EMPOWERING FEMALE INMATES: AN EXPLORATORY STUDY OF A PRISON

THERAPEUTIC COMMUNITY AND ITS IMPACT ON THE COPING SKILLS OF

SUBSTANCE ABUSING WOMEN

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ii

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Title: Empowering Female Inmates: An Exploratory Study of a Prison Therapeutic
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Over the past twenty years, the number of female inmates incarcerated for drug
offenses has dramatically increased. This surge has led to a large portion of the female
prison population coming into the corrections system with substance abuse problems.
Currently, drug relapse is the number one reason for female recidivism.

Robert Johnson (2002) has suggested that if inmates learn mature coping skills, while
in prison, they will be better prepared for the world outside and will be less likely to
return to the criminal justice system. Johnson's concept of mature coping includes three
elements: one must be able to accept the problem at hand, work through the problem
without resorting to violence except in cases of self-defense, and learn to live in a
community environment where one can assist others and empathize with their problems
(Johnson, 2002).

The therapeutic community is a program that has been adopted in many prison
systems that appears to implement Johnson's concept of mature coping. This research
specifically examines a therapeutic community for women within a Pennsylvania prison
to better understand if the women are indeed learning positive coping skills that will
replace their prior negative coping skill of substance abuse. A combination of
quantitative and qualitative methods was used to examine the differences between

women in the therapeutic community and women who were on the waiting list for treatment. Data from this study suggests that women involved in the therapeutic community were able to improve their problem solving and seeking social support skills, while many still struggled with avoidance techniques.

This study concludes by suggesting several policy implications. First, participants need to spend longer periods of time in treatment to learn and practice their positive coping skills. Second, more therapeutic communities need to be implemented within the prison to address the large number of women who are on the waiting list. A final suggestion involves adopting residential programs for these women, upon their release from prison, to provide them with support systems within their own communities.

DEDICATION

This study is dedicated to the women in the therapeutic community and on the waiting

list who shared themselves so openly and honestly with me and to those who work with

these women daily and give so much of themselves.

also want to thank my friends Jen Lee and Tammy Castle who provided me with an ear

when I needed to complain and who were role models for how I could do it.

TABLE OF CONTENTS

Chapter   **Page**

LIST OF TABLES

Table

LIST OF FIGURES

Figure

CHAPTER I: THE NEED TO STUDY FEMALE INMATES WITH SUBSTANCE

ABUSE PROBEMS AND THEIR COPING STRATEGIES

Introduction

Little research has been conducted to understand the coping skills of female inmates.

More research is needed to clarify the relationship between therapeutic communities for

female inmates who are substance abusers and the impact of this treatment on their ability

to cope. The purpose of this study is to explore and describe how participating in a

therapeutic community for substance abuse in a woman's prison affects one's ability to

cope with every day life problems during incarceration. This research studies female

inmates in a therapeutic community and compares these offenders to women who have

accepted treatment and are on the waiting list for the therapeutic community. The

differences and similarities in coping strategies are explored.

Overview of the Problem

Throughout the 1980s and 1990s in the United States, the number of people with drug

addictions entering the U. S. federal, state prison, and local jail systems increased due to

"get tough on crime" policies and changes in laws regarding illegal drugs. Women were

particularly impacted as "the number of women entering the jail and prison systems in the

United States escalated by 202 percent over the past decade" (Pomeroy, Kiam, & Abel,

1999, p. 171). As female offenders were brought into the system for drug related crimes,

they also brought with them issues related to their substance abuse. For example,

approximately one third of incarcerated American women self-reported that they were

under the influence of a drug at the time of their offense, while one half self-reported

using drugs on a daily basis (Morash, 1994).

For women, substance abuse is one outlet to deny or avoid problems in their lives such as prior victimization (Bloom, Owen & Covington, 2003). Female inmates, in a 1997 survey, reported higher rates of physical and sexual abuse prior to their incarceration than male inmates. Forty-seven percent of female inmates reported experiencing physical abuse and 39 percent reported sexual abuse prior to their incarceration (Mauer, Potter and Wolf, 1999). Women who experience abuse and lack a social support system often turn to substances as a negative coping strategy in order to avoid the problem at hand. Therefore, due to policies and law changes stemming from the War on Drugs, female offenders are coming into the criminal justice system at an alarming rate.

<div align="center">The Rise in Female Drug Offenders</div>

Although violent crimes and property crimes continue to decrease for female offenders, the number of drug and public-order offenses continues to rise (Greenfeld & Snell, 1999). "Nearly 1 in 3 women serving time in State prisons said they had committed the offense which brought them to prison in order to obtain money to support their need for drugs" (Greenfeld & Snell, 1999, p. 9). In 2003, in Pennsylvania's state prisons, there were 1,812 women serving time, 20.3 percent or 368 of these women were there for drug offenses. In contrast, 15 percent of all men serving time in Pennsylvania's prisons were there for drug offenses (Pennsylvania Department of Corrections, 2004).

The rising number of female drug offenders in Pennsylvania's women's prisons has led to an overburdened women's prison system. Forty-three percent of the women incarcerated in Pennsylvania's state institutions are between the ages of 25-34, while 34 percent are between the ages of 35-44. A large proportion of these female inmates are also undereducated, with 44 percent having some high school or less (Greenfield & Snell,

1999). The young age of the prison population, the lack of education, and the history of drug abuse combine to create high recidivism rates for female prisoners. In the United States, "about 45 percent of women for whom parole supervision was ended in 1996 were returned to prison or had absconded" (Greenfield & Snell, 1999, p. 11).

<div style="text-align:center">Mature Coping and Therapeutic Communities</div>

According to Zamble and Proporino (1990, p. 143), "coping difficulties are a central cause of the maintenance and repetition of criminal acts, if not their origin". There are three components to coping maturely. The first step is to deal with one's problems "…head-on, using all resources legitimately at one's disposal" (Johnson, 2002, p. 84). The second component is to address one's "…problems without resort to deception or violence, except when necessary for self-defense" (Johnson, 2002, p. 90). The final step is to make "an effort to empathize with and assist others in need to act as though we are indeed members of a human community…" (Johnson, 2002, p. 93). One must be able to cope maturely before he/she will be able to be rehabilitated (Johnson, 2000). Johnson states, "warm, supportive environments promote the development of conscience", while "…harsh, repressive environments, in contrast, suppress the development of conscience and promote selfish, short-run hedonism" (Johnson, 2002, p. 96).

One way to promote coping skills is through a prison-based therapeutic community. These programs are based on a self-help model, where the inmate is encouraged to examine his/her addiction as a problem for the whole body (Lockwood, McCorkel, & Inciardi, 1998). This model allows the individual to develop coping skills to handle the everyday situations he/she encounters that provoke his/her drug usage. Therapeutic communities have been successful with female inmates because "this approach invites

clients and practitioners to explore the many issues and experiences that frame the

client's substance use, thereby ensuring that gender-specific issues facing women clients

will be addressed" (Lockwood et al., 1998, p. 195; Prendergast, et al., 2004).

Conceptual Model

Mature coping is defined as facing one's problem, addressing the problem, and

empathizing with and helping others within one's community (Johnson, 2002).

Therapeutic communities support Johnson's concept of mature coping well because the

therapeutic community teaches one to face problems and work through these issues in a

positive manner. In prisons, the therapeutic community also teaches one how to live

within a community because the therapeutic community itself is a community that is

separated from the general population. This separation allows the women in the program

to develop relationships with one another. Women who have advanced in the program

are assigned to be mentors to women entering the program. These relationships give the

mentors a chance to empathize with and assist others who are having similar problems.

Therefore, it is hypothesized that as one moves through the therapeutic community, one's

coping abilities will improve.

This study also hypothesizes that the more positive coping skills one uses, the less

likely the individual will be to experience serious depression and/or anxiety. When faced

with a difficult problem, one might react by avoiding or denying the situation. However,

even if one pretends the problem does not exist, it still does. This denial can lead to

depression and/or anxiety. Prior to incarceration, these women dealt with this anxiety

and/or depression through substance use, which eventually led to substance abuse. Now

that these women are incarcerated and their access to illegal drugs has been minimized,

substance abuse is no longer an option.

Women who are in the therapeutic community will be learning new positive coping

skills to handle their problems. These coping techniques will give the women the skills

that they need to work through their problems. The women in the therapeutic community

will experience less depression and anxiety than those on the waiting list because they

will be less likely to use negative coping strategies. Therefore, their anxiety and/or

depression will decrease as they move through the program. Women on the waiting list

to get into treatment have faced their substance abuse problem but have not yet learned

new coping skills. These women will experience more depression and/or anxiety than

women in the therapeutic community. Therefore, the more positive coping skills the

individual uses, the less likely she will be to experience serious depression and/or

anxiety.

Racial/ethnic differences in coping strategies have not been previously examined.

However, research conducted with female inmates in other types of treatment programs

has found race/ethnicity to matter in the perception of and effectiveness of treatment

(West, 2001). Therefore, this study hypothesizes that women from different racial/ethnic

backgrounds will have different experiences culturally and will rely upon different

coping strategies due to these experiences.

The Purpose of this Research

Previous research has examined how women and men adapt to their environment once

incarcerated. However, few studies have focused on one's ability to cope while

incarcerated. To date, little research has been conducted in the area of therapeutic

communities for substance abuse and their effect on female inmate's ability to cope. Therefore, this research study fills a gap in the literature and adds to the small body of research on female inmates and coping. The purpose of this research is to examine a therapeutic community for substance abusing female inmates and assess its impact on their coping abilities.

Research Questions

The following research questions are addressed:

1. Does treatment affect the female inmate's ability to cope?

2. Does one's ability to cope affect her level of depression?

3. Does one's ability to cope affect her level of anxiety?

4. Do women from different racial/ethnic backgrounds rely upon different coping strategies?

Policy Implications

It is important to better understand female inmates as the number of women incarcerated continues to increase. Women comprise a small percentage of the national prison population and are often ignored in corrections research. Historically, research has often been predicated on the assumption that women have similar experiences to men (Bloom, et al., 2003). Programs and policies that are effective with men have often been implemented in women's facilities, with the assumption that they will work equally well with women. However, these programs are often not effective because they do not take into consideration gender differences (Bloom, et al., 2003). Researchers at the National Institute of Corrections have recommended that treatment within the correctional system should be gender-responsive to be effective. This approach takes into consideration the

need for "creating an environment…that reflects an understanding of the realities of women's lives and addresses the issues of women" (Bloom et al., 2003, p. v).

Therapeutic communities are a gender-responsive program that takes into consideration how women become involved in criminal behavior, as well as their prior experiences of victimization and substance abuse. The therapeutic community also provides a safe atmosphere where women can examine life problems and develop positive coping techniques within their own community. "If women in the system are to change, grow and recover, it is critical that they be in programs and environments in which relationships and mutuality are core elements" (Bloom, et al., 2003).

 Research conducted with therapeutic communities for women who have substance abuse problems has mainly focused on the effectiveness of these programs as measured by rates of recidivism. The research shows these programs to be a promising new form of treatment that works well with female inmates (Prendergast et al., 2004). However, to date, no one has examined how this type of treatment affects one's ability to cope with everyday problems while incarcerated. Therefore, this study will fill a gap in the current literature regarding female inmates, treatment for substance abuse and the ability to cope.

In this study at the State Correctional Institution Cambridge Springs (SCI Cambridge Springs), there are 185 women on the waiting list for the therapeutic community because there is only one program with fifty beds. It takes approximately 6-9 months for a woman to finish the program, so women on the waiting list could be waiting for some time. If this research study finds that women in the therapeutic community are learning and using new coping skills and experiencing less depression and/or anxiety, this would support the development of more therapeutic communities for substance abusing female

inmates. The initiation of new programs would be important because drug relapse is currently the number one reason for female recidivism for all incarcerated women. If women who finish the program are able to utilize what they have learned upon their release from prison and stay drug free, then this could mean lower recidivism rates.

CHAPTER II: LITERATURE REVIEW

The Incarceration Binge

In the United States, the number of people imprisoned continues to rise, and there are now over two million people incarcerated (Bureau Justice Statistics, 2004). In this section, who is incarcerated and why will be examined to better understand the impact of what has been termed the U.S. "incarceration binge" (Irwin & Austin, 1994).

During the late 1980s, the prison population in the United States began an unparalleled rate of growth (See Figure 1). By 1990, there were 708,393 inmates housed in state prisons, with an additional 65,526 inmates in federal facilities (Harrison & Beck, 2002). From 1995 to 2000, the prison population in the United States grew by 23.9 percent and in 2003, there were 1,226,175 people in state facilities and an additional 161,673 in federal facilities (Harrison & Beck, 2004).
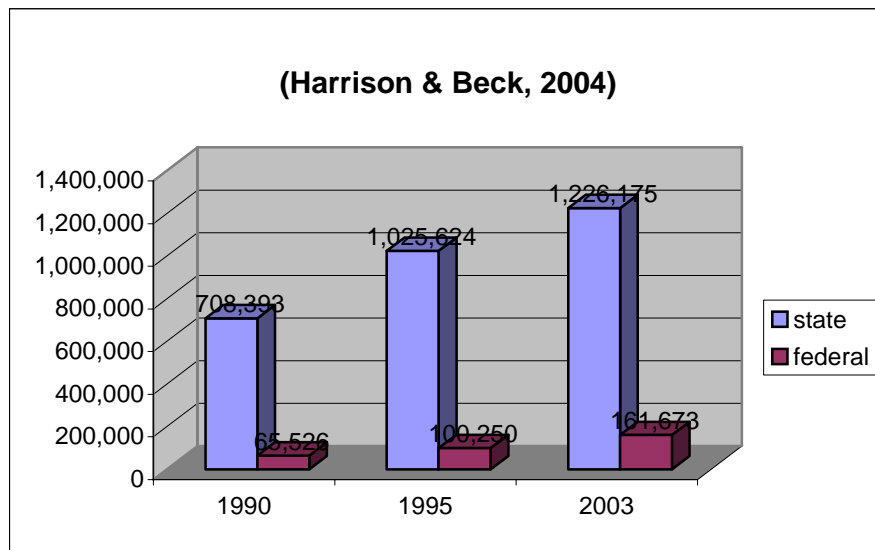
Figure 1. Prison population growth from 1990-2003.

The number of people in jail has also increased rapidly (See Figure 2). In 1990, there were 403,019 inmates incarcerated in jails in the United States, and by midyear 2004,

there were 784,538 people in jail (Bureau of Justice Statistics Statisticians, 2002; Harrison and Beck, 2004). The number of people on probation also rose, and, in 1998, there were 3,368,074 adults on probation both in the federal and state system. That same year 1,307,664 adults on probation were released from supervision, with 59 percent successfully completing their supervision and an additional 17 percent being released from supervision for incarceration (Bureau of Justice Statistics, 2002).
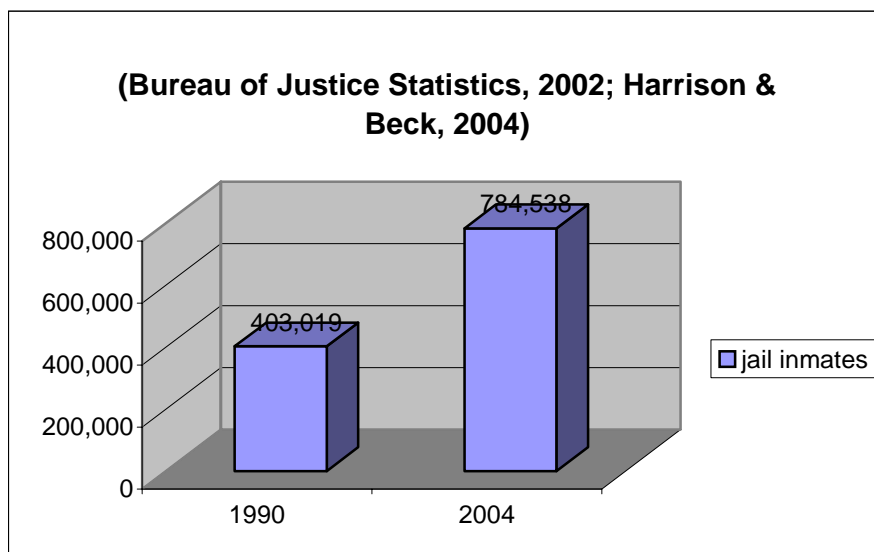
Figure 2. Jail population growth from 1990-2004.

During this twenty year period, the number of prisoners continued to increase and although corrections budgets grew as well, there were still problems regarding overcrowding. In 1990, for example, local jails were operating at a capacity of 104 percent, even though 21,402 new beds had been added the previous year. The jail population continued to grow and by 1998, jails were operating at a capacity of 97 percent, even though 26,216 beds had been added in 1997 (Bureau of Justice Statistics, 2002).

Overcrowding emerged as a problem in prisons nationwide and "at year end 2003 the Federal prison system was operating at 39 percent over capacity. Overall, State prisons were operating between 100 percent of their highest capacity and 16 percent above their lowest capacity" (Harrison & Beck, 2004, p. 7). Many states dealt with the overcrowding issue by increasing their operational and rated capacities, even though the architects had not intended for the facility to house as many. This action was considered legal as beds and bodies were added to already overcrowded facilities and programs. In Pennsylvania, for example, the operational capacity (how many the prisons can accommodate based on staff, existing programs and services) and rated capacity (number of beds available) is 33,757 inmates. However, these facilities were designed and originally intended to hold only 26,186 inmates (Harrison & Beck, 2002).

Race and the Incarceration Binge

The racial composition of correctional institutions is another critical issue that needs to be addressed. According to the 2000 United States Census, the general population in the United States at that time was 70 percent Caucasian, 13 percent Hispanic, and 12 percent African American. However, those incarcerated were disproportionately African American, while those on probation were more evenly distributed (Bureau of Justice Statistics, 2002). In 1998, for example, there were 1,299,096 people incarcerated in the federal and state prison system, where 41 percent were White and 47 percent were African American. In the state of Pennsylvania, there were more African Americans incarcerated than the national average. For example, in 1998, 56 percent of the Pennsylvania prison population was African American, while only 33.7 percent was Caucasian (Bureau of Justice Statistics, 2002).

African Americans also were over-represented in county jails. In 1998, the jail

population in the United States consisted of 41.2 percent African American, 15.5 percent

Hispanic, and 41.3 percent White. The opposite is true of probation; however, where

there were more Whites than African Americans. Whites were more likely to receive

probation in lieu of incarceration and in 1998 probationers were 64 percent White and 35

percent African American (Bureau of Justice Statistics, 2002).

Women and the Incarceration Binge

Women were particularly affected by the "incarceration binge" and the number of

female offenders increased rapidly (Irwin & Austin, 1994). Incarcerated women were

growing at a faster rate than men, even though women only made up 6.6 percent of the

entire prison population in 2001 (Harrison & Beck, 2002). In 1995, for example, the

female prison population grew at a rate of 5.2 percent, while the male prison population

grew at a rate of 3.7 percent. In 1995, there were 68,468 women in state or federal

prison, and by 2003, there were 101,179 women in state or federal prison (See Figure 3).

In Pennsylvania, the number of women incarcerated between 1995 and 2001 grew at a

rate of 2.2 percent, and by 2001 there were 1,711 women incarcerated in state prison

(Harrison & Beck, 2002; Harrison & Beck, 2004).

(Harrison & Beck, 2004)
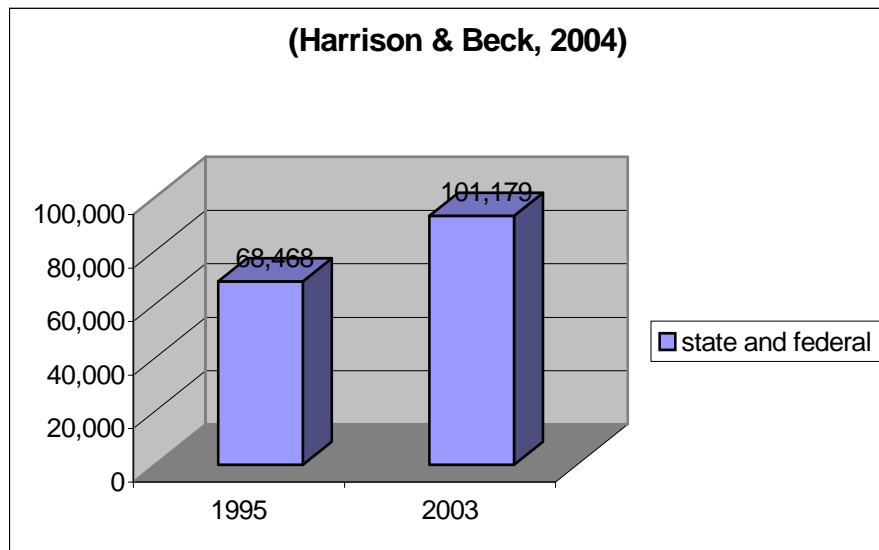
Figure 3. The growth of female inmates from 1995-2003.

Women are typically incarcerated for nonviolent crimes (See Figure 4). In 2003, there were a total of 89,544 female offenders incarcerated in state facilities, 32 percent of the women were incarcerated for violent crimes and the remaining 68 percent were incarcerated for nonviolent crimes (Harrison & Beck, 2004). Violent crimes for women include murder. Women who murder typically kill a family member or partner with whom they were involved in an abusive relationship. An additional 24 percent of violent crimes for women were assaults. Chesney-Lind has stated that although women's official rates for assault have increased, women are not committing more assaults, but rather are being arrested and prosecuted more often for this crime (Hamilton, 2003).
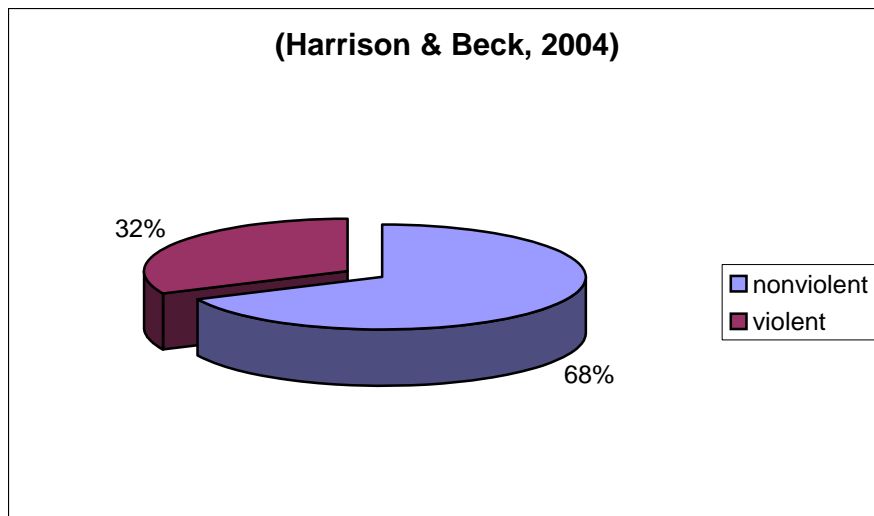
Figure 4. Non violent versus violent female offenders in 2003.

Incarcerated women are imprisoned for a variety of non-violent offenses (See Figure 5). In 2000, 25 percent of women were incarcerated for property crimes, 32 percent for drug offenses and 11 percent for public order offenses, such as "…weapons, drunk driving, court offenses, commercialized vice, morals and decency charges, liquor law violations and other public order offenses" (Harrison & Beck, 2002, p. 13).
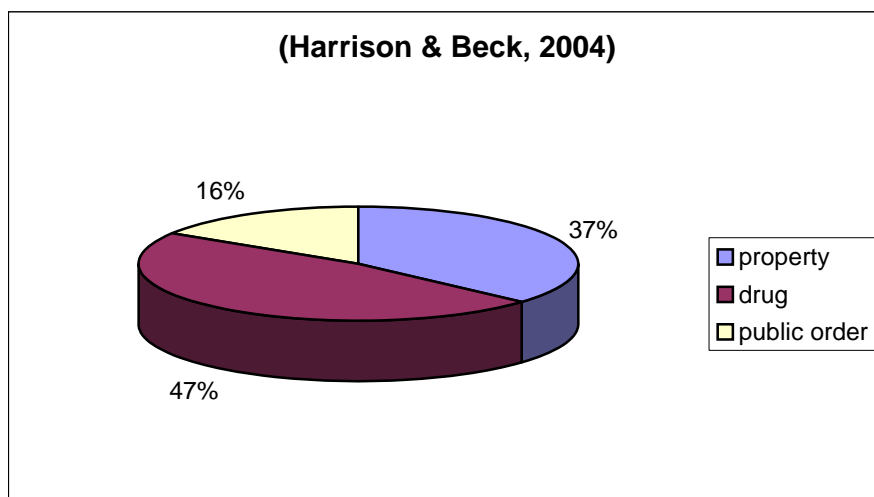
Figure 5. Non violent offenses for female inmates in 2003.

Women tend to be arrested for crimes similar to men, but at different rates. In 2003, men were arrested for drug abuse violations, driving under the influence, larceny-theft, and fraud in descending order; in the same year, women were arrested for larceny-theft, drug abuse violations, driving under the influence, and fraud in descending order (Harrison & Beck, 2004). Although drug abuse violations were the number one crime category for which men were arrested, the rate at which women were arrested for drug abuse violations grew 51.4 percent between 1992 and 2001, in comparison to 38.1 percent for men for the same time period (Harrison & Beck, 2002).

In 2003, in Pennsylvania, women were 4.4 percent of the total prison population and 23 percent of the women were serving time for drug offenses (Hartman, 2004). The majority of the women (60 percent) were serving time for non-violent offenses. However, 40 percent of the women were incarcerated for violent offenses. The majority of women (73 percent) were serving a minimum sentence of 5 years or less; therefore, most of these women will at some point in time be returned to the community. Women tend to have lower recidivism rates than men and in a recidivism study for Pennsylvania, it was discovered that within three years of release, 25 percent of women and 40 percent of men had recidivated (Hartman, 2002).

The race of female incarcerants is of importance as African American women are more likely to be incarcerated than White or Hispanic women. In 2003, African American women were incarcerated two and a half times more often than Hispanic women and four and a half times more often than White women (Harrison & Beck, 2004). This disparity has been attributed to several factors, including the level of poverty in the African American community. African American women, for example, are more

likely to be single parents and earn only .82 cents for every dollar a White woman earns. Those who have little economically are more likely to be incarcerated than those who can afford private counsel; therefore, African American women are over-represented in the correctional system (See Figure 6). In 2003, there were 92,785 women incarcerated in the state and federal prison systems, where 42 percent were White, 38 percent were African American, and 17 percent were Hispanic (Harrison & Beck, 2004).
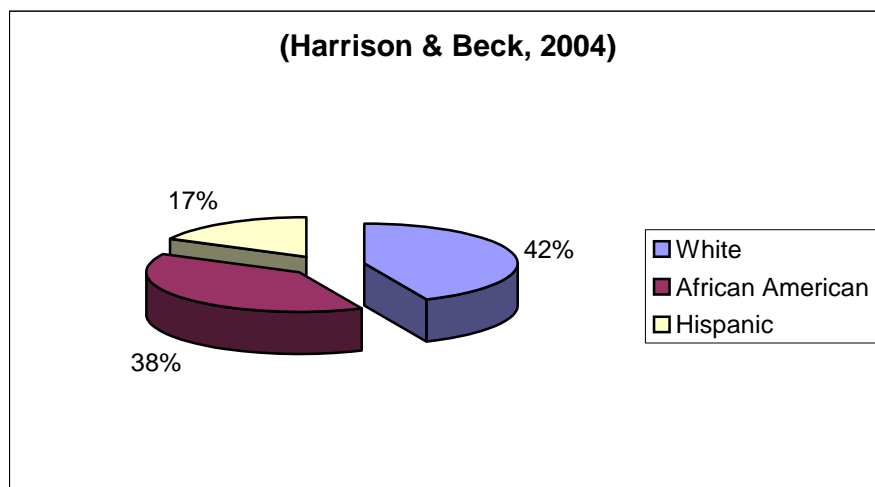
Figure 6. Race of female inmates in State and Federal Prison in 2003.

Summary

The prison population in the United States has been growing since the late 1980s and continues to grow. A large portion of this growth is the direct result of changes in policy for drug offenders. Between 1990 and 2000, for example, drug offenders in the federal prison system grew 140.9 percent and contributed to 59.3 percent of the overall federal prison growth (Harrison & Beck, 2002).

The growth in the prison population has led to overcrowding in our nation's prisons and jails. Women in particular have been impacted by the incarceration binge. Female drug abusers were not necessarily the targets of the War on Drugs and the correctional

system was not prepared for their arrival. This has contributed to overcrowding. In addition, women were an afterthought within the criminal justice system, where differences in gender are not often taken into consideration, and services provided for men are thought to be adequate for women.

<div align="center">Policy Changes and the Incarceration Binge</div>

During the 1980s, there was a shift in political ideology toward a more conservative agenda. This swing in philosophies produced "get tough on crime" policies that would later lead to an over reliance on the correctional system. This change in ideology began with the 1984 Sentence and Reform Act, which was developed to end disparity within federal sentencing. The second major policy change occurred with the passage of the 1986 Anti Drug Abuse Act, widening the use of mandatory minimum sentences. The third major policy change occurred with the 1987 federal sentencing guidelines, which implemented the idea of truth in sentencing. These three policy changes in combination widened the net and incarcerated more offenders, particularly drug offenders, for longer periods of time. These policies had a negative impact on women and minorities, as the number of women and minorities began to increase in the criminal justice system due to drug offenses.

1984 Sentence and Reform Act

Before 1984, the criminal justice system relied on indeterminate sentencing. Indeterminate sentencing occurs when the judge states the maximum amount of time that an offender would be expected to serve, but does not give a specific sentence length (Hall, 1999). Once incarcerated, the offender is given the opportunity to participate in rehabilitation programs. After serving between 40-50 percent of the sentence, the inmate

applies for parole. The parole board then assesses whether the offender has been

rehabilitated and is ready for release. This decision is based upon the inmate's

rehabilitative progress and his/her behavior while incarcerated. The parole board would

then either make the decision to release or keep the inmate. This type of sentencing

reflected the political ideology of the 1960s and early 1970s and focused on rehabilitating

and treating the offender (Hall, 1999).

During the 1960s and 1970s, indeterminate sentencing began to be viewed as unfair

because it gave too much discretion to judges. Research during this time showed that

offenders who committed similar crimes often would receive different sentences. One's

sentence often had more to do with race, class, gender, and geography than the crime

itself (Hall, 1999). This disparity along with a shift in political ideology from treatment

to punishment led to Congress passing the 1984 Sentence and Reform Act. This Act

called for the construction of the United States Sentencing Commission who would be

responsible for developing "…a system of mandatory guidelines that would eliminate

unwarranted disparity in the current indeterminate sentencing system" (Hall, 1999, p. 6).

Through the use of determinate sentencing, discretion would be taken away from judges,

who would have to use a guideline to determine an offender's sentence after taking into

account the aggravating and mitigating circumstances of the crime (Hall, 1999).

1986 Anti Drug Abuse Act

At the same time the Sentence and Reform Act was being passed, a moral panic was

being created by the mass media regarding crack cocaine. Goode (1989, p. 26) defines a

moral panic as "the widespread feeling on the part of the public that something is terribly

wrong in their society because of the moral failings of a specific group of individuals".

