oppressions; thus, depending on the context, an individual may be simultaneously oppressed and privileged. The goal of intersectional theory is to change the consciousness of the individual to empower the oppressed or educate the privileged and change social institutions such as the political and economic systems (Collins, 2000).

Intersectional theory allows for examination of the ways in which woman's lives can be impacted by gender and race, such as access to criminal opportunity, motivation for crime, and the context of offending (Steffensmeier & Allan, 1998). In addition, the social and cultural construction of gender has shaped gender differences in substance abuse. Women are more likely to have been introduced to drugs by boyfriends or husbands, amplifying the motivation for crime related offenses either for herself or her partner. In addition, women have used drugs as a form of resistance to the oppressive constraints that pushed them to offend (Twaddle et al., 2006). Gender intersected with class also greatly impacts sex for sale types of offenses. Women are able to create financial gain through the marketability of sexual services (Steffensmier & Allan, 1998).

Criminal opportunity and punishment can be affected by the intersection of one's gender, race, and economic status. Gender intersected with economic status and education can limit a woman's legitimate opportunities for employment. Women of lower economic status are more likely to prostitute for money than those earning six figures; thus economic status impacts one's motivation for criminal behavior (Alleyne, 2006; Steffensmier & Allan, 1998).

Women and men may or may not have different motivational preferences for offending. Some men are more motivated to commit a crime to improve status and competitive advantage, and some women are motivated to commit crime as a result of a relationship with a loved one. Gilligan's (1982) Moral Development theory expressed that women were less likely to engage in criminal activity due to concern for others, but research has shown that women may offend due to concern for others (Steffensmier & Allan, 1998). Since men and women differ greatly in characteristics and circumstance of



their criminal activity, the meaning of the same offenses, such as murder of an intimate partner, can differ between men and women. Research has shown that some husbands who murder their wives were motivated by rage, but some women who murder their husbands reported fearing for their lives (Steffensmier & Allan, 1998). Also, women are more likely to commit a property crime motivated by poverty and/or the abuse of drugs, and are less likely to commit a violent offense and risk being killed by their male counterpart (Covington, 1998).

Research on female inmates has shown a strong connection between childhood abuse and adult mental health problems such as PTSD, depression, and eating disorders (Bloom & Covington, 2009; Covington, 2003; Messina & Grella, 2006). Messina and Grella (2006) studied female inmates with drug dependency and found that exposure to traumatic childhood events was associated with behavioral problems in their adolescent years and mental health problems in their adult years. Messina and Grella's findings represent how substance abuse, exposure to trauma, and mental health problems are therapeutically linked. Unfortunately, often they have been treated separately within different paradigms of mental health.

There is a need to develop a gender-responsive mental health treatment that allows the different parties involved with the criminal justice system to collaborate in order to help female inmates with mental health issues and not reinforce the penal system. A primary concern of the treatment programs is the concept that clients' mental health problems are internal to one's self and not the oppressive nature of society. Mental health treatments in prisons cannot necessarily meet the needs of female clients because of the controlling penal culture (Cohen, 1985; McCorkel 2004; Pollack 2007). Haney

(2010) echoes these concerns through her work with ‘alternative’ penal systems that aimed to empower their female clients. She discovered through ethnographic work at two different correctional programs that these women were not empowered because the programs governed their needs, rights, and desires according to gender roles and stereotypes. Consistent negotiations between the women and the system impacted mental health changes and fostered institutional dependence (Haney, 2010). These concerns seemed to reflect an 1800’s prison goal of reforming women to act as proper ladies in order to be released back into society.

### **History of prisons in the United States**

In the 1700s, the first prisons were built in the US for men so they would be separated from their families and prevented from engaging in improper behavior (Grana, 2010). Eventually when women became inmates they were sometimes placed in the attics of those buildings without light, heat or water. In the 1800s, women were moved to their own building but on the same grounds as the men’s prisons and again many times these buildings were isolated or neglected (Grana, 2010). The first women’s prison was built in New York, 1835, and remained the only female prison until the 1870s. Eventually more women’s prisons opened and there was a movement to train the female inmates to act more properly (Grana, 2010). As a result, matrons tried to mold the women inmates to be “good women” by reinforcing female stereotypes and gender roles. The prisons, at the time called cottages or dormitories, were systemically set up to represent domesticity and proper womanhood, including motherhood (Grana, 2010). Since reform was the ultimate goal for the women, if a woman was not able to become a

proper lady, she was then seen as a true sinner and considered a lost soul, but the matrons believed many women were able to be reformed and released back into the community.

This movement continued into the early 1900s, until the reform philosophy started to decrease and prisons become more like a custodial institution (Grana, 2010). Custody was the prime goal until the 1960s and then gender focused programs, due to women and civil rights movements, started to develop across the country. These programs looked at the cultural variables of the women in prison and looked at the oppressive nature of the correctional system (Grana, 2010). Since much work is necessary to properly implement a gender-based program without reinforcing gender stereotypes, such as in the 1800s, collaboration between the criminal justice system and the mental health system is needed. Unfortunately, gender-based programs can be redesigned to replicate male prison institutions. Kruttschnitt, Gartner, and Miller (2000) conducted a study that assessed female gender-based prison programs in California. Findings consisted of the following: 1) women staff were as verbally abuse as male staff, 2) gender programs had a stricter regime and more militant atmosphere, and 3) there was a lack of family visits and family friendly programs. Definitions of gender equity as equal treatment can be redefined to reinforce gender stereotypes, therefore, gender based programs should be developed with the awareness of practices of control (Kruttschnitt et al., 2000). For positive gender based programs, such collaboration could increase the effectiveness of mental health care programs and/or treatments, reduce recidivism rates, and improve transitional services for females across the system (Bloom & Covington, 2009).

When working with female inmates in the criminal justice system, it is vital to understand the theories that provide the knowledge base in which mental health

program/treatments are developed (Bloom & Covington, 2009). Four theories important for understanding women with mental health symptoms include: pathways theory, relational theory, trauma theory, and addiction theory.

### **Pathway Theory**

Pathway theory indicates that the construction of gender is the primary indication into the why, how, when, and who commits a crime (Bloom & Covington, 2009). Pathways are just that, the paths women have had to travel to survive in society. Many women have traveled pathways in which they encountered trauma, physical and/or sexual abuse, addictions, poverty, and mental health issues caused by external factors. Women are more likely than men to experience these pathways and as a result the crime a woman commits is shaped by her pathway (Bloom & Covington, 2009). In her 1998 book *In the Mix*, Owen specifically explained the pathways to imprisonment for females that are caused by our patriarchal system. Owen conducted a three-year study among hundreds of female inmates using interviews, participant-observations, and surveys to explore the gendered nature of the prison system. Owen believed that understanding the lives of female inmates prior to incarceration was critical to understanding the culture in the prison system. Her results showed that the women reported prior physical or sexual abuse, disordered families, juvenile crime (might be related to gang activity), and economic disadvantage and subsequent criminality.

Pollack (2005) reported similar results to Owen's (1998) findings and stressed that female offenders often had a history of physical and/or sexual abuse that caused the pathways of juvenile delinquency, addiction and crime-related activities to occur later in life. Covington and Bloom (2006) expanded further on Owen's (1998) research and

explored the fundamentals of gender-related services and theories, such as relationship theory and female development. Bloom (2006) found that relational theory also provided an explanation of motivation towards crime for women offenders.

### **Relational theory**

Relational theory suggests that women are motivated by relational concerns to establish connection with others (Bylington, 1997; Gilligan, 1982; Jordan, Kaplan, & Miller, 1991; Miller, 1976). Relational theory suggests that women need to connect with others in order to develop a sense of self or self-worth (Bylington, 1997; Jordan, et al., 1991; Miller, 1976). Relational motivations occur for men as well, but remain under-investigated due to stereotypes. Many women in the criminal justice system have reported being violated during their childhood and thus have had disconnections, rather than healthy growth-fostering connections, in their lives. As a result, many women have committed crimes out of relational concerns (Bloom et al., 2003; Covington & Bloom, 2006; Covington, et al, 2003; Van Voorhis, et al., 2007). For example, a woman who used drugs may state she used to self-medicate because of emotional pain due to relationship problems. According to Carbone-Lopez and Miller (2012), premature transitional roles into adulthood can also alter relationship roles, create more adult responsibility, and provide more opportunity for drug use.

### **Trauma and addiction theories**

A trauma starts with an experience that overwhelms a female's normal physical and/or psychological systems. Trauma can create painful distress and subsequent behaviors which are placed into three categories: retreat, self-destructive action and destructive action (Bloom & Covington, 2009; Covington & Bloom, 2006; Harris &

Fallot, 2001; Herman, 1997). Retreat can include isolation, dissociation, anxiety, and depression. Self-destructive action can be any self-harming behavior such as substance abusing/using, suicidal actions, eating disorders, and any other deliberate self-harming behavior. Destructive action is violence, aggression or rages. All of these behaviors can be viewed as a normal reaction to what was an abnormal situation or event that was traumatic (Bloom & Covington, 2009; Covington & Bloom, 2006).

Covington and Bloom (2006) reported that trauma can include violence and/or abuse. Women may have different responses to any of these forms of trauma, depending on their development of coping skills or lack of such skills. To be effective in treatment with women who have trauma related symptoms or issues, trauma-informed services are recommended. These services include recognizing the presence of trauma-related concerns, avoidance of re-traumatizing the client, changing the behaviors of the therapists and all prison personnel to foster coping capacity, and permitting the female to be in charge of her recovery so she can feel empowered to successfully use her healthy coping skills taught in therapy to handle her symptoms on her own (Bloom & Covington, 2009; Covington, 2003; Surrey, 1991).

Addiction theory suggests that an addiction is a progressive disease, with social, biological and psychological consequences that occur over a period of time and affected by sociopolitical and environmental aspects (Bloom & Covington, 2009; Herman, 1997; National Institute on Drug Abuse, 2011). In the past, trauma and addiction have been treated separately, but more recently, these have been therapeutically linked. Research has shown that many women use substances to self medicate the pain after a traumatic experience (Bloom & Covington, 2009; Herman, 1997). In addition, research has also

shown that women who abuse substances are more likely to commit a crime than women not abusing substances. Survivors of trauma who do not have healthy coping skills are likely to turn to drugs and/or alcohol to numb the emotional pain from the traumatic experience (Bloom & Covington, 2009; Herman, 1997). Since about 80% of women in prison have addiction problems, the relationship between addiction and crime is very powerful and needs to be addressed through gender-related therapeutic approaches (Bloom & Covington, 2009).

### **Feminist Therapy and Incarcerated Women**

In feminist therapy, the abandonment of hierarchical relationships between client and therapist is essential for empowerment of the client and increased self-efficacy (Tong, 1998). Collaboration within the working alliance is promoted and the client is seen as the expert on her own life (Worell & Remer, 2003). The client's sense of control in the therapeutic endeavor can be the catalyst for a satisfactory outcome to treatment and can encourage the client to embrace her own power and make better decisions for herself (Horvath, 2001).

Feminist therapy was developed in the 1960's and 1970's during what was called the Second Wave feminist movement (Worell & Remer, 2003). Feminist therapy was influenced by Consciousness-Raising (CR) experiences such as female support groups during the feminist movement (Worell & Remer, 2003). CR groups were self-help groups and psychotherapeutic groups where women could express dissatisfaction and concerns about the oppressive nature of society and the oppressive nature of their individual lives in an atmosphere of safety and nurture (Worell & Remer, 2003). The CR groups led the way for current support groups to be established and illuminated the importance of a safe

support system as a catalyst for social and individual change (Worell & Remer, 2003). These CR groups influenced not only group support, but individual support in the counseling field. The counseling relationship needed to be a safe, nurturing and accepting relationship between client(s) and therapist (Chaplin, 1999) in order for change to occur.

In addition to the CR and self-help groups, feminist therapy for counseling was different from traditional therapy in other ways, namely diagnosing or labeling (Worell & Remer, 2003). Frustrated with conventional theories of behavior and development that portrayed stereotyped male traits as the norm and stereotyped female traits as deficient, feminist therapists refused to diagnose clients as 'sick' or 'deviant'. Feminist therapists worked against the detrimental effects of "neutral" psychotherapy by addressing cultural variables which prevented neutrality from existing (Worell & Remer, 2003). Another quality of feminist therapy was the abandonment of hierarchical relationships between client and therapist. Collaboration was promoted and the client was seen as the expert on her own life (Worell & Remer, 2003).

This feminist movement was a change for many women but many other women did not experience feminism with such open arms. The primary critique of feminism theory was that this theory did not install empowerment for all women in the same manner (Crenshaw, 1989). The application of feminist theory to minority woman was diminished because its roots were from a White racial context. Feminist approaches focused on attempting to describe the experiences of women through analyzing the patriarchal and/or sexual ideologies of society and they often ignored the role of race, class, sexual orientation, disabilities, religion, and the other forms of oppression (Pearson, 2007). Privileged feminists have ignored ownership of their racial privileges and their



own contributions to the domination of minority women (Crenshaw, 1989). They have viewed all women as having the same impediments and challenges as they fight for more equity with men. Intersectional feminism differs from other forms of feminism because it embraces many cultures, communities and multiple oppressions. In addition, intersectional feminism aims to address the multiple oppressions of minority women (Pearson, 2007). In particular, multiple oppressions, along with privilege and power, have an effect on the justice (or injustice) of women's nonlegal and legal lives (Grana, 2010).

Women who live within the legal system face many levels of oppression. The criminal justice system continues to perpetuate the subordination of mostly minority women and those of lower economic status (Grana, 2010). In 2007, the US had 12.5% of the population living in poverty, of which 54% of them were female-headed households with children under the age of six; most of these mothers were African American and Hispanics. With capitalism, sexism, and racism accounting for the high numbers of minority women living within the legal system, women's labor production in the prison is controlled by the men who own the prison market; therefore, women are under complete economic control (Grana, 2010). In addition, researchers also find that laws are made to prosecute women (Grana, 2010).

Women have historically used laws to fight for equality or individual rights, such as reproductive choices, and to try to decrease women's oppression by enhancing social and economic issues, but laws can also increase women's oppression (Grana, 2010). Belknap (1996) stated that women must have equal treatment and control over one's own body. A system that stresses equality for all, but is built based on men's needs, is a contradictive system for women wanting equal treatment. For example, the United States

has many types of laws, but the most commonly known are civil and criminal. Research has shown that poor minority women, mostly due to the lack of economic resources, are more likely to be found guilty of breaking laws and to have longer prison sentences compared to White women (Walker, Spohn, & Delone, 2000). By looking through an intersectional lens, poverty and the criminal justice system are socially constructed; those who are most privileged prefer to see crime as an individualistic concern and not a social concern because poor women, more than poor men are, socially invisible (Grana, 2010).

The criminal justice system is one of many fields that have an intensive oppressive history for minorities and poor people. The mental health system has also been criticized for reinforcing stereotypes and limiting resources to only certain folks in need. In the seventh century, medical doctors perpetrated myths that were used to justify slavery (Grana, 2010). During the 1800s, a few mental hospitals treated African Americans; usually they were placed in prisons (Grana, 2010). Since psychotherapy was modeled after a middle-class white male definition of normal and healthy, many minority women and men were misdiagnosed and mistreated (Norcross, Krebs, & Prochaska, 2011; Sue & Sue, 2008). The further away one acted, talked and behaved from a white, male, middle class norm, the more deviant one appeared; therefore, cultural evaluations strongly influenced the diagnoses of the minority client.

In addition to cultural differences, internalized oppression manifested in various ways impacting a person's ability to find or trust resources to receive mental and social support (Sue & Sue, 2008). Mental health professionals ignored or minimized the pathology of discrimination which spread into the mental health programs in the correctional system (Sue & Sue, 2008). A factor continuing from the outside community

inside the prison community is that minorities do not feel connected to the community in which they reside. The treatment minorities receive in prisons reflects the conditions out in the street; therefore, the relationship between a mental health professional and a minority client can be ruptured due to relational trust issues (Grana, 2010).

Treatment is more likely to thrive when the worldviews and cultures of clients and therapists are respected and communicated to each other (Worell & Remer, 2003). Feminist therapy involves the use of interpersonal skills by the mental health professional that should begin early in a woman's prison term to help provide her with the tools and encouragement needed to deal with the oppressive and contradictory nature of the criminal justice system and to emotionally help prepare her for post prison life (Leeder & Wimmer, 2006). Mental health services which focused on gender issues found that addressing these factors was related to lower rates of recidivism (Twaddle, 2006). Acknowledging the hierarchical relationship with clients is beneficial when forming a collaborative relationship in the correctional culture (Beck, 2006; Evens, 2006). A healthy therapeutic relationship can help clients talk about the dynamics of the therapeutic working alliance and the culture of the prison environment (Worell & Remer, 2003). Therefore, the overall goal of feminist therapy is to generate positive growth for the client while still implementing empirically researched gender-responsive treatments (Belknap, 2007; Bloom et al., 2003; Covington et al., 2003, 2006; Van Voorhis et al., 2007; Worell & Remer, 2003).

Pollack and Brezina (2006) explored treatment implications for women in prisons. Research has shown that 77-90% of incarcerated women have experienced sexual assault or domestic violence (Bloom et al., 2003; Green et al., 2005; Pollack, 2005; Pollack &

Brezina, 2006). These experiences of violation have been linked to possible pathways leading to involvement in crime, but they are not the only variable leading to the criminal justice system. Many of the women who have been victimized have high rates of PTSD. This may also impact their behaviors and thoughts, which may be perceived by those in authority as defiant or self provoking. Pollack and Brazina (2006) discovered in their study of mental health professionals working with female inmates that there was “a paradox where they attempt to empower women while also helping them survive in, and conform to, the oppressive prison environment” (p.123). In addition to the contradicting relationship dynamic, programs that used cognitive-behavioral therapy focused on “restructuring the way women think about themselves in order to prevent them from re-offending. Such approaches pathologize women’s law breaking by implying that criminal activity is the result of impairments in cognitive processes” (Pollack & Brezina, 2006, p. 121).

The researchers discovered that validating the client and not labeling her feelings or thoughts in negative ways, such as disordered thinking or irrational thoughts, allowed the client to feel empowered (Pollack & Brezina, 2006). In addition, collaboration between the client and the professional was important for the validation process to occur. This, then, impacted the relationship in a positive way. The researchers also focused on Warner’s (2001) “visible therapy” approach as a useful means of therapeutic intervention. Visible therapy allowed for professionals to build trust and collaboration with clients by being verbally clear with the client about the purpose and process of the working alliance (Pollack & Brezina, 2006). This therapy promoted emotional safety by having the clients

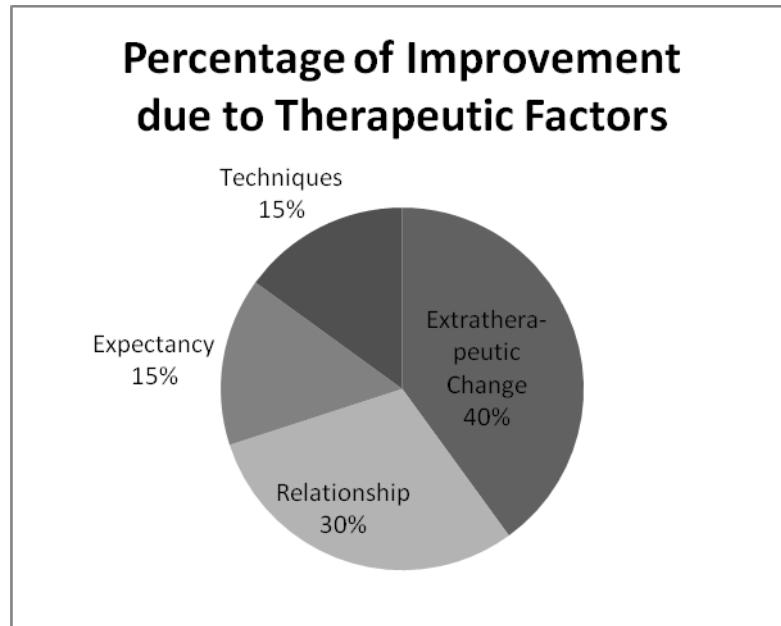
agree about interventions, techniques and other resources to make informed decisions within the therapeutic context (Pollack & Brezina, 2006).

