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“IN BLACK AND WHITE, I’M A PIECE OF TRASH:”  
ABUSE, DEPRESSION, AND WOMEN’S PATHWAYS TO PRISON

by

ALEXA ADAMO VALVERDE

Under the Direction of Megan Sinnott, Ph.D.

ABSTRACT

Women’s lived experiences of abuse and depression are examined within the context of gendered and racialized pathways to incarceration among 403 women randomly selected from a diagnostic unit in a state prison. This study utilizes feminist action research and community psychological methods to understand what factors predict incarcerated women’s placement on the mental health caseload and provides quantitative support for the pathways theoretical framework. Findings indicate that, among the sample, the prevalence of abuse experiences prior to incarceration exceeded 90%, prevalence of mental health problems exceeded 70%, and less than 35% were receiving mental health care. Being Caucasian, experiencing depression and suicidal ideation, and serving time for certain types of (non-violent, non-property, and non-drug related) crime (e.g., cruelty to children, prostitution, public order, “technicals,” and others) predicted the placement of women on the mental health caseload. Implications for trauma-informed, anti-racist, gender-responsive policies and interventions are discussed.

INDEX WORDS: Feminist action research, Incarcerated women, Depression, Mental health, Violence against women, Abuse, Pathways to Prison, Intersectionality



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by

ALEXA ADAMO VALVERDE

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

Master of Arts

in the College of Arts and Sciences

Georgia State University

2016

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2016

“IN BLACK AND WHITE, I’M A PIECE OF TRASH:”  
ABUSE, DEPRESSION, AND WOMEN’S PATHWAYS TO PRISON

by

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December 2016

## DEDICATION

In January 2015, my husband and I were chosen to adopt the baby of a pregnant, depressed, drug-addicted, and recently paroled Mexican American woman, Marie. She was sexually abused by her mother's boyfriend from the age of 7 to 11, sent to a mental institution by her mother when authorities prosecuted the abuser, and ran away from the mental institution when she was age 15. She has been using methamphetamines, and living on and off the street for 20 years. Her 16 year old son is in juvenile detention serving a two-year sentence and her 15 year old daughter is being raised by her paternal grandparents. Just before Marie contacted us, she escaped severe intimate partner violence from her boyfriend.

After a few weeks of long phone calls and days of silence, I flew out to meet Marie in her hometown in rural New Mexico. She was hiding out in an unfinished garage, afraid for her life, and anxious that her baby would be placed in foster care should she give birth without an adoption plan. She claimed this would happen because, "In black and white, I am a piece of trash." She said she has never been happy and probably would not be alive long after the birth. Adoption, she proclaimed before I left to return to Atlanta, was the best decision she ever made. This baby is now our healthy, joyful 19-month-old son, Oliver. I know that my participation in this research project prepared me to meet Marie, and my understanding of her situation facilitated our adoption. I dedicate this thesis research to Marie Antoinette Gonzales, who is, as of November 2016, alive and pregnant again.

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## 1 INTRODUCTION

### 1.1 Research Statement

Women are the fastest growing population in U.S. prisons, with the incarceration of women increasing by 400% and at a rate 50% higher than the incarceration of men since 1985 (Carson, 2015; Hester, 1987; Lapidus, Luthra, Verma, Small, Allard, & Levingston, 2005; The Sentencing Project, 2015). Increases in women's incarceration are due not to an increase in crime, but rather to social changes in sentencing and policy, which align with the development of the War on Drugs (as coined by the U.S. federal government) (Crenshaw, 2012; Lipsitz, 2012; Mauer, Potler & Wolf, 1997; Roberts, 2012; The Sentencing Project, 2015; Welch & Angulo, 2000) and "a large-scale shift toward formal incarceration as our collective social response to crime" (Bobo & Thompson, 2010, p. 324). Women of color; women who experienced abuse as girls and in adulthood; women with mental health problems; women with few socioeconomic resources, low education levels, and substance abuse problems; and mothers who are raising children without the support of a partner are highly overrepresented in the U.S. correctional system.

A significant percentage of women in prison experience two or more of these characteristics or experiences simultaneously. For example, rates of child abuse and adult victimization (e.g., intimate partner violence, rape, other sexual assault) are significantly higher among women inmates with mental health problems than the general prison population. According to the Bureau of Justice Statistics' most recent report on mental health among incarcerated populations, which was published a decade ago, 68% of women with mental health problems experience abuse; compared to 44% of women inmates without a mental health problem, 27% of all inmates (men and women) with a reported mental health problem, and 10%

of all inmates without a mental health problem (James & Glaze, 2006). The majority (75%) of women inmates with a mental health problem also experienced substance abuse.

At least 73% to 80% of women in prison experience mental health problems (James & Glaze, 2006; Jordan, Schlenger, Fairbank, & Caddell, 1996; Teplin, Abram, & McClellan, 1996) and, though it is a constitutional right in the United States for inmates to receive a basic level of mental health care (Columbia Human Rights Law Review, 2009), less than one-third of incarcerated women with a documented mental health problem actually receive mental health treatment (Ditton, 1999; James & Glaze, 2006).

Utilizing feminist action research and community psychological research methodologies, this study investigates the provision of mental health care for incarcerated women, including those with mental health problems, in a Georgia state prison. It builds on the work of feminist standpoint theorists who have, since the 1970s, advocated scientific inquiry based on women's lived experiences and the examination of relations between experience, power, and epistemology on the production of knowledge (Collins, 1990; Harding, 2004; Hartsock, 1983, 2004). Feminist action research takes a similar methodological approach in that its purpose is to understand systems of power and oppression and address complex social problems faced by those considered voiceless, particularly women and members of economically disadvantaged and underserved communities who are too often outside the realm of knowledge production and policy making (Frisby & Creese, 2011). It also builds on the work of feminist criminologists who have sought to understand women's pathways to incarceration since the late 1980s (Daly and Chesney-Lind, 1988; Wilcox Rountree & Warner, 1999) and continuing today (Chesney-Lind & Merlo, 2015; Chesney-Lind & Shelden, 2014; Daly, 2014).

While there is a burgeoning movement to ensure mental health treatment is available and beneficial to incarcerated women, little to no research explores factors that may predict which incarcerated women with mental health problems are being offered treatment, and which are not. Gender-responsive and trauma-informed policies and interventions for women in prison have been offered and promoted by criminal justice experts, but few policies exist to ensure these interventions are implemented consistently within prisons or across the nation (Miller & Najavits, 2012; Van Vooris, 2012). The purpose of this study is to quantitatively examine the pathways theoretical framework of women's incarceration and examine what predicts the provision of mental health care for incarcerated women, so that – in the light of the current knowledge that less than 35% of U.S. incarcerated women with documented mental health problems are receiving care – future mental health services and interventions will be provided consistently and equitably. This study asks, what predicts incarcerated women's placement on the mental health caseload? Are those who need it receiving care?

To answer these questions, I examine the prevalence of abuse and depression among a sample of 403 women in a Georgia state prison. I then examine whether or not women reporting mental health problems (specifically depression, PTSD symptoms, and suicidal ideation) receive mental health care; what variables along women's trajectory *predict* placement on the mental health caseload, whether abuse (childhood victimization, intimate partner violence, rape or sexual violence, other adult victimization, or polyvictimization), substance abuse, type of crime, and/or race or other demographics (e.g., income level, education level, parenting status); and examine relationships between these variables.

This thesis will further the body of research on incarcerated women's mental health and experiences of gender-based violence, provide quantitative examination of the pathways theory

of women's incarceration, and examine predictors of mental health caseload placement. It will situate incarcerated women's mental health treatment within the gendered and racialized U.S. criminal justice system to inform the development, evaluation, and consistent implementation of feminist mental health interventions that facilitate women's healing from abuse and decrease rates of recidivism. My research is offered to inform criminal justice policy makers, feminist mental health providers, and other anti-racist advocates for women involved in the criminal justice system.

## **1.2 Literature Review**

The incarceration of women is a serious problem in the United States (Covington & Bloom, 2003; Glaze & Herberman, 2013; Glaze & Herberman, 2014; The Sentencing Project, 2015). In 1990, the correctional population included approximately 600,000 women (i.e., including all in prison or jail, on parole or probation) in the United States (Covington & Bloom, 2003). In ten years, by 2000, the number of incarcerated women increased to more than one million; and in 2014, the total correctional population included 1,251,600 women, comprising 18% of the total adult correctional population (Covington & Bloom, 2003; Glaze & Herberman, 2014; Kaeble, Glaze, Tsoutis & Minton, 2015). Women comprise approximately 25% of the probation population, 14% of the jail population, 12% of parolees, and 7% of prisoners (Glaze & Kaeble, 2014). With more than twice the number of women in the correctional system in 2014 as compared to 1990, an average increase of 3.4% a year since 2010, and with arrests of girls increasing more than the arrests of boys for most juvenile offenses (Bureau of Justice Statistics, 1999; Chesney-Lind & Merlo, 2015; Zahn, Agnew, Fishbein, Miller, Winn, Dakoff, ... Chesney-Lind, 2010), women and girls represent the fastest growing correctional population in the U.S. (Covington & Bloom, 2003; Glaze & Herberman, 2014; Kaeble et al., 2015).

This literature review examines research on women's incarceration as gendered and racialized; situates women's incarceration within intersectional identities and systems of oppression based on gender, race, class, ethnicity, sexuality, age, and other social constructs; examines research on women's pathways from abuse to mental health problems to incarceration, and explores the impact of mental health problems (particularly depression and PTSD) on incarcerated women. It also examines research on mental health treatment and trauma-informed, gender-responsive interventions for incarcerated women.

### ***1.2.1 Women's Incarceration as Gendered and Racialized***

Since the establishment of separate prisons for women in the late 1800s, women's experiences of incarceration in the U.S. have been impacted by gender and racial oppression (Jones & Record, 2014; Rafter, 1985; Rivera & Veysey, 2015; Washburn, 2016). The incarcerating institutions (whether small penal units in men's prisons or reformatories that trained women inmates in "feminine" gender roles), types of crimes committed, and criminal sentences were unique for women (Jones & Record, 2014; Onion, 2015; Rafter, 1983, 1985). There is little data available on incarcerated women's historical experiences (Calahan, 1985), partly because women comprised only 1% to 7% of the incarcerated population between 1850 and 1980, and constitute only 7% of the prison population today (Glaze & Kaeble, 2014). In 1922, for example, the Bureau of Justice Statistics (BJS) collected data from almost 6,500 incarcerating institutions, including over 6,000 city or county jails, more than 100 state and federal prisons (some including small women's penal units), almost 300 "chain gangs" (of men), and just 24 women's reformatories (Calahan, 1985). Rafter (1983) described the absence of investigation into women's criminal justice experiences as due to assumptions that the development of women's prisons and incarceration experiences was the same as those for men;



and that “the evolution of the women's prison system and female experience of incarceration are irrelevant to mainstream penology just because they can shed little light on the nature of the prison system as a whole. Neither assumption is correct” (p. 129).

In the 1800s and early 1900s, women in the U.S. were less often incarcerated for violent crimes than men (as is the case today), but they were more often incarcerated for crimes of “moral turpitude”— prostitution, ‘lewd’ behavior, and vagrancy” (as cited in Pishko, 2015, online) based on strict gender prescriptions of the time. Race played a major factor. Rafter (1983) described unique racial disparities in women’s incarceration prior to 1870 based on region of the U.S.:

In the North in this period, female felons tended to be black. Even when outnumbered by whites, they were usually overrepresented in comparison to their proportion of the state's population as a whole. For instance, of the 54 women sent to the Philadelphia penitentiary in 1818, 23 three were black (Vaux 1826, p. 71); and of 38 women at New York's Bellevue Penitentiary in 1830, 25 were black (New York Mount Pleasant State Prison 1831, App. H, p. 34). A similar pattern did not prevail in the South in the pre-Civil War period, for slaves usually were punished by their owners. After the Civil War, however, prison populations became predominantly black in southern custodial units for women (p. 144).

