Women, Trauma and Incarceration

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Abstract

Trauma affects the whole person, and the impacts can be multiple, broad and diverse. Its impact extends to family, the community, health care and social systems, and society overall. Rarely is trauma discussed in relation to incarceration. This is particularly troublesome due to the fact that women are considered to be the fastest growing incarcerated population in the United States. Incarcerated women report high rates of physical, sexual and emotional abuse during both their formative years and adulthood, higher rates of mental illness and addiction problems (Wolff et al., 2012). As the population of women who are incarcerated continues to grow, so does the need to address trauma and victimization using a gender-responsive, trauma-informed approach in correctional institutions. For women entering the criminal justice system, there is a high prevalence of comorbid post-traumatic stress disorder (PTSD) and substance use disorder (SUD). However, most correctional institutions lack the awareness and understanding of how to treat both disorders simultaneously. Due to the high rates of traumatic experiences experienced by women who are incarcerated and the co-occurring diagnosis of PTSD and SUD, a call for interventions that target all three of these issues in an integrated manner are most appropriate for long-term recovery. In this paper, an integrated treatment model to treating incarcerated women with co-occurring PTSD and SUD will be discussed, with an emphasis on a three stage approach to treatment with specific cognitive-behavioral interventions as the focus. Programming in jails and prisons needs to include a strengths-based framework that is grounded in an understanding of and response to the impact of trauma on the whole woman, including physical, psychological and emotional effects in order to be most effective in treating this population.

Women, Trauma and Incarceration

According to Nixon (2017), there are more than one million women who are currently under the supervision of the criminal justice system in the United States. Of what is known about incarcerated women with trauma backgrounds, women experience high rates of PTSD and substance use problems. In fact, both substance use disorders and mental health disorders affect many women incarcerated. What is also of primary importance to remember is that women who are incarcerated have unusually high exposure rates to trauma that occurs prior to and as part of their experience of being incarcerated. Incarcerated women report high rates of physical, sexual and emotional abuse during their formative years and often into adulthood (Wolff et al., 2012, p. 703). These disproportionate rates of trauma and mental health issues can further exacerbate the issue of substance abuse among women offenders. Given the high rates of trauma exposure and substance use among incarcerated women, cooccurring PTSD and SUD are common, yet few studies have investigated the clinical outcomes of incarcerated women with cooccurring PTSD and SUD (Salgado et al., 2007, p. 12). Treatment for women is especially salient because women have been known to have higher epidemiological rates of PTSD, and usually enter prison with more severe SUD (Kubiak, 2004, p. 426). There is a present need to address women's trauma through an integrated treatment approach that addresses not only the type of trauma experienced, but the co-occurring mental health and addiction issues that are present due to the trauma.

Types of Trauma Experienced and Their Effects

Traumatic experiences are unique to the individual. It is an individual's experience of the event, rather than the event itself, that is traumatizing. Trauma can occur at both individual and collective levels and can include physical, sexual and emotional abuse, neglect, personal loss, violence, accidents, natural disasters and criminal justice involvement to name a few. Traumatic

events are more than merely stressful, they are also shocking, terrifying and devastating to the individual experiencing them and can cause residual effects long after the traumatic event has ended. For women in prison, 90 percent of incarcerated women reported being victims of sexual and physical violence, and three out of four women in prison report being physically abused by an intimate partner (Nixon, 2017). Furthermore, “up to 81% of incarcerated women have been exposed to five or more traumatic events in their lifetime” (Salgado et al., 2007, p. 11). According to Karl (2021), "For survivors of childhood trauma, physical and emotional issues often manifest in adolescence and follow into adulthood" (p. 39) and "life events that occur during childhood can have reverberating effects well into adulthood, effects that may include symptoms of PTSD and risk of substance misuse" (Ouimette & Read, 2014, p. 96). Additionally, “women with comorbid PTSD and SUD experience a greater number of traumatic events in childhood, are more likely to have experienced childhood sexual and physical abuse, and are more likely to have experienced adult sexual assault than women with a primary diagnosis of substance abuse alone” (Salgado et al., 2007, p. 10). What this means is that jails and prisons are filled with women who are dealing with unresolved trauma, post-traumatic stress disorder and substance abuse problems. Research supports the strong connection between experiencing adversity during childhood and the ensuing development of addiction (Karl, 2021, p. 39). Developing the skills to appropriately assess for trauma history and PTSD-SUD symptoms is necessary for anyone counseling women incarcerated and it is important for counselors working with incarcerated women to be able to explain what trauma is and be sure to give clients an opportunity to discuss other past events, given that rates of exposure to trauma in those with mental illness can be as high as 98% (Putts, 2014, p. 86). In addition to examining the traumatic events themselves with these women, counselors need to be able to pay attention to their level of