### **Therapeutic Relationship/Working Alliance**

A good predictor of a favorable treatment outcome for clients is for mental health professionals to build a strong therapeutic relationship, which includes building trust and making a mutual commitment to goals (Goldfield, 2007; Horvath & Luborsky, 1993). Horvath (2001) believed a client will leave treatment prematurely if the connection between the client and the therapist is not nurturing or trusting. The development of the therapeutic relationship and trust is essential for the therapist to challenge and/or confront the client when necessary. In addition to the relationship building process and trust, agreement between client and therapist regarding short or long term goals is important. Disagreement about goals can disrupt the therapeutic relationship (Asay & Lambert, 1999; Goldfield, 2007; Horvath, 2001; Lambert, 2001; Lutz et al., 2006.)

A substantial amount of research indicates that 30% of “client improvement” within the mental health journey is due to the client-therapist relationship, as illustrated in Figure 1 (Asay & Lambert, 1999; Lambert, 2001; Lutz et al., 2006).

Figure 1: IMPROVEMENT FACTORS



Bordin (1979) narrowed the concept of working alliance into three primary components: tasks, bonds, and goals. *Tasks* represent the “work” process which consists of the behaviors and processing of each individual within the therapeutic setting. *Bonds* refers to the interpersonal process attachment between the mental health professional and the client with regard to the goals of mutual trust, acceptance, and confidence. *Goals* represent the therapy goals, which Bordin stated are usually set by the therapist, but also include the desires of the client, who indicates the objectives to be obtained during the therapeutic relationship. Significant research has been conducted on the working alliance in psychotherapy; however, the research lacks in connecting these concepts to incarcerated female inmates with mental health issues. With the alarming increase of females with mental health issues being imprisoned in this country, the ability to understand the variables and perceptions of the working alliance between therapist and client would benefit a population that has been ignored for too long. Research into the interaction of the mental health professional and the female inmate would aid in providing more informed treatments and potentially better outcomes.

The therapeutic alliance is an important agent of change for the client within the counseling process (Asay & Lambert, 1999). Freud, the founding father of psychoanalytic theory, has been credited with discussing the impact of the therapeutic bond between the mental health professional and the client. Freud's theory acknowledged transference and counter-transference between the therapist and client as elements created naturally by the environment of the therapeutic relationship. He emphasized that these elements are agents for change. Subsequent theorists expanded on these concepts, but focused more on the client/therapist relationship and the perceived feelings and thoughts each had about the other and the therapeutic process (Horvath & Bedi, 2002).

Rogers' (1961) humanist movement for client-centered therapy centered on the working alliance as an agent to create lasting therapeutic change. Rogers and ensuing humanistic theorists posited that, regardless of technique and theoretical orientation, these "core conditions" are essential for long lasting and profound therapeutic change and progress. Since the 1970's, significant research has been conducted on Rogerian Theory and its usage of core conditions in order to provide evidence for the importance of unconditional positive regard and empathy for the therapeutic process and relationship enhancement (Horvath & Bedi, 2002).

Feminist therapists believe an egalitarian relationship between client and therapist is essential to the working alliance. The client is empowered to set her own goals and to learn to trust her own judgment and experiences within the therapeutic relationship. In addition to the egalitarian relationship, the feminist approach also involves consciousness-raising dialogue with the therapist about intersections of her multiple

identities and the oppressive societal structures that impact her life, learning to value herself as a woman, and identifying her strengths through ongoing validations (Worell & Remer, 2003).

As the working alliance between therapist and client has been defined and utilized in a variety of ways by a number of scholars throughout the years, a collaborative definition of the term would be of benefit here. Hence, based on the works of four generations of research, the definition for “working alliance” in this manuscript follows:

This concept is inclusive of: the positive affective bonds between client and therapist, such as mutual trust, liking, respect, and caring. Alliance also encompasses the more cognitive aspects of therapy relationship: consensus about, and active commitment to, the goals of therapy and to the means by which these goals can be reached. Alliance involves a sense of partnership in therapy between therapist and client, in which each participant is actively committed to one’s specific and appropriate responsibilities in therapy, and believes that the other is likewise enthusiastically engaged in the process. (Horvath & Bedi, 2002, p.41)

This definition includes the core conditions Rogers discussed that were essential from the therapist’s position and also includes collaboration between the client and the therapist. Collaboration that empowers the client can result in healthy goal setting, and consensus about tasks in therapy (Bordin, 1994; Horvath & Bedi, 2002). This definition also incorporates the feminist theoretical emphasis on empowering the client and giving her an opportunity to feel part of the decision making for her own therapy (Worell & Remer, 2003).



The therapist must facilitate a strong therapeutic relationship, focusing on empathy and acceptance, in order to gain the trust of the client (Horvath, 2001). When clients perceive acceptance, respect and warmth from their therapists, they have been shown to exhibit greater and dramatic positive change. A primary way to show acceptance is to treat the client without judgment, disapproval, or dislike of client's beliefs, behaviors, thoughts, and feelings. With the therapist's unconditional acceptance of the client's right to make her own decision and perceive life in her own way, the resulting self confidence and self respect will allow the client the autonomy to accept herself and the ability to change her own choices (Horvath, 2001).

Rogers (1980) defined empathy as the therapist's ability and eagerness to understand the client's feelings, thoughts, and difficulties from the client's world view. In addition to empathy, openness to feedback from the client is another aspect of the working alliance. During the process of building a working relationship, it is important for the therapist to accept and respond to feedback given by the client and to make changes if necessary. Accepting feedback from the client empowers the client to become more collaborative in the relationship and to feel more in control (Horvath, 2001).

Horvath (2001) believed that one of the most important elements of establishing a good working alliance is to emphasize the goal of working as a team. In feminist therapy, the abandonment of hierarchical relationships between client and therapist is essential for empowerment and control. Collaboration is promoted and the client is seen as the expert of her own life (Worell & Remer, 2003). The client's sense of control in the therapeutic endeavor can be the catalyst for a satisfactory outcome to treatment and encourage the

client to embrace her own power and ability to change her circumstance or perceptions (Horvath, 2001).

Bordin (1979) believed goal consensus that focused on mutually agreeable tasks and goals to be an part of the client-therapist bond (Tryon & Wingrad, 2002). The mutual collaboration of client and therapist in a positive helping relationship can decrease levels of resistance from clients and increase active involvement from the client and the therapist (Tryon & Wingrad, 2002). In addition to goal consensus, positive regard, defined as caring about the client and his or her personal experiences, can help increase the collaboration between client and counselor. Many researchers stress the therapists' ability to provide positive regard to their clients for therapeutic success (Farber & Lane, 2002).

Congruence, also labeled as genuineness, has interpersonal and intrapersonal elements. The therapist needs to exert an authentic self and communicate empathic understanding and/or unconditional positive regard (Klein, Kolden, Michels, & Chisholm-Stockard, 2002). In addition to being genuine, the therapist also has to develop trust with the client. Several qualitative and quantitative studies performed with incarcerated individuals indicated that difficulties establishing trust appeared to be one of the primary limitations to therapy and research (Evens, 2006; Kilgore, 2001; Pollack, 2005).

Serverance (2005) conducted a qualitative semi-structured study utilizing both group and individual participants. The focus of her study was to explore relationships among female inmates. Serverance noted in her study that many women did not feel comfortable talking honestly with other women because of the fear of gossip. Participants

also felt a lack of trust when sharing private matters. One particular inmate shared, “Trust is a big issue for me . . .I don’t like people to know . . . That just falls into the privacy thing for me” (Serverance, 2005, p.354). These statements are representative of the power imbalance between mental health professionals and participants. The statements also reflected the intrusiveness of qualitative studies with a population that has personal and collective trust issues (Kilgore, 2001). Serverance was able to address these trust issues with participants, allowing them to voice their concerns. Their concerns illuminated the cultural implications of the prison system and of authoritative relationships.

The matter of trust was also prevalent in Pollack’s (2005) study, whereby she noted the need to address issues of power in order to establish more accepting and collaborative relationships between the mental health professionals and the inmates (Pollack, 2005). This study was especially enlightening because she studied the use of psychological labeling/diagnosing from mental health professionals. Pollack noted from her personal experience as an outside researcher that mental health professionals revealed biases about the inmates in informal conversations and similarly, the inmates shared biased perceptions about the mental health professionals. As a result of her outsider position, Pollack was able to appear more objective to both sides, thereby facilitating her ability to gather effective data from this prison population. Pollack stressed the need for evaluation by outside professionals in order to diffuse power imbalances between prison staff and inmates.

Linda Evens (2006), a former U.S. political prisoner, shared her own experience and the culture of the correctional system when living behind bars. Evens (2006) wrote that the trauma of being locked up can impact any female inmate. Prison officials locked

up women who voiced any concerns or complaints; thus, assertiveness was punished. Women who were defiant were locked away for days in isolation until a prison official would release them from punishment. Evens considered this an oppressive form of authority that reminded women that they were not valued. Women with mental health illnesses who were locked away in their cells became more depressed or mentally ill. Women who were suicidal were not exempt from this method of control, and the other women inmates were usually the primary support group to assist her through the experience. The hierarchical prison system resulted in women in prison feeling violated or victimized on a daily basis. Women were given little or no privacy and respect from male guards. For example, male guards were able to watch them naked while taking showers, see them naked in their cells, and control their sleeping quarters.

It has been shown consistently throughout the literature that therapists who remain flexible have better outcomes with a client. A therapist that is aware and accepting of his or her client's changing needs and goals is more likely to have stronger bonds of alliance (Horvath, 2001). Goldfried (2007) believed that therapists are not always accepting of their client's pace of change and such displays of dissatisfaction can cause the client to regress. Therapists need to set realistic goals for their clients and be patient with the process; otherwise, the relationship may develop a rupture.

Researchers suggest the development of the working alliance bond in the first session can be a predictor of client attendance at future sessions or of premature termination (Barber et al., 1999; Horvath, 2001; Hwang, 2000). Ackerman and Hilsenroth (2003) reviewed research on the therapist characteristics and techniques found to be positively related to the therapeutic alliance. The authors found that the most important

personal attributes for a therapist were being honest, flexible, and trustworthy; showing confidence; appearing warm; and being respectful, interested, and open. Techniques positively impacting the therapeutic alliance were reflection of meaning and content, exploration, attending to client's individual experiences, mentioning past therapy success, interpreting accurately, and facilitating the expression of affect.

The working alliance is used to create change for a client. The capability for a therapist to establish confidence and trust is essential for success and to foster the development of a positive working alliance (Ackerman & Hilsenroth, 2003). The present review has identified specific techniques and therapist qualities are connected to a healthy and positive alliance during the therapeutic process. Although research has been done on factors regarding the process of the therapeutic bond, qualities of an effective therapists, and client perceptions of a working alliance, more research still needs to be conducted. Many working alliance studies lack qualitative data and client perceptions represented from minority and marginalize populations (Ackerman & Hilsenroth, 2003; Horvath, 2006).

### **Gender-Responsive therapy.**

Covington et al. (2006) reported data which suggested the immediate need for gender-responsive theory and practice in working with female offenders. The data was accumulated from literature reviews and self-reports from experts representing different fields and agencies in the criminal justice system. Bloom et al. (2003) defined gender-responsive therapy as

creating an environment through site selection, staff selection, program development, content, and material that reflects an understanding of the realities

of women's lives and addresses the issues of the participants. Gender-responsive approaches are multicultural and are based on theoretical perspectives that acknowledge women's pathways into the criminal justice system. These approaches address social and cultural factors, as well as therapeutic interventions. These interventions address issues such as abuse, violence, family relationships, substance abuse, and co-occurring disorders. They provide a strength-based approach to treatment and skill building. The emphasis is in self-efficacy. (p.2)

Gender-responsive therapy relates to feminist approaches in many ways such as: illuminating the differences in female and male pathways to criminology, increasing the gender appropriateness of mental health treatments and programs, changing the climate of the prison system to acknowledge the realities of female's lives, revising views of gender and gender-related behavior according to the criminal justice system, and addressing diversity and multicultural factors when implementing treatment to females (Bloom et al., 2003; Covington et al., 2006). Gender-responsive therapy incorporates feminist theoretical perspectives on women's lives in the criminal justice system into the following guiding principles: (a) recognize that gender makes a difference when treating inmates; (b) create a safe, respecting and dignifying environment for positive behavioral change; (c) develop relational treatment programs, policies and practices that encourage healthy relationship with family, children, support systems and the community; (d) acknowledge trauma, mental health issues, and substance abuse through comprehensive culturally competent services and proficient supervision; (e) provide socioeconomic opportunities for financial empowerment; and (f) establish reentry services that are

holistic and culturally collaborative and comprehensive. Such efforts will generate positive effects for females with mental health issues in criminal justice system (Bloom et al., 2003; Covington et al., 2006).

### **Research with female inmates**

Blitz, Wolff and Shi (2008) compared physical victimization rates of those imprisoned with mental health issues to those imprisoned without mental health issues. In this study, physical victimization in prison included inmate-on-inmate assault and staff-on-inmate physical assault, such as beating, hitting, choking, biting, slapping or kicking. An audio-computer administrated survey was completed by 7,221 men and 564 women by electronic means or face to face interviews. The sample was collected from 14 prisons in a mid-Atlantic state. Both men and women with mental health issues reported higher levels of prison physical victimization. Men with mental health issues had a 1.6 times higher rate of inmate-on-inmate physical assault and a 1.2 times higher rate of staff-on-inmate physical assault than men without mental health issues. Women with mental health issues were 1.7 times more likely to report inmate-on-inmate physical victimization than women without mental health issues. There were no significant differences between women with or without mental health issues regarding staff-on-inmate physical assault (Blitz et al., 2008). Limitations noted by the researchers were that only one form of abuse was studied, the results did not represent the full population of inmates, the possibility of unmeasured or uncontrolled attributes which may predict the likelihood of abuse, the possibility of biased reporting, and that the percentage of those inmates identified as having a mental health issue was lower than national percentages (Blitz et al., 2008).

Nee and Farman (2007) studied the literature on the effectiveness of Dialectical Behavior Therapy (DBT) for female inmates with borderline personality disorder in the United Kingdom prison system. Nee and Farman preferred the DBT treatment model because they believed clients diagnosed with Borderline Personality Disorder (BPD) have more problems accepting themselves and others. They found that DBT taught the client the therapeutic skills needed for acceptance and change.

Nee and Farman (2007) briefly reviewed data from seven qualitative and quantitative studies, all of which showed statistically significant improvements in outcomes such as, suicidal ideation, suicide attempts, depression, coping beliefs, self-harm, para-suicidal behavior, and dissociation. In addition to the BPD treatment model, a non-judgmental focus on acceptance during individual therapy was also important for change resulting in reducing criminogenic (promoting or causing crime) risk and mental issues. A limitation of the review is the limited number of studies using BPD with female inmates (Nee & Farman, 2007).

**Substance Abuse.** Arrests for drug related offenses increased by 29.9 % for women between 1997 and 2006, while for men they increased by 15.7%. In 2006, over 200,000 women 18 years or older were arrested for drug abuse violations, which was an increase of 23% from 2002 (Institute of Women & Criminal Justice, 2010). As a result of such dramatic increases in arrests, researchers have focused on the relationship between drug use, drug treatments, recidivism and gender.

Most women who are in prison are incarcerated for drug related offenses. While imprisoned, treatment options should match the mental health needs for women prior to imprisonment to help with rates of recidivism. Women who need treatment for substance



abuse or mental health disorders are more likely to engage in treatment while in prison than to attend community clinics due to limited economic resources and confinement (Blitz, Wolff, and Paap, 2006).

Ullman, Starzynski, Long, Mason, and Long (2008) conducted a quantitative study exploring the relationship between sexual assault disclosure and problem drinking of alcohol. The population consisted of 857 female sexual assault survivors who drank alcohol that year. The results from the surveys showed that women who had received negative social reactions to sexual assault disclosure were more likely to have problems with alcohol use than those that received positive social reactions (Ullman et al., 2008).

Langan and Pelissier (2001) analyzed data collected from a project evaluating the Federal Bureau of Prison's Drug and Alcohol Treatment Program (DAP). DAP began in 1990 and has been used in at least 30 prisons throughout the U.S. DAP is a cognitive behavioral program which consists of a minimum of 500 hours of treatment over a 9-month duration. DAP provides inmates with relapse prevention while focusing on criminal lifestyle topics or concerns (Langan & Pelissier, 2001). The data examined included 1,326 male and 318 female inmates. Face-to-face mixed method interviews were used and participants were selected on a voluntary basis during their participation in DAP. Research showed that those who participated in DAP had lower recidivism rates than a comparison group who did not participate in the DAP program (Langan & Pelissier, 2001).

Results from this study by Langan and Pelissier (2001) showed that men were more likely to use drugs for hedonistic benefits as compared to women, who reported their main use of drugs was to lessen emotional or physical pain. Women also reported

that prior to arrest, they used drugs with either a spouse (with a drug problem) or a close friend (with a drug problem) (Langan & Pelissier, 2001). Women were seven times more likely to be married to a drug using spouse and six times more likely to have been abused, compared to men. Women were much more likely to have been diagnosed with depression, and both genders were equally diagnosed for antisocial personality. Results also indicated that women were more likely than men to have physical and mental health problems, severe patterns of drug use, and to grow up in homes where physical, emotional, or sexual abuse and drug use were present. Limitations of this study noted by the authors were the lack of a measure for alcohol use, a lack of interviews with inmates from high-security prisons, and the exclusion of those who did not wish to volunteer for this study (Langan & Pelissier, 2001).

Staton, Luekefield, and Webster (2003) sampled a group of incarcerated women in Kentucky about substance use, mental health and physical health problems, and service utilization. Cross-sectional data were analyzed from the Health Services Utilization Project at the University of Kentucky Center on Drug and Alcohol Research. The study included 60 women and 661 men for interviews prior to their release from prison. A majority of the women in this study (85%) admitted to using drugs 30 days prior to their arrest. The most commonly reported health problems were: drug use, dental problems, reproductive issues, mental health and physical injuries or accidents. Lifetime problems included depression, anxiety and cognitive problems. The majority of women (80%) reported receiving substance abuse treatment prior to entering prison. About 53% of women admitted to receiving mental health services and being seen up to 14 times a year in an emergency room. Emergency room utilization was related to physical and mental

health problems such as suicide ideations/attempts, anxiety, and substance abuse issues (Staton et al., 2003). Many women reported using the emergency room for access to medications and immediate care (Staton et al., 2003).

Based on the data, Staton et al. (2003) identified important gender-specific services for substance abuse offenders: multimodal treatment, competent and professional staff, strong peer networks, isolated treatment units, cross-training sessions for prisons and program staff, vocational training, specialized health care, HIV and sexually transmitted disease education, parenting education, victimization counseling, prerelease planning, separate treatment program sanctions, and aftercare programs. Limitations reported by the researchers were the small sample size, the unknown truthfulness of participants, and that the findings were not necessarily representative of all female offenders (Staton et al., 2003).

Pelisser et al. (2001) researched cognitive-behavioral model programs extending from 9 months to 12 months of substance abuse treatment. The sample consisted of 760 treatment participants from 20 different prisons and 809 comparison participants from 30 different prisons. Of the 1,569 participants, 281 were women. Results showed that 6 months following release, participants who completed the in-prison cognitive-behavioral treatment were 73% less likely to be re-arrested than untreated participants. Also, those who completed drug treatment were 44% less likely to use drugs within the first six months after release than those who did not receive drug treatment (Pelisser et al. 2001). The reported limitations of the study included differences in the programs for men and women, a preliminary analysis that was not separated by gender, and the size of group studied was too small.