The moral panic started when the news media began to report stories on crack cocaine as an epidemic. "A review of printed news stories about these phenomena during this period in New York City reveals how the media operating within a predominately conservative political context, took the government's notions about crack, pursued these themes, and constructed a 'reality' in which drugs, crack in particular, were identified as responsible for widespread and random drug related street violence" (Brownstein, 1992, p. 88). As of November 1986, there had been 1,000 newspaper articles on the crack cocaine epidemic in print alone (Bush-Baskette, 2000).

The coverage of the crack epidemic of the mid 1980s coincided with the national midterm elections of 1986. This was the fuel for the passage of the Anti Drug Abuse Act of 1986, which was passed on October 27, 1986, just days before the national elections (Bush-Baskette, 2000). This act required law enforcement to cease focusing on large-scale drug dealers and to instead concentrate on the aggressive enforcement of drug laws with low-level street offenders. The Anti Drug Abuse Act also implemented mandatory minimum sentences for the first time, for drug trafficking, drug importing, and drug possessing including the 1:100 ratio for crack cocaine versus powder cocaine (Weinstein, 2003).

Truth in Sentencing

In 1987, the United States Sentencing Commission produced the first set of sentencing guidelines, which included the concept of truth in sentencing. There were three main goals for truth in sentencing. The first goal was to give the public a better idea of how much time an offender would serve for his/her crime. The second goal was "to increase the proportion of a sentence that is served in prison, generally to 85 percent, and/or to

eliminate parole release as a means of reducing crime by keeping offenders incarcerated for a longer period of time" (Mauer, 1996, p.1). The final goal included helping policy makers to be able to estimate how many people would be incarcerated at a given time in order to be sure there was enough bed space (Mauer, 1996). By 1994, the federal government was encouraging states to adopt the idea of truth in sentencing. "Both the 1994 and 1995 federal crime bills contained provisions to encourage states to adopt truth in sentencing as a condition of receiving federal prison construction aid" (Mauer, 1996, p. 1).

Although the Sentencing Reform Act and the guidelines that were produced from this Act were meant to decrease sentencing disparity, this has not been the case. The intersection of the guidelines and the mandatory minimums has made understanding sentencing a difficult task for lawyers and judges. Therefore, those who are assigned to public defenders are often at a disadvantage because interpreting the guidelines takes time and can be tedious. "While a public defender is likely able to make certain procedural arguments given the frequency with which they arise, she is likely to be incapable of handling the intricacies of Guideline cases if she is constrained by limits on her resources, most importantly her time" (Hall, 1999, p. 9). Therefore, public defenders are more likely to advise their clients to take the plea bargain to avoid long sentences. This creates disparity within sentencing because the sentence given is then dependent upon the prosecutor not the guidelines.

Research conducted on judges and federal sentencing guidelines shows that judges sentenced approximately 2/3 of all offenders within the sentencing guidelines. The remaining 1/3 received a downward departure from the guideline. One half of these 1/3

received less time because "…the defendant provided substantial assistance in the investigation or prosecution of others" (Weinstein, 2003, p. 5). The other half of the 1/3 sentenced to less time received a shorter sentence because the judge felt there were aggravating or mitigating circumstances that should be taken into consideration (Weinstein, 2003).

These guidelines[1] were implemented in order to reduce disparity within sentencing. However, 40 percent of a prosecutor's caseload is narcotics offenders. Because these offenders can reduce their sentences by telling on one another, their sentences remain disparate. Therefore, some narcotics offenders receive relatively short sentences; while others, who do not or cannot tell on another, receive longer sentences. In 1984, the average sentence for a narcotics offender was 27 months, but by 1993, the average sentence was 79 months in length. Therefore, "…prosecutorial discretion has become the unchecked power that allows individual prosecutors to choose among a vast range of punishments with almost no review, causing unwarranted disparity and excessive punishment" (Weinstein, 2003, p. 7).

Mandatory minimums have also increased sentencing disparity and length because some drugs have harsher penalties attached to them. Cocaine, for example, carries a different sentence based on the form of the drug, where 1 gram of crack cocaine warrants the same sentence as 100 grams of powder cocaine. Mandatory minimums allow judges to sentence more harshly than the minimum punishment set, but not to give a lesser sentence except for in the case of first time offenders who are automatically given a different set of minimums as a safety feature (Weinstein, 2003).

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[1] Two Supreme Court cases have recently found sentencing guidelines to be unconstitutional at the state (Blakely v. Washington 2004) and federal (United States v. Booker 2005) levels (www.findlaw.com, 2006).

Researchers have studied the effect of mandatory minimums and guidelines on different circuits and districts to see if there were different results based on the district or circuit (Kautt, 2002). The researchers discovered that the offense seriousness and criminal history standards were not being applied consistently across all districts and circuits. Therefore, the intent of the guidelines to end disparity has not been met. Their results suggest, "…that these formal determinate sentencing mechanisms do not actually reduce sentencing disparity. Instead, they simply give the illusion of uniformity via their strict control of discretion when, in reality, they enable indirect extralegal disparity to persist" (Kautt, 2002, p. 18).

The 1987 Federal Sentencing Guidelines also added to the length of sentences for inmates through the *truth in sentencing* concept. By encouraging the use of truth in sentencing, the federal government increased the length of sentences for inmates and contributed to the overcrowding of the prison system. Before the movement to abolish parole, inmates were encouraged to participate in programs to improve their image before the parole board. However, with the removal of parole, there is little incentive for rehabilitation or good behavior (Mauer, 1996).

Summary

In the United States, the 1960s and early 1970s represented a period of optimism regarding offender rehabilitation. This hopeful environment also incorporated the correctional system, where the focus was on rehabilitation and treatment. Then, in the late 1970s, the political ideology shifted toward a more conservative agenda. The United States moved away from a focus on reform and began, instead, to concentrate upon the elimination of crime, particularly drug offenses through increased punishment and less

treatment. This shift occurred as the media began to portray criminal activity as a widespread epidemic, even as crime rates in the United States were decreasing. The media's coverage contributed to a moral panic, leading to the public demanding protection from the perceived crisis. Politicians reacted to media coverage and political pressure from constituents by passing "get tough on crime" bills, including changes in sentencing structures. As more money was spent to aggressively enforce drug/crime laws, the number of people incarcerated continued to rise. Many new prisons/jails were constructed in order to warehouse the influx of prisoners, even though crime rates were decreasing (Beckett & Sasson, 2004).

Over the past twenty years, as a result of changes in crime policy, the number of people imprisoned in the United States has dramatically increased (See Figure 7 & 8). In 1980, before the Anti Drug Abuse Act, there were 294,000 people incarcerated in state facilities (www.ojp.usdoj.gov/bjs/, 2003) including 19,000 who were sentenced for drug offenses (Bush-Baskette, 2000). By 1990, four years after the Anti Drug Abuse Act had been passed, there were 681,400 inmates in state custody (www.ojp.usdoj.gov/bjs/, 2003) including 149,600 drug offenders (Harrison & Beck, 2002).

(Harrison & Beck, 2004)

	1980	1990	2002

204,000 681,400 1,315,006
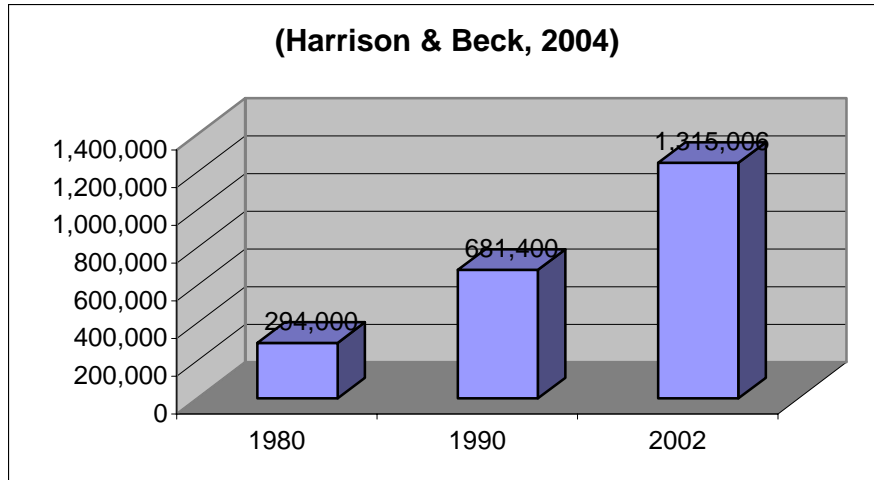
Figure 7. Men and women incarcerated in State Prison from 1980-2003.

(www.ojp.usdoj.gov/bjs, 2003)

19,000 149,600 265,000

	1980	1990	2002
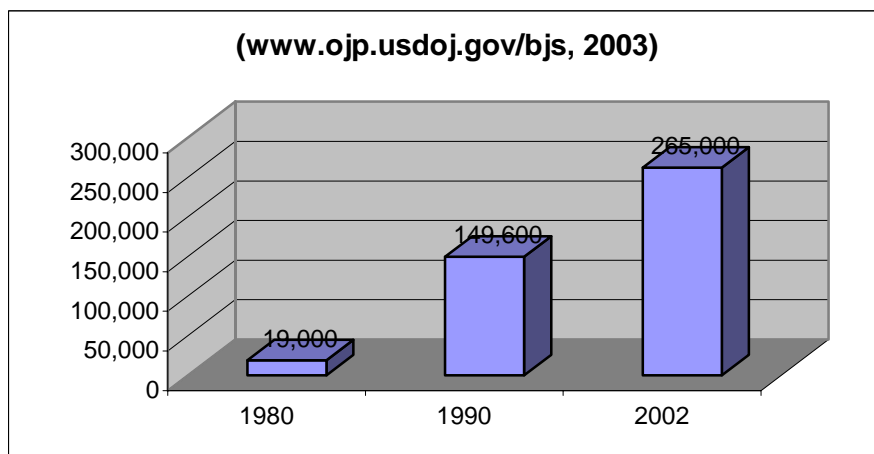
Figure 8. Male and female drug offenders from 1980-2003.

"The dragnet cast by current sentencing policies and practices are bringing into U.S. prisons nonviolent, first-time, and petty criminals who are disproportionately African American" (Gilbert, 2000, p. 230). This has been particularly true for female drug offenders (See Figures 9 & 10). Between 1995 and 2004, the average annual rate of growth for numbers of females incarcerated (**5.0 percent**) in federal or state facilities exceeded that of men (**3.3 percent**) (Harrison & Beck, 2004, p. 5).
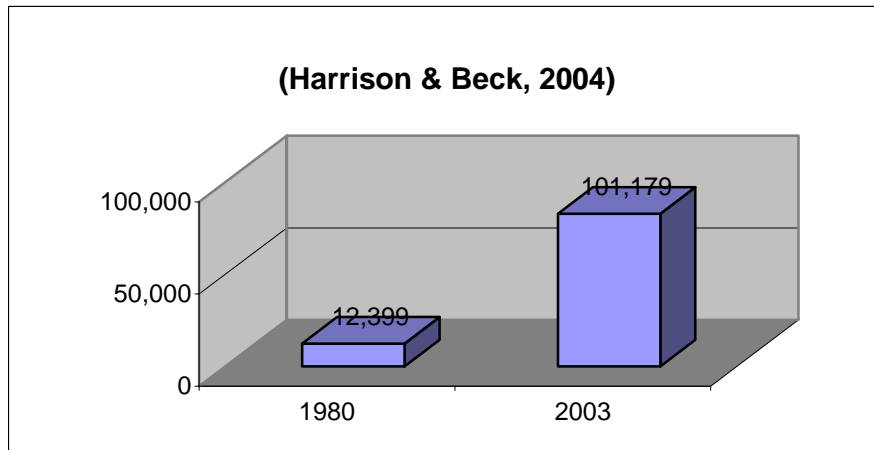
Figure 9. Growth in female inmate population from 1980-2003.
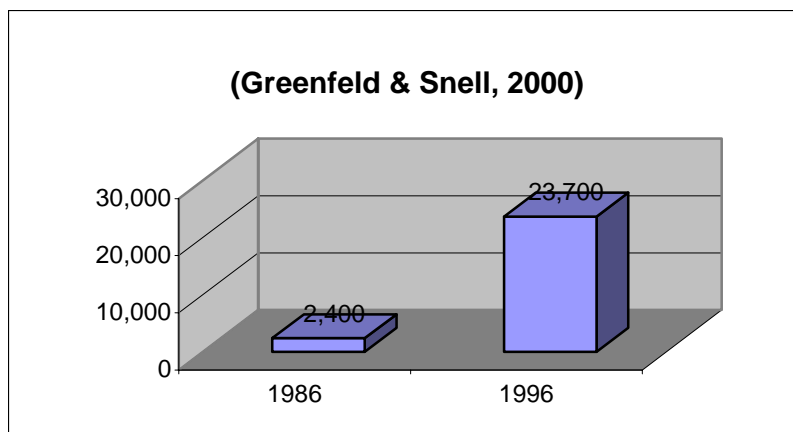
Figure 10. Growth in female drug offenders from 1986-1996.

Women in Prison

In 1998, female offenders (See Figure 11) tended to be on average 36 years old and the majority (47 percent) had never been married, 17 percent were married and another 30 percent were either separated or divorced (Greenfeld & Snell, 2000). Female state inmates also had low levels of education (See Figure 12) and only 39 percent had completed high school or the GED, while 37 percent had some high school and 7 percent had an 8th grade education or less (Greenfeld & Snell, 2000). The majority of women in state prison (65 percent) also reported having 2.11 minor children (Greenfeld & Snell,

2000). A large portion of women also experienced abuse prior to incarceration and many

women experienced economic marginalization.

(Greenfeld & Snell, 2000)
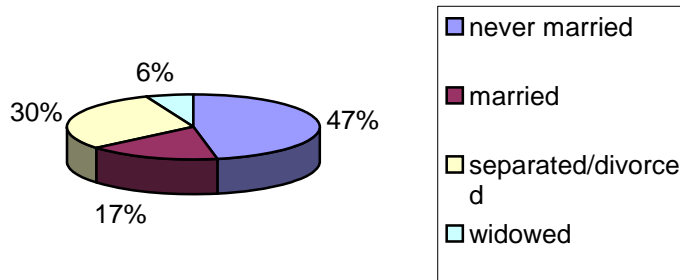
Figure 11. Female inmates and marital status in 1998.

(Greenfeld & Snell, 2000)
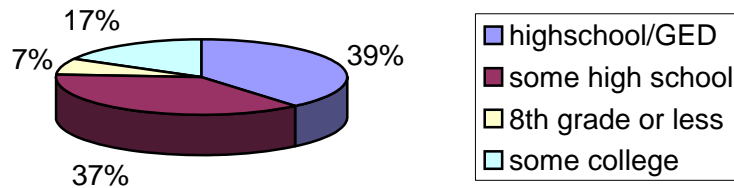
Figure 12. Female inmates and education in 1998.

Female Inmates and Race

African American women are disproportionately represented in state prisons. In 1998,

33 percent of women in state prison were White, 13 percent were Latina and 48 percent

were African American. By comparison, 70 percent of the U.S. population was White,

13 percent Latino and only 12 percent African American. The overrepresentation of

African American women in prison is partly due to African American women receiving

longer sentences than White women. Steffensmeier, Kramer, & Streifel (1993) conducted research in which they examined gender differences in state sentencing decisions in Pennsylvania from 1985-1987. The authors discovered that race did not impact the sentences of male offenders, but, on average, African American women received sentences approximately 3 months longer in length than White women. White women also are more likely to receive probation than African American women. In 1998, 62 percent of female probationers were White, in comparison to 27 percent of African American women and 10 percent of Hispanic women (Greenfeld & Snell, 2000).

African American women also are more likely to come from neighborhoods that have experienced high rates of incarceration. The research of Clear, Rose, Waring & Scully (2003) examined neighborhoods in Tallahassee, Florida and the impact of incarceration on these neighborhoods. The authors discovered that "…increasing admissions to prison in one year have a negligible effect on crime at low levels and a negative effect on crime the following year when the rate is relatively low, but, after a certain concentration of residents is removed from the community through incarceration, the effects of additional admissions is to increase, not decrease crime" (Clear et. al, 2003, p. 55). Therefore, many African American female inmates are coming from neighborhoods that have been left socially disorganized with little informal social control due to high incarceration rates. African American children, for example, are 9 times more likely to have a parent in prison than a White child (Mumola, 2000). It is not surprising then that nearly half of all female inmates have never been married and 30 percent reported being on welfare one month prior to incarceration (Greenfeld & Snell, 2000).

Female Inmates and Children

Female offenders also are more likely to have been the primary caretaker of their children prior to incarceration. In 1997, 64.3 percent of female inmates in state prison reported living with their minor children prior to incarceration, while 43.8 percent of men reported the same (Mumola, 2000). The majority of children of inmate fathers lived with their mother (89.6 percent), while 13.3 percent lived with a grandparent and 1.8 percent resided in foster care (Mumola, 2000). Children of female inmates (See Figure 13) were more likely to live with a grandparent (52.9 percent), while 28 percent of children resided with their fathers and 9.6 percent were sent to foster care. The majority of parents were being incarcerated at least 100 miles from their families, so only 23.8 percent of mothers and 21 percent of fathers received monthly visits from their children (Mumola, 2000).

(Mumola, 2000)

10%

28%

53%

- live w/ grandparent
- live w/ father
- foster care
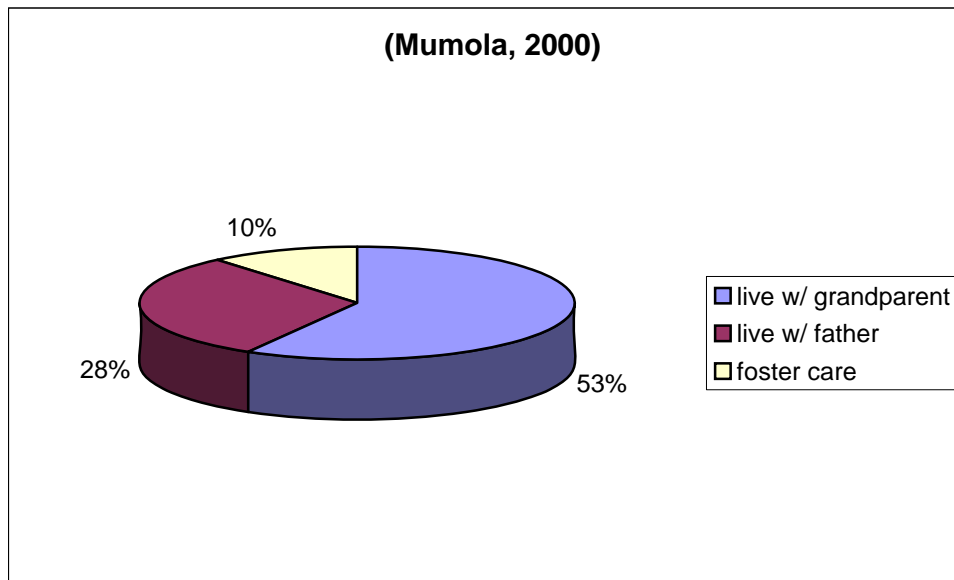
Figure 13. Caretakers of female inmates' children in 1997.

The rate of incarcerated mothers is growing faster than incarcerated fathers because the rate of female inmates is growing faster than male inmates. "Children with a mother in prison nearly doubled (up 98 percent) since 1991, while the number of children with a

father in prison grew by 58 percent during this period [1991-1998]" (Mumola, 2000, p. 2). In state prison, parents also were more likely to be serving time for a drug offense (24 percent) than non-parents (17 percent). "More than 4 in 5 parents in state prison reported some type of past drug use, and a majority (58 percent) said that they were using drugs in the month before their current offense" (Mumola, 2000, p. 7). Drugs were a serious problem for inmate mothers and 65 percent of inmate mothers reported serious drug problems versus 58 percent of inmate fathers. "In addition, 32 percent of mothers in state prisons reported committing their crime to get drugs or money for drugs, compared to 19 percent of fathers" (Mumola, 2000, p. 8).

Female inmates also experience economic marginalization. The majority of these women has never been married and supports her children on a single parent income. Therefore, 18 percent of inmate mothers experienced being homeless in the year prior to incarceration (Mumola, 2000). Unemployment also was a problem for inmate mothers; 50 percent of inmate mothers reported being unemployed prior to prison and 70 percent reported an income of less than $1,000 a month (Mumola, 2000). Overall, female inmates have a more difficult time economically than male inmates. For example, 60 percent of male inmates were employed full-time prior to prison, while the figure for female inmates was 40 percent (Greenfeld & Snell, 2000).

Female Inmates and Prior Victimization

Female inmates also have been the victims of physical and sexual abuse prior to prison, both as children and as adults. In a 1999 survey of state prison inmates, 57.2 percent of women stated that they had been abused (Harlow, 1999). Over forty-six percent of female inmates reported that they had been previously physically abused,

while 39 percent stated prior sexual abuse. Male inmates also experienced abuse, but reported much lower rates. Approximately thirteen percent of male inmates had experienced previous physical abuse and 5.8 percent had experienced previous sexual abuse (Harlow, 1999). Abuse for both male and female inmates is higher than in the general population, where 5-8 percent of men and 12-17 percent of women are abused as children (Harlow, 1999). Inmates who have experienced previous abuse are more likely than non-abused inmates to report using illegal drugs regularly; for example, 76 percent of male abuse victims and 80 percent of female abuse victims reported using illegal drugs regularly. Inmates who have experienced past abuse are also more likely to have been using alcohol or drugs at the time of their offense (Harlow, 1999).

Research has shown that neglected and abused children are more likely than non-abused children to suffer from chronic low self-esteem, anxiety, depression, substance abuse and suicide attempts (Widom, 2000a). Approximately one third to one half of children sexually abused will experience intense fear and anxiety, which are characteristics of posttraumatic stress disorder (Van Wormer and Bartollas, 2000). Widom's (2000b) longitudinal study compared individuals, at ages twenty-six and thirty-three, who had been abused or neglected as children to a control group which was comparable, but whose participants were not abused or neglected. She found that those who had been abused or neglected had a lower IQ score, less schooling, more unemployment, a higher separation/divorce rate and higher suicide attempts compared to those who had not been abused or neglected. The results were even more startling for women who had been abused or neglected. Girls who had been abused or neglected were twice as likely to be arrested as juveniles and as women (Widom, 2000b). "Females

abused and neglected in childhood were more likely than controls to attempt suicide, to abuse alcohol or be dependent on it, or to suffer from an antisocial personality disorder" (Widom, 2000b, p. 5-6a). For example, forty-three percent of women who had been abused or neglected also abused alcohol or were dependent on it versus thirty-two percent of women who had not been abused who were also dependent on alcohol. This difference between the two groups of abused versus not abused was not found for men regarding alcohol abuse. This may be attributable to differences between men and women in coping with stress.

"Some [researchers] have noted that differences between men and women in manifesting the consequences of abuse may parallel gender differences in the way psychopathology is expressed. Thus, aggression (in males) and depression (in females) may express the same underlying distress, perhaps reflecting gender-specific strategies for maintaining self-esteem in the face of perceived rejection" (Widom, 2000a, p.30). Research conducted with victims of trauma show that women cope in dangerous stressful situations by doing one of three things: denying the threat, being highly suggestible, or withdrawing from the situation emotionally (Van Wormer and Bartollas, 2000). Therefore, "abuse or neglect may encourage certain dysfunctional ways of coping" (Widom, 2000b, p. 8a).

Summary

Women are typically imprisoned for non-violent offenses and are disproportionately African American. Female offenders have little education, are the primary care takers of their children, experience economic marginalization and have high rates of previous physical and sexual abuse. Many of these women have been brought into the criminal

justice system because of their drug habits. Women are not using and/or abusing illegal drugs at a higher rate than they did twenty years ago. However, because women are more likely than men to abuse substances, women who use, sell and/or possess illegal drugs have become unintentional targets of the War on Drugs.

<div align="center">Coping</div>

Psychologists Richard Lazarus and Susan Folkman define coping "…as constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (1984, p. 141). Coping is a process that changes with the circumstances or the environment; therefore, what works well in one situation may not work well in another situation (Lazarus & Folkman, 1984).

There are two processes that occur when one copes (Lazarus & Folkman, 1984). The first, emotion-focused, handles the emotional response to the situation with feelings such as guilt or anger. After reacting emotionally to the situation, one must accept that there is a problem at hand. This begins the second part of the coping process – problem-focused. The second process occurs when efforts are "directed at defining the problem, generating alternative solutions, weighing the alternatives in terms of their costs and benefits, choosing among them, and acting" (Lazarus & Folkman, 1984, p. 152). Both processes occur in almost all situations, and, in order to be considered to be coping effectively, one must be able to perform both parts of coping well.

The coping process begins when one is faced with a decision and he/she must make an appraisal (Lazarus & Folkman, 1984). An appraisal occurs when a person examines the situation and decides what to do. There are two types of appraisals: the primary appraisal

is emotion-focused and occurs when one reacts to a current situation, while the secondary appraisal is problem-focused and occurs when one reacts to the situation over the long run. Appraisals can be ineffective when the person does not perceive harm that is there and vice versa. A person can react appropriately to a situation initially and then not be able to move on or, in other words, react inappropriately during the secondary appraisal (Lazarus & Folkman, 1984).

According to Lazarus and Folkman (1984), how well one copes during the secondary appraisal depends upon the resources that one has available to him/her. These include health and energy, positive beliefs, social skills, social support, and material resources. However, there also are constraints that can work against one using his/her resources. There are personal constraints, which "…refer to internalized cultural values and beliefs that proscribe certain types of action or feeling, and psychological deficits that are a product of the person's unique development" (Lazarus & Folkman, 1984, p. 165). Another type of personal constraint results from fears of success or failure, while "problems with authority figures, dependency needs, and preferred styles of doing things can also figure prominently as constraints" (Lazarus & Folkman, 1984, p. 166). A second type of constraint involves the environment. Environmental constraints may prevent one from using resources, or there may not be enough resources. One must also consider the level of threat when discussing resources because "the greater the threat, the more primitive, desperate, or regressive emotion-focused forms of coping tend to be and the more limited the range of problem-focused forms of coping" (Lazarus & Folkman, 1984, p. 168). Therefore, if a person feels that he/she may be harmed, he/she will rely more heavily upon emotion-based skills such as fight or flight rather than thinking the

problem through and weighing the consequences. The coping challenge here lies in one's ability to effectively move from emotion-focused to problem-focused, without relying more heavily upon either process.

Gender Differences and Coping

When examining coping, it is clear that there are gender differences in the ways that men and women cope. Psychologist Carol Gilligan (1993) believes that women differ from men in the way that they react to a situation because of differences in development and socialization. These differences affect the ways that men and women interact with others. Women rely on relationships to define themselves and their actions, whereas men rely more heavily on themselves and react based upon how the situation will affect them personally (Gilligan, 1993).

> "From the different dynamics of separation and attachment in their gender identity formation through the divergence of identity and intimacy that makes their experience in the adolescent years, male and female voices typically speak of the importance of different truths, the former the role of separation as it defines and empowers the self, the latter of the ongoing process of attachment that creates
>
> and sustains the human community" (Gilligan, 1993, p. 156).

The differences between men and women and how they cope are also expressed through psychological distress. Women, for example, are more likely to experience depression and anxiety disorders and are more likely than men to take psychotropic medications (Wethington, McLeod, & Kessler, 1987). "Research on acute stressors has discovered that although men and women do not differ much in the number of undesirable life events they experience, women are significantly more affected emotionally by life events" (Wethington, et al., 1987, p. 145). In research conducted by Wethington et al. (1987), women were more likely to be affected by events that happen to

people whom they consider to be important to them, while men were less affected. This does not mean that men lack empathy, but rather that "men's concerns for others may show itself in particular relationships; but compared to women's concerns, it does not extend as far into their social networks" (Wethington, et al., 1987, p. 149).

Summary

How well one copes with stress depends upon his/her life experiences and how one is taught to react to stress as a child. The coping skills an individual possesses allow him/her to adapt to his/her environment and to survive. The ability to adapt is particularly important for inmates who must learn to cope with an entirely new stressful environment. However, many inmates come into the correctional system with personal constraints such as abuse, poverty and little education along with the environmental constraint of being imprisoned. These constraints make it difficult to cope and adjust to the prison environment.

Coping Research and Female Inmates

The following studies examine research conducted with female inmates to assess their coping skills and their subsequent ability to adapt to the prison environment. The differences between coping and adaptation should be delineated in order to be sure that these two concepts are clear. When one encounters stress, he/she attempts to cope with the situation by relying on coping skills learned throughout life. Coping skills can range from negative to positive. A positive coping skill would include the handling of a stressful event by reflecting on the situation and deciding a course of action, while a negative coping skill is used when one attempts to avoid or deny stress through substance abuse.

If one possesses a variety of positive coping skills, he/she will be able to handle most stresses in life, allowing the person to successfully adapt to most situations. However, if one possesses few or no positive coping skills, he/she will encounter difficulty when attempting to handle stressful events and will be unable to adapt to the environment in a positive manner. Therefore, positive coping skills lead to positive adaptation when dealing with stress, while negative coping skills lead to negative adaptation when handling problem situations.

In 1966, Rose Giallombardo (1966) conducted one of the first examinations of women's lives while in prison. Giallombardo's study took place in the Federal Prison for women in Alderson, West Virginia. At the time of this study, very little was known about female inmates. After observing the women, Giallombardo concluded that prison life for women mirrored women's lives and roles on the outside. "The culture that emerges within the prison structure may be seen to incorporate and reflect the total external social structure; that is, the way in which roles are defined in the external world influence the definitions made within the prison" (Giallombardo, 1966, p. 187). Relationships, therefore, are central to women's lives on the outside and also while in prison. Female inmates in Giallombardo's study created psuedo families as a coping skill to adapt to prison life. These roles are similar to roles women play outside prison, such as mother, aunt, or sister. A small minority of women in prison was found to take on the male role within the family such as father, uncle or brother (Giallombardo, 1966).

Therefore, women in prison adapt to life in a similar manner as women adapt in the free world - by constructing relationships (Giallombardo, 1966). Giallombardo concludes her book by writing, "greater understanding of the prison communities, then,

may best be accomplished by focusing attention on the relationship of the external and internal cultures, rather than by trying to understand the prison as an institution isolated from the larger society" (Giallombardo, 1966, p. 188).

The women in Giallombardo's study were incarcerated in the 1960s. Since these women were incarcerated prior to the 1980s, there would be fewer women imprisoned for drug charges. In 1975, for example, women were typically incarcerated for larceny, forgery, embezzlement or prostitution, while by 1995, "…women were primarily incarcerated for drug-related offenses and larceny" (OJP Coordination Group on Women, 1998, p. 1). The women in Giallombardo's study possibly came to prison with a different set of coping skills than women who are currently incarcerated, reflecting changes in drug laws and convictions for drug crimes. Therefore, as suggested by Giallombardo, the current study will take into consideration women's lives before prison and how these experiences affect coping.

