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The Co-Occurrence of Multiple and Overlapping Demands among Women Leaving
Prison

by

Jennifer Schweitzer

A Thesis Submitted in Partial Fulfillment of the

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Prison

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TABLE OF CONTENTS

	Page
INTRODUCTION.....	3
LITERATURE REVIEW.....	6
Women and Incarceration.....	6
Women and Addiction.....	12
Women’s Experiences with Programming within Prison.....	17
Women’s Reentry Experiences.....	20
Standpoint Theory and Identity Work.....	24
METHODS.....	29
FINDINGS.....	33
Stable but Dependent.....	36
Unstable and Chaotic.....	39
Engaging with Formal Support Systems.....	42
(Re)Establishing Informal Support Networks.....	54
Managing Relapse.....	56
DISCUSSION.....	58
APPENDIX A.....	66
REFERENCES.....	68

INTRODUCTION

The last three decades have seen a fundamental shift in the way the correctional system responds to women: harsh drug sentencing policies, the expansion of law enforcement powers, and decreasing public support and funding for “parole-as-rehabilitation” services and programming (Petersilia 1999: 483) have all given rise to the dramatic increase in the number of incarcerated women. In the last thirty years, the number of women in prison has grown by 832 percent (Women’s Prison Association 2009). There are currently 1.6 million people in prison in the United States; 103,000 of them are women (ibid).

One often overlooked consequence of the increase in the prison population is that every day, formerly incarcerated individuals are released back into their communities (Opsal 2009). Perhaps because men constitute a larger percentage of the prison population than women, much of the research done on incarceration and reentry has been done on men; however, consistent increases in the number of women involved in the criminal justice system illustrate the importance of studying women’s experiences before, during, and after incarceration.

Women’s pathways to crime are often facilitated by gendered structural forces, such as histories of trauma and abuse, poverty, and drug and alcohol addictions. Most incarcerated women have extensive histories of interpersonal violence. Women in prison report experiences of physical, sexual, and emotional abuse at rates much higher than those of women not incarcerated (The Sentencing Project 2007). Many women in prison have not had access to health care prior to their incarceration, and because many incarcerated women are survivors of physical and sexual abuse, they are at an above-average risk for “high-risk pregnancies and life-threatening illnesses such as HIV/AIDS,

hepatitis C, and human papillomavirus infection, which may increase risk for cervical cancer” (Braithwaite, Treadwell, and Arriola 2005).

Experiences of trauma are also associated with mental health problems. Zlotnik et al. (2003) report that childhood abuse is strongly correlated with Posttraumatic Stress Disorder (PTSD). Rates of PTSD among incarcerated women are two to three times higher than the rates of PTSD reported among women who are not incarcerated. The co-occurrence of substance abuse disorders and post-traumatic stress disorder is high among women who are incarcerated (ibid). Psychologist Stephanie Covington (1998) argues that because women are socialized to derive their identity and sense of self from their interpersonal relationships, women who experience, or have experienced, abuse from loved ones may turn to drugs and alcohol in an attempt to self-medicate. Thus, it is not uncommon for women to develop and maintain addictions as a response to trauma.

For many women, drugs and alcohol are fundamentally related to their introduction into the criminal justice system. The majority of women are incarcerated for drug offenses or property crimes, and most of the property crimes committed by women are done in an effort to maintain an addiction (Covington 1998). The trend over the last thirty years to “criminalize rather than medicalize addictions” (Alleyne 2006:191) has been particularly harmful to women, who are seven times more likely to enter prison with histories of PTSD and depression, and for women who have repeatedly been victimized by others, the experience of being incarcerated can be re-traumatizing and further disempowering. Moreover, due to the lack of trauma-informed programming and services for incarcerated women, those released from prison often face the same

challenges that led them to prison in the first place (e.g., unresolved trauma, addiction, overwhelming financial deficits).

Despite the astounding increase in both the rate and numbers of women who are incarcerated, gender-responsive services for women in need of chemical dependency treatment remain limited (The Sentencing Project 2007). Many prisons rely on self-help programs, such as Alcoholics Anonymous, to address addiction issues yet evaluations of the effectiveness of such programs are based on research performed on men (Henderson 1998). Central to this type of programming is the formulation of the “addict identity” template, which in part asserts that once an individual becomes an addict, she will always be an addict, and she will always have to fight herself to control her addiction (Hunter and Greer 2011). Since this addiction model is male-based in its meaning and program implementation, the suitability of this model for women is questionable.

For many incarcerated women, histories of trauma are inextricably linked to the development of addictions as well as chronic physical and mental health problem. Individuals may attempt coping with the anxiety and depression that can result from experiences of abuse by self-medicating with drugs or alcohol. Although each of these conditions presents its own set of unique challenges to reentry, the multiplicative effects of the recursive relationship between all four (abuse, addiction, physical illness, and mental illness) can be overwhelming, making the reentry process difficult, if not impossible. Though past abuse has been consistently linked to higher rates of PTSD and depression, physical illnesses, and substance abuse (Campbell 2002, Jetter 2013), little is known about the ways women’s lives are impacted and constrained by the intersectionality of these multiple and overlapping vulnerabilities.

Using grounded theory and content analysis to examine the interviews of 13 women immediately prior to and for three years following their release from prison, this research seeks to bridge these gaps in the literature. The 13 women, selected from a larger sample of 41 women recently released from prison, are distinct because they all struggled with the co-occurrence of relatively serious physical and mental health problems, substance abuse disorders, and histories of trauma. This study uses standpoint theory to frame an analysis of the strategies used by women with these vulnerabilities as they navigated their reentrance into the community from prison. Consistent with the framework just outlined, this study will address the following questions:

- How are women's reentry experiences impacted by the presence of multiple and overlapping vulnerabilities?
- What strategies do women utilize to navigate their reentry process?
- Under what condition(s) does a woman adopt the "addict identity" template?
Under what circumstances does the "addict identity" become more (versus less) salient to women's daily lives?
- In what ways does a woman's understanding of addiction shape her experiences of reentry?

LITERATURE REVIEW

Women and Incarceration

In the last thirty years, the United States has increasingly relied on imprisonment as a solution for crimes that had been previously addressed with alternative sanctions.

According to the National Council on Crime and Delinquency, the United States has the highest incarceration rate in the world and the world's largest prison population,

including the most women in the world. (Hartney 2006). Mandatory minimum sentencing laws, an increase in law enforcement power, policy changes that preclude the use of non-carceral sanctions for certain offenses, and post-release barriers to reentry have led to an increased population of incarcerated women (Women's Prison Association 2009; Chesney-Lind and Pasko 2013; Bush-Baskette 1998). In the last thirty years, the number of women in prison has grown by 832 percent (Women's Prison Association 2009). From 1980 to 1990, the number of females incarcerated in federal and state prisons has increased 256 percent compared to a 139.6 percent increase for men (Bush-Baskette 1998:176).

The dramatic increase in the rate of incarceration is as almost as astounding as the number of people incarcerated: there are almost 1.6 million people currently incarcerated in the United States and approximately 103,000 of them are female (Carson and Sabol 2011). While these figures themselves are astounding, they pale in comparison to the number of people under community supervision, which Maruschak and Parks (2011:1) define as "adults on probation, parole, or any other post-prison supervision." Currently there are almost 5 million adults on community supervision; over 1 million of them are women (ibid).

Who are these women in prison? An examination of the literature reveals that black, poor, females who are mothers to at least one child are overrepresented among incarcerated women (Bush-Baskette 1998; The Sentencing Project 2007). The increased reliance on incarceration has been most deleterious to minority groups, particularly black women. In fact, "black females are imprisoned at 2-3 times the rate of white females" (Carson and Sabol 2011).

Women who are incarcerated tend to be young and poor. Slightly over half of the women in prison are between the ages of 30 and 44 (Women's Prison Association 2009). At the time of their arrest, most women live in low-income communities and less than half report having full-time employment prior to their incarceration (Richie 2001). Nearly half of women in state prison have neither graduated from high school nor earned their GED and only 14 percent of women in state prisons have any college education (The Sentencing Project 2007).

The majority of women in prison have at least one child. In 2011, 62 percent of women in state prisons were mothers to minor children (The Sentencing Project 2012). Over three-fourths of incarcerated mothers report having provided most of the daily care for their children prior to being in prison (Women's Prison Association 2009); Ferraro and Moe (2003) report that the women in their study identified mothering as a primary concern. The motherhood role is central to many women's identities and "separation from children is considered to be among the most damaging aspects of imprisonment for women" (Covington and Bloom 2003:8).

Many women who are incarcerated express guilt about being a "bad mom." Ferraro and Moe (2003) conducted semi-structured interviews with thirty women who were incarcerated at the Pima County Adult Detention Center. The women ranged in age from 21 to 50 years, with an average age of 34. Fifteen of the women identified as white, seven as Black, three as Latina, three as American Indian and two as biracial. Respondents were asked open-ended questions that were designed to elicit topical life-history narratives as researchers were interested in examining the connection between violent victimization and incarceration.

Using a grounded theory approach, the authors analyzed the data and found themes that illustrated the importance of motherhood: the motherhood identity influenced the types of crimes women committed and shaped their experiences with incarceration. Women in the study reported that they turned to crime, such as forgery, welfare fraud, or drug sales, in an effort to be a “good mom” by providing for their children; they saw crime as a viable alternative to letting their children go hungry. Women also reported that losing custody of their children to child protective services was often the impetus to begin using drugs and alcohol again. Mothers who are incarcerated often express a tremendous amount of guilt for being physically separated from their children (ibid).

Research illustrates that childhood trauma and witnessing violence have a profound effect on adult physical and psychological well-being and may facilitate women’s pathways to crime (Schnaffer 2007; Bowles, DeHart, and Webb 2007). Women who are incarcerated have suffered physical, sexual, and emotional abuse at rates higher than the general public; 57 percent of women who were in state prisons reported that they had been victims of sexual or physical abuse prior to their incarceration (The Sentencing Project 2007). One study found that almost 80 percent of women in the sample had experienced some form of abuse at some point in her life (Covington 1998:8). Hunter and Greer (2011:200) found that almost one third of the incarcerated women in their study reported being sexually abused as children. In a study of 444 incarcerated juveniles, Belknap and Holsinger (2006) found that girls had experienced higher rates of physical, sexual, and verbal abuse and witnessed more violence than the boys in the study. Richie (2001) reported that the women in her study described the ways in which being violently victimized as children and suffering extreme intimate partner violence as

adults had influenced their criminal activity. As Marcus-Mendoza (2011:479) stated, “We are incarcerating people who cope with their own prior abuse through three common pathways: depression, anger and violence, and substance abuse. In many ways we are incarcerating last generation’s abuse survivors, rather than treating them.”