Messina, Grella, Cartier, and Torres (2010) used a randomized controlled trial in a prison setting to compare gender-responsive treatment (GRT) to standard prison-based therapeutic community (TC) programs. The population included 115 post release women offenders who participated in either of the two programs over a two year duration. The purpose of the study was to compare the psychological benefits, aftercare retention, relapse rates, and recidivism rates between participants who completed either the GRT or the TC programs. Messina et al. (2010) found that there were no differences in the psychological well being of participants across the two programs. However, the GRT participants showed less relapse rates of drug use over time, remained in aftercare longer and were less likely to be reoffend than those in the TC program. Limitations of the study included that participants were predominantly White (48%) and almost 50% of all participants had never been married and were in their late thirties. These percentages were not representative of the female prison population.

Lindforss and Magnusson (1997) evaluated a solution-focused approach with prisoners in Sweden. The sample included prisoners with high rates of recidivism. The study lasted two years and 60 participants were randomly assigned to either an experimental group or a control group. The goal of the study was to find an efficient approach to working with prisoners to reduce rates of incarceration after the initial release. Lindforss and Magnusson (1997) suggested that within the solution-focused treatment paradigm, there was a competence-based belief that clients are their own personal experts at knowing their needs and what is the most beneficial for them. Therefore, the therapeutic sessions were focused on client successes. In addition, scaling questions helped the clients to set small goals and provided opportunities for the therapist

to compliment the participants on their current improvements (Lindforss & Magnusson, 1997).

Lindforss and Magnusson (1997) reported a positive outcome from the study. Twelve months after the initial release of the prisoners, the experimental group had a recidivism rate of 53%, compared to the control group recidivism rate of 76%. At a sixteen-month follow up, 40% of the experimental group remained crime free, compared to 14% out of the control group. In addition, the control group had committed 153 offenses after one year, and the crimes committed were more serious than the treatment group who had committed a total of 86 offenses in the same period. Thus, the crimes committed by the control group required more prison time. Limitations of the study are rooted in the theory; there are no mechanisms for addressing power and gender issues built into solution-focused therapy. In addition, the responsibility of change is all on the client and not on the prison system (Dermer, Hemesath, & Russell, 1998).

In a qualitative study by Twaddle et al. (2006), the results indicated that implementing a feminist support group for female prisoners in Guam was a beneficial way to process issues such as trauma, addictions, separation from family, and coping with prison life. The program involved 4 to 6 women participants in five, six month cycles of substance abuse treatment. The therapists and clients worked together as a collaborative team. The women were able to work through emotions and teach and implement empathic feedback with one another and with their mental health professional (Twaddle et al., 2006). They were taught about the social roots of their problems and levels of oppression and how these concepts influenced their life as a whole. In addition, women explored cultural roles and social expectations that might further oppress them or liberate

them. The goal was to use education as a tool for empowering the women so they could use this knowledge when making future decisions about personal, social, and political issues (Twaddle et al., 2006). The feminist support consisted of only women with an egalitarian approach to therapy. According to Twaddle et al., the relationship between the therapist and client was essential for the program to be effective and beneficial to all participants (Twaddle et al., 2006).

Of the 24 women in treatment, 22 successfully completed the program and then five were returned to prison, representing a 23% rate of recidivism (Twaddle et al., 2006). Follow-up programs continued empowering women through a feminist lens to tackle post prison life issues (Twaddle et al., 2006). This example of a gender responsive therapy program allowed the women, prior to release, to emotionally help each other and to prepare for post prison life. Through semi-structured interviews the women were able to validate these goals. For example, one participant said “And after I’m done releasing it in here, it helped me to accept people out there, because I already let it out and I’m not carrying that burden anymore.” (p.229). The therapy also helped provide them with the tools and encouragement to deal with the oppressive nature of the system, “instead of picking up drugs again, or bad habits, it’s good to find a good form of group like (this) group...so you don’t have to fall back on those things.” (p.226). The program showed that female empowerment and psychoeducation were key elements for effective group therapy (Twaddle et al., 2006). Limitations reported by participants were inadequate socioeconomic aftercare resources, which they believe impacted the recidivism rate. Other limitations included: a small sample, 83% were Chamorro, and a lack of follow-up interviews of all participants.

Historically, all prison-based substance abuse programs have been designed with male inmates in mind. However, since the proportion of females inmates incarcerated due to drug-related offenses is larger than the proportion of male inmates incarcerated for drug-related offenses, treatments need to be more culturally sensitive for female inmates. Knowledge about the four theories (pathways, relational, trauma and addiction) can be very important for understanding females with addictions so treatment in and out of counseling is appropriate and positive for the client. Research has shown that clients need primary treatment while incarcerated and post-treatment after release to prevent relapse. Also, addiction and trauma need to be treated together because they are interrelated problems for many incarcerated women. In the past these two issues have been treated separately, but research has shown they are linked and should be processed together.

Research has shown that female inmates in treatment are likely to have lower levels of recidivism than those who did not receive any treatment. Addressing the mental health needs for those with addictions involves a gender-responsive approach that includes the content and context of female's lives, including trauma. Addiction treatment should be a multidimensional approach incorporating a focus on psychological, social and biological problems (Bloom & Covington, 2009).

**Dual Diagnosis.** Research reveals that 75 percent of females incarcerated in state prisons have mental health disorders along with substance abuse problems (Bloom & Covington, 2009). Several studies have looked at the presence of more than one mental health issue along with substance abuse problems in treatment for effective rehabilitation. For example, in a study conducted by Leeder and Wimmer (2006), drama therapy was

used with different groups of incarcerated women dealing with different life issues and different mental health illnesses, such as PTSD, depression, psychosis, anxiety, or co-occurring disorders. The following groups were formed in the study: females with drug and alcohol problems, females who had experienced domestic violence, and female inmates with their family members. All the women had a dual diagnosis and ranged in age from 18-45. The groups of women were diverse in age, race, class and education. All the women were at the end of their sentencing and about to enter the outside world. The drama therapists and counselors worked together to help these women process their current identity and the potential roles they thought they would find themselves fulfilling or wanting to fulfill in the near future (Leeder & Wimmer, 2006).

The drama therapy program met weekly for 1.5 hours for 12 weeks. The goal of drama therapy among female inmates was to empower the women to recognize their self worth and to use their voice to express themselves (Leeder & Wimmer, 2006). Drama therapy allowed for creative outlets for the inmates in front of other female participants and at times in front of their family members and friends. As a result, drama therapy permitted an environment for the women to feel validated for their feelings, thoughts, and behaviors without judgment and compliance. The women were able to use these creative forms of expression as safe and healthy outlets (Leeder & Wimmer, 2006).

Drama therapy allowed “powerful personal healing” to be fostered (Leeder & Wimmer, 2006). Women were able to find connections from their past to help explain their current situations and beliefs. With awareness and understanding, another goal of drama therapy was to help the women forgive themselves (Leeder & Wimmer, 2006). Self-forgiveness was promoted and provoked during several exercises. Many of the



women were able to find self-forgiveness and process the emotions connected to their self-beliefs and life journey. Right before entering the community, these women were able to rediscover roles they wanted to live and to forgive themselves for roles they were ashamed of living (Leeder & Wimmer, 2006). The women expressed that they felt some control in their lives and the confidence to make decisions that would better themselves and that they had healthy forms of self expression, new communication skills, self awareness, and self-esteem. These women were ready for a new chapter in their life in which they could feel empowered to feel some control so they could make decisions that would better themselves (Leeder & Wimmer, 2006). Limitations to this study included a small sample size of 40 women and the use of written feedback from participants, which could limit responses from those lacking education or lacking communication skills.

Women who have mental health disorders are more likely to abuse drugs/alcohol (Bloom & Covington, 2009). The prevalence of dual diagnosis increases one's chances of imprisonment and women have higher rates of dual diagnosis than men (Scott, Lewis, & McDermott, 2006). Prison staff should be aware of the dual diagnosis and assign inmates to treatment programs that will target all the presenting issues (Marquart, Brewer, Simon, & Morse, 2001). Therapists in the prison environment should work at understanding the significant prevalence of dual diagnosis in incarcerated women to be more effective in treatment. Issues of females with dual diagnosis need to be treated concurrently and not sequentially for positive change to occur and these treatments should be gender-responsive.

Research indicates that females with mental health issues are increasing in the criminal justice system. A number of studies have shown that counseling programs in

prisons are effective for reducing recidivism in female offenders but what they have not shown is if a working alliance can be created and how the working alliance is related to the effectiveness of treatment among White and minority females. An overall task for researchers in this area of study is to validate the practices of therapy with qualitative data that establishes the effectiveness of their practices for one's well-being. This study will primarily focus on the relationship between female inmates who have received mental health services and the mental health professionals who conduct these services. Studies have shown that the dynamic between client and therapists can shape the overall counseling experience and outcome for both client and therapists. The studies mentioned in this chapter highlighted the importance of gender-responsive theories including pathway, relational, trauma and substance abuse. The researcher will examine how these dynamics and perceptions influence the overall counseling experience. Lastly, the researcher will ask about ways to improve the experience of receiving and conducting mental health services.

## CHAPTER THREE

### Methodology

The purpose of this study was to explore the therapeutic working alliance experiences of female inmates in a mid-western correctional center for women. Using a basic qualitative design with grounded theory tenets, this study examined the relationship between female inmates who have received mental health services and the mental health professionals who conducted these services. Studies have shown that the dynamics between client and therapist could shape the overall counseling experience and outcome for both client and therapists (Bordin, 1994; Horvath & Bedi, 2002). I examined how these dynamics and perceptions influenced the overall counseling experience and client recommendations for improvements to the mental health services in the prison system. I gathered information by interviewing female inmates who had received mental health services.

### Research Questions

1. How do female inmates feel about the working alliance with mental health professionals within a correctional facility?
2. What is the overall quality of experiences for incarcerated women receiving mental health services in a correctional facility?
3. What are suggested improvements for mental health services in the prison system and beyond identified by the clients?

### Participants

**Female Inmates.** I interviewed 12 female inmates who represented a diverse sample. Due to the sensitivity of the setting of this study, inmates were selected by their

caseworker to determine if the female inmate was eligible and available, under prison policies, to partake in this study. Eligibility for this study was determined by the following criteria: the inmate must have received one-on-one mental health services from a mental health specialist for at least three months at the correctional facility. All participants were inmates serving time at the Midwest correctional facility at the time of the study. Although participants were required to be at least 18 years of age to take part in this study, the age range was 32-55 years, and all identified as female.

All participants completed a demographic survey (Appendix E) and the results are summarized in Table 1:

Table 1: Demographic overview of participants N=12

N	Race	Sexual Orientation	Religion	Education	Had Children	Had MH prior Tx
Annie	White	H	None	GED	Y	Y
Atia	AA	H	Eastern Religion	GED	Y	Y
Karen	AA	H	Christian	GED	Y	Y
Grace	White	H	Christian	1yr college	Y	Y
Deanna	White	H	Christian	GED	Y	Y
Elaine	White	H	Evangelical	HS	Y	Y
Jackie	White	L	Christian	HS+VOC	Y	Y
Stacy	White	Bi	None	GED	Y	Y
Maria	Biracial	Other	Christien	HS+voc	Y	Y
Hope	White	H	Christian	GED	N	Y
Laura	White	Bi	Christian	GED	Y	Y
Bianca	AA	H	None	GED	Y	N
N=12	White=8 African American=3 Biracial=1	Heterosexual=8 Lesbian=1 Bisexual=2 Other=1	R/S=9 None=3	GED=8 HS=1 HS+Voc=2 College=1	Y=11 N=1	Y=11

Note: Age category was deleted to protect participant confidentiality.

### **Plan of Action**

Prior to the study, I had outside experts, experienced with criminology and counseling, critique the interview questions to be used for the study. I also contacted the State Department of Corrections, Planning, Research and Evaluation Unit to receive approval for conducting the study. After Institutional Review Board (IRB) approval at University of Missouri- St. Louis was obtained, I contacted the midwestern correctional center for women to schedule times and dates to visit and recruit willing participants. I provided the female inmates with a participation invitation form (see Appendix A). After the participant read the participation invitation form, those who chose to be in the study signed the consent form. All participants had to be willing to participate voluntarily and to sign informed consent forms (Appendix C). Each participant was paid a stipend of \$10.00 at the end of the interview, although the stipend was not contingent on completion of the interview. The inmates received this payment in the form of a \$10.00 credit to their individual prison bank account. To protect participants from potential harm, I explicitly stated in the consent form that subjects could withdraw from the study at any time with no punitive consequences. There were no anticipated physical risks associated with this research. It was possible (but not probable) that psychological risks for participants could occur if negative feelings arose related to the therapeutic relationship. In addition, there was a small chance that participating in the research could result in social, economic, or legal risk if the interviewee's answers to questions about the therapeutic relationship became known to prison staff.

The other risk for the inmates was the hierarchical relationship. I worked to empower participants to make their own decisions regarding how and when to answer questions but there could have been an uncontrollable paradox within the power dynamic between me and the female inmates due to the prison's social control realities (Pollack & Brezina, 2006).

I explained to the inmates that I was performing a research study regarding their overall experience of receiving mental health services and regarding their relationship dynamics with their therapists. I informed participants that data (consent forms, interviews, and transcripts) would be confidential from everyone other than myself and my dissertation advisors. Data were kept locked in a safe and secured file cabinet at my home. All individual identifiers were linked to exclusive pseudonyms that I assigned and used on all field notes. Individually identifying information was kept in a logbook that was computer based and that only I had access to; no identifying information was connected to the data other than the assigned pseudonym. All data collected was kept safe and confidential on a password secured computer and access to raw data was limited strictly to me and my advisors.

Participants who were selected by the caseworkers and identified as meeting the criteria were called the day of the interview to ask for participation. I waited in the interview room while the caseworker called each unit to find out if any inmates wanted to participate in this study. Very little information was related to them and I was not allowed to personally ask for participants. Once inmates did agree to participate or expressed possible interest, they were then instructed to meet with me. When an inmate agreed to participate, I gave her a "participation information form", asking her to

participate in the study. This explanation was read to each participant, and a copy was left with her in case she should want to contact me in the future (Appendix A). Since I was not present for most of the recruiting, I was not made aware of the refusal rate by women asked to participate in this study. I did have two women say “no” in person, stating that they were “not interested” in participating in this study. In-depth semi-structured interviews were conducted with participants who completed and returned forms and gave consent to being interviewed. These interviews were planned to last 60-90 minutes each, but the actual interviews ranged from 45-140 minutes, and were audio taped. If follow-up questions were needed after interviews had taken place, participants could have been reached by contacting their caseworker.

After forms were turned in and appointments were verified, the administrator for the correctional facility set up interviews for the participants who had provided voluntary consent to partake in the study. For the female inmates, interviews were conducted in a private office within the correctional facility with a security guard sitting in front of the office. The participants had a set schedule and were informed about their upcoming interview. I worked at keeping the participants’ involvement with the study concealed from other inmates through the following process. I entered the prison from the front entrance location and asked the proper official to walk me to the unit where interviews took place. An official called the inmate’s supervisor to inform her that the inmate was needed at a particular office. When the inmate arrived at the interview location, I asked the inmate if she wanted to partake in the study. If the participant agreed, I met with the participant in a closed office without other personnel present but with a proper level of security within close proximity. These steps were used to decrease the chances that other

inmates or mental health professionals could witness the participant walking to meet me, but this process did not prevent all officials from witnessing the interaction.

Confidentiality and privacy were only the beginning to protecting one from harmful risks. The term “harm” could be used subjectively when dealing with participants in any study (Murphy & Dingwall, 2001). Research participants may have had felt anxious before the interview, causing them stress, or they could have interpreted a question or statement made by the interviewer in an unintentionally offensive way. I allowed all participants to review a draft of questions at the beginning of the interview to help decrease inappropriate questions or remarks and to allow all participants time to reflect.

After the participants had time to settle in and concerns had been discussed, the interview began. I started interviews with a very brief paper demographic questionnaire which explained how identities would remain anonymous and partial demographic characteristics would be used to describe the sample in the final results of this study. The demographic questionnaires were completed within five minutes (see Appendix E).

After the participants completed the demographic survey, I conducted a 60-90 minute semi-structured interview with each participant. All participants were informed that I was mandated by law to report any information they shared that could be considered a threat to their safety or to the safety of others (Cottone & Tarvydas, 2003). All interviews were audio-recorded for transcription purposes. All interviews were transcribed within two weeks of the actual interview being conducted. For confidentiality purposes, all transcriptions were coded with numbers to represent each participant interview. Also I removed identifying information from the interviews and



field notes by using pseudonyms (Berg, 2004; Murphy & Dingwall, 2001). Once the study was completed, all tapes and audio recordings were deleted.

### **Research Design**

For this study, I utilized qualitative in-depth, semi-structured interviews (see Appendix G). I looked for patterns among interviews by first employing open descriptive coding and then applying axial coding to organize and categorize groups and codes. In addition, I worked to understand each person's perspective about the therapeutic relationship and the overall psychotherapeutic experience. As such, the use of a qualitative study was appropriate because describing, interpreting, and understanding the phenomenon of the therapeutic relationship was accessed through capturing perceptions in a specific context (Merriam, 1998; 2002).

A semi-structured interview consisted of a combination of both structured questioning and flexible questioning; there were structured questions to guide the interview, but I asked probing or exploratory questions to encourage elaboration on the participant's answers (Merriam, 1998, 2002; Shank, 2006). Semi-structured interviews helped ensure that the interviews were consistent in general format, and that each participant could fully express herself without the influence of leading questions.

To enhance the trust and validity of this study I kept detailed field notes and kept a personal log (Emerson, Fretz & Shaw, 2001; Shank, 2006). In addition to the recording of the interview, I also made mental notes of particular verbal and non-verbal events. After each interview, I immediately wrote down any concerns or observations in the field notes. The field notes consisted of observed events describing particular issues during the interview (e.g. nervous, tics, fear, behaviors, eye avoidance, etc. (Shank, 2006). In

addition to documenting these events, I kept a personal log about my own feelings and thoughts about the interviews (Emerson et al., 2001; Shank, 2006). I listened to the audio interview and read all transcripts, field notes, and personal logs previous to analyzing the data. A codebook was developed with definitions of emergent categories after using open and axial coding.

### **Data and Data Analysis**

After initial review of data from the interviews, I used Atlas ti software to conduct open coding, and then used axial coding to develop a set of codes with definitions (Tunnell, 1998). After I had analyzed all 12 interviews, including completing coding, I felt no additional interviews were needed to reach saturation so additional subjects were not recruited (Tunnell, 1998). To ensure confidentiality, I removed identifying information from the findings and used themes to discuss the findings rather than presenting individual narratives. This process is noted in the final findings.

Data analysis tracked the perceptions of participants about their experiences with psychotherapeutic services and the relationship dynamics connected to these services. I listened to the female inmates' stories to gain insight into understanding their cultural worldviews; however, for the purpose of this study, I focused on gender analysis. In addition, I asked questions to determine what cultural factors were valued by the participants as most important within the working alliance.

The goal of the study was to capture the participants' interpretation of their counseling experience. Hearing the "voices" of the participants helped me gather meanings of these experiences perceived by those engaging in the counseling process (Bruner, 1990). By gaining a deeper understanding of the experiences of incarcerated

women participating in the counseling process, I was able to identify the quality and usefulness of therapy. Through interviewing, I could hear what participants experienced as meaningful and important. The participants’ words captured the essence of the research questions.

As noted above, initially open coding was used to break down and analyze the data and create concepts and categories (Strauss & Corbin, 1998). During this stage, I analyzed all the transcripts, coded them line-by-line to identify themes and refined codes. After the completion of the initial open coding, I continued to analyze the concepts found in the interviews, and developed and refined the concepts related to the codes obtained. The concepts, codes, and information from the interviews were then compared for commonality to the research questions. This information was used to sort and categorize by determining which interview questions shed light on which research questions (Strauss & Corbin, 1998). I reviewed this information question by question across participants using Atlas ti.. In addition, the software had the tools needed to locate and annotate findings and codes in the data systematically and build a coding structure, as illustrated in Figure 2.

