The management and treatment of female offenders has followed a historical course similar to that of male offenders (see Chapter 1) and in many ways has reflected contemporary attitudes and beliefs about females and their roles in society. Very early beliefs about the causation of criminality, both male and female, involved supernatural explanations, including possession by evil spirits. Subsequent theories focused more on biological or innate characteristics. Lombroso (1911/1968), for example, asserted that inborn tendencies resulted in engagement in criminal behavior and in differences between male and female offenders. Societal responses to such beliefs were reflected in females being incarcerated in the same or similar asylums, almshouses, or custodial institutions as men for purposes of isolation and punishment.

During the late 1800s, societal attitudes concerning offenders began to change once again. Early social reformers and emerging psychological and sociocultural explanations of human behavior heavily influenced this shift in societal thinking. Theorists argued that the behaviors of offenders, especially those of females, were more significantly influenced by social and psychological forces over which individuals had little voluntary control and that efforts should be made to rehabilitate rather than punish.

Because of the pervasive societal belief of the time that men were better suited for productive work outside the home and women were better intended for child care and other household activities and for working cooperatively with other women, the establishment of women’s reformatories and rehabilitation programs became widespread. The emphasis on domesticity was reflected in the architectural...
and program design of the new female institutions that included small cottage-style accommodations with individual rooms and small family-style dining facilities in each cottage. Training programs emphasized household, clerical, and farm skills and the reinforcement of appropriate feminine decorum.

This rehabilitative emphasis with concurrent focus on differential treatment of male and female offenders continued until the 1970s, when societal changes once again created a resurgence of focus and insistence on equality of treatment for incarcerated men and women. This renewed interest in equal correctional treatment was in part a result of the women’s movement of the late 1960s and early 1970s that rekindled interest in women’s issues and societal conditions, including conditions of confinement for women. Women’s and equality advocates began to demand correctional education and training programs beyond traditional domestic, clerical, and farm activities. They demanded programs that would better enable women released from incarceration to enter, compete, and be successful in the modern workplace and be able to provide adequate financial support for themselves and their families.

The renewal of arguments for equal treatment was furthered by litigation over the issue of differential correctional care and programs. *Glover v. Johnson* (1979), a case based on Fourteenth Amendment arguments, was the first of several court actions that resulted in improved conditions of confinement as well as expanded and enhanced programs for female offenders. Other research and litigation have continued to challenge sentencing laws and biases that make women liable for longer prison terms than men with similar offenses and criminal records and that address inequities in availability of correctional programs and services for female offenders (Bershad, 1985; Raeder, 1993; Wikler, 1990).

Current approaches to correctional management and treatment of female offenders have attempted to combine the best elements of both equal and differential treatment approaches to form the basis for a unique, more efficacious, and more productive intervention model. This newly evolving way of developing and implementing systems and programs for female offenders has begun to take several factors into account. These factors include an attempt to identify and understand the demographic and psychosocial descriptors of female offenders in general, a careful assessment of specific offender needs and responses to incarceration, consideration of the social
and vocational environments from which offenders came, and a thorough review of the persons and circumstances to which offenders will return after incarceration. This chapter discusses these and other factors in some detail.

Characteristics of Female Offenders

Demographic Data

Although the number of incarcerated women in the United States remains considerably less than that of incarcerated men, the rate at which women are arrested, convicted, and sentenced to incarceration has increased steadily over the past two decades. Women accounted for only 4.1% of prison populations in 1980. By 1998, that figure had risen to 6.5% (Camp & Camp, 1998; Greenfeld & Snell, 1999). The mean annual increase in female incarceration through the 1980s was 8.3% (Curry, 2001). This trend is likely to continue in view of a 24% increase in female arrests through the mid-1990s compared with a 13% increase in arrests of men during the same period (Curry, 2001). By 1998, more than 950,000 women, or about 1 in every 109 women in the United States, were under some form of correctional supervision. Jails, state prisons, and federal prisons held approximately 15% of that number. Accompanying this steady rise in female imprisonment has been a concomitant interest in the identification of, and attention to, the characteristics, historical experience, and unique needs of female offenders.

Considerable demographic data have been collected on women involved in the criminal justice system. Following is a sampling of the general demographic data that have been found:

Responses to Incarceration

Correctional professionals who have worked with both male and female offenders historically and consistently report significant observable differences between these two populations, including variations in socialization and social learning, expression of
emotion, behavior patterns, perception of interpersonal role, use of institution services
and programs, and general experience of incarceration (Morash, Bynum, & Koons,
1998). This section discusses several of these differences, as observed by this author
and others over the course of their correctional careers.