James Fox, during the 1970s, conducted a second study on female inmates and coping (Fox, 1988). This study took place over a period of five years in the Bedford Hills Prison, New York's maximum-security state prison for women. Fox found that women did form pseudo families or close relationships with other women, but that these relationships helped the inmates to "…deal with the impersonal nature of confinement" (Fox, 1988, p. 210). Fox concluded women in prison formed relationships to meet needs that could not be obtained in the prison (Fox, 1988). However, there also were problems that these relationships were unable to address such as "…the interaction of accumulated tensions and situational influences" (Fox, 1988, p. 211).

Fox documented three main problems that tended to cause stress for female inmates. The first problem was staff and rules, more specifically, conflicting rules and inconsistent application of the rules. A second problem that stressed female inmates was the perceived lack of respect from prison staff. Fox, however, noted that this was more of a problem for younger inmates. A third stress-inducing problem for female inmates was separation from their children. The women worried that their children were suffering from this separation and also about their care in their absence. Fox (1988) reported that women dealt with these stresses through emotional outbursts or by requesting medication to deal with the stress to avoid an emotional outburst.

Fox concluded that female inmates cope by seeking social support in order to adapt to the prison environment. However, Fox also noted that there were other stressors that female inmates were unable to handle through peer relationships, including inconsistently applied rules, disrespect from staff, and separation from children. Since female offenders are in prison where rules ensure safety, it seems likely that substance-abusing female inmates would also find this to be a source of stress. Female inmates also tend to be the primary care taker of their children, and the majority of these women do have children. Therefore, separation from children also would be a valid source of stress for substance abusing female inmates.

Stress related to staff and rules, as well as separation from children, caused the women in Fox's study to rely on negative coping skills. The female inmates coped by either having emotional outbursts or by requesting medication to avoid such outbursts. These are both negative coping skills because the emotional outburst is a reaction prior to assessing the situation, while the medication request is avoidance of the problem. The

current study recognizes that female inmates with substance abuse problems possess poor coping skills and have in the past coped with stress by abusing substances. Now that reliance on illegal substances is not an option due to incarceration, it is hypothesized that these women will replace one set of negative coping skills with another, such as emotional outbursts or reliance on prescription medication.

MacKenzie, Robinson, and Campbell (1989) conducted research with female prisoners to assess their coping skills and to determine if length of sentence affected one's ability to cope and adjust to prison. The authors compared three different groups of female inmates, each with varying sentence lengths, as well as differing lengths of time served. The first group consisted of those with a short sentence who had not yet been imprisoned for a long period of time. The second group had been in prison for a short amount of time, but had been given a long sentence. The third group had been imprisoned for a longer period of time, but was also serving a long sentence. The authors hypothesized that those who had been imprisoned for longer periods of time would possess better coping skills, having had more opportunity to become oriented to the prison environment and therefore become better adjusted to prison life (MacKenzie et. al, 1989).

The authors concluded that those who had been imprisoned for a short period of time, regardless of length of sentence, tended to be concerned with security issues. This led newer prisoners to cope by forming play families that allowed them to adjust to the prison environment. Those who had been imprisoned longer reported that they had more needs and problems related to their environment, such as missing favorite foods or lack of job opportunities. Overall, the three groups did not show differences in anxiety or

coping. This led the authors to conclude that length of sentence had little to do with one's coping skills because these skills were learned before incarceration (MacKenzie et. al, 1989).

In MacKenzie, Robinson and Campbell's (1989) study, women's ability to cope with stress and adjust to their environment is examined through length of incarceration. This study examines a sample of women from a minimum-security prison that is representative of the many different types of offenders found there. Therefore, the women in this study are not all drug offenders and could possibly be coming to prison with better coping skills than women addicted to drugs. The authors concluded that length of stay had little to do with the ability or inability to cope with stressors in the prison environment. The ability to cope in prison had more to do with skills learned before incarceration. It seems likely that for drug-addicted female offenders, the differences in ability to cope with stress in prison will be based upon experiences prior to prison as well. Therefore, the current study will also examine life before incarceration to assess its effect on one's ability to cope.

Negy, Woods and Carlson (1997) also examined coping and adjustment with 153 female inmates in a minimum-security facility. The researchers had the inmates fill out a selection of psychosocial measures to both determine coping strategies and identify strategies associated with positive adjustment. The researchers discovered that those who engaged in poor coping skills, such as denial and physical withdrawal, experienced depression, anxiety, and low self-esteem. Those who utilized positive coping skills were proactive, planned a specific course of action for dealing with a problem, thought a problem through before reacting, reinterpreted events in a positive manner, and turned to

religion to handle stress. Therefore, those who used and possessed a variety of positive coping skills experienced less depression and anxiety and higher self-esteem.

The women who possessed positive coping skills had obtained these skills before their incarceration and were able to successfully adapt to the prison environment using these positive coping tools. However, women who possessed poor coping skills before imprisonment were unable to adjust to the prison environment because they were unable to handle the daily stresses of prison life and so experienced anxiety, low self-esteem, and depression (Negy, et. al, 1997).

Female substance-abusing inmates will also be relying upon previously learned coping skills. It seems likely that drug addicted female inmates who are in treatment will be exposed to positive coping skills during treatment, while female inmates on the waiting list for treatment will be relying on what they know, which is denial as a negative coping technique. The women on the waiting list will then experience higher levels of depression, anxiety and low self-esteem due to their use of poor coping strategies. However, women in treatment will begin to rely more on newly learned positive coping skills, such as seeking social support and problem-solving. It is likely that female offenders in treatment will then experience less depression, anxiety and have higher self-esteem.

Barbara Owen (1998) conducted a more recent study on female inmates and coping within their environment. Owen's research took place in the Central California Women's Facility, a maximum-security prison in Chowchilla, California. This facility is currently the largest female prison in the world. Owen was interested in two main questions; how do women do time and "how has the prison culture for women changed from the findings

of earlier empirical research" (Owen, 1998, p.1)? Owen's research took place over a

three-year period where she made observations and conducted individual and group

interviews with a diverse group of women.

Owen argues that the women's lives before prison greatly influence their lives in

prison. "In examining their lives before prison, three central issues specifically shape the

study of prison culture for women: multiplicity of abuse in their pre-prison lives; family

and personal relationships; particularly those relating to male partners and children; and

spiraling marginality and subsequent criminality" (Owen, 1998, p. 41).

Owen, prior to her interviews with the women in her current study, conducted a

survey with a sample of female inmates from all of the California women's facilities

(Owen, 1998). This survey revealed that 71 percent of the women had suffered from

ongoing physical abuse as a child from a father, stepfather or mother, while 62 percent

reported ongoing physical abuse as an adult by a spouse or partner. Many of the women

also reported sexual abuse with 41 percent reporting ongoing sexual abuse as a child and

40 percent reporting ongoing sexual abuse, as an adult. Rates of emotional abuse were

also high. Eighty-five percent reported ongoing emotional abuse as a child by a mother,

father or stepfather, and another 85 percent reported ongoing emotional abuse as an adult

coming from a spouse or partner (Owen, 1998, p. 43).

Children and family also were a major concern for female inmates in California's

Central Women's Facility. A majority of the interviewed women (80 percent) had

children who were their primary connection to the outside world. "Relationships with

children are sacred among the women at CCWF and provide[d] a basis for attachment to

the outside world not always found among male prisoners" (Owen, 1998, p. 101). Owen

noted that many of the women also had family members who were incarcerated while they were growing up.

Economic marginality was another problem for the women that Owen (1998) interviewed. About half of the women interviewed reported they had never worked. Nearly one-third of the women attributed not working due to substance abuse problems. For some of these women, criminal activity paid their bills. Struggling with poverty and prior victimization, these women attempted to avoid and deny their problems through substance abuse, typically supported by criminal activities. Their poor coping skills, learned and utilized in their pre-incarceration environment, played a role in their eventual incarceration (Owen, 1998).

Approximately 68 percent of the women did not finish high school or obtain a GED. Many became pregnant at a young age and were unable to finish school. Therefore, with few skills and little education, many of the women remained unemployed or unable to obtain legitimate employment. Owen wrote, "…these data also suggest that the prime motivation for most women's crime is economic, psychological and emotional survival" (Owen, 1998, p. 61).

Through her interviews, Owen found that the majority of women in prison relied on two primary mechanisms to cope with and adapt to their environments. The first was avoidance of what the women referred to as "the mix". The mix included being involved in fights and drug use, both of which got the women into trouble and reduced their "good time". Drug use, drug sales and fights typically take place in the prison recreation yard. Therefore, most of the women interviewed tended to avoid the yard area and preferred to

spend time in their cells where they felt safer. Women were able to avoid the mix by staying busy either through programs or work assignments.

Women also coped with their environment by developing close relationships with other women in the form of pseudo families or a close friendship with another woman (Owen, 1998). These relationships were usually heterosexual in nature.

Owen found that overall prison life for women had changed little since the days of Giallombardo's study. She concluded that women's lives before prison should still be taken into consideration when trying to understand prison life. Women continue to adapt to prison life, just as they adapt to life on the outside, by using the positive coping skill of seeking social support through relationships with the people around them. "Personal relationships with other prisoners, both emotionally and physically intimate, connections to family and loved ones in the free community, and commitments to pre-prison identities continue to shape the core of prison culture among women" (Owen, 1998, p. 4).

As discussed by Owen, other aspects of these women's lives before prison, are just as important for drug abusing and non drug abusing female offenders and include economic marginalization, children, and prior abuse. Most female offenders have children and are the primary care taker of their children. This is true for both drug abusing and non-drug abusing female inmates. Overall, female offenders experience high rates of abuse and economic marginalization, while drug addicted female offenders experience even higher rates of prior abuse. In Karageorge and Wisdom's 2001 study, for example, about half of the women who were participating in community-based substance abuse treatment had experienced prior abuse "…compared to about one-third of women in the general population" (p. I).

Owen does not discuss the impact of race/ethnicity or class on coping. It seems likely that women from different ethnic/racial and class backgrounds will cope differently based upon different cultural and life experiences. Therefore, a White middle class woman will have different life and cultural experiences than an African American working class woman. These differences will affect the ways in which the women cope and how they respond to treatment. West (2001), for example, examined an HIV/AIDS education program in a women's prison and concluded that race/ethnicity differences accounted for the program being more effective for White and African American women than Latina women. Latina women did not respond to the AIDS education program because of cultural and religious differences. For example, Latina women were less likely to use condoms during sexual intercourse due to their Catholic upbringing and their male partner's beliefs in machismo, thus refusing to wear condoms (West, 2001).

Greer (2002) also conducted qualitative research with 35 female inmates at a medium security prison to examine the ways in which female inmates handle their emotions or cope while incarcerated. Greer noted that the women felt vulnerable when expressing their emotions and so rarely did. The women stated that if they cried, they were thought to be weak by other inmates, and staff would refer them to psychological services, which the inmates feared would not look good for early release. The women also stated that they feared expressing anger or frustration because these emotions could result in a rule violation and further punishment. Many of the women interviewed by Greer had dealt with problems in their lives through substance use and abuse and "as a consequence of being in prison and substance-free, they now found themselves at a loss for understanding how to respond to their emotions" in a positive manner (Greer, 2002, p. 124).

Greer (2002) found five main coping strategies used by the women she interviewed. Some of the women had developed positive coping techniques such as prayer/religion, humor and reflection and analysis of one's problems. Several of the women, however, also engaged in negative coping techniques. For example, some avoided the stress altogether and participated in activities such as watching television or playing cards for diversion. The women also buried their emotions, so that others would not see them hurting. Several women stated that they would often cry in the shower where no one could hear or see them. Those who utilized poor coping skills often had difficulty adjusting to their environment. "Repressing their emotional experiences had definite consequences for themselves and their social relationships – resulting in a vicious interactional cycle, one that limits development of individual resources for coping with emotional experiences and discourages formulation of edifying and supportive social relationships" (Greer, 2002, p. 134).

Greer found that women did not express their emotions because this made them appear vulnerable to staff and other inmates. In Greer's research, some women handled their emotions positively through religion, humor and problem-solving skills, while others relied on negative coping skills where stress was avoided by burying emotions or playing cards and watching television. It seems likely that drug addicted women will also fear expressing their emotions and appearing vulnerable.

Summary

Women inmates' lives tend to be shaped by their pre-prison experiences and their families. The stress of everyday prison life and the stress of being separated from children weigh heavily on women in prison. Giallombardo(1966), Owen (1998) and Fox

(1988) all found that female inmates rely on personal relationships both within and outside the prison in order to cope with their environment. In Owen's study, the women dealt with these stressors by avoiding additional problems (or the mix) and developing personal relationships with other women, which is similar to Giallombardo's findings. In Fox's study, women tended to have emotional outbursts or request medications when relationships were unable to help reduce the stress. Overall, these studies concluded that female inmates handle the stresses encountered while in prison by relying heavily upon friendships and support from others.

Negy, Woods and Carlson (1997) also concluded that female inmates who possessed positive coping skills were less likely to experience depression and anxiety than women offenders who utilized negative coping techniques. It is likely then that female prisoners in treatment for substance abuse will learn new positive coping techniques, and as the women move through the program, they will learn to rely upon these skills more. These new positive coping skills will allow the women to face and work through their problems, causing them to experience less depression and anxiety. Women on the waiting list for treatment will still be utilizing poor coping skills, such as denial and avoidance, and will experience more depression and anxiety than women in treatment.

None of the researchers discuss how the prisoners' class and race/ethnicity impact their ability to cope. However, if one's ability to cope is directly related to prior experiences then differences among women should impact how one copes with stress. Therefore, women from different racial/ethnic backgrounds will have different cultural and life experiences, which will cause them to cope differently with stress.

Rehabilitation and Mature Coping

Criminologist Robert Johnson (2002) has noted that prisons in the United States have

become warehouses where people are stored for periods of time and then released.

Johnson believes that this punishment is unjust because inmates are not being

rehabilitated. Johnson writes, "We should reform our prisons because we as a society

wish to make our penal institutions effective instruments of punishment" (Johnson, 2002,

p. 267).

Johnson (2002) states the best way to reform the prison system is through the creation

of decent prisons. "The goal in a decent prison is for the prisoners to adapt to life behind

bars in healthy and responsible ways and from such adaptations to develop a mature

coping strategy for life in the free world as well." (Johnson, 2002, p. 16).

According to Johnson, in order to achieve this goal, inmates must be taught to cope

maturely. "Mature coping means, in essence, dealing with life's problems like a

responsive and responsible human being, one who seeks autonomy without violating the

rights of others, security without resort to deception or violence, and relatedness to others

as the finest and fullest expression of human identity" (Johnson, 2002, p. 83). There are

three characteristics for achieving mature coping. The first characteristic is to make life

decisions and not avoid them, to practice restraint, objectively examine the situation and

then make a decision based on the resources available. The second characteristic also

includes decision-making, but adds to do so without using deception or violence except

when absolutely necessary such as in cases of self-defense. "The third characteristic of

mature coping is making an effort to empathize with and assist others in need, to act as

though we are indeed members of a human community who can work together to create a more secure and gratifying experience." (Johnson, 2002, p. 93).

Johnson (2002) believes that mature coping can take place within small niches or communities within the prison. An example of a niche would be a pod within a prison that was separated from the general population, where inmates can promote a sense of community and create a less stressful environment. As the inmates become more comfortable, they will begin to bond and trust one another. Once these relationships take place, these niches become the ideal environment for inmates to work on their coping skills. The more practice inmates have with making decisions, the better they will become, which will also enhance their self esteem and provide encouragement for more opportunities for mature coping.

The goal, then, is to teach inmates how to cope within the prison environment, so that they will be able to cope within the free community upon release. Johnson notes that there are many similarities between prison life and free life, especially for most inmates who are poor and come from rough neighborhoods. Therefore, learning how to cope within the tough environment of prison may help these men to cope in their own neighborhoods.

> "Though it may not be obvious, there are parallels, sometimes striking parallels, between the pains of prison and the pains of life in general. These similarities can be exploited for correctional purposes. Prison citizenship can serve as a rehearsal for citizenship in other harsh environments, most notably the low-income, high crime (and distinctly prison like) milieus from which most prisoners are drawn and to which the vast majority of them will return." (Johnson, 2002, p. 14).

Johnson (2002) advocates the reform of the prison system through promoting decent prisons where mature coping skills can be practiced within niches. These coping skills will then give the inmate a better chance of coping with their life problems on the

outside. Johnson believes that in order for one to cope maturely, he must face his problems and deal with them in a non-deceptive and non-violent manner. These skills should be developed and practiced within a small niche where inmates can learn to interact in a pro social manner when making decisions and learn how to live within a community (Johnson, 2002).

Johnson's concept of mature coping is based on the research of Toch and Adams (2002) and Zamble and Porporino (1988, 1990) who conducted studies with male inmates to better understand male inmate coping and adjustment in prison. It is important to note that Johnson's work never specifically examined mature coping and female inmates. To better understand the basis of Johnson's concept of mature coping, these studies will be examined in greater detail.

Coping Research and Male Inmates

Toch and Adams (2002) conducted a study in 1986 to study male inmates and how they adapt during the course of their incarceration. Toch and Adams (2002) examined a cohort released from a New York state prison between July 30, 1982 and September 1, 1983. The authors collected disciplinary and mental health records for 9,103 inmates. The sample was then weighted, so that inmates with serious mental illness and disciplinary problems were over sampled. The authors created four groups, based upon the amount of time served and then examined behavior changes in two-month intervals (Toch & Adams, 2002).

The authors discovered, using multiple regression analysis, that those inmates who were younger, unemployed before prison, undereducated, and single were more likely to have higher infraction rates within the prison (Toch & Adams, 2002). Those who

committed an infraction within the first 30 days of their stay also were more likely to have higher infraction rates when compared to those who violated rules later on during their incarceration (Toch & Adams, 2002). The biggest predictor of infractions, however, was age, with younger inmates committing the highest number of infractions. Prior research has stated that inmates who serve life sentences tend to get along better with staff and are more mature. Toch and Adams (2002) concluded that this also was true for their sample, but they also noted that those serving life sentences tend to be older inmates.

Toch and Adams (2002) further examined individual adaptation over 90-day periods. The authors found that 75.3 percent of their sample were conformers who were not disruptive at least 2/3 of the 90-day period. "This finding indicates that relatively few inmates present serious disciplinary problems over most of their sentence" (Toch & Adams, 2002, p. 68).

The authors then examined 239 cases from their original sample; these cases represented inmates who had high disciplinary infraction rates. Toch and Adams (2002) offer several suggestions for improving the adaptation process for these inmates. One way to improve adaptation is through involvement where getting the person involved in "…adaptive behavior can serve to break a pattern of maladaptive acts by providing an alternative to the 'wrong' sort of involvement or by creating meaning and purpose where it has not existed" (Toch & Adams, 2002, p. 300-01). Sometimes a person can improve if he/she finds support through a staff person or attachment through programs or work. Another way to improve behavior is to send an inmate to another facility, perhaps where there are older inmates. Toch and Adams (2002) also consider reassessing the person or

providing a rewards and punishment system. The authors concluded that as inmates' age

and mature, behavior will improve (Toch & Adams, 2002).

Zamble and Porporino (1988) conducted a second study on male inmates and coping

in two maximum-security prisons and three medium security prisons in the Ontario,

Canada region. The purpose of this study was to examine coping and its effect on

adaptation for male inmates. Inmates with short-term (45), medium-term (47) and long-

term (41) sentences were interviewed and given questionnaires (Zamble & Porporino,

1988). This research was longitudinal and took place over a 16-month time period. As

soon as an inmate agreed to join the study, he was interviewed; 3-4 months later, he was

interviewed again, with a final interview taking place about one year later, for a total of

98 completed interviews. Institutional files also were examined for disciplinary

infractions and medical records (Zamble & Porporino, 1988).

The authors found that the majority of inmates were unable to cope effectively or

work through in a positive manner, day-to-day problems. "While many of their efforts to

cope were directly oriented toward problems, these efforts were unsystematic and mostly

scattered, sporadic and unplanned" (Zamble & Porporino, 1990, p. 57). The authors also

discovered that inmates were most motivated to change during their first few months of

imprisonment, while as time went on, they were less concerned with change. The authors

stated that those with poor coping skills were more likely to recidivate with "…the lower

the rating of a subject's general coping ability on the outside, the longer was his criminal

history (r=.39), supporting indirectly the notion that poor coping leads to recidivism"

(Zamble & Porporino, 1990, p. 59). Zamble and Porporino (1990) concluded that since

coping skills were not taught and reinforced while in prison, those who came in with poor

coping skills also left with poor coping skills, "…so that those who go to prison with deficiencies will leave unchanged and will likely recidivate" (Zamble & Porporino, 1990, p. 62).

Summary

Both of these studies were conducted with male inmates; therefore, these findings cannot be generalized to female prisoner populations. However, both of these studies offer some insight into prison coping and adaptation. Toch and Adams (2002) noted that prisoners with higher infraction rates tend to be younger, while the majority conforms to their environments and have low rates of infractions. Toch and Adams (2002) also offered suggestions for improvements for those with high rates of infractions, including staff support, transfer to another facility, or attachment through work or programs. Zamble and Porporino (1990) also noted that the majority of inmates in their study were unable to cope with every day problems effectively. Zamble and Porporino (1990) found that those who had coping problems prior to incarceration tended to have longer criminal records, suggesting that poor coping skills indirectly lead to high recidivism rates.

Therapeutic Communities

For Johnson, a decent prison is one where there are several small neighborhoods that intertwine to comprise a community (Johnson, 2002). These separated pods or communities provide male inmates with a safe environment, so that they can work on improving their coping skills by practicing on one another. This allows them to "fine tune" these skills before release back into the free world. "A prison that allows inmates to live within its walls as citizens, and ideally as productive and even caring citizens, provides a rehearsal for mature living in the free world" (Johnson, 2002, p. 269).

Robert Johnson's concept of mature coping in niches can be found within U.S. women's prisons in the form of therapeutic communities. Therapeutic communities are based on a self-help model, where the inmate is encouraged to examine her addiction as a problem for the whole body (Lockwood, McCorkel, & Inciardi, 1998). These communities are separated from the rest of the general population in order to foster a positive social environment. The therapeutic community is a safe environment in which women can express themselves and work through their problems. This model allows the individual to develop coping skills to handle the everyday situations she encounters that provoke her drug usage. Therefore, the first step of mature coping is met, as inmates are encouraged to face their addiction problems. The second step is achieved as an inmate attempts to understand why she behaves the way she does and learns to work through these problems in a positive manner. The third step to achieving mature coping skills is the therapeutic community itself, which is separated from the rest of the general population to reinforce the idea of living within a community. This provides a safe environment for the women, where they can express their needs and concerns.

The therapeutic community at SCI Cambridge Springs is broken down into three phases; and the participant is moved on to the next phase of treatment as progress is noted. The first phase focuses on teaching positive coping skills to the participants and allowing them to become oriented to their new environment and its rules. In the second phase of the therapeutic community, the participant is expected to begin to utilize her new skills and to be an example to those in Phase one. The participant in Phase Three is expected to not only engage in positive coping skills, but to serve as a mentor and a positive example to the other respondents through actively taking on leadership roles

within the community. Respondents in therapeutic communities also engage simultaneously in therapy, where the reasons for their reliance on substances are examined, along with 12-step programs and education, while living and working in a simulated community environment.

Therapeutic communities provide an atmosphere in which the participants can learn to handle daily problems in a safe environment. When one engages in positive coping techniques, such as problem solving, he/she is recognized for this behavior and encouraged to continue this positive skill. This gives the participant the chance to learn and practice these positive coping techniques in a supportive climate. When one utilizes negative coping behaviors, it is brought to the participant's attention that these coping strategies are negative and why. The participant is then taught how this situation could have been handled in a different, more positive manner. If the participant continues to engage in negative coping skills after this, he/she is reprimanded in front of the entire community and is expected to acknowledge how his/her negative coping strategies affected the community.

Therapeutic communities have enjoyed successful results in prisons around the country and have been "…accepted as the most effective kind of prison drug abuse treatment intervention…" (Wexler, 1995, p. 58). For example, Martin, Butzin, Saum, & Inciardi (1999) evaluated a therapeutic community in a California women's prison after a three-year period of operation. This was a prison where more than 40 percent of the general population lacked a high school diploma/GED, and the majority of inmates admitted to engaging in high-risk behavior for HIV. However, Martin et al. (1999) found only an 8 percent recidivism rate at twelve months for those inmates who completed the

therapeutic community and participated in twelve months of aftercare. The researchers also found only a 14 percent recidivism rate for those inmates who completed the therapeutic community and twenty-four months of aftercare. Wexler, Falkin, & Lipton (1988) also evaluated the first three years of a therapeutic community, "Stay 'N' Out", in the New York Prison System. The researchers found that those men and women who completed the program were less likely to have parole revocations than those program participants who dropped out of the program before six months.

Therapeutic communities allow the person to examine the reasons why one abuses substances by getting to the root of the problem and helping inmates to develop mature coping skills to prevent future drug use. Therapeutic communities, therefore, fit well with Robert Johnson's concept of mature coping. Therapeutic communities also have been shown to be effective with female inmates (Wexler et al., 1988; Inciardi, 1998; Martin et al., 1998).

Therapeutic Communities and Female Inmate's Unique Needs

Those working within the criminal justice system have taken notice that, "treatment during incarceration is an often-missed chance to intervene in the drugs-and-crime cycle that could help to ease prison crowding and reduce costs associated with returns to the criminal justice system" (Griffith & Hiller, 1999, p. 353). This movement toward rehabilitation has allowed for the establishment of several substance abuse interventions to take place within the prison/jail setting. However, most of these programs have been developed with the typical participant being a single male addict (Farrell, 2000). Therefore, they have been much less successful with female inmates who are substance abusers. Therapeutic communities, however, have had success with female inmates.

"This approach invites clients and practitioners to explore the many issues and experiences that frame the client's substance use, thereby ensuring that gender-specific issues facing women clients will be addressed" (Lockwood et al., 1998, p. 195).

"While social disorganization and an absence of social support networks make criminal activity and drug use more probable upon release for all inmates, these conditions are heightened by women's unique prison experiences" (Farrell, 2000, p. 27). Female prisoners tend to have different needs and experiences than male prisoners. For example, 70-80 percent of United States female prisoners are mothers with two children typically under the age of fourteen. Female inmates are the primary caretakers of their children. Therefore, the quality and quantity of care that their children receive in their absence is a constant source of stress. The majority of male inmates report that their children are being taken care of by their mother (Farrell, 2000).

Many female inmates have also experienced physical or sexual abuse prior to their incarceration. Women are more likely to suffer from physical or sexual abuse from childhood on and the abuser is usually someone the woman knows. "Although less likely to experience violent crime overall, females are five to eight times more likely than males to be victimized by an intimate" (Van Wormer and Bartollas, 2000, p. 119). This is particularly true for women between the ages of sixteen and twenty-four who are the most likely to experience violence by someone close to them, particularly if they are African American, poor, and urban (Van Wormer and Bartollas, 2000). According to the Family Violence Prevention Fund, in 1999, thirty-one percent of American women reported either physical or sexual abuse (Sales and Murphy, 2000). Female offenders suffer from higher rates of abuse than male inmates and women in the general population.

Summary

Women who are unable to cope with prior abuse often become depressed and begin to abuse substances. Over time, the woman becomes addicted to the substance and begins to abuse drugs in order to avoid or deny life problems. Due to recent drug law and policy changes, women are more likely to become involved in the criminal justice system than men because of a drug charge.

Therapeutic Communities are well suited for female inmate treatment because the therapy addresses understanding of and reflection upon the underlying causes of substance abuse. This holistic approach works well for female offenders who often have histories of prior abuse. Research conducted with women who were abused as children found that women who have trouble coping with abuse often deal with the abuse in inappropriate ways that include depression and/or substance use. Therefore, it is important that treatments for women substance abusers examine prior histories of abuse and work through the trauma. These communities also address positive coping strategies for dealing with daily problems such as lack of resources and separation from children.

<center>Summary of Findings from Prison-Based Studies</center>

There are several issues that emerge from a review of the literature on prison-based studies of coping. First, there is very little information on how inmates cope within the prison environment, and there is even less information on how female inmates cope with stress in prison. To date, very little research has been conducted comparing coping differences in female inmates with substance abuse problems from different ethnic/racial and class backgrounds.

Research that has been conducted with both male and female inmates seems to suggest that coping skills are obtained prior to incarceration (Zamble & Porporino, 1990; MacKenzie et al., 1989; Negy et al., 1997). Male and female inmates also tend to cope along gendered lines, with female offenders expressing negative coping strategies in the form of emotional outbursts (Fox, 1988) and male inmates acting outward with behavior like setting fires to bedding (Toch & Adams, 2002).

The research that has been conducted on female inmates and coping states that women who cope positively use techniques that include humor, religion, problem-solving, and social support (Giallombardo, 1966; Fox, 1988; Owen, 1998; Greer, 2002). Female inmates who relied on positive coping skills were found to be less depressed, less anxious and have higher rates of self-esteem (Negy et al., 1997). Female inmates who utilized negative coping strategies often had emotional outbursts, abused drugs, both legal and illegal, and avoided dealing with problems by watching television or playing cards (Fox, 1988; Greer, 2002). These offenders experienced more depression and anxiety and had lower self-esteem than female inmates who engaged in positive coping skills (Negy, 1998).

Research conducted by Owen (1998) and Giallombardo (1966) concluded that female inmates' lives prior to prison must be examined in order to fully understand their incarceration situations. Female inmates have high rates of previous victimization and poverty, and this is particularly true for drug addicted female offenders. Another source of constant stress is separation from their children. This applies to the majority of female inmates, 80 percent of whom have two children under the age of 18.

Today the greater percentage of female incarcerees are drug offenders and their numbers continue to grow (Harrison & Beck, 2004). These women are typically non-violent, first-time offenders, and African American. There are few treatment programs available for these women in prison. One type of treatment program that has been found to be effective with female offenders is the therapeutic community, which promotes and teaches positive coping skills to substance abusing inmates. This type of treatment helps the participant to assess why she abuses drugs and how this behavior can be changed. The participant is taught positive coping skills for everyday problems, while practicing these skills in a supportive community.

Robert Johnson's concept of mature coping is exemplified in the prison therapeutic community. Johnson states that in order for one to be rehabilitated, he/she must first be able to cope maturely with the everyday stresses of life by facing and solving his/her problems in a constructive manner. Johnson notes that mature coping can be taught in the prison setting, if it takes place in "small niches". The therapeutic community is the ideal treatment setting for developing mature coping as conceived by Johnson. In order to promote a supportive environment, the community is separated from the general population. Once in the community, one is taught and encouraged to practice positive coping skills. These skills include teaching offenders to solve problems in a constructive manner, in place of avoidance or denial.

To date, little research has been conducted on female drug-addicted offenders and the impact of therapeutic communities on their coping skills. This study will address this topic, and the research questions will be guided by Robert Johnson's conceptual model of mature coping and by research conducted on the coping skills of male and female

inmates. One goal of this study is to better understand the experiences and perceptions of

drug addicted female offenders in a therapeutic community and the impact of this

treatment on their ability to cope. These findings will then be compared to data collected

on female inmates on waiting list for treatment.