FIGURE 2: Codebook Organization

Category	Sub category	Property	Dimension	Code: t access {2-0} Code: t access {2-0} quotes

I asked interview questions related to the research questions to guide the interviews. After sorting the interview responses to the research questions into groups indicating which research questions were answered, I assembled the initial themes and began to employ axial coding to simultaneously establish relationships across categories

and between the data and the research questions (Strauss and Corbin, 1998). Axial coding was relating codes or categories to subcategories (Auerbach & Silverstein, 2003).

In the next step, I grouped data and text together to correspond with a research question. In order to connect the data with the appropriate research question, Atlas ti. enabled me to link the appropriate category and its associated interview questions. After compiling all the data, I reviewed and refined the codes identified in each category to create a codebook with themes (Strauss & Corbin, 1998). This was done by reviewing each piece of text and its original coding. I memoed the process by placing codes and themes pertaining to the text in the comment section. The major concepts that were identified during this coding phase were used to help further define emerging concepts and draw relationships between research questions and the data collected. This information was used to help identify common ideas between the interviews (Auerbach & Silverstein, 2003).

After I refined the codes, the codes were separated from the text in the electronic transcripts and printed for further categorization. This created a conceptual map allowing for the visual representation of relationships between data from the interviews and the research questions. After creating the map, I analyzed the conceptual map by identifying larger concepts that emerged from the data (Merriam, 1998; 2002). These larger concepts were used for rearrangement of newer concepts as more data was included in the conceptualization. The rearrangements of concepts were used because they were indicators to find if there were any intermediary variables between the larger concepts (Merriam, 1998; 2002).

I then looked again at the collected data and worked toward illustrating and defining further meaning to it. In order to do this, I identified subcategories, properties, and dimensions of the categories (Merriam, 1998; Strauss & Corbin, 1998). This information was used to compile a codebook to organize the data, making the data easier to understand by identifying each category and its parts. In addition, examples from the interviews of quotes were included in the codebook in order to support findings.

### **Limitations**

In this study, findings do not represent the general population for female inmates since the sample was small and the research was exploratory on the therapeutic relationship between a female prison population and mental health challenges and therapy within a prison. I was not able to obtain a proportional number of participants to represent populations from all ethnicities, races, ages, and other cultural forms of identification. In addition to this demographic limitation, the perceived power imbalance in the relationship between myself and the participants may have impacted trust issues and perceived notions about the hierarchical structure. The motive to answer authentically and difficulties in establishing trust appear to be primary limitations for both qualitative and quantitative studies involving those incarcerated.

Pollack (2005) discussed the need to acknowledge hierarchical relationships and to “attend to issues of power” (p.83) for a more accepting and collaborative relationship between the mental health professional, researcher and inmate. Such approaches and limitations are necessary to understand before implementing a qualitative research study with female inmates.

I encountered two participants who may have felt that they could not trust the researcher for a range of reasons, such as power imbalances, race, gender, age, and prior experiences with researchers, and other forms of resistance. Some inmates declined to participate in the study and refused to talk to me. I was informed by the caseworker that some women refused, but I never found out refusal reasons. Because they refused, they may have had a rationale that could have been impactful to the study. The motivation of those who did participate compared to those who did not participate could have also shaped findings in the study.

To help eliminate or decrease levels of resistance, I used self-disclosure, active listening, reflection of feeling and content, and paraphrasing skills throughout the interview so the participant felt “heard”. I have seven years of counseling experience, doctoral education in the field of counseling and four years of graduate teaching. My experience, education and self-reflection were factors used to increase the chance of establishing trust with participants. By doing this, I hoped to form a collaborative relationship with the participants and, as a result, decrease feelings of power imbalances for all participants.

## CHAPTER FOUR: RESULTS

From my field notes, I recreated my overall initial experience approaching the prison site for my research. Sharing these impressions seemed important to focus on the day-to day environmental reality of these women. Once inside the prison walls, I felt a slight feeling of intimidation. After the drive to a rural community and a winding back road, the prison disclosed itself with bright exterior colors and high barb-wired fences. After parking in sight of a security camera, I walked to the front doors to enter the world “behind the walls.” Once inside the building, check-in at the front desk was mandatory; this required a photo ID and my name to contact the proper personnel who had approved my visit. Nothing except my photo ID, prison badge, two audio recorders and blank paper were allowed beyond the front desk - no phone, no purse, no feminine hygiene product, nothing. After being cleared to pass, an escort, Joe, accompanied me through the front heavy guard door that was opened by the security guard behind a glass window. After hearing the loud clank of the door closing behind me, I waited at another big door for the staff to push the right button to open a heavy sealed doorway. While trapped in the middle of these two big doors that resembled small metal gates, the man behind the security window asked to see my id and badge. After what felt like five minutes of intense inspection, the guard nodded his head of approval and the door opened slowly. I finally felt as if I passed some test and could relax. Then I walked through an empty small visiting room with about eight chairs to exit the building onto the grounds.

On the grounds, I saw about 150 women walking in straight lines or hanging around in small groups. As I walked with my escort, Joe informed me that he was going to get the proper official to recruit the participants from their units. As we made our way

to the mental health unit, Joe talked about the different personalities of the women and the overall prison atmosphere such as the attitude and culture of the different inmates, the logistics for different activities, resources, and the needs of the inmates related to changes made at the prison in the last ten years. In addition, Joe shared stories of his own encounters, mostly positive, with the inmates, and his observation of the cultural dynamics of the grounds, cells, units, and surrounding community. After hearing Joe's input, I felt excitement to finally be able to hear their stories from the women themselves. I hung onto this energy and worked to remain objective in light of his subjective beliefs about my future participants. I noticed his judgmental demeanor, but remained focused on the upcoming events.

The purpose of this study was to explore the perceived therapeutic working alliance and relationship dynamics between female inmates and mental health professionals in order to identify ways to improve the quality of alliance services. My primary goals of this study were to explore if, how, and under what circumstances, female inmates felt they had a working relationship with their mental health professional and what barriers could be present, preventing a working relationship from being created.

This study, additionally, contributes a unique perspective to the current body of knowledge on female inmates receiving services within the correctional system. Gaining trust and capturing authentic stories from at-risk populations offer particular challenges. Any identifying information on participants had to be creatively masked, as the 12 participants who were interviewed faced higher risk for being identified than in a large anonymous quantitative study. I believed ensuring confidentiality was a high priority. Narratives about entering the scene, building trust, and establishing relational contact



with participants help provide ‘thick description’ as advocated by Clifford Geertz (1973). He suggested that all anthropological writings are interpretations of interpretations. Making sense out of a local situation is what theory building is about. Delineation of each research question will be followed by identification of emergent themes, patterns, and quotes from the coding analysis of the interview data in order to support my interpretations.

### **Patterns and Interpretations**

#### **Relating to female inmates**

The mental health professional, such as the counselor or social worker, must facilitate a strong working alliance with clients, focusing on empathy and acceptance, in order to gain the trust of the client (Horvath, 2001). When clients perceive acceptance, respect, and warmth from their therapists, they exhibit greater and more dramatic positive change. Treating the client without judgment, disapproval, or dislike of client’s beliefs, behaviors, thoughts, and feelings is a primary way to show acceptance towards the client. With unconditional acceptance of the client, she feels empowered to make her own decisions and perceive life in her own way. The resulting self confidence and self respect will allow the client the autonomy to accept herself and her ability to make her own choices (Horvath, 2001).

My goal, as the researcher, aligned with many of the characteristics of creating a working alliance. I felt it was important to make the participant feel comfortable and empowered during the interview. Since first impressions are important in order to make connections, I did not want the participants to feel threatened or upset by my appearance. I purposely dressed in jeans, solid color sweaters, light make-up, no jewelry, perfume, or

any other materials which could represent class or authority. I was aware of my privilege as an “outsider” and did not want to impose more oppression than the participants already experienced within the correctional system. I wanted to be respectful of their living conditions and present myself with humbleness and modesty. As an “outsider” I knew I would need to establish trust and rapport. While I learned these skills through my counseling training and lessons found in the writings of qualitative and feminist literature, nothing prepared me for the powerful stories voiced. I was honored to hear these storied narratives under the confined and limited circumstances of this research study.

Once the guard Joe and I made our way to the mental health building for me to begin the interview process, I was left alone in an office of an employee who was currently on vacation. I waited about 15-20 minutes before the first woman arrived at my assigned office. The office was pretty bare on the walls, but offered a desk and two chairs which was all I needed. For my protection, a security guard was sitting outside the office and I was asked to keep the door open “just in case.” Although I appreciated their concern, I took these warnings with caution, but not as a deterrent; I wanted to work on building rapport and acting fearful would cripple this process.

On the first day of interviews, I was informed that some of the participants had decided not to participate for reasons never provided. Since no relationships were previously established with any participants, I realized I would have to work hard to build trust in order to listen to their stories in an open and honest way. I met with Joe at an employee’s office located near the mental health professionals unit; Joe then informed me that he had a list of participants who fit the criteria and would call them down, one-by-

one, for their interview. At 9:00 am the first participant entered the office; she appeared welcoming with her warm smile and eagerness to sit down. I could see the slight caution in her eyes behind her eyeglasses, and she remained silent and sat down with her hands on her lap, as if she were waiting for my move. Because she was the first to be interviewed, I thought she might inform the other women of her experience. A good first impression was important, so she would not deter other women from participating. To help with the process of building trust, I was very transparent about the study; she was informed of the goals of the study and the importance of her opinion. I self-disclosed my passion for women's rights and my past research experience within that specific prison. These self-disclosures seemed to help her relax and she appeared more inclined to start the study. To help with any mistrust, I showed her the question guide prior to any consent or signature. Once she felt "safe" about the study, forms were signed, and the interview proceeded with ease.

**Research Question 1: How do the female inmates feel about the working alliance when working with mental health professionals at the correctional facility?**

The first interview and the ones that followed focused on the characteristics of the working alliance and the process of how relationships with counselors changed over time. I will discuss the themes according to the order of the research questions and frequency of themes. First I asked questions to determine if there was a working alliance from the perspective of the client (Interview protocol Appendix D). I further explored how each participant defined working alliance. Primary themes that emerged from my data analysis of 12 interviews included the following themes: trust versus resistance, positive regard and empathy, and collaboration and goal consensus.

**Trust versus distrust**

Throughout this process, I continued to reflect the participants' feelings and thoughts in hopes of building trust and rapport. I felt our own short encounters (45 to 140 minutes) reflected some of the same characteristics needed to foster a long term working relationship. Once the first interview began, I noticed myself resorting to my counseling skills: paraphrasing, reflecting, and asking open-ended questions. Although I had the interview guide in front of me to provide organization, I allowed the interview to get off track at times as we found ourselves talking about other items than the ones intended for the study. Most interviews lasted about an hour and were conducted over two days to minimize fatigue.

Trust was a common emerging theme on various levels of interaction with others and interaction with the overall correctional system. At the beginning of the working relationship, 10 of the 12 women reported that they felt resistant to open up to a "stranger", possibly due to previous experiences with *distrust*. The concept of distrust, for 11 of the 12 women, stemmed from past experiences with childhood neglect and physical and sexual abuse. Many of these women also had experienced abuse as adults from their male partners. In addition to trauma, Hope reported that she had always been discriminated against due to her race and this caused her to become more distrusting against white people.

Another reason for distrust towards the counselor stemmed from fear of being "in the hole". Several women expressed that they had experienced suicidal thoughts, but did not say anything to their counselors for fear of being placed in an isolated room that is referred to as the hole. The hole "leaves you with only your own thoughts" one

participant commented, has no bed and no sheets, and may have some padding on the walls. This room is designed to assure an inmate's safety when agitated, but many women found this room too confining to feel safe. As a result of being placed in this room, some women remained silent about their thoughts and internalized their feelings rather than seeking out their counselors. Some evidence of how these women see themselves as viewed by the system follows:

- Maria: They really do, they don't look at [inmates] as human beings with a mental health problem. They look at us as criminals, that's manipulating, ain't nothing wrong with us, put her on meds and throw her in the hole for a year. Because I've been done like that myself.
- Bianca: I might be going through some issue or say I might have found out that something ain't right with my child or family and I know you [counselor] here on the camp I could just, you know... Hang there, I could come over and talk to you. I'm just not feeling right right now... Instead of me exploding on the dorm, exploding before I can even get to the psychiatrist or they done hand cuffed me, took me to the hole or something. I feel like that we should be dealt with as far as we have mental health issue, and not just I'm lashing out because I'm an offender and I'm mad... there's a reason.

Bianca expressed her "reasons" as times when she or other inmates might be depressed about missing their children and/or loved ones, overwhelmed with prison life, living with mental health issues, suffering from PTSD and having a trigger moment, and/or having a moment of anger or sadness due a personal issue not clearly indicated to the staff or professionals within the correctional system. Due to intense stressors, Bianca wanted the

option to talk to her mental health professional in a quick timely manner to meet her psychological needs before the emotions got too strong and overwhelming. Bianca felt mental health professionals should be on call to help women at times when unpredictable events occurred in their life, or the lives of their family members and/or friends. She believed constant mental health support should be available day and night without a waiting list to seek services.

In the counseling literature, the term resistance is used to describe a client's internal conflict when they refuse to cooperate or change and may appear as distrustful (Beutler, Moleiro, & Talebi, 2002). Distrust within a correctional system is different than being resistant in traditional terms. From a social influence perspective "resistance" within the prison system came across as a protective defensive response to the system that punished these women. The resistance is evoked by the counselors' authoritative power within the correctional system. As a result, distrust towards their counselors is a rational reaction and a normal part of building a working alliance. This developmental process was supported by the words of the participants.

Stacy: She'll just say, 'What's going on with you?' 'How you been doing?' And then I'll tell her and then that's when she start bringing up her stuff and saying what she gotta say.

*Researcher:* Okay. But do you feel like you can trust her?

Stacy: No... You got to have somebody you can trust, to really mean it and say how you feel... think I would want it personally to be, somebody that's concerned, that asks more questions. Look at your body language and try to know you, after so many sessions, to know when you at that point of breaking and then,

you know what I'm saying? If things like that to understand you and not judge you by your time, or what you here for, or they should take. Your conversation, I think, with your counselor should not have anything to do with the Department of Corrections. It should strictly be about your mental health issues and you as a woman and a person... I feel like my mental health issues should be totally confidential.

This reasonable set of expectations appears to have been met in most cases with counselors. Participants expressed that verbal and non-verbal forms of communication were indicators made by the counselor of different levels of validation towards the client. Stacy discussed that counselors should seem concerned, ask the right questions, show non-verbal expressions of affection, and observe the client to gather meaning of content and feeling. Most women reported feeling that they could trust their mental health professional, indicating that they had gotten beyond the initial distrust of these authority figures as counselors. Stacy felt counselors should not be working as employees for the correctional system, but as independent contract mental health professionals. Stacy's recommendation reflected her distrust with correctional authority and the correctional system. Stacy wanted total confidentiality, but she also understood that there were limitations in place due to the nature of the establishment. For example, the participants indicated these trusting attitudes toward the mental health professionals they worked with:

- Karen: And I mean it's no never an issue, he doesn't make me feel like he's going to use it against me. He makes me feel like he'll keep it confidential.

- Grace: There are a lot of things from our past that you feel are very shameful and we're gonna keep it secret and if we have a woman that we have actually learned to trust, it is easier to talk to them about it.
- Bianca: Most women in the correctional facility do have a big issue with trust...Because most of them have been abused... Yeah, I mean at first I could never recommend counseling years ago, but I would recommend it now. It's pretty good. And it gives me somebody to talk to. Like when you're having an issue in your room or you're having an issue with somebody on camp. You've got to watch what you say because if you don't watch what you say, you go to the hole...If you say something that is wrong. So it's like being able to come over here and sit down and vent about what's going on with you in your personal life and what's happening with you....easier to talk to him about anything now, like my children, or anything I can talk to him about.
- *Researcher*: How did he grow on you?
- Bianca: I guess it was just getting to know him and seeing how he was...So I guess I gained some trust for him because at first I didn't trust nobody. And you don't trust anybody here.

The concept of trust seemed to influence all of the women because of their past traumatic experiences and the concept of distrust of the environment of the prison. Once in the correctional system an inmate becomes vulnerable to all the requests, regulations and standards set by the correctional system. Inmates become depend on the resources within the system and lose autonomy during the process. Inmates expressed resentment towards



losing individual power of self choice and felt counseling should be an autonomous decision not mandated by the correctional system.

Trust in a counseling relationship was expressed as a choice made by the women towards their counselors on their terms. Although 8 of the 12 women were mandated to attend mental health services, all women believed that the interactions between the mental health professional and themselves should be a voluntary relationship in order for trust to develop.

Jackie, “ Yeah because I have the option, anybody does, to go to your appointment you must show up and you can sign a refusal and say I’m just not feeling it today or whatever on that day.”

Through emerging themes, I found that counseling was a time when the women could control the external situation and determine how much or how little she would share. The choice to see the counselor was an act of ownership and seemed to provide women with power. In addition, the choice to trust the counselor was theirs; the counselor could not force the woman to trust; the counselor had to do the work and earn their trust. For some of the women, their counselor was the first time someone worked to gain their trust without being rude or disrespectful. When I asked about how the process of trust was gained, positive regard was key.

### **Positive Regard and Empathy**

Research has indicated that positive regard is an indicator of the significance of a mental health professional’s humanity and influences the outcome of psychotherapy (Farber & Lane, 2002). When I interviewed the women, asking about positive regard was essential, especially in relation to how they socially constructed positive regard.

Several women spoke on acceptance and empathy when expressing how they felt their counselors showed positive regard:

- Annie: [counselor] teaches me to love myself. He teaches me to believe in myself because when I first started going to see him I didn't believe in myself. I was down on myself and he tells me that I've got to believe in myself again. To believe that I'm worth it... He's helped me so much. He's such a great guy...I can talk to him about anything. Usually that's not the case but I can with him, he just makes you feel comfortable. You know he's non-judgmental and you can see it...I think they need to, uh, listen and be observant.
- Atia: You know he is very understanding....He'll say like well can you explain it to me why this happened? And I will try to break it down to him why I did things or said things you know, to help him understand me and my point of view on it...I think a really good counselor is somebody that does listen to your point of view. Not try to change how you think or feel but help you to understand how you think and feel. Which my counselor does that. He doesn't tell me no you shouldn't think like that...He doesn't try to change that, he just wants me to see how I'm feeling and let me change it on my own.
- Jackie: doesn't judge us...he seen me when I was at my worst... Talk so hateful to him and he would just let it ride. ..He never once said she needs to be locked down or nothing like that. He says just let me go back to population.

Jackie believed that her counselor cared about her because he did not enforce punishment at times when he could have justified the need to be "locked down." The decision of the counselor to be accepting of her at her "worst" times translated to her as being caring and

understanding of her anger. By not retaliating against her anger and accepting it, Jackie gained respect for her counselor since he did not impose punishment.

Atia's description of a good counselor consisted of the counselor allowing her to change things on her own; he promoted ownership and responsibility which empowered Atia to find the solution within her. She appreciated his desire to understand how she was feeling without judgment. Annie also echoed the importance of nonjudgmental relationship.

Annie expressed that she did not believe in herself when she started counseling but said her counselor taught her to believe and to love herself. She said she was able to determine his feelings towards her by his nonverbal and verbal of observation and acceptance. She said her counselor was non-judgmental which created an accepting atmosphere.

Judgment was another common concern for the women. One woman summarized the root of the judgment; they have been judged by society for being "bad humans". This identity lingered in their formation of relationships within the correctional system. Prison was the ultimate indicator of poor judgment and these women expressed feeling of being judged by others. This was a weight on their shoulders. All women expressed that a counselor should not be judgmental and should see them as "human beings." They wanted their counselor to empathize with them and see the good in them as a person. They also wanted their counselor to be authentic, able to relate to them naturally and openly, within the relationship.

