

## CHAPTER 3: Mental and Physical Health Issues in Female Criminal Justice Clients

### CHAPTER OUTLINE

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#### OVERVIEW OF MENTAL HEALTH ISSUES IN FEMALE SUBSTANCE-ABUSING JUDICIAL CLIENTS

#### DUAL DIAGNOSIS IN WOMEN: COMMON PSYCHIATRIC DISORDERS FOUND AMONG WOMEN JUDICIAL CLIENTS

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#### CHAPTER REVIEW

#### LEARNING OBJECTIVES

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- To investigate the range of psychological disorders that is found among women judicial clients
- To identify and explain the specific psychiatric diagnoses frequently found in women judicial clients
- To explore the range of violent experiences in the lives of girls and women that underlies posttraumatic stress disorder and other psychiatric symptomatology in women
- To identify specific correlates and consequences of these traumatic experiences
- To assess the impact of violent domination on adult manifestation of substance abuse and other psychiatric disorders
- To explore the relationship between these experiential and psychiatric factors and women's criminal behavior

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## OVERVIEW OF MENTAL HEALTH ISSUES IN FEMALE SUBSTANCE-ABUSING JUDICIAL CLIENTS

As noted at several points in this text, the number of women in U.S. prisons has increased dramatically in the past 25 years. We have also observed a significant drop in their age of incarceration; approximately 30 percent of these females were imprisoned for drug-related crimes (Gunter, 2004). While some women in correctional facilities display few overt psychological symptoms, others have displayed a wide range of psychiatric symptoms and have been diagnosed with psychiatric disorders. It is estimated that more than 60 percent of incarcerated women might present a lifetime diagnosis of a psychiatric disorder (Haywood, Kravitz, Goldman, & Freeman, 2000). Forty-five percent present a current psychiatric diagnosis, and 40 percent of these inmates have substance-related disorders (Jordan, Schlenger, Fairbank, & Caddell, 1996). Unfortunately, only a small portion of those female detainees in need of psychiatric care receive treatment: approximately 24 percent in one survey (Teplin, Abram, & McClelland, 1996). While some researchers report lower or equal rates of mental illness in female versus male judicial clients (Watkins, Shaner, & Sullivan, 1999), others suggest that women judicial clients may more frequently present with psychological symptoms than do male judicial clients, and they more commonly receive a dual diagnosis (Veysey, DeCou, & Prescott, 1998). Substance use disorders are much more common in women judicial clients than in women in the general population (Bloom, Owen, Covington, & Raeder, 2003). The rate of dual diagnosis attributed to women in jails is as high as 60 percent (Acoca, 1998a), and the need for specific mental health services has been estimated at 45 percent for women judicial clients overall (Acoca & Austin, 1996). Markarian and Franklin (1998) report a similar tendency among alcohol-abusing female nonjudicial clients, who are more frequently diagnosed with depression and anxiety disorders than are alcohol-abusing male nonjudicial clients. Consistent with the statistics on trauma reported in Chapter 2, more than 50 percent of female substance abusers with severe mental illness report experiences of sexual assault before the age of 18, a significantly higher level than do men with substance abuse disorders or

other women with severe mental illness but without concurrent substance abuse (Alexander, 1996).

Twelve percent of women judicial clients have been hospitalized for psychiatric treatment prior to incarceration, and 36 percent of incarcerated women have attempted suicide. Suicide attempts are much higher among substance-abusing women than among their non-abusing counterparts, and the rate of suicide death is 23 times the rate among non-substance-abusing women in the general population (Markarian & Franklin, 1998). Nevertheless, 31 percent of women taking medication for a mental health disorder remain without any supervision for their prescription drug intake while incarcerated (Acoca, 1998a).

“While researchers vary in their estimates of the rate of psychiatric disorders among women in jails and prisons, most agree that diagnostic and treatment services are generally inadequate and in some cases nonexistent for this population” (Acoca, 1998a, p. 57). Disturbing patterns appear, including lack of adequate procedures for screening mental health symptomatology in women; serious deficits in psychologist-to-inmate ratios (recorded at 1:2,900 inmates in 1993); limited availability of mental health staff, who are present on an irregular and sporadic basis; inadequate supervision of medication intake; and supervisory staff who are unable to distinguish behaviors associated with mental illness from those that involve deliberate disruption of prison procedures. This last factor has led to instances where inappropriate discipline, isolation, confinement, and other punitive consequences have been used in response to psychiatric symptoms (Acoca, 1998a). Women have thereby been denied adequate services to help them resolve their mental health issues, a factor of major importance in supporting recovery. Instead, they may be exposed to consequences that feel disturbingly similar to the environmental contexts that contributed to the development of their symptoms in the first place.

