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Healing Trauma among Female Prisoners through Mindfulness:

A Phenomenological Study

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has been approved as meeting the requirement for the Masters of Science of Clinical Mental Health Counseling in the College of Education, Health, and Human Services, Department of Counselor Education and School Psychology, Program of Counselor Education.

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ABSTRACT

Aquilina, R. *Healing trauma among female prisoners through mindfulness: A phenomenological study*. Published Masters of Science Thesis, Plymouth State University, 2015.

The connection between trauma and criminal behavior has been well documented in the literature, as are quantitative data on the impact of wellness training in assisting prisoners with trauma recovery. However, there is a dearth of research exploring the perceptions of female prisoners. This research represents a first attempt to qualitatively explore the mental health needs and wellness-based treatment of female prisoners with a history of trauma. Statistics regarding both trauma and mental illness among the prison population were reviewed, as well as the rationale for the need for gender-sensitive treatment modalities for prisoners. The researcher conducted an eight-week mindfulness group at a prison in the northeastern United States with 17 female prisoners. Data collection points included open-ended, semi-structured interviews at pre-group, weekly during the group, post-group, and at both 30 and 60 days post-group. The aim of this phenomenological investigation was to assess qualitative changes in female prisoners' perceptions of their own personal traumas.

Keywords: trauma, mindfulness, wellness, counseling

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CHAPTER I

INTRODUCTION

According to The Sentencing Project (2011), more than 200,000 women in the United States are incarcerated. This translates to 65 out of every 100,000 women. According to the Bureau of Justice Statistics (2001), 25% of female prisoners at the state level have been identified as having a mental illness (as cited in Bloom, Owen, & Covington, 2002). The three most common diagnoses included substance abuse, Posttraumatic Stress Disorder (PTSD), and depression. James and Glaze (2006) put the rate of female prisoners experiencing mental illness at 73% nationally. Access to mental health care and trauma-focused therapy is deficient in prisons. Further, less than one third of prisoners with a diagnosed mental health condition receive treatment while incarcerated (James & Glaze, 2006). Thus, there is opportunity to bolster mental health treatment in prisons, most specifically among female prisoners.

Mental illness is prevalent among the prison population. Prisoners at the state level who experienced mental illness reported longer sentences, specifically a mean maximum of five months longer than those without mental illness (James & Glaze, 2006). They also reported multiple incarcerations, specifically three or more. Based on these statistics, it could be inferred that trauma may have a direct impact on not only commission of crime, but also sentence length and number of incarcerations of prisoners. Therefore, a trauma-focused treatment modality for prisoners may be germane in the reduction of these numbers.

Trauma is also prevalent among prisoners in today's correctional settings. Abuse victimization history is more common among the prison population than in the general population, and more prevalent among female prisoners compared to male prisoners (Bloom et al., 2002). The Bureau of Justice Statistics (1999) put the rate of female prisoners who have

experienced physical or sexual abuse at approximately 60%; other studies estimate that 70-80% of female prisoners have experienced trauma at some point in their lives (Maguin, 1999; Owen & Bloom, 1995, as cited in Bloom et al., 2002). The Bureau of Justice Statistics (1999) also found that approximately 17% of female prisoners had lived under state care, either in foster care or in a group home, at some point of their childhood.

Trauma exposure is significantly higher in prisons than in the general population (Komarovskaya, Loper, Warren, & Jackson, 2011). In one quantitative inquiry examining gender differences in traumatic exposure among 266 male and female prisoners, 94.7% of respondents reported exposure to trauma at some point of their lives. Approximately forty percent of the women met the criteria for PTSD in this study, versus 12.5% of men (Komarovskaya et al., 2011).

The mental health needs of female prisoners across the country are often overlooked; this, accompanied by the idea that females report higher rates of trauma and mental illness, provide a significant opportunity to enhance the mental health needs of female prisoners. Women also come into the correctional system with higher rates of mental illness and trauma than men; however, until recently, they have been a nearly invisible population in the correctional system.

Gender is often overlooked in both research and treatment involving the prison population (Belknap & Holsinger, 2006; Acoca, 1998). Many, if not most, data collection efforts and treatment modalities that focus on prisoners, are geared toward men and are implemented for both genders based on these norms (Acoca, 1998). This may create a culture of ignorance about not only the actual information about female prisoners, but also sometimes their most basic needs, including mental health treatment. In both the male and female prison populations, there is also a lack of qualitative research (Himelstein, 2011; Bishop et al., 2004). While quantitative

research has furnished a wealth of information about trauma statistics and trauma-focused treatment, an in-depth investigation of the voices of participants, an equally important part of studying the experience of the prisoner, is largely missing.

In addition, a gap in the literature reflects a greater need for a variety of manualized trauma-focused treatment modalities for prisoners. Currently there is one entitled *Seeking Safety* (Miller & Najavits, 2012). This evidence-based counseling approach addresses trauma in the context of its current impact on clients rather than exploring the trauma itself. This treatment modality is designed to teach coping skills and safety, and addresses many types of trauma (e.g., child abuse, intimate partner violence, and sexual violence). Clients in this program need not meet the criteria for PTSD or substance abuse. The absence of trauma-focused treatment in prisons could be due to the underreporting of trauma by both male and female prisoners. More stringent confidentiality limits, as well as the stigma of "ratting out" a perpetrator, may be a barrier to disclosure.

Many authors have explored the important role of early intervention after a traumatic experience in order to prevent the development of maladaptive behavior patterns (e.g., Anderson & Gedo, 2013; Widom & Maxfield, 2001; Helfer & Kempe, 1987; Joubert, Webster, & Hackett, 2012). However, there is currently little to no literature discussing intervention and treatment strategies for women and girls who have trauma histories and have already committed crimes. What is being done to help the women for whom early intervention no longer applies? Miller and Najavits (2012) discussed present-focused, trauma-informed treatment, such as mindfulness for the prison population, many of whom have experienced multiple traumas over their lifespan for which they have never received support or treatment. A mindfulness-informed treatment

modality has the potential to bridge the gap in treatment available to female prisoners and allow for a more holistic approach to healing.

Salient to the geographical context of this study, the recidivism rate among female offenders in New Hampshire exceeds that of men (New Hampshire State Advisory Committee to the U.S. Commission on Civil Rights [NHACUSCCR], 2011). The NHACUSCCR (2011) posited that this is a direct result of lack of services for women as it pertains to mental and physical health, and preparation for leading healthy, productive lives upon release. The New Hampshire State Advisory Committee to the U.S. Commission on Civil Rights (NHACUSCCR; 2011) also discussed that these "inexcusable disparities" may directly impact recidivism rates, which largely come in the form of parole violations directly related to substance abuse and mental health. By implementing trauma-focused treatment for prisoners, it may have a positive impact on their experience in the prison environment and their adjustment upon release, which may in turn lead to safer communities.

Purpose of the Study

The aim of this study was to explore how mindfulness training, as a trauma-focused treatment modality, can help female prisoners to re-conceptualize trauma that they may have faced and use this new information to gain resilience, self-esteem, and an inner sense of control over their lives. Could trauma at any point of the lifespan increase the likelihood of incarceration? If so, what is being done to address this in the incarcerated population in order to help prisoners heal from past traumas and leave prison ready to lead healthy, productive lives? In order to focus on healing and rehabilitation rather than punishment, a study is needed to ascertain what may be an effective treatment modality for current prisoners.

The purpose of this study was to qualitatively explore female prisoners' conceptualizations of trauma, perceptions of how trauma has affected their lives, and how an eight-week mindfulness training may help female prisoners reexamine the role of trauma in their lives. This emergent phenomenon will be the beginning of a detailed description and discussion of how mindfulness training may be able to help female prisoners develop healthier coping skills in relation to the impact that trauma has had on their lives.

Implications for the Professional Counseling Field

There is opportunity for better understanding in the counseling profession about the origin of issues that lead a person to commit crime, particularly regarding trauma (Miller & Najavits, 2012). This research may help counselors to enhance their understanding of the prison population and their treatment needs, which can lead to more trauma-informed treatment approaches for prisoners both during incarceration and after release from prison.

Research Significance

This study could help to provide detailed information on how mindfulness-based, trauma-focused treatment is utilized in the correctional system. In the individual person, mindfulness treatment may help to cultivate a more positive self-concept, which can lead to enhanced self-esteem and a greater sense of control over their lives (Samuelson, Carmody, Kabat-Zinn, & Braatt, 2007). Ultimately, this can lead to better adjustment upon release back into the community and may help with other stressors that female prisoners face in their daily lives, both inside and outside of prison walls. This focus on healing instead of punishment may also lead to safer communities and less recidivism.

Research Questions

The following are the research questions that guided this qualitative inquiry and form the basis of the semi-structured interview questions answered by individual participants. These questions were drawn from a review of the relevant and related literature, my personal experiences, and consultation with my thesis chair.

Q1 How can mindfulness training help female prisoners to cope with past trauma?

Q2 How do female prisoners with a history of trauma conceptualize these traumatic experiences?

Q3 How can mindfulness training help female prisoners reconceptualize the trauma they have experienced?

Q4 How can mindfulness training help female prisoners understand the impact that trauma has had on their lives?

Q5 How can mindfulness training help female prisoners cultivate a sense of self-esteem that may have been inhibited by a traumatic event?

These questions guided and oriented me as a researcher in an effort to describe an emergent phenomenon of female prisoner perceptions of a wellness curriculum's impact on past life trauma.

Assumptions and Limitations

This study contains many macro and micro limitations. The constructs of trauma and wellness are rich, expansive theories and warrant much more attention than this current study can provide. In fact, these two theories have been the focus of thought by contemporary and historic philosophers alike (Veith, 1965; Hettler, 1979; Travis, 1981; Hendricks & Weinhold, 1982; Burgess, 1983; Charlesworth & Nathan, 1984; Clark, 1996; Herman, 1992; Myers, Sweeney, &

Witmer, 2000; Sweeney & Myers, 2003). This research, however, is aimed at shedding some light on the current social and personal experiences of these particular constructs in relation to the perceptions of incarcerated women.

This study was composed of 17 incarcerated female prisoners in the northeastern United States. The population utilized for this thesis has certain demographics in common and others that are unique. The women in this sample ranged in age from 26 to 49, with a median age of 34. Twelve of the women were parents, and 16 identified themselves as addicted to drugs or alcohol. Eleven were in active recovery. Two women experienced substance abuse relapse during the study, and one had to withdraw as a result. Three of the women were married, and four had long-term partners; however, two were separating from their partners during the study. Of the participants who did not finish the study, six left because of work release, and two reached their maximum sentence and were released. All of the women, as a prerequisite to participating in this study, have experienced trauma. These traumas varied, including sexual abuse, sexual exploitation, child abuse, intimate partner violence, accidents, loss, and parental separation. Ten of the women reported polyvictimization (i.e. experiencing multiple traumas at the hands of one or more perpetrators).

It should be noted that the topics of trauma and personal wellness may be sensitive to participants, and many may be reluctant to fully share their experiences, thoughts, and feelings, or may present in an ideal manner in order to reduce the likelihood of a negative self- and other-evaluation. Because authenticity is a salient feature of qualitative research, and for this research in particular, it was essential for me to set a comfortable and accepting atmosphere during interviews (individual and in a focus group). This open atmosphere attempted to provide a profound openness and acceptance of all points of view. Although this atmosphere encouraged

openness and maintained the participants' anonymity, the setting itself could not guarantee that participants felt the necessary conditions to fully disclose their experiences with trauma and wellness.

Definitions of Key Terms

Community Corrections: The supervision of criminal offenders in the resident population, as opposed to confining them in secure correctional facilities (BJS, 2014). The two main types of community corrections supervision are probation and parole. Community corrections is also referred to as community supervision.

Incarcerated Population: The population of inmates confined in a prison or a jail (BJS, 2014). This may also include transitional housing units (more commonly called halfway houses), boot camps, weekend programs, and other entities in which individuals are housed overnight.

Mindfulness: "Receptive attention to and awareness of present events and experience" (Brown & Ryan, 2003, p. 823); "paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally" (Kabat-Zinn, 1994, p. 4); "the process of drawing novel distinctions" (Langer & Moldovenanu, 2000, p. 1)

Parole: Criminal offenders who are conditionally released from prison to serve the remaining portion of their sentence in the community (BJS, 2014). Prisoners may be released to parole by a parole board decision, according to provisions of a statute, through other types of post-custody conditional supervision, or as the result of a sentence to a term of supervised release.

Phenomenological Study: The common meaning for several individuals of their lived experiences of a concept or a phenomenon; an analysis of people's subjective lived experiences (Creswell, 2013, loc. 1669).

Prison: Long-term facilities owned by a state or by the Federal Government to house people who have committed felonies (BJS, 2014). Prisons typically hold people with sentences of more than a year; however, the sentence length may vary by state.

Prisoners: People confined in long-term facilities run by the state or federal government or private agencies (prisons; BJS, 2014). They are typically felons who have received a sentence of incarceration of one year or more.

State Prisons: Prison facilities run by state correctional authorities (BJS, 2014). Prisoners housed in these facilities are under the legal authority of the state government and generally serve a term of more than one year.

Trauma: Exposure to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence as follows: direct exposure; witnessing, in person; indirectly, by learning that a close relative or close friend was exposed to trauma; repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties, not including indirect non-professional exposure through media (American Psychiatric Association, 2013, p. 271)

Summary

Mindfulness as a trauma-focused treatment may be suitable for female prisoners. Mindfulness training specifically may help female prisoners gain coping skills and self-esteem that could be beneficial to them upon release, and in their overall functioning during incarceration. This study may shed light on the opportunity within the prison system for more trauma-focused treatment and the opportunities to help prisoners to incorporate mindfulness into their everyday lives.

CHAPTER II

REVIEW OF LITERATURE

What makes an experience traumatic? The answers differ from person to person. Trauma is defined by van der Kolk (1996) as an "inescapably stressful event that overwhelms people's existing coping mechanisms" (p. 279). This definition highlights a common thread in the description of the traumatic experience. In spite of its subjectivity, "Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning" (Herman, 1992, p. 33). When a traumatic event occurs, there are a variety of ways with which people adapt, or not. For some, the trauma can be reconciled and they can go on to live normal, healthy lives; for others, however, it is difficult for them to adapt to their new reality and incorporate the trauma as a part of their lives. A traumatic experience can inhibit cognitive and psychosocial development, and lead to the development of psychiatric disorders, altered personalities, and changes in behavior patterns. Further, in some, reaction to traumatic experiences can manifest in an inability to cope with everyday experiences, and can lead to violence, drug use, or other actions that can lead to incarceration. The literature reviewed below will discuss the history of trauma, its prevalence in incarcerated populations, and a description of a possible opportunity to help prisoners to reconceptualize trauma that they have experienced by exploring mindfulness and its role in the development of coping skills that may not otherwise be available to prisoners. An exhaustive search of professional peer-reviewed journals, as well as books relating to the history of the phenomenon of trauma based in the fields of counseling, counselor education, philosophy, and social psychology ranging from 1965 to present day was conducted using online search engines such as Academic Search Premiere (EBSCOHost),

PsycInfo, PsycArticles, Social Sciences Index, and Google Scholar in order to explore the history and relevance of mindfulness as it relates to trauma.

The History of Trauma

The concept of trauma as pathology and the debate about its origins has a history dating back to ancient times. The earliest notions of psychic trauma are found in Sumerian cuneiform tablets as far back as 2094 BC, and allude to hyperarousal, nightmares, grief, stress reaction, and somatic symptoms, among other symptoms that we know today as those related to trauma reactions (Ben-Ezra, 2010). In the writings of Homer, trauma was associated with combat and survivor's guilt. In *Iliad* in particular, Homer wrote of Achilles suffering from recurrent and intrusive thoughts, as well as sleep disturbance (Homer, 1999, p. 563, as cited in Ben-Ezra, 2010):

> But Achilles wept, ever remembering his comrade, nor did sleep, that subdues all, lay hold of him, but he turned ever this way and that…thinking on these things he would shed large tears, lying now on his side, now on his back, and now on his face; and then again he would rise to his feet and roam distraught along the shore of the sea (p. 227).

In Ancient Egypt and Mesopotamia, trauma was called a different name: hysteria. Hysteria is derived from the Greek word, "hystera", which means "uterus" (Veith, 1965, p. 1). During this time period, hysteria was a disease that was thought to have presented solely in women. It was posited by the people of that time period that hysteria was derived from sexual dysfunction, and was literally conceptualized as a disease characterized by a "wandering womb" (p. 2). Symptoms that emerged during this time were pain in the neck, teeth, joints, and jaws, as well as an inability to get out of bed.

These were thought to be caused by a displacement of the uterus, which crowded the other organs in a woman's body. In Ancient Greece, the conceptualization of hysteria was similar, but expanded on these symptoms to include choking, convulsions, vomiting, anxiety, loss of voice, perspiration, and heart problems (p 10).

Treatments of hysteria included efforts to "lure or drive the organ back as if it were a living, independent, organism" (Veith, 1965, p. 3). This could include fumigating or ingesting substances to attract the uterus in order to drive it away from the part of the body to which it had wandered. Substances included a mixture of wood tar and beer, dried excrement moistened with beer, pine sawdust, yellow ochre, and myrrh, among others.

The debate over hysteria being an organic or psychological disease also had its roots during the ancient times (Veith, 1965). During this time, hysteria was widely regarded as a physical ailment, and a common school of thought during this time was that the uterus was an organ of its own volition. Hippocrates saw epilepsy and hysteria as linked diseases, and was the first to acknowledge that "the seat of the disease is in the brain" (p. 15). He also discussed that the entire body and its functions were directed by the brain. However, he still maintained that hysteria and epilepsy were diseases of the uterus.

Throughout the discussion of hysteria as it was conceptualized in the Middle Ages, trauma was never openly discussed, but it could be conceptualized as the beginnings of the traumatic reaction as a pathological one. During this time, theological explanations of the cause of hysteria emerged and included witchcraft and moral failing. If a woman were afflicted with hysteria, it was seen as being caused by an alliance with "unholy powers" (Veith, 1965, p. 56). Hysteria became associated with bewitchment, and often, women who were afflicted with hysteria were no longer treated by doctors; they were believed to be witches and were killed.

Due to the belief that women were afflicted by hysteria, women were the main targets of witch-hunts during this time. Women were largely seen as untrustworthy. The view of women, and of hysteria, eventually began to evolve back to the medical model realized by Hippocrates in the late Middle Ages. It was posited by Rabelais during this time that women could control the "animal" that was their uterus, and by doing so, they could avoid becoming afflicted with hysteria (p. 108).

There was much discussion of traumatic reactions in Shakespearean literature without being labeled as such, particularly regarding sexual assault (Ben-Ezra, 2010). MacBeth and Henry IV both allude to sleep disturbance and nightmares in response to trauma, but perhaps the most graphic depiction of a trauma reaction written by Shakespeare was in The Rape of Lucrece, in which she suffers from "guilt, self-blame, uncontrollable crying, recurrent thoughts and flashbacks of the rape, depression, fantasizing revenge, attacks of rage, and sleep disturbances like nightmares and insomnia" (Ben-Ezra, 2010, p. 236). A century later, Thomas Sydenham was among the first to discuss that hysteria was not solely a female disease, and that the male form of hysteria manifested in hypochondriasis (Veith, 1965).

In the 1700s, hysteria was reconceptualized as a nervous disease with physical origins (Veith, 1965). It was also during this time that hysteria became known as the vapors. The symptoms were essentially the same, but Whytt and his contemporaries added fleeting pain, asthma, coughing, extreme food cravings, and "giddiness" (p. 164). Treatments evolved from ancient times to include vegetable bitters, mineral waters, quinine, steel fillings, dry air, light food, exercise, and wine.

The 1700s also saw a shift in the thinking of hysteria and how to treat it (Veith, 1965). Phillipe Panel was influential during this time period. He conceptualized hysteria as a

psychological disease, and drew attention to the idea that hysteria and other mental disorders may be curable, in an era where the general thought was that they were not. He was also among the first to classify mental and physical disorders, and he did so in five categories: fevers, inflammations, bleeding disorders, neuroses, and organic lesions. Pinel also believed that mental disorders could be moral in nature; this fell in line with his philosophy of moral treatment, which resembles modern, traditional psychotherapy in that it focuses on the welfare of the client and the role of the environment in shaping behavior (Sprafkin, 1977).

Speculation as to the causes of hysteria continued to evolve through the 1700s (Veith, 1965). Baron Ernst von Feuchstersleben believed that people were predisposed to hysteria if they were selfish, privileged, bored, scholarly, or experienced adversity. He approached treatment of hysteria and hypochondriasis in three ways: toward the causes, the manifestation, and prevention of recurrence (p. 191). He was also among the first in the field of psychiatry to emphasize the importance of dream analysis when examining patients who were hysterical. Freud was directly influenced by this idea in his practice.

Charcot was further able to give specificity to the disease of hysteria, or what became known as “great neurosis” during his time period (Gelfand, 2000, p. 221). He developed the Hospital de la Salpêtrière into a neurology institute, and conducted research on the patients housed there who were afflicted by many neurological diseases, including hysteria (Kumar, Aslinia, Yale, & Mazza, 2011). He found that hysteria manifested in similar ways in all of his patients; as a result, he was able to cluster the symptoms of hysteria into three categories: speech disturbances (e.g., mutism or aphasia), disturbance of the senses (e.g., temporary blindness or loss of hearing), and motor disturbances (e.g., tics, convulsions, or paralysis; Vieth, 1965). While Charcot held the common belief that hysteria was an organic disease, he also posited that people

with hysteria were highly suggestible based on the situations in which they were put or when they felt that it might be most necessary for them to manifest symptoms, even going so far as to suggest that a hypnotic state was a hallmark symptom of hysteria. Charcot also saw trauma as being significant in the manifestation of hysteria; he called traumatic memories "parasites of the mind" (Charcot, 1887, as cited in van der Kolk & McFarlane, 1996, p. 9). Because of this, he advocated isolation as a part of treatment for patients who were suffering from hysteria (Veith, 1965).

A shift in the thinking about hysteria and its origins started to take place around the end of Charcot's life (Veith, 1965). Pierre Janet was among the first to conceptualize hysteria as a mental disorder potentially rooted in trauma, while simultaneously minimizing the physical manifestations and origins. Hysteria, as defined by Janet (1901), "…is a mental disease belonging to the large group of the diseases due to weakness, to cerebral exhaustion; it has only rather vague physical symptoms" (p. 528). Janet also recognized the importance of the subconscious and its role in hysteria, acknowledging that "…one could not treat the hysterical accident before having reached those deep layers of thought within which the fixed idea was concealed" (Veith, 1965, p. 252). The emerging field of psychoanalysis during this time held that traumatic neurosis, as it was called, was the "pathological persistence of defense mechanisms employed to ward off unacceptable unconscious wishes and impulses" (p. 6). As these wishes are continually denied over time, the defense mechanisms become automatic reactions (Shapiro, 1965, p. 7, as cited in van der Kolk & McFarlane, 1996).