Congruence is the responsibility of the mental health professional to "keep it real" about themselves and others (Klien, Kolden, Mickels, & Chisholm-Stockard, 2002). The

goal is for the client to become less incongruent while learning to become more congruent from the mental health professional. “Keeping it real,” was a quote commonly used in the interviews. Elaine said, “She’ll [counselor] candy coat everything...I think she’s finally pretty much don’t (currently) candy coat it, just tell me.” Because her counselor “keeps it real”, the woman felt she could be more honest about self-disclosure to her counselor. Elaine first described her counselor as timid in her deliverance of paraphrasing and reframing in their sessions; as a result, Elaine felt her counselor was naïve and couldn’t relate to Elaine’s stories or presenting problems. Now, Elaine expressed their dynamic in a productive manner, appearing that she appreciated her counselor for becoming more “real” during their sessions by educating Elaine about her incongruences, being more confrontational during the session, and delivering content in manner Elaine felt was more realistic to her needs.

Self-disclosure, on the part of the counselor, is a controversial intervention among mental health professionals; some promote it while others oppose its use in counseling (Knox, 2002). Self-disclosure is any personal information conveyed by the counselor to their client. Proper self-disclosure should not add any burden to the client and should be used to encourage the client to talk and build trust towards the counselor (Cormier et al., 1997). Most of women I interviewed expressed a preference for self-disclosure as a therapeutic intervention. In an environment where self-disclosure is not promoted for reasons related to coping within a prison, for some participants the only time they felt that they could self-disclose was during a session. The relationship between client and mental health professional may be the only “normal” form of communication and as a result

many women expressed the desire to hear their mental health professional self-disclose.

Self-disclosure represented a level of trust and respect from their therapist.

- Grace: I have worked very well with a couple of counselors who kind of had similar interest that I do. So when we kind of needed to de-stress for a minute and kind of get out of it, we can talk about the canoe trip that she took last weekend or whatever, just to kind of move away from some of the emotional stuff for a few minutes and then we can get back to it and that helps. Just someone who is willing to share a little bit of themselves as well...And again there is a really thin line there as what can be shared and what can't but things that can be shared, it is kind of nice to see that. I want to spill my guts to you; it's nice to get a little something back.

Eleven of the 12 interviewees mentioned themes reflecting the difficulties of establishing trust in therapy and the importance of positive regard and empathy when building a relationship. Based on the feedback from the women, their counselors need to exert an authentic self and communicate empathic understanding and/or unconditional positive regard in a Rogerian sense.

### **Collaboration and Goal Consensus**

Many women expressed that they had been originally resistant to counseling, but with time they became more involved because their counselors worked with, not against their resistance. Some women voiced concerns about involvement related to issues of: authority, access, control, outside harassment, motivation levels, self-esteem, past mental health experiences, and lack of understanding the process. Most responses reflected their

perceptions that the client is the expert in deciding on the goals and the mental health professional should be supportive. Several of the women spoke to this theme:

- Annie: [Counselor] is not the expert... They don't even know you... Well they[psychiatrist] told me I wasn't going to get the treatment that I had on the outside, that's for sure... You know, they go about their own direction. He didn't even talk to me for 10 minutes and they go their own direction. You can say what you want about what you took on the street... But it doesn't matter.
- Atia: And he listens to my point of view and he doesn't tell me you need to change this. He tells me what do you think you need to do? How do you think you need to handle it?... Well it's not really an agreement, he asks me, 'Do I have anything to talk about today?' or "Do I want to talk about anything or do I just want to sit there and reflect?" You know he gives me the choice of what I want to do.
- Elaine: It all comes down to what I want to do. She doesn't force me into anything. You know, she will speak the positive and negatives of the situation and she's not one of those that says 'I think you need to do this;' she'll go What do you think?

Ten out of the 12 women felt that they were in an egalitarian relationship with their counselor, but with limitations such as confidentiality and gendered specific concerns.

These will be further addressed in section two. Two women felt they could openly share their presenting problems, but believed that their counselor was "definitely" the expert in the relationship and another woman expressed that her counselor was in charge within the relationship, "I think he should. He's the doctor."

- Annie: He'll let you know if you're heading in the wrong direction if he thinks you are... You know we don't need somebody to sugar coat it for us...[counselor] very honest.
- Elaine: I think she believes that I have a lot to work on. That I've got my priorities messed up. She's told me that herself. That I still make wrong choices, you know. But eventually I will be there.

Overall, all of the woman felt that their relationship with their counselors was beneficial. Although the women spoke about trust issues and concerns about being locked up “in the hole,” the general census was that counseling was a positive experience. It appeared that the benefits overrode the concerns and all the women indicated plans to continue their counseling services.

**Research Question 2: What is the overall quality of experiences for incarcerated women receiving mental health services in a correctional facility?**

**Assessment and Diagnosis**

In their first encounter with the prison system, the women described their emotion as feeling “scared.” To assess mental health issues, the first step in the prison process of admittance involved identification and diagnosis of any psychiatric disorder that might impact success. Once the newly arrived inmate had completed her intake, a treatment plan was reviewed by the clinical supervisor who was responsible for assuring that the plan was followed by the mental health professionals. Treatment plans described by the women involved mostly medication modification and brief counseling sessions. Most women reported seeing their counselor once a month, once every other month, once every three months, or as needed. Prison policy allowed the women to see their

counselor as much as needed; however, the women reported that this would show weakness and they feared being bullied by other inmates, so most went once a month.

Annie stated:

When you first come into the prison and you get all these tests run on you and all this stuff they do the mental health thing on that and I think at that time when you tell them, ‘This is what I take’ they ought to try to get you something similar to it...It takes a while to get through that process. ...I’ve seen people go over a month without their medicine.

Eight of 12 women referred to having been diagnosed prior to prison, but either did not take the recommended medication or did not attend the recommended mental health services. Some women expressed feeling or being “different” compared to when they were younger, but they did not understand that these feelings were connected to a mental health issue. They believed they acted out from this place of being “different” and used unhealthy coping mechanisms to deal with these feelings or thoughts. The primary diagnoses among the women were dual diagnoses of depression and anxiety. Some women were diagnosed with bipolar disorder and one woman was diagnosed with schizophrenia.

Research on female inmates has shown a strong connection between childhood abuse and adult mental health problems such as bipolar disorder, PTSD, depression, schizophrenia and eating disorders (Bloom & Covington, 2009; Messina & Grella, 2006; Covington, 2003). Women may have different responses to any of these forms of distress, depending on their development of coping skills or lack of such skills. To be effective in



treatment with women, ten of the participants believed those who have distress related symptoms or issues should receive trauma-informed services.

### **Substance Abuse Treatment and Trauma**

Thirty-four percent of women who are in prison are incarcerated for drug-related offenses. Eleven of the participants spoke to this truth and spoke to the need for treatment options for women in prison and in the community. Although some of the crimes that were committed by the women were not drug offenses, the crimes were a direct result of being an addicted or on drugs/alcohol at the time of the offence; therefore, drug use and trauma were primary themes in this study.

For many of the women in this study, drugs and/or alcohol were used as a coping mechanism because of past trauma. Since a few of the women did not state their offense or the nature of their addiction, I was not able to obtain specific details of their experiences, but 10 of 12 participants did express that they had experienced past trauma and drugs or alcohol were used to help them function through life. At some point in their lives, these participants used substances to self medicate the pain after a traumatic experience. As a consequence of their addiction, the participants believed there was a strong link between being under the influence and committing their crime.

One particular participant was able to trace her journey of substance abuse back to her teenage years. Annie's struggle with substance abuse started young. As a teenager she felt

. . . different from my friends... The normal girls, or whatever, that I was around, it seemed like they dealt with things differently than I did. I dealt with things on a

different level than they did... So at that time I realized something wasn't right....

I kind of started isolating myself from my friends.

Annie did not know how to ask for help and longed for the need to be 'loved'. She became pregnant with her first child at 19 years of age and, after the birth of her little girl, reports her husband "started beating on me so things really just escalated." Annie believed her abusive relationship with her husband and her upbringing in an alcoholic home contributed to the development of her substance abuse:

I actually started using because I didn't know how to deal with my mental health issues. I didn't know that I needed medicine...I was just depressed and stuff and I couldn't deal with my moods. I believe years ago I was bipolar but I wasn't diagnosed with it at that time. Probably because I was so young. But so I started using to try to alter my moods and try to make myself feel better whatever.

Annie did the best that she could with what she had, but, as time went by, she started making unhealthy decisions. She said she was constantly trying to figure out how to make her life change for the better but the emotional pain of her life kept bearing down on her and she resorted to drug use to help her cope with the hurt and desperation.

Annie's story is a common one - a hard lifestyle with few choices and unhealthy coping mechanisms. Ten women referred to substance abuse, directly or indirectly, as the primary cause for their imprisonment. Some women were in prison on drug offenses and a few other women were in prison because their substance abuse led to another illegal action. Interpretations of the justice of these outcomes varied. Grace stated, "I should be here" for the crime she committed due to her substance abuse. Another

woman, Maria, felt female inmates with mental health issues should be in another location, a “treatment center” for substance abuse issues.

The first step for a few of these women who entered prison with severe substance abuse problems was detoxification. This occurred in a medical or non-medical setting, depending on the substance abuse and level of medical risk. Once the immediate detoxification was under control, the next step included going through the assessment and diagnosis process to develop a proper treatment plan. Options for substance abuse treatment in this prison were: 30 day, 60 day, and 90 day behavior modification and psycho-educational programs. After completing the recommended program, the women could continue or discontinue their mental health services. All of the women believed that substance abuse was a relevant topic to bring up in sessions because it had contributed to their imprisonment. Also, most of the women believed that they used the substance to help them cope with negative feelings, thoughts, and relationships.

Grace shared her story of alcoholism and how it led to her imprisonment. She expressed her need to understand the root of her pain, so she could stop hurting herself and others. She shared this story:

I was drunk and because I was an alcoholic and when I start drinking, I simply can't stop. I think for me the important thing is to figure out why I started drinking and completely come to terms with that because that way I won't be as tempted to start drinking again...If I could figure out why I do it to begin with, I could find some other way to solve that problem instead of just burying it with the alcohol.

She said she was working on forgiving herself and relied on her new, healthy, coping techniques to help her move forward. Her substance abuse was not a barrier to developing trust with her counselor; her feelings of shame and judgment were important for her counselor to address within their sessions. She also wanted to understand the underlying pain causing her addiction.

Several women expressed that their mental health professional should be knowledgeable about substance abuse, including working on their recovery steps. As Annie argued,

You know like because I am in treatment, I'm in long-term drug treatment, you know for drugs. And he has helped me. I've done my step work with him and a lot of stuff. It's just a range, you know, a whole range of things I've done with him and he's very observant. Very observant, and he listens to everything you say and he don't forget.

Most of the women shared that some form of abuse or trauma was the cause of their addiction. Many shared stories of rape, physical and emotional abuse from their partners, and other forms of trauma. Among these women, most referred to being physically, emotionally, or sexually abused as an adult at the hands of a male partner. Some women reported physical or sexual abuse as a child, usually from a family member or friend; therefore, they have lived a life of abuse until they were sentenced to prison.

Due to trauma, Hope could not remember any of her childhood. She was married at age 15 and had her children back to back. She had never worked through or on her trauma:

I never worked on them issues because I was a mom. I had to take care of kids. And I was a child raising a child... I wish I could remember my childhood. But I guess from the trauma, I locked everything out when I can't remember nothing...I feel like that piece of my life has been taken from me.

Hope went on to explain how substance abuse became her coping mechanism:

At first I was ashamed of it when I would talk about it. But then I've realized that I'm not, I shouldn't be ashamed of what I've done. Because I used to use drugs too, and I didn't know that I was self medicating.

Hope still has not been able to remember her childhood memories, bad or good, but hopes to one day open the door to her past. However, she has been able to talk about her physical abuse with her counselor:

Actually when I come to prison is when I started talking about my abuse issues. I never could talk about that before and still to this day, I cannot talk to my mother about it because she stayed married to the man for 24 years.

Several of these women expressed turning to a life of drugs to cope with their traumas and several others believed that their childhood abuse taught them to be subjected to abuse as adult women. Most participants believed that their mental health professional should ask about past abuse and help them work through this trauma. When I asked if the counselor should bring up past abuse and trauma, most women said yes. What follows is a selection of quotes supporting this theme.

- Karen: I feel like, whatever plays a part in my life, because of what all I've been through, mentally, physically and emotional abuse...triggered my or made my mental issue come out even more. But I feel like it is okay to talk about it

because deep down inside most mental health people have those dark issue that they hold in or that's really bothering them....I feel it has helped me more that I talk...If I want to talk about trauma, then they get on that conversation with me.

- Elaine: Oh yeah, that's a big part... Honestly I believe that's the counselor's issue... To bring up. Yeah. Because we have enough stuff that we have to bring up. I think that is one of them that the counselor should, in getting to know us, and I understand there's 2200 women on camp. But for them to kind of know us I believe they should, you know...So by asking those kinds of questions they get to know us...They get to know our background... You know. And abuse is a big one. You talk to nine or ten woman nine of them has been abused. ...And they started offering a class on the grounds called domestic violence. And that threw a lot of us back. And some of the counselors don't, they agree that we need to take the class, but I don't think they know how to handle it. Because once we start coming to them and start saying, this, this, this, this, I don't think they realize how much that class is affecting us.
- Bianca: Most women in the correctional facility do have a big issue with trust...Because most of them have been abused...I think the women, if they want to talk about it (abuse), they bring it up....That's the better deal. Because I'm okay to talk about it now. \_ years ago when I first came, I couldn't talk to him, nobody about it...Then I worked with a lady up in \_ and she was like \_ you've got to talk about it because if you don't talk about it you're gonna keep that stuff jammed down and then you're going to continue to be sick. And you want to stop being sick so you have to talk about it. If you don't talk about it, then it's right

there stuffed in and you're just like a bomb waiting to explode on the next person that comes to you.

### **Relationships**

Relational theory suggests that women need to connect with others in order to develop a sense of self or self-worth (Bylington, 1997; Jordan, Kaplan, & Miller, 1991; Miller, 1976). One particular woman, Hope, expressed her need to connect with others while in prison:

Because I really don't want to come back in prison. I don't want to live that life that I used to live being alone all the time, nobody to talk to. And really I didn't want to talk to nobody. I was holding all of it in. And it was really a sad life and I see that now and I have really a sad life. Being alone all the time and not having nobody to talk to or socialize with. I need my family.

Bianca also expressed the importance of having relationships (sexual or non-sexual) within the prison environment to help cope with prison life. She said she would purposely isolate herself from others and no one to talk to about her feelings. She felt she was storing up all sorts of feelings and wanted to eventually open up to others. Bianca wanted a family connection with other women and desired a partnership. Bianca spoke on the concept of "gay for the stay" which means women who consider themselves heterosexual have sexual relationships with women while "staying" in prison, thus the name, "gay for the stay." However, Bianca did not want to discuss her sexual relationships with her counselor because she feared getting in "trouble".

And that's because they are missing that companionship with a man on the streets. So they find it in women here and they just be abused while they are here.... So I

mean, yeah, I think they should be allowed to talk about that. Because a lot of women, even myself, I have. I've been with females in the prison system and that's because I was looking for love in all the wrong places. And **I didn't talk about that** with my counselor because I felt, well don't talk about that, I don't want to get in trouble you know, because I'm doing something I'm really not supposed to be doing but...

I didn't want to talk about that" was unclear in meaning: Was she worried about being punished? Or feeling judged for being "gay for the stay"

Several of the women spoke about feeling judged by their counselors, guards, or other inmates for having mental health issues. This led to feelings of a lack of support.

- Karen: So I felt like it's somebody I can talk to I can vent with. You know, because I do have issues or I ain't feeling right, you know. Or, I don't know, they say that if we really, really need a see somebody, we just ask the guard "can I get a pass and go see somebody", "I don't feel right", we can just come over and get some help.
- Hope: I have a roommate now, she's a mental health patient and a lot of people didn't want to live with her... And she been in my room, she's no problem, she talks to me... I said, people don't like to be made fun of... It's like they're diseased or something... They don't want to come down because they think they'll get labeled as being crazy or mentally ill. ...They'll say go get your skittles, when they say go to med line. A lot of peoples like, well just go get your skittles. Well if you only knew that if I didn't take these skittles, you wouldn't like the person that I am today.



The most frequent reason cited by the participants for why other women do not seek mental health services was the stigma associated with mental illness and seeking treatment. The women summarized that within the prison walls a woman who was seen as emotionally “weak” could become a target of harassment and further isolation from the other inmates. These women were not able to escape the teasing or harassment from others which could well impair their course of treatment and long term progression. As Hope pointed out, the “skittles” (which was a negative label for psychiatric medication) was used to belittle the women seeking medical sources. Harassment from other inmates can impact whether or not the women attend their sessions, which can impact their overall mental health and/or their relationship with others, including their mental health professional. Hope purposely decided to help another inmate deal with the bullying and stigma of mental illness. Numerous female inmates, who could benefit from utilizing mental health services, will never receive help due to the overwhelming stigma toward mental healthcare within prison culture. None of the participants admitted to bullying others, therefore I was not able to gather meaning to the purpose or function of bullying others with mental illnesses. I was able to hear stories like Hope’s, which consisted of protecting other inmates from bullying, gaining resilience to continue treatment, and debunking the misconceptions about mental illnesses.

### **Punishment**

The hole is a small prison cell in which an inmate is isolated from everyone for short or long durations of time, “they end up right back in the hole”. This location represented the primary authoritative punishment for women who were suspected/found guilty of disobeying the prison rules or if a women appeared to be severely

psychologically unpredictable. Many of the women compared the mental ward to “the hole” and spoke about their fears of being in “the hole.”

- Karen: They’ll just say you just stay over there longer since you keep checking in that you have issues. You know. They gonna lock you up in a room like you are in a hole, instead of making us feel like we are in one of the dormitories, but over here we are just sitting around having counseling with each other, over here, you know what I’m saying...But when they get full they really don’t throw them over in a space and then they treat you like you in the hole, doing time like they is because they keep them locked up behind the door which is fine. That you go behind this (mental ward) door. They make you feel like you just locked in the hole.
- Jackie: Whether they have it or not, the hole is not a dungeon either. It’s you know, work can be done in there too. Spiritually, mentally and all that. So it is an opportunity, as long as there is life, there is hope.
- Stacy: Cause for example, some of the people need heavier medication than others. The medication, the number one side effect with me is it makes you drowsy. And real sleepy. Okay you get up and you on your medication, you take it every day, you go over there and you sleep during count time, you wrote up. You might get put in the hole. See that’s the stuff that don’t need to happen. The officers probably don’t know that; then they end up right back in the hole or in here; they just don’t care. They need some professional help; they don’t need to be in prison.

- Bianca: Instead of me exploding on the dorm, exploding before I can even get to the psychiatrist or they done hand cuffed me, took me to the hole or something. The “hole” was one of the primary complaints about the mental health system in this data. Time spent in the hole was vaguely discussed; an exact duration was never expressed but stints of days, weeks and months were implied and later affirmed by the social worker. Ten of the women feared being placed in the “hole” and as a result concealed important information from their counselors such as suicidal ideations, sexual relationships, anger, and triggers related to PTSD. Only Jackie shared a spiritual benefit of the “hole,” but overall, the hole was seen as a controlling mechanism to keep the women confined and conformed.

### **Cultural Implications**

#### **Religion and Spirituality**

Eleven of 12 women self- identified as being either religious or spiritual and reported using their beliefs as a coping mechanism in and/or out of the counseling session. Most conveyed that their counselor did not ask about their beliefs, but the women self-disclosed their beliefs within the session. The theme of religion and/or spirituality was discussed in terms of resources, support, self concept or coping skills promoted by the penal system. Some insights they shared included the following:

- Grace: Because I was all banged up from the wreck and I was in the hospital for a couple months. But I was not only going to need physical care, but I would also need mental care, emotional care and spiritual care. And he was right... As I have been able to move to getting all of those things that is when I really have seen the most improvement... We have plenty of church services available to us.