In general, higher rates of substance abuse and dependence have been found among the mentally ill, regardless of other demographic or population dynamics (RachBeisel, Scott, & Dixon, 1999). Reported incidence of substance abuse and/or dependence stands at about 50 percent among people with severe psychiatric diagnosis, and

progression of mental illness in these instances involves greater impairment in psychosocial abilities, less compliance with treatment, poorer prognosis, and more use of emergency services than among people with similar diagnosis but without substance abuse. Thus, inadequate attention to mental health symptoms in correctional facilities may actually contribute to relapse and recidivism, thereby slowing the processes of recovery that are necessary for an offender to resist reengagement in criminal offense. What's more, the continued use of emergency services comes at quite a cost to society.

Understanding the specific nature of psychiatric disorders in women judicial clients, the ways that psychiatric symptoms may differ in women as compared to men, and the etiology of their development in women can provide treatment providers with specific foci in individualized programming for the female dually diagnosed population. The more we understand about how these disorders manifest in women, about how they are produced, and the specific cognitions, emotions, or physiological processes that underlie them, the more prepared we are to provide treatment services that are directly related to these psychiatric targets.

## **DUAL DIAGNOSIS IN WOMEN: COMMON PSYCHIATRIC DISORDERS FOUND AMONG WOMEN JUDICIAL CLIENTS**

Gender differences have been reported to occur in dually diagnosed populations of women and men. These differences are found with respect to specific disorders, the frequencies of these disorders presenting clinical symptomatology, and attitudes toward treatment within each gender (Watkins et al., 1999). The following sections of the chapter present differences in the kinds of diagnoses that female and male judicial clients generally receive.

### **Depression and Other Mood Disorders**

Women are more likely to be diagnosed with chronic depression than are males (Acoca, 1998b; Covington, 1998a) and are more likely to be taking prescription medication for depression. Female judicial clients are more often diagnosed with depression than are

individuals of both genders in the general population (Gunter, 2004). Excluding substance-related disorders, major depression is the most frequent current psychiatric diagnosis among women in jail, from 5 percent (Baillargeon et al., 2003) to 11 percent (Jordan et al., 1996). Alcohol abuse or dependence co-occurred with major depression in 19 percent of women judicial clients, four times the rate in men and three times the rate in the general population of women (Covington, 2000). Women judicial clients also experience mood disorders and eating disorders more frequently than their male counterparts (Kerr, 1998). Both dysthymia and bipolar disorders are more often diagnosed among incarcerated women than among incarcerated men, respectively nearly two times and three times as frequently (Baillargeon et al., 2003). Interestingly, a gender difference that appears repeatedly among the general population does not show up in judicial clients. While women in general are more likely than men to seek medical care, this does not hold true for women in corrections with concurrent substance abuse and other psychiatric diagnosis (Watkins et al., 1999). Thus, these women often remain undiagnosed until a major event, for example, criminal arrest, brings them into contact with authorities.

### **Personality Disorders**

*Borderline personality disorder* may be commonly misdiagnosed in women, as some of its symptoms mimic the effects of violent trauma (Root, 1992). Approximately one third of incarcerated women fulfill criteria for borderline personality disorder (Jordan et al., 1996).

*Antisocial personality disorder* (ASPD) is less common among female judicial clients than their male counterparts. Twelve percent of incarcerated women present a diagnosis of ASPD (Jordan et al., 1996). In another study, 10 percent of women with alcohol problems met criteria for this diagnosis (Blume, 1990; Covington, 2000). It is estimated that the rate of ASPD among female judicial clients can be as much as 12 times higher than the rate among women in general. A study of female opiate injectors found that 27 percent met the criteria for ASPD (Lightfoot, 1997). Early onset of alcohol abuse and related problems among women may be associated with impulsive behavior and antisocial personality disorder, as they are in men (Wilsnack, 1995).

*Psychopathic symptoms* are prevalent among 15.5 percent of the population of female judicial clients in a jail setting (versus 25–30 percent estimated for men) (Bartol, 2002). Other studies have found a rate of psychopathy at 12.9 percent of female inmates (Salekin, Rogers, Ustad, & Sewell, 1998). Research suggests that female psychopaths may exhibit different presenting behaviors than their male counterparts. They may be less violent than their male counterparts (Mulder, Wells, Joyce, & Bushnell, 1994) and may return to prison for recurrent crime less often than male psychopaths and nearer to the rate of incarcerated females without this diagnosis (Salekin, Rogers, & Sewell, 1997).