Today, it is alarming how overrepresented women of color, especially Black women, are in U.S. prisons. Since 1986, the incarceration rate for African American women increased by 800%, compared to an increase of 400% for women of all races. African American women are

100% more likely, and Latina women 20% more likely, than White women to be incarcerated (Carson, 2015). Almost half of incarcerated women in the U.S. are Black, yet they comprise only 13% of all U.S. women (Bloom, Owen, & Covington, 2004). Systems of racial and gender oppression in relation to tough, “zero-tolerance policies, social marginalization, and criminalization,” (Crenshaw, 2015, p.5) and patterns of criminal monitoring and surveillance (e.g., probation), juvenile detention, and incarceration of women and girls of color help explain this high rate (Chesney-Lind & Merlo, 2015; Crenshaw, 2012; 2015; White House Council on Women and Girls, 2014).

Differential, often inferior treatment compared to that of incarcerated men, and gender-based violence have impacted incarcerated women’s experiences from the earliest records, and continues today. Women were considered “outright moral pariahs... presumed to be spoiled goods, there for the taking by their male keepers” (as cited in Johnson, Dobrzanska & Palla, 2005, p. 33). One of the most notorious sexual abuse scandals in the history of U.S. women's prisons took place as recently as 1992 in Georgia and was exposed nationally in the New York Times (Applebome, 1992). Fourteen former employees including the former deputy warden of a women's prison in Brunswick, Georgia were indicted on sexual abuse charges, including rape, sodomy, and forced abortion of 114 women occurring in the prison and at the deputy warden’s home. Today, rape and other sexual abuse in U.S. prisons is acknowledged at the federal level as an epidemic, especially for women, gay men, mentally ill inmates, and youth (National Prison Rape Elimination Commission, 2009).

While women and men’s experiences of incarceration are impacted by gender, the male experience has been considered the norm and most research has focused on that experience (Daly, Messerschmidt, Henry & Lanier, 2005; Messerschmidt, 1993; Van Voorhis, 2012). Even

so, only recently has gender been a consideration in the understanding of the male prison experience (Ricciardelli, Maier & Hannah-Moffat, 2015; Robinson, 2011). Messerschmidt (1993) asserted that while criminological theory and research has a long history of male bias, a gendered analysis has not been a focus. “Criminology has failed to explain adequately women’s and girls’ crime, [but] this does not mean that criminology effectively explains the criminology of men and boys. Indeed, what has not been ignored has been viewed fallaciously” (p 15). To more adequately understand women’s crime, feminist researchers critically examine gender differences and gendered experiences in the areas of mental health, substance abuse, entry into the criminal justice system, and offense patterns, particularly as these topics relate to women and girls’ lifetime exposure to men’s violence (Covington & Bloom, 2003; King & Foley, 2014).

In the late 1980s, the first feminist criminological theorists began situating women’s experiences within the context of gendered experiences, identities, and systemic oppression. Daly and Chesney-Lind (1988) described guiding principles that distinguish feminist criminology from the broader, hegemonic criminology (Britton, 2000, p. 59). Miller and Mullins (2006) defined feminist criminology as the “body of criminological research and theory that situates the study of crime and criminal justice within the complex understanding that the social world is systematically shaped by relations of sex and gender” (p. 218) and these gendered experiences vary according to positions in racial, class and other social hierarchies. Feminist criminological scholarship is positioned as challenging the concept of gender as an individual-level variable, only, to be controlled for in criminological research. They outlined three central themes in feminist criminology:

- (1) Gender hierarchies have been built and reproduced through the criminal justice system’s historic and current structures, policies, and practices;

- (2) Women's and men's lived experiences are navigated through gendered environments;
- (3) Gender intersects with other social constructs, including race, class, age, sexuality, and others, resulting in variations in the manifestation and effects of gender inequality that impact criminal involvement and incarceration (Miller & Mullins, 2006).

Feminist scholars in women's, gender and sexuality studies, psychology, law, sociology, mental health nursing, public health, and other disciplines were also investigating girls' and women's experiences within complex and interlocking systems of power and privilege based on oppression based on race, gender, sexuality, ethnicity, class, age, and other categories. Though they were doing so more often to understand and combat men's violence against women, and other social problems women faced, and were less often focused on women's criminal justice involvement. However, this research informed and empowered feminist criminologists and guided interdisciplinary feminist researchers to investigate the places within policy and practice where gender and racial oppression, men's violence against women, and incarceration meet.

### ***1.2.2 Intersectionality, Violence, and Women's Incarceration***

While race has become a main construct of analysis in the growing understanding of mass incarceration of men and boys, *gender* and the intersections of oppression based on race, gender, class, and sexuality, are rarely focal points of this critical conversation (Crenshaw, 2012). At the same time, the interdisciplinary examination of incarcerated women's experiences still, too often, renders women of color invisible, particularly in social science research that is not explicitly feminist. In response, cross-disciplinary feminist research on women's incarceration has explored the intersectionality of oppressions on women's lived experiences of gender-based violence and criminal justice involvement (Bloom, 1996; Crenshaw, 1991; Daly, 1992; Wattanaporn & Holtfreter, 2014).

The feminist theory of intersectionality, coined by Kimberlé Crenshaw in 1991, continues to guide feminist scholars and activists to theoretically, empirically, and actively (through community organizing and reporting to mainstream audiences, among other activism) acknowledge and deconstruct the marginalization of women and girls of color, and how the human experience is impacted by intersections of race and gender with other categories including sexuality, class, ethnicity, etc. (Crenshaw, 1991, 2012, 2015). Intersectionality has been described as one of the most important scholarly contributions of women's and gender studies (Bloom, 1996; Bloom, Chesney-Lind, & Owen, 1994; Nash, 2008) as it underscores the "multidimensionality" of marginalized subjects' lived experiences" and challenges scholars to "critically investigate subjectivity and intersections of identity, privilege, and oppression across and within groups" (Nash, 2008, p. 2). It is especially relevant to this thesis as it is grounded in research on women's experiences of intimate partner violence and incarceration.

Seminal works include Crenshaw's (1991) essay "Mapping the margins: Intersectionality, identity politics, and violence against women of color;" Daly and Chesney-Lind's (1988) book *Feminism and criminology*; Bloom, Chesney-Lind, and Owen's (1994) essay on women in California prisons and the war on drugs; Bloom's (1996) book, *Triple jeopardy: Race, class, and gender as factors in women's imprisonment*, Richie's (1996) qualitative work, *Compelled to crime: The gender entrapment of battered, Black women*, and others. Each theorize how gender shapes the organization of crime, law, and criminal justice, and posit that incarceration is a gendered experience that intersects with other social identities and oppressions (Bloom, Chesney-Lind, & Owen, 1994; Bloom, 1996; Richie, 1996; Bloom, Owen & Covington, 2004; Crenshaw, 2012). Socially constructed positions, where race, class, poverty, violence, and crime intersect, negatively impact girls and women's lives (Sokoloff, 2004) and have led to criminal

justice involvement for poor women of color, in particular, at increasing rates. The "gender entrapment theory" from Richie's *Compelled to Crime* (1996) describes this intersection and how it impacts Black women who engaged in criminal behaviors due to intimate partner violence and racialized gender identities. She identifies unique pathways battered Black women traverse that I will describe in more detail in the next section.

Women's incarceration is intricately related to the social problem of gender-based violence (i.e., men's violence against women and girls), and research developments in both fields have informed each other. After more than a decade of women's grass roots activism to end rape and domestic violence, the concept of men's "battering" against women was brought to the U.S. public eye in the late 1970s by this activism and by media attention to the work of sociologist Lenore Walker's (1979) *Battered Woman Syndrome* (BWS theory (now considered problematic) to explain the psychological impact of prolonged abuse on women by a male intimate partner (Rivers-Schutte, 2013). The theory was widely used in 1980s and 1990s court cases when women retaliated and killed their abusive partner, and also by defendants of men, including O.J. Simpson, who allegedly murdered their female partner. (See Griffith's 1995 article "Battered Woman Syndrome: A tool for batterers?") However, research on violence against women did not become a legitimate area of research until the passing of the Violence Against Women Act (VAWA) in 1994 and the provision of research grants in this area (Meloy & Miller, 2011).

Most incarcerated women in the U.S. – some studies indicate more than 90% – experienced victimization by men when they were children, adults, or both (Bloom & Covington, 2009; Bloom, Owen, & Covington, 2003; Browne, Miller & Maguin, 1999; Cook, Smith, Tusher & Raiford, 2005). In fact, high levels of abuse, mental health problems, and drug and alcohol dependency are considered "typical" profiles of women offenders (Raeder, 1993, 2005, 2007).

While many women who are victimized do not experience mental health problems, substance abuse, and increasing levels of criminal involvement resulting in incarceration, women who are economically disadvantaged, undereducated, experience polyvictimization or co-occurrence of victimization (e.g., child sexual abuse and witnessing community violence), and have little social support are at increased risk (Borja, Callahan & Long, 2006; DeHart and Moran, 2015; Soler, Forns, Kirchner & Segura, 2015).

A growing body of social science research documents the impact of (often separate and specific types of) victimization like child abuse, intimate partner violence, or rape/sexual assault on women's mental health (Acierno, Resnick, Flood, & Holmes, 2003; Ackard & Neumark-Sztainer, 2002; Bonomi, Thompson, Anderson, Reid, Carrell, Dimer & Rivara, 2006; Campbell & Lewandowski, 1997; Maw, 2013; Rodriguez, Ryan, Rowan & Foy, 1996; Salazar & Cook, 2002; Tripodi & Pettus-Davis, 2013). It is commonly understood among social science researchers and practitioners that mental health problems represent increased risk for lifetime abuse (Turner, Finkelhor & Ormrod, 2010), and significant gender differences exist in the frequency and type of victimizations by people with mental health problems (Browne, Miller & Maguin, 1999; DeHart and Moran, 2015; Soler et al., 2015).

The frequency and amount of abuse experiences over girls' lives are related to mental health problems and offending. Because most adolescents have experienced more than one form of victimization in their lifetime, Soler et al. (2015) investigated the relationship between polyvictimization and mental health, and between specific types of victimization and mental health among a sample of Spanish adolescents. Their intention was to challenge the bias that much social science research exerts by focusing on just one type of abuse or victimization (e.g., rape, child physical abuse, etc.). They found that the predictive powers of a victimization

variable, such as witnessing community violence, decreased or even lost significance when polyvictimization was taken into consideration. They also found gender-specific patterns on the impact of victimization on mental health. For example, they found that adolescent girls who experienced child abuse experienced significant traumatic stress, even when other areas were controlled for; and that girls who witnessed violence were more likely to “attribute hostile intent to peers and to generate aggressive and externalizing responses” (p. 424) such as substance use, violence, theft, or property destruction. The authors considered which types of victimization were more traumatic than others and found that the experience of sexual assault by a known adult and emotional bullying by peers or adults predicted depression and anxiety in adolescents. Polyvictimization affected the impact of each type of victimization on adolescents’ psychological health, while there were still some forms of abuse that were most traumatic for girls, even when polyvictimization was controlled for.

DeHart and Moran’s 2015 quantitative and qualitative study, with a sample of 100 at-risk girls, supported evidence that girls in juvenile detention experience very high levels of victimization and polyvictimization, and took a close look at what types of abuse were most traumatic. On average, girls in their sample experienced three of five major categories of violence: caregiver, gang, dating, sexual, and witnessing violence, and about 7 of 20 subtypes of violence within their lifetimes. Only 2% of girls in their sample reported no victimization. Their qualitative examination of the victimization–crime linkage in girls’ accounts revealed prominent themes including the most negative impacts on mental health from caregiver violence, sexual violence, and witnessing violence; patterns of substance abuse as a form of coping and self-medication, use of violence and aggression often in retaliation to witnessed violence in the home or community, and pathways from victimization to status offenses (e.g, substance use and



running away) to “street” crimes (e.g., stealing and prostitution) to experiences of community violence and intimate partner violence.

In their research for the Office of Juvenile Justice and Delinquency Prevention, Zahn et al. (2010) found that girls' delinquent acts were typically less serious and less frequent, or one off instances, than those of boys. Their research suggested that minor offenses, such as running away and truancy often masked serious abuse, including sexual assault, by caregivers. These offenses “make girls vulnerable to subsequent victimization and engaging in other behaviors that violate the law such as prostitution, survival sex, and drug use” (Zahn et al., 2010, p. 3).