Chaplin \_ just left, was a very wonderful minister. He would meet with you pretty much anytime. Whether it was technically open door or not. If you went in and said, 'I'm really struggling with this right now,' he would see you pretty much any time...He was very helpful... I talked to her (counselor) about everything. I haven't held anything back from her because I want so desperately to get better. You know, and to have some sort of a normal life, whatever normal is.

- Deanna: I don't know if it's the Prozac or not that really helped me out of it, maybe a little bit, but I just started praying a lot, like crazy.
- Jackie: In my own case, with Ms. Smith, because my thought on life often goes to the spiritual realm, and to I mean, I guess everybody does to an extent. But she's very open as far as listening to me on that level. She'll even make comments, you know, and the look in her eyes, you know, that I'm not some creature from out of space, but that's she's listening and hearing what I'm saying and there is a connection there I mean, our minds, our brains, constantly go or sleeping as well. But you know it especially has to do with the heart and the soul, it is very spiritual, but you can fill up with knowledge and retrain. I have. I did. I am learning that. You can retrain your thoughts and it you may come out feeling differently...In fact I am in the \_ program which is called the \_ program. It's over in \_ house. They call it the Christian program. I've heard about it for years, and I just recently got involved in it. And we've always made fun of those people, like those people think they're, you know, top shelf and they are Christians and all they are all better than us. But what it is really is just it's a programming of \_

based on the Bible and these leaders, the director and there is another lady under her and then there's another one that comes in. But they care...and are there, and are Christians. And you know before going in that it is all going to be based on Jesus Christ. You don't have to be Christian to even get accepted into the program, but yeah... But for real, when the Lord just given me the grace to look at things differently and I believe it's only really through him that I am able to... Not that everything is perfect, you know, but it is a process and I believe that it is. Whether the Prozac is helping me, you know, maintaining that belief.

- Maria: Yes your spirituality will affect your whole life. I'm a very spiritual person now. I always have been but I believe that since coming to prison, I've been rescued by God.

The prison had several religious/spiritual support groups for the women. Several of the women used these groups for support, and other women relied on private conversations with their counselors to conceptualize their worldview and create healthier coping skills. Religion/spiritual services provided social and personal support for coping and company (Ventis, 1995). The concept of a higher power gave several women an outlet to create spiritual meaning of their experiences, a support system to build relationships for resources (such as post release services), and a path for recovery. Religion for some women provided a structure of beliefs and behaviors to decrease their feelings of shame and guilt stemmed from past experiences. In addition, religion/spiritual beliefs helped decrease feelings of guilt, shame, and emotional healing.

**Race and poverty**

Women who live within the legal system face many levels of oppression. The criminal justice system continues to perpetuate the subordination of mostly minority women and women with lower economic status (Grana, 2010). In 2007, the US had 12.5% of the population living in poverty, of which 54% were female-headed households with children under the age of six. Most of these mothers were African American and Hispanic (Twaddle et al., 2006; Youman et al., 2010). Particularly in the US, the risks for African American women of being imprisoned in 2010 were nearly three times higher than white nonHispanic women. The Bureau Justice Statistics (2012) estimated that the rate of sentenced women prisoners under state and federal jurisdiction, per 100,000 U.S. residents, were 47% white women imprisoned, 133% black women imprisoned, and 77% Hispanic women imprisoned.

In this study, 6 out of 12 participants identified themselves as African American, African or other. When I asked if race was an issue, only one participant said yes and shared her stories of racism. With more time or a different set of questions I might have been able to explore deeper racial tensions, but I noticed that all but one participant did not appear concerned about this particular cultural identifier within the working relationship.

The women spoke about the staff, relations with other inmates, and mental health professionals, but there were undertones of race issues in the prison culture that were evident in the interviews. A few participants narrowed in explicitly on their racial experiences:

- Atia: Now my doctor, he's a white man, and he's understanding too. I mean, he's kind of the - I understand where you're coming from because we was born back in the days that I was born back in the days and he knows about the oppression and stuff.
- Hope: I think a lot of people should look at African American women with an open mind because of their upbringing in America. People my age was raised back in the depression time and all the KKK and all that. But the younger generation was raised differently. They are more on the side of the track where they want to not be judged, but then they judge, and African American woman are guarded with their feelings and you have to be, like I said, listen to them closely because sometimes they will express themselves in a manner that you are not used to hearing. You might take offense to some of the things they say. Which they might not mean to offend you...That's how they express themselves and I think doing therapy for African American women you have to listen and be open minded. You know with what they say. You know because some things may come out different.

Themes from the data showed that a few women expressed a preference for same-race mental health professionals but remained open to receiving services from those of a different race and/or ethnicity, as long as the professional validated their racial differences. It appeared beneficial to bring up racial and/or ethnic background, exploring communication styles, discussing feelings about the meaning of counseling and the dynamic of the relationship. Hope appreciated the opportunity to be honest about her distrust towards white professionals. She discussed the historical context which led to her

present racial concerns related to trust and she emphasized the importance of understanding the meaning of African American women's realities ("things they say"). The women felt that the mental health professional should be culturally competent, especially from the perspective of the women of color; understanding their worldviews was validating and important for trust to develop within the relationship. Regarding mental health services, economics surfaced more often than race. The women who had family with economic resources talked more about post release resources than those who had no financial resources. Most women who had been exposed to prior mental health services came from families who supported their wellness process.

### **Gender Connections**

Psychological distress, resulting from trauma exposure such as abuse, needs to be recognized and respected when implementing mental health services and responding appropriately to females in the criminal justice system. A mounting body of literature supports the need for gender responsive practice to acknowledge the realities of female inmates' lives, especially with regard to histories of abuse (Bloom & Covington, 2009). Overall, the women expressed that the gender of their counselor affected their relationship and their ability to self-disclose about previous traumas. As a result, some participants felt their counselor should talk to them about their relationship dynamics related to gender.

- Stacy: Yeah they should take [gender] into consideration. Because there is a lot of girls here that's just been beat so bad by their spouses and boyfriends.
- Grace: There are a lot of things from our past that you feel are very shameful and we're gonna keep it secret and if we have a woman that we have actually learned



to trust, it is easier to talk to them about it....There was some sexual abuse, for me when I was about 12 or 13 years old and I have been able to discuss some of that with her... I don't think I would have ever been able to discuss that with a man.

- Deanna: Yeah, because I would rather talk to a woman, because I'm a woman. It's more comfortable...I would rather have, I think it matters, especially for a woman, I would rather talk to a woman. I don't want to talk to a man.

Ten of 12 women preferred a female counselor than a male counselor. Themes reflected the preference of a same sex counselor due to the sexist context of the overall social system and its impact on the individual and the family. Female counselors were perceived as being "easier" to talk to due to previous victimization by men onto these female inmates.

For a few participants who were currently seeing a male counselor, they appeared to be content with the relationship and felt that the gender of their counselor did not interfere with the relationship:

- Annie: It really don't bother me....I don't think it really makes a difference.
- Karen: He never asks...I enjoy my counselor, not because he is male. I mean he makes me feel like he doesn't have an issue with me being a female or colored or being that way.

Overall, the themes that emerged from the transcript analyses demonstrated that the women were willing to have a male counselor, but may limit their self-disclosures because of previous abuse from men. While in their sessions with a counselor, eight of 12 women focused on presenting problems and avoided discussing past sexual and/or physical abuse. One particular woman felt the entire prison system should be made up of

only women staff and professionals due to the high prevalence of abused women within the correctional system.

Therapy should begin early in a woman's prison term to help provide her with the tools and encouragement to deal with the oppressive and contradicting nature of the criminal justice system and to emotionally help prepare her for post-prison life. In addition, counselors should use a cultural lens to understand how cultural variables intersect with one another, creating a matrix within the working therapeutic relationship. Atia captures woman's way of knowing in a thoughtful way:

Counselors should understand that women have a lot of issues and it's hard to pick one of those issues because they collide with each other. I think it is important that a counselor listen closely to a female. Because when she's talking, there's a story there. And you might miss it if you're not listening. Because a story doesn't just start at the beginning. And if a women tends to work herself around the story. . . and if you listen closely, you'll hear the story told.

Atia's perspective about her experience within the session illuminated the importance of understanding, being open-minded, and emotionally present with the client. She suggested that mental health professionals be active listeners to the personal journeys of each woman and recognize that there will be different tellings of these stories, but the story is there and important. Atia's statement was extremely powerful to me because I interpreted her words as meaning that all women are worth listening to and have a story worth telling; therefore, mental health professionals should have the ability to understand the client's worldview and empathize with their clients by listening to their stories.

## Age

The mean age of participants in this study was 43 years (range: 32 years to 55 years). The seasoned women (those who have spent most time in prison) were usually in their 40's or older; they exhibited perspectives of increased distrust towards the mental health professionals and overall prison staff. The sentencing duration seemed to influence the overall mental health experience of these women who expressed frustration and disappointment about their treatment and progress. If the seasoned woman was African American or African, she reported experiencing and witnessing more oppressive events and indicated stronger distrust towards the overall judicial system. Some of the more hostile participants had been incarcerated for a long time and had extensive disciplinary problems (e.g. "the hole").

- Hope, "Um, some days I come in and I'm talkative. Some days I come in and I just want to sit. And some days I cry. Get a crying spell out because I miss my family. I don't cry in population. I've got too much pride to cry in front of everybody so I can come over here and release my tears... He (counselor) knows that I'm frustrated a lot you know from knowing me since... And my problem is people judging me and trying to tell me what to do and control my every move and my every thought, my every feeling."

Overall, all of the woman felt that the quality of experiences for incarcerated women receiving mental health services in a correctional facility could improve in areas of assessment and diagnosis, substance abuse and trauma focused treatment, relationships, and punishment policies. The overall quality of experiences were also

impacted by cultural implications including religion and spirituality, race and poverty, gender connections, and age.

**Research Question 3: What are suggested improvements for the mental health services in the prison system identified by client?**

**Level of Mental Health Service Availability**

The process of being placed with a counselor starts at the very beginning of an inmate's prison arrival. Eight of the 12 participants were provided mental health services after their initial intake into the correctional system. Some initially met with their counselors weekly, then monthly, and now meet every other month. Others started with monthly meetings, then bimonthly, and now every three months. Several commented on a stigma attached to going to a counselor too often, so they chose not to seek meetings more often for fear of teasing or harrassment. Eleven participants had previous counseling services on the "street," but there were mixed reviews on whether those services helped their situations. Some services were conducted at hospitals with limited sessions, six or less, or at non-profit agencies with limited staff and resources. Most women disclosed that they were displeased with their previous counseling experiences due to the limited social, emotional and financial resources, very limited sessions, inexperienced mental health professionals, and negative attitudes from professionals or staff members. The primary complaint was the unproductivity of past services and the lack of compassion from past mental health professionals which influenced their resistance and mistrust towards their new counselors.

All participants completed a counseling service demographic survey (Appendix E). Survey results are summarized in Table 2.

TABLE 2: TABLE ABOUT COUNSELING SERVICES

N	Referral Source	Number of session(s) per month Avg. length of session Total amt of counseling experience	Received treatment before incarceration	Overall satisfaction of counseling experience 1-10.1=totally effective. 10=totally not effective.
Annie	Initial intake	1x 3mo 31-45 min 11mo total	Y	1
Atia	Initial intake	1x 2mo 46-60 min 24 mo total	Y	1
Karen	Initial intake	1x mo 60-90 min 17 mo total	Y	3
Grace	Initial intake	1x mo Varies 11 mo total	Y	3
Deana	Referral	1x mo Less 15min 27 mo total	Y	3
Elaine	Initial intake	1x mo 15-30 min 13 mo total	Y	5
Jackie	Initial intake	1x mo 15-30 min 10 mo total	Y	4
Stacy	Case worker	1xmo 31-45 min 16 mo total	Y	5
Maria	Referral	1x mo 15-30 min 25 months total	Y	7
Hope	Initial intake	1x mo 15-30 min 28 months total	Y	4
Laura	Nurse	2x mo 15-30 min 108 months total	Y	5
Bianca	Initial intake	1x mo Less 15min 11 months total	N	6
	Initial intake =8 Reference=		Y=11 N=1	Avg 3.41

	2 Case worker=1 Nurse =1			
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At this particular correctional setting there are about five to six full-time counselors that serve an inmate population of some 1,500 persons. Access to (and frequency) of mental health care was the most prevalent criticism given by inmates when asked about mental health services delivery.

- Karen: I don't feel like we can just go see our counselor when we want to. Or in an emergency. Even if I have an emergency I can't just get in to see my counselor.
- Jackie: I suppose if I was unhappy, I could (change counselors); I don't even know, because our rights are limited.
- Stacy: that would be the first thing I would want in there... an education program. I would make sure that each individual had one special person doctor or whatever therapist you want to call it. That any time you needed them, they could get a hold of them; they could be available to talk to them about anything. Because once, you know if you get a woman and you call her at 2:00am in the morning and say "I can't sleep, I'm having bad dreams, I'm going through something really bad." She said, "okay, I'll try to make it over there"
- Bianca: Yeah, and I've never taken other classes down here. I mean I've signed up for a couple of the classes, like the cognitive thinking and the thinking errors but I haven't gotten into any. And it's hard to get in classes.

Most women hoped for more time in the session with their counselor. Five women said their average session time was 15-30 minutes. Two women met with their counselors for

less than 15 minutes, another two women met for 31-45 minutes, one woman 46-60 minutes, one woman 60-90 minutes, and the last woman said “it varies.” Concerns about the flexibility of counselors to meet more often with their clients or increase the duration of the counseling session were scattered throughout the interviews. All the women agreed that mental health services should be as needed and available day or night. The themes showed services should address the presenting problems at their level of intensity and should be a collaborative decision on the number and length of sessions.

### **Gender Focused Treatment**

There is a need to develop a gender-responsive mental health treatment that allows the different parties involved with the criminal justice system to collaborate in order to help female inmates with mental health issues and not reinforce punishment as a counseling technique. A primary concern about the treatment programs is the concept that clients’ mental health problems were viewed as internal to one’s self and not due to the oppressive nature of the larger society. U.S. society generally attributes mental health issues to the individual and ignores societal issues that contribute to psychological distress (Worell & Remer, 2003).

Mental health treatments in prisons cannot necessarily meet all of the needs of female clients because of the controlling penal culture dominated by men (Cohen, 1985; McCorkel, 2004; Pollack, 2007). Males (and some females) are prominent in authoritarian roles in female prison systems, allowing them to reinforce the gender hierarchy. Stacey echoed these concerns and provided her solution to helping women feel less oppressed within the penal culture:

- Stacy: I mean I don't even think there should be male staff working there at all... Cause they (women) understand us. You know. ...That's why sometimes women go with other women because they, they've been abused by men so much they know another women in here and she want feel and be treated so, you know what I'm saying. That's what leads to that...They have a good aura with each other. And that's how I feel it should be. Everything shouldn't be prison like. There's some kids in here now in my house...I think they should focus more on the gender and get a place for all girls and all women, where you can get the help. All women feel comfortable talking to women. I don't care what nobody say. They can say it's a man. But I'm telling you, when you got a doctor or counselor, I'm ready for a woman to be my doctor or counselor any day, then a man. And I don't dislike men, it's just, they ain't got the same outlook as me.
- Bianca: Better doctors, because maybe some females. ... In a female institution.

Karen, on the other hand, felt she could open up to her male counselor but was not sure if he kept her information confidential.

My most important part with a counselor, definitely he listen to me. Hear me out. If I'm having an issue at that moment, a serious issue, I mean, you know, they let you know that we will have to, you know, when I'm feeling like I'm having a suicide thoughts, like they was concerned enough to get me to emergency across the hall because they usually have a counselor on the other side. You know go over there and get some help so. My main concern about counseling, they do



care, and they get things done, now like I say, we don't know if they keep this stuff personal.

As mentioned in my analysis of research question two, overall the women felt they could talk to their male counselors, but 10 women openly admitted their preference for female counselors due to past traumas and feeling they had more in common with female counselors and could learn from them more easily.

- Deanna: I think someone who has experience and has actually experienced and knows what it actually feels like...Somebody that actually, like I think would be a good one [counselor] because I've had things happen to me and I can go, yeah, I know exactly what's going on with you. Like I had that happen to me. I don't think so much just learning it out of a book is going to get you there.
- Elaine: One that understands, one that's been there... just let me know that there's a better life out there. You know, that they made it...That they made it a better self of them... That way I don't feel all alone.

In addition to learning from their counselors' life experiences, Annie felt the counselors should also be aware of non-verbals, and the counselors should ask questions from past sessions to show that they cared and listened. Atia added counselors should be aware of a woman's style of communication, as "a woman tends to work herself around the story." Thus, the common themes that emerged were patterns of gender related forms of communication, relationships, commonalities, trust, and safety.

### **Group Support and Group Class**

Deanna experienced many traumas in her past and felt a need for social support to help her cope with these experiences. Her concern for lack of social support was echoed throughout the questions on group support.

- Deanna: it would be nice if, I don't know, groups that you could trust each other...Group therapy where like your times were alike or maybe something in your life that maybe a support group for women whose children are not speaking to them, or you know, who have no family support out there and you know, what can you do, can you call churches maybe and ask them for help. What do you do....Yeah, more group, support groups and stuff... That would be good. Instead of just being like a grief and loss class, or... Because in here some people are afraid to talk. They will come and we will have group classes and they don't want to say anything because they don't want her to say something to somebody to somebody, we're gonna keep this all to our stuff [self?] but people don't.

Hope indicated that she had been attending a small group for abuse survivors, but it is run from an outside organization and their meetings are limited. She thought more psycho-educational classes should be offered for the women in prison to help them become more educated about their mental illnesses. Elaine echoed Hope's recommendations:

- Elaine: Personally I would like to see more classes added that are realistic...You know stress, stuff that helps us. Not saying trauma and stuff like that doesn't help us which is does. But stress and, you know, anger management when we get out there on the grounds. Which is common classes we need....They are offered

about every 6-8 weeks....I took depression [class]...And I really enjoyed it. And they made me stop and think about a lot of things.

Whether it was support groups or group classes, these resources were in high demand.

All 12 women agreed that these resources should be offered for all women and accessibility to these resources should be unlimited.

### **Medication**

Medication management appeared to be assessed when entering the prison system for all women. For Maria she felt the system failed many women initially by placing them on the wrong medication or over medicating them. "I don't think that it's good in here, at all. This right here is a hostile environment. And I mean, they put you on medication... So they should do deeper mental health evaluations on people..." Deanna was resistant to using medication when she entered the prison system, but with time she changed her mind. Deanna shared her story of her traumatic spiral downward due to her medication changes and lack of mental health services on the outside. Prior to prison, she said she was on strong medication which caused her to be very depressed; she was suicidal, and in and out of hospitals for a few years: "Every time it was just worse and worse and they just kept, you know, adding more medicine, changing medicine and it just kept getting worse and worse and worse." Deanna felt her life spinning out of control and believed that no one took her pain seriously. She felt so hopeless that she wanted it to all to end. She shared, "So I finally had decided to buy a gun, because I was going to kill myself with it and then I ended up shooting somebody."

Deanna was terrified to get back on medication when she entered the prison system, "I didn't want to take any other medicines. I was like, oh my God, I'm not going

down that road again.” But after a suicide attempt, the prison placed her in a mental health program off of the prison site. There she received counseling, group support, and medication: “It’s like, so now I’m doing great. It’s not so hard. As long as you have somebody that gives a shit... If nobody else cares it makes you not care.” The relationship Deanna had with her counselor was the best medicine she ever experienced: “She would like relate to you more like you were a human, rather than a prisoner.” With the right medication management, Deanna was willing to try another medication which has helped her psychologically and emotionally.

Other women shared stories of how medicine helped them with their progress.