Being the victim of abuse has long-term ramifications for physical health and well-being. Campbell (2002:1332) reviewed extant research on the physical and mental health consequences of IPV (intimate partner violence) and found that the “injuries, fear, and stress associated with the intimate partner violence can result in chronic health problems such as chronic pain (e.g., headaches, back pain) or recurring central nervous symptoms including fainting and seizures.” Women who had experienced IPV also reported significantly more gastrointestinal symptoms (loss of appetite and various eating disorders) and more gastrointestinal diagnoses (such as irritable bowel syndrome) that are associated with chronic stress. Victims of domestic violence were also found to have higher rates of hypertension and chest pain than women who had not been victimized. Lastly, the “most consistent, longest lasting, and largest physical health difference between battered and non-battered women” are gynecological problems. Forced sex can result in sexually transmitted diseases, vaginal infections, pain with intercourse, and urinary-tract infections (Campbell 2002:1332). While some consequences of domestic violence are evident immediately, new research indicates that intimate partner violence may have lifelong impacts: years, even decades, after a woman leaves her abuser, she may be at risk for higher-than-normal rates of chronic health problems, like arthritis, hormonal disorders, high blood pressure, and gastrointestinal problems (Jetter 2013:86). Based on a literature review of 90 papers and 21 reports or policy documents on the

subject of prisoner health, Watson, Stimpson, and Hostick (2003) report that both men and women in prison suffer from mental health problems, substance abuse, and communicable diseases but women had them to a greater extent.

Although incarceration rates are at an all-time high, there does not appear to be a corresponding increase in women's criminality (Covington and Bloom 2003). Rather, the way in which the criminal justice system responds to women has changed. Previously women who were convicted of drug offenses or property crimes could avoid incarceration through programs like community service (Chesney Lind and Pasko 2013). Currently almost two-thirds of the female prison population is comprised of non-violent offenders (Women's Prison Association 2009; Covington and Bloom 2003). While increasing arrest rates for property offenses and public order offenses are partially to blame for the rate of women's incarceration exceeding men's, the "War on Drugs" has had a negative impact on women over the last three decades.

The "War on Drugs" has resulted in mandatory minimum sentencing and harsher penalties for drug use. These policies have had a devastating effect on poor women and people of color because offenses that would previously have been sanctioned by assigning community service hours or fines now result in incarceration (Alleyne 2006:189). Black women have been especially impacted by the War on Drugs, with incarceration rates for black females increasing over 800 percent in just five years from 1986 to 1991 after the introduction of mandatory minimum sentences (Bush-Baskette 1998).

Consider that from 1986 to 1996, although the rate at which women used drugs actually declined, the number of women incarcerated in state prisons for drug crimes

increased almost 900 percent. Even though women are less likely than men to play a central role in the illicit drug economy, they are more likely than men to be sentenced for drug offenses (Sentencing Project 2007). In the ten-year period from 1999-2008, arrests for drug violations increased ten percent for men but increased 19 percent for women (Women's Prison Association 2009). Women in state prisons were also more likely than men to admit to using drugs during the commission of their crime and almost one third of them stated they had committed the crime to obtain money to purchase drugs (The Sentencing Project 2007). There has been some research that shows that some women become involved in the illicit drug market solely to earn money, but far more women develop serious addiction problems (Richie 2001). The trend to "'criminalize rather than medicalize' has been particularly damaging to women, who are seven times more likely to enter prison with histories of untreated post-traumatic stress, sexual abuse or assault and depression" (Alleyne 2006:191). Often women will turn to drugs or alcohol in response to trauma in an attempt to self-medicate. Salisbury and Van Voorhis (2009:543) found that "victimization and trauma often lead to depression and other internalized mood disorders, which then frequently leads to self-medicating behavior by abusing drugs."

Women and Addiction

The need for substance abuse treatment in the United States far exceeds the resources devoted to what many have deemed a public health crisis. Alleyne (2006:191) reports, "On any given day, an estimated 22.2 million individuals would diagnostically qualify for substance abuse treatment in this country, yet fewer than 2 million receive it." Most women come to prison addicted to drugs or alcohol. Women are more likely than men to

have been convicted of a crime involving drugs, property, or alcohol. And many of the property crimes women commit are motivated by either poverty or to maintain a drug or alcohol addiction (Covington 1998:2). Over the last thirty years, psychologists have begun to acknowledge the differences in men's and women's experiences with addiction.

Stephanie Covington's relational theory (1998), which provides a useful framework to help better understand why women develop addictions, begins with the acknowledgment that men and women follow different paths in developing a sense of self. Traditionally it was thought that both men and women experienced psychological development as a journey from child-like dependence to maturity. The ultimate goal was to become self-actualized: autonomous and independent from others. However, Covington argues that traditional explanations of psychological development are based on men's experiences; women, on the other hand, develop a sense of self precisely *because* of their relationship networks.

Covington's approach is consistent with that proposed by Jean Miller in 1976, who argues that traditional psychological theories explain men's route to maturity, not women's. She asserts that women are socialized such that their primary motivation is to build a sense of connection with others in their life: women develop their identities through their relationships with others. It is this connection, and not separation, that enables women to grow and thrive. A connection is defined as "an interaction that engenders a sense of being in tune with self and others, of being understood and valued. True connections are mutual, empathic, creative, energy-releasing and empowering for all participants." (1998:5) Covington argues that empathy and mutuality are empowering for women and when present in relationships produce five positive psychological

outcomes: 1) increased zest and vitality, 2) reciprocal knowledge of self and others, 3) confidence to act, 4) a sense of self-worth, and 5) a yearning for more connection (ibid). Miller also describes what happens when relationships are not based on mutuality and empathy. These non-mutual or abusive relationships, also called disconnections, also produce five psychological outcomes: 1) decreased zest and vitality, 2) confusion, 3) disempowerment, 4) diminished sense of self-worth, and 5) avoiding relationships.

As Covington (1998:7) and others have noted, disconnection and violation characterize the pasts of most women and girls involved in the criminal justice system (Buchanan et al 2011; Alleyne 2006; Lopez, Katsules, and Robillard 2009; Hunter and Greer 2011). As previously stated, women in prison report rates of emotional, sexual, and physical abuse that are much higher than the general population. Many of these women have experienced violent victimization and betrayal. Because they have been subjected to non-empathic relationships, many have not had the opportunity to develop empathy for self or others. Or as Wright, Crawford, and Castillo (2009) suggest, some women develop maladaptive self-sacrificing self-schemas that result from having too much empathy toward others and none toward the self. As Hunter and Greer note (2011:211), “the characterization of self as a ‘people pleaser’ was very common among the women in our study, and many related this ‘people pleasing’ emphasis directly to experiences of abuse or trauma experienced during childhood or as adults.” Women perceive themselves as having little or no power in their own relationships and often turn to drugs or alcohol to cope with “feelings of powerlessness and uncertainty” (ibid).

When a woman does not feel validated in her interpersonal relationships, it lead to a state that Miller calls “condemned isolation,” where the woman feels isolated in her

own relationships and feels that such isolation is her fault. The feeling of condemned isolation is highly correlated with drug and alcohol use as women struggle to cope with feelings of hopelessness and loneliness (Covington 1998:8).

Women often initially use substances as an attempt to foster connections with loved ones and may begin to use drugs in an attempt to fit into the relationship at hand (Covington 1998:10; Lopez et al 2009; Buchanan et al 2011).

Lopez et al (2009) interviewed 18 incarcerated teen girls and discovered that eight of them had used drugs with their parents as a relational strategy—to be close to them or as a means to spend time together. The researchers sought to understand incarcerated women's perspectives on reasons for their addictions: why they continued to use, the consequences of their addictions and how services could be improved. The researchers employed a participatory research design in which women incarcerated at the facility created and administered demographic questionnaires and conducted qualitative, open-ended interviews with other incarcerated women at the minimum security prison. Through the questionnaires researchers were able to determine respondents' drug of choice, age, situations or people that served as triggers, and how long people had abstained from drugs and alcohol. Through the qualitative data analysis, four themes emerged from respondents' drug of choice interviews: catalysts for using, reasons for continuing to use, consequences of use, and motivations to stop using. The authors identified four categories that related to the catalyst for using. They were a) family relationship and dynamics, histories, and burdens, b) effects and relationships with peers, friends, and acquaintances, c) experience of loss, and d) self-motivators. Consistent with previous research on the topic, researchers found that women identified abusive

relationships as a catalyst for using. Women turned to substances to numb the pain of violent or non-empathic relationships. The women in this study also identified four factors that contributed to their continuing to use their drug of choice. These factors were a) their family and friends, with many reporting that addiction was “normal” in their family and friend groups, b) the availability and accessibility of drugs in their lives, c) feelings of powerlessness and lack of control, and d) the physical and emotional sensation the drug provided. The vast majority of women in this study reported that drugs or alcohol took away “unwanted feelings and memories” (92).

Some research suggests that there is a recursive relationship between women’s development of self and women’s excessive substance use. While excessive substance use can interfere with positive identify formation, women who have an insecure sense of self may use excessively to cope with that insecurity. In a study conducted at a prison in the Midwest, Hunter and Greer (2011) sought to investigate how women prepared for the reshaping of their identity as they approached their release date. The authors did purposeful sampling to make the population sample representative of the demographics of the overall population of incarcerated women in the state. The authors used grounded theory to ground “emergent themes in women’s narratives” (Hunter and Greer 2011:206). One of the themes that became increasingly evident among the participants was the difficulty of constructing and maintaining a cohesive self after experiencing trauma and abuse in a “multitude of situations” (Hunter and Greer 2011:220). Though many women turned to drugs or alcohol as a method of coping with the trauma and abuse, they recognized that their drug use interfered with their ability to create a well-defined and strong sense of self. Using language acquired from treatment programming, many of the

women in the study also adopted the “addict” identity and used this label not only to make sense of their previous experiences with drugs and alcohol (identifying with rhetoric such as ‘addicts cannot moderate their drinking’) but also as a template to guide their future behavior toward drugs or alcohol, such as “avoiding people, places, and things” that will trigger relapse.

Women’s Experiences with Programming within Prison

Marcus-Mendoza (2011:83) notes “in prisons and jails we see deeply wounded and highly traumatized persons, who are placed in a highly traumatizing situation, with little to no trauma-aware care and little political openness to providing this.” There is a strong correlation between women’s use of drugs and alcohol and illegal activity (Laux et al 2008). Drug offenses are one of the most common offenses for which women are incarcerated. Over half of women in state prison have a history of drug addiction, and women in state prisons were more likely to admit to using drugs at the time of their offense than men. Comprehensive programming can contribute to successful rehabilitation but the availability of these services is sorely lacking. In fact, only 20 percent of females in state prisons and about 13 percent of females in federal prisons ever receive treatment for substance abuse (The Sentencing Project 2007). Henderson (1998) notes that there are not enough treatment slots for women in prison, especially pregnant women. Ferraro and Moe (2003:12) state that “the vast majority of prisons and jails have not developed the most rudimentary resources for women inmates.”

French philosopher Simone de Beauvoir argues that women have been historically “defined and differentiated with reference to man and not he with reference to her; she is incidental, the inessential as opposed to the essential. He is the Subject, he is the

Absolute; she is the ‘Other’” (Appelrouth and Edles 2011:317). The manifestation of this disparity through the largely unacknowledged metonymic substitution of “male psychology” for “psychology” is nowhere more obvious than when examining the type of self-help programming utilized by correctional facilities.

Currently most federal prisons employ cognitive behavioral treatment programs to address substance abuse. These programs seek to correct “faulty thinking” (Marcus-Mendoza 2011: 81) and teach incarcerated people to make better choices (Milkman and Wanberg 2007). Many prisons also utilize the 12-step recovery program, which requires participants to admit they are an addict, will always be an addict, and are powerless over their addiction. However, such programs were designed for men and ignore the complexities of women’s histories as well as the reasons why women initially develop addictions (Henderson 1998). For women whose lives have in many ways been characterized by victimization and powerlessness, the helpfulness of messages like these is debatable.