A second goal of the research is to inform future policies and programs for

incarcerated female drug offenders. There is currently no research on prison substance

abuse treatment that is gender responsive or focused on improved coping skills. It is

intended that this study will help to direct female drug treatment toward gender

responsive models.

CHAPTER III: METHODS

The purpose of this research is to examine whether participation in a prison-based substance abuse therapeutic community for female inmates promotes positive coping skills for the women who participated in the community. The objective of this research is to compare samples of women participating in the therapeutic community to those on a waiting list to get into the program. This study assesses how these two groups of women were coping with everyday problems while incarcerated.

This exploratory/descriptive study was conducted in two parts. The first part involved distributing psychometric measures in the format of a questionnaire to both the therapeutic community and waiting list samples at the institution. This questionnaire examined: 1) how the women were coping, and 2) their levels of depression and anxiety. The second part involved face-to-face interviews for a smaller group of women from both samples. The interviews solicited more in-depth information about the women, their experiences, and their coping strategies.

The following research questions were addressed:

1. Does treatment affect one's ability to cope?

2. Does one's ability to cope affect her level of depression?

3. Does one's ability to cope affect her level of anxiety?

4. Do women from different racial/ethnic backgrounds rely upon different coping strategies?

Hypotheses

H (1): As participants move through the treatment phases of the therapeutic

community, positive coping skills will increase, and negative coping skills will

decrease.

The therapeutic community promotes positive coping skills in the first phase of the

program by assigning the woman who enters the program a mentor (a woman from the

final phase of the program). The mentor is there to both help her make better decisions

and to analyze bad decisions, thus promoting problem-solving skills and the seeking of

social support, both of which are positive coping techniques. Once in Phase Two of the

therapeutic community, the women are encouraged and reminded to practice their coping

skills by treatment staff. Also during this phase, the women begin to work on the issues

that first led them to substance use and eventually abuse substances. This allows the

women the opportunity to work through their problems and to promote techniques, which

prevent denying or avoiding issues. By Phase Three, the women take on leadership roles

within the group. This again promotes positive coping skills, as these women serve as

mentors and leaders for women from phases one and two. Therefore, it is expected that

as one moves through the therapeutic community, coping abilities will improve.

H (2): As participants utilize more positive coping skills, depression and anxiety

will decrease.

If a woman is presented with an issue and she denies or avoids the problem, she will

be relying on negative coping techniques. As the problem continues, denial and

avoidance will eventually lead to depression and/or anxiety (Negy, Woods, & Carlon,

1997). Depending on the program phase, women in the therapeutic community will be learning or will have learned positive coping techniques to utilize in problem-solving. These positive coping skills facilitate the working through of problems and the accompanying decrease in depression and anxiety.   As the women move through the phases of the therapeutic community treatment, their positive coping skills will become stronger and they should experience less depression and anxiety.

H (3): Women from different ethnic/racial backgrounds have different life

experiences and rely upon different coping strategies.

Differences in coping techniques between races/ethnicities have not been examined. However, research conducted with female inmates in an AIDS/HIV education program has shown cultural differences to exist, and that they have an impact on treatment effectiveness. West (2001), for example, examined an HIV/AIDS education program in a women's prison and concluded that race/ethnicity differences led to the program being more effective for White and African American women than Latina women. Therefore, it is important to consider racial/ethnic differences. White, African American, and Latina women have different life and cultural experiences, and these differences will likely affect the ways in which the women cope and how they respond to treatment.

Methodology for Proposed Study

This research project utilized both quantitative and qualitative methods. In the first part of the project, surveys were distributed to collect demographic information, coping strategies, depression level, and anxiety level. This survey provided the researcher with information on the coping skills of women in the therapeutic community and those on the waiting list who served as a control group. Multiple regression was utilized to assess

what variables had a significant effect on coping, depression, and anxiety, while controlling for other variables such as age and race.

During the second part of the project, qualitative face-to-face interviews were utilized. The interviews were conducted with a smaller group of female inmates. The interviews provided in-depth information on their pre-prison backgrounds and current methods of coping. These in-depth interviews facilitate understanding substance abusing female inmates from their point of view.

<div align="center">Site Selection</div>

There are two women's prisons in the state of Pennsylvania. All women sentenced to prison in Pennsylvania are first sent to the maximum-security institution, State Correctional Institute (SCI) Muncy in Muncy, Pennsylvania (M. Kosienski, personal communication, January 14, 2004). This is the intake institution for women, where each offender's security level is assigned based on criminal record, medical, mental health and substance abuse assessments. Those with a lower security classification are sent to State Correctional Institute Cambridge Springs in Cambridge Springs, Pennsylvania. SCI Cambridge Springs is classified as a minimum-security facility (M. Kosienski, personal communication, January 14, 2004).

Both women's prisons in Pennsylvania have a therapeutic community for inmates with substance abuse issues (M. Kosienski, personal communication, January 14, 2004). Upon the inmate's arrival at SCI Muncy, drug and alcohol counselors administer the Texas Christian University self-report survey. This instrument assesses substance abuse over the past six months. Women who score high on this survey (a score of four or higher) are determined to be in need of substance abuse treatment and therefore eligible

to be screened for treatment in the therapeutic community (M. Kosienski, personal communication, January 14, 2004).

Upon arrival at SCI Cambridge Springs, an alcohol and drug counselor at the facility will contact the women who are identified as substance abusers at intake from the Texas Christian University self-report survey (M. Kosienski, personal communication, January 14, 2004). If the inmate has a security level of three or less (considered to be non violent) and is not actively psychotic (as determined by the institution's psychologist), then the counselor will determine if the inmate is eligible for the therapeutic community. This counselor assesses the inmate's literacy level (at least a fifth grade reading level), drug and alcohol history, physical ability (community is on 3rd floor; individuals must be able to climb stairs), motivation for treatment, and whether the inmate has any prior relationships with the women already in the community (cannot have prior relationships). Once she is deemed eligible for the therapeutic community program, she will be placed on the waiting list until a bed becomes available (there are fifty beds in the therapeutic community). The length of time one spends on the waiting list depends upon the availability of space in the program and the amount of time left for her sentence. Therefore, when a bed becomes available the woman who has the shortest amount of time left to serve will be placed in the program, so that treatment is received prior to being release from prison. If the woman states that she does not want to be in the program, she is referred to other treatment options within the prison, and she is not placed on the therapeutic community waiting list (M. Kosienski, personal communication, January 14, 2004).

Once in the therapeutic community, the women move through the program in phases (M. Kosienski, personal communication, January 14, 2004). The length of time a participant stays in each phase depends upon the individual's progress. When a woman enters the program, she will be placed in Phase One. In this phase, she will have restricted privileges, and is only allowed to be around other women in the program. Phase One is less intensive to allow the new community member a chance to get oriented to the structure of the program. Once Phase One has been successfully completed, the offender will move on to Phase Two. In Phase Two during therapy, she will begin to examine, issues in her life, such as prior victimization, that could have led to substance abuse. At this point in the recovery process, through therapy, she will begin to learn new ways to handle her pains, anger and frustrations. Once Phase Two has been completed, she will advance to the final phase – Phase Three, which focuses on re-entry. In this phase, the women assume active leadership roles within the therapeutic community. Women in Phase Three become mentors and role models to women in Phases One and Two, and exhibit leadership by running daily program activities (M. Kosienski, personal communication, January 14, 2004).

This study focuses on women with substance abuse addictions at SCI Cambridge Springs. This site was chosen over SCI Muncy due to the proximity of the institution to the researcher. The security level differences of each institution may affect the type of information gathered at each site. Female inmates at SCI Muncy are classified at a higher security level than female inmates at SCI Cambridge Springs and, therefore, will have different security needs and criminal offense histories. The differences in security needs between the institutions must be remembered if generalizing this study to the SCI Muncy

population. However, this is an exploratory/descriptive study whose purpose is to better

understand the women, their experiences and their coping strategies.

<div align="center">Part I – Survey</div>

Sample

There are fifty women in the therapeutic community at any given time. There were

also approximately 185 women on the therapeutic community waiting at the time of this

study. Originally, the plan had been to survey all the women in the therapeutic

community and all who would volunteer from the waiting list for a more rigorous

statistical analysis. However, due to policy changes, only forty women from the

therapeutic community and twenty-seven women from the waiting list volunteered.

Only volunteers[2] were utilized in this research project. All fifty women in the

therapeutic community and all 185 women on the waiting list were asked to volunteer for

the study.

Procedure

The survey was administered in small groups, and the respondents completed the

survey on their own. Literacy was not an issue with this particular population because

literacy had been established in order to participate in the therapeutic community. The

researcher was also present to answer any questions.

After completing the survey, each respondent was asked, on the last page of the

questionnaire, if she would be interested in participating in a face-to-face interview in the

future. Those who stated that they were interested in such an interview were earmarked

for Part II of the research project.

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[2] The Internal Review Board at Indiana University of Pennsylvania and the Research Review Committee
for the Pennsylvania Department of Corrections both approved this study.

Instrument

After the sample had been recruited, a questionnaire (See Appendix A) was distributed to the volunteers. The survey began with background questions on age, race, number of children, and marital status. These variables are control variables utilized later in the study's multivariate analyses to ensure that the differences found in coping, anxiety, and depression were not due to the age, race, number of children, and marital status. In addition, the questionnaire included the Beck Depression Inventory-II, Beck Anxiety Inventory, and the Coping Strategies Indicator. These measures were used to assess coping similarities and differences for the women in the therapeutic community and the waiting list.

Beck Depression Inventory - II

The first psychometric measure that was used is the Beck Depression Inventory-Second Edition (BDI-II). It is important to assess depression because those who are coping well and working through their daily problems should not be experiencing high levels of depression. The BDI-II was developed in order to increase the validity of the measure by updating the questionnaire to reflect the fourth edition of the Diagnostic Statistical Manual of Mental Disorders (Whisman, Perez & Ramel, 2000).

The BDI-II consists of 21 items that measure cognitive-affective and somatic symptoms of depression. For each item, the respondent is presented with four self-evaluative statements and is asked to choose the statement that best fits him/her. The scores for each item range from 0-3, with higher scores indicating more serious depression. Overall, those who score between 0-13 are considered to be minimally

depressed, 14-19 are mildly depressed, 20-28 are moderately depressed and 29-63 are severely depressed (Whisman et al., 2000).

The BDI-II has been shown to be both a reliable and valid measure of depression. Sprinkle et al. (2002) examined the reliability and validity of the BDI-II with college students partaking in services from the university counseling center. The authors found the BDI-II to have a test-retest reliability of .96 when the test was readministered anywhere from 1-12 days later, with a mean of 3.2 days. The researchers also concluded that the BDI-II had good construct validity, as the measure discriminated between minimal, mild, moderate and severe depression (Sprinkle et al., 2002).

Arnau et al. (2001) also examined the reliability and validity of the BDI-II. The researchers distributed the measure to patients who were waiting to see their primary care physician. The authors found the measure to have high internal consistency with an alpha of .94. In addition, the measure also was found to have good construct validity with statistically significant differences between those who were experiencing major depressive disorders and those who were not. The "…second order analysis indicated that the instrument measures distinct, albeit related, factors of depression that both tap into a higher-order factor that can be called depression" (Arnau et al., 2001, p. 117).

Dozois, Dobson and Annberg (1998) compared the BDI-I to the BDI-II using a sample of college students. The authors stated that the new BDI-II did a better job of assessing the level of depression and distinguishing between the levels of depression than the original measure. The authors also noted differences in their sample between the two sexes. Women who were assessed to be depressed tended to score higher on the cognitive-affective symptom items, while men who were depressed tended to score

higher on the somatic symptom items. The authors concluded that the BDI-II was generalizable across both sexes and that the differences in scores most likely were due to the way the two genders handle depression (Dozois et al., 1998).

The BDI-II has not previously been tested with female inmates who have substance abuse problems. However, in the current study with this sample, the BDI-II was found to be reliable with an alpha of .8837.

Beck Anxiety Inventory

A second psychometric measure that was used is the Beck Anxiety Inventory. It is important to assess anxiety because those who are coping well should not be experiencing serious anxiety. The Beck Anxiety Inventory (BAI) was developed because there was a need for a self-report questionnaire that distinguished between anxiety and depression (Creamer, Foran and Bell, 1995). The BAI is a 21-item self-report questionnaire where the respondent is asked to take into consideration recent events and their emotions over the past week including the current day. Each item measures a symptom of anxiety by providing a statement in which the respondent is asked to evaluate how well the statement applies by choosing a response on the four point Likert scale that ranges from "not at all" to "severely". Scores for each item range from 0-3, where those who have an overall score between 0-9 are considered to have a normal level of anxiety; 10-18 mild to moderate anxiety; 19-29 moderate to severe anxiety; and 30-63 severe anxiety (Creamer et al., 1995).

Research conducted with the BAI has found this measure to be both reliable and valid. Creamer et al. (1995) conducted a study utilizing the BAI, along with additional anxiety and depression tests, to undergraduate students. The tests were administered at two

different points in time. The first test disbursement occurred during the middle of the semester, and the tests were then readministered two weeks prior to final examinations. The authors found the BAI to have high internal consistency at both disbursements, with a Cronbach's alpha of .91 and .90. The test-retest reliability of the measure was moderate, with an alpha of .62. The researchers also compared the BAI to other measures of anxiety and depression and found that the BAI did a better job of discriminating between anxiety and depression than other available measures. However, the authors concluded that the BAI did a better job of assessing state anxiety (reaction to a specific threatening event) versus trait anxiety (experience anxiety in non-threatening situation) (Creamer et al., 1995).

Osman et al. (1997) also conducted research with the BAI to assess the validity and reliability of the measure with undergraduate students. The BAI along with other measures of anxiety and depression were distributed to 145 males and 205 females. The researchers concluded the BAI had a high internal consistency with a Cronbach's alpha of .90. When the authors compared the BAI to other measures of anxiety, they found the BAI to be moderately and significantly correlated, suggesting good construct validity. The researchers also noted that the BAI tended to measure state anxiety better than trait anxiety concluding (Osman et al., 1997).

Loebach and Arean (1997) assessed the reliability and validity of the BAI with older primary care patients. The authors distributed the BAI along with other measures of anxiety and depression to 71 women and 126 men. Loebach and Arean (1997) found the BAI to have high internal consistency, with a Cronbach's alpha of .92. The authors also established the BAI to have discriminant validity and concluded that, "…the Beck

Anxiety Inventory is measuring a construct distinct from the depressive symptoms measured by the Beck Depression Inventory and the Geriatric Depression Scale…" (Loebach and Arean, 1997, p. 140).

Two of the three research studies cited found that the BAI did a better job of measuring state anxiety versus trait anxiety. State anxiety occurs when one becomes anxious due to a threatening event, while trait anxiety takes place when one feels anxious in a non-threatening environment. However, the BAI for this research sample was still relevant because the focus of this research is how well one is coping with specific events, not the person's anxiety level in general. This instrument also has not been previously used with inmate populations. However, in the current study with this sample, the BAI was found to be reliable with an alpha of .9137.

Coping Strategies Indicator

The final psychometric measure to be distributed was the Coping Strategies Indicator (CSI). The CSI is a self-report questionnaire that asks the respondent to think of an event that caused stress in his/her life in the previous six months (Clark et al., 1995). The respondent is then asked to describe this event in a few words and to read through each of the 33 items to assess how he/she handled the stressful event. Each item contains a three point Likert scale consisting of "not at all", "a little" and "a lot". There are three scales in the CSI, including problem solving, seeking social support and avoidance. Each scale contains 11 items or statements of possible coping strategies (Clark et al., 1995).

Research conducted on the CSI has shown this psychometric measure to be both reliable and valid. Amirkhan (1990) distributed the CSI to two student samples and one community sample to test the measure's reliability and validity. Amirkhan (1990) found

the CSI to have high reliability for all three scales, with a Cronbach's alpha of .928 for the seeking social support scale, .894 for the problem-solving scale, and .839 for the avoidance scale. In both the student and community samples, the Pearson's coefficient also was high, averaging .82 for the student sample and .81 for the community sample. Additionally, discriminant validity was examined by comparing scores on the CSI to scores on the Crowne-Marlowe Social Desirability Scale. These two scales were compared because many self-report coping scales are unable to distinguish between coping and social desirability. When these two measures were compared, there were no significant correlations found between the two. Amirkhan concluded that the CSI

> "scales not only proved to be independent of one another, but also generally free of the demographic influences, recall problems, and social desirability biases that plague most self-report instruments. Internal consistency, test-retest reliability, and construct validity were consistently superior to what has been reported for other coping measures" (Amirkan, 1990, p. 13).

Amirkhan further conducted three studies to examine the criterion-validity of the CSI. In the first study, Amirkhan (1994) used a sample of college students who believed they were participating in a study on academic performance. The students were asked to fill out the CSI and were then told that this study dealt with academic stress and that they would be receiving electric shocks during the experiment. The students were next given three options, including listening to music (avoidance), listening to a tape of instructions on how to deal with the shock (problem-solving), and speaking with another student during the experiment (seeking social support). The results showed that those who scored high on the problem-solving scale asked to listen to the instructional tape, those

who scored high on avoidance asked to listen to music, and those who scored high on seeking social support chose to speak with another student. Amirkhan concluded that, "overall, then, the CSI proved capable of detecting the coping preferences expressed in the face of an actual threat" (Amirkhan, 1994, p. 249).

In the second study conducted by Amirkhan (1994), students in a critical thinking course who were learning specific problem-solving skills were compared to students in an introductory psychology course. The CSI was administered during the first week of the semester and then again during the last week of the semester. Amirkhan (1994) found that the students in the critical thinking course increased their problem-solving skills while the students in the introductory course remained unchanged. Amirkhan (1994) then concluded that the CSI measured problem-solving and changes in this skill well.

In the third study conducted by Amirkhan (1994), a community sample of patients receiving treatment for substance abuse issues was examined. The drug treatment programs chosen focused on teaching social support and problem-solving skills while decreasing one's reliance on avoidance or drug abuse. Patients were administered the CSI and program veterans' results were compared to newcomers. When the CSI was administered to veterans, they were asked to recall an event that recently caused stress to assure that an event before treatment was not used. Amirkhan (1994) found new patients scored below the norm for problem solving and seeking social support, while veterans scored above the norm on both scales. Veterans also had better scores on the avoidance scale than newcomers. Amirkhan concluded that since veterans had better coping skills than newcomers as hypothesized, this provided "further evidence of the instrument's criterion validity" (Amirkhan, 1994, p. 258).

After completing these three studies to test the criterion validity of the CSI, Amirkhan concluded that the CSI was valid. "The consistency of positive findings across samples suggests the broad base of validity, and hence wide applicability, of the CSI" (Amirkhan, 1994, p. 259).

The CSI has been used to examine the coping skills of inmates who participated in boot camps. The inmates all were male and included juveniles along with adults. This study showed the CSI to be both reliable and valid with this population. This instrument had not been previously used with female inmates. However, in the current study with this sample, the CSI was found to be reliable for all three scales with an alpha of .8645 for the avoidance scale, an alpha of .8930 for the seeking social support scale, and an alpha of .8971 for the problem solving scale.

<div align="center">Part I – Variables</div>

Dependent Variables

When one is faced with stress, she must assess the situation and decide what to do or how she will cope. Coping first begins with the emotional reaction that one has to the situation, such as surprise, fear, or anger. Next, the person must face the situation and decide how to handle it. This response can vary from positive to negative. Negative coping skills, for example, would occur if one decides to ignore or avoid the problem, while positive coping skills would include seeking social support from others and/or attempting to solve the problem. Coping was measured using the Coping Strategies Indicator. There are three scales incorporated in this measure including problem solving, seeking social support, and avoidance. Coping was coded using the true score from each of the three scales and each scale's score was examined individually.

Depression was measured as a continuous variable using the Beck Depression Inventory – II. Each woman received a score on the Beck Depression Inventory – II, which measured depression. The higher the score on the scale, the more depression one was experiencing. The true score received on the scale was used during the coding process.

Anxiety, another continuous dependent variable, was defined by assessing the level of anxiety one experienced. Anxiety was measured using the Beck Anxiety Inventory, where the higher the score on the scale the more anxiety one was experiencing. Each participant received a true score on the Beck Anxiety Inventory, and this score served as the code for the variable.

Independent Variable

The independent variable, coping, was measured using the Coping Strategies Indicator. There are three scales incorporated in this measure including problem solving, seeking social support, and avoidance. Coping was coded using the true score from each of the three scales, and each scale's score was individually examined.

Control Variables

Other variables that were examined during Part I included age, race, number of children, and marital status. This information was obtained during the first segment of the questionnaire. Age was defined as the age of the respondent on the day of the survey and was coded accordingly. Age is an important control variable, as more mature female prisoners may possess more positive coping skills. Race was categorized as Caucasian, African American, Hispanic and Other and was coded as 0 for Caucasian, 1 for African American, 2 for Hispanic, and 3 for Other. Race was controlled for because women from

different cultural backgrounds may have different life experiences and therefore possess different coping strategies. Number of children was defined as the number of children in one's primary care, so stepchildren and other similar relationships were counted. Number of children was coded as either 0 for no children or the number of children one has - a woman with two children will receive a code of two. Marital status was defined as married, divorced, single or widowed, and reflected the marital status of the participant on the day she completed the questionnaire. Single was coded as 0, married was coded as 1, divorced was coded as 2 and widowed was coded as 3. Children and spouses offer social support for female inmates and could serve as a resource to assist in positive coping.

Another variable that was examined by the researcher included currently prescribed medications. Prescription medications were defined as a prescribed psychotropic medication for depression and/or anxiety. This variable was measured by asking each participant on the survey what types of medication, if any, they were taking for anxiety and/or depression. If one had not been prescribed any medications, this was coded as 0; depression medication was coded as 1; anxiety medication was coded as 2, and both anxiety and depression medication was coded as 3. This control variable was included because taking these medications could affect their scores on the BDI-II and the BAI.

Data Analysis – Part I

The data gathered from the survey were analyzed quantitatively. Descriptive statistics were used to provide an overview of the respondents involved in the study and to show basic differences between those involved in the therapeutic community and women on the waiting list. Multivariate analyses were used to statistically examine the relationship between the independent variable and the dependent variables. There were 67 respondents in this study, so there were 15 respondents per each of the four independent variables. This particular number of respondents was chosen because in multivariate analyses, "…a recommended ratio of subjects to independent variables of at least 15 to 1 will provide a reliable regression equation" (Mertler & Vannatta, 2001, p. 170). Multiple regression was used in each case because the dependent variables all are continuous.

Descriptive Statistics

The descriptive statistics included in this study examine the percentages of women in the therapeutic community and on the waiting list categorized by coping skills, depression, and anxiety. SPSS was used to determine these percentages via cross tabulations.

Multiple Regression

Ordinary least squares multiple regression was used to analyze the relationship between treatment, coping, anxiety and depression. This statistical method has been chosen because the dependent variables coping, anxiety and depression all were measured as continuous variables. This technique allowed the researcher to determine the effect of numerous independent variables on the dependent variable, while controlling for other factors (Lewis-Beck, 1980). This technique was used to understand the

relationship between time spent in treatment and its effect on coping skills, as well as levels of depression and anxiety.

The first question, "Does treatment affect one's ability to cope?" was analyzed with the dependent variable, coping, being regressed upon the independent variable, treatment. The results of this regression allowed the researcher to determine the effect of treatment on one's ability to cope. Coping was measured using the true score each participant received on each of the three scales (problem-solving, seeking social support and avoidance). Treatment was measured as being on the waiting list or in the therapeutic community. Therefore, those on the waiting list were coded as 0 for no treatment, while those in the therapeutic community were coded as 1 for receiving treatment. Three separate analyses were run with coping as the dependent variable, one for each of the three coping scales. The following variables were controlled for, including prescribed psychotropic medications, age, and number of children. By controlling for these other variables, the researcher can be sure that the change in the dependent variable, indicated by the unstandardized slope, occurred due to a one-unit change in the independent variable and not due to any of these other factors.

The second question, "Does one's ability to cope affect her level of depression?" was analyzed with the dependent variable, depression, being regressed upon the independent variable coping. The results of this regression allowed the researcher to determine the effect of coping skills on one's level of depression. Depression was measured using the true score each participant receives on the Beck Depression Inventory –II. Coping was measured using the true score each participant received on each of the three scales (problem-solving, seeking social support and avoidance). Three separate analyses were

run with coping as the independent variable, one for each of the three coping scales. The following variables were controlled for, including prescribed psychotropic medications, age, and number of children. By controlling for these other variables, the researcher can be sure that the change in the dependent variable, indicated by the unstandardized slope, occurred due to a one-unit change in the independent variable and not due to any of these other factors.

The third question, "Does one's ability to cope affect her level of anxiety?" was analyzed with the dependent variable, anxiety, being regressed upon the independent variable coping. The results of this regression allowed the researcher to determine the effect of coping skills on one's level of anxiety. Anxiety was measured using the true score each participant received on the Beck Anxiety Inventory. Coping was measured using the true score each participant received on each of the three scales (problem-solving, seeking social support and avoidance). Three separate analyses were run with coping as the independent variable, one for each of the three coping scales. The following variables were controlled for, including prescribed psychotropic medications, age, and number of children. By controlling for these other variables, the researcher can be sure that the change in the dependent variable, indicated by the unstandardized slope, occurred due to a one-unit change in the independent variable and not due to any of these other factors.

The data analyses conducted in Part I of this research allowed the researcher to assess how the variables treatment, ability to cope, anxiety, and depression affected one another. After the surveys were completed, the second part of the research was initiated.

Part II – Interviews

Sampling

Those who indicated that they were interested in face-to-face interviews were asked to volunteer for Part II of the research. A total of 47 women from the waiting list and therapeutic community volunteered to be interviewed. All of the women in the therapeutic community who volunteered were interviewed for a total of 22 interviews. The researcher was allowed to remain on the therapeutic community floor and was able to easily access the women from the therapeutic community for their interviews. The researcher gave the director of the program a list of the 25 women who had volunteered from the waiting list and he scheduled the interviews. Due to the participants' schedules, not all of the respondents could be interviewed at the time the researcher was available. A total of 14 interviews were conducted with women from the waiting list.

The purpose of the interviews was to better understand the backgrounds and coping strategies of the women in the therapeutic community and those on the waiting list. The questions used for the interviews were often forced choice rather than open-ended because they were based in prior research conducted with female inmates. The data collected from the interviews gave insight as to how coping strategies change for women as they move through the therapeutic community by comparing women who have not yet received treatment to those in the therapeutic community.

Interview Protocol

The interviews (See Appendix B for Interview Schedule) were semi-structured for each participant. The Superintendent of the prison had denied the use of any type of tape recording device for the interviews. Therefore, the researcher took notes during the

interview process (See Appendix C for Note Taking Outline). After each data collection session, the notes from the interviews were immediately typed once the researcher left the prison and arrived home. The interviews conducted with women in the therapeutic community were conducted in the director's office with just the researcher and the participant present and the office door closed. The interviews conducted with women on the waiting list took place in a conference room that was located in the same building as the therapeutic community. Only the researcher and the participant were present and the door was closed for privacy.

The purpose of the interview was to understand the women's experiences, as well as how they handle or cope with stress in their lives while incarcerated. The survey distributed in Part I provided valuable information, but cannot replace the wealth of information that was gathered by speaking directly to the women and allowing them to share their own experiences and insights.

Procedures

The interview process began with the women in Phase Three of the therapeutic community. These interviews were conducted first to better understand the shared characteristics and concerns of these women. Once the interviews with the women in Phase Three of the therapeutic community were completed, the next group to be interviewed was the women in Phase Two of the therapeutic community. Again, all interviews were conducted before moving on to those in Phase One of the therapeutic community, so that the researcher could assess themes. Finally, the women on the waiting list were interviewed. Interviews continued with each group until the point of saturation was reached and took place in locations deemed appropriate by prison staff. It

was estimated that these interviews would take between 30 and 40 minutes per respondent.

<div align="center">Part – II Variables</div>

Dependent Variable

The dependent variable, coping, was defined by assessing how one reacts to stressful situations. One can rely on positive coping strategies such as seeking social support and problem-solving through friendships, using humor, and/or relying on prayer and/or religious beliefs. Negative coping strategies such as avoidance and denial are manifested through watching television, playing cards, and/or crying in the shower or in your room. This variable was measured through face-to-face interviews using questions 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11 and 12 from the interview schedule (See Appendix B). These questions asked about stressful situations in the women's lives such as separation from partners and children and how the women handled this stress such as relying on friends in prison, using humor, relying on religion, watching television, playing cards, or crying. After the interviews were typed, Winmax qualitative software was used to assess themes among the interviews (Kuckartz, 1998).

Independent Variables

Race/ethnicity data were collected during Phase One of this project. These data were used to determine the interviewee's race/ethnicity, including Caucasian, African American and Hispanic. This variable was used to establish if there were any differences in coping strategies for women from different racial/ethnic backgrounds.

The independent variable, treatment, was defined as the treatment group that each woman belonged to including those in the three phases of the therapeutic community and

women on the Waiting list. Treatment was broken down into four categories including T.C. 1 (Phase One), T.C. 2 (Phase Two), T.C. 3 (Phase Three) and Waiting list. This variable was used to assess the differences in coping strategies for the women in each of the four categories.

Data Analysis- Part II

Analysis of the data during the second part of the research was continuous and ongoing. Interviews continued until the point of saturation. Saturation occurs when volunteers begin to relay the same themes as previous interviewees, and no new information is offered during additional interviews (Maxwell, 1996). In Part II, as each interview was conducted the researcher immediately wrote memos of what occurred during the interview, including the actions and behaviors of the participant and the environment in which the interview was conducted. This was also an appropriate time to record any thoughts that the interview provoked for the researcher such as common themes and relationships. Memos help to jump-start the analysis process by causing the researcher to critically think about the interview, while it is still fresh (Maxwell, 1996).

The focus of Part II of the research was to better understand the women's coping strategies from their perspective. Winmax, a qualitative software package, was used to assess themes in the face-to-face interviews (Kuckartz, 1998). Winmax allowed the researcher to enter in the typed interviews and to code for themes. These themes were used to help understand the differences in coping strategies for the women in the three phases of the program and those on the waiting list, as well as the differences in coping strategies between races/ethnicities.

Subject Participation and Protection

Part I

Only volunteers were used in this research. There were not any rewards or penalties associated with choosing to participate or not participate in this research. Respondents were allowed to withdraw from the study at any time, and the researcher explained how they could withdraw from the research project at the beginning of the study.

Respondents were given an overview of the project, and the researcher answered any questions or concerns. Respondents were also asked to fill out a consent form and were given a copy of the form to keep. If a survey was returned without a signed consent form, that questionnaire was not used in the research project. Volunteers were guaranteed confidentiality throughout the research project. In order to assure confidentiality, the identifying consent form was removed immediately and replaced with a code number. A list of code numbers was kept in a locked box in the researcher's locked office throughout the research. They will be destroyed once the study is completed.

Part II

Only those who stated that they would be willing to be interviewed were contacted during Part II of the research. It was made known to the volunteers that if they felt uncomfortable at any time, they did not have to respond and that they could end the interview at any time. A consent form was used and the participant was given a copy of the form to keep. The researcher took notes during the interview that were later typed. Code numbers from Part I of the research were used to identify the interviews.

