Literature Review of Therapeutic Services for Women in Prison

Companion volume I
to
Program Evaluation
of Therapeutic Services at
the Prison for Women

by

Kathleen Kendall

August 1993

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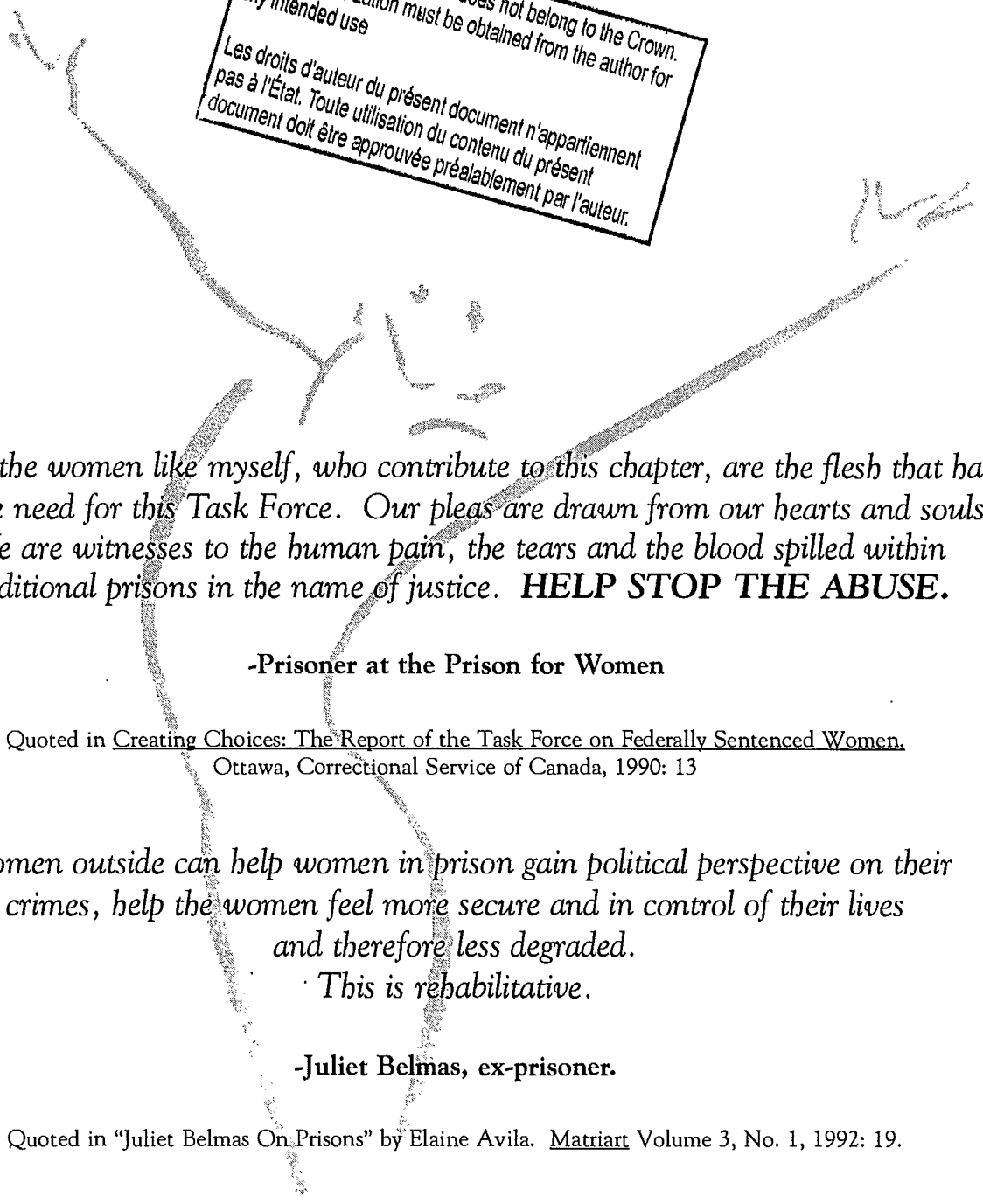

I and the women like myself, who contribute to this chapter, are the flesh that has fed the need for this Task Force. Our pleas are drawn from our hearts and souls. We are witnesses to the human pain, the tears and the blood spilled within traditional prisons in the name of justice. **HELP STOP THE ABUSE.**

-Prisoner at the Prison for Women

Quoted in Creating Choices: The Report of the Task Force on Federally Sentenced Women. Ottawa, Correctional Service of Canada, 1990: 13

Women outside can help women in prison gain political perspective on their crimes, help the women feel more secure and in control of their lives and therefore less degraded. This is rehabilitative.

-Juliet Belmas, ex-prisoner.

Quoted in "Juliet Belmas On Prisons" by Elaine Avila. Matriart Volume 3, No. 1, 1992: 19.

LITERATURE REVIEW OF THERAPEUTIC SERVICES FOR WOMEN IN PRISON

Companion Volume I

TABLE OF CONTENTS

INTRODUCTION

Until very recently, literature on imprisonment focused almost exclusively upon incarcerated males. The few studies concentrating upon the female experience typically assumed that female offenders were in some way "abnormal." Feminist scholars have shown how this situation is not unique to penology and corrections, but occurs in virtually every discipline. The almost universal tendency to regard the experience of white males as the norm has resulted in: 1) generalizing from the experience of white males to everyone else; and 2) labeling those that do not fit into this narrow framework as weak or deficient (Tavris, 1992; Harding, 1986; Bleir, 1988; Caplan, 1987; 1991; Hubbard, 1990).

Largely informed by theory and research with men, Canadian correctional practices are riddled with androcentric bias (Currie, 1986; Ekstedt and Griffiths, 1984; Baker, 1984; Ross and Fabiano, 1985, 1986; Adelberg and Laprairie, 1985; Adelburg and Currie, 1987; Deschepper, 1989). The failure to consider women's unique circumstances has resulted in serious negative consequences for incarcerated women, including: inadequate programming, inappropriate security classification and parole eligibility criteria, neglect of childcare issues, and the use of invalid psychological tests and measures (Currie, 1986; Berzins and Cooper, 1982; Berzins and Dunn, 1978; The Report of the Task Force on Federally Sentenced Women, 1990; Cannings, 1989).

Traditionally, criminological research was either grounded in sexist assumptions, or neglected women all together. Similar distortions plagued criminological theory which tended to explain women's criminal involvement in terms of innate "sickness, madness or badness" (Edwards, 1981, 1984; Smart, 1976; Gavigan, 1983, 1987; Klein, 1973). Theories of women's crimes were rooted within individual women to the exclusion of contextual factors.

In a growing body of literature, feminists have challenged the hegemeny of the "universal male". Writing in criminology (Gelsthorpe and Morris, 1990; Smart, 1976, 1989; Carlen, 1983, 1985, 1988, 1990; Currie and Kline, 1991; Laberge, 1991, Bowker ed., 1987), psychology (Penfold and Walker, 1983; Ushher, 1989, Walker, 1987, Burnes, 1992; Allen, 1987, Browne, 1987), law (Edwards, 1981, 1984; Eisenstein, 1988; Sheehy, 1987; Sheehy and Boyd, 1989; Boyd and Sheehy, 1986) and sociology (Dobash, Dobash and Gutteridge, 1986; Worrall, 1990; Jones, 1981; Hutter and Williams, 1981; Chesney-Lind, 1986; Daly and Chesney-Lind, 1988) feminists are filling the gap on knowledge about female offenders and questioning traditional approaches and assumptions. In addition, the importance of prisoner narratives has been recognized by feminists (Burke, 1992; MacDonald, 1987; Walford, 1987; Scheffler, 1986; Adelburg and Currie, 1987; Padel and Stevenson, 1988; Harris, 1988).

Whatever the particular discipline, feminist analysis has consistently demonstrated the necessity of locating women's crimes within the reality of their life circumstance. As recent scholarship has shown, women's offenses are linked to women's generally inferior socio-economic circumstances which often include poverty, racism, and violence. Following, any strategy to end

women's involvement in crime must address the power imbalances which render women unequal (Carlen, 1988; Adelburg and Currie, 1987; Currie, 1986; Daly and Chesney-Lind, 1988; Moffat, 1991; Hatch and Faith, 1989). Further, because women pose little security risk, community-based alternatives to incarceration such as mediation must be seriously deliberated and acted upon (Carlen, 1990; Shaw, 1991; Shaw et al. 1991; Immarigeon and Chesney-Lind, 1992; Culhane, 1985/86).[1]

While strategies to end women's oppression and to seriously utilize alternatives to incarceration are imperative, changes will not occur either readily nor quickly. The immediate reality of women's incarceration must be addressed. In this regard, provisions to improve women's prisons can help alleviate pain, create less oppressive surroundings, and potentially reduce the likelihood of recidivism.

This literature review was undertaken as part of a program evaluation of therapeutic services I conducted at the Prison for Women during 1992-1993. Correspondingly, I set out to examine recent literature related to therapeutic services within women's prisons. In search for an operational definition, I went to my dictionary, and found that the word therapy is derived from the Greek word **therapeia**, meaning healing. Therefore, the parameters I initially set for this project were rather broad - to review research and writing related to women's healing despite the limitations of imprisonment. Yet, although I spent hours engaged in computerized and manual searches, I uncovered very little. I felt somewhat reassured (that it wasn't just me)

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1. I would suggest that men's crimes must be also be contextualized, and that sentencing alternatives be explored for men as well.

when others noted the dearth of information on therapy with women prisoners (i.e. Burstow, 1992; Moss, 1986; Blume, 1990; Ackerman, 1987). I observed that a number of reports recommended the use of feminist therapy principles in prisons and therefore, I widened the scope of my search even further to include literature on feminist therapy (Elliot and Morris, 1987; Ackerman, 1987; Mills, 1992a; Heney, 1990). It was here that I finally found a wealth of information with practical implications for women's prisons.

What follows is my attempt to bring together some of the literature related to feminist therapy. The review is in no way exhaustive, but I have tried to pull together the information I found to be most relevant to women living inside prisons. This report is also far from conclusive - feminist therapy is still in its infancy, and like all "work in progress", is continually remodeling in order to address limitations, and incorporate new discoveries. Relatedly, feminist therapists have been looking very closely at ways to fully address diversity. Because of the importance of this work, I have reserved a section to examine some of the literature on the issue of diversity within therapy. Four other bodies of literature related to feminist therapy - women and substance use, feminist group work, women's psychology and adult education, are also briefly examined separately, because of their relevance to incarcerated women.

The literature related to vocational training, schooling and reintegration is largely outside the scope of this paper, although I recognize that effective and appropriate programming in these two areas is essential toward the development of personal empowerment, autonomy and economic security.

CURRENT ISSUES

Feminist therapy is essentially a philosophy of treatment, rather than a technique of treatment. Most fundamentally, feminist therapists contextualize individuals within the social, economic and political environment. Personal problems people have are therefore understood in relation to the context surrounding their lives rather than simply regarded as illnesses originating from within. Feminist therapists frame women's experiences within the broader social environment, and assist women in making connections between difficulties in their own lives and societal inequalities. Therapists further aim to reduce the power imbalance between themselves and clients by rejecting the role of "expert". Instead, clients are respected as experts of their own lives, and the therapeutic relationship is considered to be one of cooperation and partnership (Rosewater and Walker ed., 1985; Miller, 1976; Sturdivant, 1980; Greenspan, 1983; Mowbray, Lanir and Hulce, 1985). Fleming, (1979: 121) summarizes feminist therapy as follows:

> Feminist therapists support women in the exploration of their inner resources and recognize their capacity for nurturance and self healing. They encourage the process of individual goal setting and support those client goals that transcend traditional sex-role stereotyping. They encourage the exploration of various lifestyles and support the acquisition of skills for self-directed and independent living.

The numerous contributions of feminist therapists are beyond the scope of this paper. However, an overview of the work feminist therapists have done around issues of abuse is critical to the development of relevant policy and practice with incarcerated women, because the majority have survived tremendous abuse. The prevalence of abuse among women inmates will be discussed later in the paper.

It has largely been through the efforts of feminists that issues of violence against women and children have come to be recognized as social problems. For over twenty years, feminists of the contemporary women's movement have been working to raise public awareness around issues of violence, providing services for victims, and fighting to change the conditions in which violence is rooted. Most importantly, feminists have listened to women and children, using their words to inform theory and practice. (Price, 1989; Russell and Van de Ven, 1984; Guberman and Wolfe, 1985).

In listening to the voices of victims, patterns have emerged. Woven through experiences of violence is a common thread of male power, since it is typically men who perpetrate violence against others - women, children and other men (Morgan, 1987; Kelly, 1988; Russell, 1984; Scully, 1991; Hanmer, Radford and Stanko, 1989; DeKeseredy and Hinch, 1991; Hotaling and Sugarman, 1986; Stanko, 1990). This is not to neglect the reality that some women do commit violent actions against others nor to dismiss the fact that males are also victims of violence, but to underscore the power imbalance embedded within acts of violence. [2] Clearly, adults have power over children. In our

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2. 1991 statistics indicate that women comprised only 11% of adults charged with violent criminal offences in Canada (Canadian Centre for Justice Statistics). Furthermore,

society, men hold the weight of social, economic and political power. The writings of Women of Colour, Aboriginal Women and lesbian women, have made it clear that White, heterosexual, able-bodied, and non-working class people hold greater power as well (Rice, 1990; Lorde, 1984). Taken together, recent literature suggests that violence is best understood as means of attaining, maintaining and perpetuating dominance (hooks, 1984; Stanko, 1990). This analysis of power and control applies to both a societal level and an individual one (Brickman, 1992).

The notions of power and control are central to feminist work therapy. A number of writers have noted the psychological trauma similarly exhibited by combat veterans, survivors of the holocaust, and victims of rape, battery, incest, and ritual abuse. Common to all is a shared experience of powerlessness - being in a situation where nothing an individual does can alter their circumstance of violation. A constellation of reactions following instances where individual power and control are lost has been termed **post-traumatic stress** (Herman, 1992; Brickman, 1992; Terr, 1990; Waites, 1992; Ochberg, 1988; van der Kolk, 1987, 1984; Figley, 1985; Gil, 1988).