Zlotnik et al (2003) noted that most of the existing research on substance abuse programs in prisons has been conducted on men only or mixed groups; virtually no treatment programs have been developed to specifically address the many needs of women with addictions. In fact, Belknap (1996) argues that treatment programs for females tend to be poorer in quality and quantity than those for incarcerated men; women are also often excluded from work release programs and halfway houses. She also reports that when women in prison do receive job training, it often encourages them into gender appropriate roles, such as sewing or cosmetology classes. Regardless of the type of programming, incarcerated women appear to be disadvantaged.

Additionally, existing prison substance abuse programs focus on individualistic changes rather than addressing the structural forces that shape women's lives. Treatment programs are similar to prison boot camp programs: their goal is to induce conformity and social control by re-shaping the individual's behavior. These programs instill into the women the idea that they are deviants who need to learn to shed their criminal thinking and conform to social expectations. These strategies ignore the structural realities that constrain women's opportunities and choices (Marcus-Mendoza 2011).

Increasingly, corrections and mental health professionals are calling for programming that will reflect an understanding of the lived experiences of incarcerated women. Marcus-Mendoza (2011: 81) argues for the implementation of a gender-responsive approach based on Covington's relational theory that will emphasize self-efficacy (the belief in one's own ability to be successful at making changes in her life) and skill-building. This allows women to be included in the process of establishing their own treatment goals. A program such as this would recognize the gendered pathways to women's incarceration and would take into account social and cultural factors like race, age, and class when developing intervention programs for domestic violence or substance abuse. Marcus-Mendoza (2011:81) asserts that "positive outcomes for women will only be possible in a system based on the realities of women's lives and their pathways to prison." Stephanie Covington (2011:377) asserts that women need a trauma-informed approach to substance abuse treatment, arguing that "addiction treatment services for women (and girls) need to be based on a holistic and women-centered approach that acknowledges their psychosocial needs." Gender-awareness must be a part of this.

Buchanan et al (2011:97) argue that incarcerated women would benefit from gender-responsive treatment that will address their histories of abuse and addiction, while research has demonstrated that ensuring a woman is employable after leaving prison and providing her with a marketable skill is also an important step to reducing her risk of relapse. There is a crucial need to develop comprehensive systems of support within the community to help ease the reentry process for women who are returning home from prison (Covington and Bloom 2003); it is imperative that gender-specific and culturally-responsive programming emphasize support and empowerment and focus on women's strengths.

Women's Reentry Experiences

As a result of the dramatic increase in the use of incarceration as a response to non-violent crime, every day formerly incarcerated women must attempt to negotiate their reintegration into the community (Opsal 2009). While getting out of prison sounds ideal, the reality for many women is that the reentry experience can be stressful and even overwhelming. Bloom and Brown (2009:314) argue that women leaving prison have "significant needs that present barriers to their successful adjustment after prison. These needs are long-standing and severe." For many women the reentry experience can be profoundly difficult as they attempt to find employment and housing while bearing the stigma of a convicted felon and addict (Anderson and Ripullo 1996), reestablish relationships with (and in some cases, regain custody of) their children, and successfully manage the conditions of their parole (Brown and Bloom 2009; Richie 2001).

When women are released from prison, they are expected to find a full-time job. While this can prove to be a challenging task even under normal circumstances, for those

leaving prison it is especially hard; only 40 percent of women are able to find full-time employment within the first year of release (The Sentencing Project 2007). Many of these women do not have any higher education or marketable skills prior to incarceration. Richie (2001) states that most of the women in her study had not maintained steady employment nor attended job training or higher education in the years leading up to their arrest; half of all women did not work at all in the thirty days prior to their arrest (The Sentencing Project 2007). Less than one in three incarcerated women is enrolled in a job-training program (ibid) and many times these programs are not accredited (Richie 2001). Women report not possessing enough education or job skills to support themselves, let alone a family, after they are released (ibid). This makes the allure of illegal activity that much stronger.

One of the most difficult challenges for many women, at least initially, is securing housing that is compliant with the terms of their parole. This can be problematic for several reasons. First, while not all women leaving prison will return to their previous neighborhoods, most will and many times, these neighborhoods are economically depressed. Leverentz (2010:29) states that “prisoners are not evenly drawn from, nor released to, neighborhoods; rather, they are concentrated in a relatively small number of predominately disadvantaged urban neighborhoods.” In one study on women’s reentry experiences, one woman reported, “I just don’t have anywhere to go that will help me avoid the people, places, and things that brought me in the first place (Richie 2001:378). Most women do not leave prison with much money (O’Brien 2001:287). As many landlords require a security deposit plus the first month’s rent prior to moving in, a lack of money makes obtaining a place to live very difficult.

Second, restrictions on public assistance, especially housing assistance, prohibit people convicted of felonies from receiving aid (Opsal 2009, Richie 2001). In 1996 the federal government reauthorized the 1988 Anti-Drug Abuse Act and added the “One Strike Initiative.” This provision authorized local Public Housing Authorities to evict tenants for any drug-related activity, regardless of whether the activity occurred on the rental property. This also includes tenants who were unaware of such activity or had no power to stop the activity. In that same year, the federal government also passed the HOPE (Housing Opportunity Program Extension) Act. Under this law, local Public Housing Authorities can screen potential tenants by requesting their criminal conviction information. Rental applicants may be denied assistance based on any drug-related behavior, regardless of how old the offense is (The Sentencing Project 2007). Furthermore, these prohibitions against renting to people with felonies extend to everyone who resides in the unit, meaning that a woman cannot be paroled to her family’s house if they are public assistance because the family will lose their housing benefits. Without finding a place to live, women stand virtually no chance of regaining custody of their children.

In the United States being a “good” mom means being self-sacrificing and always providing a loving, stable home for the children (Brown and Bloom 2009; Ferraro and Moe 2003). Many women who are in prison have children under the age of 18 and more women than men had physical custody of their children prior to incarceration (Ferraro and Moe 2003:13). Several studies (Opsal 2009; Brown and Bloom 2009; Ardetti and Few 2006; Brennan 2007) have emphasized the importance of the maternal role and identity to a woman’s reentry experience. In many ways motherhood can be a double-

edged sword. It can compel women to turn to illegal activities in an effort to provide materially for their children, but motherhood can also serve as an impetus for desisting from crime (Brown and Bloom 2009). Women consistently report that the desire to be with their children is a motivating force in their desire to create a healthier life for themselves and to avoid violating parole (ibid; Brennan 2007).

Parole, with all of its demands and rigid expectations, is another structural component that shapes women's reentry experiences. Parole had historically been used to assist people recently released from prison as they transitioned back into their communities by providing job training, education, counseling, and substance abuse treatment (Petersilia 1999:482). However, over the last twenty to thirty years, public support for the rehabilitative function of parole has steadily declined, resulting in less funding for mental health and chemical dependency programs. Consequently, parole officers report they have fewer services to offer their clients and have become more "surveillance than support oriented, and drug testing, electronic monitoring, and verifying curfews are the most common activities of many parole officers" (ibid).

For approximately the last two decades, parole officers have increasingly exercised their ability to send people back to prison for violating the conditions of parole or probation, creating what some scholars call "a separate path to prison" (Opsal 2007:308). The Bureau of Justice Statistics reports that among people who had released from prison, 25 percent are rearrested in the first six months [of their release] and 40 percent are rearrested in the first year (Petersilia 1999:483). Women have reported feeling intense feelings of anxiety because they feel the threat of returning to prison is constantly looming over their head. Women face a tremendous amount of pressure to stay

sober, find a job, secure housing, and reestablish relationships with loved ones. Relentless anxiety is not good for anyone, but for someone who is struggling with “the co-occurrence of multiple demands” (Brown and Bloom 2009:314) it can be overwhelming and contribute to relapse.

Standpoint Theory and Identity Work

Women’s experiences with incarceration and their subsequent reentry processes can be best understood from within the larger theoretical framework of standpoint theory, a feminist epistemology articulated by sociologist Dorothy Smith (Appelrouth and Edles 2011:319). Standpoint theory was the result of the Smith’s powerful realization that women’s experiences in society are not the same as men’s: women occupy different and unequal locations in the social hierarchy.

Smith uses the term “standpoint” to underscore the notion that what a person knows is affected by his or her location in social hierarchies, such as gender, class, and race. She argues that what we know of the world and what we know of “others” is conditional of that location. Therefore, no two people can have the same standpoint. It is only by acknowledging one’s own standpoint that a more objective truth can be uncovered.

Smith takes as her starting point that society is socially constructed and argued that for much of history, men have been the constructors. Smith used her own experiences as a wife, mother, and female graduate student in a male-dominated field to develop her concept of standpoint (Ritzer 2011:476). She asserted that because the discipline of sociology had been developed primarily by men, it reflected the implicit biases and assumptions of men: “its methods, conceptual schemes and theories have been

based on and built up within the male social universe” (Appelrouth and Edles 2011:319). (For a more complete delineation of this argument, see also Harding [1992].) Even the very events that were the early subject of sociological inquiry reflected a male perspective. Things like wage labor, politics, crime, and formal organizations all occurred in the public sphere, from which women were historically excluded. Smith argued that because so little attention had been devoted to issues that were prominent in women’s lives, such as childbearing, domestic labor, and relationships, that sociology served to disconnect women from their own lives (Appelrouth and Edles 2011:319). The acceptance of the male standpoint as universal not only results in the silence and exclusion of women, but has the net effect of “othering” women and their experiences.

Smith argues that failing to make women’s standpoint a central focus of analysis results in a sociology that is implicitly masculine. This creates a form of domination that results from shifting attention to a particular dimension of social life, the masculine one, at the expense of another, the world of women (Smith 1992/2011). Smith asserts the male is standpoint privileged, but further that it dominates and pervades other standpoints as well; that is, not all standpoints are equal. Women’s standpoints and lived experiences are devalued, marginalized or ignored. Smith refers to the knowledge gained from disenfranchised groups as subjugated knowledge, arguing that such knowledge is viewed widely as being less legitimate. Appelrouth and Edles (2011:320) write that Smith’s Marxist orientation is evident when she argues that “objective social, economic and political relations...shape and determine women’s oppression.” While Smith based her theory on her own experiences within the field of sociology, the principles of ruling relations and subjugated knowledge apply to all social structures.

Smith's standpoint theory also has phenomenological roots; she sought to explore and explain the ways in which people actively construct their everyday life-worlds (Ritzer 2011:477). She coined the term "bifurcation of consciousness" to explain the separation between the people's lived experiences and the labels placed on those experiences by dominant groups using "official" definitions (ibid). She explains that subordinate groups, like women, are conditioned and expected to view the world according to the standpoint of the dominant group, particularly men's standpoint, because it is the male perspective that is entrenched in institutions and norms of that culture (Smith 1992/2011). The dominant group is able to enjoy the privilege of remaining ignorant to the lived experiences and standpoints of marginalized groups because other groups are expected to accommodate them (ibid).

Smith's work reflects an increasingly poststructuralist turn as she argues that in modern, Western, capitalist societies, the domination and oppression of marginalized groups occurs through texts, such as psychiatric records, health records, criminal records, and census reports, that are used for social control. She asserts that there is a male subtext to the professed "neutrality" of the social institutions, like language, health care, and education; women are still typically excluded from "text-mediated relations...the forms in which power is generated and help in contemporary societies" (Smith 1992/2011:348). Thus, substance abuse treatment programs may replace women's actual lived experiences with the label of "addict," a preexisting category derived from the dominant model. In effect, the woman is reduced to a disease and a treatment possibility, regardless of whether or not this label, and the meanings attached to it, appropriately reflect her lived experiences. As previously noted, most treatment programs used in prisons have been

developed as a result of research done on men's experiences; women's experiences are categorized and interpreted not from their standpoint but from the universal, male standpoint. It is precisely for this reason that Smith advocates that we "shift the ground of knowing, the place where inquiry begins" (Smith 1992/2011:347) to privilege women's understanding of their own lived experiences.