Zust (2009) found direct links from family violence and intimate partner violence to women's experiences of depression, criminal involvement (including being forced by abusive partners to participate), incarceration, loss of child custody, and recidivism. She also noted differences among women and men's reported reasons for returning to prison. For men, recidivism was primarily associated with drug abuse, while for women recidivism was associated with depression and other mental health problems, histories of abuse (as a child or adult), living with a criminally involved partner, or substance use and/or involvement.

### ***1.2.3 Women's Pathways from Abuse to Incarceration***

Wattanaporn and Holtfreter (2014) define an analytic framework of women's pathways to crime as “a theoretically driven, empirically rigorous method for studying female offending and victimization, and for informing gender-responsive correctional programming and treatment” (p. 191). Pathways research is a growing and convergent body of interdisciplinary scholarship that identifies women's trajectories or pathways to prison, documenting gendered experiences of abuse during childhood and/or adulthood as related to their involvement in the criminal justice system. Some call this framework the theory of women's pathways to

incarceration (Daly, 1992), while others call it a “gendered pathways-analytic framework” (Salisbury & Van Voorhis, 2009). These pathways, examined mostly qualitatively, grew out of women’s self-reports and reveal experiences of physical and/or sexual abuse, resulting mental health problems, substance abuse problems, and criminal involvement. Researchers have identified gendered pathways to incarceration as stemming from gender-based abuse that occurred during childhood (primarily from a male family member) and/or in adulthood (primarily from an intimate partner), and many identified a high frequency of polyvictimization (Bloom, 1996; Bloom, Chesney-Lind & Owen, 1994; Browne, Miller, & Maguin, 1999; Chen & Gueta, 2015; Covington & Bloom, 2004; DeHart, 2004; DeHart & Moran, 2015; King & Foley, 2014; MacDonald, 2013; Tripodi & Pettus-Davis, 2013).

Pathways-based analyses of women’s incarceration do not presume or suggest that individual characteristics or experiences are causal mechanisms of women’s victimization, mental health problems, or incarceration. Instead, feminist researchers investigate victimization and polyvictimization as it occurs within interlocking systems of oppression (gender, race, class, sexuality, etc.), and how this victimization relates to women’s incarceration and other life experiences (Grauerholz, 2000; Messman & Long, 1996; Poister Tusher, 2007). Crenshaw’s theory of intersectionality aligns with and informs the pathways theory. In fact, she uses the language of a “pathway to incarceration” repeatedly in her 2015 *Black Girls Matter* report and situates women’s lived experiences within this pathway in her 2012 article, “From private violence to mass incarceration: Thinking intersectionally about women, race, and social control.”

Current investigations into women’s trajectories from abuse to incarceration have built, some intentionally and others not, on the past few decades of feminist activism and research on “women offenders” (from the fields of law and criminology, primarily) and “men’s violence

against women and girls” (from the fields of psychology, sociology, psychiatry, social work, public health, and mental health nursing, primarily). Women’s grassroots activism to end rape and domestic violence in the 1960s and 1970s drew broad public attention to domestic violence, rape, and the systemic nature of men’s violence against women for the first time (Crenshaw, 1993). Scholars, starting in the 1980s, were attempting to bring attention to and understand the history of women’s offending in the face of dramatic increases in women’s incarceration in the U.S. (Carson, 2015; Daly, 1992; Hester, 1987; Lapidus et al., 2005; The Sentencing Project, 2015). They situated incarcerated women’s experiences along several trajectories that included men’s abuse of girls and women, to resulting mental health and substance abuse problems, to escalating involvement in the criminal justice system leading to incarceration (Bloom, 1996; Bloom, Chesney-Lind & Owen, 1994; Bloom & Covington, 2009; Chen and Gueta, 2015; Covington & Bloom, 2004; DeHart, 2004; DeHart and Moran, 2015; King and Foley, 2014; MacDonald, 2013; Thompson, 2010; Tripodi & Pettus-Davis, 2013). As stated earlier, some studies indicated more than 90% of incarcerated women experienced men’s violence against them when they were girls, adults, or both (Bloom & Covington, 2009; Bloom, Owen, & Covington, 2003; Browne, Miller & Maguin, 1999; Cook, Smith, Tusher & Raiford, 2005).

Kathleen Daly (1992) developed one of the first and most influential theories of women’s pathways to incarceration for the field of feminist criminology. In her qualitative work, “Women’s pathways to felony court: Feminist theories of lawbreaking and problems of representation,” Daly identified five “typified” pathways to women’s incarceration from a sample of 34 women convicted for felony offenses, including street women, drug-connected women, harmed or harming women, battered women, and economic offenders. Together, street

women and battered women made up about half of her sample. Descriptions of Daly's categories follow:

*Street women – Escape and survival:* Women or girls running away from gender-based abuse by family members (father, male relatives) and living on the street, often engaging in survival/coping methods including prostitution, selling or self-medicating with drugs, stealing or fraud, and experiencing high levels of victimization.

*Battered women – situational offenders:* Women running from or retaliating against violent intimate partners who engage in criminal behavior to cope or survive.

*Drug-connected women:* Women who use or sell drugs, often in collaboration with abusive family members or intimate partners.

*Economic offending:* Economic crimes by women facing poverty or, less often, by women seeking economic gains but not facing poverty – may or may not have history of victimization or substance abuse.

*Harmed and harming women:* Women who experienced serious physical and sexual child abuse and neglect, leading to school problems in adolescence, hostile aggression or withdrawn fearful and defensive demeanor, leading to chronic adult criminality.

Ritchie (1996) gathered data through life-history interviews and utilized grounded theory to identify six pathways to incarceration among 36 Black, white, “battered” and “nonbattered” women from which her theory of gender entrapment emerged. Each pathway described women's behavior as organized by both internal and external circumstances influenced by the intersections of gender, race, class and sexuality, including:

*Women held hostage –* Pattern of severe physical abuse, isolation, disenfranchisement; they thought they or their children would be killed;

*Projection and association* – Pattern of past severe abuse, resulting in violent crime against men (not the abuser) as “symbolic retaliation for past abuse;”

*Sexual exploitation* – Pattern of past sexual abuse as child, adult victimization by intimate partners and in sex work;

*Fighting back* – Pattern of adult victimization by intimate partner and retaliation violence during or directly following an assault;

*Poverty* – Economically motivated crimes often intertwined with an abusive partner (forced to commit crimes; commit crimes to protect the intimate partner, i.e., Black men more likely to be incarcerated; co-commit crimes together);

*Addiction* – Abuse preceded drug use and addiction, used drugs willingly to self-medicate or connect with the batterer;

These gendered pathways to offending, according to Richie, were determined by abuse in childhood, cultural/racial identities, violence in intimate relationships, and social, familial and institutional support (or lack thereof). Her analysis found that all her participants saw their criminal activity as “responses to violence or threat of violence, extensions of their internalized gender roles and their strong sense of racial identity, including the culturally constructed role of African American women to protect African American men” (p. 129).

Challenging the traditional epistemology of offender knowledge, pathways theories have grown out of the lived experiences of incarcerated women, who were mostly poor, undereducated, abused women of color and white women with mental health and substance abuse problems. The pathways theoretical perspective has resonated with feminist researchers (Daly, 1994; Nuytiens & Christiaens, 2016) who have positioned both researcher and researched alike, as did feminist standpoint theorists before them, within “specific social locations and

political struggles to advance the growth of knowledge, contrary to the dominant view that politics and local situatedness can only block scientific inquiry” (Harding, 2004, p. 26). I recognize the political nature of this work to transform the inequitable and oppressive practices of women’s incarceration, assessment, and treatment within prison. I also recognize that, historically, shifts in policy and practice within criminal justice and corrections institutions have been driven by quantitative evidence, especially meta-analyses (Van Vooris, 2012). Therefore, it is critical to quantitatively investigate the gendered pathways framework to understand women’s incarceration and provide evidence to inform policy changes.

Salisbury and Van Voorhis (2009) utilized a “path analytic approach” (p. 541) with a sample of 313 women probationers to investigate their trajectories to incarceration and found three statistically significant gendered pathways. The first began with child abuse that contributed to current and past mental health problems and substance abuse; the second they described as “relational,” women’s intimate relationships were dysfunctional, violent, and impacting low self-efficacy, mental illness, and substance abuse (Salisbury & Van Voorhis, 2009, p. 546). The third was described as ““a social and human capital pathway’ in which women experienced challenges or dysfunction in education, family support, self-efficacy, and relationships. These were correlated with employment, financial difficulties, and subsequent imprisonment” (Ibid, p. 547).

In 2010, Brennan, Breitenbach and Dieterich quantitatively tested Daly’s findings and found strong evidence of unique, though somewhat different, gendered pathways to incarceration among a large sample of over 700 women inmates. Their stated intention was to understand feminist pathways theories to women’s offending and provide evidence that gender-responsive interventions have advantages over traditional “gender-neutral” classification methods,

particularly for women offenders. However, the study marginalized issues of race and coded their pathways from a white, middle-class, educated lens, naming one pathway the “‘Normal’ Female Offenders,” to include 15.4% of their sample: well-educated, chronic drug users or drug-involved single mothers (Brennan et al., 2010, p. 45). From an intersectional feminist perspective, this is highly problematic. The study did test Van Vooris’ Gender Responsive (GR) Inventory and found supporting evidence for Daly’s pathways.

In their essay on the implications of gender within the criminal justice system, Bloom, Owen and Covington (2004) described what they called women’s “most common pathways to crime” as based on survival of abuse, poverty, and substance abuse. They underscored the importance of a pathway perspective to highlight not only the interconnectedness of gender, racial, class and other social identities, but also of family background, past victimization, substance abuse, physical and mental health, marital and parental status, education levels, and employment, providing a “national profile” of women offenders.

“In summary, a national profile of women offenders describes the following characteristics: disproportionately women of color, in their early- to mid-thirties, most likely to have been convicted of a drug or drug-related offense, fragmented family histories, with other family members involved with the criminal justice system, survivors of physical or sexual abuse as children and adults, significant substance abuse problems, multiple physical and mental health problems, unmarried mothers of minor children, high school degree/GED, but limited vocational training and sporadic work histories” (p. 38). The authors concluded that addressing the realities of women’s lives through gender-responsive policy and programs is fundamental to improved outcomes at all criminal justice phases. In it, they stressed the need for communities to advocate for public policy changes and for interventions targeting the characteristics described above and

“their antecedents through comprehensive mental health, substance abuse, trauma recovery, education and training in job and parenting skills, and affordable and safe housing” (p. 36).

Van Voorhis’ (2012), in an award address to the American Society of Criminology, “lament[ed] the arduously slow pace in which emerging evidence [of women’s incarceration] is impacting policies and front-line practices and services for women” (p. 112). She draws on, and points out to this distinct audience, the early classic, mostly qualitative studies of women’s entry to incarceration that “implicate abuse and trauma, poverty, unhealthy relationships, mental illness, substance abuse, and parental concerns” (Ibid, p. 112).

Today, typical criminal justice profiles of women offenders accept that high levels of abuse, mental health problems, and drug and alcohol dependency exist (Raeder, 1993; 2005; 2007), yet most criminal justice institutions, whether courts, probation offices, or prisons, do not acknowledge gender bias or offer gender-responsive programs to support women’s healing and decrease incarceration and recidivism. In their 2014 review of the theoretical development and impact of feminist pathways research to understand female offending and victimization, Wantanaporn and Holtfreter examine the fields’ influence on gender-responsive policies and practices, and suggests future directions for pathways-based analyses.

For the purposes of this study, gendered pathways to incarceration describe the lived experiences of women through childhood abuse and/or adult victimization and the long-term impacts of that abuse including mental health problems (particularly depression and post-traumatic stress disorder), substance abuse, criminal justice involvement, and incarceration (Bloom et al., 2004; Daly, 1992; DeHart and Moran, 2015). These pathways are impacted by girls and women’s lived experiences of intersectional and “mutually reinforcing vectors of race,



gender, class, and sexuality” (Nash, 2008). This research informs the development of gender-responsive interventions and policies to improve outcomes for incarcerated women.