Feminists therapists have found the framework of post-traumatic stress useful in understanding the dynamics of abusive relationships, as well as the consequences of violence upon victims lives. During abusive situations, a

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women's crimes of violence are closely connected to their disadvantaged status and often occur in situations of self-defence and where women perceive no viable alternatives (Savard and Langelier-Biron, 1986; Flynn, 1990; Jurik and Winn, 1990; Silverman and Kennedy, 1987; Ewing, 1987; Walker, 1989; Jones, 1981; Browne, 1987; Nouwens,1991). Additionally, women convicted of a violent crime are much less likely than men to recommit violent offenses once released (Savard and Langelier-Biron, 1986; Harman and Hann, 1986; Canfield, 1989).

victim finds that she cannot stop the abuser(s) from hurting her.

When her own actions cannot protect her, she learns that she does not have control over her environment, nor even control over her own body. Her sense of safety in the world and positive self worth is shattered - she realizes that she cannot determine her own destiny, that others cannot be trusted, and that her "point of view counts for nothing." The experience of abuse can leave her with psychological trauma, characterized by disconnection (from others as well as herself) and disempowerment (Herman, 1992; Blume, 1990; Finkelhor and Browne, 1986; Brickman, 1992; Waites, 1992; Straker, 1988).

Feminists use the term **survivor** to bring attention to the fact that those who become abused are not simply passive victims, but instead active agents who resist the violence being done to them, even when their options for resistance are severely restricted. The word survivor also underscores the remarkable courage and creativity victims of violence utilize in order to live through abusive situations, and to cope afterward (Gondolf, 1988; Hoff, 1990; Kelly, 1988; Lifton, 1980). Herman (1992) identifies three general types of survival responses used to live through and/or cope with trauma: hyper arousal, intrusion and constriction.

Hyper arousal occurs when a survivor's autonomic nervous system becomes extremely heightened. The body shifts into a constant state of readiness for danger and consequently the traumatized person startles very easily, sleeps restlessly, experiences a wide array of physical ailments, and over reacts to minor provocations (Herman, 1992, Browne and Finkelhor, 1986ab; van der Kolk, 1984; van der Kolk and Greenberg, 1987).

Intrusion occurs when the original trauma is relived as though it were occurring in the present - often with the vividness and emotional intensity of the initial event. The trauma may be re-experienced while asleep through intrusive nightmares, or be **triggered** in a waking state by sounds, sights, tastes or smells related to the original abusive situation. The term **flashback** is used to refer to the experience of suddenly remembering or reliving the original abuse. Some writers argue that survivors may also re-enact the traumatic moment, sometimes consciously but more often subconsciously. Dangerous risk-taking behavior is one example of reenactment. Here, survivors puts themselves into a position similar to the original abusive event with the hope of positively changing the outcome so that a sense of power and efficacy can be reclaimed (van der Kolk, 1989). However, survivors generally go to great lengths in avoiding situations which may trigger memories (Brett and Ostroff, 1985; Herman and Schatzow, 1987; Goodwin, 1988; Kluft, 1990; Blume, 1990; Burstow, 1992).

Constriction, which encompasses various kinds of altered states of consciousness, is a means of eluding retraumatization. Constrictive processes may first appear during the initial trauma when a person is completely powerless and any action of resistance is futile. In such an ordeal, a victim can escape unbearable suffering through numbing physical sensations and by escaping through psychological means. For example, some survivors recount occasions of leaving their bodies during incidents of violation. When later confronted with situations that could potentially trigger the original event, survivors may similarly dissociate or block memories of the trauma and feelings associated with it through a variety of means. These can include:

Repression: Memory of the abuse and periods of time surrounding the abuse are forgotten (Gil, 1988; Van der Kolk, 1984, 1987, 1990; Terr, 1990; Waites, 1992).

Substance Use: Licit and illicit drug and alcohol use (Barrett and Trepper, 1991; Miller, 1991; Reed, 1987; Yeary, 1982; Cohen and Densen-Gerber, 1982; MacKinnon, 1991).

Eating Disorders: Anorexia, bulimia, compulsive eating (Slogan and Leichner, 1986; Schechter, Schwartz and Greenfield, 19987; Goldfarb, 1987; Demitrack et al., 1990; Torem, 1986, 1988).

Self Injury: Cutting, burning, head banging, (Heney, 1990; Van der Kolk, Perry and Herman, 1991; Leibenluft, Gardner and Cowdry, 1987; Briere and Runtz, 1986; De Young, 1982; Waites, 1992; Simpson and Porter, 1981; Greenspan and Samuel, 1989).

Dissociation: Psychological escape from trauma such as fragmentation (Fraser, 1987; Troops for Trudy Chase, 1990; Gil, 1988; Kluft, 1985; Putnam, 1989; Braun, 1984, 1986; Rivera, 1987).

Constrictive techniques are adaptive at the moment they are engaged because they assist the survivor in escaping horror - either during the moment of abuse or later recollections and reliving of abuse. While the individual machinations of each coping strategy is unique, all serve a survival purpose by protecting the victim from a reality too painful to tolerate. In this light, coping strategies can be seen as "predictable

consequences of external events" in combination with individual characteristics (i.e. personal history, strengths) and social factors (i.e. social oppression) (Blume, 1990:78). Unfortunately, without such an understanding, many mental health professionals have labeled the coping strategies used by survivors as pathological and consequently have intervened in ineffective and/or harmful ways (Stark, Flitcraft and Frazier, 1979; Burstow, 1992; Women and Mental Health Committee, Canadian Mental Health Association, 1987).

While coping strategies are life preserving, once the immediate danger has passed, many coping mechanisms can interfere with everyday functioning and may greatly reduce the quality of life. The term *the walking dead*, has often been used by survivors to describe the emptiness felt inside, and the inability to move forward. Paradoxically, survivors are caught in a situation of "chaotic unpredictability and inevitable abuse" (Blume, 1990:120). The abuser can intrude at any moment, or memories may suddenly and unwelcomingly resurface. Survivors thus live in a "dialectic of trauma", alternating between the two extremes of reliving trauma and escaping it. Other consequences of trauma include: anger, withdrawal, shame, self-blame, guilt, distrust, phobia, depression, feelings of incompetence, anti-social behavior, immobilization and sexual acting-out (Widom, 1989abc; Alter-Reid, Gibbs, Lachenmeyer, Sigal and Massoth, 1986; Koss and Burkhart, 1989; Finkelhor and Browne, 1986; Browne and Finkelhor, 1986ab).

Since the core experiences of trauma are disempowerment and disconnection, healing is premised on empowering the survivor and creating new

relationships with others. Above all else, because trauma strips survivors of feelings of control and power, they need to have control over their own recovery process. Survivors must willingly choose to engage in therapy, and have the opportunity to leave at any point. Further, since trauma effects survivors so completely - physically, psychologically and socially - recovery work must be holistic. While no magic formula exists, Herman (1992) outlines three separate stages of therapy (see also Gil, 1988; Putnam, 1989; Brown and Fromm, 1986):

1. ***Safety***: the survivor begins to feel in control of her own body, and feels safe in the therapeutic environment as well as in the therapeutic relationship.

2. ***Remembrance and Mourning***: the survivor recounts the traumatic experience in order that the memory of trauma can be integrated into her life, and grieves the losses incurred by the trauma.

3. ***Reconnection***: the survivor understands that she has been victimized and the consequences of victimization upon her. She is ready to begin new relationships, and to take appropriate action in deepening her sense of power and control and protecting herself against future danger.

Most of those working with survivors suggest that both one-to-one and group therapy may be appropriate at different or simultaneous stages of the healing process, depending upon individual needs and circumstance (group work will be discussed later). Further, many feminist therapists strongly recommend that female survivors work only with female therapists. These

writers stress that because most survivors have incurred abuse at the hands of men, placing them into a therapeutic relationship with a male therapist can impede the development of trust and prevent the creation of safety essential to the therapeutic process (Blume, 1990; Burstow, 1992; Mills, 1992b).

Currently, there is some concern that work being done with survivors is myopic, focusing upon abuse to the exclusion of all else (Tavris,1992). The possibility of therapeutic reductionism is a danger to those not well versed in the trauma and recovery literature which emphasizes a bio-psycho-social approach to therapy, and to those unfamiliar with a feminist therapy perspective which is premised upon locating individuals and their problems within the broader environment. As Sloven (1991) suggests, the selection of theoretical framework can be likened to choosing a camera lens: a telephoto lens will sharpen the focus on only part of the picture, while a wide angle lens will capture the bigger picture. Metaphorically speaking, feminist therapists use a wide angle lens. Even so, as more information and experience accumulates, theories and practice of feminist therapists are adapted to incorporate new knowledge. An important concern in this regard is recent work around issues of diversity, discussed in the last section of this report. Also, feminists are increasingly recognizing and valuing alternative and holistic healing practices, such as native spirituality, and feminist spirituality (Allen, 1986; Bopp, Brown, and Lane, 1985; Plaskow and Christ, 1979, 1989; Eisler, 1987; Starhawk, 1986).

IMPLICATIONS OF FEMINIST THERAPY FOR WOMEN IN PRISON

Traditionally, intervention with incarcerated women has individualized women's problems as biological defects, mental illnesses, moral flaws, or personal weaknesses (Genders and Player, 1987; Shaw, 1990). Women's offenses have typically been stripped from the context of women's life experiences. Until very recently, there was virtual silence surrounding the association between women's experienced oppressions and their criminal involvements. Yet, as discussed in the introduction, there is a clear link between the crimes women commit and women's disempowered positions. Therefore, the design of realistic strategies which aim to prevent offending must be crafted through the vision of a wide-angle lens so that the myriad of circumstances encompassing women's offences become fully captured and understood.

The meshing of more inclusive understandings throughout penal practices and policies does not imply the displacement of offender accountability or agency. Rather, personal accountability becomes enhanced as the complexities of criminal involvement are made much more visible, thereby providing clearer insight into offenders' personal histories, including criminal activities. Feminists recognize that the negation of personal accountability only serves to disempower women by "rendering them harmless" and thus strips them of self-determination (Allen, 1987, Shaw, 1991). Through a clearer understanding of the dynamics between their actions and the circumstances which circumscribe their lives, women can gain greater control over their lives and make healthy life choices.

The use of a wide-angle lens also produces a picture of crime which captures the role of societal accountability. Brickman (1992) notes that the coping strategies employed by survivors of violence are simply more extreme versions of ones we all use to distance ourselves from public traumas such as the plight of the homeless and war. We all create boundaries between ourselves and the suffering of others through denial, minimization and dissociation. Similarly, we have tended to separate ourselves from people who become "criminals" by marginalizing them as a group very different from ourselves. Rather than located within the social, economic and political context, criminal activity becomes pathologized as individual acts of irrational, immoral, anti-social or sick behavior. Thus, we remove ourselves and our institutions from responsibility in the creation and prevention of crime. A feminist framework insists that crime be contextualized in a dynamic process which holds everyone accountable, including the institutions we construct.

Historically, mass silence and denial has surrounded the violence perpetrated against women and children as well as racial violence. Yet, recent research has uncovered the widespread nature of these abuses of power. The high prevalence of violence in the lives of incarcerated females has only very recently been acknowledged. Surveys of federally sentenced women in Canada indicate that the majority of inmates are survivors of abuse. For example, Shaw, et al. (1990a) found that 82% of the 102 women surveyed at the Prison for Women and 72% of the 68 women surveyed inside provincial prisons reported physical or sexual abuse[3]. Abuse was found to be

[3]. In Canada, the responsibility for the justice system is divided between the provincial and federal governments. The split in corrections is based upon a two year rule. People

even more widespread in the lives of Aboriginal women: overall, 90% reported physical abuse and 61% identified sexual abuse.

Lightfoot and Lambert (1991) write that 86% of the 80 women they surveyed from the general population serving time at the Prison for Women reported histories of abuse. Seventy-four percent of the self-injuring women Heney (1990) studied at the Prison for Women similarly disclosed histories of childhood abuse. Although these statistics indicate a high prevalence of abuse, they are likely conservative estimates. This is because women often minimize abuse, are hesitant to report their own victimization, and frequently have no conscious memory of abuse due to repression or dissociation (Kelly, 1988).

In addition to abuse, Shaw, et al. (1991) highlight the severe nature of disruption throughout the lives of women under federal sentence, noting commonalities including: parental death at an early age, foster care placement and constant changes in the location of foster care, residential placement, living on the streets, prostitution, suicide attempts, self-injury, and substance abuse. Lightfoot and Lambert (1992) report that 52.5% of the women in their study at the Prison for Women were experiencing high levels of psychological distress at the time of the interview.

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receiving sentences of less than two years, become a provincial responsibility and typically serve their time in provincial prisons. Those receiving sentences of two or more years become a federal responsibility and technically serve their time in a federal penitentiary. The Prison for Women located in Kingston, Ontario is the only federal women's penitentiary. However, the Exchange of Services Agreement, established in 1975, allows for eligible federally sentenced women to serve their time in provincial prisons. Eligibility is determined by sentence length, offence type and "personal suitability." In their study of women serving federal sentences Shaw et al. therefore surveyed women serving their time at the Prison for Women and in various provincial jails.

Approximately two-thirds of the federally sentenced women surveyed by Shaw et al. (1990a) indicated that they wanted some type of program or counseling to deal with abuse issues. Of the one-third who did not want programs or counseling, many indicated that they had come to terms with the abuse and dealt with it. Others did not want to involve themselves in abuse programs while inside prisons, and still others simply did not want any abuse programming at all. Fifty-seven percent of women at the Prison for Women and 37% of women in provincial prisons reported that they had taken programs or received counseling related to their abuse. The great majority of women at the Prison for Women had taken these while in prison, while women in the provinces had become involved in abuse programs and counseling both inside and outside the prison. Taken together, the research to date indicates that the Prison for Women population is overwhelmingly comprised of women who have survived a great amount of traumatic experiences. Discussion of the implications of this fact for both incarcerated survivors of abuse and prison policy and practice follows.[4]

Two recent and much publicized Canadian reports acknowledge the link between women's life situations (especially the abuse in their lives) and their offenses. Recognizing that in Canada there are women serving time in prison for killing their abusive partners, The *Final Report of the Canadian Panel on Violence Against Women* (1993:59) recommends that all federal,

[4]A number of studies have found a correlation between childhood victimization and subsequent delinquent/criminal involvement, ie. (Dembo, Williams, Wothke, Schmeidler, and Brown, 1992; Burgess, Hartman and McCormack, 1987). Widom's review of the literature (1989c) and original research (1989a, 1989b) suggests that while a history of abuse increases the likelihood of delinquent and criminal behaviour, the majority of abused people do not engage in such activities.

provincial and territorial governments "Co-ordinate a review of the status of women incarcerated for killing their abuser with Elizabeth Fry Society and co-ordinate a review with a pardon/release process where possible ".