Charcot (1887) discussed that a traumatically induced 'choc nerveux', directly translated as "nervous shock", could put patients into a state similar to hypnosis (as cited in van der Kolk, Weisaeth, & van der Hart, 1996, p. 49). In Charcot's description of hysteria, which he termed the

"great neurosis", he became the first to describe suggestibility in people who have suffered trauma and associate it with the emerging psychoanalytic idea of hysteria. During this time, there was debate about the origins of the traumatic reaction. There was also debate over whether the actual trauma caused the reaction to it, or preexisting genetic or situational vulnerabilities (e.g., secondary gain) caused it. Perhaps most compelling from this time, the debate ensued about whether a traumatic reaction was caused by moral weakness, or whether it was an involuntary response to stress or trauma.

Freud held the belief that hysteria was related to seduction and sexuality (van Haute & Getskens, 2004) and he posited that the memory repression and reliving that were hallmark to hysteria were not the result of failure to integrate a traumatic memory, but rather the active avoidance of it via ego defense mechanisms (e.g., repression and suppression; van der Kolk, 2007). He believed that hysteria was a pathological reaction to trauma, and that hysteria was an entirely psychological reaction, as opposed to psychosomatic (van Haute & Getskens, 2004). He also believed that it was not experiences that produced a trauma reaction, but the memories of past childhood sexual experiences that emerged as a result of a traumatic experience. Freud also posited that the origin of one's hysterical reaction could be traced back to their seduction by an adult before the age of four. Freud's seduction theory posited that perversion of children was impossible because they are not capable of a sexual response. As a result, children were not able to conceptualize the negative impacts of early childhood sexual abuse until the emergence of sexual instinct (Atkins, 2005). Freud also believed that hysteria originated from an experience as a child in which "the child is passive and experiences unpleasure" (van Haute & Getskens, 2004, p. 13). As Freud's seduction theory evolved in to his perversion theory, so too did his idea of the origins of hysteria. Freud's theory of perversion also conceptualized the Oedipal and Electra

complexes, which posited that children had the capacity to be sexually attracted to their opposite-sex parent (Veith, 1965). This evolution also meant that it could be assumed that children were sexual beings.

There was also much work done by Freud in the area of repressed traumatic memories (Monson, Friedman, & La Bash, 2007). This informed psychoanalytic treatment of trauma by retelling of the traumatic event in order to facilitate emotional catharsis. This later influenced trauma-focused cognitive behavioral therapy (TF-CBT), particularly prolonged exposure techniques.

Freud also held the belief that when people experience trauma, they cannot integrate it into their consciousness; as a result, they become fixed (Monson, Friedman, & La Bash, 2007). This was portrayed in his study of Little Hans (Garber, 2001). After threat of castration and the birth of his sister, Little Hans developed a phobia of horses and was unable to leave his house. Out of this study and others like it (e.g., Anna O.) sprung Freud's theory that phobias are borne of a child's sexual impulses, and how they resolve the stage of development in which the Oedipal Complex emerges. Pierre Janet agreed (Monson, Friedman, & La Bash, 2007). He held the belief that personal consciousness is the central issue in psychological health. Janet believed that awareness of personal past along with accurate assessment of one's current situation predicts one's capacity to respond to stress and trauma. In Janet's view, when someone experiences crisis in response to trauma, it is because they are not able to match what is happening with existing cognitive schemes, and as a result, one is unable to integrate the traumatic memory into personal awareness. This results in an effort to keep traumatic memories out of conscious awareness, which can interfere with one's capacity to learn from experience. Janet also found that this inability to integrate traumatic memories could result in dissociation, which was a direct

continuation of Charcot's concept of "the great neurosis" (Herman, 1992). This finding was simultaneously discovered by Freud, who called it "double consciousness" (p. 12). Freud's and Janet's work was noteworthy for modern-day conceptualizations of the trauma reaction, particularly relating to the ideas of synthesis and integration as part of treatment, such as exposure therapy and TF-CBT (Monson, Friedman, & La Bash, 2007).

Ferenczi, a contemporary and collaborator of Freud's, had different ideas (van Haute & Getskens, 2004). As Freud's perversion theory was emerging, Ferenczi was working on his own theory of hysteria, which incorporated seduction and trauma as its central tenets. Ferenczi believed that trauma and hysteria arise from a "confusion of tongues" between an adult and a child in that the parent takes on the role of the aggressor by providing an experience to which a child cannot assimilate, sexual or otherwise. As a result, the child does not have the coping mechanisms necessary to defend themselves, and they begin to sympathize and identify with the aggressor. Ferenczi also discussed the importance of the environment and how it elicits a trauma reaction through the social cues of adults in said environment: "the child introjects all of these interconnected reactions by the adults and comes to identify with the seducer and his feelings of guilt, and with the silence of the adults" (p. 91). There was very little research done on childhood victims of sexual assault before Ferenczi studied them; as a result, his views were so controversial that his discussion on this topic was not published in English until 17 years after his death (Monson, Friedman, & La Bash, 2007).

During this time period, the debate continued: is the traumatic reaction organic or psychological? While it may be clear that Freud and his contemporaries saw the traumatic reaction as purely psychological, there were others who disagreed (van der Kolk, 2007). Perhaps the pioneer of the idea of hysteria being a biological disease was neurologist Jean-Martin

Charcot. While he eventually partially rejected this notion, he was known to hold a belief that hysteria was caused by brain lesions (Gelfand, 2000). It was through Charcot that the notion of choice became central to the discussion of the treatment of hysteria and neurosis (van der Kolk, 2007). The treatments that Charcot proposed for hysteria, "causal will therapies", introduced physical exercise into treatment as a means to facilitate a desire for better health in his patients. This was not curative, and was in fact so painful at times that his patients, often soldiers, would go back to duty to escape it.

During the late 19th century, Carter outlined three major factors influential in the development of hysteria: temperament, the event, and the degree of repression of the causes (Veith, 1965). He believed that because women were more sensitive, this made them more susceptible to hysteria, and that this could be linked to the differences in sexual drive between men and women. Carter also believed that hysteria was a psychological disease, and did not believe that hysteria was caused by defects in the reproductive system. Carter believed that there were three levels of hysterical symptoms; "primary attacks" were seizures. "Secondary" attacks were caused by recalling of emotions that led to the primary attack, and he saw "tertiary attacks" as similar to secondary attacks, but entirely voluntary. He also believed that symptoms that evolved to tertiary attacks were borne from a desire for sympathy. In regard to treatment, Carter believed that treating other conditions (e.g., anemia) that could raise the risk of developing hysteria could prevent it, and that this could be done via iron fillings and cod-liver oil (p. 205). Carter, much like his predecessor, Pinel, believed that moral treatment was the most effective for hysteria.

The first discussions of what we now know as Posttraumatic Stress Disorder (PTSD) happened during the late 19th century (van der Kolk, 2007). Hermann Oppenheim was the first to

use the term “traumatic neurosis”; he also discussed the idea of soldiers having posttraumatic reactions. Traumatic neurosis was seen as a biological disorder, and this was favorable for the soldiers of this time; they were allowed to leave battle without being seen as cowards if traumatic neurosis was seen as a biological problem. He was first to describe suggestibility in people who suffered from “choc nerveux”, and likened hysteria to a mental state similar to hypnosis. This was the start of the discussion of the dissociative component of PTSD. His view was ultimately rejected, but he was influential in the idea of hysteria being considered a neurological disease.

Emil Kraepelin disagreed with Oppenheim’s assessment (Decker, 2004). While he believed in a biological origin of the traumatic reaction, used the terms “hysterical” and “weak-willed” synonymously (p. 256). He also believed that the problem with hysterical people was that their self-control was weaker than that of nonhysterical people, that they were unable to act of their own accord, and that this manifested itself in both physical and emotional symptoms. He believed this to be especially true of women and children, either with or without hysteria. He also believed that soldiers with combat neurosis were insubordinate, and even deserters. Kraepelin believed that receiving benefits, such as a pension, for combat neurosis was serving as a reward or enabler of hysterical behavior in people who lived with combat neurosis or hysteria.

Study of the trauma reaction continued into the 20th century and mostly applied to soldiers (van der Kolk, 2007). The term “shell shock” was coined by Charles Samuel Myers during World War I. Myers saw the trauma reaction as emotional because traumatic neurosis was seen in soldiers who had never fought. Shell shock closely resembled previous descriptions of hysteria. Shortly after World War I, Bonhoeffer’s theory emerged, stating that traumatic neurosis was a social illness and as such, could only be cured by social means. In a study done of 142 people with traumatic neurosis, Bonhoeffer found that they were predisposed to developing it.

As a result, treatment focused on patients' "inherent weakness", instead of prevention or treating the problem directly. As with Kraepelin, Bonhoeffer and his contemporaries believed that the people afflicted by traumatic neurosis were enabled to not seek treatment and continued having symptoms because they were still being paid. This resulted in a widely held belief that traumatic neurosis was incurable as long as patients experienced secondary gain via monetary compensation. Ideas like his are still influential in some areas of the world today, where things such as disability payments or pensions are much smaller than in other areas of the world, particularly for soldiers.

Abram Kardiner has been considered more influential to the diagnosis of PTSD than anyone else in the field (van der Kolk, 2007). Through his work, he observed symptoms, many of which still apply to modern diagnosis, including hypervigilance, hyperarousal, irritability, nightmares, heightened startle reaction, and aggression. Kardiner (1941) posited that symptoms of traumatic neurosis emerged because the ego was constantly trying to ensure security and protect itself by repressing the trauma (as cited in van der Kolk, 2007). He also introduced the concept of the Sisyphus dream, in which activities that a person "engages upon is greeted with a certain stereotyped futility as a result of being stuck in the trauma (p. 27); this could be called beginnings of a hallmark symptom of PTSD, which is a sense of a shortened or nonexistent future (p. 26; American Psychiatric Association, 2013). Kardiner was also a revolutionary influence of the idea that trauma memories are not only related to the trauma itself, but can also be generalized and triggered by a wide range of experiences that may be related to the trauma itself; this can account for fixation on the trauma (van der Kolk, 2007, p. 27). Kardiner also discussed the idea of trauma permanently altering one's concept of their world, and acknowledged the idea, which still holds true today in trauma therapy, that one's normal coping

strategies failed when applied to the original trauma, thereby altering their ability to cope with memories associated with it.

Between 1895 and 1974, much of the focus of trauma study was on males (van der Kolk, 2007, p. 29). As the study of trauma evolved through the 1970s, Burgess and Holmstrom (1983) noticed that many of the symptoms of trauma that were previously thought to only affect veterans, such as flashbacks and nightmares, were also experienced by rape victims (as cited in van der Kolk, 2007). Through the study of rape victims in the 1970s, literature was written primarily by feminists and held to six common themes: sense of personal outrage over the violation; lack of ability to make sense of the event, even to oneself; identity after a rape; frustration with the system's ineptitude on how to treat the victims; lack of consistent guidelines about the benefits of pursuing legal action against attackers; and lack of understanding around why rape occurs, and who the perpetrator was (Midlarsky, 1980, as cited in Burgess, 1983).

When the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* was published and included PTSD for the first time, the original criteria for a stressor was simply that a traumatic event occurred "outside the range of usual human experience" (American Psychiatric Association, 1987, p. 247). It went on to characterize trauma as involving "a serious threat to one's life or physical integrity; a serious threat or harm to one's children, spouse, or other close relatives and friends; sudden destruction of one's home or community; or seeing another person who has recently been, or is being, seriously injured or killed as the result of an accident or physical violence" (pp. 247-248).

The definition of trauma continued to evolve through later editions of this publication, adding other criteria to include a response of "intense fear, helplessness or horror" (American Psychiatric Association, 2004, p. 463). This edition also allowed for the idea that short-term

trauma reactions were possible by including a diagnosis of Acute Stress Disorder for reactions to stress and trauma "lasting less than one month" (p. 469). The symptom clusters associated with both of these disorders included re-experiencing of the traumatic event, persistent avoidance of stimuli associated with it, and increased arousal.

Today, with the most recent edition of the Diagnostic and Statistical Manual, the definition of how one can react to a traumatic has evolved to include dissociation, and allows for the idea that fear, helplessness, and horror may not be a part of the initial reaction to a trauma (American Psychiatric Association, 2013). It was also acknowledged in this edition that someone may still suffer from a traumatic reaction while not fully meeting the criteria for PTSD, and that this is likely more common than meeting the full criteria, particularly in adulthood. The full diagnostic criteria for PTSD include symptom clusters of re-experiencing the trauma, avoidance of trauma stimuli, persistent changes in cognitions and mood, and arousal.

Table 1
Timetable of Theories of Trauma, from Most Recent to Least Recent (Veith, 1965; American Psychiatric Association, 1987, 1994, 2013)

Theorist	Time Period	Concept of Trauma
American Psychiatric Association	2013-Present	• Publication of Diagnostic and Statistical Manual of Mental Disorders, 5th Edition; expansion of definition of trauma to include DSM-IV definitions, and add learning of traumatic event and experiencing repeated or extreme exposure to aversive details of a traumatic event (e.g., first responders; p. 271) • Omission of "fear, helplessness, and horror" as a reaction to trauma • Symptom cluster of PTSD expanded to include re-

		experiencing, avoidance, persistent negative alterations in cognitions and mood, and arousal
American Psychiatric Association	1994-2013	• Publication of Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV); trauma conceptualized as direct experience of an event that threatens death, serious injury, or threat to physical integrity, and newly includes witnessing of any of these events as they pertain to "a family member or other close associate" (p. 463). • Includes definition of traumatic response, including "intense fear, helplessness, or horror" • Includes examples including combat, but expands from DSM III to include sexual assault, physical attack, robbery, mugging, kidnapping, hostage situations, terror attacks, torture, incarceration as a prisoner of war or in a concentration camp, natural disasters, accidents, or diagnosis of life-threatening illness (pp. 463-464) • Symptom clusters for PTSD include re-experiencing, avoidance or numbing, and arousal
American Psychiatric Association	1987-1994	Publication of Diagnostic and Statistical Manual, Third Edition (DSM III); trauma defined as "outside the range of normal human experience" and involved a "serious threat to one's life, physical

		integrity", loved ones, or property.
Ann Burgess and Lynda Holmstrom	Birthdates unknown Research in the 1970s	Discovery that symptoms of rape trauma syndrome were similar to those experienced by soldiers in combat
Abram Kardiner	1891-1981	• Symptom cluster of traumatic neurosis emerged as a result of his work: hypervigilance, hyperarousal, irritability, nightmares, heightened startle reaction, and aggression. • Sisyphus Dream: first concept of avolition as a result of a sense of shortened future; this would later become a hallmark symptom of Posttraumatic Stress Disorder. • The idea emerged as a result of his work that symptoms of trauma can generalize to other areas of life.
Charles Samuel Myers	1873-1946	• Coined the term "shell shock" to reflect the cluster of symptoms of traumatic reaction associated with combat. • Symptoms of shell shock closely resembled those of early conceptualizations of hysteria.
Sándor Ferenczi	1873-1933	• Seduction and trauma were the causes of hysteria • Trauma reaction dictated by social cues of adults • Trauma can be caused by confusion of tongues between an adult and a child that can cause the child to identify with the adult, who is considered the aggressor

Emil Kraepelin	1856-1926	• People afflicted with hysteria were weak-willed • Self control among people with hysteria was weaker than nonysterical people • Women and children are inherently weak willed • Combat neurosis equated with insubordination • Introduced the idea of secondary gain as an enabler of symptoms of traumatic neurosis
Hermann Oppenheim	1858-1919	• Coined the term traumatic neurosis, and posited that it was a biological illness • Soldiers can have posttraumatic reactions
Robert Brudenell Carter	1828-1918	• Causes of hysteria: temperament, the event itself, and degree of repression • Believed hysteria to be psychological, and that women were more susceptible because they were more sensitive than men • Continuation of Pinel's modality of moral treatment
Sigmund Freud	1856-1939	• Little Hans • Perversion theory • Traumatic reactions happen because the traumatic experience cannot be integrated into one's consciousness • Hysteria was related to seduction and sexuality • Reliving and repression of traumatic memories was not a failure to integrate the memory, but active avoidance

		of it via ego defense mechanisms (e.g., repression, reaction formation) • Origin of hysteria can be traced back to seduction by an adult before the age of four • Discovered that hysteria was caused by trauma at the same time as Janet
Pierre Janet	1859-1947	• Hysteria is rooted in trauma • One's capacity to respond to trauma is dictated by their personal past and an accurate assessment of their current situation • Crisis is borne from an inability to match a traumatic event with existing cognitive themes • Discovered that hysteria was caused by trauma at the same time as Freud • Beginning of link between trauma and hysteria
Jean-Martin Charcot	1825-1893	• Hysteria is a biological illness caused by lesions on the brain and could be treated with causal will therapies (e.g., exercise) • Founded Salpêtrière, which was a hospital in which people with hysteria were studied • Through study at Salpêtrière, it was found that hysteria manifested similarly in all patients • Clustered symptoms of hysteria: o Speech disturbances o Motor disturbances o Disturbance of the senses

Baron Ernst von Feuchstersleben	1806-1849	• People are predisposed to hysteria if they are selfish, privileged, bored, scholarly, or have had unfortunate life experiences • Treatment of hysteria focused on causes, manifestation, and prevention of recurrence • First to highlight importance of dream analysis
Philippe Panel	1745-1826	• Hysteria was a psychological disease • Mental disorders were moral diseases
Thomas Sydenham	1624-1689	• Introduced the idea that hysteria was not a solely female disease • Hysteria manifested as hypochondriasis in males
François Rabelais	1483-1553	• Hysteria was caused by witchcraft and moral failing; as a result, women who suffered from it were thought to be witches and killed • Uterus was considered to be an organ of its own volition; when women could control their uterus, they could avoid hysteria • Hysteria was a physical disease
Hippocrates	460-370 BC	• The seat of hysteria was in the brain, and epilepsy and hysteria were seen as linked diseases

Ancient Egypt and Mesopotamia (2000-1000 BC)	• Hysteria was thought to be a disease that only affected females • Caused by a "wandering womb"
2094 BC	• Beginnings of hysteria as a pathology, which would eventually evolve into trauma

Trauma and Criminal Behavior

Widom and Maxfield (2001) conducted a longitudinal study relating childhood abuse and neglect to later delinquency. This comparison study was done on a group of 908 children involved in substantiated cases of childhood abuse and neglect and 668 children who were not officially recorded as abused or neglected. The researchers followed the children involved in these cases by examining their arrest records in adulthood in 1988 and 1994. Widom and Maxfield (2001) found that childhood abuse and neglect could increase the likelihood of future delinquency by as much as 29%. They also found that being abused or neglected as a child increased the likelihood of juvenile arrest by 59%, arrest in adulthood by 28%, and the likelihood that these were arrests for violent offenses increased by 30% (p. 1). Forty nine percent of the people studied had been arrested, but for some sub-groups, such as males, almost 66% had been arrested (p. 7).

Woodson, Hives, and Sanders-Phillips (2010) stated that adolescents who have been exposed to violence either through witnessing it or being victimized were more likely to engage in risky behavior, such as delinquency, substance abuse, and unprotected sex. While normal adolescence is marked by a lack of consideration of future consequences and impulsivity, this is particularly true of adolescents who have been exposed to violence. This can raise the likelihood of engaging in delinquent behaviors, as well as the likelihood of recidivism. In a discussion of

recidivism, Quinn and van Dyke (2004) indicated that those most likely to recidivate would do so within six months of release from incarceration or treatment. DuCloux (2003) said that a holistic approach could be effective in reducing rates of recidivism by helping to moderate the negative effects of violence exposure. This could include education, development of social skills, and family interventions (Quinn & van Dyke, 2004).

Belknap and Holsinger (2006) noted that childhood abuse is a significant risk factor for criminal behavior, both in adolescence and adulthood. The differences in trauma reactions between females and males are significantly different; for instance, running away is seen as criminal behavior, and is more often perpetrated by girls as a means to get away from an abusive situation (Gilfus, 1992, as cited in Belknap & Holsinger, 2006). Girls experience greater depression, more attempts at suicide, and a decrease in self-concept than boys after a traumatic experience (Miller et al., 1995, as cited in Belknap & Holsinger, 2006).

The history of violence in the home is also a risk factor for adult and juvenile delinquency. Belknap and Holsinger (2006) stated that women may sometimes use incarceration as a means to escape unsafe situations. They also reported that girls were more likely than boys to report that they would rather be living in the delinquent institution than living at their home.

Self-esteem among trauma survivors may also be important to consider in its implication in the commission of crime. According to Belknap and Holsinger (2006), a significant number of participants in their research study reported that they agreed with negative statements such as “I wish I could have more self-respect”; almost half reported that they felt useless at times. Moreover, more than one third agreed with the statement, “sometimes, I think I am no good at all” (p. 62). Nearly 25% of participants agreed with the statement, “I do not have much to be proud of”, and 15% agreed with the statement, “I am a failure” (p. 62). This outlines a significant

need for programs in prisons and other placements that aim to enhance the self-esteem of people who are incarcerated.

The Traumatic Experience

McFarlane and de Girolamo (1996) divided traumatic stressors into three different types: time-limited events, sequential stressors, and long-term exposure. The commonality among these types of events is the subjective experience of fear. This can have a significant impact on one's ability to make sense of their perceptions of themselves and others, as well as impede the capacity for interpersonal interaction. Another commonality is the idea that people can become stuck in their traumatic experiences, thereby causing them to fixate on the event or time period in which it occurred. This can cause the person who experienced trauma to relive it and for it to become generalized into their everyday experiences.

McFarlane and Yehuda (1996) also discussed that PTSD is not the only possible consequence of experiencing trauma. They discussed that people can be vulnerable to traumatic events and a trauma reaction, regardless of the symptoms expressed. "In particular, the meaning of a threat or traumatic loss can lead to a major shift in an individual's internal perceptual sensitivities" (van der Kolk, 1989, as cited in McFarlane & Yehuda, 1996, p. 166). They also argued that trauma can have a shift in a positive direction for a person, resulting in changes in their self-perception in terms of strength and resilience.

The notion of posttraumatic growth stems from the idea that traumatic events, while they have the potential to challenge a person's core beliefs, they can also elicit positive change in self-concept, relationships, and the meaning of one's life (Triplett et al., 2012). In a quantitative inquiry exploring the impacts of the past trauma of 98 men and 235 women, Triplett et al. (2012) found that when a traumatic event forces a person to reevaluate their worldview, it can be a

springboard toward future posttraumatic growth, and that this can lead to future psychological well-being.

Part of what makes trauma such an interesting area of study is its subjective nature. According to van der Kolk and McFarlane (1996), trauma is different than other psychological phenomena because of the subjective meaning of the experience; in other words, what one person experiences as trauma is not necessarily so for another. "…the critical element that makes an event traumatic is the subjective assessment by victims of how threatened and helpless they feel" (p. 6). This can depend on several factors, but the meaning that one attaches to a potentially traumatic experience is rooted in their past experiences and how they are incorporated into their current worldview.