Bartol (2002) reports that psychopathy is frequently associated with alcohol and other drug abuse, as well as a history of sexual abuse in childhood, prostitution, and the likelihood of having been married to a psychopath or alcohol abuser or alcohol-dependent male. Bartol cautions, however, that past use of the label “psychopathy” with women may have reflected the broader societal bias against female sexuality and may “have been attached indiscriminately to women who were believed to engage inappropriately in sexual activity” (Bartol, 2002, p. 98). Separating out sexuality from other behavioral responses, Bartol found that female and male psychopaths have similar presenting dynamics. Two broad types have been described in women. The first is women who appear to experience no regret, empathy, or guilt, are frequently bored, and engage in lying and thrill-seeking behaviors. The second type, whose symptoms tend to appear earlier in life, engage in promiscuous sexual and antisocial (but not violent) behaviors (Bartol, 2002). No significant racial differences or trends were found among female psychopaths (Vitale, Smith, Brinkley, & Newman, 2002).

### **Psychotic Disorders**

Gender differences have been found in the symptoms of schizophrenia as well (Franzek & Beckmann, 1992). For example, females tend to exhibit more affective symptoms and persecutory delusions, a more favorable profile in terms of course of illness, but increased side effects from antipsychotics. Among incarcerated women, prevalence rates of 0.7 percent for schizophrenia (1 percent for men), 0.9 percent for

schizoaffective disorders (0.5 percent for men), and 0.5 percent for other psychotic disorders were found (0.6 percent for men) (Baillargeon et al., 2003).

### **Anxiety Disorders**

Levels of anxiety disorders are also high in this population. Phobic disorders are found in 31 percent of women judicial clients (versus 15 percent of male judicial clients, and double that of women in general), and panic disorders are found in 7 percent of women judicial clients (versus 2 percent of men) (Covington, 1998b). Another study revealed lifetime prevalence rates of 2.7 percent for generalized anxiety disorder and of 5.8 percent for panic disorder among female judicial clients, whereas current diagnoses were estimated at 1.4 percent for generalized anxiety disorder and 5 percent for panic disorder (Jordan et al., 1996).

### **Suicide**

Both the number and frequency of suicidal ideations and attempts are higher among women judicial clients. Due to higher rates of substance abuse or dependence and psychiatric comorbidity, young female judicial clients are significantly more likely to attempt and complete suicide than are young men (Dyer, 2003). Another study found that suicide rates in prison are at least similar between genders and proportional to the jail population (Way, Miraglia, Sawyer, Beer, & Eddy, 2005). This is surprising given that both in the general population and among nonincarcerated substance-abusing individuals, males more frequently complete suicide. It implies that incarcerated women need to be thoroughly assessed concerning suicidal ideation. Another difference is the method of choice for suicide. Both nonincarcerated substance-abusing women and women in the general population employ less lethal methods when attempting suicide (using medicines, for instance), whereas men usually attempt suicide through violent methods (guns, knives, and hanging). While in jail, there is no gender difference in the method of choice for a suicide attempt, hanging being the most common one for both genders (Gunter, 2004).

Table 3.1 presents a summary of some differences in common diagnoses among women versus men.



Table 3.1

Most Common Diagnoses in Male Versus Female Judicial Clients		
	Women	Men
Chronic depression	19%	5%
Suicidal ideation and attempts	More frequent	Less frequent
Eating disorders	More common	
Phobic disorders	31%	15%
Panic disorders	7%	2%
Antisocial personality disorder	10% + alcohol	27% + opiates
Psychopathy	9–15%	25–30%

Sources: Acoca (1998a); Bartol (2002); Covington (1998a, 1998b, 2000).

## WOMEN AND VIOLENT TRAUMA

As discussed earlier, an issue that is central to understanding women's mental health is found in the high rates of victimization and violent trauma they have experienced. Although violent trauma occurs at quite high rates in the lives of girls and women in the general population (Crawford & Unger, 2000), the incidence of violent trauma among women judicial clients is much higher than in the general population of women. Women judicial clients are also more likely to have experienced violent trauma than their male counterparts, and dually diagnosed women experience higher levels still (Alexander, 1996). Ninety-seven percent of homeless, mentally ill women (who exhibit a rate of 50 percent for substance abuse or dependence) report at least one incident of physical or sexual assault in their lifetime (Goodman, Dutton, & Harris, 1995; Watkins et al., 1999).

These experiences place women at high risk for developing a wide range of psychological and social problems, including substance abuse or dependence and

criminal behavior. Women who seek treatment for substance-related difficulties are more likely to be victims of violent assault than are women in general, and a strong correlation between assault experience (especially in childhood) and subsequent alcohol and other drug abuse has been found (Steele, 2000). Watkins et al. (1999) conclude that "victimization and violence are normative experiences for many dually-diagnosed women, while they are not normative experiences for dually-diagnosed men" (pp. 116–117).

## Posttraumatic Stress Disorder

A frequent result of violent trauma, *posttraumatic stress disorder* (PTSD), is seen at a very high rate in women judicial clients. In one study, 33.5 percent of women judicial clients were diagnosed as having PTSD due to rape or other violent assault (GAINS Center, 1997; Teplin et al., 1996), and many service providers suggest that this figure is even higher when one considers the continuum of traumatic consequences. Women judicial clients experience higher rates of PTSD than their male counterparts; and substance-abusing women have higher rates of PTSD than women in the general population (Hidalgo & Davidson, 2000; Najavits, Weiss, & Shaw, 1997). A comprehensive review of PTSD in substance-abusing women judicial clients is the scope of Chapter 5.