Perceptions of Confinement. Incarcerated males report several typical consequences
of imprisonment that are most discomforting or debilitating (Sykes, 1958). The loss of
freedom, social rejection, and the loss of status are generally the most troublesome.
[p. 127 ↓] The loss of access to familiar and preferred material goods and services
creates a loss of perceived worth and personal control. Deprivation of heterosexual
relationships with resultant changes in physical, social, and psychological expression
often affects individual perceptions of masculinity and social standing. The imposed
rules and structure of correctional institutions, where all activities are observed,
supervised, or monitored and occur among groups of other offenders, contribute to a
loss of independence and self-direction. This limited sense of autonomy and self-control
is closely related to a loss of sense of security and safety in an environment populated
by others who perceive the same losses, limitations, and frustrations and who might
respond in irrational or violent ways.

In a seminal study of the needs, roles, and behaviors of incarcerated women, Ward
and Kassebaum (1965) found that female offenders experienced similar losses as did
imprisoned males but prioritized these losses differently and reported other unique
deprivations. Of principal importance to female offenders was separation from, and loss
of contact with, family members, especially children, parents, spouses, and lovers. The
enforced absence of contact with intimates and family was reported to be significantly
and negatively experienced throughout the course of incarceration for female offenders.

Females more often perceive imprisonment as a significant and negative change in
their continuing lives. Males instead tend to perceive incarceration as an interruption
after which they will return to and resume their lives. Because women are more
likely to express the need for continuity and attempt to maintain as many of their pre-
incarceration relationships and activities as possible, the impact of separation from
important others, the markedly diminished availability of social and emotional support,
and the relative absence of freedom, personal property, and privacy are typically
significant. Females' adjustment to incarceration, both initially and throughout their
sentences, is often characterized by anxiety, depression, withdrawal, irritability, negative changes in self-perception, and frequent and less predictable loss of emotional and behavioral control.

The second most frequently reported difficulty for female offenders was the constant stress and demands of living in close proximity and contact with other women who shared the same sense of loss and diminished self-concept. Incarcerated women reported significant deprivation as a result of the loss or disruption of social relationships and friendships of a nonsexual nature with both men and women. Persistent difficulty was reported during the entire period of incarceration as a result of the lack of privacy. For women, this included privacy of property, about which women are often very territorial and possessive; privacy of interpersonal space, which is frequently violated both intentionally and unintentionally; and modesty about their bodies and bodily functions and care.

In general, then, it would appear that male offenders are concerned more with issues of control, power, and personal capability and determination during incarceration, while female offenders often are more focused on relationships, support, and social and personal intimacy.

Differential Socialization Experiences. The socialization experiences of women reared in Western societies may help to explain some of these findings. Historically, Western women have been taught to be more cooperative, submissive, nurturing, dependent, and emotionally expressive than men, who are reinforced for more competitive, aggressive, independent, and stoic behaviors (Flynn, 1963). Female preferences to both give and receive support and nurturance can be clearly seen among incarcerated women, who tend to be quite social and group oriented, express interest in and concern for fellow offenders, and demonstrate relatively infrequent other-directed violent behaviors. Female offenders prefer to form or re-create close extended groups that resemble and function much like family units. Tittle (1969) suggested that incarcerated females tend to initiate relatively longstanding principal relationships, while male offenders establish “an overall symbiotic structure.” Although the development and organization of family-like groups may differ across correctional institutions, the delineation of gender roles and functions among female offenders is demonstrated consistently (Heffernan, 1972). Such roles provide avenues for mutual
protection and assistance, and dependable relationships offer affection, care, and respect in an environment noticeably lacking in these characteristics (Sykes, 1978). Incarcerated females frequently engage in physically close behaviors with each other, including touching, hand holding, and hugging. Homosexual relationships among female offenders are typically more open and of longer duration than those among males. Such female relationships are based on the need for social and emotional support and on the need to express and share nurturing behaviors.

Male homosexual relationships, on the other hand, are based more on instrumental gain, power, coercion and control. For male offenders who tend to attempt to remain independent, self-protective, and self-concerned, group affiliation is principally instrumental and based on hierarchies of power and coercion.

Violent behavior demonstrated by male offenders is typically intended to gain or express control. Violent behavior demonstrated by female offenders is more often an expression of perceived loss of control and an effort to regain personal identity and/or maintain survival. Female offenders employ more covert, and often quite sophisticated, means of satisfying personal needs, including social manipulation, seduction, sexuality, and passive-aggressive activities.

**Special Management, Treatment, and Program Considerations**

All incarcerated individuals, whether male or female, have basic needs, and correctional systems must be aware of and attend to these needs. While providing settings for the service of court-imposed sanctions and the protection of society at large, correctional institutions are obliged to provide offenders with medical and mental health care, opportunities for religious expression, access to appropriate legal services, avenues of communication with families, and assistance in planning for release to the community after incarceration—all in an environment that must ensure offender safety and security.

