TRAUMA MATTERS

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Beyond Violence: Women in Prison Find Meaning, Hope, and Healing

The vast majority of women involved in the criminal justice system have histories of trauma and abuse. Their abusers typically are people who are close to them, such as their parents and caretakers, siblings, extended family members, intimate partners, and acquaintances. These experiences of trauma and abuse have been linked to women's substance use, poor physical and mental health, and criminal justice involvement. In addition, women's histories of trauma and abuse have been linked to women's perpetration or engagement in acts of violence. Approximately 35 percent of incarcerated women are serving time for violent offenses, and a majority of these offenses were against victims who were known to the women (Guerino et al., 2011).

The number of women serving long-term or life sentences (most for first or second degree murder) increased over 14 percent from 2008 to 2012 (Nellis, 2013). These women have high rates of histories of sexual, physical, and emotional abuse, childhood and adulthood violence victimization, poverty, homelessness, and suicide attempts. Strikingly, 75 to 90 percent of women sentenced to life are s*erving their first prison sentence* (Dye & Aday, 2013). On average, a woman serving a life sentence is in prison for at least 29 years. Fewer than 20 percent of those serving life sentences are released from prison (Nellis, 2013).

Women who face spending the rest of their lives in prison feel very little meaning or purpose in life and very little healing. They feel that society, the prison system, and their families have "thrown away the key" in regard to them. Despite this, they describe wanting their lives to have meaning and they are motivated to help others avoid prison, become sober, improve the prison itself, and find purpose in their lives and their circumstances (Fedock, 2015). In our experience, women serving long-term or life sentences represent the epitome of resilience – the ability to recover from or adjust to misfortune or change. These are women who have an incredible ability to adapt and survive in the face of difficult life events.

Because of the small number of women who are convicted of violent crimes and prevailing ideas about women and violence, very little attention has been given to this population of women. In addition, these women have low rates of engaging with substance abuse and mental health treatment before coming to prison – a trend that unfortunately continues in prison. Approximately 60 percent of prisoners serving life sentences receive no formal treatment while incarcerated (Nellis, 2012).

To address this need, *Beyond Violence* (BV) was developed as a manualized curriculum for women in criminal justice settings (jails, prisons, and community corrections) who have histories of aggression and/or violence (Covington, 2013). Several years ago, I (Stephanie Covington) accepted a request from the Michigan Department of Corrections to develop a program of this nature. I met with women who had committed violent crimes and studied the limited research. It became clear that any program addressing the violence women had committed would also need to address the aggression and violence they had personally experienced.

The four-level model of violence prevention that creates the foundation of BV considers the complex interplay between individual, relationship, community, and societal factors. It addresses the factors that put people at risk for experiencing and/or perpetrating violence. This model is used by the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) and was used in the Prison Rape Elimination Act (PREA) research on women in prison. *Beyond Violence* has been tested specifically with this population of women in Michigan and California. To date, approximately 600 women have completed the program; 150 as part of a research effort. Michigan's Department of Corrections has adopted BV as its required program for all women convicted of violent offenses. In California, there are over 700 women on the waiting lists for the program at two women's prisons.

The research indicates that BV improves women's mental health by lessening symptoms of depression, anxiety, and PTSD and positively influences their anger (e.g., lessens their feelings of constant anger, improves their anger-management skills, and lessens their physically and verbally aggressive expressions of anger) (Kubiak et al., 2012; Kubiak et al., 2014). Also, for one year post-release from prison, women who have participated in *Beyond Violence* display lower rates of recidivism (re-arrest and jail stays) and substance use than women who have not participated in *Beyond Violence* (Kubiak et al., 2015). Thus, *Beyond Violence* shows both short and long-term outcomes that are beneficial to women. In addition, the California research project trained women with long sentences who were peer educators to be facilitators of the program. The results are comparable to those obtained in the Michigan facility (Messina, 2014).