#### ***1.2.4 Incarcerated Women’s Mental Health Treatment & Gender-Responsive Interventions***

As has been evident in the research included in this literature review, studies consistently reveal that incarcerated women in the U.S. experience high levels of gender-based abuse and mental health problems prior to incarceration. The oft-cited 2006 BJS study on mental health among offenders indicates 73% of women and 55% of men in state prisons and 75% of women and 63% of men in local jails had at least one mental health problem (defined as having a clinical diagnosis or treatment by a mental health professional in the past year). Women were more likely to report experiences of physical or sexual abuse (68%, compared to 44% of women inmates without a mental health problem, and compared to 27% of all inmates with a reported mental health problem, and 10% of all inmates without a mental health problem), and the majority (75%) of women inmates with mental health problems also experienced substance abuse (James & Glaze, 2006, p. 10).

Yet, mental health services for incarcerated women are sporadic and inadequate. Though all U.S. prisons and jails must, as a matter of policy, provide mental health services to inmates, including screening at intake with “best practice” assessment tools, determining a treatment plan to potentially include counseling by trained mental health professionals and psychotropic medication, as needed (James & Glaze, 2006; Reingle Gonzalez & Connell, 2014; Tripodi & Pettus-Davis, 2013; Van Voorhis, 2012). A 2016 National Survey of Prison Health Care reported that all sampled prisons in 45 states assessed “at least some” inmates for mental health conditions and suicide risk (Chari, Simon, DeFrances & Maruschak, 2016). It is estimated that less than one-third of female state prisoners and one-fifth of women in jails with a documented

mental health problem received treatment while incarcerated (James & Glaze, 2006; Reingle Gonzalez & Connell, 2014). In other words, the majority of women inmates receive no mental health care at all. As a result, the “traumatogenic environment of prison” further injures incarcerated women (Chen & Gueta, 2015, p. 43), mental health problems are exacerbated, women are exposed to re-victimization, and recidivism is negatively impacted (Bloom, 2004; Chen & Gueta, 2015; Reingle Gonzalez and Connell, 2014).

The development of gender-responsive interventions and mental health treatment for incarcerated women must be understood within the historical context of research on women offenders, which became its own field of inquiry in the mid-1990s (though still marginalized by much of the criminology field today). In 1985, the First National Adult and Juvenile Female Offender Conference was held. In 1998, the International Community Corrections Association held the first research conference that focused on women offenders and, in 1999, the Office of Justice Programs sponsored its first, and only, National Symposium on Women Offenders (National Symposium on Women Offenders Conference Proceedings, 1999; Schafran & Wikler, 2001; US Dept. of Justice, 1999). A movement had begun a decade earlier with the development of state-level task forces on gender bias in the courts (Schafran & Wikler, 1986). The task forces worked to counter the “denial of bias in the courts, document the existence and impact of gender bias, identify steps necessary to reduce its incidence and effects, and demonstrate that it is a serious matter deserving serious treatment” (Schafran & Wikler, 2001).

Like most feminist activism and research, the development of gender-responsive assessments and interventions is controversial and political, but have been embraced and recommended by some leading criminal justice agencies including the National Institute of Corrections (NIC) (Sydney, 2005). In fact, in the early 2000s, recognizing the lack of research on

criminally-involved women, the escalating number of incarcerated women, and the male-based assessment models impacting women's experiences in prison and recidivism, NIC funded a review of empirical evidence on best practice strategies that resulted in the publication of *Gender-responsive strategies: Research, practice and guiding principles for women offenders* (Bloom et al., 2003).

Because there had been scant research in the area, the review took the researchers outside of the criminal justice literature to cross-disciplinary studies, as have been reviewed here, mostly in the social sciences, investigating experiences of domestic violence, rape, substance abuse, poverty, etc., among women who may or may not have been involved in the criminal justice system. As Van Vooris (2012) assessed, the 2003 *Gender-Responsive Strategies* report addressed concerns including “sexual safety, hiring practices, and sentencing practices, but their treatment recommendations focused on multimodal (wrap-around) services. They recommended a focus on the confluence of mental health, substance abuse and trauma, and interventions to improve women's socioeconomic conditions. Treatment modalities also should incorporate culturally sensitive and relational approaches that maintain women's connections to community, family, children, and other relationships” (p. 126). Gender-responsive intervention developments since then have strived to holistically assess women's needs; decrease overclassification (security level) and revictimization in prison; and facilitate trauma interventions and improvements to women's socioeconomic conditions (Van Vooris, 2009, 2012; Wattanaporn & Holtfreter, 2014).

At the same time, the criminal justice field at state and local levels, especially, has vacillated between a focus on reform and anti-rehabilitation in its treatment of incarcerated people (Cullen, Smith, Lowenkamp & Latessa, 2009), so that even assessments and treatment models that exist and have been implemented widely (i.e., “gender-neutral” interventions) and

those that are burgeoning (including gender-responsive) have had difficulty with consistent implementation and evaluation, having to republish and re-prove their validity and effectiveness (Van Vooris, 2012). Some, such as Andrews and Bonta, have been hostile to feminist challenges that maintain women's unique gendered, racialized, and culturally-unique experiences must be considered in assessment development, and have responded that gender-responsive needs are "noncriminogenic and unrelated to future offending (i.e., not risk factors)" (Andrews and Bonta, 2010; as cited in Van Vooris, 2012, p. 125). Yet feminist researchers continue to provide evidence that intersectional, gender-specific factors are indeed risk factors for future offending; and practitioners advocate for policy change and funding that prioritize gender-responsive interventions to increase women's mental health, lower their recidivism rates, and decrease their return to crime, violent partners, substance abuse, and unhealthy behaviors (Bloom, 2003; Van Voorhis, 2009).

Despite what is occurring on the ground level in prisons and jails, an emerging body of feminist research draws clear connections between women's incarceration and gender-specific experiences, including gender-based abuse, mental health problems, parenting issues, underemployment, poverty, and low self-efficacy (Bloom et al., 2003; Raeder, 2007; Van Vooris, 2012). This research has led to the development of gender-responsive interventions to better serve incarcerated women. Gender-responsive interventions refer to programs, practices, and policies designed to address the specific circumstances of women's lives, taking into consideration factors regarding their individual and familial needs, and risk for victimization, substance abuse, mental health problems, and criminal involvement; and are based on best-practice research on women (Bloom & Covington, 2003; King & Foley, 2014). Gender-responsive programs take into consideration the unique pathways that lead women to commit

crimes and are trauma-informed, strengths-based, and culturally competent (Wattaporn & Holtfreter, 2014). Such interventions include assessment and comprehensive treatment for trauma recovery, mental health problems, drug abuse, job training, and parenting and life skills development (Bloom et al., 2004; National Institute of Corrections, 2014; Raeder, 2007). They are trauma-informed in that they consider how abuse experiences along girls' and women's lifetimes impact their crime, sentencing, and recidivism prevention efforts, and are designed to prevent or limit the retraumatization of abused inmates in prison (Miller & Najavits, 2012; Tripodi & Pettus-Davis, 2013).

Instrumental to the development of gender-responsive interventions, the National Institute of Corrections (NIC) has considered the growing research on women's incarceration and provided funding, "publications and technical assistance, beginning with the 1993 publication of *A guide to programming for women in prison* (Education Development Center, Inc., 1993), the creation of a curriculum in *Sentencing women offenders: A training curriculum for judges* (Cicero and DeCostanzo, 2000), and the development of the Federal Center for Children of Prisoners" (Van Vooris, 2012, p. 113).

In 1994, the U.S. Congress passed the Violence Against Women Act, establishing the Office on Violence Against Women within the U.S. Department of Justice. Relevant federal responses also have occurred under the 2003 Prison Rape Elimination Act. Later work funded by the NIC produced the award-winning publication, mentioned above, *Gender-responsive strategies: Research, practice, and guiding principles for women offenders* (Bloom et al., 2003) along with several tools to assist agencies' efforts to design programs and services that are informed by research developed with women and designed to serve women. In 2010, the Bureau of Justice Assistance, in partnership with NIC, established the National Resource Center on

Justice Involved Women to “promote evidence-based, gender-responsive policies and practices among criminal justice professionals” (Van Vooris, 2012, p. 113). Not only are these entities promoting and training criminal justice facilities to provide gender-responsive programs to women, they are tracking where gender-responsive interventions are being implemented and how effective they are. No research to-date has been published on these findings.

Why are gender-responsive interventions important? Because “gender-neutral” assessments and treatment protocols developed with samples of all male inmates have been used to determine women’s classification, risk, treatment, and release plans for more than a century, though women’s risk for violence and future crime, and their needs to return to society are qualitatively different than men’s (Raeder, 1993; 2005; 2007; Van Voorhis, 2009). One of the most common assessments, the *Level of Service Inventory–Revised* (LSI-R), a quantitative psychological assessment of “offender attributes and their situations relevant to level of supervision and treatment decisions” (Andrews & Bonta, 2016). The LSI-R is used throughout North America by staff in every kind of correctional facility (prisons, jails, detention centers, halfway houses) to predict, for women and men ages 16 and older, how they will behave (“institutional misconduct”), what their parole outcomes will be, and their likelihood of recidivism. Women’s futures – what their incarceration security level will be, what kind of institution they will be admitted to (which influences if and how they will be able to interact with their children and what kind of mental health and intervention programs they will participate in), and when they will be released – have been and continue to be influenced by tools developed for men (Van Vooris, 2012).

To assess the current state of gender-responsive policy and programs within U.S. correctional agencies, the National Institute of Corrections (NIC) conducted survey research and

focus groups with women in 2013 (NIC, 2014). They found that gender-responsive policies are not being adapted for women inmates, rather the management of offenders has been adapted to incarcerate women, creating rampant inconsistencies in how women are incarcerated and managed (NIC, 2014; Bloom, Owen & Covington, 2004). Their findings inform the need for continued feminist action research, evaluation, training, and technical assistance, to influence gender-responsive policy development and program implementation to create a more effective, and efficient correctional approach for women offenders.

The literature supports my position that women's incarceration is a gendered experience uniquely impacted by poverty, systemic racism, and men's violence; and that women's incarceration is growing at unprecedented rates. It situates women's incarceration within a theoretical pathway that describes the trajectory girls and women living in poverty, primarily, experience from abuse to mental health problems, substance abuse, to criminal justice involvement and incarceration. With more U.S. women incarcerated than ever before, and the majority of them with serious mental health problems, mental health care that is responsive to the gendered experiences of women's lives is required. Informed by this gendered pathways approach and current research on gender-responsive interventions, I will examine if women's placement on the mental health caseload in a state prison is predicted by the presence of abuse experiences, or by mental health problems, substance abuse, type of crime, or demographics. (Inmates must first be placed on the mental health caseload by the prison staff before they are given the option to utilize or decline mental health treatment.) It is my hope and intention that this interrogation will provide further quantitative support for the merits of a pathways-based approach to understand women's incarceration; reveal, for this sample, what impacts women's

receipt of mental health care in prison; and inform future efforts to implement gender-responsive interventions to facilitate incarcerated women's healing and decrease recidivism.



## 2 METHODS

### 2.1 Source

This study utilizes secondary analysis of data collected through a broader study entitled the Women's Life Experiences Project (WLEP). I was one of two WLEP research coordinators and a team of graduate research assistants working with Dr. Sarah L. Cook in the Psychology Department at Georgia State University in 2000 to 2001. After securing funding from the National Institute of Justice (NIJ), we collected data on the health (both physical and mental), victimization (context and responses), and traumatic life experiences of incarcerated and non-incarcerated women in Georgia. The current study will only examine data collected from the incarcerated sample. The primary research question for the WLEP project was to examine the context within which intimate partner violence occurred, according to women's self-reports.

I acknowledge both the benefits and shortcomings of using a fifteen-year-old dataset. Benefits include that the study design and data collection were already completed, and the dataset may be of higher quality (i.e., it involves a larger sample size than a master's level graduate student could independently collect, which can provide greater external validity; and it contains considerable breadth, as hundreds of variables were utilized). Disadvantages include that the study design and data collection are already complete, which may not facilitate the current research question (for example, we did not examine if the Georgia DOC had an existing mental health diagnosis on file for each inmate, only if they were on the mental health caseload). In addition, for some secondary analyses, information regarding study design and data collection procedures can be scarce. I have the advantage of having co-coordinated the WLEP study, close

knowledge of the study's methods and procedure, and the experience of personally interviewing over 200 of the study participants myself.