Beyond these basic needs, however, specific offender populations have unique needs based on particular characteristics, including age, sex, history, and personal
abilities. Female offenders, by virtue of physiological characteristics and psychosocial experiences and roles, consistently have specific and unique needs within the correctional environment. To the extent that these needs directly or indirectly affect the delivery of correctional mental health services, they are discussed here.

Use of Health and Mental Health Services

Women in Western cultures in general are more frequent and consistent consumers of medical and behavioral health care. It is often noted that a majority of patients in community medical and mental health settings are females who report illnesses, seek medical attention, and are prescribed medicines more frequently than are males. Not surprisingly, female correctional institutions experience higher rates of use of medical and dental care (on both scheduled and as-needed bases) and more frequent repeat clinic and practitioner visits than do male institutions. Similarly, the demand for and participation in mental health and religious services and programs are consistently higher among female offenders than among their male counterparts. This difference in the use of medical and mental health services might be related to a generally held belief among female offenders and correctional staff that because of inherently diminished personal capabilities or female dependency, women require more care and assistance than do men. Other possible influences might include cultural conditioning, which allows females to express emotion, apprehension, and pain and to seek assistance more quickly and frequently than do males (Ditton, 1999).

Obstetric and Gynecological Needs

In addition to the more frequent use of general medical and mental health services, female offenders have other needs for specialized care. Estimates are that 1 in 20, or even as many as 1 in 12, female offenders are pregnant at the times of their incarceration (Curry, 2001; Kauffman, 2001). Because a significant number of these women have received little or no prenatal care prior to incarceration, there are obvious increases in needs for prenatal, at-risk pregnancy, obstetric, and postnatal care.
Related needs include medical and psychological counseling and care involving safe sex, reproductive choice, miscarriage and abortion, and family planning.

Gynecological care of both a routine and a nonroutine nature is frequently requested. Preventive examination and postpartum and post-surgical follow-up treatment are provided regularly. Nonroutine care for anatomical and physiological abnormalities and infections, often related to sexual abuse, drug use and addiction, and lack of prior preventive health care, is commonly required. As is true among nonincarcerated women, the increasing rates of breast, lung, and colon cancer and coronary artery disease are of considerable concern for incarcerated women and correctional health care professionals.

In large measure as a result of pre-incarceration high-risk behaviors, such as prostitution and drug abuse, and limited economic resources, imprisoned women also have higher rates of infection with tuberculosis, hepatitis, HIV, and sexually transmitted diseases than do imprisoned males and nonincarcerated females (Campbell, 1993). Of course, the presence of such diseases results in a higher need for institutional preventive medical procedures and lifestyle education as well as extended individual patient care.

Dietary and Nutritional Needs

Another medically related issue of concern for incarcerated women is the difference in female nutritional needs. Incarcerated women are often provided diets similar or identical to those prepared for male offenders. The levels of carbohydrates, fats, and sodium, as well as frequently limited nutrition options, in many prison diets are typically planned for the more physically active male lifestyle. DeBell (2001) found that female offenders imprisoned for longer than 18 months reported average weight gains of 20 pounds during their incarceration.

Another nutritional concern involves the actual nutritional intake of many female offenders. Although adequate quantities of food are typically provided in female institutions, many women frequently do not avail themselves of meals or eat very little of those they do take, citing lack of tasteful preparation, aesthetic presentation, and
familiarity with the method of food preparation. Nutritionally inappropriate offerings and self-limited nutritional intake by offenders may often contribute to female health problems, including Type II diabetes, hypertension, obesity, and eating disorders. These and related disorders also contribute significantly to diminished self-esteem and confidence, as well as to increased depression and anxiety, among affected offenders.

Related to diet and nutritional issues among female offenders are increased demands for specialized dermatological, cosmetic, and behavioral and medical weight management interventions. Such requests are associated with women’s increased concern about and attention to their physical appearances that is closely related to levels of self-esteem and confidence. Not only do these medical service needs and requests directly affect correctional medical service resources, they directly and indirectly affect institutional security, mental health, counseling, and commissary resources and operations.