Part of what makes trauma such a thought-provoking area of study for prisoners is the link between the experience of trauma, either in childhood or adulthood, and later criminal activity (DeHart, 2008). This can include victimization as a child in the form of sexual, physical, or emotional abuse, or it can include the witnessing of victimization of loved ones, such as intimate partner violence. These experiences can also occur in adulthood, and have the capacity, if unaddressed, to change a person's worldview and facilitate the development of disorders and maladaptive coping skills in reaction to the trauma that they have experienced, including the commission of crime.

The Difference between Crisis and Trauma

A crisis is defined as an event that occurs when one is confronted with an unsolvable situation (Caplan, 1964, as cited in Dass-Brailsford, 2007). These can result in a traumatic reaction, and can result in an individual's inability to cope effectively. The characteristics of a crisis event include a perception of threat, an inability to reduce the impact of the event,

increased fear or confusion, excessive discomfort, and disequilibrium followed by a “rapid transition to an active state of crisis” (p. 94). The speed at which one can resolve a crisis situation and the impact that it has on one’s life can dictate whether or not a crisis evolves into a trauma. The examples below, because of the potential of their long-term impact and the inability of the experiencer to resolve them quickly, have been characterized as traumas in the context of this literature review.

Child Abuse and Neglect

An individual who demonstrates criminal behavior often has a history of childhood abuse (e.g., emotional, physical, or sexual). DeHart’s (2008) study on pathways to criminal behavior, qualitatively investigated 60 women in a maximum-security prison using open-ended interviews. Findings included information on how victimization can have both a direct and indirect influence on one’s tendency toward criminal behavior. It was found that for many of the participants studied, their criminal activity started when they were girls. A caregiver or respected adult would provide them with drugs or alcohol, or would commit acts of abuse against them. This pushed them out of what DeHart (2008) termed “the pathway to legitimacy”, and toward the commission of crime (p. 1377).

Abuse history is more likely in the prison population than in the general population, and more prevalent among female prisoners than male prisoners. Some studies put the rates of abuse history at 70% in a New York study (Maguin, 1999, as cited in Bloom et al., 2002) to 80% of a sample in California (Owen & Bloom, 1995; as cited in Bloom et al., 2002). The Bureau of Justice Statistics (1999) reported that nearly 60% of female prisoners reported a history of physical or sexual abuse.

> Child maltreatment, according to federal standards, is defined as:
>
> …at a minimum: any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act, which presents an imminent risk of serious harm" (United States Department of Health and Human Services, 2012, p. 110).

In a study conducted by Dale et al. (2009), neglect was the most common type of maltreatment, followed by physical abuse, sexual abuse, emotional abuse, and medical neglect (p. 299). Maltreatment does not necessarily result in PTSD, but it still can impact the daily lives of people who have been victims of abuse or neglect. This can impede one's ability to form healthy social relationships, personality changes, an inability to regulate one's emotions, and developing maladaptive coping skills. When discussing child abuse, Steele (1987a) highlighted four conditions necessary for its occurrence: a caretaker with a predisposition to abusive behavior as a result of abuse or neglect in their own early life, a crisis that causes stress to the caretaker, lack of support for the caretaker, or a child who is considered by the caretaker to be inadequate to meet their needs (p. 89).

Belknap and Holsinger's (2006) quantitative investigation of 163 adolescent female and 281 male delinquents found that two thirds of the girls studied reported verbal abuse from a family member, and more than half of the girls reported verbal abuse by someone outside their family system. Physical abuse in this study was characterized as "spanking, slapping, pushing, grabbing, having something thrown at you, kicking, hitting, beating, choking, burning, and having weapons used or threatened to be used" (Belknap & Holsinger, 2006, p. 56). They also found that 75% of the girls interviewed reported physical abuse by a family member, and more than 60% of the girls reporting repeated physical abuse. When discussing sexual abuse, Belknap

and Holsinger (2006) defined it as any type of sexual abuse that involved physical contact. Almost 60% of girls studied said that they had received unwanted sexual contact either by someone in or outside of the family. Of those girls that reported unwanted sexual contact, nearly 50% reported that it happened repeatedly over time. Nearly half of the respondents who indicated that they had received unwanted sexual contact, many reported having more than one abuser. Almost half of the youth in this study believed that their history of victimization was related to their delinquency, and girls were more likely to report the relation between these two phenomena than boys.

In discussing family violence, Straus and Kantor (1987) noted that there is irony in family life in that while family can be a source of respite from stress, it can also cause it. Straus and Kantor (1987) also noted the paradox that the "…family is, at one and the same time, the most physically violent group or institution…and also the group to which most people look for love, support and gentleness" (p. 42). Straus and Kantor (1987) also drew a causal link between stress and abuse, stating that the high rate of child abuse may be caused by this inherent stress and conflict in family systems (p. 43).

There are many forms of family violence. Some of these include physical abuse or neglect, either by parents, other caretakers, or siblings; intimate partner violence, both experienced directly and witnessed by a family member; or sexual abuse. In the United States, in 2009, 702,000 children were victims of maltreatment (U.S. Department of Health and Human Services, 2010, as cited in Renner, 2012). It was estimated in this same publication that 15.5 million children lived in families in which intimate partner violence occurred.

Straus and Kantor (1987), in a quantitative study of 1,146 participants between the ages of 18 and 70, found several factors in family systems that enabled the escalation from stress to

violence. These included the normalization and legitimization of violence as a means of punishment; the universality of family violence in the American culture; and inability to leave a family in which there is violence due to the involuntary nature of being a member of it. In the incidence of family violence as punishment for behavior, there are four lessons: unintended consequences of equating love with violence, the moral "rightness" of hitting loved ones, the justification of violence as a means of communicating importance of an issue, and the normalization of violence as a reaction to stress

When a child is exposed to family violence, it can result in externalizing behavior (Renner, 2012). This type of behavior is characterized by aggression, hyperactivity, and delinquency. In a quantitative inquiry by Renner (2012) of 2,572 children ages 3—18, with approximately 42% of the sample having experienced some form of family violence, likelihood of occurrence of externalizing behavior increased throughout childhood, with the highest likelihood of externalizing behavior being linked to witnessing violence against a sibling. Renner (2012) posited that indirect victimization, or the witnessing of violence against a family member, may have an equally negative effect on a child as experiencing it directly.

Sexual Assault

According to DeHart (2008), like physical violence, sexual violence may also play a role in the later commission of crime. In this study, sexual victimization seemed to underscore the experiences of most of the women. Many of the 60 women studied were prostituted as children, which in turn led them to run away from home and become prostitutes themselves as a means of income. The sexual abuse that they experienced did not only have a negative impact on their mental health, but also on physical health, including Human Immunovirus (HIV), other sexually transmitted infections, and unplanned pregnancies. This also had an impact on their

relationships, and served to push them out of the mainstream and toward the commission of crime.

The legal definition of rape varies from state to state, but generally includes provisions that address “lack of consent, force or threat, and sexual penetration” (Burgess, 1983, p. 97). However, this definition does not address the psychological ramifications of sexual assault. To address this, the clinical definition includes “somatic, cognitive, psychological, and behavioral symptoms” associated with the incidence of rape (p. 97). This can include intrusive thoughts and memories, nightmares, depression, hypervigilance, and emotional numbing, among other symptoms.

Sutherland and Scherl (1970) proposed a three-phase syndrome of reaction to rape. The acute phase includes shock and disbelief followed by fear and anxiety (as cited in Burgess, 1983, p. 99). Phase two is called pseudo-adjustment and is marked by denial, suppression of affect, and rationalization (p. 99). This phase’s purpose is to regain balance and return to normality; during this phase, a person who has been sexually victimized is less likely to seek help. In the final phase, called integration, self-blame and depressive symptoms are common, and the victim may turn their anger toward the assailant, or they may internalize it.

Intimate Partner Violence

Intimate partner violence can influence a tendency toward commission of crime in many ways. Indeed, in DeHart’s (2008) study, there were several direct pathways toward criminal activity as a direct result of intimate partner violence experienced by the 60 women in the study. Not only were these women isolated from the social supports that may have helped to get them out of their dangerous situation, but the isolation made commission of crime a means of safety for many of these women. Crimes committed by women who were survivors of intimate partner

violence included murder of their partner, theft, which was committed via coercion or threat from an intimate partner, and other crimes as a "direct response to physical victimization" (p. 1365).

Intimate partner violence has been a common social phenomenon for centuries, at times being a social norm (Bowker,1983). In the context of this literature review, intimate partner violence is defined as physical violence between intimate partners, with a male partner often, but not always, being the initiator of violence against a female partner. Violence in intimate relationships can be extensive, frequent, and occur for extended periods of time. It can also involve beating, rape, emotional violence, or a combination of any of these three factors.

While there are ways that women attempt to end intimate partner violence by nonviolent means, there are instances where the only option that they may see is violence in order to stop violence. According to Bowker (1983), there are seven common strategies that battered women use in their attempts to end marital violence: attempting to talk the batterer out of abusive behavior; attempting to get the perpetrator to promise to stop abusing them; threatening nonviolent actions (e.g., divorce, contacting the police); going into hiding, either with a loved one or into a shelter; attempting passive self-defense against physical attacks; aggressively fighting back; or avoiding the abusive partner prior to eruption of aggression. According to Campbell (1986), women convicted of spousal homicide were far more likely than males to commit acts of aggression in response to violence, as opposed to initiating it. "The factor common to these studies of battered women who murdered their abusers is the intensity of the physical and psychological immediacy of that final episode of domestic violence" (pp. 47-48).

Trauma and its Implications on Development and Attachment

There is evidence that trauma, particularly child maltreatment, can interrupt attachment and normal development. This can lead to delinquent behavior across the lifespan (Smith, Park, Ireland, Elwyn, & Thornberry, 2013). In a longitudinal study of data from the Rochester Youth Development Survey on the causes of delinquency and drug use among 1,000 people from adolescence through age 23 from an urban community, it was found that maltreatment was a "significant predictor" of later criminal activity and violence, regardless of mitigating factors (e.g., a supportive educational environment; p. 142).

Personality traits are defined as "enduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts" (American Psychiatric Association, 2013, 647). Bychowski (1968) posited that trauma can cause lasting, often permanent, changes in the personality, such as aggression, rage, loss of goal orientation, and inability to take action. By observing 40 concentration camp survivors, Bychowski (1968) noted that they all experienced permanent personality changes as a result of the trauma through which they lived. Examples of these personality changes included depression, anxiety, traumatic neurosis, aggression, hostility, blunted affect, apathy, and perpetual terror, among others; before the Holocaust, they were described by loved ones as "friendly, outgoing persons who were open toward the world and full of affirmation of life and optimism" (p. 77). The traits listed above have evolved, but the general core of symptoms has remained the same. In the diagnostic criteria for PTSD, the American Psychiatric Association (2013) echoed these personality changes due to trauma, including depressive symptoms, aggression, social withdrawal, hypervigilance, heightened startle response, and apathy, among others (p. 273).

Trauma can have deleterious effects on a person, regardless of their developmental stage.

Developmentally, normal aging may not happen because coping mechanisms that have worked in the past for people who have suffered trauma no longer work, such as hard work and taking care of the next generation (Leon et al., 1981, as cited in Fridman, Makermans-Kranenburg, Sagi-Schwartz, & van Ijzendoorn, 2011, p. 233). Because of maladaptive patterns that may have been present as a result of trauma, resurfacing of traumatic memories may result (Fridman et al., 2011). In a quantitative study exploring the generational and lifetime impact of trauma in 174 female Holocaust survivors and their daughters, it was found to be prevalent in Holocaust survivors, who, almost 70 years after, show more posttraumatic symptoms than those who did not experience the Holocaust. In the context of Holocaust survivors, the stress of past trauma is also a transgenerational phenomenon; in this same study done by Fridman et al. (2011), there was a positive correlation between stressful life events of survivors and the reporting of stressful life events of their daughters. Overall, 70 years later, Holocaust survivors still exhibited posttraumatic symptoms. The daughters of survivors reported more stressful life events than the control group.

In the discussion of pathways to criminal activity, DeHart (2008) posited that a future of criminal activity may begin with traumatic experiences at an early age, and that commission of crime may be a means to survive dangerous situations (e.g., physical abuse, sexual abuse, and interpersonal violence, among others). Experiencing trauma at an early age can change the worldview of children and young adults from one that the world is safe to one that it is dangerous, and in which no one can be trusted. This can in turn push them out of the mainstream and into illegal activity. Female prisoners can be driven to crime directly via retaliation, escaping, defense, or manipulation by a partner. They can be driven to crime indirectly by barriers in place that inhibit one’s ability to make choices where the end result is not prison.

Widom and Maxfield (2001) discussed the role of early intervention and the positive impact that it can have on the future commission of crime among adolescents; however, for women who have already committed crime, many of these therapeutic options are not available. This knowledge can have positive implications on the counseling and criminal justice fields by giving both correctional staff and counselors awareness of the struggles that victimized prisoners face on a daily basis, both inside prison and through their transition back into the community (DeHart, 2008). This can further facilitate the development of trauma-focused programming in correctional institutions and mental health agencies in order to help prisoners to develop coping skills that do not include the commission of crime.

Social and Emotional Development

Kempe (1987) stated that not only can abused children suffer physical damage, but also permanent alterations to their personality. These alterations can be severe and may coincide with the severity of the abuse, as well as the developmental age of the child at the time of the abuse. Kempe (1987) also discussed the idea that abuse and neglect can begin even before birth when a pregnant mother neglects her needs, thereby neglecting the needs of her unborn child. When physical abuse is perpetrated on infants, the risk of permanent injury to the underdeveloped central nervous system is severe and can result in cerebral palsy, blindness, developmental delay, and failure to thrive, among other difficulties (pp. 360-361). Even without the presence of physical injury, children who have been abused “still suffer significant developmental damage when there are early and sustained difficulties in parenting” (p. 361). This can disrupt attachment between the parent and child, which can also result in the child’s missing major emotional and physical developmental milestones, such as trust, object permanence, or establishment of an identity.

Kempe (1987) also discussed that when parenting is inconsistent, it makes it nearly impossible for a child to conceptualize what productive parenting is supposed to look like. This early normalization of inconsistent parental behavior can lead to black and white thinking in a child, as well as generalization of these unhealthy patterns to other relationships. As a child grows through adolescence into adulthood, this may manifest in inability for the person to relate to others, social isolation, unstable relationships, poor self-esteem, fear of failure, developmental and cognitive delays, and limited coping skills (p. 362). van der Kolk (2003) agreed with this idea, adding that maltreatment can also lead to aggression, disruptions in impulse control, inability to trust or to develop a capacity for intimacy, and many others. Because the abusive and inconsistent pattern of parenting is normalized by a child, it may lead to hostility and inability to interact with others, or delinquency or violence. The cycle of violence can often repeat over generations, which can lead to interactions with the legal system, in spite of wishes on the part of the abused person to change things in their own generation. Felitti et al. (1998) found that adolescents who were traumatized as children have a 300% greater chance of engaging in drug use, self-mutilation, and violent or aggressive behavior (as cited in van der Kolk, 2003, p. 295).

Steele (1987a) discussed the negative impact of child abuse on development and an ability to function for survival. It is common within abused families for the abusing parent to also be a survivor of abuse. A history of abuse may inhibit the facilitation of the ability to provide empathic care to a child. Steele (1987a) also pointed to inadequate empathy as being a contributing factor of antisocial caretaker behavior in particular. “Excessive punitive expression of aggression or neglectful disregard of a child’s basic needs could not occur if normal, adequate empathy existed in the caretaker” (p. 84).

Steele (1987a) also discussed the normalization of destructive or abusive behavior in the home. "…it is very common for physical abuse to occur as a 'justified' action or 'appropriate disciplinary punishment' when children fail to meet excessively high caretaker expectations" (p. 86). This type of abuse and neglect resulting from a child's failure to meet difficult-to-obtain expectations can lead to a significant reduction in self-esteem on the part of the child. It may be important to consider role modeling in particular and its role in a child's development of healthy coping skills and attachment styles as they age. Social learning can have an impact on an abused child by normalizing abusive and neglectful behavior (p. 88). Steele (1987a) noted that productive, empathic bonding can come from any caretaker, biological or not, and that modeling productive and healthy behavior is what helps shape a child's behavior through adolescence and adulthood.

Helfer (1987) noted that early childhood trauma may have an impact on adult functioning. "What happens during this day-to-day process has a most critical effect on functioning capabilities later in life" (p. 68). Regarding early learning, it is important for a child to participate in developmental processes that will help them to learn healthy adult behaviors, and those closest to the child to have the biggest hand in their development of these skills and behaviors. "These include interpersonal skills, that is, the ability to get along with others and to function in an acceptable and constructive manner during the interpersonal process" (p. 68). Helfer (1987) also discussed that if a child's developmental trajectory is normal before a trauma, and supports are present in the aftermath, "…the effects of these insults may not be permanent" (p. 69). However, without supportive caregivers or in an environment in which there is repeated or chronic trauma, it could very well impair a child permanently, particularly in their capacity to develop interpersonal relationships:

> Consider what happens when touching hurts, *most of the time*; smells about the house bring on very negative feelings, *most of the time*; mom's eyes show the threat of a swat; when the child listens to mom and dad talk, he becomes afraid, since the messages he hears are threats, screams, and anger. Over and over, day after day, the child is bombarded with negative sensory messages, messages that truly force the senses to 'shut down'. The child learns that it is far safer not to listen, not to look, and not to be touched, for when these senses are used, he hurts much more or receives no feedback whatsoever (pp. 69-70).

Early and prolonged trauma can cause significant deficits in a child in terms of communication and their perceptions of their environment. "Children and adults reared in abuse have had their senses trained in such a way that to use them for receiving or transmitting positive messages is not part of their communication systems" (p. 70). This could provide insight into how antisocial behavior is fostered within so many incarcerated people.

Attachment

Bowlby (1969) believed that attachment was a function of survival rooted in secondary drive theory, which states that a child becomes attached to his or her caregiver when their basic physiological needs are met. Eventually, the child comes to learn that the caregiver is the source of their needs being met. He posited that all attachment behavior in children is a function of survival. When an attachment is secure and a child grows, so too does their attachment behavior. The child begins to use their caregiver as "a base from which to explore"; at this point, the caregiver is no longer simply a source of food, but an example to whom a child looks for safety, social cues, and comfort in the face of perceived danger.

Borelli, Goshin, Joestl, Clark, and Bryne (2010) discussed attachment and its role in resiliency and emotion regulation. Insecure attachment may lend itself to a decreased capacity for emotional regulation (Cassidy, 1994; Fonagy, Gergely, Jurist, & Target, 2001, as cited in Borelli et al., 2010). In a study done of attachment styles of mothers in prison, they found that the participants had more insecure attachment styles than mothers from a sample in the community. Joubert, Webster, and Hackett (2012) agreed that disorganized attachment has a role in poor mental health among adolescents and adults. "There is strong evidence that youth who are exposed to abuse and maltreatment by caregivers are at greater risk to show disorganized, poorly integrated internal models of attachment relationships, as well as trauma related symptomatology" (p. 481).

According to Carlson and Cicchetti (1989), approximately 80% of traumatized children have disorganized attachment patterns (as cited in van der Kolk, 2003). When a child experiences disorganized attachment, it can lead to a child becoming "intolerably distressed, without a sense that the external environment will provide relief" (p. 296). Children can also experience anxiety, anger, and dependence. If extreme enough, this can result in the child dissociating or engaging in self-defeating aggression (van der Kolk, 2003). Children with disorganized attachment are unable to control their emotions or rely on others to help them (van der Kolk, 2003). This can result in "totalistic fight, flight, or freeze reactions and keeps them from learning from their experiences" (p. 296). As a result, van der Kolk (2003) posited that neglect may actually be more detrimental to a child's development than abuse.

In Bowlby's (1973) analysis of amoral children, he described them as "hostile, emotionally volatile, unable to set goals, lacking in self-esteem and impulse control, and overwhelmed with guilt" (p. 331). They closely resemble profiles of adolescent offenders, as

well as those of people who commit crime in adulthood. Families of these children were found to be inconsistent, lacking in trust and love among family members, and inconsistent, and sometimes violent in their use of discipline.

Van der Kolk (2003) posited that trauma can negatively impact attachment bonds between parent and child. Because a child's response to stress imitates that of their caregivers, if attachment is interrupted by trauma, it could also interfere with a child's capacity to reconcile and integrate traumatic memories, which can in turn result in "unfocused and irrelevant responses to subsequent stress" (van der Kolk, 2003, p. 295). When one parent is not present, it can also have an impact on a child's development; "the development of normal play and exploratory activity requires the presence of an attachment figure who helps modulate the child's physiologic arousal by providing a balance between soothing and simulation" (van der Kolk, 2003, p. 296). When healthy and secure attachment is present, it can help an infant control their stress reactions and develop connections in the central nervous system that specifically deal with stress (van der Kolk, 2003).

While attachment figures may change, a human's reliance on them does not (Bowlby, 1979). Attachment behavior, at its core, is seen as a survival mechanism from birth (Bowlby, 1969). When a child experiences fear, they begin to exhibit attachment behavior toward their caretaker; the availability of this attachment figure may dictate the attachment pattern between the parent and the child.

According to Bowlby (1969), attachment behavior comes in three stages. In the first stage, a child outwardly exhibits distress as an early survival tactic. If this fails, then the child may move on to the second stage, despair, in which the child becomes silent; this promotes

survival because excessive movement or noise may elicit attention from a predator. If this fails, then the child will detach in the interest of finding a new caregiver who can provide for them.

In the last four to five decades, there has been increased attention on child maltreatment and its effect on attachment (Kobak & Madsen, 2008). Child maltreatment can cause attachment issues by creating internal conflict for the child who experiences it; the very person to whom they feel the need to attach can be their source of distress. Insecure attachment patterns include psychological defenses against the unavailability of attachment figures. While they may be a means of adaptation, they eventually become maladaptive later in life (Mikulincer & Shaver, 2008, p. 519). These can also reduce resilience and can inhibit emotional regulation (Bowlby, 1979).

Bowlby (1973) posited that when a child experiences absence of a parent, either real or threatened, they may experience anger. This is considered a functional reaction and is how the child communicates their feelings about their parent's absence. This anger becomes dysfunctional, however, when separation is combined with threats or abuse. This can turn to hatred toward parents, which in turn may result in a person turning that anger and hatred outward in the form of antisocial behavior. McCord (1979) noted that antisocial personality disorder may manifest when mothers are unaffectionate and not present, and if the father is engaged in criminal activity. Many people with antisocial personality disorder also reported that they experienced discipline ranging from harsh to abuse during childhood (as cited in Dozier, Stovall-McClough, & Albus, 2008, p. 735).