- Karen: I know, because I’ve been manic depressed for a while. And to be in your world you feel like you’re all alone and just think about your own thought. Our thoughts ain’t right. You know, but what I’m saying and I’m in denial, you know, I would accept I need medication, it’s good to have somebody to talk to. Or say I’ve got to at least take medication or for a while, might need some new adjustments.
- Jackie: My mind set has changed as far as psych meds and I mean I used to be just so adamant against them; I think it’s because of the way I was raised which is a very Bible based home. I was going to say religious, but not just religion as such but just whatever needs that I have God can meet that. And I truly believe that.
- Atia: I was just like they’re trying to medicate me and they trying to give me something to act like I’m a robot you know. I thought that’s what medication was for, to make me act like a robot. ...And this medication doesn’t make me feel like that. I don’t have no side effects. Only really side effect I have is that is bloats

my stomach up. Which I'm old anyway. Old age spread is what I call it. But that's my problem was I didn't want to be controlled like that. And this medicine does not make me feel like I'm controlled in any way.

- Hope: And I'm pretty glad that they gave me some medication that they thought would help me.... I 'm tired of taking these meds. And then I start laughing to myself, you don't want to stop taking these meds, you know you like taking these meds. Because I don't want to go back to being the way I was for real.

With proper assessment and diagnosis, medication management appeared to be a primary influence on the psychological well-being of the woman. Maria's concern of women being controlled by the use of medication has been reflected in literature about keeping women conformed within the penal system. Then there is Deanna's story of how she was able to receive the proper medication that helped her process of self-recovery. Both stories illuminate the importance of enhancing medication management for women within the penal system, so women receive the proper treatment for personal growth.

### **Post release resources**

Post release resources were valued as an important topic to discuss during the session. One particular woman, Maria, was going to be released four months after the completion of this study and her primary concern was the lack of post release resources and the lack of concern from her mental health professional. She desired that her therapist would process with her the anxieties, fears and transitional issues associated with the transition. I was warned that she might be "rowdy" with "anger issues" or appear "negative" about her experiences within the prison system. Once I heard these concerns I was even more inclined to hear her stories. Once she entered the office, I

informed her of the goal of the study and she immediately agreed and added that more research needed to be done about services within the prison system. She talked for an hour and a half and I could have easily listened to more hours.. I could feel her frustrations of living behind the walls and her loneliness of being away from family and friends for many years. She had spent much of her adult life behind these walls and she was soon going to be released without any preparation for her newfound freedom. She disclosed that she had shared these concerns with her counselor, but he did not seem to focus on this presenting issue, thus, causing her to feel even more “lost” about what to do once she walked out of those heavy doors.

Her concern echoed the same fears of other women who will be back in society in the near future. Second chances are hard to come by, and, for many of these women, the first chance did not go so well. I thought about this concept on my way home. Maria did not know anything about current resources in our society, such as cell phones, Internet, cars, gadgets, social agencies, and so much more. She was entering a society that has changed so much over the past 20 years and relies so much on technology and new knowledge. Not having the emotional support or economic resources to create an independent life can be too difficult for a single minority female with a prison past. I wondered what would become of her new “freedom.” Maria’s concerns were shared by others:

- Karen: Yes. Especially up in here, even on the streets, to me life is a separate world outside. I feel, and I still feel that way today, it’s just when you ain’t ever had nobody to just talk to, hear you out. That kind of helps. That do kind of helps. Or like the last time I left here, I was seeing Ms. Smith, she was like a

counselor to me and I would ask her how can I get mental health on the street and she kind of looked it up, tried to call it up, you know.

- Bianca: And so he was like, what do you want to go to school to be. And I said I want to go to cosmetology and that's what I want to do. And he was like telling me where there's some really good schools, like in \_ and then there is a lady that teaches across here and has a friend that owns a place in \_. So he was just, you know, telling me like, helping me, you know.
- Deanna: I mean there should be somebody available so if you were just having a hard time out there and you know, especially after you've been kept locked up for a long time.
- Researcher: Adjusting?
- Deanna: It's going to be weird....It's going to be hard adjusting. Yeah, it would be nice to have somebody, that could, you know, that say you couldn't find a job, that maybe somebody could help you find a job, you know an apartment, or maybe get you some funding for clothes to get you started or something like that...Because there are a lot of people that don't have help and don't, even if they did have help when they were in here, when they get on the streets.

Post release resources that the women desired included mental health, educational, employment and financial needs. All 12 women had hope that they would eventually leave this prison and return to the outside world. The proper resources and social support should be in place to help these women from reoffending. This reality and the danger of coming back is present in their minds, but appears to not be discussed or

dismantled within the counseling process. More work should be done to prepare female inmates to reenter society, so they may transition with ease and less anxiety.

### **Conclusion**

In sum, all of the female inmates receiving mental health services supported the use of counseling within a penal system. The female inmates believed they did have a working alliance with their mental health professional which, given the constraints of a prison environment, is a strong endorsement I think. In line with Covington and Bloom (2006), I found gendered practices in the justice system that some of the women inmates acknowledged but others did not.

Some mental health professional practices were reminiscent of what would today be labeled traditional patriarchal psychotherapy that does not align with feminist theories as discussed in Chapter two. Despite prisons being one of the most gendered institutions in the United States (Silberman, 2007), I believe, with awareness and understanding, clients can feel empowered and in control of some factors in their lives, and therefore can make decisions that will support positive development.

Many of the women spoke about practical improvements the penal system could make to help ensure a better quality of mental health services. These included counseling availability, gender focused treatment, medication management, support groups and classes, and post- release resources. It was these basic but powerful elements that stood out, by those receiving counseling, as critical to their success in healing and moving onto life after prison. By not implementing more effective treatments, we will increase the probability for inmates with mental illnesses will likely reoffend.



## CHAPTER FIVE

## DISCUSSION, IMPLICATIONS AND RECOMMENDATIONS

**Discussion of Results**

Many of the participants in this study shared amazing stories of strength and appreciation of the services they received, while other participants shared disappointing stories of how they felt the mental health system and/or the correctional system has failed them. The first day I arrived for interviews, a case worker expressed to me that the prison population had increased over the last few years because the government had shut down mental health facilities and as a result, “some of these participants should not be here.” Eleven of the participants I interviewed had children; though some of the children were now adults; their mothers were in prison and families were broken. The mothers and children were suffering the consequences that could have been avoided if mental health resources had been available for those needing help prior to entering the penal system.

I approached the interviews with this systemic awareness and remained empathic with all the participants. The participants were kind, open to share their stories and, most of all, they wanted their stories to help make a positive overall difference for women receiving mental health services in the correctional system. They were motivated to make beneficial recommendations for me to share with professionals and they wanted to see these recommendations help all women.

As Horvath and Bedi (2002), Bordin (1994), and many other scholars found in four generations of research, the participants in the current study indicated improvement in their overall mental health due to their relationships with their counselors based on the qualities of a working alliance. There was a perception among all the participants that

there was a positive working alliance with their mental health professionals. Their definition of the working alliance was influenced by three common themes: 1) Trust, 2) Positive regard and empathy, and 3) Collaboration and goal consensus. As a counselor, I was excited to hear all 12 participants articulate positive traits about their relationships with their counselors, but it also surprised me because I had read research to indicate that, within the penal system, clients perceive judgment and/or mistrust from their counselors. I was glad to know that the counselors working with the participants, in this study, appeared to be effective and respected by their clients.

Similar to the analysis of Ackerman and Hilsenroth (2003), I found it was important for participants to need time in order to build trust towards their counselor and to perceive the counselor as being honest “real”, and trustworthy. Participants were able to share the perception of their counselors being honest and trustworthy through the following counseling techniques: keeping client information confidential, not reporting “deviant” behavior to staff, disclosing personal information during the session, remaining transparent, and empowering the client to determine her own level of trust and disclosure. Ten of the participants reported that at the beginning of the counseling experience they felt distrust towards anyone in the penal system, but at the time of the interviews, they said they could trust their counselor. When defining trust, there were variations in meanings among participants, and each participant had her own limitations on how much she would disclose to her counselor. Although I perceived these notions as incongruities, the participants did not seem aware of their contradictions and generalized the relationship as trustworthy.

Roger's core conditions, as described in chapter two, were also implicated in the themes of a positive working alliance. Several participants reported acceptance and empathy when expressing how they believed their counselors showed positive regard. Participants were able to share their perceptions of positive regard and empathy by the following counselor characteristics: capacity to accurately listen reflectively, summarize, and paraphrase without judgment, validate client's individual experiences without judgment, and express unconditional positive regard verbally and non-verbally. The participants reported that a counselor should not be judgmental and should see his or her clients as "human beings." Participants also wanted their counselor to empathize with them and see the good in them. I believed that unconditional positive regard is the most important characteristic influencing the outcome of psychotherapy, especially in a penal environment. During my experience, I perceived the penal system as an institution of social judgment. I believed, within the counseling process, unconditional positive regard toward the participants was needed to dismantle self shame and judgment.

Feminist therapy implications, as described in chapter two, were also indicated in the themes of a positive working alliance. In this study, participants reported that the abandonment of hierarchical relationships between client and counselor was essential for empowerment of the client and increased self-efficacy. Ten participants said collaboration within the working alliance was promoted by their counselor, empowering the participant to be the expert on her own life. Two participants deferred to their counselor for the authoritative consensus process, but also expressed that their counselors also wanted the participants' input on the decision making. These two participants did not feel that an egalitarian relationship with a counselor was essential for a working

alliance and believed the counselor was the “expert”. These two participants also felt since they had made criminal mistakes, they were not in a position to make the proper decisions to make healthier choices and foster full autonomy.

Several themes emerged under overall quality of the mental health services: 1) Assessment and Diagnosis, 2) Substance Abuse Treatment and Trauma, 3) Relationships (support), and 4) Punishment (the “hole”). The participants disclosed discontented feelings for the assessment and diagnosis process when entering the penal system. At a time when they reported feeling “scared”, a stranger (mental health professional) was obtaining personal information to make a quick judgment on their mental health. Participants reported mental health treatment as mostly medication modification and brief counseling sessions. Nine participants reported seeing their counselor once a month, or as needed. Although prison policy allowed the participants to see their counselors as much as needed; the participants reported that this would demonstrate weakness and they feared being bullied by other inmates.

Assessment, during the initial penal intake, was a time when the participants were diagnosed as being addicted to alcohol and/or drugs and recommended for psychoeducational classes. One participant believed she was not ready to work on her diagnosis at the time of intake, but, months later, she utilized her counseling sessions to analyze her negative coping skill of using substances to numb her emotional pain. Ten participants reported presenting issues of substance abuse in their sessions. In addition to learning about addiction recovery, 11 of the 12 participants identified needing trauma-informed services. Ten participants expressed that they had experienced past trauma and used drugs and/or alcohol to help them function in life.

The powerful moments in our interviews were the stories of past trauma; those were the moments I empathized with the participant's sadness, pain, and desperation, but those were also the moments I admired their strength and resilience. The trauma appeared to be the catalyst for future criminal behaviors that were impacted by the participants' maladaptive psychological coping mechanisms used to deal with underlying shame and/or pain from the trauma. Drug and/or alcohol usage appeared to be the most cited reason for their imprisonment.

One participant reported that she was in prison because she was drunk while driving and accidentally killed someone in a car accident. She shared that she had been struggling with alcoholism for years prior to the accident, was currently working on understanding the root of her addiction, and was learning to forgive herself for the unintentional death of another human being. She talked about using her time in prison to work on herself in several ways, such as emotionally, spiritually and physically. She said she wanted to discover the underlying ache that fueled her alcoholism and expressed remorse for the pain she caused others. I wondered how different her life would have been if she had received mental health services prior to the accident. I often found myself thinking about how we, as a community, could have been proactive and supportive in helping these participants before they ended up in the penal system.

The lack of social support transitioned into the lack of correctional support. Participants reported feeling judged by the correctional staff, inmates and, at least initially, by the mental health professionals; as a result, participants felt a lack of support. As described in chapter two, relational theory suggested that women needed to bond with others in order to develop a sense of self-worth (Bylington, 1997; Jordan, Kaplan, &

Miller, 1991; Miller, 1976). The participants reported the need for more support for women with mental health illnesses. Participants discussed concerns of stigma and bullying by others due to their diagnoses; therefore, friendships were rare and valued. The participants reported desires to bond with other women in several ways: emotional, physical (sexual or non-sexual), and spiritual. I found it was important for the participants to have the freedom to determine how they would bond with other women and how they would establish these friendships. One participant discussed the concept, “gay for the stay” as a form of relationship to help women cope with the isolation from their community, including loved ones. This participant said she was not gay, but during her penal time, her sense of worth was supported by a sexual and emotional relationship with another woman. Other forms of relationships reported by the participants included spiritual groups and/or spiritual mentors, other inmates, outside family and/or friends, counseling groups, and their counselors.

Relationships appeared to be influenced by cultural characteristics. While listening to their stories, I could hear similarities of cultural implications, such as issues surrounding religion and/or spirituality, race/ethnicity, age (mostly indicating time spent in prison), and sexual orientation. Nine participants identified as being religious and/or spiritual and felt comfortable discussing these cultural implications with their counselor and utilizing spiritual support groups. Through this study, I found that religion and/or spirituality was very important to these participants to help them cope with their current living situations. Religion and/or spirituality appeared to be a powerful value to make sense and meaning of their actions, thoughts and life circumstance. Participants used this cultural identity to empower themselves and/or each other during support groups. I also

noticed that participants associated with an outside church organization were more likely to receive post-release services from the organization.

During this study, I found that race and ethnicity impacted the development of friendships, or lack of friendships. There were a total of 12 participants: eight were White, three were African American, and one identified as biracial. I noticed the African American participants were more open to talk about racism and/or poverty in and out of the penal system. The White participants did not express concerns regarding racism, but instead appeared more concerned about the racial separation within the prison environment. I noticed the separation immediately myself. When I first walked onto the prison grounds, I saw a group of African American females hanging out by a picnic table and then I saw a group of White females hanging out at another picnic table; neither group interacted with each other. I felt that this racially polarized separation reflected the racial tension of the local Midwestern city, where, instead of picnic tables, the racial groups are segregated by cities and/or towns. This ongoing externalized racism was sad to witness and did not seem to be discussed within the counseling sessions. Only one participant reported that, due to her distrust of males, her counselor talked about racism, economic systems, and sexism on an ongoing basis and felt it was important to process her cultural identity about penal system. She seemed empowered during our interview to discuss these issues and brought to my attention the culture of sexual orientation. She explained she had answered “other” as her sexual orientation, but explained that may have been due to her many years in prison and not having a partner for a long period of time.

In this study, eight participants identified their sexual orientation as heterosexual, one lesbian, two bisexual and one, other. Sexual orientation was not deeply discussed and only one participant explained “gay for the stay” because she was not content with the process the penal system had in place for her sexual behaviors. She had spent time in the hole after being caught having physical interactions with other women. She believed she should not be punished for her actions and felt judged by the correctional staff. She withheld information from her counselor due to potential punishment; otherwise, the other participants did not seem concerned about discussing sexual orientation within the session. Since one participant had been punished due to her behaviors, I wondered how honest the other participants were with me about this topic. I wondered if they thought I would judge them, or tell someone else causing punitive measures or further stigma.

The mental health service with the most negative feedback was solitary confinement, termed by the participants as “the hole”. The hole was seen as a punitive mechanism, preventing inmates from disclosing to their mental health professionals issues such as suicidal ideations, thoughts of hurting others, and/or intimate behavior with other participants. Ten participants identified the hole as a controlling mechanism to keep the participants confined and conformed.

One woman shared that she had experienced suicidal ideations in the past but never disclosed this to her counselor because she did not want to be in solitary confinement. This was mostly seen as a reason to keep suicidal ideations a secret from mental health professionals. As a counselor, I was disturbed that participants were not disclosing their suicidal ideations to their counselors but could not fault them either. The hole sounded like an emotionally and physically cold place to send the participants for hours and/or



days alone with their thoughts. I was glad the participants were honest with me about their fears and concerns about the hole and I wanted to find a way to tell them that things will get better. I knew for many of the participants, their relationship with the hole would not get better and they would continue to keep secrets from their counselor to avoid the hole. Although earlier in the study the participants expressed trust towards their counselor, I realized that their trust had limitations.

In the meantime, all the participants expressed that they were still working on their own journeys and that they were determined to leave the correctional system to live normal lives on the outside. One particular participant was about to be released (within four months of the interview) and she expressed feelings of anxiety and fear of living on the outside after living in prison for over 25 years. She felt that she had no support to help her post release and she wanted her interview to make a difference for women needing mental health services. The participants who were closer to their release date appeared more open to sharing their dislikes about the system and had more recommendations to consider when revamping mental health services within the correctional system. In examining their suggested improvements for the mental health services in the prison system, I found five common themes: 1) Level of mental health service availability, 2) Gender focused treatment, 3) Group support and group class, 4) Medication, and 5) Post release resources.

At the time of the interviews, all the participants had been receiving counseling and/or psychiatric (medication) services for a long period of time; the shortest time of services recorded for a participant was ten months for both services and the longest recorded for another participant was 108 months for counseling. The average numbers for

counseling appointments were once every two-three months. For the purpose of my study, I focused on counseling services, but I did ask about psychiatric services and needs. I noticed that the relationships most appreciated by the participants were with their counselors and not their psychiatrists. Also I was surprised about the infrequent number of counseling appointments scheduled and the short length of the same sessions spent with their counselor.

From personal experience attending counseling sessions and being a licensed professional counselor, I recommend new clients attend weekly to bi-weekly counseling sessions for at least the first six months of counseling and then decrease the sessions if needed. The average length of a session ranged from 15-45 minutes. Two participants said their sessions were closer to an hour and another two participants said their sessions were about 15 minutes. I was concerned about the lack of time participants spent with their counselors and wondered if any counseling actually occurred, or if it was more of a check-in. In assessing the availability of resources, I also explored the gender dynamic of the working alliance.

The participants reported the concern that males were prominent in authoritarian roles in female prison systems and desired a female authority environment. Ten participants echoed these concerns and suggested the following recommendations: more female doctors, more female mental health professionals, more female correctional staff and more female focused resources. I found it was important for participants to express the importance for women to work with women, particularly women who had been abused by men. Nine participants openly admitted their preference for female counselors due to past traumas and felt they had more in common and more trust with female

counselors. Participants reported that support groups were helpful for survivors of abuse who wanted additional mental health services.

All participants reported the need for more group support and group classes for women. Two participants were specific, reporting more psychoeducational classes should be offered for the women in prison to help them become more educated about their mental illnesses. Recommendations for group classes included: psychoeducational groups on mental health disorders, trauma, stress, anger management, abuse survivors, and other forms of trauma. All 12 women agreed that these resources should be offered for all women and accessibility to these resources should be unlimited. In addition, participants felt utilizing the resources should be the choice of the inmate and not forced by the correctional system.

All participants agreed that the medication should be a choice and not forced onto anyone. I received the impression that the participants believed that overmedication was being pushed by the penal system to keep inmates under control and to sedate the inmates in an effort to decrease potentially defiant behavior. On the other hand, having medication was an option participants did not have on the outside due to lack financial resources, such as medical insurance. After one particular participant was assessed during her intake and then diagnosed as having bi-polar issues, she agreed to try medication to help with her bi-polar disorder; she attributed this recommendation as an instrumental step to her healing process. According to the participant, counseling sessions were most effective once her medication was regulated and she was able to process, without the extreme change in moods, within the sessions with her counselor. Medication modification is an example of a resource that was available in the penal system to help

this participant, but due to lack of financial resources outside incarceration, medication programs are often not available for clients to prevent regression of their mental health after incarceration.

The participants' post release resource needs included community mental health, education, employment and financial needs. One particular woman was going to be released soon after the completion of this study and her primary concern was the lack of post release resources. She said her mental health professional did not seem concerned about her upcoming life transition, and she desired that he would counsel her about her anxieties, fears and transitional issues associated with her new journey.

### **Implications for Practice**

The findings in this study have vast implications for counseling in the correctional system today. For positive changes to occur, mental health professionals should be educated and aware of the importance of creating a working alliance within a sexist institution, our correctional system (Bloom et al., 2003). The research in this study aligned with the research from Bush-Baskette (2004) who found that the working alliance between the mental health professional and client is more powerful than common treatment techniques, such as behavioral modification. In this research, I have given 12 female inmates receiving mental health services the voice to share their reflections and stories about how the mental health profession can support and implement services to empower and enhance the quality of care for female inmates. Based on the information I collected during our interviews, I have developed suggestions for enhancing the working alliance in the following areas: education and training on the correctional system, social

justice and advocacy, multicultural awareness of self and others, and implementation of intersectional feminist theory into counseling paradigm.