Sleep Disturbance

Sleep disturbances and disorders are quite common among female offenders. During early phases of incarceration, imprisoned women typically report difficulty in falling asleep (i.e., initial insomnia). Frequent awakening throughout the night, also quite common during the initial periods of incarceration, is reported during the entire course of incarceration. Both initial and middle insomnia are also reported to increase during the last few weeks or months of incarceration and are viewed as related to pre-release anticipation and anxiety. Early morning awakening with an inability to return to sleep is more often reported during the middle and latter phases of imprisonment. Such sleep disturbances are most often associated with situational apprehension, diminished subjective sense of security, adjustment difficulties, anxiety or depressive disorders, and drug or medication withdrawal. Women often seek medical assistance for sleep problems, typically via requests for medications, more frequently and earlier in the pattern of disturbed sleep than do men.
Pain and Pain Management

The experience of pain is an important component of medical and mental health practice and has received increased attention over the past decade. Although pain is often related to biological conditions or processes, it is inextricably related to psychological, social, and environmental factors as well. Thus, the experience of pain is best understood as an interaction among physical, psychological, situational, and social influences (Holtzman & Turk, 1986). Physical or biological factors that contribute to the experience of pain include tissue or organ pathology or destruction as a result of disease, physiological malformation or dysfunction, procedural and post-procedural effects, and the efficacy of biochemical processes and responses. A wide range of psychological processes have been noted to affect the interpretation and experience of pain, including cognitive perception (Beecher, 1959; Blitz & Dinnerstein, 1968; Brock & Buss, 1962; Festinger, 1957; Johnson, 1973; Merskey, 1978; Reesor & Craig, 1988; Zimbardo, Cohen, Weisenberg, Dworkin, & Firestone, 1966), locus of control (Davison & Valins, 1969; Weisenberg, 1977), dependency (Sternbach, 1974), self-esteem (Atkinson, 1976; Elton, Stanley, & Burrows, 1978; Engel, 1958; Sternbach, 1974; Timmermans & Sternbach, 1974), and hypochondriasis (Nabilof, Cohen, & Yellin, 1982). Clear relationships among anxiety, situational apprehension, adjustment difficulty, and acute pain have also been reported (Blitz & Dinnerstein, 1968; Bowers, 1968; Glynn, Lloyd, & Folkhard, 1981; Tan, 1982). Depressive disorders are more often implicated in the experience of chronic pain (Barg, Perez, Main, & Bond, 1981; Sternbach, 1975, 1978). The integration of depression and pain is often so pervasive that it is sometimes difficult to determine which represents the principal difficulty.

As noted previously, females experience depressive disorders, situational anxiety, diminished self-esteem, externally focused perception of control, and dependency more often than do males. These factors are exaggerated and exacerbated by incarceration and separation from familiar caregivers and interpersonal support systems. Consequently, the frequency, intensity, and duration of acute and chronic pain are heightened by these additional factors among incarcerated females.
Alcohol and other Substance Abuse Treatment Needs

Just as females have distinct and specific medical, mental health, and social needs, so too are their substance abuse treatment needs different from those of males (Amaro, 1994; Reed, 1994). Although issues in the management and treatment of incarcerated substance abusers have been a historical concern, approaches have traditionally been based on the needs and behaviors of male substance abusers (Blume, 1990; Wilke, 1994). As a result of this gender emphasis, the causative factors, consequences, and treatment needs of substance-abusing females were infrequently investigated until the mid-1970s (Mondonaro, 1989; Roth, 1991; Wells & Jackson, 1992; Woodhouse, 1992).

Since the 1975 passage of Public Law 94–371 and its requirement for the development of specialized treatment services for females, there has been increased attention to women's treatment programs (Wilsnack & Wilsnack, 1990). Research indicates that because of significantly different physiological responses to alcohol, nicotine, and other drugs, women develop harmful health consequences from substance abuse more quickly and with lower consumption levels than do men (Blume, 1990; Nespor, 1990; Reed, 1987; Urbano-Marquez et al., 1995). Women who report infertility or pelvic pain related to menstrual distress have higher rates of substance abuse problems than does the general female population (Blume, 1994; Lex, 1994). Sexual dysfunction and a wide range of menstrual cycle disruptions have been linked to excessive alcohol and nicotine abuse (Beckman, 1994; Blume, 1994; Teoh, Lex, Mendelson, Mello, & Cochin, 1992; Wartenberg, 1994). Abuse of alcohol and nicotine among women has been associated with osteoporosis (Center for Substance Abuse Treatment, 1994; Korsten & Lieber, 1994; Wartenberg, 1994) and breast cancer (Blume, 1994; Reichman, 1994) as well as cirrhosis, coronary artery disease, chronic obstructive pulmonary disease, lung and bladder cancer, and HIV infection (Blume, 1994).