Marganski (2013) identified two theories that may be applicable regarding adult attachment and the commission of crime: social learning theory and social control theory. When applied in this context, social learning theory posits that experiencing or witnessing violence

early in life can normalize violent behavior throughout the lifespan, particularly when the offender is in a position of authority over the victim. When paired with social control theory, which examines the link between impulsivity and social norms, this link becomes stronger. Social learning theory teaches that people, by their very nature, are deviant; however, social control mediates the innate impulsivity that we all possess, and this keeps many of us, regardless of traumatic experiences, from committing violence. Social learning theory also posits that insecure attachment can disrupt the balance between deviance and social control, and when one experiences a trauma, when violent behavior is normalized, an offender's sense of social control becomes skewed (Marganski, 2013). Therefore, attachment could be of integral importance in the study of criminal behavior.

Attachment in early childhood can also predict criminal behavior later in life. Derogation of attachment and lack of trauma resolution were particularly predictive of later criminal behavior (Allen et al., 1996, as cited in Dozier et al., 2008, p. 735). Devaluation is a variation of dismissive attachment style, "in which the person derogates attachment figures or attachment experiences" (p. 735). Schroeder, Higgins, and Mowen (2014) agreed with this assessment, stating that attachment to parents can be predictive of criminal behavior as an adult. In a longitudinal study of 859 adolescents, it was found that attachment, particularly maternal, can be predictive of criminal behavior as early as adolescence. Parenting practices such as rejection, inattentiveness, inconsistent discipline, and weak bonds between the parent and child consistently predicted juvenile delinquency (p. 156), and that stability of maternal attachment can vary in adolescence (p. 166). There was a distinct inverse correlation found between stability of maternal attachment and risk of commission of crime.

The Female Prisoner

According to Covington (1998), there is an opportunity to gain an understanding of the needs of female prisoners. Female prisoners represent some of the most marginalized in our society, and they remain an unseen population. In spite of the dramatic increase in the incarceration rate of women, increasing nearly eightfold between 1980 and 2000 (Bloom, Owen, and Covington, 2002), prisons have been continually unable to meet their needs. Covington (1998) discussed the idea of fostering relational growth in women and its power to heal trauma, create hope for a better life and an enhanced sense of self-worth and self-knowledge, and promote prosocial behavior among female prisoners. However, "unfortunately, the criminal justice system is designed to discourage women from coming together, trusting, speaking about personal issues, or forming bonds of relationship" (p. 148).

According to the Office of Juvenile Justice and Delinquency Prevention (OJJDP; 1998), girls are three times as likely as boys to have experienced sexual abuse. Sexual victimization at an early age is also a risk factor in high-risk behavior. High-risk behavior that leads to criminal activity can often have its start at puberty. Puberty is a particularly timely opportunity to help at-risk girls because during this time of their lives, persistent sexism makes adolescence more confusing because of mixed messages surrounding worth and women's roles in society. Artz (1998) concurred, saying that the delinquent girls in one of their studies reported very few, if any, positive attributes of being female, accepting marginalization of females as the rule, as opposed to the exception (as cited in Belknap & Holsinger, 2006). Also, during puberty, there can be a significant drop in self-esteem and confidence, which is also seen as a risk factor in delinquent behavior (OJJTP, 1998). Lack of close, caring adults has been shown to interrupt or delay a teenage girl's development. Girls who are at risk for delinquency may fit the following

criteria: age between 14 and 16; being raised in poverty, often in high-crime neighborhoods; ethnic minority; history of poor academic experiences; victims of abuse or exploitation; substance abuse; unmet needs, related to either medical or mental illness; and lack of hope for the future (pp. 8-10).

The above profile of the adolescent offender is similar to the adult female offender. According to Bloom, Owen, and Covington (2002), in more than 40 focus groups comprised of prison staff, prison officials, and female prisoners, not only are female prisoners "disproportionately women of color, low income, undereducated and unskilled", and they are less likely than men to have committed violent crime (p. 10). Statistics on trauma history of prisoners vary. They also found that almost 17% of women in prison had lived under state care, either in foster care or in a group home, at some point of their childhood (p. 14). The crimes most often committed by women in prison are nonviolent and include larceny, drug offenses, or theft. Of the women who were in prison for a violent crime, approximately 62% had a prior relationship with the victim as an "intimate, relative, or acquaintance" (p. 13). This figure could insinuate, based on the profile of the female offender, that many of these violent crimes may have been committed as a response to a dangerous situation in which violence was perceived as the only option.

Mental illness is also prevalent in the criminal justice system. According to the Bureau of Justice Statistics (2001), 25% of women in state prisons have been identified as having a mental illness (as cited in Bloom et al., 2002). The three diagnoses most common are substance abuse, PTSD, and depression, in that order. A study by James and Glaze (2006) puts this figure much higher, at 73% of women (p. 1). This has a direct impact on both sentence length and number of incarcerations; state prisoners who had a mental health problem reported a mean maximum

sentence of five months longer than those without (p. 8), and nearly 25% of state prisoners who had a mental health problem served three or more incarcerations (p. 1). In spite of these statistics, one in three state prisoners who had a mental health problem had received treatment since beginning their sentence (p. 1).

The stress of the prison environment has the potential to exacerbate traumatic responses among female prisoners (Acoca, 1998). Because female prisoners are traditionally convicted of crimes that are not seen as violent, their basic needs are seen as less serious. Female prisoners are often housed in overcrowded conditions, and they are also less likely to have access to recreation, career development opportunities, or adequate nutrition, to say nothing of access to medical and mental health services.

DeHart (2008) conceptualized female criminal behavior in the context of survival. Nearly half of the participants in her study disclosed that they committed assault that was seen as defensive or retaliatory in an effort to end abuse (p. 1365). In other instances, some women were forced to commit crime through physical attacks or threats, or taking blame for a criminal act through pressure or provocation on the part of an abuser. For some women in this study, aggression and anger was the behavior exhibited in response to victimization. This was often the means through which women, sometimes as girls, were introduced to the criminal justice system or the disciplinary system in their school as young girls. Many of the women experienced polyvictimization, both in perpetrators and in variety of traumas. These include abuse, sexual violence, interpersonal violence, and neglect.

The mechanisms through which a woman commits a crime after being victimized involve “push[ing] girls and women out of families and peer groups, homes, schools or workplaces, and institutions of worship” (DeHart, 2008, p. 1370). Environments in which women may find

validation, support, and healing are no longer available to them because they are no longer considered by society as part of the mainstream. Because of this marginalization, it can become more and more difficult for women to find productive pathways and healing. “Given the restricted options and negative influences illustrated in these women’s stories, failure to choose a pathway involving crime seems more remarkable than having chosen such a pathway” (p. 1378).

Historically, there have also been minimal efforts to identify the needs of female prisoners (Acoca, 1998). When trying to determine the rate of psychiatric disorders among female prisoners, it can be difficult because most of the statistics are gathered without regard to gender, or they are entirely gathered on men. Not only does this lead to inaccurate reporting of rates of psychiatric disorders, but it can lead to implementing programming for women that is inadequate to meet their needs. In the 1990s, there was a more than three-fold increase in the female prison population. During this time, women were also entering the correctional system at approximately twice the rate of men. When examining the reasons for this, it has been hypothesized that the change in drug laws has played a significant role (Chesney-Lind, 1994, as cited in Acoca, 1998).

The Need for Research and Treatment Involving Female Prisoners

Of the studies that explore PTSD and trauma among prisoners, most have been conducted with men or in mixed gender populations (Henderson, 1998, as cited in Zlotnick, Najavits, Rohsenow, & Johnson, 2003). As a result, trauma-focused treatment programs in prisons are generally designed for male prisoners (Peters et al., 1997, as cited in Zlotnick et al., 2003). The unmet needs of female prisoners that they rate as very important include services related to childhood abuse and drug dependency programs (Sanders, McNeill, Rienzi, & DeLouth, 1997, as cited in Zlotnick et al., 2003).

Recovery from Trauma

According to Herman (1992), there are three stages of healing from trauma: safety, remembrance and mourning, and reconnection (p. 155). Stage one, safety, addresses safety concerns in all domains. It is the first and most important priority in trauma-focused therapy; without it, healing cannot take place (p. 159). The sense of safety often needs to be established in the survivor both in relation to others and within themselves, which often involves the implementation of a self-care plan for the client. The second stage, remembrance and mourning, involves telling the story of the trauma and mourning the old self lost to the trauma (Herman, 1992). This can transform the trauma into something tangible that can be adequately integrated into a survivor's memory. Grief can happen on two different levels, depending on the trauma: psychologically, mourning the loss of attachment and identity; and physically, in some instances, if the survivor were injured. Allowing grief in a survivor may be important because it allows them to feel a full range of emotions, which may not be possible without allowing it in the context of a safe, therapeutic space. Resistance is common at this stage because of fear that the grief will never stop; resistance can often look like forgiveness, revenge, or compensation fantasies (p. 189). Moving through this phase of recovery can be powerful for a trauma survivor because it can allow him or her to "discover [their] indestructible inner life" (Herman, 1992, p. 188).

In stage three, reconnection, the survivor faces the idea of creating a new future and a new self. A central tenet to recovery from trauma is helping the survivor to reestablish a sense of control (Herman, 1992). "In accomplishing this work, the survivor reclaims her world" (Herman, 1992, p. 197). This can be a challenging stage of recovery because it can feel foreign to many who have experienced long-term trauma. In this stage, with the work done in the previous two to

establish a foundation of safety, the survivor can feel empowered to reclaim power and control over their own life (Herman, 1992, p. 197). It is also in this phase of recovery that new physiological responses to fear and danger are built (Herman, 1992, p. 198). This can also help them to challenge assumptions about their previous coping skills and how they put the survivor at risk without taking the culpability away from the perpetrator. It can be important to remember that while there are certainly stages and milestones in trauma recovery, there is no full recovery from trauma, only healing (Herman, 1992). Issues that presented in treatment may reappear at certain life stages, or after certain life experiences.

When discussing the treatment of trauma and child abuse, Kempe (1987) advocated a developmental approach. When talking about the needs abused school-age children, Kempe identified their need for nurturance, resolving the trust-mistrust conflict, poor self-esteem, poor emotional regulation and ability to express emotions, and poor problem-solving skills (p. 375). As children enter adolescence, problems of abuse may manifest in school failure, delinquency, or running away. Adolescents who have been abused may make efforts to become independent in spite of the abusive parents' need to continue to meet their child's needs. Abused adolescents may also look for loving relationships through gang affiliation, prostitution, or other premature sexual partnerships. Because of the higher likelihood of lethality as a child enters adolescence, treatment addressing a child's feelings of being unwanted may also become important. Emotional expression and regulation may also be a continued focus of treatment for abused adolescents, and impulse control may become an issue during this time. Poor self-esteem, lack of trust, and lack of coping skills may continue to be issues for abused children, which can inhibit their emotional growth into adulthood.

The subjective nature of trauma could be an integral part of trauma-informed treatment. In treating a person who has experienced a trauma, van der Kolk and McFarlane (1996) identified two areas of focus: regaining a sense of safety in one's body, and completing the unfinished past (p. 17). It may also be important to help a person identify where they have become "stuck" and help them to figure out how their trauma informs their everyday experience. It can also be helpful to a client if they are able to make meaning of the trauma they have experienced:

> The exploration of personal meaning of the trauma is critical; since patients cannot undo their past, giving it meaning is a central goal of therapy…these personal attributions can have profound affects (sic) on whether victims see themselves as capable and worthy of having restorative experiences, and whether they consider themselves capable of being entrusted with responsibility, intimacy and care (van der Kolk & McFarlane, 1996, p. 19).

When treating adults who have committed child abuse, sympathetic and supportive help is necessary (Steele, 1987b). Ultimately, treatment needs for perpetrators of abuse do not differ significantly from those of children who have been abused. "Abusive caretakers are often described as being immature, very needy, and dependent. These descriptive terms are essentially accurate, but too often they are used in a critical, derogatory sense rather than as valuable clues to the basic characterological difficulties which must be dealt with in treatment" (van der Kolk & McFarlane, 1996, p. 385).

The Need for Trauma-Informed Treatment in Prisons

Miller and Najavits (2012) discussed the importance of trauma-informed treatment for prisoners. Women who enter prison are often seen as safer from victimization than they were

before incarceration because they may have been homeless, living with a violent partner, or addicted to substances. Women often express feelings of safety in the prison environment at the time of their incarceration, which may also "contribute to a new awareness of the level of danger with which they have lived" (Blackburn, Mullings, & Marquart, 2008, as cited in Miller & Najavits, 2012, p. 2). Women who enter prison with a PTSD diagnosis report much higher rates of witnessing violence than the general population; moreover, they view the witnessing of violence to be much more traumatic than experiencing it directly (Hackett, 2009, as cited in Miller & Najavits, 2012).

Because prison environments are regarded as inherently unsafe, there has been an overall reluctance to address trauma-related issues (Miller & Najavits, 2012). This reluctance may contribute to the lack of efficacy of treatment programs in the correctional environment. The correctional environment, in many ways, may be an ideal venue for trauma-informed treatment because it provides time away from some of a prisoner's triggers, as well as providing an environment in which a prisoner can work on their coping skills and interpersonal relationships. This may in turn help a prisoner to adopt a recovery focus, as opposed to being focused on the idea that they are being punished or that they are bad people.

Women who have suffered trauma can suffer complex symptoms and disorders (Hodges & Myers, 2010). This can require trauma-focused treatment for multiple diagnoses. Lev-Wiesel (2008) posited that this is because core issues of women who have experienced trauma, particularly sexually-based trauma, "related to the separation of body and soul and the perception of the body as 'worthless, weak, and helpless,' meaning there is no hope for a better future" (as cited in Hodges & Myers, 2010, p. 140). A wellness approach could be effective in mitigating the long-term effects of trauma. This can help clients de-stigmatize their experience, provide a

positive focus of themselves, and help build a healthy foundation of healing (p. 140). What could make a wellness focus on the treatment of trauma so compelling is the idea of personal responsibility and choice; if mindfulness of everyday choices can be enhanced in a client, it can cultivate a sense of control over their own lives.

In spite of its inherent safety for many women who are incarcerated, the prison environment itself can be a stressful place. Pat downs, strip searches, and frequent discipline can all be triggers for women who have suffered trauma (Owens, Wells, Pollock, Muscat, & Torres, 2008). There is also a culture of mistrust in the prison environment; this, coupled with the idea that confidentiality has different limits in the prison environment, can inhibit a prisoner's disclosure of traumatic events (Miller & Najavits, 2012).

Mindfulness and Meditation: The Historical Context

In the historical Buddhist context, the term "meditation", when translated loosely from Sanskrit, brings to mind the idea of cultivation (Vago & Silbersweig, 2012):

> In light of these definitions, it should be clear that a traditional emphasis of most meditation practice is that of mental development, in which the practitioner is cultivating a general sense of well-being and virtue along with a level of deep familiarity with one's inner mental landscape, and ones' patterns of behavior (Wallace, 2011, as cited in Vago & Silbersweig, 2012, p. 2).

Mindfulness, in its historical definition, has its roots in memory (Vago & Silbersweig, 2012). From the Buddhist perspective, there is a symbiotic relationship between memory and attention (Thera, 1962, as cited in Vago & Silbersweig, 2012). The practice of mindfulness, in Buddhist tradition, is also strongly associated with a decrease or elimination of suffering. Even from the earliest concepts of mindfulness, there was an awareness of the need in humans to

confront suffering, rather than avoiding it.

There is no operational definition of mindfulness (Bishop et al., 2004). In spite of this, many authors agree on some central tenets. Brown and Ryan (2003) defined mindfulness as "receptive attention to and awareness of present events and experience" (p. 823); Kabat-Zinn (1994) defined mindfulness as "paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally" (p. 4). Langer and Moldovenanu (2000) defined mindfulness as "the process of drawing novel distinctions" (p. 1). While mindfulness certainly has its roots in spirituality, particularly Buddhism, the benefits of mindfulness are plentiful outside of its spiritual benefits. It can result in enhanced concentration, and helps cultivate in its practitioners an ability to accept experiences without judgment (Bishop et al., 2004). It can lead to both deeper curiosity and sense of self.

Kabat-Zinn (1994) identified three facets of mindfulness: intention, attention, and attitude. The first, intention, was discussed by Shapiro et al. (2006) as vision and focus of practice. Intentions behind mindfulness can change over time and shift from "self-regulation, to self-exploration, and finally to self-liberation" (pp. 375-376). The second, attention, involves nonjudgmental observation of one's experience as they live it. This can entail long periods of focus on one object (Parasuraman, 1998, as cited in Shapiro et al., 2006), the ability to shift the focus of attention between objects or mental sets at will (Posner, 1980, as cited in Shapiro et al., 2006), and cognitive inhibition (Williams, Mathews, & MacLeod, 1996, as cited in Shapiro et al., 2006). Attitude, or how attention is brought to attention, refers to the idea of bringing openness and curiosity to one's mindfulness practice (Shapiro et al., 2006).

Benefits of Mindfulness

Mindfulness can elicit what Kabat-Zinn (1990) referred to as a "rotation in

consciousness" (p. 193). This is "a perpetual shift from fragmentation and isolation and toward wholeness and interconnectedness" (p. 193); that is, a shift from separateness to wholeness. Mindfulness is not about curing illness, but helping the practitioner to "live with and work with the conditions that present themselves in the present moment" (p. 200). It can lead to greater physical and emotional wellness, as well as positive changes in the brain that can enhance emotion regulation, empathy, and connection with others.

Mindfulness has been shown to increase empathy in its practitioners (Wachs & Cordova, 2007, as cited in Lord, 2013, p. 1000). Lord (2013) also discussed that establishing a sense of control over one's life is critical to the lives of survivors of abuse, which can in turn help one to develop empathy and enhance interpersonal relationships. The mental health benefits of mindfulness are many, but there has been demonstrated evidence that it can help to reduce anxiety and depressive symptoms (Kabat-Zinn et al., 1992, as cited in Goodman & Calderon, 2012). Mindfulness has demonstrated efficacy in children, adolescents, and adults; it can also enhance empathy, reduce symptoms of attention deficit hyperactivity disorder, and even in short sessions, can enhance emotional regulation (Arch & Craske, 2006, as cited in Goodman & Calderon, 2012). This enhancement of emotional regulation can both help to reduce arousal when no threat is present, but can also make the fear reaction one that can be trusted. This helps to build a sense of control, as well as help the practitioner stay in the present moment; this can help to decrease the instances in which a trauma survivor re-experiences distressing events (Rothschild, 2000, as cited in Goodman & Calderon, 2012).

Brown and Ryan (2003) posited that mindfulness practice may have a direct and positive impact on well-being. Through enhanced clarity that Brown, Ryan, and Creswell (2007) discussed, it may also help with emotional regulation due to more attention to moment-to-

moment activities in daily life. Mindfulness practice may also reduce psychopathological symptoms. Tacon, McComb, Caldera, and Randolph (2003) found that Mindfulness-Based Stress Reduction (MBSR) elicited a reduction in distress and increased affect regulation (as cited in Brown, Ryan & Creswell, 2007). A study done by Astin (1997) agreed with the finding that mindfulness can reduce distress, and found that mindfulness can also enhance internal locus of control (as cited in Brown, Ryan & Creswell, 2007).

The practice of mindfulness can cultivate many positive changes in its practitioners, among them greater sensitivity to one's environment; increased openness to new ideas and experiences; a restructuring of perceptions to incorporate a nondualistic way of thinking; and an increased capacity for empathy (Langer & Moldoveanu, 2000).

Mindfulness as a Trauma-Focused Treatment Modality

There is continually emerging evidence that mindfulness-based treatment could be effective in the treatment of trauma. Incorporating mindfulness into trauma-focused treatment may be able to help both clinicians and clients better understand origin and maintenance of symptoms, as well as improving quality of life and treatment outcomes for people who have experienced traumatic events (Vujanovic, Niles, Pietrefesa, Schmertz, & Potter, 2013). It not only allows the client to recall and directly address trauma that they may have experienced, but it also helps them to regulate their attention and emotions while doing so, as well as practicing nonjudgmental acceptance (Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006, as cited in Vujanovic et al., 2013). Used as a trauma-focused treatment modality, mindfulness has the potential to effect significant positive change and healing among its practitioners. Mindfulness has been correlated with decreases in anxiety, depressive symptoms, substance abuse, and pain (Baer, 2006, as cited in Vujanovic et al., 2013); increases in ability to regulate emotions (Brown

& Ryan, 2003); a decrease in avoidant behavior and stress reactivity (Delizonna, Williams, & Langer, 2009, as cited in Vujanovic et al., 2013); and a greater engagement in treatment (Vujanovic et al., 2013).

Lord (2013) showed that surviving complex childhood trauma can affect one's capacity for empathy and compassion throughout the lifespan (p. 998). Decety and Jackson (2006) identified three components of empathy: affective response, an ability to understand another's perspective, and an ability to self-regulate (as cited in Lord, 2013, p. 999). Germer (2009) also mentioned that it is essential when addressing trauma to address the pain directly instead of avoiding it in order to work further toward self-acceptance; this in and of itself is a necessary step toward accepting oneself, no matter what one may be feeling; "It's acceptance of ourselves while we are in pain" (p. 35, as cited in Lord, 2013, p. 999).

Bernstein, Tanay, and Vujanovic (2011) posited that mindful attention and awareness could be a protective factor against psychopathology, particularly among people who have experienced trauma (p. 102). Conversely, low levels of mindfulness, or mindlessness, were identified with greater risk factors for developing psychopathology or maintenance of symptoms, particularly among people who have experienced trauma. Bernstein et al. (2011) found that mindful attention and awareness were strongly predictive of posttraumatic symptom severity, anxiety, and depression (p. 108).

In the past two decades, mindfulness has emerged as a treatment for many types of mental and physical illnesses. It started with the advent of MBSR (Mindfulness-Based Stress Reduction; Kabat-Zinn, 1990) and has evolved into other treatments such as Mindfulness-Based Cognitive Therapy (MBCT), Acceptance and Commitment Therapy (ACT), and Dialectical Behavior Therapy (DBT; Vago & Silbersweig, 2012). All are evidence-based. Mindfulness-

based treatment for trauma is an attractive idea because it can both decrease the symptoms associated with the traumatic experience, as well as working with a person holistically; as a result, a practitioner's overall wellness can be enhanced in tandem with a reduction in symptoms, which is the ultimate goal of many trauma-focused treatments.

Mindfulness-Based Stress Reduction (MBSR)

Introduced as a treatment modality to allow a person to take control over their physical ailments, MBSR is an eight-week course in mindfulness (Kabat-Zinn, 1990). Its central tenet is that "the ways in which we think and behave can have a significant effect, for better or for worse, on our physical health and our capacity to recover from illness and injury and lead lives of high quality and satisfaction" (p. xlviii). It has shown efficacy in clients' efforts to reduce physical and emotional pain through the reduction of the stress associated with it. This treatment modality started in hospitals and has widened to correctional institutions and inpatient mental health centers throughout the country.

In a study done on adult survivors of child abuse by Kimbrough, Magyari, Langenberg, Chesney, and Berman (2010), participation in a Mindfulness-Based Stress Reduction (MBSR) group was found to reduce symptoms of PTSD, particularly avoidance, which has been seen by many as the mechanism that maintains PTSD symptoms (Orsillo & Batten, 2005, as cited by Kimbrough et al., 2010). Therapies that encourage acceptance of the present moment, such as mindfulness, can offer a level of exposure with which a person can cope more easily than facing the trauma directly, which can help to disrupt avoidance.