## The Psychological Consequences of Violent Trauma: Behavioral Disturbances

Trauma may manifest in several other ways when a female offender comes in contact with the criminal justice system. For example, a history of abuse may create increased sensitivity to situations involving the use of force or coercion (Veysey, DeCou, & Prescott, 1998). A woman offender may perceive the surroundings and routine of correctional settings as menacing and unsafe, as they may recapture the feelings of entrapment she may have experienced during her abuse. This pervasive perception of threat may trigger a wide range of responses, from withdrawal and fear to rage and violent outburst, and deterioration in mental health can be expected. A woman may act out against such experiences, through self-injury, attempts at suicide, or worsening

substance abuse (Veysey et al., 1998). Clearly, such trauma-related feelings of peril experienced by women judicial clients can become major obstacles to effective treatment with this population. Veysey et al. assert, "Some, if not a majority, of the problems officers and administrators confront in supervising female inmates may be attributed to female detainees' perceptions of danger and their responses to that threat" (p. 51).

Veysey et al. (1998) go on to identify several specific factors that may exacerbate the problems of women with trauma-related issues. Any experience that rekindles memory of her abusive history has the potential to retraumatize such a woman. These trauma reminders bring her back into the frame of the abusive event and trigger equally intense emotions as during the actual experience. Among these trauma reminders, the authors name:

- Interacting with persons who remind them of the violent perpetrator, such as authority figures or men in general (also uniforms)
- Being physically restrained, kept in locked rooms or spaces
- Isolation
- Being unclothed, as during strip searches or medical exams
- Lack of privacy, as during psychiatric observation
- Loud noises
- Darkness
- Being without information regarding what will happen to them next

A provider's awareness of these issues, and anticipation of the events that may trigger them, may improve services across the entire treatment continuum. From arrest through intake, incarceration, and release, a service provider who provides support and understanding concerning these issues may reduce their impact and deter deterioration. Alternatives include supplying a woman with information so she can anticipate what her experiences might be, using female staff to perform strip searches and attend to

a woman's health care needs, addressing child care concerns soon after arrest in order to communicate interest and concern for the woman offender's family, allowing her to ask for help or support, and providing supportive staff members to accompany her through difficult correctional procedures. These cost-effective and simple interventions can markedly reduce the fear, anger, and resentment that may underlie violent or irrational outbursts during correctional procedures (Veysey et al., 1998).

## THE SPECIFIC CAUSES OF VIOLENT TRAUMA

### Childhood Sexual Abuse

Childhood sexual abuse is commonly found among female substance abusers as well as among women with histories of concurrent or independent psychiatric symptomatology. A national survey of women's drinking habits in the United States investigated the lives of 1,099 women to examine patterns among childhood sexual abuse and other substance-related and psychological difficulties. This study found that women with a history of childhood sexual domination were more likely to report alcohol dependence and alcohol-related problems and to experience symptoms of clinical depression and anxiety. A higher frequency of depressive episodes was found among these women, as well as self-reports regarding nervousness and anxiety. More than one third of the women who had experienced sexual abuse in childhood reported lifetime use of one or more illicit drugs. These women were also more likely to report lifetime use of prescription psychoactive medications as well as illicit drugs (Wilsnack, Vogelanz, Klassen, & Harris, 1997). This study concluded that sexual abuse in childhood is among the dominant factors in the etiology of substance abuse and psychiatric diagnosis in women. Possible explanations for these relationships between childhood sexual abuse and later substance abuse and psychopathology share a common denominator: substance abuse is either used to counter, or block, negative feeling states brought on by the abuse or to improve the woman's social and sexual response. Abuse in the home, perpetrated by a trusted other, especially a parent, involves a devastating violation of trust, including multiple levels of betrayal, as well as the experiences

of invasion and terror found in other relationships of abuse (Butler, 1978; Crawford & Unger, 2000; Denmark, Rabinowitz, & Sechzer, 2000). Betrayal is frequently furthered by the “conspiracy of silence” (Butler, 1978; Crawford & Unger, 2000), that is, the aura of secrecy and disbelief that a female child or woman encounters when she speaks of this abuse. Denial and secrecy in the response of others, or alternatively a “voyeuristic” probing for details, can render a female child or woman virtually unable to trust or reach out for help. Family denial, which serves to keep the abuse a secret, may leave her with feelings of guilt upon disclosure for “betraying a family secret” or for speaking badly about her parents (Crawford & Unger, 2000). These multiple issues of trust and betrayal must be dealt with delicately in the treatment process (see Chapter 7).