It is within this patriarchal context described by Smith that women engage in identity work. Identity theorists trace their intellectual roots to George Mead and Charles Horton Cooley. They believe that the self is fluid, dynamic, processual and reflexive, which means it is able to view itself as both a subject and an object. The self does not exist in isolation; it is only acquired and continuously constructed through socialization and social interactions. The self can "categorize, classify, or name itself in particular ways in relation to other social categories or classifications" (Stets and Burke 2000:224). It is through this process of classification that an identity is formed. Identity theorists argue that every culture contains "symbols that are used to designate positions—the relatively stable, morphological components of social structure that are termed roles" (ibid). Individuals categorize themselves within a structured society and in relation to other people. Standpoint theory asserts that for women, this categorization of self is done using categories developed for and by men (Smith 1992/2011).

Each role carries with it a set of socially determined expectations and obligations. Smith argues that such expectations and obligations are gendered in ways that advantage men and disadvantage women. When individuals interact with others under the auspice of a particular role, that role becomes one of their identities. However, this does not mean that every person occupies the same role in the same fashion. Identity theorists recognize

that there is flexibility and agency in the ways people enact various roles. Each person may carry out each role differently, choosing which parts to enact and which parts to disregard. The self then can be seen as a bucket containing all of the identities an individual negotiates through their identity work.

While many social identities are flexible and able to be changed or transformed, the “addict identity,” as conceived by most treatment rhetoric is relatively unyielding (Hunter and Greer 2011). According to Hunter and Greer (2011), women describe it as an inflexible, rigid identity that provides them with the sense that their only options are success (defined strictly as not using) or failure (relapsing). Women also conceive of their “addict identity” as a constant enemy, one that must be defeated if they are to lead successful post-prison lives. The rigidity of this identity affords limited agency or empowerment for women who adopt it.

Within the framework of standpoint theory, the “addict identity” can also be understood as a category of the dominant ideology that further marginalizes people of lower social statuses. Not only does this identity limit the agency of the person adopting it, but the official label of “addict” is constructed in such a way that it ignores the realities of women’s lived experiences. For instance, despite the fact that women experience considerably less power in everyday social relations, programs such as Alcoholics Anonymous further such marginalization by requiring that participants admit they are “powerless” over their addiction. Additionally, as previously discussed in the literature review section, research demonstrates that women start and continue using drugs and alcohol for different reasons than men; women’s experiences with recovery are markedly different as well.

Turner (1978) advances a set of propositions that attempt to explain the circumstances under which a role becomes all-encompassing. First, the more community members insist on the application of one primary label to a person, the less successful that person will be in attempts to enact any different identities. That person's presentation of self is constrained by dominant categories, such as "felon" or "addict." Second, Turner argues that the more a role is viewed as extremely "good" or extremely "bad" by community members, the more completely the labeled person's character and behavior will be filtered through that label. This can have profoundly negative consequences for women who are battling substance abuse while simultaneously negotiating the reentry process. All are labeled as "felons" and most as "addicts," thus, their behavior will be interpreted through the lens of such labels.

METHODS

This research on the ways women with multiple and overlapping vulnerabilities negotiate their reentry experiences will be based on Dorothy Smith's feminist sociology, which attempts to fully account for the ways gender affects our experiences of reality. I used modified grounded theory to understand how this identity impacts women's reentry experiences and under what conditions this identity remains prominent for the women in the study. I chose modified grounded theory because it does not place data into preconceived categories but rather keeps the emerging themes grounded in the women's narratives. This methodological approach is consistent with Smith's emphasis on privileging subjugated knowledge. Grounded theory does not aim for Truth but rather seeks to deconstruct people's lived experiences by striving to understand the world from the point of view of those studied.

The interviews I transcribed and coded came from previously collected data that are part of a larger study of women reentering society from prison in a Midwestern state. Drs. Kimberly Greer and Vicki Hunter recruited women for their study through the prison's Pre-Release class. There were three criteria for women in their study: the women were required to have a release date prior to December 2008, be over the age of 18 at the time of the study, and have post-release residence in the same state. In order to recruit research participants, the researchers explained the details of the study to the women in the institution and provided them with flyers. Women who were interested in participating were instructed to fill out and return the bottom portion of the flyer.

More women were interested in participating than the researchers needed for their study, so the original authors used purposeful sampling toward the end of recruitment to manipulate the sample so as to best reflect the demographics of the general prison population. Some of the demographics that were deliberately manipulated included age, race, type of offense and geographical location of reentry.

The final population sample included 41 women: 30 who identified as White, six as Black, two as Native American, and three as Hispanic. The ages ranged from 20 to 53 with the average age being 36. Consistent with national statistics on incarcerated women, most of the women in the study were incarcerated for drug-related crimes (51 percent), followed by property crimes (27 percent), and finally person offenses (12 percent). The remaining women had been convicted of crimes classified as "other" such as DUI. Sentence length for the women varied from 4 months to 16 years, and the average sentence was two years. Over three-fourths of the women in the sample were mothers; slightly more than half of the women had children who were under 18 at the time of the

study. Also much like the larger prison population, all but four of the women in the sample reported problems with drugs or alcohol.

The baseline interviews, which were used to gather biographical information from the respondents, began in June of 2008 and finished approximately two months later. Dr. Greer conducted interviews with 20 respondents and Dr. Hunter conducted interviews with 21 respondents. During the initial interview, the researchers explained the study and explained the informed consent document to each of the women. The baseline interviews were about two hours in length and included questions about family histories, post-release plans, and the state of current relationships with family and/or other significant people in their lives. Each of the researchers followed the same group of women throughout all of the waves of interviews. Subsequent interviews did not last as long and included follow-up questions that inquired into women's ongoing life circumstances, such as housing, health, employment, relationships, and programming involvement.

Interviews were audio-recorded with a digital recorder and later transcribed by the researchers or graduate assistants. The text from the interview transcripts provided the main source of data for the study. The researchers also used interviewer field notes, which contained detailed descriptions about the respondent, the setting, and the interview process as an additional source of data.

At the time I began working on this research project as a research assistant, the baseline interviews from the study, and many of the second waves of interviews were already transcribed; most of the subsequent interviews were not. I participated in transcribing the remaining interviews verbatim using Hypertranscribe and began the process of data analysis during transcription. I also participated in the preliminary

analysis through the creation of spreadsheets that systematically coded information about each of the respondents, covering topics such as relationships with children, employment and housing experiences, experiences on parole, and substance use across the waves of the study. I was also integrated into continuous dialogue with the primary investigators (and over a special summer session with other graduate assistants) during my 2 years as a research assistant on this project as codes and themes emerged from the analysis of the data. Hence, the findings from my thesis are the result of a discursive process of coding and analysis that involved constant comparisons across respondents, time, and researcher viewpoints.

Using the spreadsheets, I began by selecting women in the sample who reported problems with substance abuse, physical health problems, mental health problems, and histories of trauma and abuse. Among those selected, I analyzed each of the interviews for each respondent chronologically, starting with the women who had completed the most waves of interviews.

I used modified grounded theory coding as I began to analyze the data. I initially used line-by-line coding, which entailed naming meaning for each line of text, only for those sections of text that had some relevance to a woman's experience with physical and mental health problems, addiction, or abuse. This process "works particularly well with detailed data about fundamental empirical problems or processes" (Charmaz 2006:50). This type of coding also forces the researcher to remain open to the data and to see nuances in it. Line-by-line coding is also helpful in developing theoretical categories; Charmaz argues that the logic of discovery becomes evident as the data is coded (*ibid*). Seeking to understand the everyday lived experiences of women returning home from

prison, I looked for themes that emerged from their narratives and used memoing to describe the codes that resulted from the themes.

After doing line-by-line coding for six to seven interviews, several dominant themes emerged and I began doing more focused coding that emphasized the dominant themes, while still remaining open to additional themes. Throughout this process I discussed my findings with my advisor, one of the authors from the original study by Hunter and Greer (2011), utilizing additional insight that helped to increase the validity of the developing themes and further tease out the meanings of such themes and concepts. I used a computer-based qualitative analysis program, NVivo, to help me with the data analysis. This software was able to store the data and simplify the process of thematic coding and theoretical analysis.

I did not have to gain approval for the research through the Institutional Review Board at the university because Drs. Hunter and Greer had already obtained approval. However, since I did transcribe the interviews, I had access to the women's real names and other identifying information. To avoid violating women's privacy, I consistently used the pseudonyms already assigned to respondents by Drs. Hunter and Greer and avoided transcribing identifying information like names of children and significant others, addresses, and telephone numbers provided in the interviews.

FINDINGS

This analysis examines the strategies employed by a subset of thirteen women from the study's larger population as they navigated the reentry process. Previous research has consistently demonstrated that incarcerated women are considerably more likely than non-incarcerated women to have been the victims of multiple incidents of childhood

sexual and physical abuse (Bradley and Follingstad 2003), to suffer from chronic mental and physical illness(es) (Braithwaite, Treadwell, and Arriola 2005), and to be addicted to drugs and/or alcohol (Staton, Leukefeld, and Webster 2003). While it is not uncommon for incarcerated women to have previously reported at least one of these adverse experiences (Hunter and Greer 2011), what made this particular group of thirteen women unique was that they struggled with all four of these multiple and overlapping vulnerabilities simultaneously. Although each of these adverse experiences presents its own set of challenges during the reentry process, it became clear through some of the women's narratives that the compounding effects of all four of these destabilizing conditions made it difficult for women to not only secure employment and independent housing but to accomplish basic day-to-day tasks. In fact, by the end of the study, none of the thirteen were living independently and only four of the thirteen women were employed.

The women in this particular subsample had severe physical health problems that interfered with daily activities, including Hepatitis C, debilitating back problems, knee replacement surgeries, diabetes, anorexia, cancer, and HIV. (One respondent passed away from breast cancer before the study was completed.) In addition to these chronic illnesses, several women developed acute illnesses like staph infections and sepsis that required hospitalization. All thirteen women struggled with mental illness(es), mostly commonly depression and anxiety. Five reported that they had bipolar disorder, six women struggled with anxiety, and two had been diagnosed with PTSD (post-traumatic stress disorder). Additionally, several of the women reported debilitating types of mental

illness, such as schizophrenia, schizoaffective disorder, borderline personality disorder, and anorexia.

All of the women in this subsample reported that they struggled with severe addiction issues and for almost all, this struggle had been years-long with many reporting that they had developed their addictions as a youth. Consequently most of the women said that their adult lives had been consumed by their addictions. Additionally all of the women in this subset reported histories of extreme physical, mental, and sexual abuse, including experiences of sexual molestation, rape, and being victims of sex trafficking. Please see Tables 1 and 2 in Appendix A.

