12-1-2018

Treating Incarcerated Women with Co-Occurring Disorders

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A Capstone Project submitted in partial fulfillment of the

requirements for the Master of Science Degree in

Counselor Education at

Winona State University

Fall, 2018

Winona State University

College of Education

Counselor Education Department

CERTIFICATE OF APPROVAL

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CAPSTONE PROJECT

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Treating Incarcerated Women with Co-Occurring Disorders

This is to certify that the Capstone Project of

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Has been approved by the faculty advisor and the CE 695 – Capstone Project

Course Instructor in partial fulfillment of the requirements for the

Master of Science Degree in

Counselor Education

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Table of Contents

Abstract

Through a literature review, the treatment needs of women who are incarcerated with a dual diagnosis, both mental health and substance use disorder, will be addressed and evaluated. Specifically, this literature review will examine the impact of trauma and mental health disorders on creating addictive patterns. Since it is common for incarcerated women to have dual diagnoses, there is a need for effective and reachable treatment modalities when approaching incarcerated women. Much of the jail/prison sentences do not specifically address the recovery and treatment demands the women need to overcome trauma and substance use. This lack of availability typically renders substantial increases in recidivism and re-incarceration. Counselor-specific approaches that may be helpful include cognitive-behavioral therapy, dialectical behavioral therapy, seeking safety, acceptance commitment therapy, group versus individual counseling and self-compassion. Specific multicultural approaches will be addressed as well.

Keywords: Incarcerated Women, Needs, Dual Diagnosis, Trauma, Substance Abuse

Treating Incarcerated Women with Co-Occurring Disorders

There is a dire need for incarcerated women to have adequate access, appropriate services and availability for treatment addressing specific needs. Throughout many research studies, conclusions have rendered incarcerated women's primary concerns to be substance abuse and family issues. Additionally, multiple studies have concluded majority of incarcerated women to have high levels of trauma, depression and PTSD (Green, Miranda, Daroowalla & Siddique, 2005). Unfortunately, jail or prison may be the only option to receive services to cope with these dual diagnoses. The hurt and pain in these diagnoses are significant and cause severe distress. Green et al. (2005) calls this phenomenon the "cycle of pain." Addressing substance use, mental health and trauma together can in turn halt recidivism.

There are several approaches that can be taken to address the treatment needs of incarcerated women. The purpose of this paper is to discuss these approaches, including theoretical treatment by clinicians, criminal sentencing changes addressing treatment and recovery, and jail/prison staff awareness. First, it is important to understand the characteristics of incarcerated women and why women offend. This can inhibit knowledge into what changes are needed to address this deficiency.

Literature Review

Mental Health Considerations of Women

Characteristics of incarcerated women. Understanding the characteristics of incarcerated women is a critical component to addressing treatment. Since 1995, there has been

a substantial increase in the overall jail population. This has mainly been due to the increase in drug sentences and penalties (Green, Miranda, Daroowalla & Siddique, 2005). The approach to addiction treatment has been fairly nonexistent, a fail on the criminal justice system. Specifically, in a study, it was found that 80% of prison and jail inmates, both federally and state mandated, were under the influence of alcohol or drug at the time of their offense, conducted a crime to support their addiction, or were convicted for drug charges (Kobiak, 2004). While prison administration have these facts, approaches to treating these women for their addictions are not readily used. It is not a newly developed issue that women are not receiving the support and treatment that they need.

Several studies have shown important characteristics of incarcerated women for mental health professionals and prison systems to consider. The average age of a prison/jail female inmate is 32.3 years, according to a recent study (Green et al., 2005). In the same study, it was shown that 27% of women had minimal education, barely completed or did not complete high school (Green et al., 2005). Furthermore, minimal awareness or attention is presented on inmates who are mothers. Green et al. concluded that 7 in 10 female inmates have minor children. This is troublesome to women as they are unable to parent while incarcerated (2005). Finally, mental illness and trauma have also been presented in incarcerated women. A study concluded that incarcerated women showed high rates of depression and have been exposed to several, and severe, traumatic events (Kubiak, 2004). As previously stated, these disconcerting statistics regarding education, parenthood, mental health and trauma should be considered in the prevention and intervention of the incarceration of women.