It is important to note that the situation for women in prison is very much the same today, in 2016, as it was in 2001. The recent report *Gender injustice: System-level juvenile justice reforms for girls* (Sherman & Balck, 2015), developed in conjunction with the National Women's Law Center and the National Crittendon Foundation, described the increasing criminal justice involvement among girls and the context of their lives:

The proportion of girls in the juvenile justice system has increased and their challenges have remained *remarkably consistent* [emphasis added], resulting in deeply rooted systemic gender injustice. The literature is clear that girls in the justice system have experienced abuse, violence, adversity, and deprivation across many of the domains of their lives—family, peers, intimate partners, and community (Sherman & Balck, 2015, p. 4).

My secondary analyses of the WLEP data is intended to ask new questions and provide comparisons to, and challenge, existing research on incarcerated women. Since there is no known research asking this study's primary research question, what predicts mental health treatment among U.S. incarcerated women, it is valuable to re-examine the rich dataset that was collected through the WLEP study to examine the pathways theory with this sample and uncover correlations and/or predictors that might explain why some women in prison receive mental health treatment and some do not.

### ***2.1.1 Data Collection Site***

Data collection occurred at Metro State Women's Prison (MSWP), a maximum security facility for women in Atlanta, Georgia with 900 beds, which was run by the Georgia Department of Corrections (DOC) and closed in 2011. During the study period, 2000-2001, all incarcerated women in Georgia spent their first two weeks of incarceration in the diagnostic unit at MSWP and then either remained at MSWP or were transferred to another Georgia prison. The sample includes MSWP inmates with special healthcare needs and severe mental illness (Poister Tusher, 2007).

### ***2.1.2 Procedure***

Each week, the WLEP research team utilized a random number table to select twenty women from a list of those entering the diagnostic unit. Each group of women was invited to attend an informational meeting, receive basic information about the study, and information regarding the Georgia DOC's legal mandate for researchers to report sexual relations between inmates or between inmates and correctional staff (*Cason v. Seckinger*, 1994). Those who chose to participate signed informed consent agreements and were given the opportunity to request a summary of the research findings at the study's conclusion (Poister Tusher, 2007).

Once consent to participate was received, an interview date was provided. Extensively trained graduate research assistants and upper level undergraduate research assistants conducted the interviews. As a research coordinator of the project, I supervised research assistants, conducted interviews, and gathered, entered, and analyzed data. All researchers conducted in-person, verbal interviews with participants individually in small, private, windowed, soundproof rooms located close to a security station. Each interview lasted approximately one and one-half to two hours. At the conclusion of each interview, researchers thanked and debriefed

participants, and encouraged them to meet with a mental health counselor if they wanted to discuss the interview and its subject matter further. When given an opportunity to ask questions about the study, many inmates debriefed with the researchers about the process and their wish to better understand their past experiences. Participants were sent a thank you note and information about community resources related to healing from abuse through the mail.

### 2.1.3 *Participants*

Women who recently entered the diagnostic unit of Metro State Women's Prison during the months of June 2000 through June 2001 were eligible to participate in the Women's Life Experiences Project and a random sample of 817 women was invited to participate in one of 41 informational meetings (Poister Tusher, 2007). See Table 2.1 of participant data.

*Table 2.1 Participant Data*

Women Inmates Involved in Study	<i>N</i>	<i>Rate</i>
Total invited	817	
Attended information session	708	87%
Signed consent forms to participate	482	68%
Consented, participated	403	84%
Consented, did not participate	79	
Due to having been transferred to another institution	51	65%
Declined on day of interview	11	14%
Could not be located	13	17%
Had conflicting appointment	2	3%
Terminated interview early	2	3%
Total participation rate		57%

## 2.2 Research Questions

My three research objectives are to: examine the lifetime prevalence of abuse among incarcerated women in the sample; examine what is considered the sequelae of abuse (i.e., mental health problems, substance abuse, criminal involvement) experienced by women in the sample, and examine if these variables and/or social demographic constructs (race, socioeconomic status, age, etc.) predict mental health treatment. First, I will examine prevalence of abuse, including childhood abuse (CA), adult victimization (AV; includes physical and sexual abuse from an intimate partner or others), and polyvictimization (PV) among the sample of incarcerated women. Second, I will explore the sequelae of abuse among the sample, including mental health problems, substance abuse, and criminal involvement. Third, I will examine my main research question: whether or not women in the sample reporting mental health problems received mental health care in prison and what variables along their trajectory of lived experiences predict mental health treatment. Study variables examined include mental health problems (level of depression, PTSD symptoms, suicidal ideation), type of crime (violent, property, drug, and “other” crime, including public order and “technical”), substance abuse (substance abuse and illegal substance involvement), and demographics (race, economic status, education level, age, marital and parental status).

My hypotheses are that:

1. Prevalence and type of abuse (CA, AV, PV) will predict the presence of mental health problems, substance abuse, and type of crime.
2. Unique, predictive patterns in demographics, mental health problem severity, substance abuse, and type of crime exist among women inmates who receive mental health care in prison and those who do not.

Statistical methods, including Chi-squared tests, logistic regression, and correlations, were used to determine the relationship between predictors and categorical outcomes, the likelihood of certain outcomes, and other relationships in the data. For logistic regression, an outcome is measured with a dichotomous variable when there are only two possible outcomes, and shows the relationship between an explanatory and a response variable (Maxwell, 2009). Logistic regression models provide odds ratios which show likelihood of one outcome over another (Statistics Solutions; 2013). While correlations measure the strength and direction of linear relationships between variables, and indicate the extent one can estimate the value of one variable given a value of the other variable. Chi-square tests are utilized to analyze categorical data, or groups, to determine how likely an observed distribution is due to chance and the "goodness of fit" with the distribution that would be expected if the variables were independent.

## **2.3 Constructs and Measures**

**2.3.1 Demographic measures.** Demographic information for the sample of incarcerated women came both from self-reports and from the inmates' diagnostic files. During the interviews, inmates were asked to provide their birthdate, race/ethnicity, marital status, education level, total monthly income and sources, whether they had children and how many they had, and other questions. Annual income (monthly multiplied by 12) plus number of children was compared to the U.S. Census Bureau's 2001 Poverty Threshold data to determine if the inmate was living in poverty at the time of the interview.

### **2.3.2 Prevalence of abuse among sample**

**2.3.2.1 Child physical abuse (CPA).** The Child Abuse Questionnaire (CAQ; Goodman, 2000) was used to examine the prevalence of child physical abuse, plus our team of WLEP

researchers developed four questions about childhood physical abuse from a caretaker prior to age 16 including if they had been hit with an object, knocked down, burned/scalded, or threatened with a gun or knife. Participants experiencing at least one of these events were coded as 1= yes for child physical abuse, and those that did not were coded as not experiencing child physical abuse, 0 = no.

**2.3.2.2 Child sexual abuse (CSA).** Child sexual abuse was measured using the Sexual Abuse Exposure Questionnaire (SAEQ) and the Traumatic Life Events Questionnaire (TLEQ). The SAEQ (Rodriguez et al., 1996; Rowan et al., 1994) consists of ten items asking about childhood sexual abuse prior to age 16. The questions asked if the woman had ever been flashed and became increasingly invasive (e.g., if they received or performed oral sex). Binary coding (1=yes, 0=no) was used for all items. Participants who reported experiencing any of the ten items were categorized as experiencing CSA.

One item from the Traumatic Life Events Questionnaire (Kubany et al., 1995; Kubany et al., 2000) was used to measure CSA experiences before 13 years of age. This question asked, “Before your 13th birthday, did anyone who was at least five years older than you, touch or fondle your body in a sexual way or make you touch or fondle their body in a sexual way?” Binary coding (1=yes, 0=no) was also used for this item.

**2.3.2.3 Adolescent Sexual Abuse (ASA).** To assess sexual abuse during adolescence, one item from the TLEQ was used: “After your 13th birthday and before your 18<sup>th</sup> birthday, did anyone touch sexual parts of your body or make you touch sexual parts of their body, against your will or without your consent?” This item was also scored “1” for yes and “0” for no.

To examine child abuse in statistical analyses, I created summary fields including all of these variables measuring child abuse of any type from age 0 to adolescence, variables to

examine just child sexual abuse, child physical abuse, adolescent sexual abuse, and also created a dichotomized variable to assess any experiences of child abuse with responses “1” for yes and “0” for no.

**2.3.2.4 Adult Sexual Victimization (ASV).** The WLEP project team modified a version of the Sexual Experiences Scale (SES) (Koss & Gidycz, 1985; Koss & Oros, 1982) to measure adult sexual victimization (ASV), including five questions about nonconsensual sexual contact, attempted intercourse, intercourse, oral sex, and anal sex and the strategy used by the partner, most recent or past, to influence or coerce the behavior. Potential strategies included arguments and pressure, being given drugs or alcohol, the threat of or actual physical force, or other. Each response was coded dichotomously (1=yes, 0 = no). Lifetime ASV was assessed for participants who reported experiencing any of these nonconsensual sexual events from their most recent partner or any other partner (1=yes, 0 = no).

**2.3.2.5 Adult physical victimization (APV).** The Conflict Tactics Scale (CTS2) was used to measure adult physical victimization (APV) (Straus, Hamby, Boney-McCoy & Sugarman, 1996). Participants were asked their most recent partner had ever done any of 13 behaviors, and then if a past partner had used the behavior. For example, women were asked if their partner ever “twisted or pulled your arm,” “beat you up,” “choked you,” or “burned or scalded you on purpose.” Responses were with codes as 1=yes and 0 = no. Participants who reported experiencing *any* amount of APV from their most recent partner or a past partner were coded as experiencing APV. In addition, APV was assessed by the relationship characteristics questions, e.g., did you “consider your relationship with your last partner abusive” (0 = No, 1 = Yes) and have you “ever been in an abusive relationship” (0 = No, 1 = Yes). Participants who did not report experiencing any abuse experiences were coded as “0”.



To examine adult victimization in statistical analyses, I created summary fields for adult victimization, adult physical abuse, and adult sexual abuse; plus I created a dichotomized variable for adult victimization with responses indicating “0” for no experiences of adult victimization or “1” for yes.

**2.3.2.6 Polyvictimization (PV).** Participants who reported the experience of child abuse (any form) *and* adult victimization (any form) were coded dichotomously as experiencing polyvictimization. Those experiencing polyvictimization were coded as “1” and participants who did not report experiencing both child and adult abuse were coded as “0”. Summary fields were created for polyvictimization, child abuse, adult abuse, and a dichotomized variable for polyvictimization (“0” for no and “1” for yes).

**2.3.2.7 Mental Health Problems.** The presence of a mental health problem was assessed using the Center for Epidemiological Studies Depression Scale (CESD) (Radloff, 1977), the Traumatic Life Events Questionnaire (TLEQ) (Kubany et al., 1995), and one item from the Intimate Partner Violence Strategies Index (IPVSI) (Goodman, Dutton, Weinfurt & Cook, 2003). The IPVSI measure assesses strategies the women used before or after violence to cope and how helpful each strategy was. It also asks for the women’s three most helpful strategies. “Thought about trying to kill yourself” was an item in Part 2, section a, with values “0” for no and “1” for yes. This item was used to assess suicidal ideation. The TLEQ was utilized to assess PTSD from the occurrence of 21 potentially traumatic events, plus any resulting fear, helplessness, horror, injury, and/or force used. Degree of PTSD was assessed by examining total experiences of interpersonal violence, other traumatic events, total traumatic events, total fear, and total injury. A cutoff score above 13 has been empirically determined to indicate strong severity of PTSD (Kubany et al., 1995). For depressive symptoms, the CESD included 20 questions to measure

current level of depressive symptoms (Radloff, 1977), such as “have you felt like you couldn’t shake sad feelings, even with help,” “felt depressed,” “thought life had been a failure,” etc.

Scores higher than 16 have been empirically determined to estimate clinical depression.

Dichotomous variables were created for PTSD (score above 13) and depressive symptoms (score above 16).

**2.3.2.8 Substance Abuse.** Items from several scales were used to assess substance abuse including the IPVSI and the Risky Behavior Survey. Questions from the IPVSI included if the inmate “got help for substance abuse,” “used street drugs to relax or calm yourself,” or sought “alcohol or drug help for self.” In addition, if an inmate’s criminal profile data indicated their parole or probation revocation was due to driving under the influence (DUI) of alcohol or drugs, or the inmate reported income from “Illegal Activities – Drug Sales,” I also coded the inmate as “1” for substance abuse. For statistical analysis, I created a dichotomous variable for substance abuse indicating “0” for no and “1” for yes if any of the above variables were marked yes.