Because of the qualitative nature of this study, it is not possible to determine a cause-effect relationship; however, many women in the study were able to identify the links between substance abuse and trauma and trauma and mental illness. Trauma has been associated with higher rates of PTSD and respondents reported that using drugs or alcohol was a way to cope with mental health problems such as depression and anxiety. Also consistent with previous findings, for some of the women in the study, their drug use resulted in serious health problems, such as Hepatitis C or HIV, or in the case of one woman, an unintended pregnancy. The compounding effects of abuse, illness, and addiction cannot be overstated. For many of the women, their physical and mental health problems interfered with their daily activities, making it difficult to accomplish day-to-day tasks, like going grocery shopping or even leaving the house. This lack of activity and opportunity to build upon new social identities, like employee or student or volunteer, exacerbated the women's feelings of powerlessness and contributed to the use of drugs or alcohol as a coping mechanism.

For many, reentry can be a difficult process (Richie 2001), but for women whose physical and mental health needs are not addressed, it can be overwhelming and even impossible. Although the lives of all thirteen women were impacted by the recursive and multiplicative relationship between physical and mental health problems, substance abuse, and histories of trauma, some women were much more successful than others at navigating the reentry process to the degree that they were able to establish housing, obtain steady income, and manage their addiction(s) in ways that did not result in their reincarceration. By the end of the study, the thirteen women fell into one of two distinct groups: eight women had achieved *stable but dependent* living situations while five women remained in living situations that were *unstable and chaotic*. The first part of this analysis describes the differences that characterize the living situations of women from both groups. An examination of the women's narratives reveals interesting insights about the strategies employed to navigate the reentry process and forms the second part of this analysis.

Stable but Dependent

One defining characteristic about these eight respondents was the degree to which they were able to act agentially when navigating their own reentry experiences. This is not to say that their reentry experiences were seamless and without difficulties. However, with varying degrees of help from support networks, all eight women were able to devise solutions to such challenges that enabled the women to avoid going back to prison. By the end of the study women in this group were residing in safe living arrangements and did not have to worry about homelessness. They also had their own income or were connected to someone with income, such as a spouse. Finally, although some of the

women in this group used drugs or alcohol after they were released from prison, they able to manage relapse in ways that did not result in their reincarceration.

Even though all eight women from the *stable but dependent* group had found housing, none were living truly independently: six were living with a roommate or family member and two were in subsidized housing programs that paid two-thirds of their rent. Although these situations were stable, it did not mean that their arrangements were necessarily calm or without conflict, only that the women had a reliable place to stay and did not have to worry about homelessness. For example, during the second wave of interviews Whitney, a 42-year-old mother of an adult daughter, described what it had been like living with her daughter during the four months since her release:

Um, it goes up and down 'cause me and my daughter, we fight like we're sisters [...] ya know like last night she told me she hates me, she can't stand me, she can't wait til I leave. [Sniffs] Why would you say that to your mom? If I had my mom here...I'd give anything to have my mom here you know. [Crying] I don't understand it and you know she tells me she can't wait til I leave, and then I really don't have anywhere else to go, ya know? 'Cause she told me she wanted me to leave until I go to San Diego, she don't want me here. [Sniffs] But, everybody else can be laid up around here, but me... She has no respect for me.

When asked about the biggest challenge she had encountered after her release from prison, Whitney answered:

Um, I guess that, that my biggest challenge is to, yeah, to, have to, I feel like I'm li-, living off her, you know. I sleep on the couch and, and I feel like I'm in the way sometimes and, but at the same time I don't have nowhere else to go, you know. And so... I, um, I wouldn't have anywhere else to go if [daughter's name] wouldn't let me stay here.

Throughout subsequent waves of interviews, this relationship did not show signs of repair and through the duration of the study, Whitney and her daughter had a volatile relationship. Wendy's interviews always included stories of fights with her daughter

because her daughter did not want Wendy living with her in her apartment. In fact, even during the last interview Whitney remarked that her daughter would “throw it in her face” that she was in her 40s and living with her child.

For some women, living with a family member added additional stress to an already-precarious financial situation. For Barbara, 45 years old, concern about money was a recurring theme throughout all of her interviews. Yet in the final interview, she reported that her grown nephew had moved into her apartment with her while he was looking for work even though she was already having difficulty paying her own bills:

Cause right now it's just like, I'm living paycheck to paycheck, you know? I'm just barely letting, make ends meet. Cause at first it was sixty hours last year some time, then it went down to 50, then it went down to 40... In a two week pay period, forty hours. Twenty hours in a week. So yeah, it was crazy; it was like I struggled in my place. \$650 a month rent. My little nephew's still there but he's still going through his struggle, which I'm protecting and giving him stuff so, you know.

Another factor that contributed to the stability all eight women experienced was that they all had a steady, legitimate form of income: three were on Social Security disability, one relied on her husband's income, and four had obtained employment. This is important because previous research indicates that “the pull toward illegal activity becomes stronger” as other financial resources, like social services and friends or family, become scarcer (Richie 2001:377). To this point, when recounting how difficult the last several of months had been for her financially, Barbara said, “when I get in those binds and a few times here within the last six months I did, you know, I thought of, you know, wanting to get out and hustle and get, make, figure out where I can get some extra money.”

Finally, women in this group were able to manage drug and alcohol use in ways that did not result in their going back to prison. In the final interview, Leann, a 53-year-old woman, reported that when she had received money from her Social Security check, she went to the local casino, got drunk, and spent too much money. She told the staff at the transition housing center where she was living about her relapse and they helped her create a plan to not only stop drinking, but also helped her create a plan to budget her remaining money so she could get back on track financially.

Unstable and Chaotic

As previously stated, although none of the eight women from the group described in the previous section were completely independent, they achieved much higher degrees of success with the reentry process than the five women whose situations remained unstable and chaotic. By the end of the study, none of the five had secured housing or employment, and all had experienced relapse which resulted in their return to jail or prison at some point.

The five women in this group were released into environments that did not have much, if any, structure, and were not equipped to absorb the level of need these women had, resulting in reentry experiences that were unstable and chaotic. Although all of the women had a place to stay when they were released (family or friends, treatment, or transitional house), they frequently did not remain at that location for long: Sunny, a 30-year-old diagnosed with schizoaffective disorder, was released to a treatment center but left after a week for her dad's house. Renee, a 33-year old who had spent most of her adult life cycling in and out of prison, was released to her friend's house but left within a month, choosing to live with people with whom she could use drugs. Valerie, a 45-year-

old respondent who died of breast cancer before the study was completed, was paroled to a transitional housing center but hitchhiked to see her family and was reincarcerated by the third wave of interviews. All of the women in this group had reentry experiences that were marked by periods of homelessness or transience (moving from place to place).

None of the five respondents in this group had a steady, legal form of income. The enormity of their physical and mental illnesses made working difficult and, for some, impossible. For example, Renee reported that she had applied for dozens for jobs upon her release from prison and had become discouraged when she was not even called for an interview. Unable to handle this frustration or to imagine other solutions to her joblessness, she started using meth again and began stealing to make money. She described her feelings of frustration at not being able to find a job:

I filled all the [job] applications out, you know, and then I would call them back. "Well, we're not looking at them right now." They didn't even want to look at them because they said they weren't hiring. Before I even, they didn't even know I had a felony and they were telling me this. You know what I mean?...So I started stealing all kinds of stuff for Christmas. Well, and then I got away with it again, of course, so I kept saying, "Well, I'll just keep doing it to make money" or whatever. Kept selling to people, selling like expensive purses and stuff to these different people. Well, eventually, I, you know, I stopped looking for a job. You know what I mean? And then I started getting high.

Although none of the women was able to independently co-manage addiction and mental health problems with the demands of reentry, what differentiated this group of women's experiences with the group described previously was that these five women seemed unable to envision themselves as agentic in their own lives. Through experiences of abuse and victimization, women may learn that they are objects acted upon by others rather than subjects capable of effecting change in their lives. This can constrain and limit the options women perceive to be possible for their lives; they have a difficult time

envisioning themselves successful at identities other than “addict” or “criminal.”

Whereas the women in the group described previously were able to ask for and receive help with health problems and addiction issues before they became too problematic or overwhelming, when the women in this group experienced setbacks or challenges during reentry, there was limited-to-no effort to handle such issues before they became all-encompassing. For example, when Renee became frustrated at not finding work, she started to use heroin. Once she started using drugs again, she began stealing purses from Macy’s Department Store to support her drug habit which ultimately resulted in her return to prison. While relapse is common, none of the women in this group were able to manage relapse in a way that did not result in drawing the attention of law enforcement and their return to prison.

Another defining characteristic of this group was the severity of the mental and physical illnesses the women battled; one woman from this group died of cancer before the final wave of interviews could be completed. The five women had prolific mental and physical health problems that made day-to-day functioning difficult and without proper treatment, it often did not take long for them to end up in prison again. Sunny was released from prison into treatment without her antipsychotic medication; within a matter of days she began hallucinating. She left treatment and hid from law enforcement at her dad’s house for a week before going to the hospital to get her much-needed medication.

Sunny said:

The day after Christmas I went and turned myself into the hospital cause I needed that shot [her antipsychotic medication]. I knew I needed that shot. My dad knew I needed that shot. So I went and got my shot in the hospital and they wrote prescription for all my meds, switched a bunch of meds up and then sent me on my way. And um, New Year's day, I got out the day before New Year's and New Year's Day I consumed an extra amount of

medication. I didn't OD, I just lost track... They told me to take it four times a day. I was taking it but I think that's where it was too high of a dose. And I kinda lost track (laughs slightly). I wound up eating 37 of them in two days.

Sunny reported that she and her cousin went to a local bar where Sunny passed out. The police were called and Sunny was initially taken to detox but was transported to the hospital after officers realized how much medication she had ingested. After less than two weeks out of prison, Sunny had her supervision revoked and was reincarcerated. It is important to note here that while all women in the subsample struggled with addiction and mental health problems, the nature and severity of Sunny's mental illness make her an outlier in the subsample.

An examination of the women's narratives yields rich insights into several strategies utilized by women in the different groups which will be discussed in the second part of this analysis.

Engaging with Formal Support Systems

One of the differences between the groups that quickly became evident was the degree to which women in each group engaged with formal support systems. As part of the pre-release program at prison, all of the women were provided with opportunities to receive help from social service organizations, though not all women participated in these opportunities. However, the women who utilized these resources were ultimately the ones able to achieve living situations that were stable, if dependent. With considerable help from staff at the correctional facility, various local non-profit organizations, transitional housing centers, churches, and in some instances, attorneys, these eight women were better able to develop and implement a concrete, sequential plan for finding housing, obtaining a steady income, and perhaps most importantly, applying for and receiving

health care coverage than the five women who were not connected with and did not take advantage of such programs.

In the baseline and subsequent interviews, women were asked about their plans for the next six months and where they saw themselves in the near future. It became evident through their responses that these programs helped the women to not only act agentically about setting realistic goals for their release, they were also able to identify the steps necessary to achieve those goals, such as how to apply for a job, how to find housing, and how to manage addiction(s). Unique, a 39-year-old, recounted the support she had received through the pre-release class at the prison:

Yeah, the re-entry class was helpful, um, that's how I got hooked up with you [interviewer], that's how I got hooked up with the re-entry clinic was through [staff name] and I believe without, without my attorney...I wouldn't know half of the information I know. Um, without [staff name], I wouldn't be, I wouldn't know how to get fidelity bondage to get a job. I wouldn't know how to get my tax credit card [a debit card with her tax refund on it], I got that before I left—she gave me that before I left. Um, I wouldn't know felony-friendly jobs or apartments. I wouldn't, I wouldn't know nothing. You know what I'm saying? And I would be just stuck.