Women serving long-term and life sentences have benefited from *Beyond Violence* in multiple ways. First, they have shown positive improvements in their mental health, lessened feelings of perpetual anger, and increased anger-management skills (Fedock, 2015; Messina, 2014). Second, women who have participated in *Beyond Violence* have been offered opportunities by their prisons to be peer mentors and co-facilitators of *Beyond Violence* groups for women (Fedock, 2015; Messina, 2014). Some of them are now preparing to be released from prison. Third, the overwhelming sentiment expressed by women serving life sentences is that *Beyond Violence* has helped them to "connect the dots" in their lives – to understand their pasts, presents, and futures; to heal and improve themselves; and, most importantly, to find meaning in their lives (Fedock, 2015; Messina, 2014). These outcomes have been found for women preparing to leave prison and for women who may spend the rest of their lives in prison. *Beyond Violence* has provided them the tools to help themselves promote change, which many of them also share with other inmates and outside family members, especially their children.

Women serving very long or life sentences have demonstrated incredible resilience, even within the punitive and deprivation-based prison environment. They strive for self-growth, positive change, healing, and meaningful contribution – while facing the possibility of never leaving prison. They are a testament to the survival capacity of the human spirit.

Submitted by Stephanie S. Covington, Ph.D., LCSW, and Gina Fedock, Ph.D., LMSW

For more information about the research on *Beyond Violence*, please see:
www.stephaniecovington.com/research-papers.php

For a complete list of references for this article please visit:
www.womensconsortium.org/references_Trauma_Matters.cfm

Expanding and Improving Trauma-Informed Care for Youth Involved in the Juvenile Justice System

I began to write this piece after speaking with the Connecticut Junior Republic (CJR) Clinic Director. She shared with me the results her team is seeing in youth that have initiated Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). Many of these youth have been involved in the juvenile justice system and have previously participated in several therapeutic treatments without success. Now the clinicians are intentionally exploring and addressing with these youth their trauma experiences and symptoms, and are starting to see positive changes. This is not by coincidence but the purposeful attempt to attend to the specific mental health needs these youth have by providing the type of treatment that has been proven to work.

Youth in the Juvenile Justice and Mental Health Systems

Although youth delinquency has been declining progressively in the last few years in the United States, there are still too many youth involved in the justice system. Approximately 1.5 million adolescents are arrested each year in this country,[1] with ten thousand youth arrested in Connecticut in 2013.[2] For many of these youth, their contact with the juvenile justice system is the last possibility to get the help they need after having been known by previous systems (child welfare, school, healthcare). The great proportion of these youth experience a multitude of behavioral and mental health problems. Research has shown that 65% to 70% of youth in the juvenile justice system

have at least one diagnosable mental health disorder; while 60% meet criteria for three or more diagnosis, and 27% require immediate treatment.[3]

Furthermore, the overwhelming majority of these youth are exposed to traumatic experiences in their childhood and early adolescence such as domestic violence, sexual abuse, physical and emotional maltreatment, community violence, and traumatic loss among many others. Studies show that between 75% and 93% of youth involved in the juvenile justice system, including those that are in probation period, have experienced at least one trauma event in their lives while 84% of youth in juvenile detention experience multiple types of traumas.[4,5,6] Although not every youth who experienced traumatic stressors develops symptoms as a consequence, the prevalence rate of PTSD symptoms in this population is higher than for the general population. Studies have shown that between 3% and 50% of justice-involved youth experience PTSD symptoms,[7,8,9] which is up to eight times as high as the PTSD rate seen in community samples.[10,11] Among detained youth, more girls than boys meet criteria for a PTSD diagnosis, 52% compared to 32% respectively.[12]