Research has also demonstrated the co-occurrence of alcohol and other drug abuse with mental health difficulties. Estimates are that up to two thirds of substance-abusing females have a comorbid psychiatric disorder (Beckman, 1994; Helzer &
Pryzbeck, 1994; Schuckit & Hesselbrock, 1994). The most frequently cited psychiatric disturbances are anxiety and mood disorders, including panic, post-traumatic stress disorder, and major depression (O'Hare, 1995). Women who abuse substances experience anxiety disorders three to four times more often than do nonabusing females (Helzer & Pryzbeck, 1994). It has been estimated that depression is an antecedent of alcohol abuse among women in more than two thirds of all cases. Diagnosed antisocial personality disorders occur 12 times more frequently among alcohol-dependent women than among those who are not alcohol dependent. Female substance abusers have also been shown to be at increased risk for self-destructive and suicidal behaviors (Anthenelli & Schuckit, 1994; Blume, 1994; Evans & Lacey, 1992; Lex, 1994). Last, research has suggested that women also develop cognitive deficits related to alcohol use over shorter periods of time and with less drinking than do men (Gomberg, 1994; Nixon, 1994).

The coexistence of substance abuse disorders with several other psychiatric and medical disorders, many of which are clearly influenced by social and environmental factors, suggests the appropriateness of considering a comprehensive, multifaceted biopsychosocial approach to treating females with substance abuse problems. (Chapter 5 provided a detailed discussion of substance abuse treatment programs for both male and female offenders.)

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Trauma and Abuse

As noted earlier, a significant proportion of female offenders have experienced physical, emotional, or sexual abuse and/or domestic violence. Abuse suffered during childhood is reported by 19% to 40% of incarcerated females, while adulthood abuse is reported by 24% to 80% (Belknap, 1996; Bloom et al., 1994; Browne et al., 1999; Curry, 2001; DeGroot, 2001; Herman, 1992; Marcus-Mendoza et al., 1994; Pollock-Byrne, 1990; Walker, 1994). Incarcerated women report physical and sexual abuse more than twice as often as do nonincarcerated women and report it three to six times more often than do incarcerated men (Snell & Morton, 1994).
The relationship between physical and/or sexual abuse and a wide range of medical, mental health, and substance abuse problems is marked for women (Richie & Johnson, 1996; Stevens et al., 1995). Physical and sexual abuse has been identified as an antecedent and/or consequence of alcohol and other drug abuse among women (Amaro & Hardy-Fanta, 1995; Beckman, 1994; Wilsnack, Wilsnack, & Hiller-Sturmhofel, 1994; Woodhouse, 1992). Estimates suggest that drug use among abused females is four times that among nonabused women (Martin, 1995). Childhood abuse and trauma have also been related to diagnoses among women of anxiety disorders (e.g., panic attacks, generalized anxiety disorder, post-traumatic stress disorder) as well as substance-related anxiety, mood (especially major depression), adjustment, dissociative, sleep, eating, and identity disorders (Miller, Downs, & Testa, 1993; Wilsnack et al., 1994). Browne and Finkelhor (1986) reported additional psychosocial effects of childhood abuse and sexual assault, including social isolation, lack of development of interpersonal trust and meaningful relationships, tendency toward revictimization in later life, sexual dysfunctions and adjustment difficulties, and self-mutilation. The incidence of recurrent or persistent suicidal ideation and attempts is also heightened among female victims of physical and/or sexual abuse (Browne & Finkelhor, 1986).

Although different correctional treatment programs have provided interventions for many consequences of abuse and for certain aspects of the trauma response, specifically defined and organized programs that consider the overall female experience of abuse and trauma are a relatively recent addition to most correctional systems. Morrow (1993) proposed an early outpatient model that included program areas addressing childhood physical and sexual abuse, domestic violence, parenting values and skills, and the development of effective relationships. According to Morrow, program areas can be accessed via four different levels of intervention intensity. At the lowest level, a single-session workshop is offered, with a primary focus on increasing awareness and interest and on providing introductory information. The second level consists of multiple-session class experiences for relatively smaller numbers of participants. Classes consider specific topics, involve didactic instruction, and encourage general class discussion. The third intervention level includes group psychotherapy for a limited number of participants who have completed appropriate workshops and classes, are carefully screened for group inclusion, and express a commitment to personal disclosure.
commensurate with the group process. Co-therapists guide the integration of personal and social content and process building on cognitive frameworks learned in classes. The fourth level of \[p. 134 \] intervention involves intensive individual psychotherapy, including conditions and goals specified in a treatment plan developed jointly by the clinician and the offender. This model provides a useful basic structure on which more comprehensive abuse and trauma intervention programs can be developed. Several state and federal correctional institutions have implemented similar abuse programs. Still other facilities have initiated more structured residential programs that include more clearly defined components, activities, and sequential organization.

Regardless of the specific program parameters, the author believes that effective abuse and trauma programs must be multifaceted and include careful screening and assessment of potential program participants, individual needs assessments, a meaningful range of program content and activities, a variety of educational and learning approaches and opportunities, clearly defined and sequentially progressive organizational structure, allowances for participant review and repetition of particular program areas as appropriate, and an effective method of measuring program success.