There are many viewpoints as to what specific characteristics have brought incarcerated women to the criminal justice system. Hiseler (2015) has come up with 5 distinguishing theories

on this issue. First, Hiseler discusses "harmed vs. harming" women, believing women in this category have experienced extensive abuse and/or neglect as a child and cope with this with substances and explosive behaviors (Hiseler, 2015). Second, "battered" women pertain to a woman's history as being beaten and abused by a partner (Hiseler, 2015). Third, Hiseler describes "street" women, as women who run away from (potentially) abusive homes and inevitably raise themselves. This lifestyle then often leads to substance abuse, prostitution and other related crimes (Hiseler, 2015). Fourth, "drug-connected" women become involved with substance abuse through family connection, and potentially, genetics (Hiseler, 2015). Lastly, "other" women have no exposure to criminal involvement and have minimal traumatic experiences. Hiseler (2015) also classifies this as "economically motivated" (2015). This study is useful in that it outlines the potential characteristics of types of incarcerated women, so that counselors can begin to associate particular issues with potential treatment options.

Women's mental health propensity. It is common for women who are incarcerated to also have a mental health diagnosis. Understanding the nature of the mental health diagnosis can be helpful for treatment. A specific example is abuse. Women who have experienced severe abuse throughout their lifetime are at a high risk for developing a mental illness (Conder, Mirfin-Veitch & Gates, 2015). This includes diagnoses relating to mood disorders and personality disorders.

There are several research studies that have concluded mental health disorders have contributed to incarceration. In a study, about 97% of women stated they have problems with mental health; of those, about 92% have sought treatment (Becker et al., 2005). Tangney Tangney, Stuewig, and Hafez (2011) report in their study that depressive and anxiety symptoms are quite common in incarcerated women. As such, it is believed that depression will be the

most significant diagnosis by 2020 (Conder et al., 2015). Other disorders include eating disorders, suicidal thinking, and high rates of low self-esteem (Tangney et al., 2011) and bipolar disorder (Green et al., 2005). It is concerning that women are also experience self-harming habits which include burning of the skin and cutting. They oftentimes use these behaviors to cope with mental health symptoms while incarcerated (Hiseler, 2015). It has been shown that female offenders have higher rates of mental illness (Green et al., 2005), and ignoring this could be detrimental to any sort of recovery.

Dual diagnoses. It is common for women incarcerated to have been diagnosed with both a mental health disorder and substance use disorder. Research says that there is a dire need for both disorders to be treated, especially with the incarcerated individuals. As such, about 10 million people have been diagnosed with both a mental health disorder and substance use disorder in the United States alone (Becker et al., 2005). Women especially, have increased chances of needing hospitalization, treatment for sexually transmitted diseases, medications, family support and housing (Becker et al., 2005). Sadly, less than half of these women will receive the treatment needed addressing both trauma (mental health) and substance abuse (Becker et al., 2005). Both diagnoses are significant and cause severe distress in one's life.

Post-traumatic stress disorder is quite commonly dually diagnosed with substance use disorder. Specifically, in a study, it was concluded that 50% of individuals receiving treatment for substance use also had a diagnosis of PTSD (Kubiak, 2004). Treating these women while incarcerated helps to reduce the rates of recidivism. Unaddressed substance use disorders and PTSD creates high chances of relapse and re-incarceration (Kubiak, 2004). It is important for counselors to be aware of dual diagnoses, because, if one is treated and not the other, it could result in further trauma and damage to the individual.

Treating these dual diagnoses are not easy. This treatment is considered by researchers and practitioners as "the most challenging" (Kubiak, 2004). Sadly, it could take several attempts to treat these issues comprehensively. Taking the first step during incarceration may be a critical period to save these women. Trauma has typically begun well before the substance use disorder (Kubiak, 2004). This suggests that treating the substance use disorder without the core defect (trauma) could be ineffective. Hiseler (2015) addressed a specific example of a woman with both diagnoses:

> *"Laura wasn't an alcoholic until she was 15. She found out that if she was drunk, it was easier to deal with the sexual abuse. She would see her stepdad looking at her like he was going to do it, and she'd drink a half bottle of vodka" (Hiseler, 2015).*

The above synopsis shows that the substances are used as a coping mechanism for the trauma. It is assumed that this individual will need treatment for a dual diagnosis. The importance of addressing both disorders is key to the success of treatment.