For women who were not able to live with their families or to return their own homes after prison, such organizational support proved to be tremendously helpful to women looking for a place to live that was affordable and would accept people convicted of felonies. Prior to her release, 53-year-old Leann worked closely with a caseworker who helped guide her through the process of applying for transitional housing; consequently, Leann did not have to worry about being homeless or violating her parole because she could not find a place to live. Additionally, this type of comprehensive support allowed Leann to experience success with establishing her own reentry plan.

Leann described the support she received from the transitional housing program after her release:

They give us food, and there's community outreach programs that will assist with that. We get general assistance, and we're approved for medical when we're here. I budget myself. I live on a hundred and one dollars a month. And I'm doing it. [Interviewer: That's pretty incredible.] Yeah, thank god we got free housing and they give us laundry soap, and they give us cleaning supplies... And clothing, we get some clothing vouchers here a couple times while you're in the program. You're allowed like 20 dollars each time to go to a couple of their thrift stores that they have where you can buy stuff.

Leann's reentry process over the three-year period of the study was hardly smooth: she lived in a transitional housing center, a homeless shelter, and returned to jail before finally finding her own apartment. Throughout the waves of interviews, although the support she received from staff was still considerable, she gradually assumed a more active role in her own life. Learning to be agentic was a gradual and stepwise process, but by the end of the study, she was living in her own subsidized apartment and paying one-third of the rent from her Social Security check. Leann was making sure her health problems were being appropriately addressed by following up with her doctor appointments and taking her medications as prescribed. And arguably most importantly, Leann seemed to be much happier. She reported that her relationships with her children had improved and that she enjoyed spending time with her friend, Serena (another woman from the study), going to yard sales, or watching television.

Serena, 49, was Leann's friend and also participated in the same housing program as Leann. In the baseline interview, Serena reported that she experienced a number of disempowering events during her childhood, including being sexually abused by her brother as a young girl, and could not remember a time in her life when she had not felt

depressed or “bad about herself.” She explained that she had had difficulty making friends as a child and never felt like she fit in with her peers. As an adult she began drinking to cope with her depression. Her struggles with mental illness were compounded by a traumatic brain injury she received in a car accident; consequently, she is unable to work. Prior to her release from prison, Serena seemed very timid and expressed concern about not having a place to live when she was out of prison. She was released into a transitional housing program where women were typically allowed to reside for up to four months. Yet despite this official policy, Serena applied for 30-day extensions and was permitted to live at that facility for almost two years before she was finally accepted into a housing program for people who were formerly incarcerated. The last interview was held in Serena’s new apartment; she was bedridden because she was suffering from the side effects of a powerful drug she was taking to treat her Hepatitis C. For her, the comprehensive support and services she received through the housing program were invaluable:

I mean it's a miracle. I don't know what I would have done. Everybody is having problems... [Interviewer: So they somehow bypass the felony rule at the apartment places?] Well they kind of talk to the landlord with you. Mine did anyway, telling them my situation, and that, you know that I do have a felony, but they will pay, they pay two-thirds of your rent. And they come over every week, and talk about, I got a schedule they give me, 'cause I had a brain injury and you know, I forget everything. So they help me with that. They help you with appointments, take you to appointments, pick up your meds for you. I mean if you're really bad off, they'll give you some gas on a card. Once in a while a Walmart card. It's just a super nice program... Ohhh, it's a good program. And you go to groups [counseling and support groups] over there maybe once a month. And they have been really good too. Like dealing with, they had people from [town] come in and speak. So it's really good. The more I talk about it, the more I realize, oh god, I'm so lucky to have that program.

Conversely, women who were not connected to formal support systems described post-release plans that were vague and abstract. For example, when asked about her post-release plans, Renee said:

I know I'll see my older two kids and my grandkid. I know I'll have a job somewhere. And I know I'll be doing [Alcoholics Anonymous and Narcotics Anonymous] meetings. And I don't know how soon this will happen, but after I worked on myself for a while and got myself straightened out, I eventually want to do something to help other people like me. I don't know how I'm gonna do that, but it's gonna happen.

It was not that the five women were not thinking about the future or were unaware that they would need to find housing or employment, but rather they seemed unable to prioritize and concretize, or even identify, the steps necessary to accomplish these goals. Renee's statement above, "I don't know how I'm gonna do that, but it's gonna happen," is a great example of this less concrete approach to reentry plans that was more often espoused by women in the unstable and chaotic group. What is striking is the difference in levels of agency expressed in the narratives of the women in the two different groups; women who did not receive much post-release support also did not seem to exhibit a strong sense of self-efficacy. When describing where she was going to live after her release from prison and where she thought her life would be in a year, Wendy, a 23-year-old woman living with HIV, replied:

I wanna go home and live with my dad. And I don't know what's going on with him...So I have to have a solid release plan. And the only thing I know solid is Minneapolis. So I guess I'm going back to the cities and that's pretty much it...I'm hoping I'll be in college...And I hope I'll have at least a minimum wage paying job, and be clean, maybe living on my own finally. My own apartment and shit, you know.

But when asked by the interviewer if she had begun any pre-release planning in prison, Wendy answered, "There's nothing I can do here to start it. All I can do is try to

think about it and try to keep it in my head, and do what's right." Like Renee, her response indicates a detached and disempowered approach to the process of reentry.

In addition to housing concerns, many women leave prison with few, if any, financial and material resources. Prior research has consistently shown that incarcerated women typically have limited education, job skills, or training (Richie 2001) and poor-to-nonexistent work histories (The Sentencing Project 2007). To further complicate an already problematic situation, the thirteen women in this subsample were all limited to some degree by physical and mental health problems that interfered with their day-to-day lives. Of the eight women who were able to achieve stable but dependent living situations, three of them were approved for Social Security disability by the end of the study. However, it is important to note that all three women had to have professional assistance navigating the application process. Serena explained how overwhelming the process can be:

I just got approved for social security, and that was just like, wow. I had, um, for three, since my accident I've applied three times and they denied me every time. So, I thought, I'm not gonna deal with this anymore. So much paperwork. My memory is horrible. I just can't do it again... The computers went down, my lawyer was here, I was right in there, and my lawyer came, my lawyer came in and said the computers are down, they don't know what time they're gettin' in. And my lawyer said, well maybe we should wait it out and see when they come back in. And the judge went out for a minute and she came back in, she says, "I'm gonna approve Serena, and we're just gonna do that as it is, I'm gonna approve her." And that's it. That's all I had to do. I didn't have to go up in that, I thought they were gonna, cause they had it all set up in there with the chairs where they were gonna fire questions at you. And I was like, oh god, I was so worried about that.

Serena explained that she had tried three times previously and was ready to give up. Her statement, "My memory is horrible. I just can't do it again" indicates how stressful and overwhelming some of these processes can feel to people who have not

experienced much power and agency in their lives: if she had not received legal counsel, she may not have been approved for Social Security disability. This would have been especially problematic for Serena because the medical treatments necessitated by her health conditions require that she have health insurance to avoid disruptions in care.

Perhaps one of the greatest advantages of social services organizations and other agency support systems is their ability to provide a wide array of comprehensive services, namely health care, housing, employment, and addiction services, to women during their reentry experience. The thirteen women in this subset had all struggled for years with substance abuse problems, physical health problems, and mental illness. Unfortunately, many of their families were not equipped to absorb the level of care their loved ones needed. Throughout the waves of interviews, it became increasingly apparent that women who were released into structured environments, like transitional housing and treatment facilities, achieved higher degrees of success than women who were released into structure-less environments. During the last interview Unique, who was living in an apartment with a roommate, reflected upon what she found helpful about the transitional housing program where she lived immediately upon her release from prison:

Now, no, you gotta be in that bed by midnight, you gotta be in your house by midnight, um, there's house chores, there's mandatory house meetings, um...you have to go to group, you cannot use, um, they can breathalyze you and UA you any given moment, they don't care what time of night it is, your company have to be signed in, they also can be breathalyzed. They also can be breathalyzed and UA...They have to have identification, um. It's very structured. [Interviewer: And that helps?] Yeah.

In the interview following her release from prison, Michelle, a 42-year-old, explained that the transitional housing program she was in helped to keep her from feeling overwhelmed:

It's this program right now is really helping me a lot, um...this keeping me structured, trying to keep me focused, because when I first came out, I was so overwhelmed with so many things that I had going on that I was like, trying to get everything done in one day. And here they help keep you focused on, you can only do one thing at a time.

At this particular housing program, women were not allowed to look for work within the first month as the center recognized that women often benefit from time to acclimate to life outside of prison. This incremental approach to reentry can help women from becoming overwhelmed, a feeling often identified by respondents as a trigger for relapse. For example, when asked what she anticipated her biggest challenge during reentry to be, Serena responded:

Getting frustrated... Frustrated with, um, you say, I go into a halfway house and I gotta find a job and I can't find one. And I can't remember very much so I have to write everything down. And I'm worried that's gonna get overwhelming. I do, I worry I'm not strong enough, confident enough. You know I think I could stay sober for a while. I proved it, I've been out of prison before. I can stay stopped, but if I start again, I can't. I can't stop on my own then.

The women in this subset who were released to live with their families did not fare as well as women who were released into structured environments. Despite the fact that their families were often supportive, families were simply unable to provide the type of structure and care the women needed. Macy, a 41-year-old, was released to her mother's house. Although Macy's mother had a very stable life—she had worked at the same job for almost twenty years and did not have any addiction issues of her own—Macy's ongoing struggles with physical illness and substance abuse were too much for her mother to adequately address. While living at her mother's house, Macy did not get a job or attend any programming. She linked her homebound lifestyle to the condition of her health, her severe depression, and her concern having more of a social life might lead

to relapse. During one of the interviews, Macy was literally bedridden while recovering from surgery meant to address complications from her diabetes. When asked what her typical day was like, Macy said, “Well, right now, it’s this.” indicating that because of her health, her daily routine consisted of being home alone, staying in bed, watching television, or sleeping. She ultimately began using drugs and drinking again and was sent back to prison. Sunny, another woman from the study, had a similar experience when she was released to her dad’s house. When asked what her life was like while living there, she responded, “I didn't have *no* organization [original emphasis]. Just, I was just out there.”

Another difference between the eight women who achieved stable but dependent living situations and the five women whose living situations were unstable and chaotic were their perceptions of staff, especially parole officers, as allies or adversaries. Women in the former group generally had positive relationships with their parole officer and case managers. In fact, it was not uncommon for women to describe their parole officer as “cool” and “willing to work me” and to consider them as a resource for help. When asked what she thought of her parole officer, Unique told the interviewer:

He's cool. He's very supportive. I can call him and talk to him about anything too. You know, and he, he, he uh...he, he urges us to call him and talk to him, you know. Don't nobody else answer the phone, call me, I'll call you back, you know what I'm saying, and if you have any problems, you need to vent, whatever, whatever, anything to keep you from reoffending, reoffending or violating, you know, he's there, he's good.

In the third round of interviews, Unique reported that she was off parole but planned to maintain a relationship with her former parole officer:

He called me the day before I got off parole, at 8:20 in the morning. I answered my phone, he said “[name]?” I said, “Yeah?” He said, “You off parole, my girl! [Laughs] He said, “You made it.” He said, “I knew you was [going to make it.]” But I can call on him anytime. He's gonna give me a referral to Bridging to get me some furniture when I move. I can call him for anything. He's like, “I'll still be your PO, just not on paper. Anything you need, call me; you wanna vent, call me, leave it on my answering machine, I'll call you back.” So I call him all the time just to let him know that I'm still doing good.