functioning, both before incarceration and after to see how the trauma has effected them. As Putts (2014) states, “knowing more about a client’s level of functioning prior to the trauma can provide a baseline for understanding the impact of the trauma as well as information about the client’s resiliency and coping methods” (p. 97). This can help the counselor place the individual in the right treatment program within the criminal justice system.

Trauma and Addiction

The National Institutes of Health (NIH) asserts that traumatic events can serve as triggers for substance misuse (Karl, 2021, p. 38). Furthermore, "trauma increases the already high comorbidity (upward of 50%) between mental health and substance use diagnoses" (Karl, 2021, p. 39). Furthermore, in the National Comorbidity Survey, "SUD's were 3.1 to 4.5 times more common among women with PTSD" (Ouimette & Read, 2014, p. 254). How this relates to women incarcerated was prevalent in one study done by Salgado et al (2007) which found that in a sample of incarcerated women with current PTSD and SUD, approximately half also met criteria for lifetime polysubstance dependence (p. 19). These women also reported experiencing more traumatic events overall, including specific types of traumatic events such as crime-related and general disasters than those without lifetime polysubstance use. The findings suggest that “polysubstance dependence affects many incarcerated women with co-occurring PTSD and SUD” (p. 20) and it is important to understand that these women have different treatment needs than those simply identifying with either PTSD or SUD.

According to the Centers for Disease Control (CDC), research shows a propensity to self-medicate with substances to escape or numb negative thoughts and feelings. This would suggest that the escape from emotional pain actually triggers the onset of addiction (Karl, 2021, p. 40). Women, especially those who are incarcerated, are most vulnerable to these effects. According to

Salgado et al. (2007), “substance abuse itself can be seen as a dissociative response to trauma because it disrupts the integration of conscious thought, allowing for the avoidance of adverse memories” (p. 21). The current literature suggests not only that these disorders frequently co-occur but also that a functional relationship exists between them. Individuals with a history of trauma report greater craving for substances when exposed to trauma cues and this craving for substances is predicted by PTSD symptom severity (Ouimette & Read, 2014, p. 254). This supports the idea of the self-medication theory, "which states that individuals use substances in an attempt to manage and avoid the distress of psychiatric symptoms" (Ouimette & Read, 2014, p. 254). Although research studies have been mixed on support of the self-medication theory, “research indicates that trauma exposure usually precedes the development of an SUD” (Kubiak, 2004, p. 425). In other words, alcohol and drugs are used to alleviate the painful trauma symptoms associated with PTSD and then that can actually exacerbate these symptoms further which causes subsequent trauma to occur. This existing theory points to the need for prioritizing the integration of SUD treatment for women presenting with both SUD and PTSD (McKee & Hilton, 2017, p. 10). What is also important to understand is that “women with SUD and PTSD are significantly more likely to relapse than women with only a SUD” (Kubiak, 2004, p. 430), which further requires counselors to pay attention to trauma-related disorders among incarcerated women and help them have a safe and effective way to process their trauma and learn to work through their co-occurring conditions, which can help reduce rates of relapse, family disintegration and recidivism as a whole.