The prison system. Before proposing treatment considerations, it is important to address the needs of incarcerated women. Research shows that there is a lack of treatment and program availability among the prison population. The programs offered tend to focus more on the male versus female populations (Rose, 2004). The most common themes reported by female inmates regarding needs is substance abuse, family concerns, job trainings, skills and education (Green et al., 2005). Research literature has identified that there are some programs offered in prisons, but these often do not address women's needs entirely, especially when it comes to treatment for dual diagnoses (Kubiak, 2004). Prison programs have only recently begun to address the needs of co-occurring disorders and have begun substance abuse assessments (Kubiak, 2004). There is an evident need for further evaluation on women to be assessed with a dual diagnosis.

Counseling. It is common for women to be released and still have untreated traumas and mental health issues and leave without any new sense of outlook (Rose, 2004). Women in prison are not receiving the medical attention they need, physically, mentally and emotionally. There is also a lack of counseling services and medical doctors in prisons. Studies have concluded that few prisons, reportedly only about a third (Green et al., 2005), offer counseling services. Few prisons offered discharge planning, which is a critical component in preventing recidivism (Green et al., 2005). Perkins suggests that counseling needs of incarcerated women are substance abuse, suicidal thoughts, sleep disruptions, nutrition deficits and depression. Counseling needs relating to depression are of a high concern as well (Perkins, 2018). Women who are depressed typically lack any sort of motivation for change, and result in exhaustion and isolation (Perkins, 2018). Counselor and community awareness of these needs is crucial to making steps toward improvement.

Support for Parents. Parental support is another critical need for women who are incarcerated. In a study of incarcerated women, majority of the women were parents. In a survey question prompt, "I feel my family life is under control," only 32% of the subjects agreed to the statement (Becker et al., 2005, p.436). A substantial worry noted by participants is that of losing custody of their children (Becker et al., 2005) while incarcerated. Rose (2004) describes this separation to be one of the top "worst aspects" of the entire incarceration. Women who have their children taken away during incarceration experience immense pain, leading to post traumatic stress disorder (Conder et al., 2015). This also leaves the woman with uncertainty of the safety of the child and the guilt of leaving them. They also worry if they will even be able to re-establish a new relationship once released (Rose, 2004). The incarcerated "mothers" have a

substantial need while incarcerated to learn relationship and parenting skills, not only for the mother herself, but for the children as well.

Considerations for the Prison Environment. Incarcerated women deserve the chance for a newly developed life, however, the environment of the prison makes change hard. Having supportive, empathetic and kind jail staff is another key piece to their recovery. It has been found that women are inevitably re-traumatized when they receive verbal and physical abuse from correctional officers (Green et al., 2005). A stronger support system and encouraging individuals will in turn create recovery. It is believed that women are quite aware of their needs and typically render an interest in change (Green et al., 2005). Being responsive to the needs of incarcerated women has positive effects. Conder et al. (2015) reported a developed sense of autonomy to be a contributing factor in creating happiness. Furthermore, Conder et al. also encourages familial connections during the time of incarceration (2015). Still, there is a need for more services to become available for these women. In one study, several women reported it to be pointless to even seek services due to the failed system (Rose, 2004).

Factors Associated with Treatment of Women

Trauma. There are several types of trauma victims in the prison and jail settings. About 51% of women in the United States have experienced a traumatic experience at some point in their lives (Kubiak, 2004). Post-traumatic stress disorder is a common trauma faced in the United States, which is where one is not able to fully overcome a traumatic experience. Over 20% of trauma victims develop this disorder. They are exposed to severe situations where life-threatening conditions can occur (Kubiak). This disorder is common and is at a higher rate of those that are incarcerated compared to the rest of the population (Kubiak). Sometimes, women may become re-traumatized in the criminal justice setting. It is frequent in women's prisons for

male correction officers to sexually assault women (Kubiak). Trauma experienced by women is a weighty issue around the world, but is particularly significant with the incarcerated population, and deserves to be an integral part of therapeutic work with this population.

There have been several studies of women who face traumas relating to abuse in their lives. In one study, 91.5% of women experienced "physical abuse, including beatings, serious punishment, and threats of harm" (Becker et al., 2005, p.439) some time in their personal history. Several of these victims in this study were forced to have sex, or felt they had no choice in having sex for money, drugs or monetary items (Becker et al.). Additionally, many women reported having significant abuse in childhood. About 84% experienced emotional abuse and neglect (Becker et al.). The average age of first traumatic exposure was about 13 years old (Becker et al.). These statistics go to show that these women deserve empathy and respect versus incarceration and further traumatic exposure.