### **Education and training**

Counselor education programs need to include more training, within their curricula on populations within the criminal justice system, about how to build working alliances with this clientele. Currently, the American Correctional Association (ACA) requires defined competencies when working with clients within the prison system. These competences include the following: “knowledge in counseling, psychology, and related social sciences and the ability to apply the knowledge to corrections”, “skills in written and verbal communications,” “developing and maintaining good work relationships with offenders and other correctional personnel” (p.13). From the American Correctional Association (ACA) code of ethics one can add, “computer literacy, including the ability to learn, master and apply new technologies in the correctional setting” and “multicultural competence” (Sun, 2013, p.13).

One primary goal of correctional counseling is reducing recidivism by using social cognitive theory to help inmates understand and overcome their internal and external conflicts (ACA, 2012). Since many programs do not offer the specialty of correctional counseling, this theory should be introduced in all counseling curricula to expose students to the field, theory, and culture of the correctional system. Correctional counseling should be discussed further at local, national and international counseling conferences, local and national continuing education workshops, and counseling journals and scholarly publications. In addition to correctional counseling, there should be social

justice and advocacy training for counselors and student counselors regarding the correctional system.

### **Social justice and advocacy**

Social justice, as conceptualized by Goodman et al. (2004), is “the scholarship and professional action designed to change societal values, structures, policies, and practices, such that disadvantaged or marginalized groups gain increased access to these tools of self determination” (p. 795). The Council for Accreditation of Counseling and Related Educational Programs (CACREP) has incorporated social justice and multiculturalism throughout the 2009 standards for counseling programs. Therefore, multiculturalism and social justice are viewed as fundamental elements of a counselor’s professional identity, including education and training, and should be promoted for all counselors. To enhance this awareness, CACREP should include standards regarding correctional counseling and regarding social justice to advocate for the human rights of those receiving mental health services in the penal system. Based on this study’s findings, Figure 1 represents the relationship among factors involved in the working alliance. It is important to understand the correctional system and how individuality intersects with culture and oppression. For example, there is a need for better funding for mental health treatment for women in the prison system and mental health professionals should consider this injustice a social justice concern. The profession should collaborate with appropriate parties to request needed resources to improve the overall quality of services.



*Figure 1.* Comprehensive counseling model.

In feminist therapy, the abandonment of hierarchical relationships between client and therapist is essential for empowerment of the client and increased self-efficacy (Tong, 1998). This abandonment of hierarchical relationship was expressed by ten of the participants who commented that an egalitarian relationship between client and counselor was essential to the working alliance. Most participants in this study felt empowered to set their own goals and to learn to trust their own judgment and experiences within the therapeutic relationship.

Intersectional feminist theory addresses and explore the multiple oppressions of minority participants (Pearson, 2007). In this study, six of the participants identified themselves as minorities living in poverty and shared stories, either their own or about another's cultural clash within the penal system. Intersectional theory recognizes the existence of oppression, and examines the intersection of different forms of oppression as

mentioned in this study, such as race intersected with sexual orientation and gender (Collins, 2000; Ritzer, 2007; Tong 1998). Intersectional theory also examines how social and cultural meaning interact on many levels of societal inequalities, such as in the penal system, and throughout these participants' lives (Collins, 2000; Tong, 1998). This approach aligns with female inmates in this study because it recognizes the impact of extreme oppression and social constructs in the criminal justice system. The data in this study reflect the need for counselors to consider using intersectional theory, in addition to counseling theories (e.g. person-centered) in order to best understand the clients' worldviews and problems. By understanding the oppressive environment in which these women live, counselors can conceptualize the complexity of their clients' lives within the working relationship.

### **Limitations**

In this study, the participation recruitment process was problematic because I was unable to personally recruit the participants. Participants were asked over the phone by a caseworker if they wanted to participate in my study. I was not allowed to personally travel to each unit to discuss my study or to answer any questions about it. As a result, 12 out of 20 participants were recruited.

The findings did not necessarily represent the general population for female inmates since the sample only included 12 participants at one Midwest prison. However, since this research was exploratory, there was no intent to generalize findings but rather to understand the experience of participants in prison who have mental health issues and who work with a counselor. Furthermore, I was not able to obtain a proportional number of participants to represent populations from all ethnicities, races, ages, and other cultural



forms of identification. There was a lower response rates for African American participants. According to, Coker, Huang, and Kashubeck-West (2009) African Americans have a cultural mistrust towards research due to historical unethical practices implemented in these communities. Other possible barriers for recruiting African American women included unfamiliarity with the research process, poor recruitment process, and social stigma towards mental health research (Coker, et al., 2009). The impact of the cultural identities on the relationships formed with participants should have also been more explored during the interview and analysis. For future research, I learned that I need to be more involved with the recruiting process in order to conduct culturally competent research. In addition to the demographic limitation, the relationship power imbalance between the participants and myself could have impacted trust issues and perceived notions because of the hierarchical structure in inmates' daily lives. Although I believed the participants were motivated to answer authentically, studies have shown that difficulties with establishing trust can be primary limitations for both qualitative and quantitative research involving those who are incarcerated (Pollack, 2005).

I had hoped to gather data from at least two mental health professionals in order to achieve triangulation with the data from the inmate interviews. The goal was to use the information to examine the benefits and areas of growth for those receiving and providing mental health services within the prison system. By having both sets of data, I would have had more information to provide recommendations for mental health professionals working with female inmates in the United States correctional system. The prison officials requested that the interviews be conducted with mental health professionals away from the prison facility and not during normal working hours, which

may have contributed to the lack of volunteers. I believe that the very low number of mental health professionals employed in this particular prison system also was an issue.

Finally, all of the female inmates in this study believed that they had working alliances with their counselors; yet, for most participants, their own oppressive experiences were unnamed. With their stories came more questions and issues to further examine. Examples include: examining the different meanings of trust and how levels of trust affect the content of topics brought up in session, examining different procedures for helping suicidal and/or homicidal clients without the “hole”, changing the overall correctional system to meet the gendered needs of those receiving mental health, and whether mental health courts are an option. Finally, how can we as counselor educators promote more counselors-in-training to pursue correctional counseling?

Post release concerns and needs were a theme I did not investigate as much as I should have during these interviews. For two of the participants scheduled for release within a year of the study, one had no post release resources or social support and the other had continuing counseling services and a halfway house and social support from her church to assist her with her transition. I was worried about the first participant who appeared to be entering the outside world without assistance. I felt her chances of making it seemed slim and wished she had more support. I could not imagine reentering a world alone that I had been excluded from for over 25 years.

### **Conclusion**

The purpose of this study was to determine if, within the penal system, a working alliance could exist between a client and a mental health professional. All participants in this study believed they were able to form a working alliance with their mental health

professional although they gave clear evidence that they did not always fully disclose their history or feelings to the counselors with whom they worked. The participants expressed themes focusing on empathy and acceptance as the best ways to gain the trust of the client. Participants wanted to be treated without judgment, disapproval, or dislike of their beliefs, thoughts, and past experiences. With unconditional acceptance from their mental health professional, participants were more likely to feel empowered to make their own decisions and perceive life in their own way. The resulting self-confidence and self-respect allowed them to feel more autonomy to accept themselves and the ability to make their own choices.

In addition, all the participants supported the use of counseling within the penal system and advocated for post-release mental health services. All the participants maintained hope that they would eventually leave this prison and return to the outside world. They expressed that proper mental health resources and social support should be in place to help participants from reoffending. This reality was present in their minds, but appeared to not be discussed within the counseling process. The participants felt more work should be done to prepare female inmates to reenter society, so they could transition with ease and less anxiety.

### **Final Remarks**

I feel so connected to the women behind bars because their stories are so powerful and their strength is admirable. I also wanted to understand their stories in order to understand their needs. Many studies indicate that female inmates want to use their “voice” to share their own experiences within the prison system to make a positive difference for others (Ross & Lawernce, 2009). In addition, I also believed that

participants wanted to educate those on the “other side” about their counseling journey (Ross & Lawerence, 2009) to help those in the future seeking mental health services while incarcerated.

This social interest motivation was a concept developed by Alfred Adler (Adler & Brett, 1998). Adler believed that people are capable of contributing to the well being of their community. The participants in this study could have wanted to indirectly or directly give back to either their prison community or “outside” community. I witnessed this social interest among participants when conducting this study and was educated by every participant’s “voice”. I was honored to hear their stories and I know that this experience has changed me, my soul, and my professional identity. Since conducting this study I have spoken at conferences, to college classes, to other professionals, and to politicians about the need for human rights for female inmates. I want to use their words, the space between their words, and their silence to advocate for an improved mental health system within the penal system because as Atia stated. “A woman tends to work herself around the story.” We should listen.

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**Appendix A**  
**Department of Counseling and Family Therapy**

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**Voices From Behind Bars: A Working Alliance?**

**Participant Invitation for Client**

Dear Potential Participant,

My name is Mariamee (Maria) Gonzalez and I am a doctoral student in the Division of Counseling and Family Therapy at the University of Missouri-St. Louis, conducting research under the supervision of Dr. Susan Kashubeck-West. In 2008, I conducted research at WERDCC and felt so honored to hear stories and experiences from amazing women that I wanted to come back to do a research study on the working relationship between female inmates and mental health professionals. Did you know that the numbers of inmates in prison needing therapy is three times the number of patients in mental health agencies in the community? Little research has looked into the mental health services provided for you and the many women receiving mental health services while incarcerated. You have been asked to participate in this research because you are a client/patient receiving mental health services. I believe your input regarding mental health services is important and valuable and can make a difference.

If you choose to participate, I will interview you about your experiences with mental health services at WERDCC and your relationship with your therapist. These interviews will be confidential and will take place in a private room in WERDCC. I expect the interviews to take from 45-90 minutes. I will deposit a stipend of \$10.00 to your personal account when the interview is over.

Your participation is voluntary and you may choose not to participate in this research study or to withdraw at any time without penalty.

I will audio-record the interview so that I can listen to it later. A typed copy of the interview will be made and the audio-recording will be erased. I will use a fake name on the typed interview to conceal your identity.

This study is to understand what works and what does not work for women receiving mental health services. Your voice in this study may make a difference for women in the prison study who are seeking treatment or thinking about seeking treatment.

If you have any questions or concerns regarding this study, or if you would like to participate, you may contact Charles HorseMeyer (ph:573-594-6686).

I want to thank you in advance and I look forward to our time together,  
 Maria



## Appendix B

## Department of Counseling and Family Therapy



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**Voices From Behind Bars: A Working Alliance?  
 Informed Consent for Participation in Research Activities**

Participant \_\_\_\_\_  
 \_\_\_\_\_

HSC Approval Number

Principal Investigator Mariaimee Gonzalez  
314.516.5782

PI's Phone Number

Dear participant,

My name is Mariaimee (Maria) Gonzalez and I am a doctoral student in the Division of Counseling and Family Therapy at the University of Missouri-St. Louis, conducting research under the supervision of Dr. Susan Kashubeck-West. I am doing a research study on the working relationship between female inmates and mental health professionals. You have been asked to participate in this research because you are a female inmate receiving mental health services. Your participation in this research is voluntary.

Please read this form and ask any questions before agreeing to be in research. By signing in the space provided below, you give your consent for me to use the information from the interview in my study. Your participation is voluntary and you may choose not to participate in this research study or to withdraw your consent at any time. You may choose not to answer any questions that you do not want to answer. You will NOT be penalized in any way should you choose not to participate or to withdraw. Your decision whether to participate will not affect your current or future relations with the University or WERDCC, or the Department of Corrections. If you decide to participate, you are free to withdraw at any time without affecting that relationship.

This interview will occur at your convenience and will take 45-90 minutes. The interview will take place in a private room in WERDCC. I will pay a stipend of \$10.00 to your personal account when the interview is over.

It is possible (but not probable) that you might have negative feelings come up about the therapy relationship with your therapist. If this happens, you can choose to not answer certain questions or you can end the interview. In addition, there is a small chance that participating in the research could result in social, economic, or legal risk if your comments about your therapy relationship with your mental health provider became known to prison staff. Please know that I will not share any information you tell me with prison staff, your mental health professional, or other public officials. The only exception to this is if you tell me that you plan to harm yourself or someone else.

In that case, I am required by law to notify the proper authorities. I will not ask any questions about harm and you are asked not to make such statements.

I will audio-record the interview so that I can listen to it later. The tape player will remain on the entire interview and edited afterwards. A typed copy of the interview will be made and the audio-recording will be erased. I will use a fake name on the typed interview to conceal your identity. I plan to interview 20-25 participants for this research.

By agreeing to participate, you agree that your data may be shared with other researchers and educators in the form of presentations and/or publications. In all cases, your identity will not be revealed. In rare instances, a researcher's study must undergo an audit or program evaluation by an oversight agency (such as the Office for Human Research Protection). That agency would be required to maintain the confidentiality of your data. In addition, all data will be stored on a password-protected computer and/or in a locked office.

If you have any questions or concerns regarding this study, or if any problems arise, you may call me, Mariamee Gonzalez at 314.516.5782 or my Faculty Advisor, Susan Kashubeck- West, at 314-516-5782. You may also ask questions or state concerns regarding your rights as a research participant to the Office of Research Administration, at 314-516-5897.

**I have read this consent form and have been given the opportunity to ask questions. I will also be given a copy of this consent form for my records. I consent to my participation in the research described above.**

X

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Participant's Printed Name

Mariamee Gonzalez

\_\_\_\_\_  
Signature of Investigator or Designee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Investigator/Designee Printed Name

**Appendix C**

**Client (CL)**

**Demographic Survey**

Question #1 Are you at least 18 years of age?  YES  NO  
 Question #2: Do you wish to continue with the study?  YES  NO

If you answered YES to Question 1 **and** Question 2, please continue with survey.

1. Are you Female?  Yes  No
2. What is your age? \_\_\_\_\_
3. What race(s) or ethnicity(ies) do you consider yourself? \_\_\_\_\_
4. Sexuality (check all that apply): \_\_\_\_\_Heterosexual \_\_\_Gay \_\_\_Lesbian \_\_\_Bisexual \_\_\_Other (specify)
5. Do you identify with a spiritual, religious tradition, denomination, or church?  Yes  No  
 If marked yes, what spiritual, religious tradition, denomination, or church do you belong to? (Please mark all that apply)  
 None  Protestant  Baptist  Wicca  
 Spiritual, do not belong to any affiliation  Christian  
 Atheist  Muslim  Pentecostal  
 Agnostic  Buddhist  Presbyterian  
 Catholic  Hindu  Lutheran  
 Jewish  Evangelical  Methodist  
 Something else \_\_\_\_\_  
 Don't know
6. How much schooling have you had?  
 Less than 12thgrade  GED or high school equivalent, no high school diploma  
 Completed high school  Some vocational-technical, no diploma  
 Beyond high school  Vocational-technical diploma  
 1 or more years of college, no degree  
 Associate degree (for example: AA, AS)  
 Bachelor's degree (for example: BA, AB, BS)  
 Master's degree (for example: MA, MS, MEd, MSW, MBA)  
 Professional degree (for example: MD, DDS, DVM, LLB, JD)  Doctorate degree (for example: PhD, EdD)  
 Don't know
7. Do you have children?  Yes  No How many \_\_\_\_\_
8. How many months or years have you been incarcerated? \_\_\_\_\_
9. How much time do you have left to serve? \_\_\_\_\_
10. How did you find out about the mental health services here?  
 Referral  
 Word of mouth  
 Case worker  
 Initial intake into WDRCC  
 Other \_\_\_\_\_  
 Mandated by \_\_\_\_\_
11. For the purpose of this study, which mental health professional will you be discussing?  
 Counselor  
 Psychiatrist  
 Psychologist  
 Social Worker  
 Other \_\_\_\_\_
12. How many times a week do you meet with your mental health professional?  
 0  
 1  
 2  
 3  
 4  
 5  
 Over 6
13. How much time do you usually spend with a mental health professional at each appointment?  
 Less than 15 minutes  
 15-30 minutes

- 31-45 minutes
- 46-60 minutes
- 61-90 minutes
- 91-120 minutes
- Over 120 minutes

14. How long have you been receiving mental health services from this professional?

\_\_\_\_\_  
 Years                  Months                  Days

15. Have you had prior mental health services?     Yes     No

16. Please circle your overall satisfaction with mental health services at (WERDCC):

totally effective	very effective		somewhat effective		not very effective		not at all effective		
1	2	3	4	5	6	7	8	9	10

*(Thank you for your time.)*

## Appendix D

### Interview Guide – Female Inmates at WERDCC

#### **First Step – Review the Consent Procedures**

Thank you for agreeing to participate in an interview about your relationship with mental health professionals and services at WERDCC. Just to remind you, everything you tell me will be kept confidential. This means that I will not use your real name or any information that might identify you as an individual when I write up my study. You don't have to answer any questions you don't want to, and you can end the interview at any time. Also I can turn off the tape recorder at any time if you ask.

I would prefer to record our interview so that I will remember the information that you tell me as accurately as possible. Once I transcribe the tape and analyze the data, the audio record will be erased.

#### **Interview Questions: (sub-questions are for follow-up and will only be asked if necessary)**

1. Let's start by you telling me a bit about yourself and your feelings about working with a mental health professional – good or bad.
2. Overall, do you feel that you have a good working relationship with the mental health professionals here at WERDCC? Could you talk with me a bit about why you feel this way?
  - 2a. What do you think makes a “good” mental health professional?
  - 2b. Do you think the counselors understand or “get” you or other women like yourself?
  - 2c. Do you think age, gender, race, ethnicity, or sexual orientation make a difference in how you talk to a mental health professional?
  - 2d. Do issues of faith and your spiritual self affect your relationships with mental health professionals?
3. How do you feel about your relationship with your therapist in this particular correctional setting?
  - 3a. Do you and your therapist generally agree about the things you will need to do in therapy to help improve your situation?

- 3b. Are you and your therapist working towards mutually agreed upon goals?
- 3c. Do you feel that you can trust your therapist and say what you really think? Do you feel that your therapist trusts you? Examples?
- 3d. Can you share with me your sense of who has the most power in the therapeutic relationship? Explain.)
- 3e. Would you choose to see this person again for counseling if there were other options? Why or why not?
4. Please tell me about the overall quality of your experience receiving mental health services during your time here.
- 4a. What did you like most about it?
- 4b. What did you dislike most about it?
- 4c. Can you tell me about the assessment/evaluation process? What types of questions were asked?
- 4d. How do you feel about this process? Did anything upset or confuse you?
- 4e. Are there any changes you would make to this process?
- 4f. Did you agree with the evaluation of your mental health status? (Why or why not?)
5. In what ways has your life here at WERDCC changed (or not changed) as a result of these mental health services? (Ask for examples to illustrate answer).
6. Would you seek counseling again at another point in your life to get support for a problem? (Why or why not?)
7. Would you recommend counseling to other women in your situation? (why or why not?)
8. What is the general feeling among the woman inmates about the value or usefulness of mental health services? Why might they feel the way they do?
9. What changes in the current mental health services in the prison system would improve your counseling experience? (more time with counselors, different personnel, etc.)
- 9a. Tell me about any specific experiences as a woman that would be useful or important to cover in counseling sessions?

- 9b. Tell me about any specific experiences as a \_\_\_\_\_ (race/ethnicity) person that would be useful or important to cover in counseling?
- 9c. Should past trauma/abuse, along with current issues related to abuse, be covered in counseling? Explain/elaborate?
10. What would the ideal mental health support program look like to you?
- 10a. What therapy changes would you make?
- 10b. What kinds of follow up services after you get out of prison would be most helpful?
- 10c. What options might help therapy be more effective for more people?
11. Is there anything else you would like to share about your experiences that I have not asked about?

THANK YOU FOR PARTICIPATING