The report of the *Federal/Provincial/Territorial Working Group of Attorneys General Officials on Gender Equality in the Canadian Justice System* (FPTWG, 1993) forwards a number of proposals which hinge upon a recognition of the association between women's disadvantaged backgrounds (including histories of abuse and drug addiction) and their offenses. Taken together, the proposals urge action to promote greater awareness among criminal justice system personnel as well as the general public about "the influence of physical, sexual, emotional and economic abuse on women in conflict with the law" (FPTWG: 27). The report further recommends that appropriate counseling and assistance be provided for women who come into conflict with the law. The working committee additionally recommends that much greater emphasis must be placed upon non-incarcerative solutions to sentencing such as diversion services and community alternatives (FPTWG:25).

Research on women's experiences inside prison indicates the importance of implementing non-incarcerative options. For example, the prison environment can exacerbate and replicate women's traumatic experiences. As Eaton (1993) writes, prisons most often remove whatever autonomy women have left by imposing rigorous control over their day-to-day existence. An inmate's movement, schedule, activities, phone-calls, visits, and correspondence, are regulated by prison policy via prison staff who can exercise a great amount of discretion in enforcing prison rules. Velimesis

(1981) suggests that standard correctional practices are particularly inappropriate for women, given their histories of abuse. The control exercised within prisons, coupled with the often arbitrary enforcement and application of rules, may replicate the powerlessness and chaotic unpredictability characteristic of abuse. Eaton (1993) uses the phrase "taken down" to refer to the dynamic in which prisoner's space, time and action become controlled and defined by others. She writes that as women are "taken down," they are stripped of their former identities and thereafter related to as "prisoners". Furthermore, prison practices send inmates "double messages" by holding women individually responsible for their crimes and future choices, while simultaneously denying personal autonomy and decision-making power (Genders and Player, 1987).

The process of prison retraumatization was demonstrated in Heney's (1990) study of self-injury at the Prison for Women. Heney found that the occurrence of self-injury escalated under "tense" conditions in which inmates perceived staff to use their power unfairly such as in the inconsistent and petty application of rules, intrusion of privacy, and punitive responses to emotional expression. The author further found that 26 of the 44 (59%) inmates she interviewed had histories of self-injurious behavior. The most common method of self-injury was slashing (92%). Heney (1990:8) states that while the exact number of women who self-injure while incarcerated is difficult to ascertain, " self-injurious behavior is a problem for a large number of prisoners at some point in their incarceration." The findings of Shaw et al. (1990a) verify Heney's reports. The authors write that over half of the Prison for Women population they surveyed had injured themselves at some point in their lives, and 20% had self-injured during their current sentence. The

women in their survey reported engaging in self-injurious behavior when they felt they had no control over situations, as well as when they became lonely or depressed.

Routine institutional procedures, such as body searches and constraints are often experienced as violations of personal boundaries in the same way physical and sexual abuse were invasions upon a survivor's body. Unwittingly, prison security practices can trigger the original abuse and result in an inmate utilizing one of the coping strategies mentioned earlier. Unfortunately, such coping mechanisms are often misperceived by prison staff to be disordered behavior, manipulation or attention-seeking conduct and punitive measures are taken which only further the cycle of trauma (Velimesis, 1981; Heney, 1990; Baskin, Sommers, Tessler and Steadman, 1989). Heney (1990) emphasizes that prison staff must regard self-injury as an indication of emotional pain and an attempt to gain personal control, rather than a security issue.

Without an understanding of the dynamics and consequences of abuse, prison staff may misinterpret various kinds of behavior exhibited by women inmates. For example Pollock (1984:85) found that when asked to compare incarcerated males and females, correctional personnel were much more likely to use the following adjectives in their descriptions of women: emotional, temperamental, complaining, moody, quarrelsome, demanding, and changeable. Many of these qualities are consistent with female socialization, such as societal acceptance for women to display emotion. These descriptors also fit closely with the consequences of trauma. However, the perceptions staff hold toward women inmates often translate into

infantilizing, paternalistic or punitive behavior, further perpetuating the lost sense of control and diminished self-efficacy common among female inmates (Pollack-Byrne, 1990; Fox, 1984; Velimesis, 1981; Genders and Player, 1987; Wilfley, Rodon and Anderson, 1986).

Emphasizing the importance of positive prisoner-staff relations, Heney (1990) recommends on-going staff training in the dynamics of childhood sexual abuse. With such knowledge, staff can avoid unknowingly creating situations which may trigger abuse, and react to inmates distress appropriately. In her study at a Georgia women's correctional facility, Katrin (1974) found noticeable improvements among inmates following staff involvement in facilitation training designed to develop their interpersonal skills. In their review of innovative correctional alternatives, Di Pisa, Bertrand and Biron (1992) praise the positive staff-inmate relations in Shakopee prison. Such excellence in affiliation is partially due to the ongoing specialized training focused upon the specific needs of women mandatory for all Shakopee staff (Minnesota Correctional Facility - Shakopee Mission Statement).

The federally sentenced women surveyed by Shaw et al. (1990a) were overwhelmingly in agreement that staff need special training or qualities to work with women in prison. Overall, the women stressed: "the need for staff to have more awareness and understanding of their behavior, and to be able to provide them with support and concern when they feel the need" (Shaw et al. 1990a:50).

Enhanced staff-inmate relations was uniquely demonstrated at the Prison for

Women, when correctional officers were allowed to participate in the Peer Support Team (PST). Briefly stated, the PST is designed to train inmates to become peer counselors (the PST is described in Companion Volume II and discussed in this report in the section entitled "feminist group work"). However, over the course of different training sessions, inmates have invited a small number of staff members to participate, in the hope of enhancing staff-inmate relations. Pollack's (1993) evaluation of the PST confirmed that such relationships were in fact improved following PST training.

Health care staff may also greatly benefit from staff awareness training, including learning about trauma and its consequences, because women's histories of abuse impact directly upon prison health care departments. As discussed above, hyper arousal (characterized by sleeplessness and numerous physical ailments), eating disorders, self injury, and substance abuse are common coping defenses among survivors. Stress-related illnesses are also prevalent among abuse survivors. Sexual and physical trauma often cause long-term ailments such as gynecological difficulties, gastrointestinal problems, impaired senses and broken or damaged limbs (Blume, 1990; Browne, 1987; Stark, Flitcraft and Frazier, 1979; Browne and Finkelhor, 1986ab). Furthermore, survivors of abuse often neglect self-care (Herman and Schatzow, 1987).

Resnick and Shaw (1980) found that female inmates report substantially more medical problems than male inmates. Similarly, studies by Sobel (1982), Glick and Neto (1977) and Ingram-Fogel (1991) substantiate a high degree of health care utilization in American women's prisons, and conclude that prison health services are inadequate. Women's acute use of prison

health care services may be due in part to women's greater likelihood to seek medical help and report physical symptoms (Kessler, Brown and Broman, 1981). However, it is also likely related to social and economic factors such as abuse and poverty (Lapierre, 1984).

In their survey of federally sentenced women, Shaw et al. (1990a) report that physical health was a major concern to nearly everyone interviewed. When asked whether they had any specific concerns about their own health, 45% of the sample at the Prison for Women, and 69% of the women surveyed in provincial prisons responded affirmatively. Two-thirds of the women felt that health services inside the prison were inadequate. Taken together, the concerns of respondents centered around the lack of access to medical treatment, the poor quality of service provided and the negative attitudes of staff. Underlying each of these issues was perceived "loss of control over care of their own bodies". These findings correspond to those of Moore, McDermott and Cox (1988) who report that the prison environment diminishes the control women believe they have over their bodies.

While non-incarcerative options must be given highest priority, women who are in prison need to be recognized and valued as self-determining, autonomous human beings. Changes in the prison environment and policy, and prisoner-staff relationships which would allow women more control over their daily routines, future choices, and bodies may reduce the likelihood of retraumatization. For example, procedures such as medical examinations, body searches and situations involving restraint could be modified to make them less intrusive for inmates. Greater opportunities for self-determination could be provided by allowing women equal participation in the design of

their correctional plan and more choice in programs availability (Velimesis, 1981).

Structural, policy, and relational changes may not only reduce the emotional distress associated with incarceration, but could assist in providing a safer environment critical to the success of meaningful healing work. This is not to diminish the limitations imposed upon healing work within a prison, nor is it meant to be interpreted as complicity in the incarceration of women. Recovery from abuse is most promising in an environment where autonomy and self control are maximized. However, for women who are in prison, appropriate support and resources, can help to begin the healing process.

There is very little literature available regarding the effectiveness of various interventions inside of women's prisons (Ackerman, 1987; Ross and Fabiano, 1985, 1986; Moss 1986). Because the literature on trauma and recovery is so recent, there is even less information available about its application inside prisons (Burstow, 1992; Blume,1989). However, the few studies which are available, indicate that individual and group therapy rooted in principles of empowerment and informed by an understanding of power and control issues create positive changes including: increased self-concept, greater trust, enhanced feelings of self-control, better adjustment and coping inside prison, and improved relations with other inmates as well as staff (Sultan and Long, 1988; Sultan et al., 1984; Sultan, Long and Kiefer, 1986; Clark and Boudin,1990; Women of Ace, 1990; Richie, 1992; Inowlocki and Mai, 1980; Smolick, 1990). Unfortunately, because there have been no follow-up studies completed, it is not known how these changes translate into life outside of prison.

Finally, it is important to note the difficulties survivors often have in forming trusting relationships. As Blume (1989:243) writes, consistency is a prerequisite to establishing trust and survivors are often given mixed messages: "words don't mean what they say...things are not what they seem, and that what appears safe is generally not to be believed." This unpredictability is carried into later relationships, particularly with authority figures (Brookes, 1992; Herman, 1992, Women's Research Centre, 1989). Indeed, many survivors have reason to doubt those in positions of authority. Victims of abuse often report countless incidents in which they informed those in positions of authority about their abuse, only to be disbelieved, labeled as "crazy", or re-victimized. Survivors have disclosed numerous examples of victimization at the hands of those in positions of trust, mostly men, including: family, psychiatrists, therapists, teachers, residential school staff, foster parents, coaches, police officers, baby-sitters, and clergy (Herman, 1981; Armstrong 1991; Blume, 1990; Burstow, 1992; Kelly, 1988; Stanko, 1985; Hanmer and Maynard, 1987; Russell, 1984; Schoener, Milgram and Gonsiorek, 1984; Suppeene, 1990). Seen in this light, as well as with the contradictory nature of prison practice and policy, inmate distrust, withdrawal or hostility toward staff may be logical, and indeed self-protective.

Additionally, Cassell (1992) Traxler (date unknown) and Hawkes (1989) describe incidents of sexual abuse occurring inside American women's prisons. At the time of concluding this report, there is an investigation into allegations of sexual abuse in Grandview, a juvenile detention centre for girls which operated in southern Ontario during the 1960s and 70s (Harris, 1992; Spires, 1992; *The Toronto Star*, January 2, 1992: A1, A8; April 11, 1992: A25;

April 25, 1992: A1, A10). A number of inmates once held in detention at Grandview, later became incarcerated at the Prison for Women.

As indicated earlier, because most survivors have been abused by men, often in positions of authority over them, feminist therapists strongly recommend that only female therapists work with female survivors. After reviewing the literature, Mills (1992b) recommends "women-only" staffing for those involved in the care of incarcerated women. The author further proposes that inmates who meet administrative criteria be given day passes in order to access community therapy resources. These two steps may reduce actual and perceived power differentials between therapists and inmates, thereby promoting the development of trust in the therapeutic relationship.

An innovative way to further reduce power imbalances is the use of peer counselors. In Bedford Hills Correctional Facility, New York state, inmates are trained to provide peer counseling, support and education around issues of AIDS: "Inmate peer educators/counselors may be most effective because prisoners are more likely to listen to and trust other prisoners. Counselors can provide extra support for behavior change from their own experience and may be able to change attitudes towards prisoners with AIDS by setting an example" (AIDS Advisory Council, quoted in Clark and Boudin, 1990:107). ACE (AIDS counseling and education) has been successful in Bedford Hills Correctional Facility in providing support to women infected with AIDS, building community, and raising awareness of both inmates and staff (Clark and Boudin, 1990; Women of ACE, 1990).

The Peer Support Team (PST), Prison for Women, also provides training to inmates so that they can become peer counselors. In her evaluation of the PST Pollack (1993) found that inmates who received peer counseling reported that it helped to reduce feelings of isolation, depression and self-harm. Peer counselors emphasized that the PST was successful in large part because they shared common experiences with those they were supporting - they had "been there." (see also "feminist group work" in this report and an excerpt of Pollack's evaluation in Companion Volume II).

It must be emphasized that peer counselors do not provide intensive therapy, but rather offer support, information and referrals (PST training manual). As Herman (1992) and Steele (1989) state, therapy with survivors is very difficult work, requiring extensive knowledge and experience in trauma and recovery. They further argue that feminist therapists engaged in work with survivors must establish their own support systems and commit themselves to continual self reflection. Sobel (1982) expounds upon the implications of this for establishing therapeutic relationships inside prisons. She notes that increasingly, security staff are playing a dual role of counselor and rule enforcer, but have little or no training in counseling skills. While the support and comfort correctional officers can provide to inmates is very important a supportive role should not be conflated with the role of a therapist. Officers do not typically have therapeutic expertise, and the hierarchical nature of the security-prisoner relationship is counter to effective and safe therapy, and may also place correctional officers in a serious conflict of interest.

Mechanisms to bridge therapeutic practices across correctional facilities and the community have been largely neglected, yet, it is an area with serious

implications. The Report of the Task Force on Federally Sentenced Women (1990) states that women are not provided with enough information regarding the programs and services available to them in the community. Mills (1992) recommends that women prisoners be allowed to make use of community resources and therapists through the use of day passes. A survey of federally sentenced women released into the community found that women were not given adequate choice in selecting their counselor, nor in the right to decline therapy (Shaw et al. 1990b). As this review has shown, forced therapy, both inside and outside of prison, is counter to the healing process. Much more needs to be done to ensure a continuity of caring for female offenders (Report of the Solicitor General's Special Committee on Provincially Incarcerated Women, 1992).