Mindfulness-Based Cognitive Therapy (MBCT)

MBCT utilizes aspects of mindfulness that focus on nonjudgmental awareness and can enhance awareness of the present moment. This treatment has seen efficacy in prevention of

relapse in clients with treatment-resistant depression (Baer, 2003). MBCT also focuses on detachment from one's thoughts, emotions, and physical states.

According to Kabat-Zinn (1990), MBCT focuses on allowing the client to shift their focus from "fixing" what is wrong to accepting and allowing the feelings without judgment or acceptance as the absolute truth (p. 428). Initial studies of this treatment saw a relapse rate in the experimental group that was half that of the control group.

Acceptance and Commitment Therapy (ACT)

ACT is based on the idea that distress is borne from avoidance (Bach & Hayes, 2002). Central tenets of treatment include encouraging a client to abandon previous internal control mechanisms, acceptance of difficult emotions, nonjudgmental awareness of all thoughts and feelings, and focus on positive outcomes. A focus of ACT is the reduction of avoidance techniques. Common in people who may benefit from ACT is thought suppression, which can actually exacerbate the frequency of negative or unwanted thoughts (Salkovskis & Campbell, 1994, as cited in Bach & Hayes, 2002).

ACT also emphasizes nonjudgmental observation of thoughts and feelings (Brown, Ryan, & Creswell, 2007). This can enhance awareness of thoughts and emotions without attaching to what they might subjectively mean to the observer. Components of ACT include mindfulness meditation, experiential exercises, and the use of metaphor (p. 219). The goal of ACT is the facilitation of awareness of behavior and values, and commitment to behavior that aligns with those values (Hayes et al., 2006, as cited in Brown et al., 2007). Results of studies measuring efficacy of ACT include short-term reductions in psychotic symptoms, self-harm, and stress, and improved emotion regulation and overall mental health (Gratz & Gunderson, 2006, as cited in Brown et al., 2007).

Dialectical-Behavior Therapy (DBT)

DBT, originally developed for the treatment of borderline personality disorder (BPD) and disorders of impulse control, utilizes mindfulness, but through the use of non-meditative exercises; this differs from the other three treatment modalities, in which experiential meditation-based exercises are a central component (Brown et al., 2007). DBT is rooted in biosocial theory, which states that BPD manifests when an individual who already has challenges regulating their emotions is raised in an invalidating environment (Linehan, 1993, as cited in Becker & Zayfert, 2001, p. 110).

In assessing the efficacy of DBT among people with BPD, it has been shown to be significant in reduction of symptoms, particularly when combined with antidepressants. The efficacy of DBT can also be long-term; there were still positive effects of DBT evident one year post-treatment (Linehan, Heard, & Armstrong, 1993, as cited in Brown et al., 2007).

DBT has its roots in cognitive-behavioral therapy (Baer, 2003). Its aim is to help a client cope with suicidal thoughts and change related behaviors, as well as improve emotion regulation (Linehan, 1993, as cited in Becker & Zayfert, 2001). Ways that DBT differs from CBT include its emphases of “validation, mindfulness, and the dialectic and acceptance of change” (Becker & Zayfert, 2001, p. 107). DBT also has efficacy in the treatment of trauma. It can help clients manage hyperarousal, as well as help a client engage more deeply in exposure therapy because of their enhanced capacity for emotional regulation.

DBT can be effective in the treatment of trauma because it helps the client to accept their past and understand what can and cannot be changed in relation to them, including present symptoms that may manifest. The focus on decreasing avoidant behaviors can be important for people who have experienced trauma.

Mindfulness skills incorporated into DBT include three "what" skills: observing, describing, and participating, and three "how" skills": taking a nonjudgmental stance, focusing on one thing in the moment, and being effective (Linehan, 1993, as cited in Becker & Zayfert, 2001, p. 117). DBT is different than many other trauma-based treatments in that it does not aim to change the level of distress; rather, it aims to help the client to tolerate it and view it in a nonjudgmental manner, which is seen as a central goal of any trauma-informed treatment.

Mindfulness in Prisons

Mindfulness as a wellness-oriented treatment among women who have experienced trauma may provide a necessary strength-based approach to treatment (Hodges & Myers, 2010). Through wellness-focused trauma treatment, it can help clients realize the power of their choices, which can in turn help them to create a positive change in their own lives. Many of the traditional treatments for trauma focus on the trauma itself and its impact on the person who experienced it; while this is certainly an important part of treatment, there is an opportunity for a deeper focus on coping skills and life strengths. This may increase self-efficacy, resiliency, cultivation of healthy coping skills, and generalize these positive changes to a trauma survivor's everyday life.

Mindfulness may be important to introduce into the incarcerated population because "for many inmates, this may be their first experience of inner control of mind or body states" (Samuelson, Carmody, Kabat-Zinn, & Bratt, 2007, p. 255). Some of the specific benefits of mindfulness that could apply to prisoners would be increased self-esteem, increased well-being, and a sense of inner balance. This could contribute to an enhanced sense of inner control, which could help to reduce stress in the prison environment due to decreased reactivity to it. This can also give women tools upon release that would not only help them to more productively react to

their community, but it also may help them to face difficulty without resorting to coping behaviors that may have contributed to their incarceration. Mindfulness could have tangible benefits for its incarcerated practitioners, as well as the communities into which they are released at the ends of their sentences.

Conclusion

Trauma can have profound effects on one's self-esteem, resilience, and ability to function. There is evidence, also, that it could be a significant factor in one's pathway to criminal activity. Trauma-focused mindfulness activities and interventions with female prisoners may have significant, positive, and lasting impacts on their ability to heal and make meaning from trauma they may have experienced. It may also enhance their ability to cope with the prison environment, and may enable them to go on to lead healthy, productive lives after release.

CHAPTER III

METHODOLOGY AND RESEARCH PROCEDURES

Within this chapter, I present the phenomenological design of the study of female prisoners' conceptualization of trauma, perceptions of how trauma has affected their lives, and how an eight-week mindfulness training may help female prisoners to reexamine the role of trauma in their lives. This section includes epistemology, theoretical perspective, epoche, methodology, participants, procedures of investigation, methods of data collection, analysis, and trustworthiness.

Within this chapter, I also outline the process used for collecting qualitative data from multiple sources to move beyond the descriptions of the lived experiences of participants to formulate an emergent phenomenon of female prisoner insights from a wellness-based curriculum on their awareness of the role of trauma in their daily lives. The emergent phenomenon was grounded in data retrieved from 17 female prisoners in a transitional housing unit. Phenomenology was the most appropriate method of research for this study because of the focus of the common lived experience of trauma among female prisoners and the commonalities of the impact that trauma has had on these women's lives.

Epistemology

In an attempt to philosophically ground the research, subjectivism was chosen as the epistemology. Subjectivism can be conceptualized as truth based on an internal reality, as opposed to objectivism, which can be conceptualized as the truth as an external force with absolutes. Subjectivism was applicable to this study because of the differences of the lived experiences of each participant and the impact that those experiences have on their internal reality.

Theoretical Perspective

This study was set upon a phenomenological theoretical perspective, or, in other words, the study of personal experiences to identify and describe a common phenomenon among all participants. As a researcher utilizing a phenomenological lens, I put aside, to the best of my ability, my own values and beliefs regarding prisoners and the stigma put on them by society, trauma and its impact, and mindfulness with the positive impact it can have on people's lives.

Epoche

According to Newsome et al. (2008), an epoche, or bracketing, is an aspect of phenomenology in which researchers set aside their opinions and assumptions about what is happening in the world so that they can examine the participants' worldviews without undue interference of the researcher's subjective experience or bias (as cited in Christensen & Brumfield, 2010, p. 137). It was important for me to explore this and the impact that it has had on my life in order to set aside any assumptions about the people with whom I would be working and the potential impact that trauma has had on their lives.

As part of the project for another class, my first experience observing the prison environment illuminated the issue of trauma among prisoners and the potential for trauma to be a predictor of criminal activity. I found myself wondering how much healing could go on in an environment in which there is consistent oppression of women and ignorance about their mental health needs. Moreover, I questioned how much healing could also take place in an environment in which there is a focus on punishment with seemingly little capacity for attending to the needs of these women to heal. As these ideas continued to evolve for me, I found myself thinking about my own trauma history and wondering what the difference was between people who have experienced trauma and have committed criminal activity and those who have not. Because

mindfulness continues to be a significant part of my recovery from trauma, I found myself wondering if introducing a mindfulness practice to prisoners could possibly help them to gain new awareness and coping skills.

Research Methodology, Procedures, and Analysis

Qualitative Methodology

A qualitative research methodology was used for this study. According to Denzin and Lincoln (2011), qualitative research "involves an interpretive, naturalistic approach to the world" (as cited in Creswell, 2013, chapter 3, section 2, para.1). To that end, it can be important in qualitative research to study phenomena where they naturally occur in order to build the most accurate picture. Also important in qualitative research is the idea of addressing the meaning of the problem being studied from the perspective of the participant. Inherent in qualitative research is the voice of the participant, and complexity in interpretation and description of the problem being addressed. Particularly compelling for this research study was Creswell's (2013) finding that qualitative inquiry is appropriate when "quantitative measures and the statistical analyses simply do not *fit* the problem" (chapter 3, section 3, para.3). Dehart (2008) noted that there has been little qualitative study of the female prison population and their experiences with trauma. This can create a barrier to adequate treatment and research for female prisoners because it does not provide a detailed context in which the commission of crime can occur; moreover, without the voices of the participants being heard, their actual needs for treatment may go unaddressed.

According to Creswell (2013), phenomenological research "describes the common meaning for several individuals of their lived experiences of a concept or a phenomenon" (chapter 4, section 1, para. 1). The phenomenon being explored in this research was trauma. It is a universal experience among the specific population being studied; the percentage of prisoners who had experienced at least one traumatic event at the particular transitional housing unit where

this research took place was 100% (LeClerc, 2014, verbal communication). A core tenet of both phenomenology (Creswell, 2013) and trauma as a phenomenon (McFarlane & de Girolamo, 1996) is that of subjectivity, and perception as reality. There is no concrete definition of what trauma is, because the experience of a traumatic event and its impact is different for every person; what may be traumatic for one person may not be for another, and vice versa.

Another key tenet of phenomenological inquiry is that of the collective lived experience of all of the participants. Creswell (2013) discussed that the context for which phenomenology is best suited is when one studies a small group, and that it is important to understand all of their common experiences. There are two general questions that are asked of participants in phenomenological research: What have you experienced in terms of the phenomenon, and what contexts or situations have typically influenced or affected your experiences of the phenomenon (Moutsakas, 1994, as cited in Creswell, 2013, chapter 3, section 4, para. 6). These were both illuminating questions for the participants in this research study, because it provided specifics of the life situations of the women that were studied.

Participants

Consistent with the standards for phenomenology, minimums of 3-15 participants were necessary, all of whom have experienced the same phenomenon (Creswell, 2013). In this study, the phenomenon being explored was trauma. Seventeen women began the study; they completed an informed consent, demographic questionnaire, and a pre-group questionnaire exploring their relationships both in and outside of the prison, coping skills, their perception of the impact of the trauma they experienced, their concept of mindfulness, their self-concept, and the impact of their experiences in prison. The women who participated in this study lived in a minimum-security, transitional housing unit. In this particular facility, there are two security classifications; C-1

denotes work release, where prisoners can go out into the community to work and participate in other activities (e.g., grocery shopping and laundry). They are also eligible, with written permission and verification of constant supervision, to go home for overnight stays. C-2 classification denotes mandated living on the premises with the ability to walk around the community accompanied by a correctional officer, and ability to work on the premises (e.g., cooking, cleaning, and repair of the facility). All of the women in this study were C-2 at the beginning, with five of the participants moving to C-1 status before the conclusion of the study.

Of the 17 participants in this study, five completed demographic questionnaires; however, demographic information on many of the participants was also collected as part of the initial interview process. Participants ranged in age from 25-49, and the median age of all participants was 32.6. All participants were native English speakers, and 16 identified as Caucasian. Of the fifteen participants who disclosed their relationship status, seven identified as single, three identified as married, four identified themselves as being in a long-term partnership, and one identified as divorced. Many of the participants were parents; of the 16 participants who disclosed this information, five had one child, four had two children, three had two children, and two had four children. Of the six participants who disclosed their home state, all were from New England; five disclosed that they will be returning to their home states upon release. Of this same sample of five women, all completed high school, and four completed associates degrees or certificate programs. In regard to socioeconomic status, two identified as working class, one as lower-middle class, and three as middle class.

Nine women in this study disclosed their religious or spiritual beliefs; one identified as “not spiritual or religious”, four identified as Christian, and four identified as spiritual. Overall,

these women were very open about their lives; more details will be provided from the initial interviews and weekly questionnaires in the proceeding chapters.

Data Collection and Procedures

In order to conduct the study, permission was gained from Plymouth State University's Institutional Review Board and the research office of the Department of Corrections. Once this permission was obtained, there was collaboration with officials at the transitional housing unit; women at the pre-work-release security level (C-2) were mandated to participate. All participants were provided with an informed consent document, demographic questionnaire, and an opportunity to ask questions prior to the beginning the study.

The structure of the weekly groups consisted of an opening activity to build trust among the group members, a mindfulness activity, and a group debrief. Opening exercises consisted of activities that centered around disclosure, exploration of feelings, and non-judgment. The mindfulness activities ranged in duration from five minutes to 45 minutes and centered on breathing, lovingkindness, forgiveness, physical mindfulness, and overcoming the freeze response (Rizvi et al., 2008). Each group was followed by an open-ended, written questionnaire that consisted of exploring what that week's mindfulness exercise may have brought up for them in terms of their trauma, how they felt about the exercise itself, disclosure of anything they may not have been comfortable sharing with the group, any changes in their view of mindfulness, and any changes in their view of trauma.

There was a check-in with the participants, as a group, at week four; this was an opportunity for them to give any feedback about their experience of the activity, and to allow them to provide input into the structure of the group based on this feedback. Written questionnaires were implemented immediately at the end of the group, 30 days post group, and 60 days post group.

These questionnaires were implemented in order to assess whether what participants learned had a lasting effect on them.

Instrumentation

The instruments in this study were open-ended questionnaires administered pre-group, weekly, immediately post-group, 30 days post-group, and 60 days post-group. These questionnaires addressed two purposes: the impact of traumatic experiences on the participants, qualitative change in participants' perceptions of this impact during the duration of an eight-week mindfulness training group. The preliminary questionnaire asked the following questions about self-esteem, locus of control, current coping skills and their perceived efficacy, participants' concepts of trauma, their concept of mindfulness, relationships, and the prison experience:

- What do you hope to gain from participation in this mindfulness group?
- What do you hope to give from participating in this mindfulness group?
- What are your fears about participating in this group?
- What does trauma mean to you?
- What does mindfulness mean to you?
- How has your trauma impacted your life?
- What have you done in the past to cope with your trauma?
- Of the things you have done in the past to cope with trauma, what has worked? What hasn't? Why?
- What is your relationship with your family members like? Please specify:
    - Parents
    - Siblings (if any)

    - Any other relatives or caregivers who have been important in your life
- What has your experience been in the prison environment? Please describe:
    - Relationships that you may have formed
    - Any difficulties that you may have encountered in your experience
    - Any ways that the prison experience may have been a benefit to you (examples include more options for treatment, you may feel safer in prison than you did out in the community, or you may have been able to build skills that you may not otherwise have gained)
- Who are the three closest people to you? What is your relationship like?
- Please list three ways that you would describe yourself.

The weekly questionnaires are more specifically geared toward trauma, and ask the following questions:

- What did this week's experience bring up for you in terms of trauma you have experienced in your life?
- How did you feel about this week's meditation?
- Is there anything that you did not share with the group that you would like me to know? If so, what is it?
- How is your view of mindfulness different than it was last week?
- How is your view of trauma different than it was last week?

The post-group questionnaires were administered one week after the end of the eight-week group, three months post-group, and six months post-group, and were designed to examine the longer-term impact of mindfulness on how the participants viewed the impact of their trauma on their lives. The questions asked in the post-group questionnaire include the following:

- What do you feel that you have gained from participation in this group?
- Over the course of the eight weeks, what do you feel that you have given through participation in this group?
- Please think about the fears that you had coming into this group. Did the things you feared happen? If so, how so?
- What does mindfulness mean to you?
- Does trauma impact your life in the same way as it did eight weeks ago? Please discuss either way.
- Has the way you cope with your trauma changed in the past eight weeks? If so, how so?
- Have your relationships changed at all since participating in this group? If so, how?
- Has your experience in the prison environment changed at all as a result of participating in this group? If so, how?
- How do you feel about yourself?

The 30 and 60 days post-group questionnaire were the same, and asked the following questions:

- What does mindfulness mean to you?
- Have you been able to practice mindfulness in the month (or two months) since this group ended? If so, what have been your experiences? If not, what has been challenging for you?
- What do the traumas you have experienced look like in the overall picture of your life?
- Does your past trauma impact you the same way as it used to? Either way, please discuss.
- Has your experience in the prison environment changed at all in the past month (or two months)? If so, please discuss.
- Please list three ways that you would describe yourself.

Ethical Considerations

Ethical codes set forth by the American Counseling Association (ACA; 2014) were followed while conducting this research. Broadly, applicable ethical codes addressed client welfare, informed consent, avoiding harm, protecting clients in a group setting, respect for clients' rights to privacy and confidentiality, maintenance of records, accurate reporting of results, and submission for publication. At the beginning of this study, all participants were required to sign an informed consent acknowledging the potential risks and benefits of participation.

Through the Institutional Review Board approval process, because of the sensitive population and the sensitive subject nature of the research, care was also taken to ensure that if participants felt distressed at any point of study, they would be supported. This included the researcher being available for debriefing after the group meetings if a participant experienced distress, and verifying with transitional housing unit administration that there would be a mental health practitioner available at all other points during the study if a participant needed support.

Data Analysis

Data analysis was conducted by identifying themes, and followed five steps: thematizing, data immersion, first-cycle theming, second-cycle theming, and organization (DeSantis & Ugarriza, 2000; Saldaña, 2012). The researcher worked with her thesis chair in order to describe the phenomenon being investigated. Both cycles of theming allowed for a detailed understanding of the nuances of the traumatic experiences of the participants. The first cycle of theming allowed for simple description and generalization of meaning. The second cycle of theming allowed the researcher to more finely describe themes in the contexts of in vivo codes, manifest

themes, and latent themes. Finally, all of the themes were integrated in order to describe the essence of the findings.

Trustworthiness Procedures

Trustworthiness in qualitative research is established using four measurements: credibility, dependability, transferability, and confirmability (Christensen & Brumsfield, 2010). Key facets of credibility include prolonged engagement, persistent observations, and triangulation. In studies such as these with sensitive populations such as prisoners, establishing relationships and trust with the participants was a key component to the trustworthiness of the study. Because of the nature of the phenomenon being studied, trust was essential both between each individual participant and the researcher, as well as among the participants themselves. Establishing this trust took a great deal of time and effort, but yielded much information that is relevant to this study. The timeline between establishing contact with the prison system and the end of data collection was approximately 15 months due to the sensitive nature of the environment, the participants, and the subject matter.

Triangulation was achieved in the study via regular consultation with the researcher's thesis advisor; it was also achieved through multiple data collection points. Confirmability was achieved through a member check, which was done at week five in order to assess the accuracy of themes that were beginning to emerge and correct any inaccuracies that may have been emerging in the data. Participants were given direct information regarding themes that were emerging among all participants, and they were asked to verify the validity and accuracy of these themes.

Transferability was achieved through a multidisciplinary review of the literature, and through thick and rich descriptions of the data. While no study currently exists assessing the

impact of mindfulness training on trauma recovery among prisoners, there is literature that exists on the impact of mindfulness study among prisoners (Samuelson, Carmody, Kabat-Zinn, & Bratt, 2007).

Dependability was achieved through supervision of a research advisor and a thesis committee, as well as a dependability audit with the research advisor. Review of materials used for the study, including all questionnaires and the mindfulness group proposal was done at the beginning of the research process with approval from the Institutional Review Board, the Department of Corrections Research Director, and the administration at the transitional housing unit. All materials were provided and opportunity for feedback was given to all parties involved in this approval. Data and its subsequent analysis were reviewed by the researcher's thesis advisor and committee.

CHAPTER IV

FINDINGS

In this chapter, data will be presented reflecting how female prisoners' perceptions of trauma may have changed as a result of participation in an eight-week mindfulness training group. Participation was open to all C-1 (i.e., work release) and C-2 (i.e. pre-work release) security levels at a transitional housing unit in New England. Seventeen female prisoners participated in the initial, pre-group interview, six participants completed the group, and five completed post-group questionnaires. Because there was no audio or video recording permitted for this research, data was gathered from written pre-group interviews, written questionnaires, artifacts, and reflective journal analysis.

The group meetings had a consistent format comprised of an opening activity, a meditation activity, processing the activities as a group, and filling out a written questionnaire after the group finished. All of the opening activities were psychoeducational in nature, and encompassed themes such as nonjudgment, self-disclosure, being present, and emotion identification. Meditation activities included breathing, lovingkindness, forgiveness, physical awareness (e.g., walking and body scan meditations), positive self-affirmation, and overcoming the freeze response. While prison officials communicated to many of the participants that this was a mandated group, the structure was open (i.e., I encouraged participants to choose whether or not they wanted to attend) in order to allow for a challenge-by-choice atmosphere. As a result, the number of participants was not consistent until approximately week four. There was also a member check at week five in order to give feedback to participants about emerging themes, and to solicit their opinions and allow them to add feedback of their own. Participants were given the opportunity to provide feedback about the group and suggest any changes they might like to see.

In the next section I provide an in-depth description of the participants. All names have been changed to protect participant anonymity.

Participant Descriptions

- Rachel was a 28-year-old White female. She participated in all group sessions with the exception of the first, and was released before the 30- and 60-day questionnaires were administered. When asked what trauma meant to her, she reported that she saw it as an experience that was “self-inflicted”. She also stated that trauma is why she is in prison. Rachel identifies as a person in recovery from addiction, and she discussed that her addiction and the trauma that she experienced were related in that she used substances to stop constantly reliving her trauma. In discussing the impact of trauma on her life, Rachel stated that it shaped who she is, in both good ways and bad. When asked what mindfulness meant to her, she discussed the ideas of thinking before acting, and being careful of what she is doing.
- Emily was a White female. She attended the first group session only, and withdrew after obtaining C-1 status due to working during the time of the group. When asked what trauma meant to her, Emily disclosed that it meant being “beaten physically and emotionally”. In discussing trauma’s impact on her life, Emily said that it has shaped her relationships and made her who she is in that it made her stronger. Emily also disclosed that because of the trauma that she has experienced, she highly values safety and honesty. When asked what mindfulness meant to her, Emily discussed awareness and attention to feelings, and being thoughtful about what to do with this awareness.
- Carrie was a 28-year-old female. She participated in weeks two through five of the mindfulness group, and withdrew after obtaining C-1 status due to working during the

time of the group. When asked what trauma meant to her, Carrie discussed that it means different things for different people, and that she caused the trauma in her own life. Carrie also discussed her experience of chaos and trauma becoming a normal part of life, and that “little things” can be traumatic for people. When discussing the impact of trauma on her life, Carrie reported that she has discomfort with balance, and that trauma has caused her life to become chaotic. Carrie also linked her trauma with substance use. When discussing mindfulness and what it meant to her, Carrie talked about mindfulness practice being “her time”, and identified stillness and sitting quietly.