### **Sexual Assault in Adulthood**

As mentioned previously, sexual assault is a prominent factor in women’s lifetime risk of addictive disorders. Alcohol abuse or dependence occurs among women who have been assaulted at three times the rate of women with no history of assault, and drug abuse or dependence occurs at four times the rate than among non-abused women (Blume, 1998; Koss & Dinero, 1989). Rates of violent trauma in addicted women are far higher than those experienced by addicted men.

Most rapes involve people who know each other, that is, date, acquaintance, and marital rape. Only 20 percent of all rapes are performed by strangers (Denmark et al., 2000). Among women judicial clients, prostitution provides another important route for the occurrence of sexual assault (Falck, Wang, Carlson, & Siegal, 2001). Increased exposure to men who may be abusing substances (in bars, clubs, the “drug scene,” and so on), as well as the stigma-related associations between women using substances and sexual availability (discussed in Chapter 2), increase risk of sexual assault among women who engage in criminal conduct.

### **Domestic Violence**

Domestic violence is another important source of trauma among women that may be complicated

by substance use. It includes any sort of physical, sexual, or emotional abuse perpetrated by one partner to another, as well as abuse toward children and the elderly. Substance use (by the perpetrator, the victim, or both) is involved in as many as 92 percent of reported episodes of domestic violence. Alcohol use seems to be involved in up to 50 percent of the cases of sexual assault. Substance use may also be involved in domestic violence in more subtle ways, such as arguments over financial matters (the substance user takes money from the spouse or diverts money that should be used to pay household bills to buy drugs, for example) and conflicts related to seeking and splitting drugs (Zilberman & Blume, 2005).

A full 81 percent of women judicial clients report experiencing physical assault in their lives, 29 percent of them in childhood and 60 percent in adulthood, generally by a partner (Bloom, Chesney-Lind, & Owen, 1994; Kerr, 1998). Repeated experiences of emotional or physical violence perpetrated by an intimate partner, along with its psychological consequences for the woman’s self-esteem, may produce exaggerated perception of threat and the associated defensive and attack postures commonly observed in women judicial clients (Niehoff, 1999).

### **Institutional Abuse**

Unfortunately, abuse may also occur within treatment settings. Women judicial clients who have been abused by service providers feel a sense of betrayal as well as powerlessness, and they often feel that there is no safe place for them to go. Needless to say, this abuse undermines the effectiveness of the treatment setting, as it imbues this setting with suspicion and fear, secrecy, and a sense of betrayal. The woman offender who has been abused within a treatment setting may feel that it is impossible for her to speak out about this abuse, as she may fear retaliation and punishment. This secrecy mimics the “conspiracy of silence” involved when abuse occurs within the family. Individuals who have been entrusted to help her instead contribute to her problems and difficulties. It is important that women judicial clients be educated regarding the illegality of this type of abuse as well as empowered with mechanisms of redress should this abuse occur.

Institutional abuse is not confined to treatment settings. Unfortunately, cases are documented with regularity that involve abuse by doctors, church officials, police officers, employers, teachers, baby-sitters, social workers, halfway house directors—just about anyone in a woman’s life may have perpetrated a violating and invasive act upon her body. It is important that service providers be aware of the potential for this type of abuse in a woman’s life and address the extreme sensitivity to danger that may develop when a woman perceives there to be “no safe place” for her to go. Being able to feel ownership of the space one occupies is a necessary ingredient for the empowerment necessary to achieve successful recovery and resistance to recidivism.

### **Trauma and Criminal Conduct in Women**

A vicious cycle of victimization, chemical use, slowing of emotional development, limited stress resolution, more chemical use, and heightened vulnerability to further victimization may also involve criminal behavior, contact with corrections, incarceration, release, relapse, and recidivism (Steele, 2000). Women judicial clients tend toward less violence than their male counterparts. Their criminal behavior often arises through experiences with trauma and subsequent substance abuse or dependence and/or contact with the drug culture.

Particularly, women who engaged in juvenile criminal behavior, or criminal behavior before the onset of drug use, tend to experience polydrug problems. Emotional abuse has been experienced by 57 percent of these women, physical abuse by 49 percent, and sexual abuse by 40 percent (Palacios, Urmann, Newel, & Hamilton, 1999).

### **MEDICAL CHALLENGES FOR WOMEN JUDICIAL CLIENTS**

Women in correctional facilities have a wide range of unique health needs and difficulties (Acoca, 1998a). Yet the “gender-based disparity in medical response is perhaps most evident in the nation’s prisons and jails, where...women receive inferior health care compared to their male counterparts” (Acoca, 1998a, p. 51). Acoca and Austin (1996) report that

61 percent of female judicial clients are in need of medical treatment for one or more health problems. Also, women generally have more health concerns, different types of medical problems, and require health care at four times the rate of men. Continuing treatment and follow-up of women offenders’ health concerns once they do receive care is minimal. For instance, 42 percent of women judicial clients who take medications for medical problems are not under supervision. Overmedication is common, as are resulting side effects and physical decline (Acoca, 1998a). Two factors have recently been associated with self-reported poor health among incarcerated women. Women reporting recent use of heroin and a history of physical assault are three times more likely than men to present with deteriorated health (Fickenscher, Lapidus, Silk-Walker, & Becker, 2001).