The interview process might cause the respondent to recall experiences that could cause stress for her. Counselors were available for inmates at any time and each woman had a counselor who was assigned to her upon arrival to the prison. The researcher has counseling experience and would be able to identify those who were in need of counseling if this situation should occur.

CHAPTER IV: QUANTITATIVE FINDINGS

In this chapter, the quantitative results are examined. First, descriptive statistics are presented to better portray the characteristics of this population including crosstabulations and t tests. Second, the bivariate correlations for all of the variables are examined and discussed. Finally, the quantitative hypotheses are examined via multivariate analyses, followed by a summary of the quantitative findings.

Descriptive Statistics

The descriptive statistics are presented in Table 1. A total of 67 women volunteered to participate for the survey portion of the research project. At the time the survey was conducted, 60 percent of the women (n = 40) were currently in the therapeutic community and 40 percent (n = 27) were on the waiting list for the therapeutic community. The therapeutic community is divided into treatment phases, so that one begins the program in Phase One and completes the program in Phase Three. Sixteen of the therapeutic community volunteers were in Phase One; 12 were in Phase Two; 8 were in Phase Three, and 4 were graduates who were working in the therapeutic community as peer assistants. Due to the small numbers within each of the individual phases, this variable was collapsed into a dummy variable. Those who were on the waiting list were coded as 0, and those who were receiving or have received treatment were coded as 1.

Table 1

Descriptive Statistics for all Variables

Variable	Mean	SD	Minimum	Maximum	N
TC	.60	.50	0	1	67
Age	37.72	8.86	20	63	67
Race	.43	.50	0	1	67
Children	.81	.40	0	1	67
Visit	.41	.50	0	1	67
Marital	.10	.31	0	1	67
Medication	.28	.45	0	1	67
BDI-II	14.56	10.11	0	42	66
BAI	12.47	5.55	0	45	66
CSI:PS	25.82	5.65	11	33	67
CSI:SSS	25.04	5.34	11	33	67
CSI:Avoid	19.52	5.54	11	33	67

The mean age for all volunteers was 37.72 years old. Fifty-six percent of the women

(n = 38) were Caucasian; 26.9 percent (n = 18) were African American; 7.5 percent (n =

5) were Hispanic, and 9 percent (n = 6) self identified as "other." For the analyses,

whites were coded as 0, and nonwhites were coded as 1.

The majority of the women (80.6 percent) had children. However, only 41 percent of

those with children reported that they received visits from their children. Those who did

not receive visits from their children were coded as 0, while those who received visits

from their children were coded as 1.

Most of the volunteers (64.2 percent) were single, while 19.4 percent of the women

reported being divorced or separated, 10.4 percent were married, and 6 percent had been

widowed. Those who were single were coded as 0, while those who were married were

coded as 1 during the quantitative analyses.

Slightly more than 71 percent of the volunteers reported not taking any type of psychotropic medications for anxiety or depression at the time of this survey. Seven-and-a-half percent reported taking depression medication, 4.5 percent used anxiety medication, and 16.4 percent of the sample reported using both anxiety and depression medications. Those who were not taking medications were coded as 0, and those who were taking depression and/or anxiety medications were coded as 1.

Depression, anxiety and coping were also measured in the survey using the Beck Depression Inventory II (BDI-II), Beck Anxiety Inventory (BAI), and the Coping Skills Indicator. The BDI-II consists of 21 items that measure cognitive-affective and somatic symptoms of depression. For each item, respondents were presented with four self-evaluative statements and asked to choose the statement that best fits them. The scores for each item ranged from 0-3, with higher scores indicating more serious depression. Each item was then combined into an overall depression scale, ranging from 0 – 63. Overall, those who score between 0-13 were considered to be minimally depressed; 14-19 were mildly depressed; 20-28 were moderately depresses, and 29-63 were severely depressed (Whisman et al., 2000). The average depression score for this sample was 14.56 or mild depression.

The BAI is a 21-item self-report questionnaire in which the respondent was asked to take into consideration recent events and her emotions over the past week including the current day. Each item measured a symptom of anxiety by providing a statement where the respondent was asked to evaluate how well the statement fit her by choosing a response on a four point Likert scale that ranges from "not at all" to "severely". Scores for each item range from 0-3. The scores were then combined into an overall anxiety

scale that ranged from 0 – 63. Those who had an overall score between 0-9 were considered to have a normal level of anxiety; 10-18 mild to moderate anxiety; 19-29 moderate to severe anxiety, and 30-63 severe anxiety (Creamer et al., 1995). The average anxiety score for this population was 12.46 (minimal anxiety).

The final psychometric measure to be distributed was the Coping Strategies Indicator (CSI). The CSI is a self-report questionnaire that asks the respondent to think of an event that caused stress in her life in the previous six months (Amirkhan, 1993). The respondent is then asked to describe this event in a few words and to read through each of the 33 items to assess how she handled the stressful event. Each item is measured as a Likert scale (i.e., not at all, a little, and a lot). There are three separate scales in the CSI: problem solving, seeking social support, and avoidance. Each scale contains 11 items or statements of possible coping strategies, which are then totaled for each scale.

Those who scored between 11-15 on the problem-solving skills scale have very low problem-solving skills; 16-20 low; 21-30 average and 31-33 high. The mean score on the problem-solving scale, for this sample, was a 25.82 or average problem-solving skills.

The Seeking Social Support scale was categorized, so 11-12 reflected very low seeking social support skills, 13-17 low, 18-27 average, and 28-33 high. The average score on the seeking social support scale was a 25.04 or average seeking social support skills.

The final scale measured avoidance, where those who scored between 11-14 have low avoidance; 15-22 average; 23-26 high, and 27-33 very high (Amirkhan, 1993). Finally, the mean avoidance score was 19.52 or average reliance on avoidance techniques when confronted with a problem.

Crosstabulations

Tables 2 through 6 display crosstabulations of each scale and corresponding treatment phases. Each table shows the percentages of those on the waiting list, in the beginning of the program (phase 1), and those who are advanced within the program (phases 2 and 3) that fall into the two categories of the scale. It is necessary to examine these crosstabulations to have a better understanding of how participants from different parts of the treatment fared on the scales. As mentioned earlier, during subsequent multivariate analyses, therapeutic community was collapsed into a dichotomous variable. This information was lost during regression analyses because the independent variable therapeutic community had to be turned into a dummy variable to meet the criteria for an interval level independent variable.

It had been hypothesized, that as one moved through the phases of treatment her depression score would decrease (See Table 2). Participants from the beginning of the program reported higher levels of depression than those on the waiting list or in the advanced stages of treatment. This may be due to the first phase of the program being an orientation period where the participants are getting used to the rules of the program and their new living environments. However, as hypothesized, once in advanced stages of treatment the depression scores do tend to decrease and are lower than depression scores for those on the waiting list and in advanced stages of treatment. These results should be interpreted with caution due to the small sample size.

Table 2

Beck Depression Inventory II & Treatment Phase Crosstabulation

	Waiting List	Beginning	Advanced	Total
Minimal/mild Depression	61.53% (n=16)	56.25% (n=9)	83.33% (n=20)	68.18% (n=45)
Moderate/Severe Depression	38.47% (n=10)	43.75% (n=7)	16.67% (n=4)	31.82% (n=21)
Total	100% (n=26)	100% (n=16)	100% (n=24)	100% (n=66)

It had also been hypothesized that as one moved through the phases of treatment her anxiety score would decrease (See Table 3). Participants from the beginning of the program reported higher levels of anxiety than those on the waiting list or in advanced stages of treatment. This may be due to the first phase of the program being an orientation period where the participants are getting used to the rules of the program and their new living environments. However, as hypothesized, once in advanced stages of treatment the anxiety scores do tend to decrease and are lower than anxiety scores for those on the waiting list and in advanced stages of treatment. These results should be interpreted with caution due to the small sample size.

Table 3

Beck Anxiety Inventory & Treatment Phase Crosstabulation

	Waiting List	Beginning	Advanced	Total
Minimal/Mild Anxiety	62.96% (n=17)	56.25% (n=9)	78.26% (n=18)	66.66% (n=44)
Moderate/Severe Anxiety	37.04% (n=10)	43.75% (n=7)	21.74% (n=5)	33.34% (n=22)
Total	100% (n=27)	100% (n=16)	100% (n=23)	100% (n=66)

It had been hypothesized, that as one moves through the phases of treatment her problem solving skills score would increase (See Table 4). Those on the waiting list

reported higher problem solving skills than those in all parts of treatment. This seems to suggest that treatment does not impact problem solving skills in a positive manner. However, there may be other factors contributing to one's problem solving skills score than treatment alone. It is also possible that this measurement is not tapping into the problem solving skills that women in the therapeutic community are learning. These results should be interpreted with caution because of the small sample size.

Table 4

Coping Strategies Indicator – Problem Solving Skills & Treatment Phase

Crosstabulation

	Waiting List	Beginning	Advanced	Total
Very low/low Problem Solving	18.51% (n=5)	25% (n=4)	20.83% (n=5)	20.89% (14)
Average/High Problem Solving	81.49% (n=22)	75% (n=12)	79.17% (n=19)	79.11% (n=53)
Total	100% (n=27)	100% (n=16)	100% (n=24)	100% (n=67)

It had been hypothesized, that as one moved through the phases of treatment her score on the seeking social support scale would increase (See Table 5). Those in the beginning and advanced stages of treatment reported higher levels of seeking social support than those on the waiting list. This seems to suggest that as one moves through the phases of treatment her seeking social support scores increase, however, these results should be interpreted with caution because of the small sample size.

Table 5

Coping Strategies Indicator – Seeking Social Support & Treatment Phase

Crosstabulation

	Waiting List	Beginning	Advanced	Total
Very low/Low Seeking Social Support	22.22% (n=6)	6.25% (n=1)	12.5% (n=3)	14.92% (n=10)
Average/High Seeking Social Support	77.78% (n=21)	93.75% (n=15)	87.5% (n=21)	85.08% (n=57)
Total	100% (n=27)	100% (n=16)	100% (n=24)	100% (n=67)

It had been hypothesized, that as one moved through the phases of treatment her avoidance scores would decrease (See Table 6). Reliance on avoidance techniques did decrease as one participated in treatment. This seems to suggest that as one moves through the phases of treatment her avoidance scores decrease, however, these results should be interpreted with caution because of the small sample size.

Table 6

Coping Strategies Indicator – Avoidance & Treatment Phase Crosstabulation

	Waiting List	Beginning	Advanced	Total
Low/Average Avoidance	66.66% (n=18)	68.75% (n=11)	87.5% (n=21)	74.62% (n=50)
High/Very High Avoidance	33.34% (n=9)	31.25% (n=5)	12.5% (n=3)	25.38% (n=27)
Total	100% (n=27)	100% (n=16)	100% (n=24)	100% (n=67)

T-Tests

T-tests were also used to determine if the hypotheses were supported. The variables were coded 0 for no treatment and 1 for treatment and equal variance assumed were used

to interpret the results. The Coping Strategies Indicator (CSI) Problem Solving scale had a t of -.489, where those in treatment reported more problem solving skills than those not in treatment, however, this t was not significant. The CSI Seeking Social Support scale had a t of –2.697, where those in treatment reported more seeking social support skills than participants not in treatment. This t score was significant at the .009 level. The CSI Avoidance scale had a t of 1.923, where those in treatment reported relying on avoidance techniques less than those on the waiting list. This t score was significant at the .05 level. The Beck Anxiety Inventory had a t score of .145, so those in treatment reported less anxiety than those not in treatment. This t score, however, was not significant. The Beck Depression Inventory II had a t score of .856, where those in treatment reported less depression than those on the waiting list. This t score was also not significant.

These t tests seem to support the hypotheses of this research, where those who are in treatment will have higher problem solving skills and seeking social support skills; rely less on avoidance techniques; and experience less depression and anxiety than those on the waiting list. Only the Seeking Social Support and Avoidance scales were found to be significant, however, this is likely due to the small sample size of 67.

<div align="center">Bivariate Results</div>

An estimated correlation matrix that includes all the independent/control and dependent variables is presented in Table 7. When reviewing the correlations, one must remember that the values in the table only indicate the statistical association between two factors without controlling for other variables. However, it is important to examine correlations because they can show general relationships between the variables.

First, the correlations were examined for multicollinearity. None of the correlations was extremely high, and further statistical tests confirmed that multicollinearity was not a concern as all tolerances were greater than .4 and all variance inflation factors were less than 2.5 (Kutner, Nachtsheim, Neter, and Li, 2005).

In examining the bivariate relationship between therapeutic community and seeking social support, a significant positive relationship was found. Those in the therapeutic community tended to score higher on the seeking social support scale than those who were not in treatment. Significant relationships were not found between therapeutic community and the other four dependent variables (i.e., problem-solving, avoidance, depression and anxiety). Therefore, participation in the therapeutic community did not significantly affect one's problem-solving, avoidance, depression, or anxiety scores.

There were not any significant relationships found between race and any of the dependent variables. Also, no significant relationships were found between social support and depression and anxiety. The score one received on the seeking social support scale did not significantly impact one's depression or anxiety score. An insignificant relationship was also found between problem solving and depression and anxiety, so one's problem-solving score did not significantly impact her depression or anxiety score.

A significant positive relationship was found between avoidance and anxiety. Therefore, as one's avoidance score increased, her anxiety score increased as well. A positive significant relationship was also established between avoidance and depression; as one's avoidance score increased, her depression score also increased.

Several significant relationships emerged between the control variables and the dependent variables in the bivariate correlations. A significant negative relationship was

found between age and seeking social support. As age increased, one's seeking social support score decreased. A negative relationship was also found between marital status and seeking social support, so those who were married scored lower on the seeking social support scare than those who were not married. A negative significant relationship was found between one's children visiting and depression; therefore, those who received visits from their children tended to be less depressed than those who did not receive visits. A positive significant relationship was also found between medication and anxiety scores. If one was on depression and/or anxiety medication, she tended to score higher on the anxiety scale than those who were not on those medications.

Table 7

Estimated Correlations between All the Variables

VARIABLE	1	2	3	4	5	6
(1) TC	1.00					
			(67)			
(2) Race	.04	1.00				
	(67)	(67)				
(3) Age	-.11	-.07	1.00			
	(67)	(67)	(67)			
(4) Visit	-.02	-.12	-.04	1.00		
	(54)	(54)	(54)	(54)		
(5) Marry	-.28	..10	.23	.07	1.00	
	(67)	(67)	(67)	(54)	(67)	
(6) Meds	.11	-.08	.04	-.13	-.18	1.00
	(67)	(67)	(67)	(54)	(67)	(67)
(7) Children	.21	.20	.22	"."	.04	.06
	(67)	(67)	(67)	(54)	(67)	(67)
(8) CSI:PS	.06	.00	.05	.12	-.01	.17
	(67)	(67)	(67)	(54)	(67)	(67)
(9) CSI:SSS	.32**	-.04	-.24*	.12	-.47**	.17
	(67)	(67)	(67)	(54)	(67)	(67)
(10) CSI:AV	-.23	-.05	-.19	-.11	-.11	.04
	(67)	(67)	(67)	(54)	(67)	(67)
(11) BAI	-.02	-.16	-.12	-.19	-.06	.27*
	(66)	(66)	(66)	(53)	(66)	(66)
(12) BDI	-.11	-.09	-.06	-.32*	.05	.13
	(66)	(66)	(66)	(53)	(66)	(66)

N's are in parentheses
"." Is printed if coefficient could not be calculated

*p < .05
**p < .01

Table 7 (continued)

_____

VARIABLE	7	8	9	10	11	12
(7) Children	1.00					
	(67)					
(8) CSI:PS	.01	1.00				
	(67)	(67)				
(9) CSI:SSS	.05	.40**	1.00			
	(67)	(67)	(67)			
(10) CSI:AV	-.08	-.14	-.13	1.00		
	(67)	(67)	(67)	(67)		
(11) BAI	-.03	.10	-.03	.49**	1.00	
	(66)	(66)	(66)	(66)	(66)	
(12) BDI	.08	-.05	-.23	.54**	.63**	1.00
	(66)	(66)	(66)	(66)	(66)	(66)

N's are in parentheses
"." Is printed if coefficient could not be calculated

*$p < .05$
**$p < .01$

Multivariate Results

Bivariate correlations only examine the relationship between two variables; it does not take other explanatory factors into consideration. Therefore, it cannot be concluded that the change in the dependent variable was due to the independent variable alone. Therefore, multivariate analyses were used to clarify the effect of the independent variables on the dependent variables. It must be remembered, however, that because random assignment was not utilized in the current research, cause and effect relationships cannot be fully established (Shadish, Cook, and Campbell, 2002).

Backward ordinary least squares regression was used to determine which four independent variables should be included in the model due to the small sample size of 67, allowing for 15 respondents per independent variable (Mertler & Vannatta, 2001). When using backward ordinary least squares regression, one must enter all the possible

independent variables, which are then regressed on the dependent variable and removed, one by one, to determine the best model or the four independent variables with the highest levels of significance. This method was used for each statistical model to determine which independent variables would be included in the analyses.

<div align="center">Hypothesis 1: Treatment and Coping</div>

The first hypothesis states that as participants move through the treatment phases of the therapeutic community, positive coping skills will increase, and negative coping skills will decrease. The Coping Strategy Indicator was used to measure coping skills and includes three scales: problem solving, seeking social support, and avoidance. Therefore, coping skills was broken down into three separate statistical models to test the effect of therapeutic community on each coping strategy, while controlling for other explanatory factors.

Backwards ordinary least squares regression was used to determine which independent variables would be included in the problem-solving model. Therapeutic community was determined to be one of the variables with the lowest significance and was therefore dropped from the model. However, it was added back into the model because the hypothesis examines its potential effect on problem solving. Therefore, the three independent variables with the highest levels of significance (i.e., race, medication, and children visits) were used along with the therapeutic community. Once these variables were identified, ordinary least squares regression was used to determine the effect of being in the therapeutic community on problem-solving, while controlling for the effect of the other explanatory variables (see Table 8).

Table 8

OLS Regression Estimates for the Determinants of Problem-solving Scores (n=67)

VARIABLE	B	SE	Beta	| T|
TC	-.477	1.676	-.040	.285
Race	.911	1.615	.080	.564
Meds	1.619	1.771	.130	.914
Visit	1.722	1.653	.148	1.042
Constant	24.523	1.838		13.344***
F	.478			
R-square	.038			

*p < .05
**p < .01
***p < .001

At the bivariate level, there was no significant association between being in the

therapeutic community and problem solving. This insignificant relationship remained for

the multivariate analyses, as the coefficient for therapeutic community did not reach

statistical significance. In addition, none of the other factors in the model was

statistically significant, so therapeutic community, race, children visits, or taking

medication for depression and/or anxiety did not impact problem-solving scores. The

lack of statistical significance in this model was further exemplified by its weak

explanatory power, as this model only explained 3.8 percent of the variance in problem

solving, strongly suggesting that other explanatory factors impact problem-solving.

The second statistical model examined the effect of therapeutic community on seeking

social support. Backwards ordinary least squares regression was used to determine which

independent variables would be included in the model for seeking social support. Race

was determined to be one of the variables with the lowest significance and was therefore

dropped from the model. However, race was added back into the model because of its

importance in hypothesis three, where the effect of race was examined on coping.

Therefore, the three independent variables with the highest levels of significance (i.e., therapeutic community, children visit, and marital status) were used along with race. Once these variables were identified, ordinary least squares regression was used to determine the effect of being in the therapeutic community on seeking social support, while controlling for the effect of the other explanatory variables (see Table 9).

At the bivariate level, participation in the therapeutic community had a positive and significant association with seeking social support, so if one participated in the therapeutic community, seeking social support scores increased. As presented in Table 9, however, when controlling for rival causal factors, the effect of therapeutic community did not reach statistical significance. In other words, there was no difference between those in the therapeutic community and those on the waiting list for seeking social support scores. In fact, the only factor in the model that was statistically significant was marital status. Those who were married scored lower for seeking social support than those who were single. This model explained 25.1 percent of the variance found in the dependent variable, again suggesting that other explanatory factors affect seeking social support.

Table 9

OLS Regression Estimates for the Determinants of Seeking Social Support Scores (n=67)

VARIABLE	B	SE	Beta	|T|
TC	2.423	1.382	.223	1.753
Visit	1.678	1.319	.159	1.272
Marital	-6.377	2.125	-.386	-3.000**
Race	.488	1.307	.047	.374
Constant	23.405	1.424		16.434***
F	4.102*			
R-square	.251			

*p < .05
**p < .01
***p < .001

    The third statistical model examined the effect of therapeutic community on avoidance. Backward ordinary least squares regression determined that therapeutic community, children visits, race, and age would be used in the multivariate analyses. At the bivariate level, there was no significant association between being in the therapeutic community and avoidance. As shown in Table 10, the insignificant effect remained in the multivariate analyses, as the coefficient for therapeutic community did not reach statistical significance. In addition, none of the other factors in the model was statistically significant, so one's race, age and whether her children were able to visit did not have a significant effect on one's avoidance score. This model explained a weak 8.7 percent of the variance found in the dependent variable, strongly suggesting that other factors impact on avoidance scores.

Table 10

OLS Regression Estimates for the Determinants of Avoidance Scores (n=67)

VARIABLE	B	SE	Beta	|T|
TC	-2.608	1.590	-.225	1.641
Race	-1.060	1.552	-.096	.683
Visit	-1.490	1.550	-.133	.962
Age	-.118	.094	-.177	1.257
Constant	26.688	4.270		6.250***
F	1.171			
R-square	.087			

*p < .05
**p < .01
***p < .001

Hypothesis 2: Coping, Depression & Anxiety

The second hypothesis stated as participants utilize more positive coping skills, depression and anxiety will decrease. The Beck Depression Inventory II and the Beck Anxiety Inventory were used to measure depression and anxiety. Therefore, this hypothesis was broken down into two separate models: one model examined anxiety, and the second model examined depression.

Backward ordinary least squares regression, again, was used to determine which independent variables would be included in the depression model. Problem-solving score and seeking social support score were determined to be variables with low significance and were therefore dropped from the model. However, because the hypothesis was meant to examine the effect of coping (problem-solving, seeking social support and avoidance) on depression, both variables were added back into the model. Therefore, the two independent variables with the highest levels of significance (i.e., children visit and avoidance score) were used along with problem-solving score and seeking social support score. Once these variables were identified, ordinary least squares regression was used to

determine the effect of coping on depression, while controlling for the effect of one's

children being able to visit.

At the bivariate level, the relationship between avoidance score and depression score

was found to be significant. Therefore, as one's avoidance score increased their

depression score increased as well. As shown in Table 11, this significant relationship

remained for the multivariate analyses, so as one's avoidance score increased her

depression score increased as well, while controlling for rival causal factors. However,

problem-solving scores and seeking social support scores were found to not have a

significant effect on depression. Children visit also significantly impacted depression

scores in that those whose children were able to visit were less depressed than those

whose children were not able to visit. This model was fairly strong and explained 39.6

percent of the variance in depression. However, there is the possibility of a temporal

ordering issue. It is sometimes difficult to determine the ordering of events in cross-

sectional or quasi-experimental research (i.e., does avoidance affect depression or does

depression affect avoidance?). Due to the design of the current research, this should be

considered when interpreting the results.

Table 11

OLS Regression Estimates for the Determinants of Depression Scores (n=66)

VARIABLE	B	SE	Beta	|T|
Visit	-5.357	2.394	-.255	-2.237*
Problem Solve	.247	.223	.138	1.108
Seek Social Support	-.283	.277	-.144	-1.144
Avoid	.959	.209	.521	4.593***
Constant	-.650	7.963		-.082
F	7.870***			
R-square	.396			

*p < .05
**p < .01
***p < .001

For the second model, backward ordinary least squares regression was used to

determine which four independent variables would be included in the anxiety model. The

Seeking Social Support score was determined to be a variable with low significance and

was therefore dropped from the model. However, it was added back into the model, due

to the hypothesis examining the effect of coping on anxiety. Therefore, the independent

variables utilized in the current model were seeking social support score, avoidance

score, problem-solving score, and medication for depression and/or anxiety. Once these

variables were identified, ordinary least squares regression was used to assess the effect

of coping, while considering the effect taking medication for anxiety/depression.

At the bivariate level, one's seeking social support score and problem-solving score

were not significantly associated with the score one received on the Beck Anxiety Index.

However, one's avoidance score and anxiety score were significantly associated, so as

one's avoidance score increased her anxiety score increased as well. As shown in Table

12, this significant relationship remained for the multivariate analyses. As one's

avoidance score increased, her anxiety score increased also, while controlling for rival

causal factors. Once again, proper temporal ordering cannot be established. Problem-solving scores and seeking social support scores were found to not have a significant effect on anxiety. The medication coefficient was also significant, where those taking anxiety and/or depression medications had higher anxiety scores than those who were not taking those medications. This model explained 32.2 percent of the variance in anxiety scores. Temporal ordering could also be an issue for this model, as it is possible that those who experienced more anxiety were more likely to be taking psychotropic medications.

Table 12

OLS Regression Estimates for the Determinants of Anxiety Scores (n=66)

VARIABLE	B	SE	Beta	|T|
Problem Solve	.294	.222	.153	1.323
Avoid	.961	.209	.493	4.605***
Seek Social Support	-.143	.234	-.071	-.611
Meds	5.544	2.575	.233	2.153*
Constant	-11.890	8.241		-1.443
F	7.226***			
R-squa	.322			

*p < .05
**p < .01
***p < .001

<div align="center">Hypothesis 3: Race and Coping</div>

The third hypothesis stated women from different ethnic/racial backgrounds have different life experiences and rely upon different coping strategies. The Coping Strategy Indicator was used to measure coping skills and includes three scales: problem solving, seeking social support, and avoidance. Therefore, the dependent variable coping skills were broken down into three separate models that were also the same models used when participation in the therapeutic community was examined (See Tables 8, 9, and 10).

The first model examined the effect of race on problem solving. At the bivariate level, there was no significant association between race and problem solving. As seen in Table 3, this insignificant relationship remained in the multivariate analyses, indicating that there was no race effect on problem solving. In addition, none of the other factors in the model was significant. This model explained 3.8 percent of the variance found in the dependent variable, suggesting that other explanatory factors impact problem solving.

The next statistical model examined the effect of race on seeking social support. At the bivariate level, there was no significant association between race and seeking social support. As shown in Table 9, this insignificant relationship remained for the multivariate analyses, as there was no significant difference between whites and nonwhites in seeking social support scores. This model explained 25.1 percent of the variance found in the dependent variable, suggesting that other explanatory factors impact seeking social support.

The third model examined the effect of race on avoidance scores. At the bivariate level, there was no significant association between race and avoidance. This insignificant relationship remained for the multivariate analyses, meaning there was no race effect on avoidance. In addition, none of the other factors in the model was statistically significant. This model explained 8.7 percent of the variance found in the dependent variable.

<div align="center">Summary</div>

Due to the small sample size, generalizations cannot be made about the population as a whole, but conclusions can still be suggested regarding this sample. First, the effect of the therapeutic community on coping was examined. Problem solving and

avoidance were not impacted significantly by any of the independent variables included in the multivariate regression model. Seeking social support was significantly impacted by marital status, where those who were married scored lower on the seeking social support scale. This seems to suggest that participation in the therapeutic community had little or no impact on one's ability to cope with everyday problems while in prison. However, crosstabulations and t tests seem to suggest that treatment did impact coping skills and support the hypotheses that as one moves through treatment her coping skills improve. These results must be interpreted with caution since the sample size was small.

Second, the relationship between coping, depression, and anxiety were examined. When examining t tests and crosstabulations, treatment did appear to impact depression and anxiety scores and as hypothesized, those who were in treatment appeared to be experiencing less depression and anxiety than those on the waiting list. During multiple regression, only children visiting and avoidance were found to impact depression scores. For the anxiety model, at the multivariate level, avoidance and medication were found to be significant. This seems to suggest that it is not positive coping skills (problem-solving and seeking social support) that affects depression, but rather if one's children were able to visit in prison and how much one relies on negative coping skills or avoidance techniques when facing a problem. When considering anxiety, these results suggest that reliance on avoidance techniques and medication, not problem-solving and seeking social support, impact anxiety scores. Therefore, higher scores on the problem-solving and seeking social support scales did not decrease anxiety or depression, but rather other factors such as reliance on avoidance techniques, use of psychotropic medication for depression/anxiety and whether your children can visit did impact these scores. There is,

however, the issue of temporal ordering when examining the dependent variables depression and anxiety. It is difficult to know whether one's reliance on avoidance techniques, use of medication, and children's visits came before or after her depression and/or anxiety.

Next, the effect of race on coping was examined. A significant relationship between race and the three coping scales was not found at the multivariate level. This seems to suggest that race does not impact how one copes with everyday problems while in prison.

The quantitative conclusions reached must be interpreted with caution because of the small sample size (n=67) and non-experimental research design. One must have at least 15 respondents per independent variable for multivariate regression. This limited the number of control variables that could be entered into each model. Participation in the therapeutic community was also examined to determine the program's impact on one's ability to cope. It had been hypothesized that as one moved through the program, participant coping skills would increase. It was not possible to look at each of the phases individually because of the small sample size and because interval level data is required for multivariate analyses. Therefore, the variable therapeutic community had to be collapsed into a dummy variable. This prevented the examination of the differences between phases. However, when the results were broken down by waiting list, beginning and advanced for crosstabulations for the effects of treatment on coping, depression and anxiety the results seemed to support the hypotheses. Race was also coded as a dummy variable to allow for regression analyses. This coding process could have also affected the results during the regression analyses.

CHAPTER V: QUALITATIVE FINDINGS

In this chapter, the qualitative results from thirty-six face-to-face interviews are discussed in detail. The women ranged in age from twenty-three to fifty-three. The majority of women who volunteered to be interviewed stated that they were Caucasian; however, there were also eight African American volunteers and three Hispanic volunteers. First, life prior to and in prison was examined to understand the women who volunteered to be interviewed and their experiences. It was important to understand whom these women were prior to prison, including when and why they began using substances, to get a better sense of how their addictions began. The relationships the women were involved in prior to prison were also examined because prior research had identified relationships as an important factor in female inmates lives both inside and outside of prison. Once in prison, it was important to identify what types of stress the women faced. How did these stresses impact their later attempts to cope?

Next, differences in coping strategies for women in treatment and on the waiting list were explored to examine the relationship between coping skills (problem-solving, seeking social support and avoidance) and the therapeutic community. It had been hypothesized that as the women moved through the phases of treatment, their ability to cope with problems in prison would improve and their reliance on negative coping strategies would decrease. Therefore, the categories of Waiting list, Phase One, Phase Two or Phase Three included eight women from Phase One, five from Phase Two, nine from Phase Three and fourteen from the Waiting list. The women were placed in these categories, so the differences between the women in treatment versus women not in treatment along with the differences between the phases of treatment could be examined.

Finally, it had been previously hypothesized that women from different races/ethnicities would have different life experiences, which would cause them to rely upon different coping strategies. Therefore, the final section of this chapter examines reported differences between races/ethnicities in life prior to and in prison. Next, the impact of prior and in prison differences between races/ethnicities on coping skills one primarily relied upon when faced with a problem in prison was examined. Coping skills were again broken down into the categories problem solving, seeking social support and avoidance, where each set of coping skills was examined separately, comparing the differences between races/ethnicities. Treatment, in terms of coping strategies, was also split into the categories waiting list, Phase One, Phase Two, and Phase Three, so differences between the treatment phases and races/ethnicities could be examined as well.