- Joanna was a 28-year-old White female. She participated in all eight weeks of the mindfulness group, as well as all of the post-group interviews. When asked what trauma meant to her, Joanna identified rape and death. Joanna identified her trauma as something that changed her life completely and put things into perspective. She also reported that her trauma helped her to value things more, and helped her to evaluate the things that were really important in her life. When asked what mindfulness meant to her, Joanna identified peace and tranquility.
- Liz was a 28-year-old White female. She participated in weeks 2-5, 7, and 8 of the mindfulness group, as well as all of the post-group interviews. When asked what trauma meant to her, Liz identified guilt and abuse; she identified intimate partner violence, and physical, emotional, sexual, and verbal abuse. Liz also discussed the raid that led to her arrest, and identified that as traumatic. When talking about the impact of trauma on her life, Liz reported that it hurt her family and relationships, and she said that she has “never” had a healthy relationship because of her own trust issues. However, Liz also identified a positive side of her traumatic experiences in that they fueled her desire to be a

better parent and to break negative patterns in her life. When asked what mindfulness meant to her, Liz identified centering herself, being aware of her body, surroundings, and thoughts, and being present.

- Erin was a 43-year-old White female. She participated in weeks one through three of the mindfulness group, and then withdrew for personal reasons. When asked what trauma meant to her, Erin said, “my life”, delving more deeply to describe parental sexual exploitation from the ages of 6-13, as well as miscarriage in her eighth month of pregnancy. When asked about the impact that trauma has had on her life, Erin also linked her substance abuse and addiction history to the trauma she had experienced. Erin said that her trauma has caused her to be unable to trust a lot of people. When asked what mindfulness meant to her, Erin identified hope and peace.
- Isabelle was a White female in her late 20s. She attended six sessions of the mindfulness group, and withdrew after obtaining C-1 status due to working during the time of the group. When asked what trauma meant to her, Isabelle identified a car accident in which she almost died and when she was stabbed in a home invasion. When discussing the impact of trauma, Isabelle reported that trauma changed the way that she viewed things and made her humble. When asked what mindfulness meant to her, Isabelle discussed groups that she had attended, and identified awareness and living in the moment.
- Katie was a White female in her late 20s. She attended six sessions of the mindfulness group, as well as participating in all of the post-group questionnaires. When asked what trauma meant for her, Katie identified violence and sexual trauma. Katie reported that her traumatic experiences have impacted her in that she shut down when it happened and she

did not “deal with it”. When asked what mindfulness meant to her, Katie identified awareness of feelings and emotions, both in herself and others.

- Molly was a 26-year-old White female. She participated in week one, and weeks 4-7 of the mindfulness group, staying after she obtained C-1 status, but then withdrawing when she found a job in the community that prevented her from being able to participate further. Molly participated in two of the post-group questionnaires (e.g., immediately post-group and 30 days post-group). When asked what trauma meant to her, Molly identified parental separation and terrorism. Molly also disclosed that at the beginning of her addiction, she was exploited by a male family friend for drugs. When asked how trauma impacted her life, Molly reported that her trauma lowered her self-esteem and led to her drug use. Molly also said that her desire to please others was what led her to commit her crime. When asked what mindfulness meant to her, Molly discussed being calm and aware of her surroundings.
- Caroline was a 32 year-old White female. She participated in weeks 1-4, at which point she began experiencing emotional difficulty and addiction relapse and had to leave the study. When asked what trauma meant to her, Caroline identified “bad things that happen throughout life”. In discussing the impact of her trauma, Caroline reported that her trauma made her shy, angry, and confused. Caroline also linked her trauma to her addiction and substance abuse issues. When asked what mindfulness meant to her, Caroline disclosed a familiarity with mindfulness practice, and identified an awareness of what is going on.
- Claudia was a White female in her 50s. She participated in weeks 2 and 3 of the mindfulness group, and withdrew after obtaining C-1 status due to working during the

time of the group. When asked what trauma meant to her, Amy identified her childhood with an alcoholic mother. When discussing the impact of trauma on her life, Amy reported that she was motivated to do better for her children than what she experienced, and that it led to her drug use and negatively impacted her relationships with her family members. When asked what mindfulness meant to her, Amy reported that she felt that it was boring because she did not know anything about it.

- Angela was a 40-year-old female. She participated in week 2 of the mindfulness group, withdrawing both because she obtained C-1 status, and for personal reasons. When asked what trauma meant to her, Angela identified abuse. When discussing the impact of trauma on her life, Angela reported that it caused her to not grow up "normally", it changed the way she looked at the world, she felt unsafe and nervous in her relationships, and it eventually caused her to lose her children. When asked what mindfulness meant to her, she identified being in the moment.
- Karen was a 49-year-old White female. She participated in the first two weeks of the group, withdrawing after obtaining C-1 status due to working during the time of the group. When asked what trauma meant to her, Karen reported trauma being "forever". She also used being hurt physically and emotionally as descriptors. When discussing the impact of trauma on her life, Karen reported that she has trouble trusting others, especially men, and that it has caused her to become "jaded". Karen also reported that she felt regret over what life could have been without the trauma that she experienced, but also felt gratified that she spared her children from having the same experiences. When asked what mindfulness meant to her, Karen identified being conscious of one's surroundings, emotions, and perceptions.

- Bree was a White female. She participated in weeks one through three of the mindfulness group before being released from the transitional housing unit. When asked what trauma meant to her, Bree reported, “my life”. Bree disclosed that she had been sexually assaulted multiple times and that she had a parent diagnosed with schizophrenia. When discussing how trauma has impacted her life, Bree identified her trauma as a contributor to her mental health issues, her addiction, and loss of feelings that she might normally have had. When asked what mindfulness meant to her, Bree identified awareness.
- Donna was a 38-year-old White female. She participated in the first five weeks of the mindfulness group before reaching her maximum sentence and being released. When asked what trauma meant to her, Donna identified “unwanted things that happen to a person” and elaborated further, saying that past things can “still happen in the present”. When asked how trauma impacted her life, Donna reported resentment, and that before she was incarcerated, she did not know how to move forward. When asked what mindfulness meant to her, Donna identified thinking before acting and awareness.
- Lynnette is a 26-year-old White female. She participated in week two of the mindfulness group before withdrawing from the group due to reaching her maximum sentence and being released. When asked what trauma meant to her, she identified sadness, hurt, and loss of trust. She also reported that she was sexually abused by a family member and that nothing was done when she told her family. When asked how trauma has impacted her life, Lynnette reported that it made her stronger; she also connected her inability to cope with traumas to why she went to prison. When asked what mindfulness meant to her, she identified being aware and in the moment.

Primary Themes

There were six primary themes that emerged in the data: internal and external factors in coping with trauma, developmental factors in perceptions of past trauma, the link between trauma and substance abuse and addiction, mistrust versus desire to help others, and direct antecedents and consequences of participating in the mindfulness group. There were several sub-themes that emerged under each of these themes.

Sources of Data

The data presented in this chapter represents information gathered at 12 separate points. Individual interviews were administered pre-group and consisted of questions related to participants' perceptions of mindfulness and trauma, relationships, the prison experience, and expectations that they may have had before going into the group. Questions also explored participants' perceptions of internal resources for coping (both what worked and what has not), and the self-perception of each participant. Weekly interviews were also administered after the end of each group meeting, and explored prisoners' perceptions of any changes that were taking place in how they viewed trauma and mindfulness as they participated in the mindfulness group.

Individual Interviews

Individual interviews were conducted before the first group meeting in order for me to get a clear picture of the lives of each participant. These interviews took approximately one hour each and helped me to gather information about several facets of the participants' lives. The individual interview questions included:

1. What do you hope to give from participation in this group?
2. What do you hope to gain from participation in this group?
3. What fears, if any, do you have regarding participation in this group?

4. What does trauma mean to you?
5. What does mindfulness mean to you?
6. How has trauma impacted your life?
7. What have you done in the past to cope with your trauma?
8. Of the things you have done in the past to cope with trauma, what has worked? What hasn't? Why?
9. What is your relationship with your family members like? Please specify:
    a. Parents or caregivers
    b. Siblings (if any)
    c. Any other relatives or caregivers who have been important in your life
10. What has your experience been in the prison environment? Please describe:
    a. Any relationships you may have formed
    b. Any difficulties that you may have encountered in your experience
    c. Any ways that the prison experience may have been a benefit to you
11. Who are the three people closest to you? Please describe your relationship.
12. Please list three ways that you would describe yourself.

The purpose of this interview was two-fold: for me to begin to build a relationship with the participants, and to build a baseline for each participant in order to facilitate the ability to identify qualitative changes that took place among participants around their perceptions of trauma, their coping skills, their understanding of the impact that trauma has had on their lives, their ability to reconceptualize the trauma that they have experienced, and their self-esteem.

Artifacts

All group participants were asked to provide artifacts resulting from participation in mindfulness group activities that represented their interpretation of their feelings, nonjudgment, collaboration, and life experiences. These artifacts included index cards writing "headlines" from their lives, index cards describing their definitions of forgiveness, drawings from a "Guest House" art activity, and artwork from a collaborative art activity exploring judgment of self, others, and experiences.

Weekly questionnaires

Weekly written questionnaires were administered after the end of the group meeting each week. These questions were drawn from a review of the relevant and related literature, my personal experiences, and consultation with my thesis chair. Each questionnaire asked five questions:

1. What did this week's experience bring up for you in terms of trauma that you have experienced in your life?
2. How did you feel about this week's meditation?
3. Is there anything you did not share with the group that you would like me to know? If so, what is it?
4. How is your view of mindfulness different than it was last week?
5. How is your view of trauma (either your own or in general) different than it was last week?
6. How is your view of mindfulness different than it was last week?

The purpose of these questions was not only to measure qualitative change, but also to ensure that I was consistently monitoring the well-being of each participant. Because of the opportunity

for participants to process the week's activities as a group, there was also a built-in opportunity to check in with participants who may have been experiencing difficulty.

Post-group Questionnaires

Questionnaires were administered one week post-group, 30 days post-group, and 60 days post-group in order to measure any lasting changes among participants in the mindfulness group. The post-group questionnaire followed up on several points raised in the pre-group interview:

1. What do you feel that you have gained from this group?
2. What do you feel that you have given to this group?
3. Please think about the fears you had coming into this group. Were they realized? If so, how?
4. What does mindfulness mean to you?
5. Does trauma impact your life in the same way it did eight weeks ago? Please discuss either way.
6. Has the way you cope with your trauma changed in the past eight weeks? If so, how so?
7. Have your relationships changed at all since participating in this group? If so, how?
8. Has your experience in the prison environment changed at all as a result of participating in this group? If so, how?
9. How do you feel about yourself?

30 and 60-day post-group questionnaires were similar, but also explored participants' abilities to practice mindfulness in the time that passed between the end of the group and the administration of the questionnaire. They asked the following questions, and were identical:

1. What does mindfulness mean to you?

2. Have you been able to practice mindfulness in the time since the group ended? If so, what have been your experiences? If not, what has been challenging for you?
3. What do the traumas you have experienced look like in the overall picture of your life?
4. Does your trauma impact you the same way it used to? Either way, please discuss.
5. Has your experience in the prison environment changed at all in the time since the group ended? If so, please discuss.
6. Please list three ways that you would describe yourself.

Researcher Reflective Journal

I wrote in a reflective journal on a weekly basis after individual interviews and the weekly mindfulness group meetings, reflecting on disclosures of participants, any issues that may have come up for the participants either individually or as a group, and my own reflection on the participants' responses to activities.

Member Check

At week five, there was a member check. During this time, I discussed themes that were emerging, and solicited feedback from participants about their perceived accuracy of these themes. There was also discussion about what was helping participants and what might be helpful to them going forward. Participants agreed with the accuracy of the emerging themes, and also were able to reflect on how they were feeling emotionally and what might help them as the group continued, including positive affirmations and leaving recordings of meditations at the transitional housing unit so that they could practice between group meetings.

Primary Themes

Internal and External Factors for Coping with Trauma

Through my research journal, I reflected on how participants in the mindfulness group appeared to have a keen awareness of their coping resources, as well as an ability to discern between what was helpful and what was maladaptive and discuss both equally candidly. The perceived coping skills among participants varied widely, but several subthemes emerged from the pre-group interviews: therapeutic intervention, mindfulness, achieving and sustaining sobriety, and familial influence. Because substance abuse and its link to trauma is its own theme, it will be discussed in more detail in an ensuing section; however, in the context of sobriety as a coping mechanism, it is salient in the discussion of internal and external factors for coping with trauma.

Therapeutic intervention.

The participants in the mindfulness group identified several factors that either enhanced or inhibited their ability to cope with the trauma during the pre-group interviews. A significant component reported by 11 of the participants was therapeutic intervention. 10 of the participants reported engaging in group therapy ranging from trauma-focused groups to Dialectical Behavioral Therapy (DBT) while incarcerated. One participant reported having engaged in therapy before incarceration, some spanning as far as childhood. Eleven participants also reported having engaged in individual therapy at some point of their incarceration.

Mindfulness.

Five participants reported previous experience with mindfulness. Through my research journal, I reflected on the interpretation that all of the participants had a fairly clear picture of what mindfulness meant to them, even with no previous mindfulness training. However, five

participants who had no mindfulness experience expressed reticence and fear both to me verbally and in their initial interviews because they did not know enough about it. When asked about their fears about participating in the group, the most common response was lack of knowledge regarding mindfulness and what to expect in a mindfulness group.

Achieving and Sustaining Sobriety.

All of the participants in the group reported having co-occurring substance abuse or addiction issues; ten participants identified participation in 12-step or similar programs as integral to their recovery from both trauma and substance abuse. Not only did participation in sobriety maintenance groups remain a significant part of their recovery, but six participants identified being surrounded by others in recovery as an integral part of their ability to maintain sobriety. Moreover, seven of the participants reported a family history of substance abuse and addiction. Of the participants that identified a family history of substance abuse and addiction, three reported previous substance use with family members in the pre-group interviews. In the pre-group interviews, three participants also reported detachment from family members who abuse substances in order to preserve their own sobriety.

Conflicting reports of familial support.

All of the participants reported a wide range of support from their families; this ranged from self-describing as an orphan to very close attachment to caregivers throughout their lifespan. There was also a pattern of participants reporting the death of a close family member; nine participants reported loss of either an immediate family member or someone they considered as very close to them during their lifetime, and four of the participants who reported these losses said that they happened while they were incarcerated.

Avoidance of Negative Familial Influence.

Many of the trauma histories reported in the pre-group interviews were violent, and many of these reports also implicated family members or partners. Nine of the participants identified family members whom they did not consider a source of support, and seven of these participants identified their parents as a negative source of support. This ranged from being self-described as an orphan, to participants saying things such as “I’m all set with my family” or “when my mother died while I was incarcerated, I felt nothing.” Of the participants that identified their family as a negative source of support, four expressed a desire to work to change that dynamic; moreover, the people who identified a desire to do so were more likely to say that they wanted to change the relationships that they had with their children than they were to say that they wanted to change the relationship with their parents or other people in their same or older generation.

Maintenance of positive familial influence.

Juxtaposing the reporting of negative familial influences was the participant identification of positive familial support. Fourteen participants identified family members as strong sources of support, and this bond was most often with one or both parents. When questions were asked about relationships post-group, six of the participants reported an increased willingness to communicate with family members and an increased desire to build relationships that they did not report before the mindfulness group. One participant also disclosed that they were more open about their feelings and experiences with their family members to whom they felt close. Within the research journal, a pattern emerged relative to this theme. I felt that the participants were less afraid to express their emotions with those close to them than they were previously.

Developmental Factors in Perception of Past Trauma

As with any therapeutic group, there was a developmental pattern of growth, both as a system and individually (Corey, Corey, & Corey, 2014). While the general pattern of group cohesiveness was certainly present in the mindfulness group, there was also an underlying pattern of growth as a result of mindfulness training. It should also be noted that developmental changes did not necessarily occur at the pre-set weeks of the group; rather, it occurred based on the individual experiences of each member. Because this was an open group, participants were not always able to attend every week; as such, these developmental changes corresponded with the number of weeks that participants attended, rather than the corresponding week and educational theme of the group.

Pre-group perceptions of trauma and mindfulness.

Before discussing the developmental change, it was important for me to develop a baseline for the participants' perceptions of trauma and mindfulness; what, exactly, did these participants think of when they thought about mindfulness and trauma as two separate constructs? Moreover, at any point before the mindfulness group, did participants perceive mindfulness as something that might help them in their recovery from trauma? The data presented in this section was gathered from the pre-group questionnaires, which asked each member individually about their perceptions of trauma and mindfulness. Data were also gathered weekly assessing changes in these perceptions.

Participants' pre-group perceptions of trauma.

Seven participants identified trauma as a lifelong experience; indeed, many participants either experienced polyvictimization, or were still significantly affected by trauma that they experienced in childhood. Eleven participants also associated trauma with violence, frequently

associating emotional, verbal, physical, and sexual abuse with their ideas of trauma. Participants also associated loss with trauma, and eight of the participants had lost a parent, partner, or other close loved one at some point of their lives. Participants who identified loss as a component of trauma cited loss of loved ones, divorce of parents, abandonment, or loss of a child.

Participants' pre-group perceptions of mindfulness.

The overwhelming consensus of the meaning of mindfulness among participants during the pre-group interview was awareness, reported by ten participants. This not only included awareness of self, but also awareness of the experiences of others and their surroundings. Another reported perception of mindfulness was the idea of being present, centered, and thoughtful, which was identified by four participants. I also reflected in the research journal that when discussing the idea of mindfulness with participants, they seemed to see mindfulness as a spiritual construct; moreover, four participants associated mindfulness with spirituality or religion, and two participants expressed reticence about mindfulness because of their perception of its association with spirituality or religion.

Stage one: Stagnation.

The stagnation period of the group occurred within the first two weeks of participation. There was no reported change in participants' perceptions of the constructs of mindfulness or trauma after week one, and very little change reported in their perceptions of trauma and mindfulness after week two. Of the change that was reported, two participants discussed that they felt more open to the idea of mindfulness, and that not coping with trauma was only hurting the participant further.

There was further evidence of this lack of change in the first two weeks in the observations as reflected in my observations in the research journal. Normal group process in the

initial phase of a group included anxiety and insecurity about the structure, norms, and other participants; this mindfulness group was no exception (Corey, Corey, & Corey, 2014). In the research journal, I noted my sense of anxiety among the participants, which manifested in difficulty on the part of the participants to concentrate through the whole meditation, and communication among participants in the social groups in which they were already comfortable before the group convened. In the research journal, I reflected on the reaction of the participants that sitting still was clearly uncomfortable for them in this beginning stage, and also reflected on reticence on the part of some participants to engage in the mindfulness group in a way that was meaningful for them.

Stage two: Awareness of past trauma and acceptance of work needed for recovery.

Stage two of the group occurred at weeks three and four, and was marked by a perception of growing awareness reflected in the research journal among many participants of the connection between mindfulness and recovery from trauma. There was also a sense reflected in the research journal of participants being more willing to work through and broaden their thinking of working through trauma to reconceptualize trauma work as being continuous instead of a one-time event. Lastly, there appeared to be an increased willingness to work through trauma by all participants.

This stage of the group was also marked by increased confidence among participants. There was the general sense as noted in the research journal that mindfulness was beginning to help the participants in that there were noted changes in participants' perceptions of mindfulness and their ability to be mindful. There was also a change in participants' perceptions of trauma in that four of the participants saw it as more subjective. Statements such as "trauma can be big or

small", "trauma can be good or bad", and "trauma can come in all forms" were common elements of the written questionnaires.

It was made clear to participants in the pre-group phase of this research and throughout the group itself that they would not be required to directly visit their trauma. At no point were participants required to disclose their trauma to me, and at no point would they be required to directly talk to the group about the trauma that they experienced. I reflected in the research journal that at this stage of the group, the participants seemed to trust that this was true. Perhaps as a result of this or as a result of their increased awareness, participants began to disclose more about their trauma and the impact that these experiences had on their lives.

Stage three: Perceptions of new awareness.

Stage three of the group occurred at weeks five and six, and was marked by a clear and deeper awareness of both mindfulness and the impact that trauma has had on the lives of the participants. There was not only a shift in the awareness of what mindfulness meant to each participant, but also their own internal ability to practice it. Six participants noted a sense of increased capacity for mindfulness, and that mindfulness was not just meditation. One participant noted that "I was practicing mindfulness without even realizing it." There was the sense reflected in the research journal that engagement of the participants had deepened, and that learning and growth were happening among the participants.

Eight participants also reported a significant shift in awareness of the role of trauma in their lives in the weekly questionnaires. There was reporting of statements such as, "I have a lot of trauma", "Trauma is deeper/ more than I thought", and "I still suppress my trauma". Changes were observed and reflected on through the research journal in interaction among participants during this time; they were sharing more deeply, and they were actively trying to support the

input of each other. Given this shift in awareness in the previous stage and this current stage, it could be hypothesized that there was a growing sense of kinship among the participants around the commonality of having experienced trauma.

There were also two significant occurrences during this stage of the group. The first was that there was an intervention at the transitional housing unit due to substance abuse, and the second was that I reflected in the research journal that I observed a sense of "now what?" among the participants. Due to the low-security environment of this particular housing unit, people allowed on work release in the community were bringing drugs and alcohol back to the transitional housing unit; I noted in my research journal that participants disclosed that this happens occasionally, and that in the past, there would be a raid and the offending women would get "shipped back to [the higher security prison]." Instead, there was an intervention by the drug and alcohol counselor on site, and five women were identified; all were mandated to treatment. Three were participants in the study. Using this as an opportunity to allow candid discussion helped the participants to realize that mindfulness can be a tool for forgiveness, and it can be a tool for recognizing and expressing genuine emotions. As noted in the research journal, all participants reported that this was a difficult exercise, but all participants noted that it was helpful for them to see how mindfulness can be applied in their daily lives.

Stage four: Understanding and ability to self-regulate emotional hurt.