Family Relationship and Parenting Issues

Another vital aspect worth considering with incarcerated women is the centrality of children and family systems in their lives. While an estimated 5% to 10% of female offenders are pregnant at the time of their admission to prison, an additional 15% have given birth within the year prior to their incarceration (Curry, 2001; Kauffman, 2001). Wooldredge and Masters (1993) reported, however, that fewer than 50% of state prison systems have written guidelines for medical care of pregnant offenders, and less than half of these institutions provide prenatal care. Of those facilities providing such services, 21% offer prenatal counseling, 15% provide infant placement counseling and assistance following birth, and 15% have provisions for appropriate institutional work assignments during pregnancy.

Approximately 60% to 80% of incarcerated females have children, the majority of which are under 10 years of age (Kauffman, 2001; Snell & Morton, 1994). While only 44% of incarcerated males resided with their minor children prior to incarceration, nearly two
thirds of female offenders lived with their children before imprisonment (Greenfeld & Snell, 1999; Snell & Morton, 1994). Although 28% of children reside with their fathers following their mothers’ incarceration, the great majority of minor children reside with grandparents. Approximately 10% to 15% of children of incarcerated parents are placed in foster homes or agency care (Snell & Morton, 1994; Temin, 2001).

The fact that the majority of female offenders are mothers of, and primary care-givers to, minor children underscores the importance of parenting and family services and programs for incarcerated women. Imprisoned females are more likely to maintain contact both during and following incarceration with their children than are incarcerated males. Approximately 90% of female offenders have contact with their children via mail, telephone, or personal visitation (Snell & Morton, 1994). This figure may be somewhat misleading, however, given that more than half of imprisoned mothers report never having personal visits with their children during [p. 135 ↓] incarceration (Temin, 2001). Such limited personal contact is often the result of a number of factors, including the distance between the site of incarceration and the location of the offender's children. In view of the significantly greater number of state and federal prisons that house male offenders compared with those designated for females, women are typically incarcerated much farther from family and other social support systems than are men. In addition, the limitations of economic and social resources experienced by many female offenders markedly diminish the availability of adults and reliable transportation to bring children for institution visits (Snell & Morton, 1994; Temin, 2001).

Early correctional institutions and programs designed and constructed for women emphasized socially traditional, feminine family values and practices, including development and continuation of family and parenting relationships. For example, the Federal Correctional Institution at Alderson, West Virginia, and the New York State Institution at Bedford Hills have operated institution hospitals and nurseries where children born at the institutions remain until they reach 1½ to 2 years of age. This opportunity for children to remain with their birth mothers for the first 2 years of their lives continued at the Alderson facility from its opening during the late 1920s until the early 1970s, when it was discontinued at the urging of social theorists and service agencies. These theorists and agencies regarded correctional institutions as inappropriate places for the healthy development and well-being of children. As a result of these views, offenders began to deliver their babies at community hospitals, and their
infants were immediately taken into the care of family or friends of the mothers or social service agencies. The Bedford Hills institution continues to operate an on-site nursery and parent education program (Gwinn, 1992; Kauffman, 2001).

The dramatic increase in incarceration of females over the past several years and a contemporaneous societal resurgence of interest in parent-child relationships and the identification, learning, and reinforcement of effective parenting attitudes and skills have led to renewed consideration of the potential advantages and appropriateness of services and programs for female offenders and their children. Although the numbers remain relatively small, there has been a noticeable increase over the past decade in the establishment of programs that focus on the specific concerns and issues facing incarcerated mothers and their children. These programs include enhanced visitation opportunities and facilities that emphasize continuity of family relationships as well as specific programs sponsored by community agencies and organizations such as the Girl Scouts of America. Other programs designed to build and maintain relationships between offenders and their children include week-long summer camps in which children participate in daily organized activities at the correctional institutions with their mothers and stay at night with selected families in the local community. Other facilities encourage several overnight visits annually at the institutions between offenders and their children (Kauffman, 2001). More structured and extensive programs, such as Linking Inmate Families Together (LIFT) and Mothers With Infants Together (MINT), combine educational components addressing prenatal care, child and family nutrition, communications and parenting skills, and the use of community resources with parent-child interaction, practical parenting experience, and family relationship counseling.