Some of the women found case managers and other staff to also be valuable sources of support. In the second wave of interviews, Leann describes the support she receives from her case manager:

And [name], she's just, I mean she's always there. We have meetings, one-on-ones, anytime we knock on her door. If she's not at Shakopee, she's here and available always, for anything... She came from here to [name of prison], and I talked with her there for like ten months there before I got out. [Interviewer: So you talked with her, was it...?] A case plan, set up a case plan. [Interviewer: Like, monthly or...?] Weekly, she goes out to [name of prison] on Mondays and Wednesdays. I used to talk to her every Wednesday.

When asked about her experiences in the transitional housing facility where she was residing, Unique echoed similar sentiments:

I go to groups, I go to Black Women in Recovery. I have three case managers, I go to meetings, NA [Narcotics Anonymous] meetings. Um, it's a lot of support here. A whole lot of support. I mean basically, I can walk into this building and talk to anyone in this building. It don't matter who it is. Any staff member in this building I can talk to and they don't look at me as being an addict or, nor anything. They just look at me as being [name], you know? So it's a lot of support here.

Identity theorists assert that the self is a collection of identities acquired and constructed through socialization. Beginning in childhood, people begin to learn the social scripts associated with different roles and as they mature, they look for feedback from others to either invalidate or reinforce that identity. Eventually the identities that are invalidated by others will dissipate while the ones that are reinforced by others will

become more central to a person's sense of self. For women who had not had an opportunity to achieve success at many other identities beyond 'addict' or 'felon', simply having someone who believed in their ability to succeed during the reentry process allowed the women to see themselves as successful too, providing them with validation of a positive picture of themselves. As Leann said, "But [name of staff] believed in me too. It makes a big difference. It's really important that somebody recognizes and believes in you."

These descriptions of staff as sources of support are in stark contrast to how most of the five women in the other group perceived their parole agents: several respondents felt their parole officers were too strict or looking for reasons to violate the conditions of their (the women's) paroles. Opsal (2009) reports that women in her study felt that parole was not so much a resource to help them during their reentry process as it was a way for the DOC (Department of Corrections) to monitor their actions any time of the day or night. Women explained that this surveillance produced feelings of anxiety, fear, and stress. Consistent with these findings, Macy was eager to be off supervision because she felt like her every action was being monitored:

You know, I'll be able to do whatever I wanna do without worrying about someone watching me. 'Cause they, right now, I am, am on restricted, like a restricted life right now. But I know at a point I will be able to do what I wanna do without having to contact someone to say, "Is this okay if I do this?"

Two of the women in this group of five explained that they had violated parole because they did not see the conditions of their supervision as possible or reasonable for their situation. Valerie applied for an interstate compact to Kansas because she wanted to

be near her family during her illness. After being denied, Valerie hitchhiked and was rearrested while living under a bridge in Kansas after three weeks. Although her fleeing the state caused disruptions in her medical care and violated the conditions of her parole, Valerie desperately wanted to be near her family during her battle with cancer. (However, once she arrived in Kansas, her mom refused to see her because Valerie was technically a fugitive of the law.) Macy missed an appointment with her parole officer because her sister was hospitalized in a coma. Despite Macy having called to inform her parole officer that she was not going to make the appointment, a warrant was issued for her arrest. In her last interview, Macy reported that her sister had died, but because of her incarceration, Macy had been unable to attend the funeral, causing her to struggle with feelings of grief and guilt. Finally, some women felt that their parole agents were unwilling to work with them. Wendy recounted that when she attempted to go to her parole officer for help with her addiction, he threw her back in jail:

I got out, on parole from the work house, and I was out for a day. And I called my parole officer and I told him that I relapsed, and he locked me back up...I had relapsed. I fell off the wagon. Pshhhh, right out the door of the workhouse, I lit the pipe up. And I called him right away, and I said, "Look man, I'm getting high, I need help." And he said, "You violated. You're going back." There was my help. You're going to jail.

All five women in this group reported years-long struggles with addiction as well as having been incarcerated previously (one respondent had been in prison six times as an adult) and consequently, had not had much, if any, experience successfully developing alternative identities. This made it difficult for women to envision themselves as agentic actors in their own reentry experience. However, all five women had had considerable success cultivating identities as 'felon' or 'addict' and, consistent with identity theory,

felt comfortable enacting those roles. When asked if she thought she was an addict, Wendy responded, “Oh yeah! Hell yeah! Like, fuckin’, that’s one thing I’m good at!”

(Re)Establishing Informal Support Networks

Although formal support systems were best at providing comprehensive services, informal support networks were important to women too. Covington (1998) and others have argued women are socialized to develop a sense of identity through their relational networks, that women are motivated to build meaningful connections with people in their lives. When asked if she could identify a critical resource that helped contribute to her success, Peggy, a 42-year-old mother of four biological children and six stepchildren answered:

The main thing that has helped me be at where I’m at right now, which is I’m content, I’m happy this way, is that I still have my family. That is the number one thing. I think I would be—like I said, it’s, it’s, (laughing)...I’m wired that way. If I wouldn’t have this, I’d be lost... So first thing is my children, and the second thing definitely would be the support that my husband gives me. Definitely.

Most of the eight women who achieved stable but dependent living arrangements either reported improvements in their relationships with their children or that they had always been close to their children. It is important to note that none of the women in either group were responsible for parenting minor children when they were released from prison: one respondent did not have children, some had lost custody or had children who were being raised by family or friends, while several women had children who were legally adults and not residing at home.

Another important difference between the two groups of women was the degree to which they were able to develop or expand upon new and positive identities and more importantly, have those new identities validated by others. All of the women who had

achieved stable living situations were able to establish and cultivate relationships with friends, family, and employers. Serena told the interviewer that she would babysit other women's children when she living at the transitional housing facility, "I loved the kids. They'd give me a headache sometimes, but more than not, I loved 'em and tried to treat 'em with the respect they needed after going through what they were going through."

Whitney was able to go back to work for a former employer after she was released from prison. She explained, "And he's happy I'm back. I'm the number one salesperson and I make him a lot of money." Barbara experienced validation as an employee when, after volunteering for several months with a transitional housing center, she was hired for a part-time paid position within the organization. As women were able to experience successes practicing healthy identities, the more familiar those roles became and women were able to develop a sense of agency in their own lives; over the course of the study, identities like "drug addict" and "convicted felon" became less central to their conception of self.

Unfortunately several of the women in the group whose reentry experiences had been unstable and chaotic were too ill, either physically or mentally, to hold down employment or, in one case, even leave the house. Thus, there were fewer opportunities for these women to cultivate any identity except "patient" or "parolee." Additionally, the interactions women had as clients in the troubled persons industry continued to reaffirm these identities (Loseke 2003). Valerie explained why she started using drugs again:

I think that's one of the main reasons why I got high too, is because I was lonely... And because, it seemed like the whole—my, my whole life consisted of going to the doctor, of one form or another, my internal—internalist, either my hepatitis doctor, or my regular doctor for my blood, or my therapist, or my psychiatrist, or whatever, it seemed like that's all my life consisted of... was going to these medical and professional visits

and I had no... no real life. You know, that's all there was, all, my whole life centered around medical, being sick and going to medical appointments... And then the professional people that I did have in my life, I just went to them saying the same thing over and over again. You know, cause I'd see my therapist, I'd tell her how I felt, then I'd see my psychiatrist and I'd have to repeat the same over, then I would go to my doctor and they would want to know how I'm feeling, so I'd repeat it all over again. It just got old... See, I had a lot of good support system, like I had my therapist and my ARMHS [Adult Rehabilitative Mental Health Services] worker and all of those people in my life, but that's still not the same as having friends.

Although formal support agencies were better able to meet the financial and material needs of women during reentry, they were not as capable of providing emotional support as informal networks of friends and family.

Managing Relapse

Prior research has shown that women who have battled substance abuse addiction identify fear of relapse as a primary concern (Hunter and Greer 2011). Though this was true for most women in this subsample, their narratives reveal that women in each of the two groups utilized different strategies to manage relapse. Among the eight women whose reentry experiences were stable and dependent, three reported that they had not relapsed at all, three women were able to use drugs or alcohol in moderation, thereby altering the traditional definition of an addict, and two women relapsed but were able to stop using again with the help of agency support.

Tiffany, a 40-year-old, reported that she had been smoking marijuana since she was 18 years old. She saw marijuana as medicinal. As soon as she was off of probation, Tiffany said she stopped taking her prescription medications for insomnia and anxiety:

And weed's not that, you know, to me weed is like an anti-depressant to me, it's like a pain reliever for me... So, but yeah, that's kinda the reason why I executed [her whole sentence rather than being on parole]: so I

could smoke my weed and not have to worry about UAs and- cause I really don't care about drinking but I love my weed.

Michelle reported that she had had two glasses of wine with Christmas dinner but did not consider it a relapse because she had been able to successfully moderate her own drinking, stopping before she suffered any negative consequences. Although traditional 12-step programs define sobriety as all-or-nothing, both women modified parts of this definition to fit within their understanding of their own experiences.

Leann's experiences with relapse are perhaps the most informative when considering policy implications for parole and probation. Leann describes how, after an extended period of abstinence, she spent her Social Security check at the casino and started drinking. Fortunately, she was able to tell both her doctor and her caseworker from a transitional housing program where she was living. She describes the response of the caseworker:

And that's like being with [name of housing program] too. They don't care, I mean they care, but they, if you need help, if you want to go to treatment, (they ask you) do you need a Rule 25? They ask you if you think you can come out of this, you know without, with just your social support network. But if you need further help, we'll help you. They're willing to do that. [Interviewer: So how *did* they respond?] They just, you know, we went to meetings. I stepped up my meetings a little bit, you know, AA does work. I stepped up my meetings a little bit, and got out of my house. And made a budget plan with them for my money and got a rep payee. So, now I got a rep payee...Representative Payee. They handle your money for you. They give you so much. So now, they'll take my rent out, and they'll take my utilities out, and then they'll give me \$80 for the week. So then tomorrow I'll get 80 dollars, and that's for me to live on, and get a few groceries, 'cause I don't get food stamps anymore. Sixteen dollars a month is all, and that's not very much. So it's really, it's really a good program, they really help you a lot.

The agency worked with Leann to help her get sober again; they did not make her feel judged or like they were shaming her for her addiction. It took Leann some time to

get her financial situation back on track but she did not end up back in prison as a result of her drinking.

For the five women in the other group, there was no successful management of relapse. In fact, women in this group all relapsed in such a way that drew the attention of law enforcement and resulted in their reincarceration. As previously stated, Sunny's mental illness interfered with her ability to keep track of the number of pills she'd consumed, eventually passing out at the local bar 14 days after her release. After she was monitored at the hospital for signs of an overdose, she had her supervision revoked and was sent back to prison. Renee reported that she starting using drugs again to cope with the frustration of not being able to find a job and how her use resulted in her reincarceration:

Yeah. So I started getting high right after, a couple days after Christmas...Just kept doing it. [Voice over intercom in background] Kept stealing and once I started getting high, I knew som- I knew I was going to end up back here [in prison] cause I knew the whole time, when I first started doing it I was going to end up back in prison, cause it's happened before, you know?