Adverse childhood experiences (ACE) and the brain. Trauma can begin as early as childhood and affects brain development. Children are born with a need for attachment to parents or adults to have effective brain development. When this is negatively altered, trauma occurs. When children are exposed to severe stress at a young age, it can "physically change a child's brain and be hardwired into the child's biology via genes in the DNA" (Sciaraffa, Zeanah & Zeanah, 2018, p.343). This is especially apparent when there is long term exposure and lack of a supportive parent. It negatively affects learning, puts a child at health risks and alters behaviors (Sciaraffa et al.). The long-term exposure can in turn affect brain development and inhibit the individual's ability to cope with stressful situations (Sciaraffa et al.).

Specifically, connection to both a mother and a father (Perkins, 2018) as role models is crucial to development. It is common for females to have emotional detachment throughout their

lifespan when they do not have adequate parents. In a study conducting interviews with women with high ACE scores, they describe their relationship with their mother as distant and withdrawn or angry and forcing a sense of control. Additionally, they reported fathers who were physically, sexually and emotionally abusive or were absent (Perkins, 2018). These parents frequently instill fear in their children at a young age.

As a result of said exposure, women are more susceptive to difficult lifestyles. This includes premature and abusive relationships, poor decision making and feelings of abandonment (Perkins, 2018). Depression and anger are frequent triggers experienced. In adult women, these feelings and thought patterns tend to be geared toward ineffective parents and cause women to inevitably lash out (Perkins, 2018). Counselors may see this reaction through their fear, pain, distance, denial or isolation (Perkins, 2018). This pain could be buried so deep that it may take extensive rapport building to unfold the truth. However, this unfolding is critical to the recovery process.

This discussion on adverse childhood experiences suggests the importance of an assessment of Adverse Childhood Experiences (ACES) for those incarcerated to determine treatment. Childhood exposure is only one of the many categories of traumatic exposure for women, though. As many as 98% of women reported they had been exposed to at least one traumatic event; a common exposure was the abuse of a partner (Green et al., 2005). Having had these traumatic experiences, it is likely that women resort to substance abuse to self-medicate (Green et al., 2005). This is detrimental to the recovery from trauma.

Addiction. Understanding addiction is a controversial topic, whether one considers it to be a choice or classifies it as a disease. There are many addictions in the world, yet this dependency typically originates from a hidden pain, such as rape, rejection, early abandonment,

abuse as a child, addicted parents or several other traumatic experiences (Maté, 2010). Incarcerated women have extremely high rates of addictive patterns (Green et al., 2005). Addiction begins as a passion and then becomes an impairment and a compulsive, uncontrollable behavior, despite its negative consequences (Maté, 2010). In turn, addiction affects lives drastically, especially those around the person with the addiction. Addiction can either be a behavior or a substance, such as drugs, and many individuals suffer from more than one addiction (Maté, 2010). It makes addicts intolerable and vulnerable as they use their addiction to numb the pain suffered inside (Brown, 2010). There have been many raised questions as to the influence of parenting as well. Sometimes parents are unaware of neglect, specifically relating to attunement where they are physically there, but not emotionally (Maté, 2010).

Addiction and society. Criminalizing addicts has been found to be a failure in society. It is in the social stigma that puts a bad image on addicts and inevitably pushes them to the bottom of society (Maté, 2010). As a result, this makes addicts feel like less of a person and causes stress (Maté, 2010). Stress is the main cause of relapse and by adding more of a burden in their life is simply not fair. Money spent on incarceration could be spent treating individuals who suffer with addiction. "Drugs do not make the addict into a criminal, the law does" (Maté, 2010, p. 293). Addicts who are criminalized lose respect for law enforcement officials (Maté, 2010). The stigma of addiction associated with criminal behavior leads to stereotyping and discrimination of individuals with addictions, who in turn become defensive and hopelessly misunderstood, leading to a vicious cycle between society and those combating addiction.

Addiction and the brain. An addicted brain looks different than a non-addicted brain (Maté, 2010). This is due to many different reasons. This change could begin as a child, where children first develop a prefrontal cortex internally, externally and environmentally (Maté, 2010).