### **Health and Overcrowding**

Other health care concerns that directly relate to conditions of imprisonment result from the overcrowding and lack of clean air that are often characteristic of these environments. Institutional vehicles for transportation of inmates are often crowded and stuffy, and negative air pressure rooms, which might reduce the risk of infection from an individual with a contagious disease, are in short supply. These conditions foster circumstances conducive to the spread of airborne contagious disease such as influenza and tuberculosis (Acoca, 1998a). Routine assessments upon intake do not generally include screening for such conditions. In recent years, the prevalence rates of tuberculosis have increased in correctional facilities, estimated as 8 percent in 2000, double the rate in the U.S. general population. It has been estimated that incarcerated individuals are also at higher risk for having latent tuberculosis infection and later developing tuberculosis (McNiel, Binder, & Robinson, 2005). As women are generally less violent than men, they are frequently kept in even more crowded conditions than are male inmates, many sleeping 6–8 to a cell (Acoca, 1998a). Fast identification of contagious cases through rigorous screening might reduce potential exposure to tuberculosis (Saunders et al., 2001). Without a continuing program of care to supervise medication, dosage requirements frequently go unfilled, and medications may be stopped before the necessary terms of effectiveness have been



reached. Drug-resistant strains are thus bred within the nation's prisons and may be transmitted into the general population upon release (Acoca, 1998a).

## Hepatitis

Other sexually transmitted diseases (STDs), such as hepatitis B and C, are also transmitted through the pathways of intravenous drug use, unprotected sex, and tattoos. Contrary to rates within the general population, various studies have found the prevalence of hepatitis C among incarcerated women to be higher than among incarcerated men (Baillargeon et al., 2003). In California state prisons, 54 percent of women inmates test positive for hepatitis C (versus 39 percent of males) (Acoca & Austin, 1996). Among reincarcerated women in Rhode Island in 1996–1997, the prevalence of hepatitis B was as high as 29 percent, and hepatitis C was even higher, 40 percent. Self-reported risk behaviors included substance use (84 percent), previous incarceration (68 percent), sexual behavior (44 percent), and injecting drug use (40 percent) (Macalino et al., 2004).

Despite high rates of HIV/AIDS and other STDs (syphilis, gonorrhea, chlamydia, and papillomavirus infections) among women in prisons, and in contrast to health care resources that are available to male judicial clients for such problems, health-related facilities specifically designed to deal with these health problems in women are “limited or nonexistent” (Acoca, 1998a, p. 53). Effective interventions in jails include hepatitis C testing, hepatitis B vaccination, and education (Macalino et al., 2004).

## HIV and AIDS

AIDS is an important health problem in jails. Of the total cases of AIDS in the United States in 1996, 4 percent were found in incarcerated individuals. The AIDS rate for incarcerated persons is estimated to be six times the overall U.S. rate. Although cases of AIDS are still more common in incarcerated males (89 percent) as compared to females (11 percent), among persons incarcerated at the time of their initial AIDS diagnosis, rates were higher for females (Dean-Gaitor & Fleming, 1999). Incoming female inmates in Texas criminal justice in 1999 presented

higher rates of HIV infection compared to males (Wu et al., 1991). Other recent studies show that rates of HIV for incarcerated females were higher than for males, probably due to elevated rates of women with substance abuse and dependence. Risk factors for HIV in prisons include substance use or dependence, sharing injecting equipment, sexual activities—heterosexual and homosexual, consensual or not—prostitution, tattooing, and body piercing (Hellard & Aitken, 2004).

HIV and AIDS are among the most prominent (25–30 percent) medical conditions in women judicial clients (Acoca, 1998a). Seventy percent of women infected with the virus acquire their HIV infection either through drug injection or sex with a man who injects drugs (Blume, 1998). Just under a third of incarcerated women report sharing needles at some time in their drug use history, 10 percent reporting they had shared needles with 50 or more users (Acoca, 1998a). In addition, 86 percent of incarcerated women in this study reported engaging in unprotected sex, with 10 percent of these women reporting 50 or more sexual partners. Exchanging sex for drugs (and outright prostitution) are major routes whereby female judicial clients who use either crack cocaine or heroin become infected (Blume, 1998).