One possible mode of post-release intervention is the formation of a peer-support group for ex-inmates. ACE, the AIDS peer support and counseling group in Bedford Hill Correctional Facility, has recently expanded to include a successful community outreach program - ACE OUT - run by and for formerly incarcerated women. Also out of Bedford Hills, Kaplan (1989) discusses the success of another group which began as a support program for women imprisoned for the death of a child (this group is discussed in more detail in the section entitled "feminist group work"). Once released into the community, participants in this group continued monthly meetings for a two-year period to confer upon a wide array of issues related to readjustment. Additionally, group members became involved in the creation of a telephone hotline for ex-offenders. In her study of 34 British prisoners, Eaton (1993) found that organizations run by and for ex-prisoners assisted many women to take charge of their own lives and to stay out of prison. Ex-prisoners

organizations offer women a space to be with others who have shared their experience of imprisonment and who further share post-release experiences.

In closing, it is important to note that while feminist therapists recognize the profound impact of abuse upon the lives of survivors, they **do not** regard abuse to be the **only** issue. Furthermore, feminist therapists do not see women simply as victims, but recognize women's strengths, agency and accountability. Oversimplifications of complex patterns, and the label of "victim", only serves to perpetuate paternalistic notions and disempower women prisoners even further.[5] Most significantly, feminist therapists aim to empower women by assisting them to see their own strengths, recognize their agency, identify alternatives, and thus take control over their own lives. Within the prison environment, the degree to which women can become empowered is limited by the myriad of ways in which control is exerted over their everyday lives. Therapists and others working with women in prison must be aware of the restrictions, limitations, and legal obligations posed by the prison environment. Program providers, counselors and therapists must come to terms with issues surrounding confidentiality and truthfully inform the women they work with of the realities associated with confidentiality and other such factors within the prison. Women must be able to make an informed choice as to whether or not they will engage in counseling and become involved in programs with full awareness of all the consequences.

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[5] The dangers inherent in a reductionist, victim-oriented approach are evident in Scott's book, **Inmate** (1982). In recounting his experience as a psychiatrist at the Prison for Women, Scott (1982:138) writes: "I call them the 4-H Girls. Hate, heroin, hustling and homosexuality are the dominant features of their lives. Each hates men, each controls the hate with heroin, each hustles to get money to buy more heroin. Each **trick** increases their anger at the male sex" [emphasis in the original]. Coleman-Forgues (1979) also working as a psychiatrist at the Prison for Women, similarly reduces inmates to passive victims, predicting limited scope for recovery.

Despite the hardships of prison life, exemplified by unequal power relations, prisoners continually create ways and find spaces in which to exercise their agency. Feminist therapists can respect and build on women's strength and resilience by assisting women to critically assess power relations, including those operating within the prison, so that they can resist harm and take self determined action in ways which are most empowering and least destructive to themselves. Hattem (1991a:148) for example, quotes the following case worker describing her work with female prisoners:

> Being aware of the power structure, and how power is used and how it can be or is abused - here or anywhere else - gives [women] the ammunition to approach or challenge the system in ways that are not going to be destructive to her...Whether or not it's clear to them in their head, whether or not they understand intellectually, what the power is, and how the power is used and how it can be abused, they feel it, they experience it, and react against it in very often destructive ways. So I see it as providing a safer way for them to channel their anger or their pain, with a conscious awareness of what they're doing, rather than it being an unconscious, emotional response, that is not clearly directed, where they're not as clear about the consequences to themselves or the punishment they might receive. And the increasing powerlessness of batting their head against the wall rather than looking at it and saying: "Okay. This is here. What can I do about it? How can I change the configuration on the wall? What ways are there that are open, that I didn't see before?" [translated from French]

WOMEN AND SUBSTANCE USE

CURRENT ISSUES

Recent literature considers substance use to often be a coping mechanism whereby which individuals attempt to gain control over their life circumstances (Bepko, 1991:1). Because men and women occupy distinct social, economic and political positions and therefore experience the world differently, addictions research and intervention must consider the particular experience and needs of women. Additionally, there is sexual variance in the absorption and metabolism of substances because of physiological differences between men and women (Forth-Finegan, 1991). Furthermore, there is greater stigma attached to chemical dependency among women than among men (MacKinnon, 1991).

Despite gender and racial differences, addictions research and treatment has traditionally been oriented toward white males. This has resulted in inappropriate and ineffective intervention provided to those falling outside the scope of this narrow framework (Reed, 1987; Bepko, 1991; Beckman and Amaro, 1984; Pasick and White, 1991). Indeed, when the experience of women is considered, distinct patterns emerge.

One of the clearest patterns is that women are more likely to be polydrug users. That is, women are more likely than men to use a variety of different drugs, especially legal mood-modifying drugs. In fact, the majority of women's drugs addictions involves prescriptions of antidepressants,

tranquilizers, barbituates, amphetamines, etc. prescribed to women by physicians and psychiatrists (Finkelstein, Duncan, Derman and Smeltz, 1990). In Canada, women are prescribed between 67-72% of all psychotropic (mood-altering) drugs (Harding, 19986; Cooperstock, 1976, 1980). Many writers maintain that women are prescribed more drugs of this nature because of sexism within medicine and the drug industry (Stephenson and Walker, 1980; Penfold and Walker, 1983; Women and Mental Health Committee, 1987). Women are also more likely than men to be cross-addicted to drugs and alcohol. **Cross addiction** can create a **cross-tolerance** so that the person using both drugs and alcohol develops an increased need for either or both substances in order to reach the same effect. In addition, a **synergistic** effect can occur when alcohol and certain mood-altering drugs are combined, increasing the likelihood of addiction, withdrawal and accidental overdose (Finkelstein, Duncan, Derman and Smeltz, 1990).

Generally, women use illicit drugs less often than men, although women's use of heroin, marijuana and other psychoactive drugs is increasing. Women are likely to be introduced to illicit drugs and supplied with them by men with whom they are involved in an intimate and/or sexual relationship (Finkelstein, Duncan, Derman and Smeltz, 1990).

Other issues identified in recent literature as important in designing and implementing substance abuse intervention with women include: pregnancy, parenting and addiction (Arbiter, in press; Chasoff, 1988; Beckman and Kocel, 1982; Moise, Reed and Ryan, 1982; Wilsnack and Beckman, 1984) women's feelings of shame, guilt and low self-esteem (Mason, 1991; Gomberg, 1988; Fossum and Mason, 1986, Beckman, 1978; Evans, 1991), depression

(Braun, 1989; Turnball and Gomberg, 1990) sexuality (Beckman, 1979; Howard, in press) and physical, sexual and emotional abuse (Kramer, 1990; Miller, 1991; Barrett and Trepper,1991; MacKinnon,1991).[6]

Concern with women's substance use also surrounds the relationship between women's risk of HIV infection and intravenous (IV) drug use. Women who share IV needles are clearly at risk of exposure to HIV. Additionally, women who engage in unprotected sex with IV drug users are in jeopardy of contracting the HIV virus. Drugs can furthermore be considered co-factors in the transmission of HIV because being under the influence of drugs and/or alcohol may inhibit concern with and/or ability to negotiate safer sex. Being stoned or drunk moreover increases women's vulnerability to violence (Saalfield, 1990).

Feminists frame women's addictions within the broader environment, including gender socialization, power imbalances and trauma. Following, effective intervention assists women to define their own social position, locate their addiction within the broader environment, understand the function addiction serves for them, develop alternative strategies, reclaim their strengths, and finally regain power in their lives. Program plans fostering empowerment, would further encourage clients to participate in assessment, planning and goal setting. The recovery process may also include intensive trauma recovery work (Bepko, ed., 1991; Reed, 1985).

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[6]This is not to imply that these issues are not relevant to male users, but to suggest that they are more prevalent among women and closely related to women's patterns of substance use.

As discussed earlier, substance use may serve a constrictive function by suppressing painful traumatic memories. Unsurprisingly then, the prevalence of abuse and/or eating disorders among addicted women has been found to be substantially high. In this light, substance use can be seen as an adaptive response to traumatic and stressful situations (Krestan and Bepko, 1991; MacKinnon, 1991). Intervention that dismisses the coping function substance use serves (i.e. by demanding complete and immediate abstinence), will likely lead to early relapse and ultimate failure (Root, 1989; Barrett and Trepper, 1991).

IMPLICATIONS OF SUBSTANCE USE FOR WOMEN IN PRISON

A number of studies have found that female offenders have a relatively high rate of chemical dependency (Ladwig and Anderson, 1989; Harrison and Hoffman, 1989; Miller; 1984, Ford, Houser and Jackson, 1975; Martin, Cloninger and Gaze, 1982; Weitzel and Blount, 1982).

To determine the prevalence of drug use among the Prison for Women population, Lightfoot and Lambert (1991, 1992ab) administered the Drug Abuse Screening Test (DAST) to 80 women. The results indicated that 14% of women surveyed reported severe levels of drug related problems. Twenty-one percent admitted to substantial levels of drug use, 19% disclosed moderate levels, 11% indicated low levels, and only 35% of women reported no drug related problems.

The women in Lightfoot and Lambert's study were further asked to describe their drug use in the six month period previous to committing the offense for

which they were currently serving time (their index offense). During this interval, the class of drugs most often used by women (39%) was benzodiazepines (minor tranquilizers such as valium, librium and halcion). Other drug used in this six month span included: narcotic analgesics (i.e. 222s, 292s, demerol, talwin, 35%), cocaine (31%), cannabis (24%), barbituates (i.e. seconal, amytal, 17.5%), hallucinogens (11%), amphetamines (i.e. ritalin, dexedrine, 12.5%), antidepressants (i.e. sinequan, elavil, 10%), tranquilizers (i.e. haldol, trilafon, 16.3%), volatile nitrates (i.e. rush, 2.5%) and inhalents/solvents (i.e. gasoline, cleaning fluids, 1.2%). When asked to describe their lifetime use of drugs (ever used), the women reported the following: cannabis (59%), benzodiazepines (56.3%), narcotic analgesics (51%), barbituates (47.5%), cocaine (47.5%), hallucinogens (46%), amphetamines (44%), antidepressants (37.5%), tranquillizers (24%), inhalents/solvents (20%) and volatile nitrates (20%).

**DRUG USED BY DRUG CLASS
A SAMPLE OF EIGHTY WOMEN AT
THE PRISON FOR WOMEN, 1991**

DRUG CLASS	LIFETIME, EVER USED (%)*	IN THE SIX MONTHS PRIOR TO INDEX OFFENSE (%)*
Cannabis	59%	24%
Benzodiazepines	56%	39%
Narcotic Analgesics	51%	35%
Barbituates	47.5%	17.5%
Cocaine	47.5%	31.%
Hallucinogens	46%	11%
Amphetamines	44%	12.5%
Antidepressants	37.5%	10%
Tranquillizers	24%	6%
Inhalents/Solvents	20%	1.%
Volatile Nitrates	20%	2.5%

SOURCE: Lightfoot, L. and Lambert, L (1992) *Substance Abuse Treatment Needs of Federally Sentenced Women, Technical Report #2*, Correctional Service Canada: 25.

*Percentages are rounded off to the nearest whole or half figure.

These findings suggest that the use of licit drugs among women prisoners is substantive. The context in which these licit drugs are obtained is not indicated by the report, but it does raise questions regarding the use of prescription drugs by women prisoners. As indicated previously, research with general populations of women show that women are over prescribed mood-modifying drugs. This pattern may be even more marked among women prisoners. An American study found that female inmates were prescribed two to ten times more psychotropic drugs than male inmates (Resnick and Shaw, 1980). Similarly, a study conducted by the Quebec Human Rights Commission showed that female inmates in the Tanguay detention facility, Quebec, were administered two to four times more medication (especially psychotropic drugs) than men serving prison sentences in Quebec City and Montreal (Quebec Human Rights Commission, cited in Hattem, 1991b).

Hattem's (1991b) biographical interviews with eighteen women sentenced to life imprisonment for murder in Canada, describes the perceptions held by women prisoners regarding their own use of psychotropic medications. Nine of the eighteen women interviewed reported using legally obtained psychotropic drug medication either prior to and/or following their entry into the penal system. Inside the prison, psychotropic medication was obtained either by request, through the recommendation of a doctor or psychiatrist, or through the request of correctional authorities. Women sometimes asked for these drugs to help them cope with prison life. As Hattem points out, there are few options open to women to escape from the deprivations and frustrations of everyday life inside of prison. The women in Hattem's study reported that doctors and psychiatrists often refused to listen to them when

they simply wanted to talk, and would instead give them drug prescriptions.. The expression of feelings or venting of frustration in ways deemed "inappropriate" can result in punitive sanctions. Therefore, the use of psychotropic drugs by prisoners to suppress their feelings and thereby gain a sense of "self-control" is understandable. However, many came to realize that in the long run, their dependency upon psychotropic medication actually reduced their self-control and diminished their ability to take self-determined action.

Ultimately, any meaningful strategy to address the use of psychotropic drugs inside prisons must "take into account the living conditions of women in prisons, the management of behaviours that are deemed unacceptable and the correctional and medical practices that contribute to the development and maintenance of drug consumption habits" [translated from French] (Hattem, 1991b:60).

Prisoners use of injection drugs is also an important concern. A 1989 study undertaken inside a medium-security women's prison in Montreal found that 130 (52%) of the 248 women surveyed reported injection drug use between the time of the study and 1979. Of these 130, 84% stated that they had loaned or borrowed needles: 52% had done this with strangers and 10% reported having shared needles with a person who was HIV-positive. Eight percent of the women participating in the study were HIV-positive. Non-sterile drug use practices and sexual activity with an intravenous drug user were the strongest risk factors in HIV transmission (Hankins, 1989).

The rates of alcohol dependency were lower among the Prison for Women

sample surveyed by Lightfoot and Lambert (1991, 1992). As measured by the Alcohol Dependency Scale, 72.5% of women reported low levels of alcohol dependence, 15% disclosed moderate levels of dependence, 7.5% substantial, and 5% reported severe levels of dependency. The women were also asked to define their own drinking patterns. In response, 25% described themselves as alcoholic, 16% as heavy users, 19% as moderate users, 39% as occasional drinkers, and 22.5% as teetotalers. Overall, the women surveyed admitted to drinking an average of 6.3 drinks per day in the six month period preceding their index crime. Forty-five percent of the women indicated that they had experienced problems related to their use of alcohol, including difficulties surrounding: family (81%), legal (69%), work and health (53%).

Shaw, et al. (1990a), found that 27 (26%) of the 102 women they surveyed at the Prison for Women disclosed addiction/prolonged use of drugs only, 16 reported addiction/prolonged use of alcohol only, 18 admitted addiction to both drugs and alcohol, 11 reported that they had experimented, but were not addicted now, 4 stated that they sold drugs but did not use them, and 26 disclosed that they were social drinkers only. Twenty-four of the 68 federally sentenced women surveyed in provincial prisons admitted to addiction/prolonged use of drugs only, while 11 reported addiction/prolonged use of alcohol only. Thirteen women disclosed addiction/prolonged use of both and 18 indicated that they were social users only. One woman reported that she had experimented only, and was not addicted, and one woman admitted to selling drugs but not using them.