Those who experience traumatic experiences never develop their prefrontal cortex adequately, or it is left impaired (Maté, 2010). There are three essentials to a proper brain development in youth: nutrition, physical security and consistent emotional nurturing (Maté, 2010). Without this proper development, one is trapped in a child-adolescent brain which results in addiction-seeking behaviors (Maté, 2010). Additionally, drugs alter the way individuals act and feel due to the replacement of the drugs on one's own natural producing chemicals (Maté, 2010). The less satisfied the internal system is, the more individuals are driven to substance-seeking behaviors (Maté, 2010). This in fact is why drug addiction damages the part of the brain it is used for decision making (Maté, 2010).

Recovering from addiction. Recovering from addiction takes time, extensive effort and support. According to Haroutunian (2013), it takes 8-10 years to normalize into a sober lifestyle or to develop emotional sobriety. The key to this sobriety is awareness; one recovering from addiction is always fighting and always recovering, no matter how long they have been sober (Haroutunian, 2013). Family and friends try to enforce, disengage or resent addicts to push them into recovery, but the only time addicts put forth effort into recovery is when they are ready to do so (Maté, 2010). Everyone inevitably has their own lowest point, whether it is because of the effects on family members, legal issues or one's health. Counselors should know and always assess the client's readiness for change through the Transtheoretical Model (Prochaska & DiClemente, 1983): pre-contemplation, contemplation, preparation, action, maintenance and relapse. Capuzzi and Stauffer (2016) discuss applications to addictions' populations. The counselor can help the client by working to establish a positive sense of self-worth or seeing where one may be at in the change process is crucial in recovery (Maté, 2010) so that a support system can be developed to help the client achieve goals. The following quote by one author

underscores the importance of supportive others, while recognizing that the only person who can really make the change is the individual facing the addiction:

> Help me make peace with my greatest enemy – myself. (Maté, 2010, p.64)

Recidivism. Recidivism is quite common after incarceration. However, there are ways that it can be prevented, or decrease in frequency. It has been found that individuals who receive some sort of treatment during their stay in prison have a decreased rate of recidivism and relapse (Kubiak, 2004). When specific needs are addressed and put into perspective during treatment, recidivism could be decreased that much more. For example, one study showed women who received treatment with dually diagnosed disorders were more likely to relapse if PTSD was not addressed in treatment (Kubiak, 2004). Addressing shame and guilt may also improve outcomes for incarcerated women.

Shame vs. Guilt. It has been shown that shame and guilt both play an important piece in morality and emotions. They are quite similar, yet play different figures in our minds, which can be key points of intervention to change in female offenders (Tangney, Stuewig, & Hafez, 2011). Shame has been known to be an internal moral defect, defining oneself by the act (Tangney, Stuewig, & Hafez, 2011). An example may be if a female offender defines who they are by their addictive actions. Whereas, guilt may be a healthier feeling; that is, placing the act itself at fault, such as the criminal behavior, rather than the person themselves (Tangney, Stuewig, & Hafez, 2011). Many individuals who feel shame carry a lot of hurt and oftentimes define themselves as "worthless and powerless" (Tangney, Stuewig, & Hafez, 2011). Shame leads to denial, stuck points and recidivism, whereas, guilt induces change. This change could be an apology, acknowledgement of the act and the notion of letting go (Tangney, Stuewig, & Hafez, 2011).

Counselors tend to work towards moving clients from feelings of shame toward recognition of guilt.

As mentioned, shame keeps incarcerated women stuck. Shame and anger can be a big factor in lack of change or progress. One who defines themselves by their wrongdoings have internal and external anger. They tend to blame others, deny their offense or justify wrongdoings (Tangney, Stuewig, & Hafez, 2011). Whereas, guilt leads to self-forgiveness and individuals to take responsibility for their behavior (Tangney, Stuewig, & Hafez, 2011). In one study, shame versus guilt was positively correlated with recidivism and substance abuse. Individuals who had immense shame more often re-offended (Tangney, Stuewig, & Hafez, 2011). It is highly suggested to work towards changing shame to guilt in treatment to promote self-forgiveness and moving forward. By doing so, recidivism may be reduced. Recidivism can be a difficult topic to address in the prison setting, but if safeguards are put in place, proper treatment could potentially save lives and support recovery.

Treatment Approaches to Incarcerated Women with Co-Occurring Disorders

Trauma-informed care. Treating dually diagnosed incarcerated women may be complicated, but doable. It is in the provider's approach on how well outcome may be. It is crucial to address these women in a safe, comfortable manner, maintaining boundaries and following through with what is said. Minimizing the damage already done is needed during prison stay; at the same time mental health providers can reframe their stay as a time to maximize their opportunity to work on themselves in prison (Covington, 2018). This is related to trauma-informed care. Correctional Officers who are trauma-informed have a better approach to these women and create a safer atmosphere (Covington, 2018). Approach and accountability are monumental in treatment.