People with chronic mental illness and comorbid substance use disorders are at increased risk for contracting HIV; estimates have reached 10–76 times greater than the general population (Lerner, 2001). This wide range is probably due to the fact that individuals with co-occurring substance abuse and mental disorders are difficult to track and to test randomly for HIV infection. As described previously, intravenous drug use is a major route for infection; however, another, very prominent risk factor is high-risk sexual behavior. A study of sexual behaviors among people with severe psychiatric diagnosis revealed that sexual encounters involved low rates of condom use, trading sex for drugs (or cash, a roof over their heads, or other basic needs), sex with many partners, sexual assault, and sex between women and bisexual men (Lerner, 2001).

HIV/AIDS hits certain populations especially hard. Rates among incarcerated African American women and Latinas are especially high (Acoca,

1998a), reflecting rates among women in the general population, where the rate of AIDS is 13 times greater for African American women and 8 times greater for Latinas than for white women (Acoca, 1998a). Dually diagnosed individuals also face increased risk for contracting HIV; they become infected at a rate 10–76 times greater than the general population (Lerner, 2001). In addition to the risk factors named previously, low rates of condom use, trading sex for drugs, money, and a place to stay, coerced sex, and women having sex with bisexual men increase their level of risk.

Specific prevention programming has been explored in some countries, but attempts are sparse. Some of the initiatives that have been tested include syringe exchange programs, bleach programs, and condom distribution.

## Cancer

Cancer risk factors—including alcohol, tobacco, and other drug use, as well as viral infections, including HIV and hepatitis B and C—are known to be highly prevalent in incarcerated populations. Survival rates among incarcerated women with cancer are lower than those for women in the general population. The most common types of cancer among female inmates are cervical cancer, followed by breast and lung cancers (Mathew, Elting, Cooksley, Owens, & Lin, 2005).

## Pregnancy

Pregnant substance-using women judicial clients pose a significant challenge in terms of health care in jails. Imprisoned women are more likely to have premature labor and low birth weight (Knight & Plugge, 2005; Mertens, 2001). Drug use in the perinatal period is associated with a variety of obstetric and postpartum complications, including *abruptio placentae*, meconium staining, premature rupture of membranes, and reduced birth weight and height. Poor nutrition and lack of appropriate prenatal care further complicate pregnancy outcomes (Zilberman & Blume, 2005).

## Fetal Alcohol Syndrome

Fetal alcohol syndrome represents the third most common cause of mental retardation in the United

States, after Down syndrome and spina bifida. It is completely preventable through abstinence from alcoholic beverages during pregnancy. Because of the high use of alcohol among female judicial clients, their risk for having children with these problems is also high. The estimated prevalence in the general population is 1 to 3 cases per 1,000 live births, with increased risk associated with binge drinking, increased maternal age, and increased parity. The full syndrome is characterized by pre- and post-natal growth retardation, central nervous system abnormalities (including microcephaly), facial dysmorphisms (with maxillary hypoplasia, shortened palpebral fissures, and epicanthic folds), and cardiac abnormalities. Other fetal alcohol effects include spontaneous abortion, reduced birth weight, and behavior changes (Zilberman & Blume, 2005).

## Substance Abuse and Women's Health

Health care problems are frequently exacerbated by substance abuse or dependence. Once again, recall that many medical complications due to substance abuse develop more rapidly in women and become more severe, even at lower levels of consumption. This “telescoping” of female alcohol-related problems relates to a wide range of medical complications, many of which are reproductive. Among these we find breast cancer and sexual dysfunction (Blume, 1998). Acoca (1998a) reports that women who have experienced violent sexual or physical trauma require medical services at twice the rate of nonvictimized women; their medical problems include surgical, gynecological, and gastrointestinal difficulties, as well as the by-products of suicide attempts. Of course, these women are also more likely to require mental health services.

Chronic and heavy alcohol consumption may underlie sexual dysfunction in women, in that it may suppress both sexual arousal and orgasmic function. This is contrary to widely held beliefs of women judicial clients who frequently assume that alcohol will boost their sexual pleasure. Sixty percent of female alcohol users report that they believe alcohol enhances sexual responsiveness, and women who consume alcohol at higher levels are more likely to hold this belief. Research has also found that these sexuality-related alcohol expectancies are correlated with high-risk sexual behavior

in women. There may be a bidirectional relationship; however, as clinical studies suggest, sexual dysfunction may also contribute to substance abuse problems in women (Wilsnack, 1995).

Health care clinicians may help women reduce their alcohol consumption and their risk for HIV infection by explaining that their drinking has suppressed rather than enhanced their sexual responsiveness. Women may be educated to understand that, in fact, they may enjoy sex more during sobriety than they do while drinking (Blume, 1998). A great opportunity for providing women with education regarding reproductive health, safe sex, and family planning is missed due to the lack of specialized health care for women judicial clients. Acoca (1998a) reports, "There are no consistently applied policies regarding contraception, abortion, and general reproductive education and counseling for incarcerated women" (p. 56).