Life Prior To Prison

First, life prior to prison was examined for all thirty-six of the women who volunteered to be interviewed face-to-face to better ascertain their life experiences. All of these women had been identified as substance abusers upon intake into the Pennsylvania prison system. Therefore, the first section of the interview consisted of questions that attempted to understand when and why these women had been abusing substances and what substances they were abusing.

Next, what was going on in the respondent's life at the time she began using was examined. Prior literature on addiction has documented that a woman who has poor coping skills often copes with stress through substance use and eventual substance abuse (Gilligan, 1993). Therefore, it was important to also identify what was going on in the respondent's life at the time she first began using substances. Relationships had also

been identified in the literature as a source of self-esteem and strength, as well as, a positive coping strategy for women (Fox, 1988; Giallombardo, 1966; Owen, 1998). The next set of questions dealt with what types of relationships in which these women had been involved before their incarceration, including children and significant others.

The age one first tried illegal drugs or alcohol ranged from five to forty-six. Nearly half of the interviewees (17) stated that they first used illegal drugs and alcohol between the ages of twelve and fifteen. One's primary drug of choice ranged from PCP to Ecstasy, with the most commonly reported abused substance being alcohol - 1/3 of the women stated that alcohol was their primary drug of choice. The next most commonly used drugs were heroin, prescription pain medication, and cocaine.

All of the women reported stress in their lives at the time they began using their primary drug on a regular basis. These stressors included: death of a family member or child; using with friends due to peer pressure; parental problems (with parent or parental addiction); having a child at a young age; being abused physically, emotionally or sexually; personal health problems; and dropping out of school. The three most reported stressors were being abused, parental problems, and peer pressure.

[Interview # 1]: She stated that she was a good student at school and attended a Catholic school. Her father had been a whiskey alcoholic who physically abused her mother and emotionally abused her and her siblings. There was a lot of shame with her father's drinking because they lived in a small town. Her parents made her present a picture of a functional family to the rest of the town and she was instructed to not discuss their family problems with others. She began to smoke weed with other kids to escape her situation at home.

[Interview # 46]: She started drinking beer at age twelve on special occasions. By 13, she started drinking beer more heavily. Her father was molesting her at this age and she began to act out. Her boyfriend also took advantage of her by giving her alcohol. When she passed out, he would rape her. By age sixteen she was drinking liquor and by age twenty-nine, she was using cocaine on a regular basis.

[Interview # 23]: When she was fourteen, she began using alcohol experimentally and by twenty-one, she was drinking every weekend. At age fourteen, she was on her own and dealing with neglect from her parents and her own anger over her home situation.

[Interview # 58]: She first drank alcohol at age seven and by thirteen, she was drinking every day. During this time, she moved a lot with her mother who also had an addiction. This was also around the time she lost her virginity, got into fights with other kids, and dropped out of school.

[Interview # 51]: She first used marijuana at age eighteen, but not on a regular basis. At age thirty she used heroin and became addicted. She stated that she was hanging out with the wrong people and tried it.

[Interview # 47]: She began using marijuana every day at age thirteen. By age twenty-three, she was using cocaine. She believes that she began using cocaine because it was a generational thing. Her father strictly forbid drug usage, she came from a well-to-do family, and she did not experience any abuse as a child. She stated that using cocaine was fun and it led to using heroin and a fifteen-year addiction to methadone.

[Interview #10]: Between the ages of sixteen and eighteen she was in juvenile probation and stopped using all together. At age eighteen she began using PCP and cocaine daily. At this time in her life she began hanging out with different people and she was no longer on probation.

[Interview #22]: She left home at age thirteen and had abandonment issues from this. At this age, she met the wring person and tried to follow in her footsteps.

[Interview #16]: At this point in her life she was using with her boyfriend. Her mom was a single mom and she just did what she wanted including playing hookie.

[Interview #28]: At twenty-two she began drinking heavily because she did not want to deal with the loss of her son and the abuse she had suffered as a child.

The women interviewed began using substances on average between the ages of twelve and fifteen, with one third of the volunteers abusing alcohol as their primary drug of choice. All of the women reported experiencing stress in their lives at the time they began using, which adds support to the conclusions of prior research that, for women, substance abuse was often the solution not the original problem (Gilligan, 1993).

Twenty-nine of the thirty-six women interviewed stated that they had a significant other prior to prison, and twenty-six of these women reported living with their significant other before coming to prison.

[Interview #10]: She lived with her boyfriend prior to prison.

[Interview #29]: She lived with her girlfriend prior to prison.

[Interview #39]: She has a boyfriend who she lived with prior to prison.

[Interview #18]: She had a boyfriend, prior to prison, that she had lived with.

[Interview #48]: Prior to prison, she had been married and lived with her husband.

The majority of women also had children, and only five women reported that they did not have any children. Thirty-one women reported having a total of 81 children who ranged in age from nine months to thirty-two years of age.

[Interview #10]: She has a seven-year-old son.

[Interview #11]: She has two children ages nineteen and eleven.

[Interview #22]: She has six children ages eight, seven, five, four, three, and two.

[Interview #26]: She has four children ages six, four, 18 months, and 9 months.

[Interview #39]: She has six children ages twenty-two, twenty, eighteen, thirteen, seven and three.

[Interview #18]: She has three children ages thirty-two, thirty, and twenty-eight.

The majority of the women had been involved in a relationship with a significant other and only five women reported not having any children. This finding was also similar to that of other studies conducted with women inmates, where the majority were involved in a relationship and most were mothers (Owen, 1998).

Life in Prison

The next set of interview questions attempted to better understand the experiences of female inmates. Background questions such as age and race were asked along with questions about stress due to separation from one's significant other and/or her children. It was important to identify what types of stress the women faced in prison as it is a key element in the analysis of coping.

Out of the twenty-nine women who reported being involved with a significant other prior to prison, only seven were involved in the relationship at the time of the interview. Twenty of the twenty-nine women had broken off the relationship since their incarceration, and two significant others had died while the interviewee was in prison. Twelve of the twenty-nine women with significant others prior to prison stated that being separated from their significant other did not affect them. However, many reported that this separation had bothered them at one time, but they have since broken off the relationship and no longer have contact.

[Interview # 28]: She was living with her boyfriend prior to prison. He is now living with his mother. She said that this separation at first stressed her out because she always wondered what he was doing. After she had been in prison for a while they broke up. Now she does not have any contact with him and she does not feel any stress.

[Interview # 4]: She stated that their relationship does not cause her any stress now because they have been separated since 2002, and she is over him.

[Interview # 59]: At the beginning of her prison stay, her relationship with him caused her stress, but now it does not.

The majority of women (17) stated that being separated from their significant other caused them stress.

[Interview # 23]: She stated that being separated from her boyfriend was hard
She felt she was doing o.k. with it, but her boyfriend was not handling it as well.
This has caused her to experience depression, and she is going to see the doctor
to inquire about medication.

[Interview # 16]: She had lived with her girlfriend prior to prison and her
girlfriend is now living on her own. She stated that this relationship was
on the rocks because of her own jealousy issues.

[Interview # 18]: She had a live-in boyfriend before she came to prison. They
separated after she came to prison because of her addiction. They broke up because he
was tired of her addiction. He had tried to help her, but she destroyed the relationship.
He did not drink or do drugs. She did not know what a good thing she had and regrets
losing him. They had to say goodbye, but it still makes her sad.

[Interview # 26]: She had a boyfriend prior to prison who is now living on
the street. They have a baby together, and she gave birth two weeks prior to
jail. Her boyfriend has an addiction problem; he does not want help and does
not do anything to help out with their child. The baby is now nine months old, and he
has only seen him once because her mother had the baby at the county jail to visit her
at the same time he was visiting his current girlfriend in jail. She has not had any
contact with him since February when he wrote to her in prison and threatened to get
custody of their child. She stated that he was just upset because he had been ordered
to pay $45 in child support. She called her mother who has custody of the child and
her mother obtained a lawyer.

The children of the women interviewed lived in a variety of care situations –from

being an adult and caring for one's self, to living with the other parent, grandparents or

foster care. Only one woman stated that being separated from her children did not cause

her stress. However, this interviewee also stated that she wished her son would write to

her, but remembers what it was like to be fifteen. This statement seemed to suggest that

this separation did cause her some stress.

[Interview # 47]: She stated that being separated from her children did not
cause her stress. She knows that prison is where she is supposed to be and it is
the best thing for her. She needed to come to prison to get sober, and it is the first
time she has been sober in two years. She stated that she would like to hear from
her son more, but remembers what it was like to be fifteen.

The majority of women experienced an immense amount of stress due to the
separation from their children.

[Interview # 22]: She can't look at their pictures because she thinks about
what she could have done to prevent this and it causes her pain. She said that she
does not get depressed too much. She will fight for what is hers and will always
fight to get them back. This gives her strength to continue.

[Interview # 39]: Being away from her children causes her stress due to
separation, sense of failure, depression and anxiety.

[Interview # 9]: Being separated from her children causes her stress. She
fears that something will happen to them, something tragic.

[Interview # 19]: Her second husband will no longer accept calls from her
because the last time she spoke with her children, they told her that they were
being physically abused by their father. She called Children and Youth Services
and by the time they followed up on the case, her children did not have any
physical signs of abuse and nothing happened. She had turned her husband in
because he had tried to bite her son's nose off last summer. She misses her kids,
and the last time she spoke to them, they told her they wanted her to come home.
She worries that when she gets out, she won't be able to get custody of them.

[Interview # 46]: She stated that being separated from her children caused her
a great deal of stress. After her incarceration, her youngest daughter tried to hang
herself at the age of five. Recently, the daughter tried to burn down her aunt's
house, stating that she can't take it anymore. She asked her aunt to get counseling
for her daughter and their minister helped her aunt do this. Her daughter sends
her pictures and she feels that she is well taken care of. Her daughter is now in
the church choir and recently got involved in a program that gives a violin and
two years of music lessons to children with incarcerated mothers.

Those with younger children feared what they were missing and whether their
children would remember them when they returned home.

[Interview # 10]: She worries that he won't recognize her when she comes
home. She also worries that he won't respect her, and she stated that she would
not blame him if he did not. She is worried that he may not want to come
with her and live because he already has a life with her aunt.

[Interview # 26]: She worries that the youngest two who were infants when she
left for prison will not remember her. She talks to them a couple of times a week,
but her mother is unable to bring them in for a visit because the prison is seven
hours away.

[Interview # 4]: She misses them and has feelings of guilt because she is away from them. She realizes how much she has missed because of her drug use. She stated that between her addiction and being incarcerated, she has missed out on a lot of big events in their lives.

[Interview # 34]: In the summer, many people get visits, but it is an eight-to-nine hour drive for her parents to bring her son. Her parents are older and she does not want them to make the drive. Her son's father will not bring him because he does not feel that the boy should see his mother in prison. Recently, her son expressed an interest in seeing her. She has not seen him in person in three years.

[Interview # 64]: She deals with depression and is having a particularly hard time being separated from her youngest because she has missed out on a lot and is aware that she can never get that back.

Those with adult (age eighteen and older) children worried about their children's life

choices and not being there to guide them or discuss problems with them.

[Interview # 11]: She has a difficult relationship with her daughter that she is unable to confront because she is incarcerated. Her daughter's fiancé brought an informant into her house to buy oxycotin from her. The informant told her that he had a really bad back and begged her to sell a couple of pills. She stated that both her daughter and her fiancé knew that this was an informant. After she was incarcerated, her daughter and fiancé withdrew $33,000 from her bank account. She stated that there was a lot of bad blood between her and her daughter and she was unable to do anything about it because she was in prison.

[Interview # 23]: She feels as though the better half of her is missing. She is in pain, anxious, depressed and feels lonely. She is angry with herself for failing them as a mother. She wanted to do the right thing, but was unable to. She worries about her oldest son who is at the same age she was when her parents abandoned her. She stated that her son has not been abandoned, but she is concerned about him repeating the pattern.

[Interview # 8]: She has not yet met her son's girlfriend, although her sister says that her son is a good kid. She feels that she misses out and wonders if they'll follow her path because they saw her drug use. She worries about her son because they were close prior to prison and now he is upset with her and does not write or send pictures. She hopes that he will open up and talk to someone about this.

[Interview # 7]: She worries about her children hanging out with the wrong crowd. She is also concerned about her daughter who recently moved to Florida with her boyfriend.

[Interview # 48]: She misses him and it hurts to be away from him. He recently got married two months before she came to jail. She hopes that he waits to have children until she is released.

[Interview # 60]: Her children are all struggling. One son sells drugs; another son sells drugs and is involved in a gang, while the third son is looking for love in all the wrong places. Her daughter runs around, while her boyfriend cares for their children. Being separated from her children causes her a lot of stress because she wants to be able to touch and kiss them. She also wants to be able to give them advice, so they do not make the same mistakes, but she is a long way from home in Philadelphia.

The women who participated experienced stress as a result of having been separated from significant others. At the time of this interview, only seven of the women were still involved in a relationship with their significant other. However, most of the women had been involved in a relationship with a significant other prior to prison. These relationships and their significance are often overlooked in research conducted with female inmates because once in prison most women report they are single (Owen, 1998). The majority of women in this study did report some level of stress due to being separated from their significant other. Therefore, these prior relationships with significant others need to be taken into consideration when trying to understand female inmates behavior and how they cope with the prison environment.

Participants reported that the separation from their children caused them an enormous amount of stress. Women who had younger children feared missing important events in their children's lives and that their children would not recognize them as their mother upon release. Women who had adult-aged children were concerned that they were not there to give advice and support to their children as they faced tough adult decisions.

These findings support prior research (Giallombardo, 1966; Owen, 1998) that stated relationships were extremely important to female inmates, both inside and outside of prison, especially the relationship between mother and child. These women, like the women in previous research, were experiencing significant stress due to the separation from their children and to a lesser extent the separation from their significant other.

<div style="text-align:center">Does Being in Treatment Improve One's Coping Skills?</div>

<div style="text-align:center">Problem-solving Skills</div>

Overall, there were five main problem-solving skills that the women were taught and utilized. The first skill involved breathing and thinking exercises, where the women when faced with a problem stopped, took deep breaths and then thought about the best way to solve their problem. A second problem-solving technique was physical exercise, so one can face a problem with a clear mind. A third problem-solving skill was journaling, in which the women wrote their problems into a journal and reflected on what happened. A fourth problem-solving technique included prayer to a higher power. The fifth technique included reading the Bible or other religious material to reflect and look for answers.

Breathing & Thinking Exercises

There were three women on the waiting list who used breathing/thinking exercises when faced with a problem. All three of these women had been in treatment programs either in prison or "on the street". One woman was currently in a program entitled *Thinking for a Change*. A second woman had been in several rehabilitative programs in prison, while the other woman had an extensive background with treatment programs on the street.

Women in Phase One of the therapeutic community appeared to be buying into the

concept of the breathing/thinking exercises and were learning how to use these

techniques.

[Interview # 39 phase 1]: She has a problem with anxiety and was having severe
attacks that would last for days. Now she is able to control some of these
feelings using deep breathing techniques.

[Interview # 4 phase 1]: When she gets upset, she has a feeling in her gut that
makes her uncomfortable. This is the same feeling she would get right
before she would go out and get high. Now she is able to recognize this
feeling and will step outside for a minute and count to 100, use breathing
techniques, pray and ask for peace. She stated that it feels like an ocean
taking over inside. She had never felt this way and not used. Now she is
able to recognize this feeling, cope with it and make it go away. She stated that
this was a great feeling.

No one in Phase Two reported using breathing or thinking exercises. Instead, they

relied primarily on journaling and prayer. However, those in Phase Three reported being

faced with a problem, thinking about the problem and then coming up with a solution.

[Interview # 3 phase 3]: When she has a problem, she has to work through it right
then. If she has something on her mind, then she would not be able to enjoy
anything else until she has solved it. She does not keep much in and must work
on a problem immediately. She stated that this was because of the program.

[Interview # 34 phase 3]: When she is finished crying, she will process it because it
needs to be dealt with right then. If she sits and cries, she cannot move on, she learned
this in the therapeutic community. She had never realized that her feelings were valid
and that is alright to have boundaries. She is learning to assert her boundaries and
gave the example of talking to her roommates about her problem with them. She
would not have done this before.

It appeared that women in the therapeutic community have learned/are learning

breathing/thinking exercises and that these skills have improved/are improving as they

move through the program. There were only three women on the waiting list that

reported using breathing/thinking skills; all three of these women had been involved in a

treatment program in prison or prior to where they had learned these skills. One woman

on the waiting list did not report using any problem-solving skills. Women in Phase One of the program seemed to be learning how to use breathing/thinking techniques, while women in Phase Three were putting these skills to use.

Physical Exercise

There was one woman in each phase of the program and two from the waiting list who utilized physical exercise when faced with a problem in prison. This seemed to suggest that physical exercise, as a problem-solving skill was something that women learned prior to prison. Therefore, those who physically exercised prior to prison when faced with a problem also did so when in prison.

Journaling

There were women in all phases of the program that wrote in journals when upset or faced with a problem. The use of journaling as a problem-solving skill was slightly more common for women in the therapeutic community. Women in the therapeutic community seemed to be accepting that they had problems and were attempting to work through them, while women on the waiting list were using journaling as a last resort. Therefore, it seemed that journaling was a skill that many had prior to participating in the therapeutic community; however, those in the therapeutic community were encouraged to journal and did so more often as they began to face and work through their problems.

> [Interview # 51 wait list]: If she is unable to contact her mother, she will write a letter to herself and rip it into pieces. This allows her to get all of her feelings out, so she will not say the wrong thing.

> [Interview # 56 wait list]: Sometimes her problems are so overwhelming that she will write them down.

> [Interview #10 phase 1]: When she gets upset from thinking about her son, she writes letters to him and then does not send them. She stated that this was like a journal for her.

[Interview # 23 phase 1]: In the therapeutic community, if she does not have anything nice to say then she will not say anything at all. She has learned in the therapeutic community to write down her feelings first and then talk about it rather than to react verbally immediately.

[Interview # 18 phase 2]: During her free time is usually when she gets time to think. She will write letters and put them in her Bible and not send them out. She is then able to write it down and get it out.

[Interview #1 phase 3]: When upset about her son, she will write in her journal. When she becomes upset, she usually writes in her journal and then reads back over the journal entry.

Prayer

The majority of women stated that they prayed prior to prison. One woman from Phase One stated that she did not pray prior to prison along with two women each from Phases Three, Two, and the waiting list. This seemed to suggest that prayer was a coping skill that most learned prior to prison. However, the majority of women reported that they prayed more often in prison compared to when they were on the streets, and acknowledged that they prayed for different things. Most prayers on the street involved personal problems, such as dealing with one's addiction or staying out of trouble. A few women prayed for their family, guidance or thanks, but the majority mentioned personal problems.

[Interview # 47 wait list]: Prior to prison, she did pray, but not enough. She stated that her prayers were 911 prayers, where she would pray for help when she got into trouble.

[Interview # 60 wait list]: Prior to prison, she prayed every day for God to keep her safe, while she robbed other people for money for her drug habit. She began hustling on the streets when she lost her job.

[Interview # 22 phase 1]: Prior to prison, she prayed almost every day because she wanted out of her lifestyle and abuse. She stated that she would not be here if it were not for God. She had been close to death many times. She prayed whenever she was beaten, which was almost every day.

[Interview # 39 phase 1]: She prayed prior to prison for her addiction to be taken away and to do what she needed to do for her children.

[Interview # 16 phase 2]: She prayed prior to prison, but only when she was in trouble.

[Interview # 28 phase 2]: She prays more often in the therapeutic community than she had on the streets.

[Interview # 13 phase 3]: She prayed prior to prison, but only when she thought something was going wrong. She prayed when she was on the run to come back to prison because she was tired of being on the run.

[Interview # 19 phase 3]: She prayed prior to prison, but these were often fox hole prayers, where she would state get me out of this one and I won't ever do it again.

[Interview # 34 phase 3]: Prior to prison, she prayed every few days or when she was having a bad time. Now her prayers involve names, problems people are going through that do not always involve her, and acceptance for other things.

All of the women in the therapeutic community reported praying while in prison. Only one woman on the waiting list reported that she did not pray in prison. The women prayed for a variety of things including blessings/thanks, family/children, wisdom/strength, others in a difficult situation, problems faced in prison and the correction officers. One woman in Phase One stated that she prayed due to her fear of getting into trouble by breaking the rules of the therapeutic community, but none of the other volunteers mentioned this. There was one main difference between the women in the program and the women on the waiting list. The women on the waiting list reported praying, but never when faced with a problem. This seemed to suggest that they were not identifying their problems, which is the first step in mature coping.

[Interview # 50 wait list]: In prison, she prays every day multiple times a day for strength, wisdom, patience, forgiveness, family, for other people and to give thanks.

[Interview # 54 wait list]: In prison, she prays each day continually through out the day for strength to continue, safety for self and others, her children and family, and for the staff when the roads are bad.

[Interview # 56 wait list]: In prison, she prays about one time a week for her children and older people in general.

[Interview # 11 phase 1]: She prays once an hour because she is scared in the therapeutic community. She feels like she can get into trouble for anything she says or does.

[Interview # 22 phase 1]: She prays in prison for problems and for humility and strength. She prays constantly as problems arise.

[Interview # 16 phase 2]: She prays every day in prison for problems and to give Him glory.

[Interview # 18 phase 2]: When they broke up, she prayed.

[Interview # 13 phase 3]: She prays every day in prison for problems, inner peace, guidance and knowledge.

[Interview # 19 phase 3]: She prays in prison several times a day, sometimes for problems and other times to give thanks.

Prayer appeared to be a problem-solving skill for the majority of the interviewees prior to coming to prison. Prior to prison, the women prayed for personal problems. Once in prison, the women reported praying more often and for a variety of reasons. Women who were in the therapeutic community prayed for current problems, while the women on the waiting list did not mention praying for problems that they faced in prison.

Reading the Bible

Only a few interviewees from each phase of the program and the waiting list reported reading the Bible when faced with a problem in prison. This seems to suggest that this was a problem-solving skill that one relied on prior to prison.

Seeking Social Support

The participants reported that they relied on a variety of seeking social support

strategies including: discussing one's problems in group sessions, with friends in prison,

with a correctional officer, a professional (therapist or clergy), through letters or during

phone/visits with friends/family. Women also sought out social support through church,

both on the street and in prison. The two most-reported strategies of seeking social

support were relying on friends in prison and attending church.

Friends

Women, from all phases of treatment and the Waiting list, who had close friends with

whom they were able to discuss problems prior to prison also made close friends that

they could talk to while in prison.

> [Interview # 48 wait list]: Prior to prison, she was able to discuss her problems
> with both of her street friends such as the ending of her second marriage, abuse that
> occurred during her childhood, and her son. In prison, she talks to her close prison
> friend when she is having problems and they discussed the break-up with her husband.
> This friend told her that her husband was not good enough for her and she needed
> someone who would respect her.

> [Interview # 23 phase 1]: Prior to prison, she discussed problems with her street
> friend and stated that she knows everything about her. In prison, she will talk to her
> close friend in the therapeutic community when she is upset.

> [Interview # 8 phase 2]: Prior to prison, she discussed problems with her
> street friend and gave the example of when she and the father of her daughter split up
> and she wanted to go to the bar. Her friend talked her into coming over to her house
> instead. She took the kids to the friend's house and their kids played together, while
> they sat in the kitchen and talked and she shot heroin. In prison, she was close to her
> roommate and stated that she was able to talk to her roommate when she was upset
> over missing her children.

> [Interview # 46 phase 3]: Prior to prison, she had close friends who were very
> supportive of her even through her incarceration and drug addiction. She talked to
> them about problems including her son's murder. She can let them know how she is
> feeling and they will encourage her. In prison, she stated that when she was in the

therapeutic community [recent graduate] that she felt comfortable talking to the other women because they already knew so much about her that she did not have to explain the background of the problem.

Women on the waiting list who stated that they did not have any close friends prior to prison also did not have any close friends in prison.

[Interview # 60 wait list]: Prior to prison, she did not have any close friends because all of her friends were addicts who would take her money when they did not have any. The people that she hung out with all knew she had a job and would be there when she got paid. In prison, she stated she did not have any close friends.

[Interview # 51 wait list]: Prior to prison, she had close friends as a teenager, but she has not had any close friends in recent years. In prison, she stated that she did not have any close friends because a friend was someone who you can talk to about certain things. She does not discuss deep stuff with anyone here because she does not trust anyone.

The majority of women in the therapeutic community who reported not having friends prior to prison made friends with whom they discussed their problems in the therapeutic community as they became more comfortable with their surroundings and began to trust the other participants.

[Interview # 22 phase 1]: Prior to prison, she only had her husband and his friends and family. Her family and friends were not allowed to come over, and she was not allowed to leave her home. In prison, she shares a lot about her kids with other women in the therapeutic community and feels they have supported her just by listening.

[Interview # 16 phase 2]: Prior to prison, she did not have any friends. In prison, she has a close friend that she met in the therapeutic community. When she is upset she talks to her roommate who has been very supportive and positive.

[Interview # 13 phase 3]: She did not have friends prior to prison. She spent most of her time with her grown children. She started making friends after she came to the therapeutic community. She has one close friend in the therapeutic community.   She discusses her problems with this friend. She is a happy person and people can tell when something is bothering her. She doesn't hold back because she wants to process it and get over it.

There were a few women in Phase One who were not comfortable enough to discuss their problems with the group or a friend and were still relying on friends and family outside of prison for support through letters, visits and phone calls.   Only one woman in Phase Two reported not feeling comfortable enough to discuss her problems with a friend, but she had opened up in group settings. There were two women in Phase Three who stated that they did not have any close friends in prison that they could talk to about their problems. One woman was a graduate of the program who had recently moved to a new floor and the other was a graduate/peer assistant who stated that she tried to keep her distance for professional reasons, but mentioned "opening up" to women on her floor. Therefore, when faced with a problem, women on the waiting list and in Phase One seemed to rely more often on outside social networks through letters or talking/visiting with family/friends. Women in Phases Two and Three were more likely to report that they discussed their problems with women in the therapeutic community.

These interviews suggest that women who had close friends prior to prison with whom they were able to discuss their problems also made close friends once in prison. Those in the therapeutic community who did not have close friends prior to prison made friends with others in the program once they began to trust the other women. Therefore, participating in the therapeutic community did help to strengthen seeking social support skills. Those therapeutic community participants who did not have friends prior to prison were learning to open up and trust others with their problems, while those who were already able to make close friendships were given the opportunity to strengthen this skill.

Church

Most of the women interviewed attended church prior to prison; however, how often

the women attended church on the street varied. Some women attended church regularly,

while others attended church as a child and less often as an adult when they were abusing

drugs/alcohol.

> [Interview # 58 wait list]: Prior to prison, she attended church as a child, but
> has not attended since then. She did not lose her faith, but drug dealing
> became more important.

> [Interview # 29 phase 1]: Her family is religious, but she fell out of practice
> when she began to drink heavily.

> [Interview # 9 phase 2]: She attended church as a child, but not as an adult.
> She quit going to church around the age of 15 or 16 when she began to use
> more often.

> [Interview # 13 phase 3]: She attended church every couple of weeks prior
> to prison. When her addiction would worsen, she would not attend as often, but
> she was raised in the church.

A few women became reacquainted with church after they were in trouble with the

law or right before coming to prison.

> [Interview # 59 wait list]: Prior to prison, she attended church each Sunday
> and was beginning to attend a drug and alcohol program at the church when
> she was convicted. She stated that she had been raised in the church.

> [Interview # 23 phase 1]: She attended church prior to prison two days a week.
> She started attending church right before she was incarcerated because she knew
> she needed to make some changes, so she started taking her children.

> [Interview # 18 phase 2]: She had been brought up with religion and got away
> from it due to her addiction. She then got involved again eight months before
> she came to prison and has attended a church service one day a week.

> [Interview # 3 phase 3]: She quit attending church after her godmother died
> when she was 8 years old. She did not attend church again until she was charged,
> then she attended church once a week.

Those who attended church prior to prison also attended church in prison, with the exception of one woman on the waiting list. This interviewee believed that people at church were judgmental and only in attendance to see their girlfriends. There were a few women who did not attend church prior to prison, but began to attend church once in prison. The majority of these women began attending church prior to the therapeutic community, with the exception of three women who began attending church once in the therapeutic community and one woman who reported not attending church prior to or in prison.

The results of these interviews suggested that for most, church was a coping skill that they had prior to prison and not one that they learned while in the therapeutic community. Going to church was a coping skill that most women relied on outside of prison, but quit using or relied on less when abusing drugs/alcohol. Once in trouble on the streets or sober and in prison, those who relied on church as a coping skill at some point in their life began to rely on it once again.

<center>Avoidance</center>

Avoidance occurred when one was unable to face a problem and instead acted as if the problem was not happening. Overall, there were three main avoidance techniques on which women from all phases of the therapeutic community and Waiting list relied upon. The first avoidance technique involved ignoring the problem altogether and not reacting to it or avoiding the problem at hand and doing other things as a distraction. Many of the women reported crocheting, reading, listening to music, watching television or daydreaming as techniques they relied on to avoid the problem they were currently facing. A second way women avoided their problems was by not facing the problem, but

by crying about it instead. A final way that women avoided their problems was by joking about the situation to relieve the tension and change the topic.

Avoid Problem and/or Do Other Things

The majority of women on the waiting list reported avoiding their problems in prison and doing other activities to distract themselves from their problems. Two women on the waiting list stated that they avoided their problems initially, but later came back to their problems to solve them. One of these interviewees had participated and was currently involved in other treatment programs within the prison. The other woman had been an inmate in the prison for four years and appeared to be adjusted to prison life and how to avoid problems. Two other interviewees from the waiting list did not report any instances of avoiding their problems; both of these women had been and were currently involved in other treatment programs within the prison system.

> [Interview # 47 wait list]: When she is faced with a problem in prison, she will watch television, draw, listen to music or daydream.

> [Interview # 56 wait list]: When she is facing a problem in prison, most of the time she will avoid the situation by playing cards, watching television, or by focusing on others problems. She stated that she focused on others' problems because she was unable to help herself.

> [Interview # 48 wait list]: She watches television and reads books to distract herself from everyday problems. She does not do this all of the time, but a lot to take her mind off of the problem. She will return to the problem at a later time to try and work it out. She avoids the problem initially to avoid crying.

> [Interview # 67 wait list]: When she is faced with a problem in prison she will read a book. She always does this because she needs time to think and process the situation. She will get around to the problem and not avoid it all together, but she has a tendency to run at the mouth. Therefore, she needs time to let her brain process the situation, so she can see it from a different perspective.

All of the women in Phase One of the therapeutic community reported avoiding the problems that they faced everyday in prison either altogether or by doing other activities as a distraction. Many of the women in Phase One also stated that they were under a lot of stress because they were still adjusting to the new rules of the program. It is a violation in the therapeutic community, for example, to talk negatively about another participant in the program. The stress of this adjustment period has caused many of these women to rely on avoidance techniques such as daydreaming.