**2.3.2.9 Type of Crime.** Information regarding the offense that lead to inmates’ incarceration and their sentence was obtained from their diagnostic file, including offense type (first offense, probation violation, parole revocation), type of crime, and sentence. Type of crime was grouped as either violent, property, drug offense, or other types of crime (Rodriguez, Curry & Lee, 2006; Snyder, 2012). As examples, property offense includes fraud, forgery, embezzlement, theft, and prostitution; violent offense includes aggravated assault, burglary, statutory rape, cruelty to children; drug offense includes driving under the influence (DUI) of alcohol, DUI-drugs, possession of cocaine; and “other” types of crime includes public order (e.g., prostitution), and “technicals” (i.e., behaviors that would not receive a prison sentence if committed by someone uninvolved with the criminal justice system, including probation or

parole violations). Sentence was recoded into the three groups including 1 = 0-5 years, 2 = 5-20 years, and 3 = more than 20 years.

### 3 RESULTS

To examine the hypotheses, twelve logistic regression models, one correlation model, and fifteen cross-tabulation models were run. Prior to analysis, all participant responses (cases) were examined for missing data. Complete data was available on all but four of the variables. Those include age (1 missing case), marital status (11 missing cases), estimated monthly income (5 missing cases), and suicidal ideation (69 missing cases, as only women who reported intimate partner violence were asked this question). Women who responded to some but not all of the study items were included. A total of 403 participants were included in the final sample. Descriptives on all study variables, including minimum and maximum responses, mean and standard deviations, are provided in Table 3.1.

*Table 3.1 Descriptive Statistics of Study Variables (N = 403)*

Variables	<i>Min.</i>	<i>Max.</i>	<i>M (SD)</i>
Age	18	58	34.32 (8.03)
Race	1	5	1.47 (0.59)
Education Level	1	7	2.46 (1.62)
Marital Status <sup>a</sup>	1	6	2.23 (1.40)
Do you have children?	0	1	0.83 (0.38)
Estimated monthly income <sup>b</sup>	\$0	\$150,000	\$2,353 (\$8,237)
Type of Crime: Violence	0	1	0.15 (0.36)
Type of Crime: Property	0	1	0.57 (0.50)
Type of Crime: Drugs	0	1	0.49 (0.50)
Type of Crime: Other	0	1	0.52 (0.50)
TLE Total Events*	0	21	8.43 (4.04)
PTSD (Dichotomous)	0	1	0.12 (0.32)
Total CESD Score**	0	57	23.99 (12.40)
Total CESD Score above 16	0	1	0.68 (0.47)
Suicidal Ideation <sup>c</sup>	0	1	0.23 (0.42)
Mental Health Caseload	0	1	0.35 (0.48)

Substance Abuse	0	5	1.32 (1.13)
Substance Abuse (Dichotomous)	0	1	0.71 (0.46)
Child Abuse (Sum of total experiences)	0	16	3.86 (3.99)
Child Sexual (Sum of total experiences)	0	11	2.72 (3.02)
Child Physical (Sum of total experiences)	0	4	0.87 (1.06)
Adolescent Sexual Abuse (Dichotomous)	0	1	0.27 (0.44)
Child Abuse (Dichotomous)	0	1	0.73 (0.45)
Adult Victimization (Sum of total experiences)	0	71	12.85 (12.13)
Adult Physical Abuse (Sum of total experiences)	0	25	7.38 (4.98)
Adult Sexual Victimization (Sum of total experiences)	0	50	5.49 (8.49)
Adult Victimization (Dichotomous)	0	1	0.91 (0.29)
Polyvictimization	0	81	16.65 (14.27)
Polyvictimization (Dichotomous)	0	1	0.93 (0.25)

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\*TLE Total events: Traumatic Life Events Questionnaire (PTSD Measure)

\*\*CESD: Center for Epidemiological Studies Depression Scale

<sup>a</sup> ( $N = 392$ ), <sup>b</sup> ( $N = 398$ ), <sup>c</sup> ( $N = 334$ )

### 3.1 Demographics, Prevalence of Abuse and Mental Health Problems, Offense Data

Demographics of the sample are found in Table 3.2. Most of the incarcerated women in the sample were living at or just above poverty; they were single mothers (83%) that identified as either Black/African American (55%) or white/Caucasian (44%). The median age was 34 years with ages ranging from 18 to 58 years old. Of those who were mothers, most had between one and three children. Study participants were similarly economically disadvantaged with the majority living below or just above poverty with estimated incomes less than \$25,000 annually (78%). The poverty threshold in 2001, according to the U.S. Census Bureau, for one adult with two children (the typical family composition for this sample) was \$14,269. Almost 60% reported income below this level. The education level of participants was low, with almost half dropping out of high school and one-third achieving no more than their GED or high school diploma.

*Table 3.2 Demographics of the Sample (N = 403)*

Characteristic	<i>Percentage</i>
<b>Race</b>	
Black/African American	55.3
White/Caucasian	43.7
Other (Asian, Multi-ethnic, Other)	1.0
<b>Age<sup>a</sup></b>	
21 and under	5.5
22 to 30	26.4
30 to 44	57.0
45 to 60	11.2
Over 60	0.0
<b>Marital Status</b>	
Single	45.7
Married	15.4
Separated	12.4
Divorced	18.4
Widowed	3.2
Common Law	2.2
<b>Parental Status</b>	
Mother	83.1
No children	16.9
<b>Education Level</b>	
Did not complete high school	43.4
GED	14.6
Completed high school	16.9
Completed trade/technical school	6.7
Attended some college	15.1
Completed bachelor's degree	2.5
Completed graduate school	0.7
<b>Income<sup>b</sup></b>	
Less than \$10,000	37.7
\$10,000 to \$14,999	21.4
\$15,000 to \$24,999	18.6
\$25,000 to \$34,999	6.5
\$35,000 to \$49,999	7.3
\$50,000 to \$74,999	2.8
\$75,000 to \$99,999	1.5
\$100,000 to \$149,999	2.3
\$150,000 to \$199,999	0.5
\$200,000 or more	1.5

<sup>a</sup> (N = 402)

<sup>b</sup> (N = 398)

Prevalence of abuse and mental health problems among the sample are found in Table 3.3. Participants reported higher levels of abuse, depressive symptoms, and exposure to traumatic life experiences than general populations. For example, the majority of women in the sample were survivors of child sexual abuse (62%, compared to 20.7% of the general population) and half experienced child physical abuse (50%, compared to 28.3% of the general population) (Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, Koss, & Marks, 1998; National Center for Victims of Crime, 2016). The vast majority (93%) reported experiencing polyvictimization, both child abuse and adult victimization.

In regards to mental health problems, participants reported an average of 13 traumatic victimization experiences, which is the cutoff level used to determine severe PTSD, compared to an average score of 6.4 for study participants without PTSD (as reported by Kubany et al., 2000). Participant responses to the CESD to measure depressive symptoms were well above the cutscore of 16, the level used to indicate clinical depression (Radloff, 1977), with an average score of 24. Almost 68% of the WLEP sample, compared to 70% of psychiatric inpatients and 21% of the general population, scored at or above the cutoff of 16 to indicate clinical depression.

*Table 3.3. Frequency Distribution of Abuse and Mental Health Variables in Sample (N = 403\*)*

Variable	Percentage of Respondents indicating Yes
Child Abuse (Any)	72.5
CPA (SAEQ)	49.4
CSA (SAEQ)	61.8
ASA (TLEQ)	26.7
Adult Victimization (IPV, rape, SA)	90.8

APV	88.0
ASV	87.0
Polyvictimization	93.3
Mental Health Problems	
Depressive Symptoms (CESD above 16)	67.5
PTSD	11.9
Suicidal Ideation	18.9
Mental Health Caseload at MSWP	34.6
Substance Abuse	27.0

\* Lower *N* than total sample size due to missing values

CPA: Child physical abuse

CSA: Child sexual abuse

ASA: Child sexual abuse before age 13 by a person at least 5 years older

APV: Adult physical victimization

ASV: Adult sexual victimization

IPV: Intimate partner violence

SA: Sexual assault

SAEQ: Sexual Abuse Experiences Questionnaire

TLEQ: Traumatic Life Events Questionnaire

CESD: Center for Epidemiological Studies Depression Scale

Participants were either serving their first prison sentence (43.1%), were in prison due to a probation violation (44.2%), or were serving time due to parole revocation (12.2%). They were serving sentences for drug offenses (48.9%), property offenses (57.1%), “other” offenses (51.9%), or violent crimes (14.9%). The rate of violent crime among this sample is lower than the current national trend which finds an estimated 37% of female state prison inmates being held for violent crimes, compared to 54% of males (Carson, 2015). Within the categories of drug, property, violent, or “other” crime, the most common offenses for which participants were serving time (many were serving a sentence for multiple offenses) were related to financial crimes (e.g., 14.7% for forgery), drugs (e.g., 13.2% for possession of cocaine), and theft (e.g., 9.6% for shoplifting). The average sentence length was 7.15 years ( $SD = 7.5$  years), with most serving 0 to 5 years (51.1%); the remaining participants (37.7%) were serving 5-20 years and a few participants (4.5%) were serving sentences of greater than 20 years.



### 3.2 Testing the Hypotheses

Prior to running logistic regression analyses, I ran Chi-squared tests to ask if women who needed mental health care received it, and I compared the two groups of women inmates being tested by the main hypotheses, those receiving mental health treatment and those who were not. Using measures for depression (the CESD cut score of 16) and PTSD (the TLEQ cut score of 13), the answer is no. Most women in the sample who needed mental health care were not receiving it. As can be seen in Table 3.4, almost sixty percent ( $n=155$ ) of women with a CESD score above 16 and 45% of women with PTSD scores above 13 ( $n = 22$ ) were *not* on the mental health case load. The Chi test yields a  $p$  value of zero ( $p = 0.00$ ) for both comparisons, indicating one can be 100% confident in rejecting our null hypothesis. Of the sample, 115 women with high levels of depressive symptoms and 26 women with high levels of PTSD were receiving mental health care. Plus, 24 women *without* depressive symptoms and 113 women *without* high levels of PTSD symptoms were getting mental health treatment. (They may have had other mental health issues.) These results invite further analysis. Correlations between study variables and demographics are shown in Table 3.5 and correlations between study variables, abuse experiences, and sequelae of abuse are in Table 3.6.

Table 3.4. Group Comparison: Mental Health Caseload by Depression ( $N = 400$ )<sup>a</sup> and PTSD ( $N = 402$ )<sup>b</sup>

Mental Health Caseload		CESD Score Above 16			TELQ Score Above 13		
		16 or Below	Above 16	Total	13 or Below	Above 13	Total
No	N	106	155	261	241	22	263
	(%)	(40.6)	(59.4)		(68.1)	(31.9)	
Yes	N	24	115	139	113	26	139

	(%)	(17.3)	(82.7)		(31.9)	(16.6)	
Total		130	270	400	354	48	402

<sup>a</sup> Chi(df) = 22.535(1), ( $p = 0.00$ )

<sup>b</sup> Chi(df) = 9.247(1), ( $p = 0.00$ )