Some correctional systems have established or reestablished institutional nurseries in which children born therein can remain with their mothers for up to 18 months. These programs allow opportunities not only for the development and strengthening of children's relationships with their mothers but also for parent education and release preparation. The criteria for participation in these programs typically include consideration of date of release from incarceration, history of violent behavior, intention of being the child's or children's primary caregiver on return to the community, and participation in appropriate educational, parenting, and/or substance abuse treatment programs.
An extremely comprehensive and innovative program for incarcerated mothers and their children is operated in Frankfurt, Germany, where the correctional administration acknowledges primary parenting as a viable and important occupation and consequently as an appropriate and productive work release placement. Although higher security offenders may keep their children with them in the institution until 3 years of age, the children of low-security offenders may remain with their mothers until 5 years of age. Infants remain with their mothers during the day. Offenders whose children are older but still of preschool age work within the prison or in the community during the day while their children are cared for by certified child care workers. On return from their assigned places of work, offenders again assume primary responsibility for their children. School-age children of offenders do not reside in the institution but may live in the surrounding area. The mothers of these children may be placed on work release to assume parenting responsibilities and related homemaking duties for their families and children during the day and then return to the prison at night after their children have been put to bed.

Such programs, which emphasize the importance of parenting and family relationships both to the individuals involved and to the society at large, provide an extensive variety of educational and pragmatic experiences. Many of these activities or programs focus on the attainment of information necessary for the understanding of the needs, development, and behaviors of children; appropriate self-assertion and decision making; situational coping strategies; the development of positive relationships; family health care and budgeting; the use of legal and support services; and other needs unique to the offenders.

Although it is important to consider the family and parenting needs of incarcerated mothers, it is critical not to ignore the effects of parental incarceration on children. The imprisonment of mothers, who are frequently the primary child care-givers and sources of social, emotional, and financial support within the family, often results in serious disruption within, or dissolution of, their families. Separation from parents or primary caregivers, especially during early developmental periods, can be traumatic for and have long-lasting effects on children (Bowlby, 1982). In addition to impaired development of trusting and stable interpersonal relationships and psychiatric or behavior disorders, these effects can include the increased likelihood that children of incarcerated parents will become involved in illicit activities and in
criminal justice systems as compared with children whose parents have not been imprisoned (Kauffman, 2001; Temin, 2001). By providing program opportunities for female offenders (both with and independent of their children) for the development, implementation, maintenance, and reinforcement of effective communications, parenting, and relationship skills, the negative effects of separation between offenders and their children may be reduced and the likelihood of the children of those offenders engaging in the same behaviors and experiencing the same personal and social difficulties as their mothers may well be diminished.

**Mental Health Services**

Integrally related to the general and specialized medical, substance abuse, trauma and abuse intervention, and parenting and family support needs of female offenders are specific mental health concerns and needs. As noted previously, incarcerated women are generally more likely to express emotion, to behave more passively and dependently, and to seek assistance with little or no hesitation or embarrassment. This typically results in consistently large numbers of female offenders requesting and participating in a wide variety of mental health services from crisis intervention through long-term therapeutic programs.

The psychological components and consequences of medical disorders and concerns are not insignificant among female offenders who are facing the uncertainties and stresses of new or ongoing medical disorders without the support of family and friends. The relationship of mood and anxiety disorders with diseases such as diabetes, coronary artery disease, cancer, HIV, persistent and recurrent eating disorders, and major mental illnesses must be addressed with immediacy and efficacy. The physical and psychological effects of miscarriage, abortion, and sexual assault can be significant for the individual as well as for other offenders within an institution. The significant co-occurrence of psychiatric disorders and substance abuse was already noted earlier.

For a large proportion of female offenders who enter prison with preexisting psychiatric disorders, the demands of incarceration can quickly—and often dramatically—exacerbate affective, cognitive, and behavioral difficulties. For those without preexisting
mental health concerns, admission to prison can contribute to adjustment disorders and
to the development of other initial mood, anxiety, and psychophysiological disorders.

Because of the perceived multitudinous losses and absence of support that many
women experience in response to incarceration, suicidal behavior is a constant and
serious concern within female correctional settings. It is the author’s belief that many
of the suicidal thoughts, gestures, and attempts by female offenders are in response
to family disruption and other effects of incarceration as well as to continuing or
exacerbated psychiatric disturbance.

Correctional mental health programs that have established close working relationships
with medical, pastoral care, and substance abuse treatment programs and with
institution administrative, security, and case management staff can provide consultation
and direct offender care services that result in improved institution operations and
offender safety and care. Significant positive impact can be demonstrated by reported
decreases in areas such as subjective pain, anxiety, depression, and adjustment
difficulty; requests for medications; housing changes; institution transfers; and disruptive
or violent outbursts.