Substance use also appears to be a factor in women's patterns of offending. One-hundred and twenty (71%) of the 170 federally sentenced women

surveyed by Shaw et al. (1990a) in both provincial prisons and at the Prison for Women, stated that drugs or alcohol were a factor in their offending. Of these 120 women 89 (52%) reported that they were under the influence of substances at the time of their offense. In addition, 40 said their offense was committed in order to support their habit and 45 were convicted of drug offenses such as trafficking or possession. Shaw et al. (1990a:26) write: "many women saw addiction as the main reason for their offending, while others said it was one factor, but not the main reason."

Lightfoot and Lambert (1992a) state that approximately 60% of the women they surveyed at the Prison for Women reported using substances on the day of their index offense: 22.5% disclosed using drugs, 16% admitted to using alcohol and 20% stated combined alcohol and other drug use. Most of the women who reported use on the day of their index offense reported that their use of substances may have affected their judgment: 60% felt that their judgment was seriously impaired, 11% thought their judgment to be moderately, impaired, and 11% mildly. Only 17% reported no effect on their judgment.

The Report of the Task Force on Federally Sentenced Women (1990:53) states that because of the high rate of substance use among incarcerated women, and the availability of drugs inside prison, the need for women's substance abuse programming is urgent.

Shaw, et al. (1990a) found that most of the women in their survey who regarded substance abuse to be a problem, had taken part in a treatment program either prior to their prison stay, or during their current sentence.

Overall, women found the programs to be helpful, but fairly superficial and too basic. Women tended to "go through the motions" of attendance without any real commitment. When asked what types of addictions programs they wanted, the women listed: longer, residential programs, better group programs, individual counseling, and native based. Moreover, respondents wanted the choice whether or not to attend programs, and a wider choice of programs available to them.

The reported inadequacy of substance abuse programming in meeting the needs of federally sentenced women may partially be explained by program design, if programs were not developed and delivered specifically for women. In summarizing their findings, Lightfoot and Lambert (1991:41) state that overall, incarcerated women have a different range and type of substance abuse problems than incarcerated men, which relate to their histories of trauma: "highlighted in this report is the accumulating evidence that eating disorders, major affective mood disorders (depression) and a history of abuse, possibly related to post-traumatic stress disorder are highly prevalent in women with substance abuse disorders." Correspondingly, they recommend that substance abuse intervention should be uniquely designed for women, or at the very least, include additional modalities.

Informed by the results of their study with the Prison for Women population, Lightfoot and Lambert (1992b) developed a typology of federally sentenced women's substance use and program needs. Incorporated into their model is a consideration of the interrelationship between women's substance use, eating disorders, distress and trauma related to abuse. The authors identified the following types of substance use and program needs:

TYPOLOGY OF SUBTANCE USE AND PROGRAM NEEDS BASED ON A SAMPLE OF 80 WOMEN, PRISON FOR WOMEN, 1981	
TYPE	**PROGRAM NEED**
Substantial Alcohol or Drug Problems (29.5%)	High Intensity Long Duration, Multi-Modal
No alcohol or Drug Problems (28.5%)	Preventive Education
Moderate Drug Problems (22%)	Moderate Intensity Broad Spectrum
Low Alcohol or Drug Problem Severity (19%)	Low Intensity Brief Treatment

SOURCE: Lightfoot, L. and Lambert, L. (1992b) *Typology of Substance Abusing Female Offenders*. Unpublished Paper.

Any substance abuse program for imprisoned women must realistically consider the limitations posed by the prison environment. As discussed previously, there are many stressors inside prison which may trigger traumatic memories or anxiety. Licit and illicit substances serve a useful purpose by helping women to cope both with past difficulties and with stressors inside the prison by avoiding negative and painful feelings. Further, despite security measures, drugs and alcohol are consumed inside prisons. One author suggests that a number of Canadian inmates who enter correctional facilities with no previous history of drug use become drug users during their incarceration (Riley cited in ECAP:5). Shaw et al. (1990a:25) state that one of the federally sentenced women interviewed during their survey reported that drugs were easier to obtain inside the prison than on the street, and that she was introduced to drugs while serving her time. The use of shared needles among inmates is of particular concern because of the associated risk of HIV transmission. In order to reduce the harms from injection drug use inside prison, ECAP (1993:88) recommends that small

quantities of bleach be made available to inmates and that they also be given confidential access to methadone. Recognizing the complexities of substance use in no way endorses or promotes the use of substances, but rather, highlights the necessity of comprehensive planning in the design of holistic and realistic programs.

The gender of substance abuse program providers and the gender composition of groups must also be considered in planning substance abuse programs. As with all intervention, the establishment of safety and trust is a prerequisite to healing. Because many women with addictions are survivors of male violence, and because of the role power imbalances play in women's use of substances, a number of authors recommend that only women provide counseling services to women and that groups be similarly limited to women, at least initially (Joyce and Hazelton, 1982; Reed, 1985, 1987). Program providers and counselors must further recognize that substance use is not experienced the same by all people, but rather relates to a number of factors, including social, economic and class position (Howard, 1993).

Peer education appears to be one of the most effective means of drug education. As such, ECAP (1993: 145) recommends that inmates "be encouraged to develop and assisted in delivering their own peer education, counseling and support programs." Peer education and peer counseling is discussed in the following section on feminist group work.

CURRENT ISSUES

Feminist groups have their origin in the "consciousness raising" (CR) groups of the 1960s and 1970s. Disillusioned with traditional therapy, women came together in groups to talk about their shared experiences as women. This type of self-help offered an alternative to the power imbalances embedded within customary therapy and medicine. CR groups also circumvented the isolation and the self-blame women felt, because in sharing common experiences, women came to analyze their position in political rather than individual terms.[7] In short, women came together to learn from one another (Lerman, 1987; Kirsh, 1987).

Initially, in efforts toward maintaining equal power among participants, CR groups had no leader. Soon, however, women took turns sharing the leadership role, and eventually, some women trained to serve as group facilitators. Contemporary feminist groups are often facilitated by trained professionals, but remain premised on the notions of consciousness-raising and shared participation (Lerman, 1987; Kirsch, 1987).

Today, many feminist therapists advocate group work as part of the healing process for women. Feminist groups are characterized by their participatory nature and the centrality of political analysis which encourages women to connect their own experience with societal power imbalances. Most

[7] This is encapsulated in the phrase "the personal is political".

fundamentally, such groups help women to know that they are "not alone", that they are not to blame for their disadvantaged social circumstance, and to assist them in taking control over their own lives. Overall, the goal of feminist group work is empowerment (Butler and Wintram, 1991; Brody, 1987). Stated simply, **empowerment** refers to a process designed to assist individuals in gaining insight into their life experience, including the ways in which they have been made powerless, identify their strengths, and receive support and encouragement to take self-determined action (Richie, 1992).

Feminist groups often form around shared themes including: eating disorders, substance abuse, adult survivors of child abuse, battered women, sexual assault, and AIDS. Herman (1992) suggests that groups for survivors of trauma are extremely valuable because they provide solace through shared understanding, and help to restore trust and connection with other human beings.

Because of the intensity of trauma-focused groups, Herman (1992) recommends that they be co-facilitated by people with a great deal of training and experience related to trauma and recovery. Furthermore, as discussed in the previous section on substance abuse, women should facilitate female groups, and same-sex groups are preferred.

IMPLICATIONS OF FEMINIST GROUP WORK FOR WOMEN IN PRISON

While there is little published material about women's groups in prisons, the available information suggests that groups which are premised upon the

empowerment of participants are valuable. Unfortunately, no long-term data has been collected in which to ascertain the impact of feminist based groups once an inmate is released from prison.

Sultan and Long (1988) found that a group for sexually and physically abused women in the North Carolina Correctional Centre for Women resulted in enhanced self-esteem, a greater sense of "being in control", and increased trust in others. Participants also reported improved relationships and reduced violence. The group was structured on a psycho didactic-support model. In this type of model, group participants initially set the tone and pace of meetings. Gradually, discussion and interaction become more focused around relevant educational materials prepared by group facilitators. Participants are encouraged to connect their own experiences with the information, to make linkages with one another by learning about shared histories, and to provide mutual support and encouragement for one another in improving individual and social circumstances.

Also at the North Carolina Correctional Center for Women, the psycho didactic-support model was used in the design of groups to help inmates adjust to prison life (Sultan, Long, Kiefer, Schrum, Selby and Calhoun, 1984; Sultan, Long and Kiefer, 1986). Each group had between six and eight members and was co-facilitated by an inmate and staff psychologist. Initial group meetings occurred within 72 hours following an inmate's arrival. The groups were comprised of six sessions lasting for three weeks, and were 60 - 90 minutes in length.

Self-report measures indicated that women who were involved in the groups

were less anxious and found it easier to adjust to prison life than women who were not in the groups. Sultan et al. (1984) conclude that the opportunity for inmates to discuss their early days in prison was related to decreases in physical complaints, and that the inclusion of an inmate as co-faciliator was very beneficial.

The Family Violence Program in Bedford Hills Correctional Facility, New York State, offers a number of different groups to women relating to issues of violence, including: battering/abusive relationships, adult survivors of child abuse, survivors of incest, survivors of rape, and women with child-related crimes. Because the overall goal of the program is to create a healing environment through empowering and supporting women, group participants determine the process. Therefore, each group is uniquely specific to the needs, issues and concerns of its members (Smolick, 1990).

Prior to their involvement in a family violence group, all members must take part in an orientation process, six sessions in length, with each session lasting one and one-half hour. Overall, orientation workshops establish a shared understanding and language about violence and empowerment, and help to create a safe and supportive environment. Individuals are also provided with individual therapy, if requested. (Smolick, 1990).

In addition to reported success with individual participants, the family violence program offers educationals to security staff as well as to the surrounding community. An innovative aspect of the program is the Bedford Women's Theatre Collective. In their own words, the purpose of this collective: "is an effort to express the mental, emotional, physical and sexual

abuse of people who've been abused...In sharing our personal truths with each other we have begun to heal and grow stronger individually and as a community" (The Women of the Family Violence Program, 1991:16).

Included within the overall family violence program at Bedford Hills, is a peer support group for women incarcerated for the death of a child (Kaplan, 1989). Because women imprisoned for filicide are typically ostracized by the general population, peer support is particularly important to this group of women. The group at Bedford Hills was facilitated by a community social worker and inmate participation varied from four sessions to regular attendance over a two-year period of 85 sessions. The group attracted women who rejected the traditional institutional services as inappropriate to meeting their needs. Five phases marked the group process: "reduction of isolation, emotional acceptance of responsibility for the crime, mourning the loss, identification of destructive patterns in dealing with negative feelings, and the development of constructive alternatives for these negative patterns" (Kaplan, 1989:11).

Group participants indicated that the greatest impact the group had upon their lives was providing them with the realization and relief at knowing that they were not the only ones who had been responsible for the death of a child. Because they were able to mutually voice and confront their experiences and concerns in safety, they were able to achieve greater self acceptance, responsibility, and self-determination. The women also reported that by helping others within the group, they were helping themselves. Some of the women continued meeting as a group once released from prison, and continued to meet monthly for a two-year period. These post-release

meetings focused upon a broad range of issues related to reintegration.

An anger group for female offenders at Renz Correctional Facility, Columbia, Missouri, was also reported to be successful (Wilfley, Rodon and Anderson, 1986). The aim of the program was to assist inmates in acknowledging, accepting and constructively releasing their anger. The group was co-facilitated by two women who based the program upon women's unique experiences with anger. A screening process was initially employed to ensure participant input and to screen out potentially inappropriate members. Group sessions usually began with social conversations in which personal experiences were shared. These conversations served as an important source of support to members. Other components included educationals followed by group discussion of the material, participation in a variety of exercises and homework assignments. The group is reported to have assisted women in becoming accountable for their past, present and future actions. Participants reported that group membership contributed toward increased personal control, self responsibility and empathy. These findings were corroborated by the observations of other group members. The mutual support system which developed from the group was also regarded as a very important consequence of participation.

The Empowerment Program at Rikers Island Correctional Facility, as indicated by its name, is also oriented toward mutual support and understanding. The groups overall aim is to reduce the risk of AIDS through positive social action. Group members are encouraged to develop skills which protect their health, to learn from one another, and to view their individual circumstances in relation to the larger social context. While a

detailed curriculum manual is available, the facilitators use it more as a guide than as a recipe, and encourage participants to define and take ownership over the group process (Richie, 1992).

Ownership is fostered by intensive interviews and focus meetings held prior to the beginning of each group. The interviews and meetings establish key themes for group discussion. Each group consists of five two hour sessions, and involves discussion, role plays, and the construction of action plans. The facilitator's main role is to assist members in making the connection between AIDS and other issues in their lives (Richie, 1992).

A unique adjunct to therapy inside the Prison for Women is the The Peer Support Team (PST, also mentioned in the earlier section entitled "feminist therapy"). The purpose of the PST is to provide officially sanctioned peer counseling, support and comfort to inmates. Each PST counselor must take part in training sessions designed to assist inmates in developing their own coping and counseling skills, and to instill confidence in their ability to support others through crises. Counselors must initially undergo a screening process, and afterward participate in a six week training session. Graduates of the program are expected to continue involvement in PST training by attending subsequent groups with new trainees. Furthermore, all counselors are required to meet once a week in between training sessions, in order to discuss any pertinent issues, provide support and receive feedback (PST Training Manual, 1992; Pollack, 1993).

Similar to the groups at Bedford Hills and Rikers Island, Peer Support Team training aims to empower participants by encouraging them to contextualize

their own position within the larger societal picture, and assisting them to recognize shared experiences (Darke, 1990). Pollack's (1993) evaluation of the PST found that the program was very valuable to the peer counselors who reported that the group training sessions helped them to learn new skills, develop trust, improve self-concept and establish more positive perceptions of others. The ethnic and racial diversity was found to be particularly important to participants in helping them to bridge differences and reach a common understanding. The general prison population surveyed reported that the PST was a valuable asset to the prison (See Companion Volume II for a brief summary of Pollack's evaluation).