Elements for a Comprehensive Mental Health System

These numbers demonstrate the extraordinary need for expanding and improving trauma-informed and trauma-focused services. As has been pointed out elsewhere,[13] collaboration, identification, diversion and treatment are the four key elements of a comprehensive mental health system. These are the most critical areas of improvement to enhance the delivery of mental health services to justice-involved youth. Connecticut has been a leader nationwide in responding to the mental health and trauma needs justice-involved youth have with providing evidence-based treatments such as Multi-systemic Therapy (MST) and Trauma Affect Regulation (TARGET). Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is also being disseminated and implemented statewide and made available for youth in the juvenile justice system. The Child Health and Development Institute (CHDI) in partnership with the Court Support Services Division (CSSD) are bringing together mental health agencies, Juvenile Probation Officers (JPOs) and the Child Youth Family Support Centers (CYFSC's) for a yearlong learning collaborative in TF-CBT. CT Junior Republic, or CJR, is one of the agencies invested in this learning collaborative process, whose clinicians are working side by side with JPOs and staff from the CYFSC's to help youth affected by trauma. They are seeing really positive outcomes with the justice-involved youth who are in TF-CBT.

Juvenile Justice TF-CBT Learning Collaborative

This learning collaborative focuses in three of the four key elements mentioned above. It seeks to foster *collaboration* pathways between the mental health and the juvenile justice system that goes beyond referrals. It also guides juvenile justice staff in the *identification* of youth with trauma history, and training mental health professionals *to provide an evidence-based trauma focused treatment*. With the purpose of identify youth experiencing PTSD symptoms, JPOs in the learning collaborative are using the Structured Trauma-Related Experiences & Symptoms Screener while the CYFSC's are universally screening with the 10-item Connecticut Trauma Screen. When youth are found to be suffering from traumatic experiences and symptoms, treatments such as TF-CBT and TARGET are among the array of services juvenile justices staff have available when making recommendations. In the specific case of TF-CBT, this evidence-based treatment is disseminated and implemented through a process that combines in-person trainings with continuous clinical consultation by TF-CBT experts and technical assistance by CHDI during the course of 10 months. Mental health providers begin the TF-CBT work completing a trauma assessment with the youth and a caregiver, when possible, which entails a more complex process than screening. A trauma assessment involves an in-depth and individualized examination of the youth's behavior, mental functioning, developmental status and environmental influences to evaluate the severity and impact of the trauma events. After this assessment, mental health providers follow the TF-CBT PRACTICE components in their work with the youth: *P*sychoeducation, *R*elaxation techniques, *A*ffect expression, *C*ognitive coping, *T*rauma narration, *I*n-vivo mastery of trauma reminders, *C*onjoint youth-caregiver sessions, and *E*nhancing safety.

This time period is also used for developing and enhancing the partnership between the juvenile justice and the mental health systems. A year after rolling out this learning collaborative, we have learned that given the obstacles these youth face to engage in services (transportation barriers, lack of trust in service providers, fear of talking about trauma, among others) the type of relationship between the juvenile staff and the mental health provider is a determinant factor in the quality of provision of services. We realize that partnerships require intentional effort and are built overtime; consequently, emphasis is put not only in sharing information about services, but understanding each other's context, procedures, language, etc. Likewise, to assure that justice-involved youth truly receive and engage in trauma treatment, representatives from the two systems embark in the process of establishing common goals, strategies and outcomes. This process is at the same time informed by the report of and analysis of data related to the collaboration process and the identification-referral-treatment of youth who have experience trauma events.

TF-CBT is a treatment that has been proven to work with youth suffering from trauma. Youth involved in the juvenile justice system are and will continue benefiting from having access to evidence-based trauma treatments that are driven by highly efficient system collaboration.

Submitted by Mayte Restrepo, MA, MPH
Juvenile Justice TF-CBT Project Coordinator Child Health & Development Institute of CT