Recommended Approaches to Treatment

Due to the fact that PTSD and SUD's share an interactive relationship with one another, it is essential that effective treatment be available to address both disorders simultaneously. In fact,

“recovery from PTSD is complementary with recovery from SUD because recovery from PTSD involves learning how to deal with unfinished emotional business resulting from trauma without denial and with personal responsibility” (Ford et al., 2007, p. 477). Historically, clinicians have been hesitant in addressing PTSD and SUD together, however, a growing body of research supports the idea of an integrated treatment model to address PTSD and SUD. Furthermore, guidelines issued by the National Institute of Corrections have noted the high rates of traumatic experiences, PTSD, and substance use among incarcerated women have called for interventions that target all three of these issues in an integrated manner (Lynch et al., 2012, p. 89).

According to Ouimette & Read (2014), "It is well established that recovery from trauma and addictions can benefit from a stage-based approach" (p. 281). Judith Herman (1997) introduced the idea of three stages of recovery as part of an integrated treatment approach to PTSD-SUD. These include safety, mourning and remembrance, and reconnection. In the first stage, the individual is to identify steps towards healing, set attainable treatment goals, establish safety and stability, develop inner strength, learn to regulate emotions and manage destructive symptoms, develop skills for managing painful experiences, and address any comorbid problems such as alcohol or drug use. In the second stage, individuals are to review and discuss traumatic memories to lessen their emotional intensity, to work through grief about traumatic experiences and to mourn positive experiences that did not happen. Lastly, the third stage involves the individual reconnecting with people and meaningful activities (Ouimette & Read, 2014, p. 222). Also, when treating individuals who have experienced trauma and who also struggle with addiction it is important to treat the individual from a strengths-based approach. As Karl (2021) states, “These struggles are not born of characterological weakness but result from the impact of lived trauma experiences” (p. 42). Treatment programs such as Seeking Safety (SS), Creating

Change (CC) and Integrative Cognitive Behavioral Therapy (ICBT) are just a few methods that would be beneficial for women who are incarcerated to have the ability to process their trauma and work through their issues with both PTSD and SUD in a safe and effective manner.

Clinical Strategies for Integrated PTSD-SUD Treatment

Offering integrated treatment for participants with co-occurring PTSD and SUD is associated with improved mental health, acquisition of relevant skills and knowledge, improvement of self-esteem and led to strong satisfaction with programming to address these issues (Mckee & Hilton, 2017, p. 13). There are a variety of promising cognitive–behavioral interventions for those dually diagnosed with PTSD and SUD are emerging, which include programs such as Seeking Safety, as well as treatment that focuses on cognitive restructuring, cognitive skill development, life skill enhancement and behavioral interventions. From a cognitive-behavioral standpoint, PTSD and SUD are the result of dysfunctional beliefs, cognitive biases, and reactive behavior patterns that lead to an escalating sense of anxiety, anger and helplessness and from a strengths-based perspective, PTSD and SUD involve a loss or breakdown of the persons psychological and interpersonal resources (Ford et al., 2007, p. 479). Programs such as Seeking Safety aim to address PTSD and SUD from both a cognitive behavioral and strengths-based perspective which "consistently teach complementary cognitive and behavioral skills for building or acquiring personal strengths" (Ford et al., 2007, p. 479) which is great for women who are incarcerated to help them heal from their trauma and develop interpersonal coping skills for when they re-enter the community after incarceration.

Seeking Safety (SS) is the most researched integrated approach to treating both substance abuse and trauma (McKee & Hilton, 2017, p. 13) and has been associated with a substantial empirical base identifying treatment results with multiple populations (Lenz et al., 2016, p. 51),