Another peer-based group which offers training in counseling skills to its members, is the AIDS counseling and education (ACE) group at Bedford Hills Correctional Facility (see also the earlier section entitled "feminist therapy"). As with the other groups, ACE is premised on empowering participants as well as the prison community. It is different from the other groups however, because it is essentially completely run by inmates. ACE contributes to the prison community by: providing support to Persons with AIDS and HIV infected women, advocating for medical services, assisting women with pre-release planning, and peer education (Clark and Boudin, 1990; Women of ACE, 1992).

Before becoming a counselors, ACE members are required to take part in a series of eight workshops. Following the workshops, graduates must participate in a screening process. Successful graduates are then given more intensive training, and finally become ACE members. While ACE has helped to create a more caring, trusting and supportive environment, it is unknown

how well the knowledge gained inside the prison translates into the community upon release (Clark and Boudin, 1990; Women of ACE, 1990).

It is important to recognize the particular limitations posed by the prison environment upon group effectiveness. Juda (1984) reported that the group he facilitated with co-ed inmates in a New England Correctional Facility, collapsed due to impositions by prison staff and administration. He states that prison forces often mitigate the establishment of group cohesiveness essential to group success. Juda (1984) recommends that group facilitators working within prisons must ensure the following: a private room which is recognized as special within the prison, consistent meeting times, regular attendance, and maximum staff and institutional support for group leaders and members. Women of ACE (1990) and Pollack (1993) similarly note the importance of establishing institutional support and respect for the success of peer counseling programs, so that access to peers is not readily prevented by staff.

Furthermore, facilitators need to be aware of institutional rules, schedules and procedures. Flexibility and patience are often required, as institutional measures such as "lock ups" and "lock downs" can interfere with or prevent groups from running. Additionally, facilitators should be aware that "external" factors, such as personal grievances, family visiting days, holidays, inmate problems with staff and/or management, and smuggled drugs, can have great impact upon inmates, and may influence the group process. In addition, it must be remembered that groups inside correctional facilities are very different than groups in the community, because participants live with one another. This may cause added tension in a population which already

has diminished trust (Sultan and Long, 1988; Loewenstein, 1983).

As this report has shown, much of the literature indicates that for incarcerated women to heal, they must begin taking control of there own lives. Women who participate in groups which are premised upon this assumption may in fact, recognize their strengths, and begin demonstrating self assertion (Craig, 1981). Traditionally, however, prisons have discouraged women's independence and self-control (Velemisis, 1981). Prison policy and practice which stifle or punish women's new-found self-efficacy could create a high degree of frustration and potentially retraumatization (Craig, 1981; Genders and Player, 1987). The examples provided within this report suggest that groups encouraging empowerment can operate inside prisons without posing a security risk.

CURRENT ISSUES

The term "adult education" refers to a variety of educational programs and can be defined simply as any course taken by adults, regardless of content (Purvis, 1976). Adult educators typically regard education as a "second chance" for adults to improve their social circumstance. Relatedly, those working in the field have traditionally been concerned with understanding and changing class inequality (Gaskell and McLaren, 1987). One of the most influential in this regard has been Paulo Freire.

Paulo Freire was a Brazilian educator who developed a program for illiterate peasants. Freire (1970) employed a pedagogy "for the oppressed" he called **conscientization**, whereby learners were regarded as knowing subjects, who could develop a deep of awareness of the social context which shape their lives, and become empowered to change their circumstances. Freire criticized the predominant mode of education which he likened to "banking" because students are seen as depositories of knowledge and teachers as the depositors of such knowledge. In contrast to the banking model which promotes inequality between teacher and learner, Freire emphasized the importance of valuing the experiences, knowledge and realities of learners, and to regard learning as a process where students and teachers participate together in partnership. Freire's writings have been very influential, and a number of international programs have been based upon his ideas (Otte, 1975; Craig, 1981).

Despite Freire's impact upon adult education, the application of his pedagogical process pertaining to the specific situation of women has been largely unaddressed (Maguire, 1987; Craig, 1981). The failure to consider women's unique experience is reflective of such neglect in the broader theory and practice within adult education (Thompson, 1983). Increasingly, however, educators are filling the gap by placing women in the center of their theories and practice (Hughes and Kennedy, 1980; Jean, 1984, Rockhill, 1987; McLaren, 1987; Tom, 1987; Horsman, 1990). Taken together this new scholarship has much to offer in efforts toward developing a pedagogy relevant to the experience of women. Central to this body of work is an understanding that educators must recognize the full complexity of women's lives including power and control issues. The new scholarship in adult education suggests that if pedagogy is to be relevant to women's lives, the following points must be recognized:

1) Educational programs have the potential to empower women by encouraging them to think critically about their lives and to consider the commonalities between their own lives and the lives of other women (Horsman, 1990; Maguire, 1987; Mies, 1983; Craig, 1981).

2) Women occupy a marginal status in society, and education alone will not transform the position of women either collectively or individually. Societal inequalities and realities such as joblessness, must be acknowledged in the creation, transmission and impact assessments of adult education. Relatedly, educators should be careful not to regard a woman's lack of participation in educational programs or to view her inability to rise in status following her attendance in educational programs as an individual

inadequacy such as lack of motivation, or a bad attitude (Horsman, 1990; Gaskell and McLaren, 1987; Mulqueen, 1992).

3) Educators must consider that women's time is often organized around the demands of others including children, male partners and extended family members. Therefore, flexibility and innovation is crucial in the scheduling, delivery and location of educational programs (Horsman, 1990).

4) The social aspect of learning is very important to women. Rather than viewing education simply as something which occurs in isolation and silence, teachers should regard the opportunity for social interaction as not only credible but central to women's learning (Belenky, Clinchy, Goldberg and Traule, 1986; Horsman, 1990; Gilligan, et al., 1988).

5) The impact of violence upon women's lives, and it's effect upon learning must be recognized. For example, writers have documented the ways in which men resist women's involvement in education, including responding with violence. Others have discussed the difficulties victims of violence have in attending programs and concentrating in the classroom (Rockhill, 1987; Thompson, 1983; Horsman, 1990; McNulty, 1981; Krisch and Wells, 1992/93; Spring, 1987). Many women have suffered violence at the hands of male authorities, and the relationship between this history and interaction with male teachers must be recognized (Belenky, Clinchy, Goldberg and Tarule, Brookes, 1992).

6) Educational resources, curriculum and standards of evaluation should be developed in partnership with those it is meant to serve. Learners can

participate in the construction of their own resources and curriculum design, define their own educational needs and evaluate the effectiveness of educational programs in terms of their own goals. This will help to ensure the relevance of education to their lives. (Krisch and Wells, 1992/93 Gogia; 1992/93; Belenky et al.,1986).

7) Dialogue among learners and between teachers and learners is essential. Women should be encouraged to actively participate in their learning, and teachers should confirm and support the evolution of students' thinking. In this way, knowledge is not regarded as the secret property of experts, but rather as existing inside all of us (Belenky et al, 1986; Loewenstein, 1983).

8) Women frequently report prior negative experiences with primary education, having been met with silence and themselves silenced. Often, schools leave girls feeling "stupid" and incapable of learning. Women may therefore, demonstrate hesitancy in becoming involved in educational programs, and educators should be aware that inappropriate education could further perpetuate self-deprecating beliefs (Gilligan, Lyons and Hanmer, 1990; Gilligan, Rogers and Tolman, 1991; Brown and Gilligan, 1992).

IMPLICATIONS OF ADULT EDUCATION FOR WOMEN IN PRISON

The literature on adult education is consistent with the previous sections in emphasizing the necessity of contextualizing women's experiences within the larger social context, emphasizing empowerment, and reducing power imbalances by encouraging participation throughout the learning process. It further underscores the need for realistic planning, in terms of setting

program goals and evaluation measures. Relatedly, a woman's refusal to enroll in a program, failure to complete a program, use of substances, or reconviction should not be isolated to individual shortcomings, but rather be contextualized within a larger framework. Even the best program cannot mitigate social factors and power imbalances outside the prison, such as unemployment, racism, and sexism.

Given the fact that many women inmates have histories of abuse, program planning and implementation should consider the consequences of women's abuse histories upon their learning processes. As Brookes (1992:6) writes: "Teacher: Imagine. How it feels to learn how to read; write and think when all you feel is badly about yourself. Imagine." Relatedly, the difficulties women prisoners may have with male authority figures, should be considered in the choice of educators.

An innovative program for survivors of abuse, based upon the principles of empowerment, is the BRIDGES Employment Training Project in Victoria, British Columbia. The program is designed specifically for women survivors of childhood and/or adult abuse who recognize abuse as a major barrier in attaining employment. The BRIDGES program begins teaching from where women themselves are at, and creates a positive and supportive learning environment which is experience-based. The program includes a diverse range of approaches in which to engage the learner. A Learning Style Inventory is used, allowing women to identify their own learning style and strengths. "Superlearning" techniques and experiential learning help women to build positive self images by allowing them to see their strengths, skills, values and desires. Follow-up studies indicate that the program has been

successful in creating positive self perception and in assisting women to attain employment, further training, and education (Krisch and Wells, 1992/93; Artz, 1992).

Similar to the BRIDGES program, Maguire (1987) worked with survivors of abuse. As part of her doctoral degree, Maguire (1987) used feminist participatory research in working with a group of former battered women in Gallup, New Mexico. Participatory research is composed of three areas: social investigation, education and action. In working with the Former Battered Women's Group, Maguire set out to facilitate problem solving and community outreach to other battered women. Before founding the support group, the researcher met with potential participants to define common themes upon which to frame group dialogue. Group dialogue assisted women to analyze their abusive experiences in the context of sexism and isolation, and to encourage problem-solving strategies. The group also engaged in collective education by informing people outside the group about their experiences. The suitability of this type of program for incarcerated women should be considered.

In fact, there is precedence for establishing a program similar to BRIDGES and to Maguire's group, within a women's prison. Craig (1981) designed a literacy/conscientization program for women in Huron Valley Women's Facility, Michigan. Based upon Freire's "pedagogy for the oppressed," and feminist therapy, the program was aimed at women whose reading level was below Grade six. Craig initiated the program by first meeting with and interviewing women, in order to find out what themes were most relevant to their lives. These themes later became the foundation for learning in which

participants linked their shared experiences to a variety of educational materials which included: films, records, television programs, photographs, fiction, nonfiction and poetry. In this way, participant's increased their literacy by drawing upon themes they could identify with, and in an environment which valued individual learning styles.

In Framington Correctional Institution, Massachusetts, Loewenstein (1983) used writing as means to foster individual awareness and strength. Women were encouraged to explore oral and written poetry, plays, songs, stories, songs, and letters in the context of their experiences. Rather than teaching to women, Loewenstein (1983) participated with women to find out what they needed to say and how to say it. The author reported that this approach met with a great deal of success, and highlighted one particular example to illustrate the potential of writing. One woman wrote a play about her experiences within prison, and women came together to produce it. The shared experience helped to create a sense of community and mutual trust. The Bedford Hills Women's Theatre Collective, mentioned previously in the section on group work, is another example of the positive application of drama within women's prisons.

Based upon her review of the literature, and on her own experience, Ross (date unknown) argues that gender studies can be a very valuable asset to prison education. The author found that courses with a feminist content can make a significant difference to the lives of students, and should be included in correctional education curriculums. Overall, gender studies encouraged women to envision and act upon positive choices by allowing them to connect their offenses within the broader social context and to other aspects of their

experiences. Furthermore, she advises that such courses and workshops would be very beneficial to prison staff.

The adult education literature obviously has direct relevance to the department responsible for inmate education. It would be valuable for such departments to consider the recommendations for fostering women's learning suggested by adult educators.

CURRENT ISSUES

Feminist writers have demonstrated that many mental health professionals retain distorted notions about women, carry little knowledge of women's psychological development as it differs from men's, and have incomplete understanding of the realities and complexities of women's lives. Drawing upon their own perspectives, men have developed the prevailing theories, and set the values which have guided psychological principles for both men and women (Greenspan, 1983).

The consequences of a male-centered psychology are very evident in the study of psychological development, where male bias led to conclusions that women lacked moral reasoning skills, were morally deficient and developmentally delayed. The predominant theory held that growth in development was signified by the attainment of separation and individuation (Kohlberg, 1973, 1976, 1981; Piaget, 1932; Freud, 1961). Within such a framework, women appeared abnormal because they follow a different developmental process - one which emphasizes **connection** and **relationship**, rather than separation and individuation. For example, Gilligan (1982) found that women approach moral decisions differently than men. Whereas men base moral decisions on principles of justice (i.e. what is fair?), women make their determinations on the basis of compassion and care (i.e. who will be hurt?). In sum, women tend to **care for** others, while men strive to **protect the rights** of others.

A number of feminist psychologists have similarly found that women's psychology is best understood in a context valuing women's developmental process as **self-in-relation**, characterized by the importance of connection with others (Chodorow, 1978; Belenky, Clinchy, Goldberger and Tarule, 1986; Miller, 1976; Surrey, 1984; Gilligan, Ward, Taylor and Bardige, 1988; Gilligan, Lyons and Hanmer, 1990; Gilligan, Rogers and Tolman, 1991; Brown and Gilligan, 1992; Jack, 1991). This does not imply that gendered differences in psychology are natural, rigid, immutable, or that one is superior to the other. It does however, suggest that psychological differences between men and women must be recognized in both psychological theory and practice. The following list considers some of implications for a women's psychology:

1) A learning model appropriate to women, "emphasizes connection over separation, understanding and acceptance over assessment, and collaboration over debate" (Belenky, Clinchy, Goldberger and Tarule, 1987: 229). For women, knowledge and empowerment develops from the process of mutual empathy (Jordan, 1984).

2) Assessment tools, surveys, and questionnaires must be developed in ways relevant and appropriate to women's psychology. Interpretation of information must likewise occur within a paradigm meaningful and specific to women's psychology (Belenky, Clinchy, Goldberger and Tarule, 1987; Currie, C., 1986; Gilligan, 1982).

3) Treatment programs for women must be developed, implemented and evaluated in ways which recognize the centrality of relationships for women.

Treatment models should emphasize collaboration and cooperation rather than hierarchy and power imbalance (Walker, Eric, Pivnick and Drucker, 1991; Miller, 1976).

4) Physiological differences between men and women must be considered in research, assessment and treatment. For example, in the study and treatment of alcoholism, sex differences in absorption and metabolism is important (Forth-Finegan, 1991). It is critical however, that gendered variance in behavior, socialization, etc. are understood through a non-sexist perspective and never reduced simply to physiology (Tavris, 1992).