## **ETHNIC CONSIDERATIONS IN HEALTH CARE**

McQuaide and Ehrenreich (1998) found that, as with men, a disproportionate number of incarcerated women are from minority groups. In 1991, 14.2 percent were Hispanic women (while Hispanics made up only 7.3 percent of the general female population at that time), and 46 percent were African American women, compared to 12.5 percent of the general female population.

Health care concerns, which are disproportionately found among African Americans, include diabetes, certain kinds of heart disease, hypertension, and sickle cell anemia. These diseases often receive no special attention in prisons' health care systems (Acoca, 1998a).

## **IMPLICATIONS FOR TREATMENT AND POLICY: WHAT FACTORS REDUCE RECIDIVISM?**

Acoca (1998a) recommends gender-specific interventions in the health care of women. Differences in the mental and physical health needs of male and female judicial clients require specific services designed to address the issues found within each gender. Investigators into the health needs of the incarcerated women assert that successful treatment of chemically dependent women with a history of violent trauma

should include simultaneous components to address their co-occurring disorders of substance abuse and mental illness. Careful attention should be paid to sorting out the source and etiology of a woman's psychological difficulties, as experiences with trauma, substance abuse or dependence, and posttraumatic stress disorder may all present with symptoms that mimic other psychiatric diagnoses. Mental and physical health care services in correctional facilities must be expanded to allow for accurate screening, assessment, and treatment of these gender-related difficulties (Acoca, 1998a; Steele, 2000).

In addition, access to the few medical and mental services that are available may be blocked by ethnic and linguistic differences. It was estimated that 20 percent of incarcerated women spoke little or no English or were more comfortable speaking in their own language. At the same time, few members of the correctional, mental health, or medical staff at correctional facilities were bilingual (Acoca & Austin, 1996). Thus, there is a great need to reorganize mental and physical health care services in correctional settings so that they are both gender- and culture-responsive (Acoca, 1998a).

## **CHAPTER REVIEW**

Chapter 3 has described a full range of both medical and psychological difficulties found at high incidence among the female incarcerated population. Issues regarding psychiatric diagnosis have been explored, as has the adequacy of prison services to meet these needs. Substance use problems as well as accompanying psychological and mental health difficulties in women judicial clients have been found to stem from experiences with violent trauma. Specific sources of this trauma were explored and were found to occur at very significant rates among female judicial clients. Finally, the aftermath of trauma was examined with relation to behavioral disturbances, posttraumatic stress disorder, and dual diagnosis. Some key findings are outlined below:

- The number of women in U.S. prisons has increased dramatically in the past 25 years.

- It is estimated that more than 60 percent of incarcerated women present a lifetime diagnosis of a psychiatric disorder.

▶ Forty-five percent of incarcerated women present a current psychiatric diagnosis, and 40 percent of these inmates have substance-related disorders.

▶ Only a small portion of those female detainees in need of psychiatric care receive treatment.

▶ While researchers vary in their estimates of the rate of psychiatric disorders among women in jails and prisons, most agree that diagnostic and treatment services are generally inadequate and in some cases nonexistent for this population.

▶ Excluding substance-related disorders, major depression is the most frequent current psychiatric diagnosis among women in jail, from 5 percent to 11 percent.

▶ Alcohol abuse or dependence co-occurred with major depression in 19 percent of women judicial clients, four times the rate in men and three times the rate in the general population of women.

▶ Phobic disorders are found in 31 percent of women judicial clients (versus 15 percent of male judicial clients, and double that of women in general).

▶ A frequent result of violent trauma, posttraumatic stress disorder (PTSD), is seen at a very high rate in women judicial clients. In one study, 33.5 percent of women judicial clients were diagnosed as having PTSD due to rape or other violent assault and many service providers suggest

that this figure is even higher when one considers the continuum of traumatic consequences.

▶ Domestic violence is another important source of trauma among women that may be complicated by substance use. A full 81 percent of women judicial clients report experiencing physical assault in their lives, 29 percent of them in childhood and 60 percent in adulthood, generally by a partner.

▶ Sixty-one percent of female judicial clients are in need of medical treatment for one or more health problems. Also, women generally have more health concerns, different types of medical problems, and require health care at four times the rate of men.

▶ Despite high rates of HIV/AIDS and other STDs (syphilis, gonorrhea, chlamydia, and papillomavirus infections) among women in prisons, and in contrast to health care resources that are available to male judicial clients for such problems, health-related facilities specifically designed to deal with these health problems in women are limited.

▶ HIV and AIDS are among the most prominent (25–30 percent) medical conditions in women judicial clients.

▶ Pregnant substance-using women judicial clients pose a significant challenge in terms of health care in jails. Imprisoned women are more likely to have premature labor and low birth weight.