Consistent with previous research done on the addict identity (Hunter and Greer 2011), Renee believed that if she relapsed at all, she would inevitably end up back in prison. While for some people this absolute, all-or-nothing thinking may act as a deterrent, for people like Renee, who believed that her return to prison was inevitable if she relapsed, there is little reason to try to moderate or manage episodes of drinking or drug use.

DISCUSSION

Incarcerated women frequently report very troubling pasts; biographies marked by violence, addiction, and mental illness are the rule rather than the exception among

women in prison. Consistent with extant literature about the lives of incarcerated women, the thirteen respondents in this subsample reported extensive histories of physical and sexual abuse (often beginning early in childhood and extreme in nature), addiction to drugs and/or alcohol, mental illness, and physical health problems. While these results are not surprising, what is distinct about the subsample of women in this study is the degree to which their lives have been impacted by the compounding and often-debilitating effects of the recursive relationship between trauma, substance abuse, and physical and mental illness(es).

All of the respondents described the various ways that the co-occurrence of these multiple and overlapping vulnerabilities had facilitated their involvement with the criminal justice system and had also resulted in additional obstacles during their reentry. In their interviews women were able to articulate how experiences of trauma (usually suffered at the hands of loved ones) were directly linked to their subsequent addictions and mental health problems: many had turned to drugs and alcohol to anesthetize themselves to the feelings of pain and powerlessness they felt in these abusive relationships. Substance abuse not only intensified existing mental illness(es) but also resulted in behaviors that jeopardized women's physical health, such as sharing used needles for intravenous drug use or having unprotected sex with multiple partners. When women's health problems interfered with their daily activities, including their ability to even leave their house, women were provided with few, if any, opportunities to develop identities based on healthy, law-abiding behaviors such as working or volunteering. This, in turn, further contributed to existing feelings of depression and powerlessness. Though all thirteen woman had many biographical similarities with regard to histories of abuse,

addiction, and mental and physical illness, an examination of their narratives revealed considerable differences in the stability in their living situations after their release from prison. Because of the longitudinal and qualitative design of the study, I was able to analyze their interviews over three years and to understand, from the women's perspectives, what strategies they used to navigate their reentry process. The principal theme of my analysis focuses on the ways the intersectionality of all four overlapping vulnerability affects women's reentry experiences.

An examination of the women's narratives revealed that their experiences with reentry fell into one of two groups: by the end of the study, eight women had achieved stable but dependent living situations while five women's experiences with reentry were unstable and chaotic. (Please see Appendix A.) By the end of the study, women in the former group were appropriately addressing their physical and mental health problems (attending doctor appointments, participating in therapy groups, and taking medication as prescribed) and had all found housing, obtained income, and received help with tasks like budgeting their money, paying their bills, and obtaining resources. Most importantly, they were able to gradually assume varying degrees of agency in their own lives, albeit with extensive and sometimes long-lasting and comprehensive help from social support agencies.

These experiences are markedly different from the experiences of the five women whose living situations remained unstable and chaotic through the duration of the study. The women in this group were unable to assume agency in their lives because of debilitating mental and physical health problems that not only made it difficult to accomplish simple, day-to-day tasks but also contributed to their drug and alcohol use. In

the third wave of interviews, Valerie was back in prison for violating her parole. She reported that when she had been diagnosed with cancer, she started using drugs again because she was scared of dying and was overwhelmed by the enormity of her physical health problems. Sunny was rearrested and sent back to prison for a parole violation when she was found, passed out, at a local bar by law enforcement. She told the interviewer that she had been released without the medication necessary to treat her schizoaffective disorder and she started hallucinating within a week. Due to the severity of her mental illness, Sunny is unable to function without her medication, making tasks like getting a job and finding housing impossible.

One of the most striking, and immediately apparent, differences between the two groups of women was the degree to which they were engaged with formal support systems, such as transitional housing centers and social services agencies. Although the prison provided all women with opportunities to participate in such programs prior to release, not all did. (It is worth mentioning here that the women who did not engage with and were not connected to these programs were not being willfully defiant; rather, the women did not see the goals that DOC had set for them as possible or congruent with what the women wanted for themselves.)

However, the eight women who were connected into formal networks of support were better able to develop and implement concrete plans for their future. With considerable help from staff, these eight women were able to find housing, secure some type of steady income, and obtain health coverage. While these are important reentry milestones for anybody, for a person battling the effects of mental and physical health

problems, previous trauma, and addiction issues, ensuring that these resources are in place prior to release is vital.

Formal support agencies were better able than informal support networks to absorb the incredible level of need these women had. When women were released into halfway houses or treatment centers, they reported benefiting from the structured environment such facilities were able to provide. Michelle, Serena, and Unique all identified that feeling overwhelmed was a trigger for relapse: being eased into reentry helped to alleviate anxiety and stress, decreasing their likelihood that they would relapse. When women had problems, they were encouraged to talk to staff who would help them reestablish control over their lives. Sometimes this included help budgeting money, obtaining resources, or helping women after they relapsed. Serena, Barbara, and Leanna all recounted that they had worked with staff extensively to construct a post-release plan, and in all three instances, planning for release began months prior to their actual release date. Women were included in and guided through the case-planning process by staff with the expectation that the women would increasingly and gradually begin to assume control over their reentry plan. This approach is known as scaffolding and was utilized by one of the transitional housing centers mentioned by several of the women in the study:

Scaffolding situations are those in which the learner gets assistance or support to perform a task beyond his or her own reach if pursued independently when "unassisted"... Once the learner has a grasp of the target skill, the master reduces (or fades) his participation, providing only limited hints, refinements, and feedback to the learner, who practices successively approximating smooth execution of the whole skill (Pea 2004: 431).

As women experienced success with setting and achieving goals, they were able to develop a sense of self-efficacy and become agentic actors in their own lives.

Another difference between the two groups of women in this subset was the opportunities they had to build upon positive social identities and to have those identities validated by others. Identity theorists argue that through socialization, we begin to develop a sense of who we are based on our interactions with others (Turner 1978). For many of the woman in this study, identities like “addict” or “felon” had become primary to their conception of self; for the five women who did not achieve stability in their living situations, they were not immersed into any new networks that could provide an alternative role, like church, school, or the workforce.

Conversely, the identities with which we do not experience success, or those not validated by others, are the ones that become less central to our identity, the ones that atrophy, so to speak. For women in the study who were able to find employment or reestablish healthy relationships with loved ones, the primacy of negative identities (“felon” or “addict”) gave way to new, positive identities like “employee” or “friend” as these roles were validated by others.

The two groups differed in their perceptions of parole officers as allies or adversaries. It is interesting and worth mentioning that of the eight women who had achieved varying degrees of stability by the end of the study, five of them had “executed their sentences,” (they had served their full sentence in prison or jail rather than be on parole) because they knew they would not be able to comply with the terms of their supervision, specifically random tests for drug or alcohol use. However, most of the women cited positive relationships with their parole officers and various staff members. Unique said that her parole officer told her after she was off parole that he had known she was going to be successful, providing her with a positive image of herself.

While it is true structured environments offer many benefits to women attempting to negotiate reentry while juggling multiple and overlapping vulnerabilities (chronic health problems, mental illness, history of trauma, and substance abuse histories), there are some women who present with such high need that it is difficult to imagine an effective solution other than institutionalization. Sunny was one such example and may be representative of a very small percentage of the larger prison population. Short of complete institutionalization, her mental health problems, complicated by her problems with addiction, made it difficult to envision a solution that would be appropriate for the magnitude of difficulties she faced.

These findings have profound implications for departments of corrections. While all women in prison could benefit from gender-responsive, trauma-informed programming, a small population of incarcerated women may need more long-term and ongoing comprehensive support upon release. Additionally, women may benefit from a shift in response to relapse from one of abstinence-only to one of harm-reduction—that is, teaching women how to minimize the severity a relapse. These findings also suggest that need for more transitional housing facilities and halfway houses as they are better able to provide structured environments and centralized services for women as they reintegrate into their communities. Utilizing an approach known as scaffolding, these formal systems of support help women address their mental and physical health needs, including therapy to work through previous trauma, obtain resources, and manage relapse. When women had these needs met, they were able to focus on developing other, pro-social identities.

Appendix A: Multiple and Overlapping Vulnerabilities

Table 1. Stable but Dependent

Respondent	Mental Health Problems	Physical Health Problems	Substance Abuse History	Past Trauma
Barbara	Bipolar disorder, anxiety	Had both knees replaced	Crack-cocaine; marijuana; alcohol	Described a "strict" Southern upbringing
Leann	Anxiety; depression; OCD (Obsessive Compulsive Disorder; and PTSD	Hepatitis C; cancer 3 times (double mastectomy); back problems; chronic asthma and emphysema; high blood pressure and high cholesterol	Cocaine (shooting, smoking, or snorting it); prescription medications (Ativan, Xanax); alcohol;	Dad was an alcoholic; mom was emotionally abusive and "cold."
Michelle	PTSD; anxiety; bipolar disorder; ADHD (attention deficit hyperactivity disorder)	Periodontal disease; Hepatitis C;	Acid; mushrooms; marijuana; LSD; Angel dust; heroin; cocaine; meth	Sexually abused by stepdad and his friend from age 5-12; was "tortured" by her boyfriend from age 17-22; abusive relationships with boyfriends as an adult
Peggy	Anxiety and depression	Arthritis; degenerative disk disease	Crack cocaine	Raised in a gang-related family; lots of transience in her youth
Serena	Anxiety and depression	TBI (Traumatic Brain Injury); Hepatitis C; sepsis and other acute infections	Cocaine; alcohol; meth	Sexually molested as a child by her brother; dad was an alcoholic; very abusive marriage
Tiffany	Anxiety and depression	Knee and back problems; hysterectomy	Alcohol	Lived in foster care because of abuse from her stepdad; involved in mutually abusive relationships as an adult
Unique	PTSD; anxiety; depression; bipolar disorder	Gynecological and breast health problems	Heroin; crack; alcohol; marijuana	Emotionally abusive mom, involved in an abusive relationship, mom was an alcoholic

Whitney	Anxiety; bipolar disorder; anorexia	Anorexia, asthma, breast health problems	Meth; marijuana; alcohol	Childhood sex abuse by cousin
Table 2. Unstable and Chaotic				
Respondent	Mental Health Problems	Physical Health Problems	Substance Abuse History	Past Trauma
Macy	Depression	Had to have several surgeries because of complications from diabetes, like edema and cellulitis	Alcohol	Alcoholic parents; dad was emotionally and physically abusive; sister was killed in an accident when she was a teen
Renee	Depression; schizophrenia; anxiety	Had to have a blood transfusion after miscarrying in prison	Heroin and alcohol	Sexually molested at a Catholic elementary school; was beaten and trafficked by a pimp as a teen
Sunny	Schizoaffective disorder; depression;	Hospitalization after drug overdose	Prescription pills; alcohol	Childhood abuse by cousin and grandma; very abusive relationships with men as an adult
Valerie	Anxiety; depression; has experienced psychotic breaks	Cancer; hepatitis C; episodes of staph infection	Meth	Raped and impregnated by stepdad at age 13; baby died during childbirth physical, mental, and sexual abuse by boyfriends throughout adulthood
Wendy	Depression	HIV	Crack cocaine	Mom had substance abuse problems; Dad was neglectful; both parents were physically abusive; sexually abused by neighbor at age 6; victim of sexy trafficking by boyfriend

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