[p. 138 ↓ ]

Conclusions

The population of female offenders and their needs and characteristics have long
been ignored, underestimated, misunderstood, and maligned. Reasons for this have
included the small numbers of incarcerated females relative to those of males; the
relatively low visibility of incarcerated women due to infrequent acts of violence,
disruptions, and disturbances within correctional institutions; the perceptions, beliefs,
and preferences of correctional professionals and the society at large; and the
consequent allocation of significantly limited resources for female offender services
and programs. Communities often forget females incarcerated far from their homes,
families, and friends. Correctional workers often express dissatisfaction, hesitancy,
and ambivalence with respect to working with female offenders. Increased interest
in the needs, characteristics, and rights of females, both in society in general and
within incarceration settings, has emerged as a result of the evolution of social and correctional perceptions, beliefs, and practices.

The long-accepted correctional practice of approaching offenders in a firm, fair, and consistent manner provides an appropriate and productive basis for the safe, secure, and effective management of both male and female offenders. It has also been demonstrated, however, that provision of the same environment, services, and programs for males and females does not necessarily result in equality of treatment. As this chapter has described, female offenders have unique characteristics, needs, and responses to incarceration that are distinctly different from those of incarcerated males. Clear and significant differences were discussed in the areas of medical and mental health care, problematic substance use, trauma and abuse, and family and parenting relationships. Efficacious and meaningful responsiveness to the particular needs of female offenders, although perhaps requiring reevaluation and reprioritization of resource allocations, need not necessarily demand additional resource expenditures. Ensuring effective services for incarcerated women requires that the specific characteristics, priorities, and psychological and sociocultural attributes of female offenders continue to be accurately identified, understood, and addressed in the development of programs and services. Continuing or returning to attempts to provide female offenders with services and programs developed for males is clearly ineffective and unjust to society, to correctional professionals who must manage and treat offenders, and to female offenders themselves.

The basis for future female offender services must include, as a beginning, those procedures, programs, and priorities that have been demonstrated to be currently the most effective, responsive, and heuristically promising. In view of the consistent importance of relationships to females, especially female offenders separated from families and friends, it appears reasonable to conceptualize and implement new best practices with this significant factor in mind. Review of current best practices in the areas of medical services and mental health services suggests that those programs must go beyond provision of basic services to programs that specifically and directly address the unique needs of female offenders. The most efficient service delivery systems are those that provide care in an integrative and inclusive manner that conceptualizes and actualizes conjoint comprehensive medical and mental health care.
The most productive and promising current substance abuse treatment approach, as noted in Chapter 5, appears to be a comprehensive and adaptable model that simultaneously addresses biological, psychological, and sociocultural aspects of participants' lives and addiction processes. Treatment programs that employ biopsychosocial aspects as a foundation, then, provide additional emphases on longitudinal perspectives of individuals' lives; the importance of gender role and relationships; a holistic approach to prevention, intervention, and post-intervention treatment efforts; and the particular assets of each individual program participant. As such, they offer increased potential for female offenders.

Programs that address issues of trauma and abuse will be most effective when they provide a needs-based range of intervention intensity and involvement across an appropriate variety of treatment experiences. Included in this multilevel and multifaceted approach must be access to brief inpatient psychiatric services as needed as well as comprehensive outpatient programs. As with optimal intervention strategies in other program areas, the basic emphasis must be on continued awareness of and attention to the participant's total life experience and unique needs, particularly with respect to the development and maintenance of effective relationships. Staff who provide trauma and abuse program services should be well grounded and experienced not only in the treatment of the range of clinical presentations but also in the identification and treatment of processes such as acute and post-traumatic stress and self-destructive behaviors and suicidality.

Female offender programs that address parenting and family relationship concerns must also involve multiple educational and experiential components at a variety of levels of personal intensity and involvement. Again, principal consideration of the importance of relationships across the lives of participants is vital. Beyond the effective formation of meaningful relationships, program emphasis must include aspects of relationship continuity and resumption and of the dynamic nature and characteristics of interpersonal relations. The programs that are most productive are those that involve sequential learning activities that form a solid basis for subsequent and contemporaneous applied learning, parenting, and family relationship experiences with maximal opportunity for rehearsal and feedback as well as transition services to ensure compatibility and continuity on return to the community.
The conceptualization, development, and implementation of correctional services and programs for female offenders have evolved from archaic and punitive practices, to those that were generally a secondary adjunct to male offender programs, to recognition of female offender programs as a beneficial and necessary component of proactive correctional management. It now appears clear that the unique needs and gender and cultural expectations and experiences of female offenders significantly affect correctional management as well as results of correctional services and programs. In view of such influence, these specific female offender characteristics and experiences should be viewed as potential assets, strengths, and foundations for further personal development and skills enhancement rather than as problems or inconveniences. Correctional programs and services for female offenders must involve a comprehensive and holistic approach that provides sensitivity to and understanding of female offender needs, opportunities for meaningful and reasonable decisions, respect, dignity, and empowerment in an environment that is safe, secure, supportive, and appropriately structured.

References


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10.4135/9781452224947.n7