Stage four marked the participants' ability to connect mindfulness and healing. This was indicated through five participants reporting a feeling of more awareness and reduced anxiety. During this time, there was reflection in the research journal that while there was a sense of skepticism among the participants at the beginning of the group around how mindfulness could possibly benefit them, by the end, there was little doubt that mindfulness was and would

continue to be a useful coping tool. In the research journal, I also reflected that the participants seemed to have gained a new awareness of the connection between ability to be aware of painful emotions and the ability to control them. I also noticed a pattern of markedly less fear about acknowledging trauma, and all participants reported that trauma had less control over their lives than it previously had in the weekly questionnaires. In terms of group dynamics, it was reflected in the research journal that at this stage, the participants supported each other and helped everyone to feel empowered; toward its end, participants approached this group from an emotional place of empowerment rather than fear.

Disclosure feedback loop among participants.

Because of the significant sense of mistrust among prisoners in this particular transitional housing unit, creating a safe space to disclose was essential, but not enough. It took participants several weeks to feel comfortable enough to disclose deeply, and there was a pattern that became apparent as this began to occur. Not only did reflections in my research journal highlight the need among participants to feel trust and validation, but also a sense of "you first" among nearly everyone in the group. However, once someone disclosed more deeply than perhaps she was comfortable with, she was met with support and validation. This in turn encouraged others to begin to disclose and discuss deeper issues and to trust each other.

Developmental Change in Self-Description

There was significant developmental change in self-description reported among participants in the mindfulness group between pre-group and post-group interviews. In the pre-group interviews, common self-descriptions among participants included loyal, energetic, compassionate, funny, caring, and strong, among others. There were also descriptors that are commonly seen as negative, such as stubborn, lonely, shy, sarcastic, angry, and many others.

Moreover, three of the 17 original participants in the pre-group interviews identified themselves as honest or trustworthy pre-group. Post-group, all six participants described themselves as either honest, trustworthy, or as a person with integrity.

The Link Between Trauma and Substance Abuse

Many researchers have explored the link between previous trauma and substance abuse (Puimette et al., 2000; Dansky et al., 1996; Rohsenow, Corbett, & Devine, 1988; Carruth & Burke, 2006). In this study, all of the 17 participants reported a history of substance abuse or addiction. In the context of this study, several sub-themes arose around the subject of substance abuse: substance use to cope with past trauma; substances as a gateway to prison; the relationship between substance use, self-esteem, and adjudication; and mixed perceptions of the benefits of coping via substance use.

Substance use to cope with past trauma.

The link between trauma and substance abuse arose in the pre-group interview phase of this study; 15 of the participants interviewed cited drugs or alcohol as a means to cope with past trauma. Twelve participants provided a direct link between substance abuse and trauma; eight participants expanded on this point, discussing that use of alcohol and other drugs were a means to numb difficult emotions associated with traumatic experiences. Four participants of the 15 in active recovery also discussed that sobriety caused them to experience more emotional difficulty related to their traumatic experiences, and that sobriety has forced them to, in a sense, re-learn how to feel negative emotions.

Substances as a gateway to prison.

While the crimes committed by the participants was never openly discussed, seven participants who disclosed their crimes said that they committed a drug-related crime, they were

under the influence of substances when they committed their crime, they committed crime in order to fund their substance abuse, or any combination of the three. For nine participants, there was a less direct, but still present link between substance abuse and crime through the trauma they had experienced, their subsequent coping via substances, and imprisonment. Four participants cited trauma as being a reason they were incarcerated, and many cited substance use as their reason for imprisonment, either in the pre-group interview or the weekly questionnaires.

The relationship between substance use, self-esteem, and adjudication.

As explored in earlier chapters, trauma can be significantly damaging to one's self-esteem. Five participants discussed loss of self-esteem indirectly by self-identifying as "people-pleasers", or through their perception of their ability to form healthy relationships and attach to others.

Mixed perceptions of the benefits of coping via substance use.

In the pre-group interviews, participants reported their perceptions of their own coping skills, and substance abuse was chiefly among them. All participants identified substance abuse as a means to cope with trauma, and there were mixed reasons about why this coping strategy was effective, or not. All of the participants identified substance use as a maladaptive coping strategy; however, seven participants were also able to identify what they perceived as benefits of substance use as it was related to their trauma, such as escape from difficult feelings or self-medicating.

Conflictual Relationship Between Mistrust and Desire to Help Others

In the pre-group questionnaire, all participants were asked what they hoped to give to the group, as well as what they hoped to gain from the group. Nine participants had received group counseling, individual counseling, or both, and 16 participants also hoped to give support, help,

knowledge, and insight to other participants. However, also apparent throughout participants' answers and feedback in the pre-group interview was a sense of mistrust of other people who might participate in the group, which was reflected in the research journal. Fourteen participants reported a feeling mistrust toward other prisoners and authority figures, and I interpreted this in my reflection in the research journal as originating from an expectation of betrayal by others. Seven participants reported that they kept to themselves or had few friends in prison, and three participants went further to say that they avoided confiding in people because it could later be used against them, by reporting that "I got close to someone here and it turned my friends against me." The other two participants reported that "Trust is difficult here. Secrets are weapons." In reflecting on her negative experiences in prison, one participant stated, "I did not know what it was like to be bullied before I came to prison." Indeed, there was ample evidence in participant answers to the pre-group interview that illustrated this point; not only were fears reported by four participants linked to having to tell others too much about themselves, but five participants described prison as a lonely place, and one where they trusted very few, if any, other people by saying things such as "I don't trust anyone here", "It is not very friendly behind the wall", "there are no serious friends or loyalty here", and "I am close with a few people, but I won't hang out with them when I leave."

Perhaps lending credibility to the reciprocity of the relationship between being helped and future helping, only one of the seventeen participants reported having been in counseling or treatment of any kind before entering prison. Five participants went further to report that prison saved their life. It could be inferred that among this particular group of participants, receiving treatment and support may have ignited a desire to help others. This was also apparent in an opening "headlines" activity in which participants engaged at week three. In this activity,

participants were to write five headlines: one for the day they were born, three for transformative moments in their lives, and one for ten years in the future. All of the participants identified future goals for themselves that involved helping others, either through addiction, emotional difficulties, or other kinds of service.

Direct Antecedents and Consequences of Participating in the Mindfulness Group

There were several experiences and feelings that were common to many, if not all, participants before coming into the group that seemed to co-occur with the participants' experiences of trauma and incarceration. These experiences included feelings of fear and isolation, mistrust of most people in their living environment, and a negative reaction toward being mandated to be in the mindfulness group. During the pre-group interviews, seven participants stated that they trusted "one or two" people in the prison environment, and that the connections that they made with others were impermanent.

There were two periods of recruitment for this group in the transitional housing unit. In the first, potential participants were invited to participate in an informational meeting; when this did not yield enough participants for a sample, prison officials mandated C-2 prisoners to participate in the mindfulness group. I reflected in the research journal that there seemed to be significant reticence among the participants after this phase of recruitment, and this was evident both in individual interviews and the first two weeks of the mindfulness group.

For the duration of the mindfulness group, not only was it reflected in all data points that there was a burgeoning awareness of the trauma that participants had experienced, but they also gained significant awareness of their own internal resources. This particularly came to light as participants discussed their experiences of others, and there was ample opportunity to discuss how these experiences could be related to mindfulness. Through the research journal analysis,

there were several points at which it was identified that participants had insight into their awareness of their effects on other people. Through the individual interviews, all participants identified points at which they became more aware of the depth of their trauma, as well as shifting their perspective on how they conceptualized their trauma. In the pre-group questionnaire, two participants reported that they not only defined themselves by their trauma, but they also blamed themselves for it and saw it as something that was unchangeable. Two participants blamed themselves for their trauma, saying things such as “my trauma is self-inflicted”, and “I caused the trauma in my own life.” While all participants were able to make indirect connections between the trauma they experienced and their subsequent incarceration, one participant drew a direct link, stating, “Trauma is why I am in prison.” Four participants cited the long-term consequences of trauma, both in the changes that it caused in them internally, as well as the continued impact of their traumas. One participant said, “Trauma has made me who I am”; another stated, “Trauma changed my life completely. Similarly, another participant said, “Trauma changed the way I look at the world”, and another stated that she saw trauma as “forever”.

However, there was significant change in both the ways that the participants conceptualized their trauma as it related to the overall picture of their lives, but they also saw it in a new way - as a work in progress as opposed to something that would always be there to affect them negatively. Three participants cited a new awareness of coping skills. One participant stated, “I have a new way to work on trauma”, and another participant said, “Trauma is more of a learning experience than something that will hold me back.” Three participants identified more awareness of their trauma; one participant stated, “I am more aware of how prominent trauma is among people and I feel less alone”, and the other disclosed, “[My traumas] don’t play as

significant a role as they used to." All participants disclosed a new awareness of a sense of control over the impact of the trauma they had experienced. One participant in particular reflected on this by saying, "I have allowed my traumas to cause me a lot more heartache and struggle than necessary." Participants also noted a reduction in anxiety in general, but also as it relates to their trauma. One participant in particular noted, "I am more at ease with things that have happened."

At the post-group phase of this research, there were several consequences of participating in the mindfulness group. Some of these included increased awareness, increased ability to self-soothe, acceptance of self and others, and contentment. More specifically, there was increased optimism, as cited by one participant, who said, "I am more optimistic for the future." Increased confidence and self-esteem were reflected by five participants, who said such things as "I feel good about who I am", "I am a work in progress but generally I feel pretty good about myself", "I have more confidence. I feel more secure about myself as a person." Five participants also cited decreased anxiety about life in general and increased coping skills, saying things such as "I am able to just stop and breathe now when I am in a stressful situation", "I have gained awareness regarding myself, my trauma, and my ability to cope with it in different ways", "I am more at ease", "I feel like I cope better and feel more deserving of forgiveness and love", and "I am more positive. I am not as hard on myself."

Conclusion

There was significant qualitative change among the participants of the mindfulness group in their ability to cope with stress and past trauma, their self-perceptions, and their ideas of mindfulness. Regardless of whether or not they finished, all of the participants reported new learning and growth at some point of their time in the group. Most also reported a significantly

increased awareness not only of how their trauma has impacted their lives, but also their abilities to cope and heal.

CHAPTER V

DISCUSSION

The goal of the current investigation was to create an emergent phenomenon after examining the effect of a mindfulness curriculum on participants' abilities to reconceptualize past trauma, and the mindfulness curriculum's impact on participant's ability to gain resilience, self-esteem, and an inner sense of control over their lives. Data were gathered from an examination of 17 female prisoners' thoughts, feelings, and reflections on a holistic wellness curriculum's impact on past life trauma and their current incarceration. This chapter begins with a summary and exploration of the emergent themes related to the aforementioned phenomenon. Within this summary, literature and research will be discussed and synthesized as it pertains to this study, and the emerging phenomenon of social support and its integral role in helping female prisoners to heal from trauma. Next, a description of the phenomenon itself is presented. The chapter concludes with a discussion of known limitations, implications and directions for additional research in professional counseling.

Primary and Secondary Themes

Internal and External Factors in Coping with Trauma

The first primary theme that emerged in the data related to coping skills that the participants already relied on before the beginning of the study, as well as factors that helped participants to heal from trauma. These included both coping skills that participants saw as positive (e.g., exercise, cooking, creative outlets) and negative (e.g., violence and drug use), as well as therapeutic interventions that participants may have found helpful (e.g., individual or group therapy). This investigation uncovered several internal and external factors in coping with trauma, which are also highlighted in the literature. Therapeutic intervention in particular seemed

to be a compelling factor in helping participants heal from trauma, with group experiences being an important part of therapeutic work. Not only is the importance of the therapeutic alliance discussed, but also participants promoted the transformative nature of prison-based therapeutic groups.

Therapeutic intervention.

A secondary theme that emerged under the umbrella of internal and external factors for coping with trauma was therapeutic intervention. This not only encompassed the idea of participation in either group or individual therapy, but also considered the idea of the therapeutic relationship and the ability to trust another person enough to talk to the participants about their issues. According to Grady and Broderson (2008), the therapeutic alliance is a central tenet to effective group counseling with prisoners. In a quantitative study conducted by these same authors of 21 male sex offenders exploring perspectives on effectiveness of treatment, this alliance between the counselor and the support of the group were integral to the effectiveness of the treatment. This closely aligns with the findings of the present investigation, in that participants identified support from peers, counselors, and group work, as important to their recovery from trauma. Similar to the present investigation, there was high value placed on the process of group work over the actual content of the group. According to Grady and Broderson's (2008) findings, participant improvement in a mindfulness group included increased awareness, self-esteem, empathy, assertiveness, and changes in relationships. Moreover, previous research (Bucklen & Zajac, 2009) has reported that the therapeutic relationship was essential in achieving and sustaining sobriety and trust others; this in turn helped participants to develop healthier coping skills.

Achieving and maintaining sobriety.

Achieving and sustaining sobriety was reported as not only a high priority among all of the participants in the current study, but also an identified positive coping skill. Bucklen and Zajac (2009), in their qualitative study of prisoners and recidivism, found that relapse into substance abuse may be a symptom of a larger problem involving difficulties with stress management. In this same study, maladaptive coping skills were identified as a possible predictor of substance abuse relapse and subsequent parole violation. It could be inferred from the data presented in this study and the literature that helping prisoners to gain coping skills outside of drug use may be an integral part of reducing recidivism.

Conflicting reports of familial support.

In terms of family support, Welch, Roberts-Lewis, and Parker (2009) identified family support as a protective factor from not only post-traumatic maladaptive coping, but also delinquency among adolescents. They went on to build a common profile of the family of someone who might be likely to offend, outlining conflict, substance abuse, and violence as common factors for both substance abuse and offending (Medrano, 1999, as cited in Welch, Roberts-Lewis, & Parker, 2009).

Additional evidence exists supporting the finding that female prisoners are invested in changing negative patterns in future generations. Poehlmann (2005), in a mixed-methods study of 98 female prisoners, found a link between early trauma and seeing relationships with their children as opportunity to change patterns that led to their own trauma. Moreover, not only may incarcerated mothers have a strong desire to stay in contact with their children while incarcerated, but this also may be important to their recovery from mental illness (Jiang & Winfree, 2006). Further highlighting this connection, Greenfeld and Snell (1999) discussed that

incarcerated mothers' abilities to maintain relationships with their children correlated with their mental health status (as cited in Poehlmann, 2005). As reflected in the pre-group interview, questionnaires, and reflective journaling, 14 of the participants identified as parents. Of the participants who identified as parents, four corroborated the discussion in the literature, reporting a desire to change negative patterns and build healthy relationships with their children in spite of negative familial influences.

The Link between Trauma and Substance Abuse

The third primary theme that emerged was the indirect and direct connections between trauma and later substance abuse. Welch, Roberts-Lewis, and Parker (2009) stated that treatment of substance abuse should include issues of victimization, empowerment, self-efficacy, self-esteem, and relationships in order to be as effective as possible, given this link between trauma and substance abuse that has become more direct in recent studies (Dass-Brailsford & Myrick, 2010; Brady, Beck, & Coffey, 2004; Malcolm, 2004). Indeed, the findings in the data of this study not only suggest that substance abuse treatment was effective in helping participants heal from trauma, but trauma-informed treatment, either in a group or individual context, was also helpful in the recovery of the participants who took part in it.

Simpson et al. (2007) discussed the link between PTSD and substance abuse as self-medication, and the idea that use of substances may enable people who have experienced trauma to manage PTSD symptoms, specifically intrusive thoughts (Simpson, 2003, as cited in Simpson et al., 2007). However, while substance abuse served to ameliorate symptoms of PTSD, it also contributed to lower distress tolerance, thus leading to increased probability of relapse (Simpson et al., 2007). Dass-Brailsford and Myrick (2010) agreed with these findings, expanding on this idea by discussing the typical lifestyle with those who chronically abuse substances. These

lifestyle factors included activities that carry with them increased exposure to trauma, including violence, crime, abuse, and accidents.

Peterson, Buser, and Westburg (2010) further illustrated the connection between substance abuse and trauma in their study of youths from a high-poverty urban area. Not only did they find a relationship between healthy attachment and high self-esteem, but they also found that self-esteem was negatively correlated with engagement in risky behaviors, such as substance abuse or illegal activity.

Conflictual Relationship Between Mistrust and Desire to Help Others

Throughout this research, reflective journal entries highlighted a reticence among group members to disclose information that they viewed as private. Particularly in the beginning, there was a sense of mistrust among the group members, both of each other and of the researcher. However, pre-group interviews reflected a desire among all participants to help others in the group, either through insight, support, or sharing of knowledge. Padgett et al. (2006) discussed that this was not a new phenomenon among people, particularly women, who had experienced trauma at some point of their lives. In a qualitative study of 21 formerly-homeless women with co-occurring mental health and substance use disorders, betrayal of trust was a primary theme among participants. Padgett et al. (2006), in their discussion of this theme in particular, highlighted the idea that “assumptive worlds were calibrated early on to include bad things – family violence, neglect, poverty, and crime” (p. 464).

Also highlighted in Padgett et al.’s (2006) study is the idea of status loss and gender, another primary theme in their findings. Because of the stigma of mental illness and homelessness, women have fewer options than men for earning a living, and most of these options are illegal (e.g., prostitution, shoplifting, assisting partners or significant others in the

commission of more serious crimes). The ultimate conclusion of this particular theme was that women are more vulnerable to being cast out by society as a result of difficulties they may have with their mental health, thus potentially leading to criminal activity.

Group Developmental Factors

There was minimal study on the developmental factors of group therapy in prisons. Several authors (e.g., Wilson, 2005; Erickson & Young, 2010; Loeffler et al., 2010) have written extensively on group therapies in prisons, yet there was little discussion of the developmental process in this unique environment and population. However, Wilson (2005) highlighted some similar factors in his work with prisoners that were compelling for this study as well. In this researcher's reflective journal, there was recognition of the idea that the study participants held this notion about themselves as being inherently "bad", and that they did not deserve things such as lovingkindness and forgiveness. Wilson (2005) articulated this idea when he cited Freud's notion that people commit crimes because they already feel guilty and that they are beyond help. Group therapy in the prison setting can give prisoners the opportunity to let go of this societal role and allow participants to make the choice to value honesty and feel protected, and to see the benefits of doing so.

In typical group development, therapeutic groups may go through five stages: pre-group (i.e. "forming"), initial (i.e. "norming"), transition (i.e. "storming"), working (i.e. "performing"), and termination (i.e. "adjourning"; Corey et al., 2013). While there were many aspects of the mindfulness group that were typical to the group process outlined by Corey et al. (2013), trust among members was an integral part of what made this group unique. The stages outlined in the previous chapter paint a picture of individual changes to be sure, but a deeper level of trust was also discussed in the research journal. I reflected that there was deeper support and cohesion

among participants as the mindfulness group progressed, and a general sense of feeling less alone was reflected on by participants in the weekly questionnaires. The developmental process of this group is outlined in Figure 1 below.

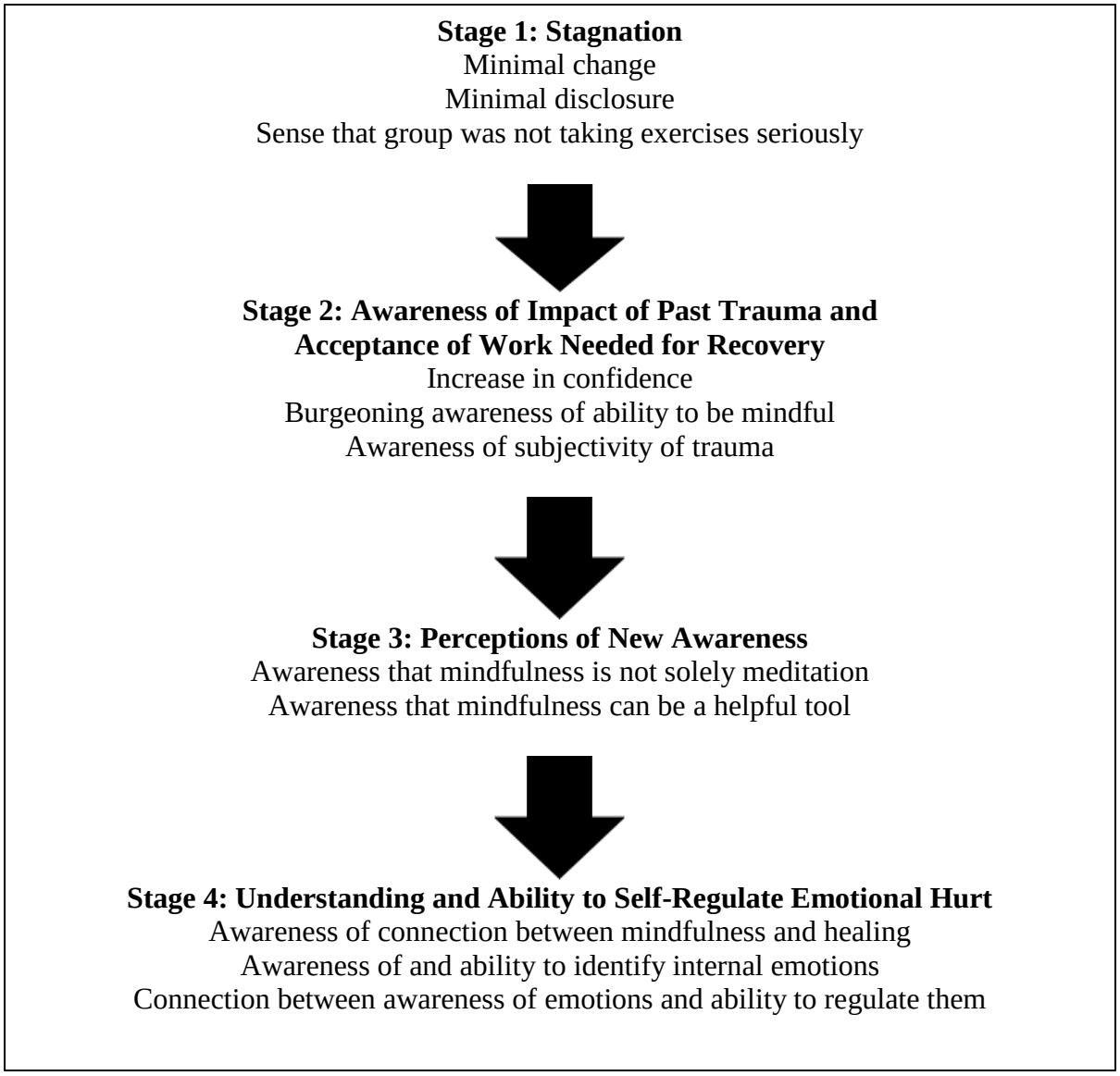

Figure 1. Developmental trajectory of mindfulness group. This figure illustrates developmental changes that took place among participants in the mindfulness group

Integral to the developmental trajectory of the mindfulness group was the feedback loop that was present in the disclosures of the participants. The link between these two phenomena was trust; in order to ensure emotional safety, participants were continually tentative about their disclosures. As reflected in the previous chapter, mistrust was related to the fears of the participants before engaging in the mindfulness group, not only of each other, but also of me as a

researcher and group facilitator. The feedback loop illustrated in figure 2 below was the manner in which the participants gained trust in the environment of the mindfulness group and were able to move through the stages that emerged.