> [Interview # 39 phase 1]: She handles stress by trying not to think about it and blocking it out.

[Interview # 10 phase 1]: She crochets to relax and distract herself from her problems. She tries to distract herself from her thoughts regarding everything because she has bad anxiety. She felt that the program was horrible because she did not have any time to herself. She believes that when a person is incarcerated she needs time to herself so that she can soul search. There are so many meetings that she cannot focus on her family and is unable to write them a decent letter. She wants to complete this program because she is afraid of jeopardizing getting out. She felt the therapy portion of the program worked.

[Interview # 11 phase 1]: She felt that the program was a good one, but that it needed more individual attention because one can get lost in it. She felt they relied too much on discipline and that it was not necessary because people wanted to change.

[Interview # 29 phase 1]: When she is having a bad day she will daydream. She does this because you cannot vent in the therapeutic community or you will get into trouble.

All of the women in Phase Two stated that they avoided problems they faced everyday in prison by doing other activities to distract themselves; however, there were two women who said they did not do this every time they had a problem. There were also fewer instances of avoidance reported by women in Phase Two in comparison to women in Phase One and women on the waiting list.

[Interview # 18 phase 2]: When she gets upset, she will read.

[Interview # 8 phase 2]: When upset she will make an excuse, get up, and leave.

[Interview # 28 phase 2]: She crochets and listens to her Walkman to relax and to distract herself from problems. She does not do this every time she has a problem.

[Interview # 9 phase 2]: She crochets both to relax and distract herself from her problems. She does not do this every time she has a problem. Before the therapeutic community when she would face a difficult situation she would get up and walk out. Now she will stay and laugh off the situation. The program has helped her to realize that she can try again and that it is ok to fail.

The interviewees from Phase Three reported varying levels of avoiding their problems and distracting themselves. Three of the women interviewed stated that they avoided their problems in prison and did other activities; while another woman in the same phase said that she only avoided problems and distracted herself when things were really bad. Three more interviewees from Phase Three of the program did not report any instances of avoiding their problems in prison.

[Interview # 19 phase 3]: When she is faced with a problem, she plays cards and daydreams both to distract and relax her. She sometimes will pace and pick at her nails.

[Interview #5 phase 3]: Sometimes when she is having a really bad day she will daydream about leaving prison, watch television, crochet or read a book. If the problem is something she cannot solve because she is in prison, she will stay busy.

[Interview # 13 phase 3]: She does not have bad days in prison and so does not rely on any activities to distract her.

Two of the women interviewed in Phase Three were no longer in the therapeutic community and were having a difficult time adjusting to prison life outside of the program. One woman had graduated from the program and was now a peer assistant who

resided in the general population. She was also going through a difficult time in her life

due to the recent death of her young adult son. She reported daydreaming when upset,

but mentioned that because of the therapeutic community, she realized this was an

unhealthy coping mechanism. Now, she talks to someone about her problems when she

catches herself daydreaming. She also stated that she fills her time through arts and crafts

and by staying quiet when things are really bad. The second woman who was having a

difficult time adjusting to prison life outside of the program had been removed from the

therapeutic community due to rule violations. She reported being under a lot of stress

because she feared that her removal from the program would affect her parole eligibility.

She coped with this stress by avoiding her problems and self-mutilating.

> [Interview # 46 phase 3]: She daydreams when upset. This is a safe place for her to
> go. This is something she learned to do as a child to survive her abusive
> situation. When she catches herself daydreaming, she will stop and talk to
> someone about it. She has been daydreaming more often lately since her son passed
> away. This is usually brought on because of something someone will say or do that
> will remind her of him. She also crochets, puts together puzzles and creates arts and
> crafts when upset. Doing these activities comforts her. When she is in a tense
> situation or facing a problem, she will get quiet and stay to herself. Often she will
> isolate herself because of her living situation in another unit.

> [Interview # 7 phase 3]: She has had trouble sleeping since she left the therapeutic
> community and has been handling this stress by picking at herself. She lifted her
> sleeve and showed me where she had been picking at her arm. She had twenty or
> more small round scabs on each arm that were in different stages of healing. She also
> stated that she reads to distract herself from her problems. She has been reading more
> lately and mentioned that she was worried about her parole status after having been
> kicked out of the therapeutic community.

The majority of those interviewed from the waiting list avoided their problems

through distractions such as daydreaming and television, while those in Phase One of the

program reported difficulty adjusting to the therapeutic community and appeared to be

relying on distractions to get them through this stress. However, women interviewed

from Phases Two and Three reported far fewer instances of avoiding their problems than women in earlier phases. Therefore, it appeared that the therapeutic community had helped to improve one's coping skills by reducing or eliminating the need to avoid problems.

Crying

   Crying is not always a negative coping skill or avoidance technique. Therefore, the act of crying was categorized into three types of crying. The first category, healthy crying, included crying with a friend or group where one was able to discuss her problem or crying by herself as long as she did not always cry alone or excessively. The second category, unhealthy crying, occurred when one cried alone only and always in isolation often due to anger or depression. The final category, repression, occurred when one was unable to cry or only cried on rare occasions.

   Many of the women on the waiting list reported crying by themselves due to depression or anger, while two women reported repressing their feelings and crying on rare occasion. There were a few reported instances of healthy crying; however, several of those who reported healthy crying behaviors had participated in prior treatment programs inside the prison. Another woman on the waiting list who reported healthy crying stated that she did not cry for the first three years of her prison sentence.

   [Interview # 67 wait list]: When she is upset, she will cry with her roommate in her room. Because she usually cries with her roommate, she talks to her about the situation when she is done crying. When she first came to prison, she did not cry for the first three years. She stated that she has changed a lot over the past three years and has had a chance to take a good look at herself and learn to cope with things.

[Interview # 56 wait list]: When she is upset she cries by herself in her room. When she is finished crying, she will try to let her problem go and not think about it because there is little that she can do.

[Interview # 58 wait list]: If she is mad enough to cry, then she is mad enough to fight.

[Interview # 61 wait list]: She does not cry when upset. She did cry when she missed her boyfriend, but so many things have happened to her that nothing surprises her anymore, and she is prepared for the worst and the best.

Only one woman in Phase One of the therapeutic community reported healthy crying; however, she stated that she cried during group sessions only after others' sharing their stories triggered her own memories. The other participants in Phase One reported unhealthy crying behaviors, with the exception of one woman who stated that she tried to repress her tears.

[Interview # 22 phase 1]: She cries when others share because it sometimes will trigger her own memories or because she feels empathy for that person.

[Interview #23 phase 1]: She cries when upset in the shower by herself. She tries not to think about what made her cry, but feels crying is good because it eases her pain.

[Interview # 10 phase 1]: She cries when upset in meetings and by herself. She feels that she is forced to cry in front of others because she is so busy with meetings. She tries to hold it in, but is unable to.

In Phase Two, no one reported healthy crying behavior; the majority of women relied on unhealthy crying. Two women in Phase Two stated that they did not cry when upset or faced with a problem. However, it is possible that they were repressing their feelings, so they would not cry.

[Interview # 28 phase 2]: When upset, she cries by herself in her room or in the shower. She does not think about what made her cry because she only gets frustrated which turns to anger and then rage. She is trying to learn the coping skills to handle her problems.

[Interview # 8 phase 2]: She cries when upset by herself in the bathroom or her room if her roommate is not around. She would be crying more if she were not taking medication for depression.

In Phase Three, about half of the women reported healthy crying behaviors, while the other half tended to cry alone in the bathroom or in their bunk late at night. One woman, who was categorized as unhealthy crying, had recently graduated from the program and had moved to another floor. She did not feel as though she could share with her new floor mates, so she cried alone. The rest of the women who reported crying alone stated that they did not cry as much as they used to, and one woman reported thinking about what made her cry. No one in Phase Three commented that she repressed her crying.

[Interview # 1 phase 3]: She usually cries with friends or during group meetings. She cries a lot less now than she used to.

[Interview # 3 phase 3]: She cries on occasion by herself, with friends or during group sessions.

[Interview # 34 phase 3]: She cries by herself in her bunk late at night when things go through her head and she can't get away from it. She does not cry as much as she used to.

[Interview # 19 phase 3]: She usually cries by herself in her room or in the bathroom. When she is done crying, she will think about what made her cry and then will move on because she can only do so much while she is in prison. When she first came to prison, she cried all of the time and did not understand why. Now she is starting to realize what is going on around her and how it affects others.

It appeared that women in Phase Three of the program had learned to rely less on unhealthy crying and repressive behaviors. It seemed, however, to take reaching this phase before there was a noticeable reduction in these behaviors. The changes noticed in crying behaviors during Phase Three may be a result of program structure.   A major focus of Phase Three of the program was to examine what was going on in the

volunteers' lives at the time they began to abuse substances, along with the connection between these events and their addictive behaviors. The process of analyzing these events has allowed for women in Phase Three to open up in a way they had not been able to before due to the new forum to work through their feelings. The analytical process itself could also have brought the women in Phase Three closer together as they listened to others who faced similar problems in life, making it easier to open up to others in the therapeutic community or during group sessions. However, women in Phase One were still adapting to the program, while women in Phase Two were only beginning to feel comfortable with one another. Therefore, women in Phases One and Two did not talk about what made them cry when they felt rage or depression and chose to cry alone.

Joking

Joking was defined as a negative coping skill, when one joked to cover her real feelings to avoid facing and working through emotions. A few women stated they did not have the extroverted personality needed to make jokes in tense situations and instead became very quiet.

Only four women on the waiting list reported not joking in tense situations and two of these women had participated in prior treatment programs within the prison. The rest of the women reported joking when they were in a tense situation, except for two women who stated that they smiled or became quiet instead. In Phases One and Two, all of the women reported joking to break the tension, except for one woman in each phase that became quiet.

> [Interview # 56 wait list]: In a tense situation, she always makes a joke. She pointed out that when she came in for the interview she made a joke to me and stated that she does this when she is nervous.

[Interview # 10 phase 1]: She does use humor to break the tension, but does not do this every time. She tends to do this if she or someone else is getting into trouble because it makes her nervous whenever someone is called out individually. She does not say the jokes out loud because she knows she will get into trouble, so she only says them in her head.

[Interview # 28 phase 2]: She does not make jokes when she is in a tense situation because she is a quiet person and is unable to. She stated that she would like to be able to do this.

Women in Phase Three reported joking less often in comparison to women on the waiting list and in Phases One or Two. One woman in Phase Three reported not joking at all, while a few women stated that they used to joke when in a tense situation, but do not do this any longer. A few women stated that they joked when faced with a tense situation, but some noticed that they were doing this less often.

[Interview # 1 phase 3]: Every time she was in a tense situation, she used to make a joke to break the tension. She learned in the therapeutic community that she was masking her problems by telling jokes. Now she realizes that things she thought were really funny were actually not funny at all and she is more serious.

[Interview # 5 phase 3]: When she is in a stressful situation she will try to laugh it off, so that it does not appear to be a big deal. She gave the example of being in a group session where they were examining her life. She will pretend to laugh so that people do not feel sorry for her. She used to do this every time she was in a stressful situation, but now she does this less often.

Joking was an avoidance technique for some women, so they did not appear to be vulnerable. It appeared that the therapeutic community did help the women to rely less upon joking as an avoidance technique since women in Phase Three joked less often or not at all. However, it again took until Phase Three before the women began to show improvement in this area. This could be due to the structure of the third phase of the program and its reflective nature in which women began to reflect upon their own behaviors and examine why they behaved the way they did.

Do Women from Different Ethnic/Racial Backgrounds Have Different Life

Experiences That Cause Them to Rely Upon Different Coping Strategies?

Life Prior to Prison

The three Hispanic women who were interviewed began using substances between the ages of seven and fourteen, and all three women stated that their primary drug of choice was alcohol. These three women were facing parental problems in their homes at the time they began to use such as neglect and/or the parents' own addiction. The eight African American women who were interviewed stated that they first tried alcohol or drugs between the ages of twelve and eighteen, with the exception of one woman who reported that she began using at the age of twenty-nine. These eight women reported using cocaine/crack cocaine, alcohol, and PCP, but reported that alcohol and crack cocaine were the most widely used. One woman began using crack cocaine with her boyfriend when her mother died, but the rest of the women reported their substance use coincided with abuse or parental problems in the home.

There were differences between women from different races/ethnicities in the age of onset, the types drugs used, and what was going on in their life at the time they began to use drugs and alcohol. White women began using at a variety of ages, but were more likely to have tried drugs after the age of eighteen. The White women who tried substances for the first time after the age of eighteen were often dealing with the loss of a family member or marital problems. In contrast, one White woman reported that the stress of having a child led her to try substances, while another White woman stated she tried substances due to health problems. There were also differences in the drugs that women reported using as their primary drug of choice. White women were the only ones

who reported using heroin, prescription pain medication, methamphetamines and Ecstasy.
White women were also more likely to report that they first used drugs due to peer
pressure, while only one African American woman stated that she first used substances
due to peer pressure.

All of the minority women reported having a significant other prior to prison and
living with this person with the exception of two women. One Hispanic woman stated
she did not have a significant other prior to prison, and one African American woman had
a significant other, but did not live with him. The majority of White women also reported
that they had a significant other prior to prison and that they lived with this person.
Therefore, there did not appear to be any differences between races/ethnicities and having
a significant other prior to prison. There were also not any differences found between
races/ethnicities and having children. Women from all races/ethnicities reported having
children with the exception of four White women and one African American woman.

There were some similarities and differences found between women from different
races/ethnicities in their lives prior to prison. The majority of women reported having a
significant other and living with this person prior to their incarceration. Most women
also stated that they had children. One difference was White women tended to try
substances for the first time later in life and reported abusing substances that African
American and Hispanic women did not report using such as heroin. White women were
also more likely to try substances for the first time due to peer pressure.

Life in Prison

The Hispanic women interviewed ranged in age from twenty-eight to thirty-two. The
African American women who participated were twenty-five to forty-eight years old; five

of the eight respondents were in their forties. The White women interviewed ranged in age from twenty-three to fifty-three, which was close to the ages reported for African American and Hispanic women.

One Hispanic and one African American woman reported current involvement with their significant other since their incarceration, while all other minority women had broken off their relationships. This was similar to White women, where only five were involved in their relationships at the time of the interview. The majority of the minority women who had a significant other prior to prison stated that they did not experience any stress due to this separation, while White women were much more likely to report stress due to the separation from their significant other.

Minority children were being cared for in similar situations as White children, while their parents were incarcerated including: foster care, grandparent, other parent, or the child was an adult and able to care for himself/herself. The stress of being separated from one's children was just as intense for Hispanic and African American women as it was for White women. Women, no matter their race/ethnicity, had similar fears for their children. Women who had younger children were concerned about their children remembering them upon their release and missing events in their children's lives, while women who had adult children were worried about their children's life choices and not being there to give advice.

Once in prison, the women were more similar than different, no matter their race/ethnicity. The women were similar in age and were not usually involved with their significant other once incarcerated. Most women had children who were being cared for in similar settings and reported having experienced stress due to the separation from their

children. The women also reported similar concerns for their children. There was only one difference; White women were more likely to report having experienced stress due to the separation from their significant other.

<div align="center">Problem-solving & Race/Ethnicity</div>

There were five problem-solving techniques that women from all races/ethnicities relied upon when facing everyday problems in prison including: breathing/thinking exercises, physical exercise, journaling, prayer, and reading the Bible. There were not any differences between White, African American, and Hispanic women in their use of breathing/thinking exercises. Women, both white and nonwhite, reported some use of breathing/thinking exercises in Phase One of the program, while by Phase Three of the therapeutic community most of the women relied upon breathing/thinking exercises when faced with a problem in prison. Out of all the women interviewed, only four reported they exercised when faced with a problem. This suggested that no matter your race/ethnicity, physical exercise was a coping technique that few relied on prior to prison. There were also not any differences between women of different races/ethnicities and their reported use of prayer in prison and prior to prison. Women of all races reported praying more once in prison and praying for different reasons than when they had been on the street. Three African American women from the waiting list and one African American woman from Phase One reported that they read the Bible when working through a problem in prison. This was similar to White women, where reading the Bible was not a heavily relied upon problem-solving technique.

The use of journaling was the only reported difference in problem-solving skills between White, African American, and Hispanic women. Only four non-white women,

two African Americans and two Hispanics, reported that they wrote in a journal when working through a problem in prison. However, fourteen White women from all phases of the program reported that when faced with a problem in prison they wrote in their journal. Two of the three Hispanic women interviewed also reported that they used a journal when upset. These findings suggested that White and Hispanic women were more likely to have relied on journaling when faced with a problem in prison than African American women.

Women, no matter race/ethnicity, appeared to have relied upon similar problem-solving techniques, mainly breathing/thinking exercises and prayer. There was one difference in problem-solving skills used, where White and Hispanic women reported that they wrote in their journals more often than African American women. However, there were only three Hispanic and eight African American women who volunteered to be interviewed, which could have skewed the results.

<div style="text-align:center">Seeking Social Support & Race/Ethnicity</div>

Minority women also relied on the seeking social support strategy of discussing problems with prison friends. Only three of the nonwhite women interviewed stated they had friends on the street with whom they could talk about their problems. These three women also had friends in prison with which they could discuss issues when upset. This was similar to White women, where those who reported having friends on the street also had friends in prison.

There were two main differences between races/ethnicities in seeking out social support. First, African American and Hispanic women who did not have friends on the street commented that they had friends in prison that they could talk to about their

problems, with the exception of two women who reported discussing their problems in group settings. However, White women who did not have friends prior to prison did not tend to make friends until their participation in the therapeutic community. Second, White women on the waiting list and in Phase One of treatment were more likely to report that they relied on outside social networks when upset, such as, writing letters and talking/visiting with family/friends. This second difference could help to explain the first. If White women were more likely to rely on outside social networks, they would have less of a reason to turn to other women in the prison for help. Therefore, it may be that minority women were turning to others in prison for help at an earlier time out of necessity, since it did not appear that seeking out social support was a skill that many of the African American and Hispanic women utilized prior to prison.

The second most-relied-upon social support strategy for African American and Hispanic women was church attendance.   The majority of minority women interviewed attended church prior to prison. The only exceptions were two women who attended church in childhood, but not as adults and one woman who began to attend church once she was in trouble. Only one minority woman commented that she did not attend church in prison. This was similar to White women, where those who attended church prior to prison were likely to have attended church once in prison and those who did not attend regularly on the street did so once in prison. This seemed to have suggested that the use of church as a seeking social support strategy was for, both White and nonwhite women, a coping skill acquired prior to prison.

There were only two differences between races/ethnicities in how seeking social support was utilized. First, African American and Hispanic women who did not have

friends prior to prison were more likely than White women to make friends in prison

prior to the therapeutic community. Second, White women on the waiting list and in

Phase One were more likely to have relied upon outside social networks when faced with

a problem than Hispanic or African American women. These two differences could have

impacted the timing of when one sought out other inmates in prison to help her work

through her problems. Therefore, those who had fewer outside resources may have felt

they had few options and sought out social support when faced with a problem, while

those who had more outside resources may have been putting off the inevitable.

<div align="center">Avoidance & Race/Ethnicity</div>

Minority women also relied on three primary avoidance techniques including: avoiding

a problem and/or doing other things as a distraction, crying, and joking. There were not

any differences between women from different racial/ethnic backgrounds and their use of

these avoidance techniques. Women from all races/ethnicities tended to avoid their

problems in prison through distractions such as daydreaming, while the further along in

the program they were the less likely they were to state that they used this avoidance

technique. Women from all races/ethnicities also reported that they had unhealthy crying

behaviors. The only difference was White women reported that the unhealthy crying

behaviors decreased by Phase Three. However, there was only one minority woman

interviewed from Phase Three, a peer assistant, who had recently moved to another floor.

This participant was under stress due to the recent loss of her young adult son. Therefore,

this difference in crying behaviors was most likely due to the loss of her son and her

having been the only minority participant in Phase Three. There were also not any

differences between women from different racial/ethnic backgrounds and their reliance

on joking when faced with a tense situation. Women of all races/ethnicities from the waiting list, Phase One, and Phase Two still relied on joking as an avoidance technique. They did not appear to be vulnerable, but women in Phase Three reported joking less often and becoming aware of their behavior.

Summary

For the respondents, treatment did appear to help improve coping skills. Those in treatment were learning breathing/thinking exercises and by Phase Three women were using these newly acquired skills. The problem-solving skills of journaling and prayer also improved as women received treatment. The program helped women to become aware of their problems and the consequences of their behavior, and it encouraged the volunteers to use these problem-solving techniques. Seeking social support skills also improved as women became acquainted with the program and the other volunteers. The therapeutic community gave women who did not previously have friends the opportunity to make friends, while it also gave women who had made friends the chance to strengthen this skill. There was also a decrease in the use of avoidance techniques, but this was not noticeable until the women entered into Phase Three of the program. There were women in all phases of the program that continued to struggle with their reliance on this negative coping strategy.

Women from different racial/ethnic backgrounds tended to have similar life experiences both inside prison and out. There were only three differences reported between the races/ethnicities prior to prison. White women were more likely to have used drugs due to peer pressure; were the only ones to have reported using certain drugs like prescription pain medication or heroin; and were more likely to have tried drugs for

the first time at a later age. Once in prison, the only noted difference was that White women were more likely to have reported having a difficult time with significant other separation. Therefore, there were a few differences between races/ethnicities prior to prison, but once in prison most of the women reported similar life experiences.

There were only two differences reported between the races/ethnicities for coping skills. The majority of African American and Hispanic women who did not report having friends prior to prison stated that they had friends in prison. White women who did not have friends prior also made friends in prison, but not usually until they entered the therapeutic community. White women on the waiting list and in Phase One of the program reported relying on outside social networks more often than Hispanic and African American women, which may account for the noted differences in when one made friends with others in prison. White and Hispanic women were also more likely to have reported that they relied on journaling when upset than African American women.

It appeared that for the most part women, no matter their race/ethnicity, had similar experiences prior to and in prison, which has caused them to rely on most of the same coping techniques once in prison. There were some reported differences, but it is difficult to know whether these were real differences because of the small number of minority interview participants. Only three Hispanic women and eight African American women volunteered to be interviewed, while twenty-five White women volunteered for face-to-face interviews.

CHAPTER VI: CONCLUSION

This chapter discusses the relevant quantitative and qualitative results of the study. First, the research questions and their associated findings are examined to provide a better understanding of the questions and their answers, drawing on both quantitative and qualitative data. Second, the differences and similarities between this study and past research regarding female prisoners' lives prior to and in prison are noted and discussed in detail. This includes problem-solving skills; relationships and seeking social support behavior; avoidance and negative coping strategies; depression and anxiety; race/ethnicity, and class and coping. Third, the conceptual model of mature coping is examined to document the fit between prison therapeutic communities for female substance abusers and Johnson's concept. Next, policy implications for female inmates and therapeutic communities are noted, with the conclusion that this type of programming should be expanded within the prison system. Finally, suggestions for future research and the limitations of the current study are discussed to help improve future research in this area.

Research Questions and Associated Findings

Does Treatment Affect One's Ability to Cope?

Overall, the volunteers received average scores for problem solving, seeking social support and avoidance on the Coping Strategies Indicator. Applying multivariate analyses, problem solving and avoidance were not impacted significantly by any of the hypothesized variables. Seeking social support was only impacted significantly by the marital status variable; those who were married scored significantly lower on the seeking social support scale than those who were single, divorced or widowed. Therefore, it

appeared, after conducting multivariate analyses, that treatment did not impact one's ability to cope. However, t tests and crosstabulations did suggest that treatment did impact coping skills and seemed to follow the general pattern of the hypotheses.

During the qualitative face-to-face interviews, differences were documented between the waiting list and the different phases of the program in the ability to cope. First, problem-solving skills advanced with treatment, as those in treatment were learning breathing/thinking exercises and by Phase Three were using these new techniques. The problem-solving skills of prayer and journaling also saw improvement as the frequency and quality of these skills increased with treatment. Overall, women in treatment were learning to recognize their problems and the consequences of their behavior, while also being encouraged to practice the positive problem-solving skills of breathing/thinking, journaling, and praying.

The second coping strategy examined, seeking social support, also appeared to improve as the women in the therapeutic community became comfortable with the program and its participants. Those who did not have friends prior to the therapeutic community had the chance to make friends in the program and those who had friends prior to the therapeutic community were able to improve upon these skills.

The negative coping strategy of avoidance also decreased after participation in the therapeutic community. There was a noticeable decrease in the number of reported incidents of avoidance in Phase Three participants. However, the women who relied on avoidance techniques were from all phases of the program and the waiting list.

It had been hypothesized that as one progressed through treatment, coping skills would improve. The multivariate analyses suggested that coping did not improve with

treatment. However, the number of participants who volunteered for the survey was low due to difficulties recruiting women from the waiting list. It was also impossible to examine the differences between the phases and the waiting list because the independent variable *treatment* had to be defined as treatment or *no treatment* due to the small sample size. However, the qualitative results offered a more in-depth examination of the coping strategies on which the women relied. The qualitative results suggest that coping skills did improve with treatment and the differences found between phases and the waiting list strengthened this finding. Therefore, it does appear that treatment did affect coping skills; those in treatment have better problem solving and seeking social support skills and rely less often on avoidance techniques.

Does One's Ability to Cope Affect Her Level of Depression/anxiety?

The Beck Depression Index II and the Beck Anxiety Index were used to measure levels of anxiety and depression in the participants. Overall, the women received scores that placed them in the categories of mild depression and minimal anxiety. For this sample, 71% of the women were not taking any psychotropic medications for anxiety or depression.

Multivariate analyses found that those who had children who were unable to visit experienced significantly more depression, similar to those who scored higher on the avoidance scale. The only variables notably related to anxiety were avoidance and medication, i.e., those who scored higher on the avoidance scale and those who took psychotropic medications experienced a significant degree of anxiety. Problem solving and seeking social support did not impact depression or anxiety considerably. Therefore, positive coping skills such as problem solving and seeking social support did not impact

one's level of depression or anxiety. The more one relied on negative avoidance techniques, the higher the reported levels of depression and anxiety.

Previously, it had been hypothesized that as participants moved through the treatment program and learned more positive coping techniques, their depression and anxiety scores would decrease. However, the multivariate analyses did not indicate that depression or anxiety was significantly affected by either of the positive coping strategies of seeking social support or problem solving. During t tests and crosstabulations, depression and anxiety did appear to decrease with treatment following the general pattern that had been hypothesized. Depression and anxiety were not measured qualitatively; therefore, the differences between each phase and the waiting list were not examined. This makes it difficult to investigate whether problem solving and seeking social support skills do not influence levels of depression and anxiety as suggested by the multivariate analyses.

Do Women from Different Ethnic/Racial Backgrounds Rely Upon Different Coping Strategies?

Finally, the differences between White, African American and Hispanic women and the pre-prison and in prison coping strategies were examined. This study hypothesizes that women who were from different racial/ethnic backgrounds will have different life experiences. These experiences mediated by race and ethnicity will differentially impact coping strategies. Qualitative findings suggest that women, no matter their race/ethnicity, have similar life experiences both inside and outside of prison and only a few differences were found. Prior to prison, White women were more likely to have reported peer pressure influences on first time substance use, compared to African American and Hispanic women.   In prison, comparing African American and Hispanic prisoners to

White prisoners, the only difference was White women reported experiencing stress more often due to separation from their significant other. In sum, the volunteers in this study, regardless of race/ethnicity, had more in common than they did not prior to being incarcerated and once in prison.

There were only a few differences evident between races/ethnicities and the use of coping skills. First, White and Hispanic women were more likely to report the use of journaling as a problem-solving technique. Second, among African American women, the volunteer was more likely to have friends in prison prior to treatment in the therapeutic community, even if she reported that she did not have any friends prior to prison. In contrast, White women who did not have friends before prison were more likely to report that they relied on outside resources such as friends and family once in prison.

There were not any significant quantitative differences between participants' race/ethnicity and one's ability to cope. The qualitative analyses did uncover some racial/ethnic differences in life experiences and the use of coping skills. It is likely that so few differences were found in life experiences and use of coping skills due to the small number of minorities who volunteered to be interviewed. It is also possible that there were few differences noted between these women because they had similar life experiences both inside and outside of prison.

<div align="center">Links between Findings and Prior Research</div>

Life Prior To and In Prison

Giallombardo (1966) and Owen (1998) both concluded that women's lives prior to prison should be examined when trying to understand the experiences of women in

prison. Giallombardo (1966) found that women in prison relied on relationships to help them adjust to the prison environment, similar to women outside of prison who depend on relationships to help them through problems in life. Giallombardo emphasized the need to understand female inmates' before prison lives to get the whole picture. Owen (1998) also examined female adaptation to prison. She learned that prior to prison, most of the women had experienced abuse, poverty, and motherhood, and these experienced shaped the ways women adapted to prison. Owen also concluded that the pre incarceration lives of women must be a critical element of research.

The current study also supports Giallombardo (1966) and Owen's (1998) conclusions. The female prisoners in this study answered questions about their lives before and during incarceration. This information served to better understand the coping strategies on which women relied prior to prison and the degree to which they changed as they adapted to prison.

Problem-solving

Just as female inmates brought poor coping skills with them to prison, some also came with positive coping skills. Negy, Woods and Carlson (1997) concluded that female inmates who had good coping skills often turned to religion, thought about the situation before reacting, and planned a specific solution for the problem when faced with in prison problems. The authors also found that those who utilized positive coping skills had learned these techniques prior to imprisonment. Similarly, Greer (2002) found that women prisoners relied on the positive coping skills of prayer and religion, as well as analysis of or reflection on their problems.

In this research, the majority of female inmates, from all phases and on the waiting list, relied upon religion when faced with stress in prison. Many of the women reported before prison prayer use, but their prayers were often focused on their own immediate concerns, such as pleas to help them not get into trouble with the police officer that just pulled them over. Once in prison, the women continued to pray and more often. The women in the therapeutic community reported praying for specific problems and attempting to work through them with prayer. In contrast, those on the waiting list did not mention praying for specific problems. This finding is similar to previous research where inmates applied their positive coping skill of prayer to work through their problems in prison (Greer, 2002; Negy, Woods, & Carlson, 1997).

The current study notes the majority of the women on the waiting list did not engage in breathing/thinking exercises. Women in Phase One of the therapeutic community were beginning to recognize their problems and were learning breathing/thinking exercises to help to work them through. Women in Phase Three reported facing their problems and solving them.

These findings, again, are similar to earlier studies, where female inmates were utilizing positive coping skills when faced with a problem (Greer, 2002; Negy, Woods & Carlson, 1997). However, women in the current study did not come to the prison system with the positive coping skill of breathing/thinking exercise. This skill was learned in the therapeutic community. Throughout this research, the author has noted the link between a history of substance abuse and poorer coping adaptation skills (Gilligan, 1993; Harlow, 1999; Wethington et al., 1987; Widom, 2000a; Widom, 2000b). Inmates in the current study have all been classified as substance abusers while inmates in the previous studies

were serving time for a variety of offenses. In sum, those who were abusing substances

prior to prison and focusing on strategies to avoid their current problems may have less

experience with positive problem-solving skills.