Other key components to addressing treatment approaches to incarcerated women include being gender responsive (Covington, 2018) and teaching self-compassion (Hiseler, 2015). It is important for treatment professionals to know and understand the needs of each gender, as well as understanding that there are many differences. Creating programs that address gender differences is needed. Covington (2018) has pointed out that women specific needs have just started to be identified. This began with substance abuse (Covington, 2018). Another key component is self-compassion. Teaching women to be kinder to oneself, especially during times of high stress, can make room for change (Hiseler, 2015). This approach can teach women to find meaning and instill hope for their future (Hiseler, 2015). These are few of the many approaches to treating incarcerated women. Specific theoretical approaches are outlined below.

Cognitive behavioral therapy (CBT). CBT has been known to be quite popular in several treatment modalities. This approach helps treat both PTSD and substance abuse. It targets key techniques designed to help individuals with cravings and triggers (both internal and external) (Vujanovic, Smith, Tipton & Schmitz, 2018). It inhibits relapse prevention in substance abuse and inevitably focuses on thought process on emotions and behavior (Vujanovic et al., 2018). CBT focuses on changing the thought process relating to traumatic experiences (Vujanovic et al., 2018). Other skills gained while utilizing this theory include: mindfulness, coping strategies, trauma narrative rewrites, grounding techniques, and identifying one's thoughts, emotions and triggers for substance use (Vujanovic et al., 2018). There are several beneficial therapies within the scope of cognitive behavioral therapy.

One of the CBT approaches is prolonged exposure. Prolonged exposure is known to be one of the best treatment approaches for both PTSD and substance abuse (Berenz & Coffey, 2012). This approach includes breathing practices, brain re-training, imaginary/imagery

exposure and in-vivo exposure. Specifically, in in-vivo exposure, the patient and the clinician come up with several triggers/fears relating to the trauma and cognitively change those thoughts until the anxiety subsides (Berenz & Coffey, 2012). This therapy is a safe approach to addressing trauma. This typically renders twenty-three 60-minute individual sessions (Vujanovic et al., 2018).

Another helpful approach in this theory is the TIPSS (Treatment of Integrated Posttraumatic Stress and Substance Use) (Vujanovic et al., 2018). This approach is conducted in twelve individual sessions, at about 60 minutes per session. It focuses on relapse prevention principles, specifically intending on encouraging awareness and identified skill management for cravings. Individuals will identify several coping skills to use when high-risk situations are presented, both in traumatizing situations and substance abusing scenarios (Vujanovic et al., 2018). Women are able to render the ability to connect the thought process, feelings and behaviors.

Dialectical behavioral therapy (DBT). This therapy is known to address many areas in one's overall wellbeing as well as several diagnoses. It is a well-established treatment approach (Dimeff & Linehan, 2008). People who conduct crime typically struggle with "impulse control, distress tolerance, and emotion regulation" (Hiseler, 2015). These are multiple key factors within the theory. Given trauma and substance abuse both disengage individuals from their emotional wellbeing, DBT skills may be helpful. This is a comprehensive approach that intends on improving overall wellness, including emotion regulation and independent skill enhancement (Dimeff & Linehan, 2008).

DBT was created for specific diagnoses (borderline personality disorder and suicidality) and has since grown to treat several disorders (Panos, Jackson, Hasan & Panos, 2013).

Specifically, this therapy aims in establishing stabilization in mood and attempts to control destructive thinking and behavior (Panos et al., 2013). It is conducted via individual sessions, group work and telephone communication (Dimeff & Linehan, 2008). A constant focus in this treatment is with change and acceptance. This is accomplished through intentional behavioral changes and identification of essential functions of behavior (Dimeff & Linehan, 2008).

Individuals who receive DBT therapy go through many changes; both behaviorally, **c**ognitively and emotionally. Panos et al. describes the behavioral approaches in 4 ways (2013). These include decreasing suicidal thinking and self-harmful behaviors; halting therapy intervening behaviors (such as dependence); decreasing life-factor behaviors (trauma or substance abuse) and increasing knowledge of skills (Panos, Jackson, Hasan & Panos, 2013). These skills are the tools specifically taught and practiced in DBT. Panos et al. concludes that DBT enhances behavioral control and emotional stability (2013). Contrarily, Dimeff and Linehan identify 5 key functions in practicing this theory (2008). These are improving motivation, raising capabilities, identifying new behaviors, environmental changes and therapist growth (Dimeff & Linehan, 2008). These approaches can both treat PTSD and substance abuse.