Ask the Experts:
A Conversation with Laura van Dernoot Lipsky

By Paul Shanley, ACSW, LCSW and Mary Painter, LCSW, LADC

Laura van Dernoot Lipsky, founder and director of the Trauma Stewardship Institute and author of *Trauma Stewardship: An Everyday Guide to Caring for Self While Caring for Others*, has worked directly with trauma survivors for 27 years. Over a decade ago Laura experienced what she calls a near-psychotic break. It was the result of years of witnessing and being intimately involved in trauma without tending to herself in the necessary ways. After that, she began a journey of inquiry into the lasting effects on individuals and groups of exposure to the suffering, hardship, crisis, or trauma experienced by humans, other living beings, or the planet itself. She offered her first version of a workshop on trauma stewardship to a group of public health workers in 1999. Since then, she has trained a wide variety of people, including zookeepers and reconstruction workers in post-Hurricane Katrina New Orleans, community organizers and health care providers in Japan, U.S. Air Force pilots, Canadian firefighters, public school teachers, and private practice doctors. She has worked locally, nationally, and internationally. Laura is known as a pioneer in the field of trauma exposure. (Retrieved from: www.traumastewardship.com/who-we-are/laura-van-dernoot-lipsky/. You can learn more about Laura's work by visiting her website at: www.traumastewardship.com).

Q: Why did you enter the trauma field?

A: I didn't know it at the time, but I was drawn to social justice because I was trying to reconcile things from my past. This was not conscious. I came from a family with many traditions and a strong ethic for service to help address social justice issues in the world.

Q: Can you tell us what you consider to be the most helpful stabilization skill or tool one can teach to a trauma survivor?

A: I hesitate to say "the most", but, the ability to engage ones breath is critical. That's really, really important. The efficiency and effectiveness of learning to regulate through breath, to create an integral oasis of calm within, even if things are incredibly stormy externally, is important. Through breath you can create an internal spaciousness. That is what our ancestors, in every ancient tradition teach, engaging one's breath to be present. Also, it is important to do no harm and be transformative. It's woven into our fabric.

Q: What is the one thing you believe all trauma-focused clinicians should know?

A: Internally engaging your breath to effectively impact your nervous system, whether it's through meditation, walking, working out or singing. This leads to the ability to be present and connected. Being present is a vulnerable place to be but empowers us to effectuate change. 2. We are not alone. Isolation leads to a lot of harm both to the people we are serving and isolation also harms people who care about others. Guard against isolation. There are no shortage of ways people can repair the world, what is most important is to find a sustainable way for yourself. We have the ability to effect change and should strive to while caring for ourselves.

What About the Kids?
How Incarceration Effects the Children Left Behind and What You Can Do To Support Them

In the U.S., it is estimated that:

- **1 in 346** children has a parent deployed in the U.S. military
- **1 in 191** children is in foster care
- **1 in 28** children has a parent incarcerated

What is the value of a child's bond with a caregiver?

Over time our society has gained awareness and compassion – *and has put systems in place* – for children separated from one or more parents, be it through such divergent realms as military involvement or the child welfare system. We are, however, only beginning to consider the impact of that separation on children with incarcerated parents (CIP).

It is widely understood, in a general sense, that a child separated from their parent or primary caregiver will struggle. Yet this awareness does not translate when incarceration is the cause of that separation. With an estimated 2.7 million children in the U.S. enduring parental incarceration and a growing body of knowledge on the harm parental incarceration can cause children, we have an ethical-responsibility-to ask the questions: *How are the policies and practices we develop for adults, affecting the children? And why have we not considered this impact before?*

Answering this question begins with exploring the cause for their invisibility.

For many CIP, some of the greatest challenges stem from the stigma associated with having a loved one affiliated with the criminal justice system. Our justice system seems to impose the perpetual punishment of the perpetrator as its primary means to exact justice. With the U.S. incarcerating more people than any other country, leaving 1 in every 28 children with a parent in prison, is this either logical, or humane? We are in the midst of a reform movement that is beginning to question our current criminal justice policies. This reform must utilize a macro analysis of the multitude of factors that contribute to ones involvement with the criminal justice system, as well as the detrimental ripple effect left in its wake, including the impact these policies have on CIP.

Everyone, even the most well-intentioned person, has biases. These biases that we carry, both explicit and implicit, influence our perceptions of CIPs and their families, and subsequently our interactions with them, and the policies and procedures we create that affect them. A primary bias that plagues our policies, procedures and research, even those intended to benefit CIP, is that the parents (incarcerated and remaining) of those children are not 'good' parents: that they do not provide or try to provide what their children need, nor even know what is best for their children. These biases oftentimes result in a lack of appreciation and respect for the role that parents can play to mitigate the harm parental arrest and incarceration may have on children. That absence influences the practices associated with parental criminal justice involvement (arrest protocols, charging decisions, sentencing, corrections placement, termination of parental rights, etc.), the policies surrounding parent-child interaction, and design of programs serving incarcerated parents, remaining parents and children.