including women who are incarcerated. Treatment for both PTSD and SUD occur simultaneously, and "there is a focus on helping clients understand these disorders, how they interact, and how they are affecting the present experience" (Lenz et al., 2016, p. 52). During treatment, clients are supported in making their personal safety their first priority, while concurrently addressing both PTSD and SUD symptoms. Integrative Cognitive Behavior Therapy (ICBT) would also be beneficial for women in the criminal justice system. The focus on psychoeducation on the link between PTSD-SUD, breathing training, cognitive restructuring and individual addiction counseling is ideal for women who are incarcerated because this type of therapy has been shown to be more effective for those with more severe PTSD. Following a stage-based framework would be most ideal when working with women who are incarcerated. This would involve using the SS program in Stage 1, because it is present focused and encompasses psychoeducation and coping skills (Ouimette & Read, 2014, p. 282). Stage 2 would be devoted to a new manual called *Creating Change* (CC) which provides a natural next step from Seeking Safety. This stage involves a past-focused integrated model for PTSD-SUD recovery which includes processing the painful memories and past emotions. Like SS, CC has a structured way of addressing past trauma, but the difference is that it addresses the clinician role in detail. Currently, only SS is offered to women who are incarcerated, and this important second component, addressing the painful memories and related emotions with a counselor is missing. The final stage would include reconnection with safe and supportive family members and pertinent community resources prior to release. This addresses the third stage in Herman's three-stage approach which is "future focused, building a strong social and work life ahead" (Ouimette & Read, 2014, p. 282). This final stage is so important to women being released from jail or prison in order to help them be successful in their recovery and growth after incarceration.

Future Clinical Practice

Although there may be some programming within the criminal justice system to address the comorbidity of PTSD and SUD, these programs are quite limited. Programs such as Seeking Safety have its limitations in that "integrated treatment is psychoeducational, and detailed discussions about past trauma are specifically prohibited in the Seeking Safety program" (Lenz et al., 2016, p. 52). This further strengthens the need to provide continuation of services after incarceration to help women transitioning back into the community successfully. Seeking Safety guidelines encourage development of coping skills for symptom prevention and management, but dissuade in-depth processing of past traumatic experiences (Lenz et al., 2016, p. 58) so it is important to refer these women to a counselor so that they can take the next step in addressing these traumatic experiences on a deeper level. Ford et al. (2007) discusses that "trauma survivors with PTSD are not fragile but rather are highly resilient because they have had to develop ways of coping with extreme stressors" (p. 477) however, resiliency can only go so far without the proper structure to provide continuity of care after incarceration. Many individuals who identify with PTSD-SUD do not feel ready to disclose more than small amounts of their trauma until they have established a trusting therapeutic alliance, which cannot happen in the prison setting. This must be done on a one-on-one basis between client and therapist once the individual is released. A counselor is able to provide a therapeutic structure for the formerly incarcerated individual that can support them in their recovery and life management in a much more organized manner than can be provided while still in jail or prison. Correctional facilities need to partner with community mental health facilities and victim service providers so that referrals are made to these organizations prior to release. These partnerships will allow facilities to provide services to

newly released women offenders that can specialize in their specific needs, thus promoting sustainability and positive outcomes after incarceration.

Conclusion

Karl (2021) states, “use of alcohol and other illicit substances damages mental and physical health in numerous ways and often intersects with the trauma experience” (p. 43). Knowing this, it is no wonder that the rates of incarcerated women who have PTSD and SUD is so high. In order for women who are incarcerated to heal from trauma and reach their full potential, then the process of healing must begin before they leave. To succeed, jails and prisons need to be a safe, nurturing and empowering place to do so. Developing and implementing an integrated three stage approach gives incarcerated women the best opportunity to address their trauma and addiction together in a structured manner. Ford et al. (2007) states, “integrated PTSD-SUD treatment requires a shift from asking ‘whether’ to treat to asking, ‘how best’ to treat PTSD in an effective an integrated manner with clients in recovery from SUD” (p. 487) and I think that women who are incarcerated have specific programs and interventions that are best for them to be treated due to their unique circumstances of how their PTSD-SUD developed initially and the types of trauma they have experienced. Having a continuity of care after incarceration will allow women to be successfully integrated back into society, having the ability to reconnect with safe family members and continue their work in recovery from trauma and addiction in a safe and effective manner.

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