DBT has specifics within the theory that address substance abuse. The overarching goal of this theory approaching substance use disorders align with the Twelve-steps in Alcoholics Anonymous (Dimeff & Linehan, 2008). Linehan emphasizes several approaches, including decreasing substance use, combating urges/cravings and avoiding unhealthy and triggering situations (Dimeff & Linehan, 2008). Other emphases include expanding healthy relationships and changing the environment (Dimeff & Linehan, 2008). This may include participating in AA group meetings and obtaining sponsorship. This theory is a beneficial and helpful approach in treating incarcerated women with dual diagnoses.

Seeking safety. This approach recognizes that treating substance abuse alone does not exude PTSD symptoms. In fact, it could even make them worse (Najavits, 2003). Many approaches treat one diagnosis over the other or pick one to treat first. However, it is recommended that this dual diagnosis be treated at the same time, according to developers of the Seeking Safety approach (Najavits, 2003). This is an integrated model that treats both PTSD and substance abuse at the same exact time. This is considered one of the most effective approaches in treating dually diagnosed patients. It focuses less on pathology and more so on potential (Najavits, 2003). It is also known to derive from CBT and encourages present moment living and problem focus (Najavits, 2003). This comprehensive treatment plan has several beneficial therapeutic interventions.

Seeking Safety is a psychotherapy that is specific towards dual diagnosis, not one or the other. This includes both PTSD and substance abuse (Najavits, 2003). A big goal in this therapy is to actively listen to the needs of each client using a person by person stance. It includes 25 topics, ranging from cognitive, behavioral and interpersonal modules. Each of these topics address safe coping mechanisms related to both diagnoses (Najavits, 2003). These sessions are conducted via individual and group sessions. The word "safety" is an umbrella term for the approach (Najavits, 2003). It intends on promoting safe environments, situations and emotional states. Individuals are encouraged to address trauma at a deeper level and engage healing (Najavits, 2003). This approach has positive implications for the female prison setting.

Acceptance, commitment therapy (ACT). ACT is a CBT based newly developed therapy. It is a strongly supported psychotherapy that helps patients from a wide range of diagnoses, including physical difficulties (Dindo, Liew & Arch, 2017). The major belief in this theory rests upon pain and mental illness as part of human life and one can adapt “psychological

flexibility" to cope with these issues (Dindo et al., 2017). Ways that this is accomplished is through values exploration and behavioral changes (acceptance, commitment, etc.) (Dindo et al., 2017). This theory also emphasizes mindfulness; the power of staying in the present moment. This helps clients let go of the past and gain hope for the future (Dindo et al., 2017). This therapy can be helpful while approaching incarcerated women given the above discussed techniques in comparison to their needs.

Groups vs. individual counseling. While reviewing several theoretical standpoints, incarcerated women may benefit from both individual therapy and group treatment. Grover discusses the importance of individual therapy in comparison to self-exploration. He distinguishes that it may be beneficial for one to receive individual therapy to explore one's history and fears in individual counseling (2017). He then discusses the importance of group work. The focus in group treatment is remaining in the present, or the "here and now" (Grover, 2017). Group therapy is beneficial for individuals to know that they are not alone and gain a connectedness to other women who suffer from similar diagnoses. Group is also a safe place to practice communication styles to take with them into the outer world (Grover, 2017). Grover recognizes, "If you can do it in group, you can do it in life" (Grover, 2017, p.2). Both interventions are quite beneficial; however, after assessment of each client, it is upon the therapists' discretion on which modality they would recommend as appropriate, based on the individual's needs.

Community approaches. There is a necessity in addressing the needs of incarcerated women with the community; both before, during and after their stay in jail/prison. Assessment and having options are critical pieces for improvement. This includes assessing trauma in its' entirety along with substance abuse histories (Becker et al., 2005). Staff and correctional

officers can also benefit from shame vs. guilt training to enhance healthy feelings in the women, understanding of the criminal act and promote change (Tangney et al., 2011). More opportunity, follow-up care and a larger pool of options would improve the outcomes of incarcerated women (Becker et al., 2005) as well. These women need help and to feel heard; therefore, advocacy can go a long way and it is in the role of the counselor to be this advocate. More treatment and less criminal justice punishment can improve recovery success.