*Table 3.5. Correlations Between Study Variables and Demographics (N = 403)*

#	Variables	1	2	3	4	5	6
1	Age	1					
2	Race	.02	1				
3	Education level	.22**	-.01	1			
4	Marital status	.36**	.18**	.18**	1		
5	Do you have children?	.10*	-.01	-.02	.08	1	
6	Estimated monthly income	.04	.01	.11*	.01	.01	1
7	Type of Crime – Violence	-.13*	-.05	-.12*	.00	-.04	.09
8	Type of Crime – Property	-.03	.01	.11*	.04	.13**	-.05
9	Type of Crime – Drugs	.19**	.05	-.11*	.05	-.01	-.03
10	Type of Crime – Other	.03	.05	-.02	.02	-.40	.03
11	TLE Total Events <sup>+</sup>	.10*	.15**	-.02	.13*	.02	.03
12	PTSD (D <sup>++</sup> )	.02	.16**	-.08	.05	.00	.02
13	Total CESD Score	.03	-.02	-.05	.01	.06	-.01
14	Total CESD Score above 16	.03	-.01	-.06	.04	.05	.01
15	Suicidal Ideation	.05	.13*	.03	.00	.03	.00
16	Mental Health Caseload	.12*	.18**	.01	.10	.02	-.05
17	Substance Abuse	.20**	.15**	-.2*	.10	.01	-.02
18	Substance Abuse (D)	.21**	.10	-.08	.10*	.00	.02
19	Child Abuse (Any)	-.08	.17**	-.08	.06	-.02	-.09
20	Child Abuse – Sexual	-.09	.18**	-.11*	.09	-.02	-.01
21	Child Abuse – Physical	-.03	.09	-.00	-.02	-.06	-.04
22	Adolescent Abuse – Sexual	-.02	.06	.01	.00	.01	.09
23	Child Abuse (D)	-.04	.03	.02	-.03	-.04	.05
24	Adult Victimization (Any)	-.01	.06	-.05	.10	-.05	-.03
25	Adult Victimization – Physical	-.01	.06	-.13**	.14**	-.06	-.02
26	Adult Victimization – Sexual	.00	.05	-.01	.06	-.03	-.03
27	Adult Victimization (D)	-.01	-.02	-.02	.12*	-.07	.02
28	Polyvictimization	-.03	.10	-.07	.10*	-.05	-.03
29	Polyvictimization (D)	.15	-.04	-.03	.07	-.04	.02

<sup>+</sup> TLE Total Events = PTSD Measure, <sup>++</sup> D = Dichotomous variable, <sup>+++</sup> CESD = Depression Measure

\*  $p < 0.05$  level, \*\*  $p < 0.01$  level

Table 3.6. Correlations Between Study Variables, Abuse Experiences, and Sequelae of Abuse (N = 403)

#	Variables	1	2	3	4	5	6	7	8	9	10	11	12
1	Type of Crime – Violence	1											
2	Type of Crime – Property	-.23**	1										
3	Type of Crime – Drugs	-.23**	-.40**	1									
4	Type of Crime – Other	-.03	-.03	.07	1								
5	TLE Total Events <sup>+</sup>	.03	.02	.11*	.04	1							
6	PTSD (D <sup>++</sup> )	.08	-.07	.10*	.08	.63**	1						
7	Total CESD Score	.06	.03	-.08	.11*	.21**	.08	1					
8	Total CESD Score above 16	.02	.08	-.04	.11*	.18**	.10*	.75**	1				
9	Suicidal Ideation	.05	-.00	.01	.09	.30**	.21**	.30**	.18**	1			
10	Mental Health Caseload	.01	-.04	.07	.13*	.25**	.06**	.31**	.04	.27*	1		
11	Substance Abuse	-.12*	-.20**	.62**	.17**	.35**	.02**	.05	.01	.16**	.15**	1	
12	Substance Abuse (D)	-.21**	-.21**	.63**	.16**	.24**	.07**	.01**	-.03	.04	.12*	.75**	1
13	Child Abuse (Any)	.07	.03	.05	.07	.69**	.56**	.24**	.17**	.30**	.25**	.23**	.09
14	Child Abuse – Sexual	.08	.03	.05	.04	.66**	.54**	.21**	.15**	.28**	.23**	.21**	.09
15	Child Abuse – Physical	.02	.01	.06	.10*	.56**	.42**	.22**	.16**	.25**	.23**	.22**	.10*
16	Adolescent Abuse – Sexual	.05	.06	-.03	.09	.44**	.35**	.15**	.08	.21**	.14**	.12*	-.00
17	Child Abuse (D)	.01	.06	-.01	.04	.50**	.23**	.10*	.11*	.17**	.10*	.16**	.08
18	Adult Victimization (Any)	.15**	.02	-.02	-.04	.52**	.29**	.16**	.14**	.21**	.05	.22**	.10*
19	Adult Victimization – Physical	.08	.04	.02	-.02	.55**	.26**	.15**	.12*	.16**	.07	.28**	.17**
20	Adult Victimization – Sexual	.17**	.01	-.04	-.05	.42**	.26**	.14**	.13**	.21**	.03	.15**	.04
21	Adult Victimization (D)	.04	.09	.02	.04	.39**	.12*	.14**	.15**	.10**	.01	.21**	.12*
22	Polyvictimization	.15**	.02	-.00	-.02	.63**	.40**	.20**	.17**	.27**	.11**	.25**	.11*
23	Polyvictimization (D)	.03	.07	.00	.06	.35**	.10*	.16**	.20	.09	.01	.17**	.01

<sup>+</sup> TLE Total Events = PTSD Measure, <sup>++</sup> D = Dichotomous variable, <sup>+++</sup> CESD = Depression Measure

\* p < 0.05 level, \*\* p < 0.01

I used correlational and logistic regression analyses to test if the presence and type of abuse (CA, AV, PV) would predict the presence of mental health problems, substance abuse, and type of crime. Furthermore, I utilized correlational and logistic regression analyses to examine patterns in demographics, mental health problem severity, substance abuse, and type of crime among women inmates who received mental health care in prison and those who did not.

### ***3.2.1 Correlations among abuse variables and the sequelae of abuse***

Child abuse was significantly correlated with PTSD symptoms, depressive symptoms, suicidal ideation, substance abuse, and being on the mental health caseload. The strongest correlation was between child abuse (a summary field including any form of child abuse) and PTSD symptoms, and between child sexual abuse and PTSD. The correlation between the former, child abuse summary and PTSD, was positive and moderate-to-strong ( $r = .69, p = 0.00$ ), indicating zero risk of concluding that a relationship exists when there is none. The latter, child sexual abuse and PTSD, was also a moderate-to-strong, uphill correlation ( $r = .66, p = 0.00$ ).

There were significant, though weak, positive correlations between adult victimization (including adult physical abuse, adult sexual abuse, and the summary field including any type of adult victimization) and substance abuse. The strongest of these correlations was the weak-to-moderate association between adult physical abuse and substance abuse ( $r = .28, p = .00$ ).

When looking at polyvictimization and being sentenced for a property, drug, or “other” offense, there was no correlation; but there was a significant, though weak, positive correlation between polyvictimization and violent crime ( $r = .16, p = .00$ ). There also was no correlation between polyvictimization and mental health care. Receipt of mental health treatment was weakly though significantly positively correlated with race (0 = Black, 1 = White;  $r = .18, p =$

.00), child abuse ( $r = .25, p = .00$ ), child sexual abuse ( $r = .23, p = .00$ ), substance abuse ( $r = .15, p < 0.01$ ), and “other” types of sentence ( $r = .13, p < 0.01$ ).

There were significant though weak positive correlations between race and marital status ( $r = .18, p < 0.01$ ), PTSD ( $r = .15, p < 0.01$ ), suicidal ideation ( $r = .13, p = 0.02$ ), substance abuse ( $r = .15, p < 0.01$ ), child abuse (any form) ( $r = .17, p < 0.01$ ) and child sexual abuse ( $r = .18, p < 0.01$ ). White women were slightly more likely to be married, experience child abuse (particularly child sexual abuse), substance abuse, and PTSD, and they were more likely to be on the mental health caseload.

A significant but weak uphill correlation existed between depression (CESD score above 21) and suicidal ideation ( $r = .18, p < 0.01$ ).

### ***3.2.2 Predictors of pathways to incarceration and mental health care provision***

To go beyond merely examining correlations, I sought to determine what predictors might account for the correlations found between abuse (whether child abuse, adult victimization, or polyvictimization) and mental health problems, substance abuse, and criminal offense types. I also sought to determine what key study variables accounted for the placement of a woman on the mental health caseload at Metro State Women’s Prison. I utilized correlation analyses to examine relationships between key variables without controlling for other potentially influencing variables, and then utilized logistic regression models to test predictive relationships between study variables. Detailed results follow.

In my first three logistic regression models, I tested whether experiencing child abuse (including physical or sexual abuse during childhood, or sexual abuse during adolescence) predicted mental health problems (i.e., depressive symptoms, PTSD symptoms, or suicidal ideation; see Table 3.7). Significant predictive relationships were found in all three models. If a

woman in the sample experienced child abuse, she had a 10% greater likelihood ( $p = 0.00$ ) of reporting depressive symptoms with scores above 16 (the level typically used to indicate clinical depression among mental health inpatients), a 58% greater likelihood of reporting PTSD with scores above 13 (the level typically used to indicate strong severity of PTSD), and an 18% greater likelihood of reporting suicidal thoughts.

*Table 3.7. Results of Logistic Regression Analyses for Models 1, 2, 3: Child abuse predicting mental health problems (N=403)*

Type of Mental Health Problem	<i>B</i>	<i>SE</i>	<i>OR</i>	<i>R</i> <sup>2</sup>
Depression (CESD Above 16)	0.10	0.03	1.10*	0.03
PTSD (TLEQ Above 13)	0.46	0.06	1.58*	0.25
Report of Suicidal Ideation	0.17	0.03	1.18*	0.08

\* $p \leq .01$

[ $R^2 = \text{Cox \& Snell } R \text{ Square}$ ]

In logistic regression model 4, I tested adult victimization, including physical and/or sexual abuse as an adult, as a predictor of substance abuse. It did not show significance. However, I did find, in model 5, a significant predictive relationship between polyvictimization and violent offense ( $p = .003$ ). There was a small (3%) but significant increase in likelihood that an inmate who experienced polyvictimization prior to incarceration was serving a sentence for a violent crime (See Table 3.8). With models 6, 7, and 8, I tested the likelihood that experiencing polyvictimization prior to incarceration would predict being sentenced for a property, drug, or “other” offense, respectively. Polyvictimization was not found to be a significant predictor of these offenses. However, with logistic regression model 9, there was evidence of a small (2%)

but significant ( $p = .02$ ) increase in likelihood that an inmate who experienced polyvictimization prior to incarceration would be on the mental health caseload (also in Table 3.8).

*Table 3.8. Results of Logistic Regression Analyses for Models 5, 9: Polyvictimization predicting violent offense and mental health caseload (N=403)*

Variable	<i>B</i>	<i>SE</i>	<i>OR</i>	<i>R</i> <sup>2</sup>
Violent Offense	0.026	0.009	1.026**	0.021
Mental health treatment	0.016	0.007	1.016*	0.013

\* $p \leq .03$ , \*\* $p \leq .01$

[ $R^2 = \text{Cox \& Snell R Square}$ ]

Through Models 10, 11 and 12, I tested the impact of demographics on outcome variables, removing the very few cases ( $n = 4$ ) that reported racial identification other than African American/Black or Caucasian/White. These cases were too few to be considered a separate racial group. A dichotomous variable was created with 0 = African American/Black, and 1 = Caucasian/White.

Model 10 examined multiple variables as predictors of mental health treatment, including age, race, marital status, having children, income, sentence, type of crime, substance abuse, polyvictimization, PTSD, depression, and suicidal ideation. Of the 296 records (the total number with complete data on each of these variables) included in the analysis, 102 (34.5%) were on the mental health caseload. Four variables were significant predictors of mental health treatment: depression ( $p = .00$ ), suicidal ideation ( $p = .00$ ), race ( $p = .01$ ), and “other” types of offense ( $p = .04$ ). Inmates were 104% more likely to be on the mental health caseload when the inmate was White, and 149% more likely to be receive mental health care when the inmate (regardless of

race) reported experiencing suicidal ideation. There was a more than 3.2 times greater likelihood that an inmate would be on the mental health caseload when reporting depressive symptoms above the 16 cutscore (that indicates clinical depression). There was also a 170% greater likelihood to be on the mental health caseload when the inmate was sentenced for an “other” type of crime (non-drug, non-property, and non-violent, though this sentence could have been in addition to sentences for one of these crimes).

Model 11 examined, in two steps, the same multiple variables as model 10 to predict mental health treatment for the purpose of strengthening the evidence of these predictions. Therefore, this data is shown in Table 3.9. Of the 296 cases included in the analysis, 102 or 34.5% were on the mental health caseload. Variables examined in step 1 included age, race, education level, having children, income, and sentence. In this step, race was the sole significant predictor ( $p = .00$ ) of receiving mental health treatment. It is significant above and beyond demographics. In step 2, variables included sentence, type of crime, substance abuse, polyvictimization, PTSD, depression, and suicidal ideation, controlling for the demographic variables examined in step 1. As in model 10, four variables were significant predictors of mental health treatment: depression ( $p = .00$ ), race ( $p = .01$ ), suicidal ideation ( $p = .01$ ), and “other” types of offenses ( $p = .04$ ). Inmates were 200% more likely to be on the mental health caseload when their race was White and when they reported suicidal ideation. There was a more than 300% greater likelihood to be on the mental health caseload when inmates reported high numbers of depressive symptoms (above the 16 cutscore that indicates clinical depression); and a 170% greater likelihood when the inmate was sentenced for an “other” type of crime.