5) Women often feel responsible for relationships and blame themselves when relationships fail. This should be understood in context of the interplay between women's psychology and socialization, rather than in a framework of mental illness (i.e. masochism, self-defeating personality disorder; see Caplan, 1987, 1991).

IMPLICATIONS OF WOMEN'S PSYCHOLOGY FOR WOMEN IN PRISON

The literature in women's psychology echoes earlier findings within this report, supporting recommendations for correctional research, evaluation, programs and therapy that is rooted in the experiences of women. Fundamentally, current research on women's psychology indicates the importance of connection to women's learning and interaction styles. This includes women's active participation in the learning process, shared dialogue, and empathic rather than confrontational approaches to learning. If therapy, group work and schooling are to be effective for women, the value

of connection must be central.

An understanding of women's psychology may also help staff to better understand women's behavior inside prisons. As alluded to earlier, Pollack-Byrne (1984) found that correctional officers reported women to be "harder to work with" than men, in large part because of their greater emotionality. When asked to describe what they meant by emotionality, officers reported the following: "1. Open displays of feelings through crying, laughing, hostile expression, and so on; 2. Sharing among women of feelings and emotions, strong attachments between women, and 3. Changeability of emotions without any observable reason" (Pollack, 1984:85). These descriptors fit closely with women's desire for connection with others, through sharing of emotions. Rather than a sign of "illness" or "badness", emotional displays and attachment to others, is congruent with women's "normal" psychology.

Perhaps most significantly, the research indicates the importance of relationships. More specifically, the research shows the need for women prisoners to be involved in relationships of equality. As Eaton (1993) writes, women prisoners have typically experienced subordination and control by others in relationships. In forming mutual relationships where they are recognized as equals and where their individuality is valued, women become empowered to recognize their own self-worth and self-efficacy. Relating to others in ways which affirm women's sense of self, enables them to see that they can take control over their own lives. For example, Eaton (1993:96) quotes the following words of a former prisoner discussing her relationship with her probation officer:

> I actually had someone who would listen to what I said I wanted from my life and not what they wanted or what they thought I should have...I decided I was going to have control of my life as much as I could do instead of letting other people have control. I never realized that I could have control, but you can.

Relatedly, the essential message from federally sentenced women across Canada, as reported by Shaw et al. (1990a:49), was the need for support, rather than control. The women indicated the desire to be treated with dignity and respect, and to be related to as women, rather than as prisoners:

> ...they stressed that staff should treat women as human beings and with respect, that they should have understanding of the kinds of lives and circumstances they have lived through, that they should be able to talk through problems rather than punish, and that they should have compassion.

In their interviews with federally sentenced women released into the community, Shaw et al. (1991b) found that the quality of relationships established between themselves and their community workers, classification officers and parole officers was integral to their progress and reintegration into the community.

Studies indicate that the relationship between staff and inmates in a women's prison is qualitatively different than staff-inmate relations in male prisons. Overall, female correctional staff are found to engage in more personal relationships with inmates and display greater sensitivity to inmate difficulties (Ackerman, 1972, Pollack-Byrne, 1990). The foundations for cultivating mutually respectful relationships within the prison environment may therefore be present. While prisoner-staff relations are always limited by the hierarchical nature of prisons, efforts to create more equitable relationships would benefit both staff and inmates.

CURRENT ISSUES

A number of feminist therapists have shown that feminist therapy, both in practice and theory, has given insufficient attention to the range of diversity among women. Until recently, feminist therapy and practice has operated from a white, middle-class heterosexist bias, obscuring the fact that the burdens of oppression fall heavier upon some women than others. The priorization of gender as **the** issue has rendered the impact of racism, anti-Semitism, classism, heterosexism, ageism, refugee and immigrant status, and the consequences of disability upon women's lives almost invisible within the feminist therapy literature (Lerman, 1987; Brown and Root, 1990; Siegel and Cole, 1991; Cole, Espin and Rothblum, 1992; Boston Lesbian Psychologies Collective, 1987; Falco, 1991; Burstow, 1992).

Currently, feminist therapists are striving toward more encompassing theories and incorporating more appropriate methods of intervention Some of the overall findings within the recent literature suggest the following:

1) The term "white privilege refers to the automatic access bestowed on Whites...simply as a result of their skin color and living in a historically racist society" (Rave, 1990:314). Others in our society have privilege by virtue of their gender, class, sexual orientation, ability, age and religion. Therapists should continually strive toward understanding the effects of their own privileges, how they may be contributing toward and perpetuating

power imbalances, and ways in which they can work toward confronting the various facets of oppression (Brown and Root, 1990; Fulani, 1988).

2) Therapists should actively endeavor toward the inclusion and promotion of diversity within their profession, so that clients can have the opportunity of working with therapists who share similar background and experience. For example, recent literature suggests that it is preferable for Aboriginal clients work with Aboriginal therapists, Women of Color therapists work with Women of Color clients, disabled women work with disabled women, and lesbians work with lesbians (Burstow, 1992). This does not negate the possibility and benefits of working across differences, but recognizes that shared position assists in reducing power imbalance and exposes the value of common lived experience in the therapeutic relationship (Fulani, 1988; Brown and Root, 1990). Ultimately, women should be able to choose a therapist with whom they are comfortable.

3) Therapists should be cognizant of their own privileges during therapy, and educate themselves in issues of diversity in order to prevent faulty and dangerous assumptions, based upon their own experience or ignorance (Fulani, 1988; Brown and Root, 1990; Burstow, 1992; Sue, 1981; Siegel and Cole, 1991; Cole, Espin and Rothblum, 1992; Falco, 1991).

4) Therapists must consider a woman's difficulties and strengths in the context of racism, heterosexism, anti-Semitism, classism, ageism and a society which discriminates against the differently abled. The ways in which various oppressions, including violence, impact upon people are complex, and therapists should avoid the tendency to priorize gender inequality as the

issue to focus upon (Fulani, 1988; Brown and Root, 1990; Rafiq, 1991; Dua, 1991; Gupta and Silvera, 1989; Berrill, 1986; Canadian Council on Social Development and Native Women's Association of Canada, 1991; Kosberg, 1983; Cole, Espin and Rothblum, 1992; Boston Lesbian Psychologies Collective, 1987; Falco, 1991).

5) Feminist therapy research, theory and practice, grounded in white heterosexual women's experience, may not be relevant to the experiences of other women. Much more work needs to be done to develop and implement therapeutic research, analysis and treatment appropriate to the diverse experiences of women, and this work should be done by and for marginalized people (Fulani, 1988; Brown and Root).

IMPLICATIONS OF DIVERSITY IN FEMINIST THERAPY FOR WOMEN IN PRISON

The rich diversity among incarcerated females has been woefully neglected, and therefore very little information exists in this regard. I have attempted to bring together some information which begins to touch upon issues of diversity among women inmates - yet I realize that this section is still very meager. Furthermore, it does not encompass the range of experience within each of the groups discussed. Individual women do not belong solely to any one category of women. Women simultaneously occupy a variety of statuses and experience different oppressions. However, the following overview does provide some indication of considerations that must be made in the design and practice of therapy within prisons.

In Canada, Aboriginal women and men are disproportionately represented inside prisons (Report of the Task Force on Federally Sentenced Women, 1990).[8] Research indicates that Indian, Metis and Inuit peoples are the most marginalized communities in Canada, sharing a history of racism, oppression, and genocide. These factors are all related to the crimes Aboriginal people are charged with, and must be addressed in any consideration of correctional research and planning (LaPraire, 1984; 1987; Sugar and Fox, 1990, 1989-1990; Dubec, 1982; Grossman, 1992; Report of the Aboriginal Justice Inquiry of Manitoba, Volume I, 1991).

In their survey of federally sentenced women serving sentences in the Prison for Women and in the provinces, Shaw et al. (1990a) found the rate of abuse to be higher among Aboriginal women than non-Aboriginal women: 90% indicated that they had been physically abused, and 61% disclosed being sexually abused. The use of substances was also higher among Aboriginal women than other women: 10/39 reported addiction to drugs, 12/39 indicated addiction to alcohol and a further 12/39% disclosed addiction to both. Overall, the survey found that Aboriginal women have histories of much greater disruption than non-Aboriginal women.

The Prison for Women survey further found that Aboriginal women reported feeling discomfort with non-Aboriginal medical staff, and with non-Aboriginal facilitators of addictions programs. While many found their individual sessions with psychiatrists and psychologists helpful, women

[8] 1991-1992 statistics indicate that approximately 20% of the on-register federal female offender population was comprised of Aboriginal women (**Basic Facts About Corrections in Canada 1992 Edition**, Ottawa: Minister of Supply and Services Canada, 1992).

would have preferred to work with a Aboriginal counselor particularly in programs dealing with abuse and substances. Women who had the opportunity to participate in Aboriginal-based addictions programs, found them helpful and more relevant to their lives. Shaw et al. further found that access to cultural and spiritual traditions was very important to Aboriginal women who stressed that these traditions should be honored in all aspects of their incarceration.

Fox and Sugar's (1989-90, 1990) survey of 39 Aboriginal women who had served federal sentences confirmed the findings of Shaw et al. (1990a). Twenty-seven of the women interviewed reported experiences of childhood violence, and 34 disclosed experiences of violence in adulthood. Thirty-one of the women reported that they had abused alcohol, and twenty-seven stated that they were severely addicted to narcotics. Twenty-three of the women spoke of being addicted to prescription drugs provided by institutional psychiatrists or physicians while inside various institutions. Barriers in developing trusting relationships with White authority figures was illustrated by reports that twenty of the women had encountered negative experiences with police, and thirteen had negative experiences with their case management officers. Relationships with correctional officers was described in very negative terms, including physical beatings, rape, sexual harassment and verbal intimidation. Overall, Aboriginal women in Fox and Sugar's study experienced the prison as sexist, racist and violent.

A report published jointly by the Native Women's Association of Canada and the Canadian Council on Social Development (1991:26) suggested the following strategy for ending violence:

> The preferred approach to dealing with violence is to establish aboriginal lodges in the community for individuals (offenders and victims) and family members to work towards healing, through their renewal of spiritualism and customs.

In her study conducted at the Prison for Women during 1992 -1993, Pollack (1993) reports that there were no Persons of Colour on the mental health staff. A full-time Native counselor had been providing support to Aboriginal inmates by organizing cultural ceremonies and providing some case management duties, but was no longer working at the prison. Several of the peer counselors Pollack interviewed emphasized the need for culturally specific support. In particular, the author reports that the mental health needs of Black women are neglected. Because there were no Black mental health providers with whom Black women would be more likely to identify with, many of those interviewed felt that Black women were not receiving adequate counseling.

This literature search uncovered almost no information on Black inmates, and none on Asian inmates[9]. In a file review of Black offenders under supervision in the Halifax community, Miller (1991) identified the following factors to be related to offending: alcohol, drugs, emotional problems, lack of employment, and academic/vocational. The author further interviewed 51 offenders under supervision, and found that 42% reported that they wanted to receive drug treatment. Twenty-two percent expressed an interest in alcohol programs, and 25% indicated a need for emotional support. Further data indicated that 42% of those interviewed had received some type of

[9] 1991-1992 data indicates that approximately 8% of the on-register federal female offender population was comprised of Black women, and 3% was comprised of Asian women (**Basic Facts About Corrections in Canada 1992 Edition**, Ottawa: Minister of Supply and Services Canada, 1992). Current patterns indicate an increase in the number of Black women serving federal sentences.

treatment either in the institution or in the community. What is not known from this data, is the number of women in the sample, and any differences across gender. However, eighty-four percent of Miller's (1991) sample indicated that the needs of Black offenders were different than others offenders, and less than 50% reported that they were given good treatment by staff. The respondents provided numerous examples of racism displayed by staff members. Miller's recommendations include hiring visible minority staff and implementing specialized drug intervention for Black offenders. Again, it must be recognized that the representation of women's voices within Miller's findings is unclear.

Immigrant and refugee women encounter racism as well as the experience of dislocation. Stressful factors impacting upon the lives of these women may include: the hazards associated with migration, adjustment to a new culture, isolation, loss of family, property and status, and economic hardship. Furthermore, these women may have experienced trauma, and possibly torture, associated with war or civil unrest (Cole, Espin and Rothblum, 1992; Skodra, 1989). Although I was unable to come across any literature specific to the experience of incarcerated immigrant and refugee women in Canada, it is likely that the prison experience magnifies stress - particularly where language and customs are different from the majority of the population. Statistics extracted from the Offender Population Profile System for November, 1992 indicate that the Prison for Women population included seven women with landed immigrant status, and women with the following citizenship status: South America (n=1), Trinidad-Tobago (n=1), Jamaica (n=2), Nigeria (n=1), Ghana (n=1), Poland (n=1), France (n=1), England (n=1), and U.S.A. (n=9). While prison populations are always in flux, the

unique needs of immigrant and refugee inmates must be recognized, particularly by those people providing therapeutic services.

Approximately 40% of French speaking women serving federal sentences are incarcerated outside of Quebec. Shaw, et al. (1990a) found that these women reported difficulties in communicating their problems to non-French speaking medical and mental health care staff. In particular, Francophone women wanted the option of working with a French-speaking psychologist. The Report of the Task Force on Federally Sentenced Women (1990) recognizes the importance of being able to communicate in one's own language.

A woman's religion or spirituality is often an important aspect of her identity and therefore should also be acknowledged and respected within the prison environment (VanBaalen, 1992). Similarly, therapists should be respectful and have familiarity with the religious and spiritual beliefs and practices of their clients, but should not make assumptions in this regard.

Feminist therapists are beginning to address experiences unique to Jewish women, and those working within the prison environment should do likewise.(Siegel and Cole, 1992; Burstow, 1992). It is important to recognize that Judaism is only one aspect of Jewish identity, which encompasses a shared culture, history and ethnic identity (Kaye and Kantrowitz, 1992). Therapists need to be aware of the impact anti-Semitism may have upon the lives of Jewish women. I was unable to locate any material specific to the experience of Jewish incarcerated females.

I was further unable to uncover material specific to the experiences and needs of differently-abled incarcerated women. There are many different conditions faced by women which should be considered, including: impairment in vision, hearing, mobility, learning and development (Saxton and Howe, 1987; Matthews, 1983; Browne, Connors, and Stern, 1985). Chronic pain and illnesses as well as hidden conditions such as pelvic inflammatory disease need to be recognized as well. Therapists should be particularly aware of the experiences of disabled women within the context of an ablest society preoccupied with body image (Burstow, 1992). Many disabled women face the hardships of poverty, restricted movement (blocked by physical barriers such as curbs and stairs) and restricted communication (i.e. the lack of Braille, sign language or other communicative devices). Furthermore, statistics indicate that disabled women are sexually assaulted three times as often as non-disabled women (Burstow, 1992: 94). Additionally, disabled inmates may experience an intensification of the infantilization prevalent within prisons.