An extension of this bias is the belief that the parent's incarceration is relieving children of a present harm (i.e., the parent's negative behavior). Although this is at times true and important, those children may still struggle with conflicting feelings over the removal (e.g., children love their parents but also experienced harm, at times, from the parent's behavior) and could experience loyalty conflict. Most often, children struggle at each stage of the criminal justice process – arrest, pre-trial, conviction, sentencing, incarceration and reentry.

Children may suffer from traumatic stress associated with the parent's arrest (witnessing or discovering it), mourn the loss of their parent and endure the stresses that often result from the removal of a caregiver. These stresses frequently include a reduction in household income, added expenses associated with incarceration, effects of increased stress on the remaining caregiver, and the strain placed on the children's relationship with their incarcerated parent. Children face the potential for relocation, switching schools and child welfare involvement. These stressors increase CIPs' risk for experiencing attachment disruption, trauma, shame, stigma and toxic stress that predisposes them to an array of poor health outcomes.

The ACE study, conducted by the Center for Disease Control (CDC), has recognized parental incarceration as an adverse childhood experience (ACE); a traumatic experience in childhood that alters the structure of the developing brain in a manner that exposes them to greater risk for a multitude of short and long term poor health outcomes. However, it is distinguished from other ACEs, like the loss of a parent due to separation or divorce, by the unique combination of trauma, shame and stigma.

In Kristin Turney's 2014 article, "*Stress Proliferation across Generations? Examining the Relationship between Parental Incarceration and Childhood Health"*, she further demonstrates that CIP experience disadvantages across an array of health outcomes and argues that children's health disadvantages are an overlooked and unintended consequence of mass incarceration.

With the U.S.'s rate of incarceration and an awareness of the resulting effects on children, it is our individual and collective responsibilities to reduce the number of children affected and mitigate the resulting harm. In doing so, we should also be mindful to acknowledge the resilience manifested in many of the children placed in such difficult situations.

Earlier this year, the Institute for Municipal & Regional Policy (IMRP) at Central Connecticut State University published *Children with incarcerated parents: A quantitative evaluation of mentoring and home-based counseling and case management services,* which suggests that strengths based practices and interventions implemented by staff with expertise in CIP improve children's wellbeing. This report is a product of one component of a larger effort, the Children with Incarcerated Parents Initiative at the IMRP.

In 2007, the Connecticut General Assembly tasked the IMRP with determining an outcome-based approach to the state policy on CIP. The mission for the CIP Initiative is to improve the quality of supports for CIP by using the various data and knowledge it gains to inform public policy and practice.

For a copy of this publication, more information about the CIP Initiative and helpful CIP resources visit: www.ctcip.org. This report is listed under Publications – IMRP, at www.ctcip.org/app/download/8021123/CIPEvaluationofMentoringandCounselingCaseManagement.pdf

Submitted by Aileen Keays, M.S.
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Featured Resource:

Prison Baby: A Memoir by Deborah Jiang Stein

Beacon Press ©2014

In this powerful memoir Deborah Jiang Stein shares her remarkable experience of growing up with multiracial features in a Jewish family and how she discovers that she was born in prison to a heroin-addicted mother. Her story of transformation will take the reader through her emotional despair and show how she was able to heal to become the resilient woman she is today. Now the founder of the unPrison Project, she works to build public awareness about women and girls in prison. She provides mentoring and life-skills programs for inmates. Deborah Jiang Stein will be speaking at the Adult and Juvenile Female Offender (AJFO) Conference hosted by the CT Women's Consortium. Her general session presentation on Thursday, Oct. 15, 2015 will be followed by a book signing.

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For more information or to register for this conference event day, go to:

www.ajfo.org or www.womensconsortium.org.

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