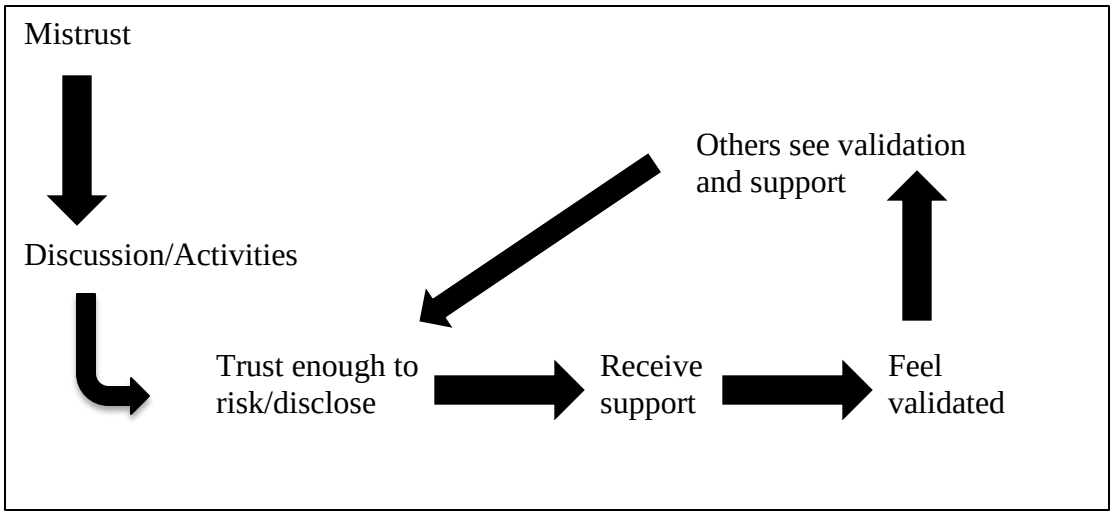

Figure 2. Disclosure patterns among participants. This figure illustrates the patterns of communication and disclosure among participants in the mindfulness group.

Wilson (2005) also discussed phenomena that were compelling for the stagnation period of this group. The most compelling idea, however, was that all of these participants seemed to feel alone in their pain, and that no one else could understand what they were going through. Wilson (2005) also considered the idea that past experiences have no impact on present circumstances, and that this could have been what caused the participants to hesitate to connect with each other at first. The idea of mistrust is also highlighted in this discussion, because this researcher felt a sense of deep mistrust in each other and lack of other participants' capacity to understand and support, rather than "use information as a weapon", as one participant put it. Emotional security and the deep need to protect it may have been the impetus behind this stagnation period among this study's participants.

In their discussion of chaos theory as it relates to group counseling, Rivera et al. (2005) described phase space, or patterns of instability and stability that emerge as a group evolves as one unit. In Chaos theory, these patterns are unpredictable and nonlinear, but patterns may still emerge. This point is illustrated in the developmental nature of the mindfulness group in that while growth was certainly nonlinear, with starts and stops among all individual participants and the group as a system, there was a pattern of growth that emerged.

There is another central tenet of group chaos theory that posits that times of conflict and destabilization may help a group to ultimately become more cohesive by helping the group and its individuals reorganize as a result of the new information that emerges (Rivera et al., 2005). This was certainly true in the mindfulness group; there were several opportunities in the group where conflict arose and they were able to use mindfulness in order to reconceptualize their situation and move forward more cohesively. This also happened on individual levels during the mindfulness group as well; all of the participants had elements of chaos in their personal lives at some point, and when these were brought into the group, they were able to use mindfulness to make new meaning of these events, and ultimately understand themselves and their environment more deeply.

While there were few authors discussing group development in prisons, chaos theory most effectively outlines the process of this development as seen in this research. While many group theories see group process and development as nonlinear, finding patterns among the chaos and using it to better understand the development of the mindfulness group was essential to understanding and being able to effectively synthesize the data being presented.

Emerging Phenomenon

During the course of this research, five primary themes materialized as a result of the reflective journal, focus groups, individual interviews, and member checks. These primary themes were organized to develop an emergent phenomenon to answer the following questions:

1. How can mindfulness training help female prisoners to cope with past trauma?
2. How do female prisoners with a history of trauma conceptualize these traumatic experiences?
3. How can mindfulness training help female prisoners reconceptualize the trauma they have experienced?
4. How can mindfulness training help female prisoners understand the impact that trauma has had on their lives?
5. How can mindfulness training help female prisoners cultivate a sense of self-esteem that may have been inhibited by a traumatic event?

These themes, which emerged from the research, were utilized to develop a phenomenon to explain the changes in perceptions of past traumas among participants. The tie that binds all of the literature and findings from this study is one of finding nonjudgmental social support from peers who have experienced similar circumstances in order to heal from trauma. This not only helped participants to cultivate a sense of empathy for their peers where there may not previously have been any, but it also helped them to take emotional risks in the safety of an empathic group. The overwhelming message in this study was that people who have been both traumatized and imprisoned seem to need an emotionally safe space where they can connect with others in order to openly discuss the impact that trauma has had on their lives without worry of being further stigmatized. Further, tools such as mindfulness can help people in this unique situation to learn

skills to more deeply connect with others, and create the environment in which healing from trauma can be facilitated by meaningful, nonjudgmental social support.

Results were examined through the lens of phenomenology; all participants reported experiencing a deep sense of loss of self and a change in their worldview as a result of having experienced trauma. According to reports from participants, further loss included coping skills, relationships, and eventually, freedom. All participants who finished this study, six in total, reported a greater sense of confidence, self-worth, and ability to cope with situations or people that they found difficult. Moreover, all participants who finished the study reported that trauma had less of an impact on their lives and their worldviews than before the study began.

Limitations

A limitation of this study was the inconsistent sample size from the beginning of the study to the end. Because of the changing nature of the population of the transitional housing unit, it was difficult to have a consistent number of participants each week. Data collection was also a limitation in this study, due to prison policies prohibiting the use of recording devices of any kind. While alternative arrangements were able to be made, there were times that recording data in this manner was difficult and time-consuming for the participants. However, in order to allow for as varied and holistic a data set as possible, weekly and post-group questionnaires were administered in a group format in order to allow for interaction among participants and discussion when necessary to allow for explanation or deeper reflection of the participants' experiences.

Another limitation of this study was that participation in the group was eventually mandated due to a lack of interest amongst participants; keeping the group compulsory would

have resulted in an inadequate sample size. However, in an effort to maintain the data's integrity, I developed a challenge-by-choice atmosphere in the group.

Implications for the Counseling Field

This study may shed light on the need in prisons not only for gender-sensitive mental health programming, but also a more trauma-informed, wellness-based approach. Acoca (1998) identified a gap in data collection, stating that most data collected from prisoners is from men; as a result, there is also a significant gap in treatment modalities in prisons, nearly all of which have been normed on male prisoners. The themes emerging from the data in this thesis surrounding relationships and self-esteem (e.g., perceptions of new awareness, increased empathy for others in the group, and developmental changes in self-description) support the need for gender-sensitive programming in prisons. Moreover, through the review of the literature, gaps were found regarding trauma-informed treatment modalities for prisoners (Miller & Najavits, 2012). While 14 participants reported receiving trauma-informed treatment while in prison, three participants reported engaging in wellness-focused treatment. The convergence of the data in this thesis outlines not only a need for trauma-focused treatment, but also for that treatment to have wellness-based underpinnings. Using a mindfulness-based approach could help participants see significant gains in their self-concepts and options outside of unhealthy coping skills in order to manage stress and heal from past traumas. This study also could help counselors out in the community to have a better understanding of released prisoners and their unique struggles surrounding past trauma and the impact it has had on their lives.

This study also highlights the need for advocacy on behalf of prisoners in the context of counseling. Not only does this research create the opportunity for mental health counselors to advocate for the mental health needs of prisoners and trauma-focused interventions, but also to

advocate for enhanced support for prisoners as they transition back into communities. These advocacy efforts can include testifying in front of legislative bodies at the federal, state, and local levels, as well as writing letters to legislators, and advocating for the unique treatment needs of prisoners to be considered in multicultural education of emerging counselors.

Opportunities for Further Study

There is opportunity, through the work done in this study, to further examine the emerging phenomenon of mindfulness and how it can cultivate further social support among prisoners from a quantitative or mixed-methods vantage point. This would not only give more of an evidence base, but it could also allow for generalizability. There is also opportunity to further explore the nuances of perceived social support in prisons, and how other treatment modalities may help to cultivate this. There may be opportunity for longitudinal research in this area; while the research extended 60 days past the end of the mindfulness group, carrying this work out for a longer timespan may be beneficial to seeing the long-term impact of this work.

Conclusion

Mindfulness can cause distress, especially in people who have experienced trauma, and particularly in places like prisons, which do not inherently instill a sense of personal safety. However, because of the nuanced and multi-faceted experiences of prisoners and the impact that trauma can have on their lives, studies of this nature are essential in helping prisoners to heal. Also abundantly clear to me as a researcher by the end of this study was the need for providing safety to prisoners, even in an environment full of chaos, turmoil, and conflict. The participants in this study had a need to feel valued and trusted by each other and by me, and providing social support in a nonjudgmental manner helped all of the participants to deeply examine, in some manner, the impact that trauma has had on their lives safely. By creating safe spaces for work of

this nature to happen in prisons, essential skills are being taught to prisoners, in turn helping them to live healthier, more productive lives both inside and outside of prison.

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APPENDIX A
RESEARCH AGREEMENT WITH DEPARTMENT OF CORRECTIONS AND EMAIL GRANTING EXTENSION TO JUNE 30, 2015 FOR DATA COLLECTION

Attachment 1

STATE OF NEW HAMPSHIRE
DEPARTMENT OF CORRECTIONS
OFFICE OF THE COMMISSIONER
PO BOX 1806
CONCORD, NH 03302-1806

603-271-5600 FAX: 603-271-5643
TDD Access: 1-800-735-2964

William Wrenn, Commissioner

RESEARCH AGREEMENT.

I. ALL AGREEMENTS REGARDING ACCESS MUST BE IN WRITING

II. IN ACCORDANCE WITH DEPARTMENT OF CORRECTIONS POLICY AND PROCEDURES:

A. I HAVE READ AND AGREE TO ABIDE BY THE DEPARTMENT OF CORRECTIONS POLICIES ON ACCESS TO OFFENDER INFORMATION.

B. I AGREE TO REQUEST AND PRESERVE THE CONFIDENTIALITY OF STAFF AND OFFENDERS THROUGHOUT AND AFTER THIS PROJECT, AND TO ADHERE TO TITLE 45, PART 46: PROTECTION OF HUMAN SUBJECTS, CODE OF FEDERAL REGULATIONS.

C. I AGREE TO PROVIDE THE DEPARTMENT OF CORRECTIONS WITH A DRAFT COPY OF THE RESEARCH FINDINGS FOR PURPOSES OF REVIEW AND COMMENT NOT LESS THAN 60 DAYS PRIOR TO THE PUBLICATION OR SUBMISSION OR FINDINGS TO ANY OUTSIDE ENTITY, PUBLIC OR PRIVATE.

D. I UNDERSTAND ALL OFFENDERS PARTICIPATION IN RESEARCH ACTIVITIES IS VOLUNTARY.

E. I UNDERSTAND THE DEPARTMENT OF CORRECTIONS PROHIBITS OFFENDERS FROM PARTICIPATING IN MEDICAL, PHARMACEUTICAL, OR COSMETIC TESTING FOR EXPERIMENTAL OR RESEARCH PURPOSES.

F. I AGREE TO SUBMIT STATUS REPORTS ON THE PROGRESS OF RESARCH ACTIVITIES IN A TIMELY FASHION, AS MAY REASONABLE BE REQUESTED BY THE DEPARTMENT OF CORRECTIONS.

III. I UNDERSTAND THAT VIOLATIONS OF ANY OF THE ABOVE PROCEDURES ON MY PART, OR THE PART OF MY STAFF COULD RESULT IN ADVERSE ACTION.

TITLE OF RESEARCH PROJECT Healing Trauma among Female Prisoners through Mindfulness: A Phenomenological Study

INSTITUTIONAL AFFILIATION Plymouth State University

PROJECT START AND END DATES Start 07/15/14, end 12/01/14

DATE 06/26/14 PRIMARY INVESTIGATOR Ryan Aguilera

DATE 06/26/14 COMMISSIONER William Wrenn

DATE 06/26/14 DIRECTOR OF RESEARCH

Please know that I am willing to extend the period identified on our signed Research Agreement to June 30, 2015 to enable you enough time to collect and analyze the data.
Please continue to keep me posted on your progress with this study.
Thank you.
Joan
P.S. Please keep a copy of this email for your records.

Joan Schwartz, PhD
Director, Office of Research and Planning
NH Department of Corrections
105 Pleasant St, Box 1806
Concord, NH 03302-1806
Ph. 603-271-5662

APPENDIX B
INFORMED CONSENT

Informed Consent

INVESTIGATOR(S) NAME: Ryan Aquilina

STUDY TITLE: Healing Trauma among Female Prison Inmates through Mindfulness: A Phenomenological Study

PURPOSE OF THE STUDY

The purpose of this research is to explore how female prisoners cope with past trauma, as well as exploring whether or not mindfulness can increase self-esteem, internal locus of control, and resilience among female prisoners. I am being asked to be a participant in this study because I am an incarcerated female with a personal history of trauma.

DESCRIPTION OF THE STUDY

The focus of this research study will be to investigate how mindfulness has a positive impact on coping skills and resilience of female prison inmates. This will be accomplished by having participants engage in an eight-week mindfulness training group experience. During this time, participants will be taught mindfulness techniques including meditation. The hope is that participants will inherently learn new ways to cope with traumatic experiences, as well as learning to cope with the stress of everyday life in the prison environment. Learning will be assessed via a questionnaire and interview at the beginning of the study, followed by a weekly questionnaire, an informal check-in at week four, a more in-depth questionnaire and check in immediately post-group, and another questionnaire 30 days post-group.

TIME COMMITMENT

Participants will be expected to participate in a mindfulness training group approximately two hours per week, and participate in homework exercises at least three times per week. The total weekly time commitment for this study's participants is approximately three to four hours per week, including the time in the group.

RISKS AND DISCOMFORTS

As a participant in this study, I may experience risk or discomfort. Potential risks are primarily psychological, and include feeling distress or discomfort due to revisiting any trauma that I may have experienced (please see risk statement for a more detailed outline of these risks).

BENEFITS

The potential benefits of participating in the study may include increased resilience and greater tools to handle stress, and increased self-esteem.

ALTERNATIVE PROCEDURES

The alternative procedure would be to not take part in the recording of data. If at any time I feel uncomfortable continuing my participation in the group or in the study, I am free to leave without consequence. If I need assistance understanding this form (either via a translator or

alternative method of dispensing the information) or any other materials related to this study, then I will be provided with assistance.

CONFIDENTIALITY

I understand that my confidentiality will be protected by the researcher in accordance with the limits set forth by the New Hampshire Department of Correction. All documents and information pertaining to this research study will be kept confidential in accordance with all applicable federal, state, and local laws and regulations. I understand that data generated by the study may be reviewed by Plymouth State University's Institutional Review Board, which is the committee responsible for ensuring my welfare and rights as a research participant, to assure proper conduct of the study and compliance with Plymouth State University regulations. If any presentations or publication result from this research, I will not be identified by name.

I understand that I am responsible for anything that I disclose in the group setting, and that respect for confidentiality, while guaranteed by the researcher, cannot be guaranteed on the part of other group members. I acknowledge that the researcher assumes no responsibility for breaches of confidentiality on the part of group members, and that certain disclosures may result in interpersonal conflict. I also understand that there may be legal risk in what I choose to disclose in the group setting.

I understand that the information collected for this study will be kept in a double-locked confidential area. Information will only be identified by a pseudonym unrelated to the participant's identity. Participant confidentiality will be also be protected by shredding the information generated after the data has been reviewed. Data stored on statistical software will have no identifying information other than a pseudonym unrelated to my name.

TERMINATION OF PARTICIPATION

I understand that participation in this study is voluntary, and I may choose to withdraw from this study at any time and for any reason. If I choose to drop out of the study, I will contact the principal investigator and my research records will be destroyed.

COMPENSATION

I will not receive payment for being in this study. Participation in this study is strictly voluntary. There will be no cost to me for participating in this research. Participation in this study is strictly voluntary.

INJURY COMPENSATION

Neither Plymouth State University nor any government or other agency funding this research study will provide special services, free care, or compensation for any injuries resulting from this research. I understand that treatment for such injuries will be at my expense, or via the New Hampshire Department of Corrections.

QUESTIONS

All of my questions have been answered to my satisfaction and if I have further questions about this study, I may contact Ryan Aquilina at rsrogers04@mail.plymouth.edu. If I have any questions about the rights of research participants, I may call the Chairperson of the Plymouth State University's Institutional Review Board at 603.535.3193.

VOLUNTARY PARTICIPATION

I understand that my participation in this study is entirely voluntary, and that refusal to participate will involve no penalty or loss of benefits to me. I understand that if at any time I start to feel unsafe or uncomfortable with the content that I am disclosing, I can let the researcher know and she will stop or change topics. I understand that the researcher will always respect my opinion and wishes regarding the level and depth that I wish to disclose. I also understand that I am free to withdraw or refuse consent, or to discontinue my participation in this study at anytime without penalty or consequence.

Signatures:

_____ _____

Participant's Signature Date

I, the undersigned, certify that to the best of my knowledge, the subject signing this consent form has had the study fully and carefully explained by me and have been given an opportunity to ask any questions regarding the nature, risks, and benefits of participation in this research study. I have received a copy of this consent form for my reference as needed, which includes all pertinent contact information for the principal investigator and Plymouth State University's Institutional Review Board.

Ryan S.R. Aquilina

Investigator's Name (Print)

_____ _____

Investigator's Signature Date

Plymouth State University's IRB has approved the solicitation of participants for the study until

Leave blank, a date will be assigned.one year from IRB approval.

APPENDIX C
PRE-GROUP INTERVIEW QUESTIONS

1. What do you hope to gain from participation in this mindfulness group?

2. What do you hope to give from participating in this mindfulness group?

3. What are your fears about participating in this group?

4. What does trauma mean to you?

5. What does mindfulness mean to you?

6. How has your trauma impacted your life?

7. What have you done in the past to cope with your trauma?

8. Of the things you have done in the past to cope with trauma, what has worked? What hasn't? Why?

9. What is your relationship with your family members like? Please specify:

    a. Parents

    b. Siblings (if any)

    c. Any other relatives or caregivers who have been important in your life

10. What has your experience been in the prison environment? Please describe:

    a. Relationships that you may have formed

b. Any difficulties that you may have encountered in your experience

c. Any ways that the prison experience may have been a benefit to you (examples include more options for treatment, you may feel safer in prison than you did out in the community, or you may have been able to build skills that you may not otherwise have gained)

11. Who are the three closest people to you? What is your relationship like?

12. Please list three ways that you would describe yourself.

APPENDIX D
WEEKLY QUESTIONNAIRES

Week 1 Questionnaire

1. What are some of the benefits of mindfulness that we discussed this week that may apply to you?

2. What are questions or concerns that you may have about participating in this group now that we have discussed ground rules?

3. Is there anything that you did not share with the group that you would like me to know? If so, what is it?

4. What did this week's experience bring up for you in terms of the trauma you have experienced in your life?

5. What does mindfulness mean to you?

6. What does trauma mean to you?

7. What did this week's experience bring up for you in terms of trauma you have experienced in your life?

8. How did you feel about the lovingkindness meditation?

9. Is there anything that you did not share with the group that you would like me to know? If so, what is it?

10. How is your view of mindfulness different than it was before this week?

11. How is your view of trauma different than it was before this week?

Week 2 Questionnaire

1. What did this week's experience bring up for you in terms of trauma you have experienced in your life?

2. How did you feel about the lovingkindness meditation?

3. Is there anything that you did not share with the group that you would like me to know? If so, what is it?

4. How is your view of mindfulness different than it was last week?

5. How is your view of trauma different than it was last week?

Week Three Questionnaire

1. What did this week's experience bring up for you in terms of trauma you have experienced in your life?

2. How did you feel about the freeze response meditation?

3. Is there anything that you did not share with the group that you would like me to know? If so, what is it?

4. How is your view of mindfulness different than it was last week?

5. How is your view of trauma different than it was last week?

Week Four Questionnaire

1. What did this week's experience bring up for you in terms of trauma you have experienced in your life?

2. How did you feel about the breathing meditation?

3. Is there anything that you did not share with the group that you would like me to know? If so, what is it?

4. How is your view of mindfulness different than it was last week?

5. How is your view of trauma different than it was last week?

Week Five Questionnaire

1. What did this week's experience bring up for you in terms of trauma you have experienced in your life?

2. How did you feel about the forgiveness meditation?

3. Is there anything that you did not share with the group that you would like me to know? If so, what is it?

4. How is your view of mindfulness different than it was last week?

5. How is your view of trauma different than it was last week?

Week Six Questionnaire

1. What did this week's experience bring up for you in terms of trauma you have experienced in your life?

2. How did you feel about the walking meditation?

3. Is there anything that you did not share with the group that you would like me to know? If so, what is it?

4. How is your view of mindfulness different than it was last week?

5. How is your view of trauma different than it was last week?

Week Seven Questionnaire

1. What did this week's experience bring up for you in terms of trauma you have experienced in your life?

2. How did you feel about the body scan meditation?

3. Is there anything that you did not share with the group that you would like me to know? If so, what is it?

4. How is your view of mindfulness different than it was last week?

5. How is your view of trauma different than it was last week?

Week Eight Questionnaire

1. What did this week's experience bring up for you in terms of trauma you have experienced in your life?

2. How did you feel about the breathing meditation?

3. Is there anything that you did not share with the group that you would like me to know? If so, what is it?

4. How is your view of mindfulness different than it was last week?

5. How is your view of trauma different than it was last week?

APPENDIX E
POST-GROUP QUESTIONNAIRES

Post-Group Questionnaire

1. What do you feel that you have gained from participation in this group?

2. Over the course of the eight weeks, what do you feel that you have given through participation in this group?

3. Please think about the fears that you had coming into this group. Did the things you feared happen? If so, how so?

4. What does mindfulness mean to you?

5. Does trauma impact your life in the same way as it did eight weeks ago? Please discuss either way.

6. Has the way you cope with your trauma changed in the past eight weeks? If so, how so?

7. Have your relationships changed at all since participating in this group? If so, how?

8. Has your experience in the prison environment changed at all as a result of participating in this group? If so, how?

9. How do you feel about yourself?

30 and 60 Days Post-Group Questionnaires

1. What does mindfulness mean to you?

2. Have you been able to practice mindfulness in the month since this group ended? If so, what have been your experiences? If not, what has been challenging for you?

3. What do the traumas you have experienced look like in the overall picture of your life?

4. Does your past trauma impact you the same way as it used to? Either way, please discuss.

5. Has your experience in the prison environment changed at all in the past month? If so, please discuss.

6. Please list three ways that you would describe yourself.