Morton (1993) suggests that the experiences of older female inmates are almost completely overlooked in correctional planning. While older female offenders represent a heterogeneous group, they share experiences related to aging which may include physical health problems, discrimination, poverty, and issues of loss. The author recommends that staff have training in issues related to aging, and that consultants and volunteers specializing in aging be utilized.

Pregnant inmates also have unique needs. Hufft, Fawkes, and Lawson (1993) state that the experiences of stress, restrictions and isolation, common

to all inmates are exacerbated during pregnancy. Pregnant inmates not only lose their freedom, self-esteem and privacy, they must also cope with the impending loss of a child and identity as a mother. Inadequate and/or inappropriate pre-natal medical care compound emotional difficulties and create health risks. Yet, inmates are often afraid to complain about problems with health care for fear of adversely affecting further treatment. The authors recommend that inmates be supported to actively participate in decision-making processes and that they receive clear and extensive information regarding what to expect during pregnancy and childbirth. Furthermore, staff must empathically respond to women's distress. General principles guiding maternity and nursing care include: "plans to reduce stress, to decrease environmental restrictions, to promote a healthy lifestyle, and to develop decision-making and coping skills for resolving infant placement problems and assuming a maternal role after the birth" (1993:56).

Following the delivery of her child, an inmate encounters further stresses and difficulties. While individual experiences of parenting differ and depend partially upon prison regulations (i.e. if the child is allowed to remain inside the prison with her/his mother, visiting privileges and arrangements) those providing counseling and other services must be aware of issues common to prison mothers, including: barriers to mother-child bonding and relationships, loss and grieving, guilt, and parental involvement with child welfare agencies (Cannings, 1990; MacLeod, 1986, Wine, 1992).

Shaw et al. (1990a) found that two-thirds of federally sentenced women had children. Fifty-eight percent of women serving time at the Prison for Women, and three-quarters of those in the provinces were parents. Many of these

women had tremendous concern over lost custody of one or more of their children. Women reported that contact with their children, regardless of their age, was essential to personal well-being. The majority of the Prison for Women population and 40% of the provincial population indicated an interest in programs about children. Shaw et al. (1990a) identified a need for programs addressing issues surrounding coping with parenting in prison and parenting from a distance. In her extensive study of the impact of criminal justice involvement on women and their children, Wine (1992) concluded that policies and procedures in all levels of the Canadian justice system are inadequate in meeting the needs of mothers and their children. She suggests that women and their children be provided with assistance before, during and following their involvement in the correctional system.

A report by Cannings (1990) which describes a number of existing parenting programs, is a useful resource in the construction of program planning for incarcerated mothers. The author emphasizes that organizational commitment from the institution and personal commitment of staff are essential to the success of such programs. In recommending programming for the new regional facilities, The Report of the Task Force on Federally Sentenced Women (1990) suggests that a mother and children centre, equipped with appropriate resourcing and support, be established to assist families in fostering positive relationships.

I was able to find very little lesbian-positive material relating specifically to incarcerated women. Research focusing upon lesbian women within prisons has been overwhelmingly negative, homophobic, and often voyeuristic. When lesbian relationships are discussed, it is invariably within the context of the

"prison subculture" or "deviant lifestyles." In her article on myths surrounding female offenders, Faith (1987) criticizes social scientists for objectifying lesbian prisoners and describes how Hollywood prison movies portray demeaning images of incarcerated lesbians as "predatory."

Grounded in heterosexism, the mental health system has traditionally regarded homosexuality to be a mental illness. The psychiatric institutionalization of women simply because they are lesbians has been well documented both in the academic literature and in narrative accounts (Blackbridge and Gilhooly, 1986; Smith and David, 1976; Penfold and Walker, 1983). It is unsurprising therefore, that two reports by psychiatrists who worked at the Prison for Women, refer to lesbianism as a mental illness (see also footnote number 5, page 29). For example, in her discussion of the prevalence of mental illness among the Prison for Women population, Coleman-Forgues (1979) lists "gender uncertainty" and "in-prison lesbian behavior" among her descriptors of disordered behavior. Similarly, Scott (1982) includes "homosexuality" among the vices prevalent within the Prison for Women population. Additionally, a 1989 mental health survey of the population reports that 13% of the inmates in their survey were diagnosed as having "ego-dystonic homosexuality" (Correctional Service of Canada, Research Branch, 1989). The term "ego dystonic personality" is defined as "a sustained pattern of overt homosexual arousal that is unwanted and a persistent source of distress." However, within a society in which homosexual men and women face both overt and covert violence, such distress is completely realistic.

Challenges to heterosexuality have further contributed to a recognition and

valuing of bisexuality within the therapeutic literature. Recent research indicates that a number of women and men identify themselves as bisexual and/or engage in bisexual relationships. Yet, bisexual people often experience isolation related to the lack of social support and positive validation for their sexual orientation (Klein and Wolf, 1985; Shuster, 1987). Homophobic and biphobic therapeutic practices can have serious deleterious consequences for lesbian and bisexual clients who experience and internalize homophobic and biphobic attitudes and behavior (the Boston Lesbian Psychologies Collective, 1987; Falco, 1991). People working within prisons, and particularly those providing therapeutic services, must challenge their own assumptions around heterosexuality, bisexuality and homosexuality, and understand the issues facing lesbian and bisexual inmates within the context of a heterosexist society.

Increasing attention is being focused upon women who are infected with the Human Immunodeficiency Virus (HIV) and AIDS. Studies indicate that women are the fastest growing population to become HIV infected, and that they have fewer resources and support systems available. Additionally, women's vulnerability to violence and other forms of sexism increase the possibility of women contracting HIV and further disempowers them when negotiating for safer sex (Santee, 1989; Christensen, 1990).

Since there has been no widespread testing of inmates for HIV infection or AIDS among prisoners in Canada, there is no data available regarding the number of prisoners with HIV infection. However, *reported* data indicates that since late 1985, there have been 21 confirmed cases of AIDS and 152 cases of HIV infection among federally incarcerated populations. During

April 1993, there were 60 inmates infected with HIV in Canadian federal correctional institutions (unpublished information, Health Care Services, Correctional Service of Canada, April, 1993). The number of women represented within these figures is not available.

In June, 1992, the Solicitor General of Canada created an Expert Committee on AIDS and Prisons (ECAP) to examine the issues of AIDS and HIV infection in Canadian correctional facilities. The committee reported that while no Canadian data is available regarding the number of federally sentenced women with HIV infection or AIDS, international research shows a high rate of HIV infection among women prisoners. Furthermore, rates of HIV infection among women prisoners is generally greater than that of male prisoners (ECAP, 1993:129). The only Canadian HIV study of women in prison was conducted in a medium-security prison for women in Montreal. The research concluded that 8% of the study's 248 participants were HIV positive and that 52% reported injection drug use (Hankins, 1989).

ECAP (1993:8) emphasizes the importance of contextualizing the experience and needs of women prisoners within the larger social picture:

> Women generally experience HIV infection and AIDS differently than men, both socially and physically, and the problems they encounter in the correctional environment often reflect, and are augmented by, their vulnerability and the abuse many of them have suffered outside prison.

Consequently, ECAP(1993:133) recommends educational and preventive programs designed specifically for women inmates which would "decrease their vulnerability to abuse in general and to HIV infection and drug use in

particular." The committee also recommends peer and community involvement in any programs.

In their investigation, ECAP (1993:35) found that many prisoners refuse to be tested for antibodies to HIV because they fear that the results will not remain confidential. In order to encourage testing, the committee recommends that all inmates have access to anonymous HIV testing, whereby inmates alone are able to link their results to a code. In this way, anonymity is guaranteed because no one else, including the physician, knows the identity of the person being tested. ECAP stresses that all testing must be voluntary, with the express consent of inmates, and further suggests that inmates have access to HIV testing from community clinic personnel independent of CSC as well as from CSC health-care. Furthermore, it is recommended that all testing should be preceded and followed by counseling and education (ECAP, 1993:35).

Women of ACE (1990) and Clark and Boudin (1990:92) report that HIV infection and AIDS have serious implications for incarcerated women, including "secrecy and denial, shame and fear, ignorance and ostracism, and poor medical care." The authors emphasize the necessity of addressing crises posed by HIV and AIDS within prisons. As discussed earlier in this report, women at Bedford Hill Facility and Rikers Island have addressed these issues through organizing women within the prison community to provide peer support and educationals. The needs of HIV infected women and women with AIDS, as well as the impact of HIV and AIDS upon the general prison population, must be addressed in the development of correctional programming.

Finally, the unique needs of women serving long-term sentences must be acknowledged. In their survey of the Prison for Women population, Shaw et al. (1990a) found that many women reported the need for programs designed specifically for lifers and those serving long sentences. Although the exact nature of the programs lifers would like to see made available was unclear, a few women mentioned that they would benefit from having an ex-long termer come in and speak. Some also spoke of the need for support in coping with long term separations from children and families, and others suggested family counseling. Many women serving life sentences also reported being neglected by mental health service workers. [10]

Axon (1989) reports that the experience of incarceration for long-term inmates is profoundly distinct from those serving shorter sentences, and recommends programs developed specifically for small groups of long-term inmates. A study of women incarcerated in Louisiana found that the severity of problems typically experienced by female inmates becomes intensified for women serving long prison sentences (Mackenzie, Robinson and Campbell, 1989). In a qualitative study of women serving life sentences, Jose-Kampfner (1990) discovered that inmates went through a grieving process similar to terminally-ill patients. The chronological stages of adjustment to prison were as follows: denial, anger, depression, mourning, acceptance and hope for the future. However, the grieving process was found to be impeded by the prison system, because expressions of grief (such as anger) were not tolerated, and

[10] 1991-1992 data indicates that of the total number of on-register federal female offenders in Canada, 61 (19.6%) were serving life/indeterminate sentences. Twenty-two (7%) were serving sentences of ten years or more, 42 (13.4%) were serving six to ten years, 114 (36.4%) three to six years and 74 (23.6%) were serving sentences of under three years (**Basic Facts About Corrections in Canada 1992 Edition**. Ottawa: Minister of Supply and Services Canada, 1992).

often punished. The author suggests that in order for therapy to be effective, the prison environment must be modified to make allowances for the behaviours associated with the stresses of daily living. She cautions that failure to grieve and express other emotions, results in subsequent emotional and physical difficulties.

MacDonald (1987) and Walford (1987) provide insightful narrative accounts of women serving life sentences inside the Prison for Women.

There is a paucity of data and literature available regarding the diversity woven throughout the fabric of incarcerated women's lives. The unique concerns and therapeutic needs of Aboriginal women, Women of Colour, Francophone women, immigrant and refugee women, Jewish women, differently-abled women, lesbians, bisexual women, HIV infected women, women with AIDS, pregnant women, mothers, and older women must be valued and considered in the design and delivery of therapeutic services. Class difference should also be recognized. Moreover, the complexity in women's lives must be recognized. Women simultaneously hold a variety of statuses and experience different oppressions. Because the establishment of trust and safety is critical to successful therapy, it is important for inmates to have the opportunity of engaging in therapy with someone who shares their experience or who at the very least, is knowledgeable about experiences relevant to their lives. Perhaps most important, is the ability for therapists to honor mutually respectful relationships.

CONCLUSION

Research specific to therapeutic services for incarcerated women is meager. This paper has attempted to bring together literature from a number of areas in order to establish some principles for meaningful intervention with imprisoned women.

Taken as a whole, the lessons learned from this literature review can be summed up in two words: **EMPOWERMENT** and **CONNECTION**. Empowerment simply means to help restore power. Incarcerated women are a group whose power has been stolen from them through abuse, racism, sexism, classism, and other power-based oppressions. Imprisoned women are, however, also survivors. They have resisted violence in its various manifestations, and invoked creative ways of coping, even in the most oppressive conditions. Feminist intervention can **empower** women by assisting them to **connect** with their own power through strategies which enable women to see and build upon their own strengths and agency.

Those working with women prisoners can help guide them toward a critical understanding of power relations (connecting their individual experiences to the broader social, economic and political context) including those operating within the prison, so that women can resist harm and take self-determined action in ways which are most empowering to themselves. The extent to which women can become empowered within prison is limited by the very nature of prison which is premised on an unequal distribution of power. However, imprisoned women can be given the opportunity to reclaim and

express their unique and collective voices, to: "put the knower back into the known and claim the power of their own minds and voices." (Belenky, Clinchy, Goldberger and Tarule, 1986:19).

It is important that therapists and others working with women in prison are aware of the restrictions, limitations and legal obligations posed by the prison in which they are working. Each must come to terms with issues surrounding confidentiality and truthfully inform the women they are working with the realities associated with confidentiality and other related factors. Women must be given accurate information in order to make informed choices, prior to their involvement in counseling or groups, with full awareness of the consequences. Optimally, empowerment occurs in an environment free from coercion and therefore, alternatives to incarceration must be actively sought and encouraged. However, the immediate reality is that women are living within prison walls, and they must not be forgotten.

Empowerment can also be nurtured by encouraging and supporting connected ways of learning, which is grounded in active participation. Most significantly, however, women will become empowered through mutual relationships with others, wherein their individuality is respected and they are treated as equals. Connecting to others in ways which affirms a woman's sense of self enables her to see that she can take control over her own life. Prison policies and practices must be connected to these aims if the potential of feminist intervention is to become translated into reality.

In her extensive overview of programs for female inmates, Axon (1989) writes that while there are many promising new beginnings in female correctional

programming; personal, political and financial commitment are all essential if hopeful visions are to become more than a rhetorical exercise. This understanding is echoed cogently in a quote by Sharon Smolick written with women incarcerated at Bedford Hills Correctional Facility (1991:2):

> ***The most important thing we need to know and trust is that if you are going to start something, don't fail (and give us the usual excuses - lack of funding, partial and bandaid responses) - don't start if you can't finish. That doesn't mean you don't struggle and some things work better than others - but you give up too easily. It's not about money, it's not about programs, it's about relationships - it's about trust and commitment, it's about integrity, consistency, and tenacity.....the bottom line is that people make the difference, not a program, not an agency, not a service, but people - people who are consistent, knowledgeable and caring. People who bring laughter and tears into our lives and share both with equal heart.***

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