Beginning at the time of sentencing, professionals can provide an intervention. This includes creating sentences that focus more on achieving success rather than punishment. Judges can give sentences that promote healing and a focus on guilt rather than shame (Tangney et al., 2011). This can in turn create healthy behaviors for individuals to have a better grasp and understanding of their behavior and how it affects the community. For example, drunk drivers can participate in efforts that include: empathizing with victims, advocating and assisting with drunk driving campaigns, writing apology letters, etc. (Tangney et al., 2011).

Building resiliency in women is also a need for growth and change. Resiliency is known to be a person's ability to cope with life stressors appropriately and to adapt to different life changes (Conder et al., 2015). Raising resiliency can improve problem solving skills, increase social and familial bonds and women can learn to cope effectively (Conder et al., 2015). This can be built from staff/correctional officer encouragement and through therapeutic intervention.

Additional community approaches can be brought incorporating the biopsychosocial model and hierarchy of needs. Women in prisons would benefit from specific skills training, or parenting training (Green et al., 2005). This may help them regain parental rights or to adopt new skills upon release. Poverty is also an issue and can be addressed while incarcerated (Green et al., 2005). Other needs that can be addressed are housing, employment, education, clothing,

medical concerns and time/organizational management (Green et al., 2005). Addressing these needs in prison may create better outcome upon release and increase confidence.

Multicultural approach. Counselors are trained to develop appropriate and healthy therapeutic relationships with clients. This includes rapport building, addressing individual needs, active listening, remaining genuine and empowering the individual (Shearer & King, 2004). Cultural differences may hinder this process, making rapport building difficult. Shearer and King discuss the term "cultural empathy" where counselors develop an understanding of the client's worldview (2004). Counselors receive multicultural training to maintain cultural empathy. Effective multicultural counselors are in touch with their own culture, values and can respect others' differences (Shearer & King, 2004).

One key concern is addressing gender specific needs. Women have a more difficult time re-entering society after incarceration. Women typically have experienced more traumatic experiences than men (Kubiak, 2004). Without skill development, woman who have experienced trauma are more likely to face re-traumatization, which makes it difficult to re-engage with the outside world (Kubiak, 2004). Additionally, it is also more common for women to have mental health diagnoses. Perkins determined that women with depression symptoms outnumbered men 2 to 1 (2018). This shows that approaches need to incorporate gender specific needs.

A particular multicultural group, the Latinos, make up about 30% of federal inmates (Packard, 2005). Understanding their culture is important for correctional officers. The most common concern in working with this population is the language barrier. For example, exacerbated hand gestures and loud voices are commonly used during communication (Packard, 2005). It has also been reported that this population has difficulty identifying feelings of

depression. Packard found that Latino inmates commonly report physical discomforts (headaches, stomach ache, etc.) rather than expressing how they truly feel (depression, sad, etc.) (2005). Prior to working with these individuals, treatment personnel and staff should participate in multicultural training outlining these concerns.

In summary, it is important for counselors to have knowledge of the cultures they are treating, and to develop culturally competence and stay up-to-date on current issues. Culturally competent counselors are comfortable and confident to conduct therapy with clients who are different from them and can refer them to another provider if they are not able to make a connection (Shearer & King, 2004). Being aware of these concerns will help clients feel understood and heard, as they should. The criminal justice system can make substantial improvements on becoming more sensitive to cultural approaches and understanding individuals' worldviews as human beings; not just as "inmates" (Shearer & King, 2004).

Conclusion

This research paints a picture of the needs of incarcerated women facing dual diagnoses; substance abuse disorders and trauma-related disorders. Many of these incarcerated women face both disorders. Even though the need is apparent, there is a lack of services provided to these women. Staff, correctional officers and treatment teams can improve upon this need, and in turn, decrease recidivism.

Recognizing and responding to this need through prevention and intervention can inhibit positive outcome. Through therapist treatment approaches, clinicians can enhance awareness and change within the scope of these dual diagnoses. Staff, prison administration and the community can gain an understanding of trauma-informed-care, as well as women's needs, to

encourage and provoke offender change. Advocacy is the instillation of change for these women to elicit a hopeful and promising future with forgiveness, acceptance and self-growth.

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