*Table 3.9. Results of Logistic Regression Analyses for Model 11: Multiple variables in two steps predicting mental health caseload (N=296)*

Variable	<i>B</i>	<i>SE</i>	<i>OR</i>
Race	0.71	0.27	2.04**
Type of Crime - Other	0.57	0.28	1.78*
Depression Cut Score	1.15	0.35	3.20**
Suicidal Ideation	0.94	0.33	2.49**

\*( $p \leq .05$ ) \*\*( $p \leq .01$ )

[ $R^2$  (Cox & Snell R Square) = 0.18]

Model 12 includes only the significant predictors (depression, race, suicidal ideation, and “other” types of crime) from step two of model 11, and the demographic variables (to control for them). With these added in, there is stronger evidence of race, depression, suicidal ideation, and “other” types of offense as predictors of placement on the mental health caseload (see Table 3.10). “Other” types of offense includes what is coded in the diagnostic file under “Original Offense” or “Reason Revoked” with variables including cruelty to children, obstruction of officer, prostitution, “technical,” and others. Women serving more than one sentence could be serving an “other offense” sentence with a drug, property, or violent offense.

*Table 3.10. Results of Logistic Regression Analyses for Model 12: Significant predictors of mental health caseload controlling for demographics (N=296)*

Variable	<i>B</i>	<i>SE</i>	<i>OR</i>	$R^2$
Race	0.76	0.26	2.14**	0.17
Type of Crime – Other	0.61	0.28	1.84*	0.17
Depression cutscore	1.16	0.35	3.20**	0.17
Suicidal Ideation	0.99	0.32	2.68**	0.17

\*( $p \leq .01$ ) \*\*( $p \leq .05$ )

[ $R^2$  (Cox & Snell R Square) = 0.17]

I used cross-tabulation analyses to compare the groups of women inmates being tested by the hypotheses. As described earlier in Table 3.4, Chi-squared tests revealed that most study participants with depressive symptoms above typical clinical levels were not receiving mental health treatment ( $p = .00$ ), and over 60% of women receiving mental health care were serving sentences for the “other” types of crime ( $p = .01$ ). In addition, I found through Chi-squared analyses that the same number of women inmates experiencing PTSD were on the mental health caseload as were not on it ( $p = .00$ ). Table 3.11 provides a summary of all major predictive findings.

*Table 3.11. Summary of Significant Predictive Findings*

Predictor	Pathway Variable	Odds Ratio	Significance
Child abuse predicting:			
	Depression	1.10	$p = .00$
	PTSD	1.58	$p = .00$
	Suicidal thoughts	1.18	$p = .00$
Polyvictimization predicting:			
	Violent offense	1.03	$p = .00$
	Mental health treatment	1.02	$p = .03$
Multiple variables predicting MH treatment:			
	Race	2.14	$p = .00$
	Type of Crime – Other	1.84	$p = .03$
	Depression cutscore	3.20	$p = .02$
	Suicidal Ideation	2.68	$p = .00$

In sum, my results indicate that child abuse and adult victimization predict the presence of mental health problems, substance abuse, and type of crime. More specifically, child abuse predicts depression and other mental health problems; polyvictimization (experiencing abuse as a child and as an adult) predicts violent crime; and both child abuse and adult victimization are

significantly correlated with different types of mental health problems, type of crime, and substance abuse. Unique patterns in demographics, mental health problem severity, substance abuse, and type of crime predict women's receipt of mental health care in prison. More specifically, clinical depression, suicidal ideation, race (being White), and "other" types of crime predicted receipt of mental health care. Implications of these findings are presented in the discussion.

## 4 DISCUSSION

This study provides quantitative, empirical support for the theoretical gendered pathways to incarceration framework and uncovers predictors of mental health caseload placement among a sample of incarcerated women for the purpose of influencing policies and practices that support incarcerated women's healing, decrease their recidivism, and promote social justice. Lifetime prevalence of child abuse, adult victimization and polyvictimization among a sample of 403 incarcerated women was examined in relation to their pathways to incarceration that included mental health problems, substance abuse, and criminal involvement. The impact of abuse experiences along women's pathway to prison was examined, along with demographics, to better understand what predicts women's placement on the mental health caseload in prison.

### 4.1 Quantitative support for the pathways to incarceration theory

Not unexpectedly, there was an extremely high prevalence of abuse, mental health problems, and economic disadvantages among this random sample of mostly (85%) nonviolent offenders. Incarcerated women in the sample were survivors of child sexual abuse (62%), child physical abuse (50%), adolescent sexual abuse (27%), adult physical violence (88%), adult sexual violence (87%), including rape and sexual assaults, and polyvictimization (93%). They were Black (55%) and white (44%) – in the state of Georgia where whites/Caucasians are 65.1% of the population and Blacks/African Americans are 28.7%. They were vastly economically disadvantaged (78%), depressed (68%), undereducated (83%) and parenting (83%). Almost 70% of the sample experienced depressive symptoms at levels aligned with clinically depression, 21% experienced suicidal ideation, and 12% experienced severe PTSD symptoms. Yet, only 35% were on the prison's mental health caseload.

There is clear, quantitative support for the pathways framework that positions gender-based violence against women and girls as related to women's mental health problems, substance abuse, and criminal involvement. Results reveal that types of past abuse experiences significantly predicted the sequelae of abuse – defined as, for the purposes of this study, mental health problems, substance abuse issues, and offense patterns – while other types of abuse correlated with these variables.

Experiences of child abuse (including physical or sexual abuse during childhood, or sexual abuse during adolescence) predicted type and severity of mental health problems and were correlated with substance abuse. Women who had been abused as girls were 58% more likely to experience severe PTSD, 18% more likely to report suicidal ideation when dealing with intimate partner violence, and 10% more likely to report clinical-levels of depressive symptoms, than women in the sample who had not experienced abuse as girls. Surprisingly, adult victimization (intimate partner violence, rape, other sexual assault) did not predict mental health problems or substance abuse, but were significantly and positively correlated with PTSD, clinical depression, suicidal ideation, and substance abuse.

Experiencing polyvictimization, including abuse as girls and as adults across a woman's lifetime, was also correlated with mental health problems and substance abuse. In addition, polyvictimization predicted one type of offense by a small margin. Women who experienced polyvictimization, including experiences of abuse as girls and in adulthood, were 3% more likely to be serving a sentence for a violent offense. But with only 14% of the sample serving time for violent crime, almost all inmates experiencing polyvictimization, and the potential for women to be convicted for violent crime along with male co-defendants, the predictive nature of polyvictimization must be carefully interpreted. Further investigation into the impact of

polyvictimization on incarcerated women's lived experiences and their pathways to crime is warranted.

#### **4.2 Institutional racism and the need for anti-racist, gender-responsive interventions**

Results also revealed that white women were 114 times more likely to be on the mental health caseload than Black women. This study asked what predicts incarcerated women's receipt of mental health care, and whether women who need care are getting it. My findings indicate that clinical depression, suicidal ideation, race, and "other" types of offense predicted receipt of mental health care in prison. Women who experienced suicidal ideation were 168 times more likely and clinically depressed women were 220 times more likely to be on the mental health caseload. Not all women who needed care the most were on the mental health caseload. More than half of clinically depressed women and just under half of women with severe PTSD were *not* on the mental health caseload, and many of these women were Black.

It has been substantiated here that the incarceration of women occurs within the context of a criminal justice system plagued with racial, gender and class oppression. Research indicates that arrest, conviction, sentencing, and reentry patterns result in the consistent overrepresentation of low-income women of color in prison (Chesney-Lind & Merlo, 2015; Crenshaw, 2012; 2015), and "profound racial bias is routinely mobilized into the operation of the modern criminal justice system" (Bobo & Thompson, 2010, p. 324). My finding that there is a significant overrepresentation of white women and underrepresentation of Black women among those being placed on the mental health caseload cannot be explained in "race-neutral terms." The provision of mental health services is a structural factor related to, or possibly caused by, institutional racial oppression at MSWP. Many African American women with severe mental health problems were not getting the mental health care they needed and had a civil right to receive.

These findings support policy recommendations for gender-responsive interventions and anti-racist activism within the criminal justice system. Gender-responsive interventions are needed because, first, “gender-neutral” assessments and interventions developed with and for men are still used to determine women’s classification, risk, treatment, and release plans, despite a growing body of research that proves women’s risk for violence and future criminal involvement is significantly lower, and their needs to return to society qualitatively different, than men’s. Secondly, gender-responsive interventions have been effective to improve mental health outcomes, reduce women’s recidivism, and support their reunification with families and reintegration into society (Van Vooris, 2012; Wattanaporn & Holtfreter, 2014). Women’s futures – what their incarceration security level will be, what kind of institution they will be admitted to (which influences if and how they will be able to interact with their children and what kind of mental health and intervention programs they will participate in), and when they will be released – have been and continue to be influenced by tools developed for men (Van Vooris, 2012).

That institutional racism impacts the receipt of mental health care in prison is important to future implementation efforts of gender-responsive programs. Not only do sexist practices of utilizing assessments based on research with men impact women’s classifications, treatment and release plans, among other aspects of their incarceration, racist practices impact their placement on the mental health caseload and, likely, other service provisions. Anti-racist policies and practices must be put in place so that gender-responsive interventions are equitably delivered to women in prison. There is scant research on this issue, yet, according to the American Civil Liberties Union (ACLU), racist injustices may rampantly occur as there is no independent U.S. agency monitoring the protection of human and civil rights of incarcerated people (ACLU, 2016). International human rights law and standards can provide guidance to advocates for

reform in U.S. women's prisons (Gainsborough, 2008). Future questions include how feminist scholars and concerned citizens can support the monitoring of human and civil rights protections within women's prisons and equitable provision of mental health treatment services. How can we and the general public support policies and funding for anti-racist, gender-responsive assessment and intervention programs for incarcerated women?

### **4.3 Complexities in sentencing of women offenders**

Another unique finding was that women were 84 times more likely to be on the mental health caseload when sentenced for an "other" type of crime (non-drug, non-property, and non-violent). "Other" types of crime, coded in the diagnostic file under "Original Offense" or "Reason Revoked," included crimes including cruelty to children, obstruction of officer, prostitution, public order, "technicals," and more. This could include prison sentences for crimes that would not receive a prison sentence if committed by someone uninvolved with the criminal justice system, including probation or parole violations. Many women were serving a sentence for an "other" type of crime in addition to a sentence(s) for a drug, property, or violent crime. This finding that "other" types of crime predict women's placement on the mental health caseload warrants further quantitative and/or qualitative investigation of this issue and is beyond the scope of this thesis.

### **4.4 Conclusion**

This feminist action research situates women's incarceration within the gendered and racialized context of the U.S. criminal justice system. It provides quantitative support for the pathways theory of women's incarceration demonstrating that abuse of women and girls impacts their mental health, substance abuse, and criminal involvement. As one of the first studies to examine predictors of mental health care provision in prison, it also identifies clinical depression,



suicidal ideation, “other” types of crime, and race as predictors of placement on the prison’s mental health caseload. White women were 114 times more likely than Black women to be placed on the mental health caseload, offering evidence of institutional racism in the provision of mental health care in a Georgia state women’s prison. This study, through self-reports and quantitative analysis, places incarcerated women’s voices in the center of knowledge production, while building on the work of feminist researchers to understand women’s trajectories to incarceration and develop assessments and interventions that are grounded in women’s experiences, rather than men’s. The development, evaluation, and consistent implementation of feminist mental health interventions are needed to facilitate women’s healing from abuse, address mental health problems, and decrease rates of recidivism. At the same time, primary prevention of violence against girls and women is needed to lower rates of criminal justice involvement and incarceration among this group. Systemic racism and sexism in the criminal justice system at the levels of juvenile justice, sentencing, incarceration, and mental health service provision must be examined and addressed at federal, state, and institutional levels for there to be justice for women.

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