Relationships and Seeking Out Social Support

As was found in earlier research (Fox, 1988; Giallombardo, 1966; Owen 1998),

friendships with other women in prison were an important positive coping strategy for

female inmates. Giallombardo (1966) and Owen (1998) both concluded that

relationships were a positive coping strategy for women prior to and during incarceration.

In the current work, female inmates also utilized relationships as a positive coping skill

by seeking out social support when faced with a problem. Female inmates, from all three

phases and the waiting list, talked to friends in prison about their problems, similar to

their pre-prison experience. There were, however, women who reported not having

friends prior to prison. Many of these women said they did not have close friends in

prison until after they had participated in the therapeutic community and felt comfortable

in their surroundings.

The differences between earlier research and this study can be attributed to differences

in the populations studied. The earlier studies of Fox (1988); Giallombardo (1966), and

Owen (1998) did not specifically focus on female inmates who had substance abuse

problems, while this study focused solely on this population. Upon intake into the prison

system, the women in the therapeutic community and on the waiting list had been

screened and found to be substance abusers. All who tested addicted to substances at

intake were put on the waiting list for treatment in the therapeutic community. In theory,

if one refused treatment, she was taken off of the waiting list. However, during the

interviews, the author learned that most women who initially refused treatment later wanted to participate in the therapeutic community. Therefore, in practice, the women were kept on the waiting list even if currently they did not want to attend the therapeutic community. Since women were kept on the waiting list after refusing treatment, the population studied here was representative of those who were addicted to substances within this prison system.

Often, when people are addicted to substances, the drug becomes more important than the relationships they had previously valued; and over time, they lose many of their relationships (Markus, 2003; Zlotnick, Tam, & Robertson, 2003). In this study, many of the women were deep into their addictions before incarceration and had lost relationships due to their dependence on alcohol and/or drugs. For example, the majority of women reported they had a significant other prior to prison. However, once in prison, many no longer maintained a relationship with this person. The majority of women also had children, but many women noted that they had strained relationships with their children due to their incarceration and substance abuse. Finally, in prison and prior to, many of the respondents stated that they did not have any close friends to share their problems with before their participation in the therapeutic community.

The findings of the current study are very different from previous studies (Fox, 1988; Giallombardo, 1966; Owen, 1998), where relationships were found to be a primary coping mechanism for female inmates inside and outside of prison. In this study, prior to prison, the respondents abused substances when they were faced with a problem. However, in prison they did not have the same coping mechanism available, so they often relied on avoidance techniques such as reading or listening to music. Many did not seek

out relationships for support in prison because they did not rely on relationships prior to prison. Therefore, the volunteers in this project were qualitatively different from the female inmates in previous studies because of their substance abuse histories and lack of relationships prior to and in prison.

Avoidance and Negative Coping Strategies

Previous research had found that female and male inmates often come to the prison system with poor coping skills and that they rely upon these same poor coping skills once in the prison system (Mackenzie, Robinson & Campbell, 1999; Negy, Woods & Carlson, 1997; Zamble & Porporino, 1988, 1990). Fox (1988) found that when women in prison were unable to work through their problems by seeking out social support, they often had emotional outbursts or sought out psychotropic medications.

The current research, as well, finds most women came to the prison system with a poor set of coping skills. Before imprisonment, they had relied on the avoidance technique of substance abuse, but now in prison and sober, they are forced to find a new way to deal with their problems. Unlike Fox's study, the majority of the women here did not have emotional outbursts or rely on psychotropic medications. This is, in all likelihood, related to the criterion for participation in the therapeutic community - inmates cannot have any major psychological problems.

Nonetheless, the women studied still relied on avoidance techniques. They avoided their problems through distracting activities, such as watching television or telling jokes, while women who labeled themselves as shy became quiet to shift the attention elsewhere. Other women avoided their problems by repressing their feelings and not showing emotion. Still others only cried in private. Women in all phases and on the

waiting list reported using one or more of the previously mentioned avoidance strategies. It was not until the final phase of the program that there was a noticeable decrease in avoidance techniques. This finding is similar to Greer's (2002), which documented reliance on avoidance techniques such as humor, distraction, or emotional repression.

Depression & Anxiety

Negy, Woods & Carlson (1997), after examining coping and adjustment with female inmates, concluded that those who had poor coping skills physically withdrew and experienced denial, depression, anxiety, and low self-esteem. In this study, and related to previous findings, those who relied on avoidance techniques experienced significantly more depression and anxiety.

Depression was also associated with child visitation in prison. Those who did not receive visits from their children experienced more depression than those who received visits. This corresponds with studies conducted by Fox (1988) and Owen (1998), who concluded that the stress caused by separation from children was one of the greatest problems experienced by women in prison.

Anxiety was also impacted to a great degree by medication, where those who took prescribed psychotropic medications experienced more anxiety. Most women on the waiting list and in the therapeutic community were not taking psychotropic medications due to the program's eligibility requirements. Therefore, those who were taking psychotropic medications were likely experiencing a higher level of anxiety than most, which is why they were prescribed the medications.

Race, Ethnicity, Class and Coping

Prior research conducted with female inmates on coping did not discuss race or ethnic differences. The findings indicate that there were some differences between female inmates due to race/ethnicity. African American female inmates who did not have friends prior to prison were more likely to report having close friends with whom they could discuss problems once in prison. White and Hispanic women who did not have friends prior to prison said they did not make close friends until they were comfortable in the therapeutic community.

This variability in seeking out social support from other women may be due to race or culture, but there could also be a class difference. In a study conducted by Kruttschnitt, et al. (2000), there were not any noted racial differences between the women studied in two California prisons. However, class did play a role in how women adapted to the prison environment. "Most of the women from economically-disadvantaged backgrounds…adjusted more quickly than middle-class women because they had learned from previous experiences with institutions of social control" (Kruttschnitt, et al., 2000, p. 698).

In this study, one's social class prior to prison was not measured. However, the White and Hispanic women who stated they did not have any close friends in prison also were more likely to report that they relied more heavily on outside social networks through letters or talking/visiting with family/friends. These would all be considered strategies of seeking out social support, but these techniques tend to cost money. The prison itself is located in a rural community, while most of the inmates are from major cities making

visits difficult and expensive. Long distance phone calls, envelopes, and stamps are all privileges that cost money and may not be available to all due to the expense.

In the United States, White women are less likely to experience poverty than African American women (Fronczek, 2005). Although the majority of female inmates fall below the poverty line, it is possible that White female inmates have access to more financial support than African American female inmates, just as White women outside of prison do. Therefore, White female inmates who have access to some financial support might be more likely to rely on outside sources of social support until they feel comfortable in the therapeutic community. African American women may have less access to outside support systems due to a lack of resources, causing them to seek out social support from other female inmates sooner than other women when faced with a problem.

Mature Coping and the Therapeutic Community

One is considered to be coping maturely when he/she faces his/her problem and finds a solution without resorting to deception or violence. Mature coping is also characterized by the ability to empathize with and assist others in need (Johnson, 2002). Johnson wrote that mature coping could take place in the prison system if small niches were created where prisoners could learn and practice mature coping skills.

For this study, Johnson's concept of mature coping was applied to a therapeutic community for substance abusing female inmates. In the therapeutic community, the women learned how to face their problems and work through them with skills such as breathing and thinking, journaling, and praying. Through these skills, the women learned to recognize their problem and find constructive solutions. These are the first steps in Johnson's mature coping process.

Most of the women in the therapeutic community also reported avoiding their problems at some time. Therefore, the women in the therapeutic community met the first two criteria for mature coping when faced with some problems, but they also engaged in negative coping skills, particularly distraction, when confronted with other difficult situations. It was not until Phase Three of the program that there was a noticeable decrease in reliance on avoidance strategies for women in the therapeutic community. The majority of women on the waiting list, however, did not recognize their problems and engaged in avoidance techniques. This suggests that the therapeutic community did help participants to recognize their problems and work through them. Yet, participants from all phases of the program struggled with their use of avoidance techniques.

The therapeutic community provided the safe environment or niche that was needed for the women to develop friendships with other participants. Women who did not have friends prior to the therapeutic community made friends in the program, while participants who had friends prior to the program were able to practice this skill. The women in the therapeutic community developed close friendships with one another and sought each other out when they or another needed help. Therefore, the women have met the criterion for mature coping of assisting and empathizing with others in the community.

The findings of this study support the application of Johnson's concept of mature coping to the prison environment, specifically in therapeutic communities. Women in the therapeutic community learned how to recognize their problems and how to come up with solutions, which are the first steps to mature coping. The women also supported one another in a community environment. However, most of the women in the therapeutic

community reported relying on avoidance strategies at times, which suggests the women need more practice utilizing their positive coping skills in the therapeutic community environment.

Policy Implications

In previous studies, therapeutic communities have been found to be successful with drug addicted inmates. Most of this research has focused on therapeutic communities and their success with male inmates. Welsh, for example, evaluated therapeutic communities in five male State Correctional Institutions in Pennsylvania. After following the respondents for two years, Welsh found a reduction in recidivism of 11% for those who participated in the therapeutic community (Welsh, 2003). Due to the success of therapeutic communities with male inmates, many have been developed for female inmates and evaluations of these programs have found them to be successful as well (Butzin, et al., 2002; Hall, et al., 2004).

Treatment programs in female prisons are often based on treatment programs that have been successful with male inmates. Therefore, many of these programs were created for the single male addict and are not gender responsive or cognizant of the differences between men and women. Female inmates often have different needs than male inmates. For example, the majority of female inmates have children and many have experienced prior physical, sexual and/or emotional abuse (Messina, Burdon, & Prendergast, 2003). In contrast, therapeutic communities are gender responsive programs that can be easily adapted for female inmates. Therapeutic communities offer a safe environment for female inmates, where participants can feel comfortable discussing and working through their issues while developing friendships and a sense of community.

Prisoners have also found therapeutic communities to be an acceptable treatment method. Melnick, et al. (2004) conducted a study where they examined the inmate participants' perception of the therapeutic community and the results were positive.

> "Thus, despite often being mandated into treatment, many offenders appear to welcome the opportunity to address addiction issues and prefer being in treatment programs. The implication of these findings is that rather than feeling coerced and resentful, many offenders are cooperative and welcome the opportunity to engage in the treatment program when they perceive the planned active elements or activities of the program as being carried out by the staff" (Melnick, et al., 2004, p. 134).

In this study, the therapeutic community was able to improve the coping skills of women who, prior to prison, had turned to substance abuse when faced with a problem. After participating in the therapeutic community, most of the women had learned new skills and many had the chance to strengthen and practice old skills. This finding is similar to Peat and Winfree's (1990) results, where therapeutic community participants were able to attain the "short-term goal of resocializing participants' attitudes and orientations" (Peat & Winfree, 1990, p. 290). However, it was not until the third phase of the program that there was a noticeable decrease in avoidance techniques. This seems to suggest that the women needed a longer period of time to practice the coping skills that they have learned. However, extending the length of the program may be difficult due to the long wait to enter the program. There are about 185 women on the waiting list, and there are only 50 beds available in the therapeutic community.

Due to the lack of space for treatment, many of the women on the waiting list reported that they had been on the waiting list for a number of years. Women with longer sentences waited until their sentence was almost completed before they were admitted for

treatment, while women who had shorter sentences were pushed to the front of the waiting list, so they would receive treatment before their release date.

If there were more therapeutic communities available to the women on the waiting list, more women could be receiving treatment. The women who have longer sentences would then have more time to practice their new skills and the opportunity to participate in aftercare sessions, while those with shorter sentences would still have the chance to receive treatment. Therefore, the program needs not only to be extended to allow the women more time to practice their skills, but also expanded so there is more than one program available to the many women who are waiting for treatment.

Other evaluations of therapeutic communities have found that the longer one is in treatment, the more likely they are to continue with treatment upon release (Burdon, et al., 2004; Hall et al., 2004; Prendergast, et al., 2004). In California, male and female participants of therapeutic communities have the opportunity to participate in residential aftercare once on parole. Evaluations of these programs have found that the more time one spends in treatment, both in prison and upon release, the less likely he/she is to recidivate. In an evaluation of a female therapeutic community, Hall et al., (2004) concluded that parolees in residential treatment had significantly fewer arrests and less drug use than comparison groups. Those who participated in treatment post prison were also more likely to be employed, which is an important factor in reducing recidivism (Hall, et al., 2004; Prendergast, et al., 2004). For example, Welsh found "post-release employment strongly and significantly reduced the likelihood of drug relapse, rearrest, and reincarceration" (2005, p. 3).

Currently, in Pennsylvania, there is a program entitled the Substance Abuse Violators Effort (SAVE) for drug-addicted parolees who relapse. In this program, if a parolee relapses he/she is placed in the Eaglesville State Hospital in lieu of reincarceration. Upon completion of treatment, the parolee is gradually released back into his/her community (Pennsylvania Department of Corrections, 2005). A residential program similar to this, upon release instead of after relapse, may help female inmates to keep from recidivating by allowing them more time in treatment and the chance to readjust gradually to their life outside of prison.

Due to the War on Drugs, there has been a dramatic increase in the number of first time female nonviolent offenders in the prison system. Many of these women could receive their treatment and punishment within their own communities if more intermediate sanction programs were available such as drug courts. These intermediate sanctions not only save money, but the offenders remain in their community developing the necessary bonds with family needed for when they are released from the criminal justice system. If intermediate sanctions were utilized more often, this would also free up space and money for treatment within the prison system, so that those who must be incarcerated also have a chance to receive the treatment they need.

Currently, the number one reason for female recidivism is drug relapse. Drug addicted female offenders will continue to recidivate until the root of the problem is solved – their drug addiction.   Recently, more research has been conducted with the therapeutic community model in corrections supporting the conclusion that this type of programming is successful with female inmates (Butzin, et al., 2002; Hall, et al., 2004). This study also found that therapeutic communities were successful in teaching positive

coping skills to drug addicted female inmates. Therefore, it is the conclusion of this study that more drug treatment programs, both within the female offenders' communities and within the prison system, need to be implemented to end the cycle of substance abuse and reoffending.

Limitations of the Current Study and Suggestions for Future Research

The quantitative results yielded little information about the differences between those in the therapeutic community and those on the waiting list. This was most likely due to the small sample size of sixty-seven for the survey, forty volunteers from the therapeutic community and twenty-seven volunteers from the waiting list. Women in the therapeutic community readily volunteered to participate in the survey, while only fifty women out of one hundred eighty-five volunteered from the waiting list. Due to the low response rate from women on the waiting list, those who volunteered to participate could be qualitatively different from women who did not volunteer. In the future, researchers may consider multiple mailings of invitations to participate in the study to increase volunteer rates. The author learned that even under the best of circumstances, prison regulations and the need for security greatly impact access to data and information.

Most women who volunteered to be surveyed also agreed to be interviewed at a later date. This high response rate may have been due to the researcher explaining the project and answering questions prior to the volunteers filling out their surveys. Importantly, there was a low response rate for African American women in the therapeutic community, and only four African American women from the therapeutic community volunteered for interviews. There were few differences found between female inmates from different races/ethnicities and their coping strategies. It is possible that these results

occurred due to the low number of minority volunteers. In a study conducted by Burdon, et al. (2004), the authors found that Hispanic participants, upon release, relied less on aftercare than African American respondents; however, Hispanics were significantly less likely to recidivate than African Americans. This finding suggests that there is a cultural difference between African Americans and Hispanics and that Hispanics are more successful when they are able to rely on social/family support than on an after care program. In 2004, the Pennsylvania Department of Corrections implemented a Hispanic therapeutic community for males (the first of its kind in the nation), which also recognizes that there are cultural differences present that affect of treatment influence (Pennsylvania Department of Corrections, 2005).

The low response rate of minority volunteers may be due to the race of the researcher, because African American women may not have been comfortable being interviewed about their substance abuse by a White woman. Therefore, future researchers should have interviewers from different racial/ethnic backgrounds present when they ask for volunteers and during the interviews. This strategy may increase volunteer rates for women from different backgrounds.

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Appendix A: Questionnaire

1. Are you currently involved in the therapeutic community?

Yes _____   No_____   On waiting list _____

2. If you are currently in the therapeutic community, which phase of the program are you in? **(If you are not currently in the therapeutic community please skip to question #3)**

Phase One _____   Phase Two _____   Phase Three_____

3. How old are you today?

_____ years old

4. Which race/ethnicity do you consider yourself to be?

Hispanic _____   Caucasian _____   African American _____ Other _____

(IF you do not have any children please skip questions 5, 6, 7 and 8)

5. Do you have children?   Yes _____ No _____

If yes, how many? _____

6. Do you have step children?   Yes _____ No _____

If yes, how many?_____

7. Before prison were your children living with you?   Yes _____ No_____

If yes, how many? _____

8. Are your children able to visit you in prison?   Yes _____   No _____

If yes, how often are they able to come?   _____

9. What is your marital status?

Married _____   Single _____   Divorced/Separated _____   Widowed _____

_____

  I am interested in how people cope with the problems and troubles in their lives.

  Listed below are several possible ways of coping. I would like you to indicate to what extent you, yourself, used each of these coping methods. All of your responses will remain confidential.

  Try to think of a problem you have encountered in the last six months or so. This should be a problem that was important to you, and that caused you to worry (anything from the loss of a loved one to a traffic ticket, but one that was important to you).

  Please describe this problem in a few words (remember your answer will be kept confidential):

  With this problem in mind, indicate how you coped by checking the appropriate line for each coping behavior listed on the following pages. Answer each and every question even though some may sound similar.

  Did you remember to write down your problem? If not, please do so before going on.

Keeping <u>that</u> stressful event in mind, indicate to what extent you…

1. Let your feelings out to a friend? ＿＿ A lot ＿＿ A little ＿＿ Not at all

2. Rearranged things around you so that your problem had the best chance of being resolved? ＿＿A lot ＿＿ A little ＿＿ Not at all

3. Brainstormed all possible solutions before deciding what to do? ＿＿ A lot ＿＿ A little ＿＿ Not at all

4. Tried to distract yourself from the problem? ＿＿ A lot ＿＿ A little ＿＿ Not at all

5. Accepted sympathy and understanding from someone? ＿＿ A lot ＿＿ A little ＿＿ Not at all

6. Did all you could to keep others from seeing how bad things really were? ＿＿ A lot ＿＿ A little ＿＿ Not at all

7. Talked to people about the situation because talking about it helped you to feel better? ＿＿ A lot ＿＿ A little ＿＿ Not at all

8. Set some goals for yourself to deal with the situation? ＿＿ A lot ＿＿ A little ＿＿ Not at all

9. Weighed your options carefully? ＿＿ A lot ＿＿ A little ＿＿ Not at all

10. Daydreamed about better times? ＿＿ A lot ＿＿ A little ＿＿ Not at all

11. Tried different ways to solve the problem until you found one that worked? ＿＿ A lot ＿＿ A little ＿＿ Not at all

12. Confided your fears and worries to a friend or relative? ＿＿ A lot ＿＿ A little ＿＿ Not at all

13. Spent more time than usual alone? ＿＿ A lot ＿＿ A little ＿＿ Not at all

14. Told people about the situation because just talking about it helped you to come up with solutions? ＿＿ A lot ＿＿ A little ＿＿ Not at all

15. Thought about what needed to be done to straighten things out?   ____ A lot   ____ A little   ____ Not at all

16. Turned your full attention to solving the problem?   ____ A lot   ____ A little   ____ Not at all

17. Formed a plan of action in your mind?   ____ A lot   ____ A little   ____ Not at all

18. Watched television more than usual?   ____ A lot   ____ A little   ____ Not at all

19. Went to someone (friend or professional) in order to help you feel better?   ____ A lot   ____ A little   ____ Not at all

20. Stood firm and fought for what you wanted in the situation?   ____ A lot   ____ A little   ____ Not at all

21. Avoided being with people in general?   ____ A lot   ____ A little   ____ Not at all

22. Buried yourself in a hobby or sports activity to avoid the problem?   ____ A lot   ____ A little   ____ Not at all

23. Went to a friend to help you feel better about the problem?   ____ A lot   ____ A little   ____ Not at all

24. Went to a friend for advice on how to change the situation?   ____ A lot   ____ A little   ____ Not at all

25. Accepted sympathy and understanding from friends who had the same problem?   ____ A lot   ____ A little   ____ Not at all

26. Slept more than usual?   ____ A lot   ____ A little   ____Not at all

27. Fantasized about how things could have been different?   ____ A lot   ____ A little   ____ Not at all

28. Identified with characters in novels or movies?   ____ A lot   ____ A little   ____ Not at all

29. Tried to solve the problem?   ____ A lot   ____ A little   ____ Not at all

30. Wished that people would   ____ A lot   ____ A little   ____ Not at all
    just leave you alone?

31. Accepted help from a friend   ____ A lot   ____ A little   ____ Not at all
    or relative?

32. Sought reassurance from those   ____ A lot   ____ A little   ____ Not at all
    who know you best?

33. Tried to carefully plan a course ____ A lot   ____ A little   ____ Not at all
    of action rather than acting on
    impulse?

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by each symptom during the PAST WEEK, INCLUDING TODAY, by checking the appropriate line next to each symptom.

NOT AT ALL	MILDLY It did not bother me much	MODERATELY It was very unpleasant but I could stand it	SEVERELY I could barely stand it

1. Numbness or tingling.   _____   _____   _____   _____

2. Feeling hot.   _____   _____   _____   _____

3. Wobbliness in legs.   _____   _____   _____   _____

4. Unable to relax.   _____   _____   _____   _____

5. Fear of the worst   _____   _____   _____   _____
   happening.

6. Dizzy or lightheaded.   _____   _____   _____   _____

7. Heart pounding   _____   _____   _____   _____
   or racing.

8. Unsteady.   _____   _____   _____   _____

	NOT AT ALL	MILDLY It did not bother me much	MODERATELY It was very unpleasant but I could stand it	SEVERELY I could barely stand it
9. Terrified.	_____	_____	_____	_____
10. Nervous.	_____	_____	_____	_____
11. Feelings of Choking.	_____	_____	_____	_____
12. Hands trembling.	_____	_____	_____	_____
13. Shaky.	_____	_____	_____	_____
14. Fear of losing control.	_____	_____	_____	_____
15. Difficulty breathing.	_____	_____	_____	_____
16. Fear of dying.	_____	_____	_____	_____
17. Scared.	_____	_____	_____	_____
18. Indigestion or discomfort in abdomen.	_____	_____	_____	_____
19. Faint.	_____	_____	_____	_____
20. Face flushed.	_____	_____	_____	_____
21. Sweating (not due to heat).	_____	_____	_____	_____

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today.** Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Patterns) or Item 18 (Changes in Appetite).

1. Sadness

      0   I do not feel sad.
      1   I feel sad much of the time.
      2   I am sad all the time.
      3   I am so sad or unhappy that I can't stand it.

2. Pessimism

      0   I am not discouraged about my future.
      1   I feel more discouraged about my future that I used to be.
      2   I do not expect things to work out for me.
      3   I feel my future is hopeless and will only get worse.

3. Past Failure

      0   I do not feel like a failure.
      1   I have failed more than I should have.
      2   As I look back, I see a lot of failures.
      3   I feel like I am a total failure as a person.

4. Loss of Pleasure

      0   I get as much pleasure as I ever did from the things I enjoy.
      1   I don't enjoy things as much as I used to.
      2   I get very little pleasure from the tings I used to enjoy.
      3   I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings

      0   I don't feel particularly guilty.
      1   I feel guilty over many things I have done or should have done.
      2   I feel quite guilty most of the time.
      3   I feel guilty all of the time.

6. Punishment Feelings

      0   I don't feel I am being punished.
      1   I feel I may be punished.
      2   I expect to be punished.
      3   I feel I am being punished.

7. Self-Dislike
- 0   I feel the same about myself as ever.
- 1   I have lost confidence in myself.
- 2   I am disappointed in myself.
- 3   I dislike myself.

8. Self-Criticism
- 0   I don't criticize or blame myself more than usual.
- 1   I am more critical of myself that I used to be.
- 2   I criticize myself for all of my faults.
- 3   I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes
- 0   I don't have any thoughts of killing myself.
- 1   I have thoughts of killing myself, but I would not carry them out.
- 2   I would like to kill myself.
- 3   I would kill myself if I had the chance.

10. Crying
- 0   I don't cry anymore than I used to.
- 1   I cry more than I used to.
- 2   I cry over every little thing.
- 3   I feel like crying, but I can't.

11. Agitation
- 0   I am no more restless or wound up than usual.
- 1   I feel more restless or wound up than usual.
- 2   I am so restless or agitated that it's hard to stay still.
- 3   I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest
- 0   I have not lost interest in other people or activities.
- 1   I am less interested in other people or things than before.
- 2   I have lost most of my interest in other people or things.
- 3   It's hard to get interested in anything.

13. Indecisiveness
- 0   I make decisions about as well as ever.
- 1   I find it more difficult to make decisions than usual.
- 2   I have much greater difficulty in making decisions than I used to.
- 3   I have trouble making any decisions.

14. Worthlessness
0   I do not feel I am worthless.
1   I don't consider myself as worthwhile and useful as I used to.
2   I feel more worthless as compared to other people.
3   I feel utterly worthless.

15. Loss of energy
0   I have as much energy as ever.
1   I have less energy that I used to have.
2   I don't have enough energy to do very much.
3   I don't have enough energy to do anything.

16. Changes in Sleeping Pattern
0   I have not experienced any change in my sleeping pattern.
_____
1a   I sleep somewhat more than usual.
1b   I sleep somewhat less than usual.
_____
2a   I sleep a lot more than usual.
2b   I sleep a lot less than usual.
_____
3a   I sleep most of the day.
3b I wake up 1-2 hours early and can't get back to sleep.

17. Irritability
0   I am no more irritable than usual.
1   I am more irritable than usual.
2   I am much more irritable than usual.
3   I am irritable all of the time.

18. Changes in Appetite
0   I have not experienced any change in my appetite.
_____
1a   My appetite is somewhat less than usual.
1b   My appetite is somewhat greater than usual.
_____
2a   My appetite is much less than before.
2b   My appetite is much greater than usual.
_____
3a   I have no appetite at all.
3b   I crave food all of the time.

19. Concentration Difficulty

0	I can concentrate as well as ever.
1	I can't concentrate as well as usual.
2	It's very hard to keep my mind on anything for very long.
3	I find I can't concentrate on anything.

20. Tiredness or Fatigue

0	I am no more tired or fatigued than usual.
1	I get more tired or fatigued more easily than usual.
2	I am too tired or fatigued to do a lot of the things I used to.
3	I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0	I have not noticed any recent change in my interest in sex.
1	I am less interested in sex that I used to be.
2	I am much less interested in sex now.
3	I have lost interest in sex completely.

In the near future, I will be conducting face-to-face interviews. These interviews will help me to better understand how you cope with every day problems in prison and in your life before prison. These interviews will take approximately 30-40 minutes and all information obtained will remain confidential. If you are interested in being interviewed please print your name below. Thank you for your time.

Please Print name below if interested in being interviewed:

_____

Appendix B: Interview Protocol

1. When was the first time you remember using drugs/alcohol?
      Probe: How old were you?
      Probe: How often did you use?
      Probe: What was going on at the time in your life?
            Probe: Were you having any difficulties at school?
            Probe: Were you having any difficulties at home?
            Probe: Were you having any difficulties with your peers?

2. Who were you residing with before you came to prison?
      Probe: Did you live with a significant other?
      Probe: Who is this person residing with now?

3. How does being separated from this person affect your relationship?
      Probe: What do you do when you miss this person?
            Probe: Do you talk to someone about this, do you write down how you
            feel, do you keep these feelings inside?
      Probe: Did you ever use drugs/alcohol with this person?
            Probe: When you were with this person were you usually sober or high?

4. Do you have children?
      Probe: If yes, what are their ages?
      Probe: If yes, who is taking care of your children now?
      Probe: If yes, are you comfortable with this person taking care of your children?
      Probe: Were you taking care of your children prior to incarceration?
            Probe: If not, then who was taking care of your children?

5. Does it cause you stress being separated from your children?
      Probe: If yes, how do you handle this stress? What do you do when you get
      upset?
            Probe: Do you discuss being separated from your children with anyone?

6. Do you have friends here in the prison?
      Probe: If yes, how many?
      Probe: If yes, how did you meet?
      Probe: If yes, do you discuss problems you have with your friends?

7. Did you have friends that you saw regularly before you were incarcerated?
      Probe: If yes, how many?
      Probe: If yes, how did you meet?
      Probe: If yes, did you ever use drugs/alcohol with this person?
      Probe: If yes, did you ever hang out with this person when you were sober?
          Probe: Were you usually sober or high when you were with this person?

8. Do you attend any religious activities here in the prison?
      Probe: Did you attend religious activities before you were incarcerated?
          Probe: If yes, how often did you attend and for how long?

9. Do you ever pray when you are upset or having problems?
          Probe: Did you pray when you were upset or having problems before your
          incarceration?

10. When you're in a tense situation or working through a problem do you ever tell a
joke or make a funny comment to break the tension?
      Probe: If yes, do you tell a joke every time you are dealing with a problem?
          Probe: When do you use humor?

11. If you're having a bad day do you ever watch television or play cards to distract you
from your problems?
      Probe: Do you do this every time you have a problem?
          Probe: How often?

12. When you are having a bad day here, do you ever become upset and cry?
      Probe: Do you cry with friends or by yourself?
      Probe: Where do you usually cry?
      Probe: How often?
      Probe: After you are finished crying, do you think about what made you cry or do
      You do something else?
          Probe: If do something else, what do you usually do?

Appendix C: Note Outline for Interviews

1. First time used:

   a. age _____
   b. how often_____
   c. what was going on:
      school_____

      home_____

      peers_____

2. significant other: _____y   _____n
     a. live w/ them   _____y   _____n
     b. who live w/ now_____

3. separation affect relationship:

   a. what do you do
      talk to someone(SSS)_____
      write it down (PS)_____
      keep inside (A)_____

   b. use w/ them   _____Y   _____N
    usually _____sober _____high

4. children _____Y   _____N
    ages:
    takes care _____
    comfortable _____Y   _____N

    were you taking care prior _____Y _____N
    if no, who_____

5. stress: _____Y _____N
what are some problems face:

Handle stress:
      Problem solving:_____

      Seek Social_____

      Avoidance_____

6. Friends _____Y _____N
      how many:_____
      how met_____
      do you discuss problems _____Y _____N
EX-

7. friends prior ____Y _____N
      how many _____
      how met_____
      use _____Y _____N
      hangout _____sober or _____high
      discuss problems _____Y _____N
EX-

8. religion prison _____Y _____N

      types:_____

      how often_____

      involved prior to tc _____Y _____N

religion prior _____Y _____N

      types:_____

      how often_____

      how long_____

9. pray prison _____Y _____N

      pray for problem _____Y _____N

      how often_____

pray prior _____Y _____N

      pray for problem _____Y _____N

      how often: _____

10. joke _____Y _____N

      every time _____Y _____N

when: _____

11. day dream _____

    cards_____

    TV _____

    Other _____

Every time _____Y _____N

How often: _____

12. cry _____Y _____N

friends_____ by self _____

where_____

how often:_____

think _____ do something else _____

what do you do:_____