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Personality pathology, criminal careers, and disciplinary problems of women in a county jail.

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PERSONALITY PATHOLOGY, CRIMINAL CAREERS, AND DISCIPLINARY PROBLEMS OF WOMEN IN A COUNTY JAIL

A Dissertation Presented

by

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DEDICATION

In dedication to Rick Goldberg for seeing me through.

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Finally, I would like to thank all the women at HCHC who participated in the study. By agreeing to participate, these women were willing to examine themselves and their lives in a way that required courage and honesty. I am especially grateful to the nine women who participated in the biographical interview portion of the study. These women revealed poignant life stories filled with both tragedy and hope. They engaged in this process not only for themselves, but also for the benefit of women who may also find themselves at HCHC.

ABSTRACT

PERSONALITY PATHOLOGY, CRIMINAL CAREERS, AND DISCIPLINARY PROBLEMS OF WOMEN IN A COUNTY JAIL

SEPTEMBER 2001

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The present study was conducted as an evaluation of women in a county jail. Using a combined qualitative and quantitative approach, 49 women were administered the Personality Assessment Inventory and the Schedule for Nonadaptive and Adaptive Personality. Nine women were interviewed regarding their developmental experiences, psychological symptoms, criminal histories, and behavior while incarcerated. Of the nine women, the narrative data of three women are discussed in detail. Results of the study suggest that many women have a range of clinical problems, most commonly alcohol and drug dependence, traumatic stress, depression, and suicidality. Many women also showed evidence of antisocial and borderline personality traits, yet few women had narcissistic or histrionic traits. Personality disordered women did not differ from non-disordered women with respect to the number of disciplinary violations or time spent in solitary confinement. Aggressive women, however, had a greater number of disciplinary violations and spent more time in solitary confinement than non-aggressive women. Neither aggressiveness nor the presence of a personality disorder was related to the seriousness of current criminal charges, or the level of violence associated with those

charges. Various themes from the narrative data regarding the relationship between personality disorder, criminal history, and disciplinary problems are discussed. Conclusions and recommendations for reducing the number of incarcerated women are also discussed.

PREFACE

My interest in the topic of my dissertation grew out of a love of psychological assessment. The rewarding process of evaluating psychological functioning started as a labor of love in my first assessment course. That course, taught by my advisor and chair of my dissertation committee, Richard Halgin, began a process of clinical inquiry that continues to stimulate and fascinate. In electing to do a forensically focused internship at the Hampden County House of Correction (HCHC), I had hoped to broaden my early experiences in psychological assessment.

At HCHC, I worked in the Crisis Stabilization Unit (CSU), a 24-cell acute psychiatric unit housed in the medical building. My duties were primarily to conduct psychological evaluations, many of which were personality assessments. Objective and projective personality instruments were used to make diagnostic clarifications and treatment recommendations. The entire jail was my territory; I interviewed and tested patients (whom I now called inmates) on the CSU, on the men and women's units, even in solitary confinement. Michael Sherry, my supervisor at the time, taught me how to work with difficult and often unwilling inmates.

The women at HCHC fascinated me. First, the women wanted to talk with me. Unlike the men I had seen, who felt that talking about anything "psychological" was akin to abdominal surgery, the women talked freely of their lives in jail, families, fears, hopes, and disappointments. Second, their lives were complex, which made evaluating them and recommending treatment options challenging. The women had multiple identities; some saw themselves as drug addicts, criminals, and abuse victims, while others saw

themselves as mothers, students, activists, writers, and would be entrepreneurs. Last, most women whom I encountered were not only in need of psychological services, but were also desirous of them. They wanted help, which made working with them especially rewarding.

My love of psychological assessment and my positive experiences working with the women at HCHC congealed into a potential dissertation topic: a personality study of incarcerated women. Women's disciplinary records and criminal histories were two practically relevant variables to examine as they might relate to personality.

I had several hopes for the project. First, I hoped that my research would help to provide important diagnostic information on the prevalence of psychological symptoms, such as depression, suicidality, traumatic stress, and substance abuse, which are especially prominent in incarcerated women. Second, I hoped that the results of my study would help to elucidate the importance of taking into account personality and personality pathology in assessing incarcerated women for classification, treatment, and release planning. Last, I hoped to provide an in depth examination of the lives of a select group of women to provide a story and context for understanding their psychological symptoms, criminal involvement, and behavior in jail. One potential outgrowth of the project would be the development of a screening tool for personality pathology to help correctional staff identify women prone to disciplinary problems and in need of closer observation and management.

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CHAPTER 1

THE EMERGENCE OF THE WOMAN INMATE

Women Behind Bars: Why?

While the number of incarcerated men in the United States doubled during the years of 1983 to 1994, the number of incarcerated women increased three-fold (Maguire & Pastore, 1995). Numerous psychological, sociological, and criminal-justice theories have been proposed to account for these increases in general, and for women's steadily increasing in particular. Some theorists (e.g., Chesney-Lind, 1997; Pearson, 1997) have emphasized the increased permeability of social norms and roles for women during the last thirty years that has led women to challenge traditional gender roles and engage in more male gender-typed behaviors. Alternatively, Teplin (1990) described the apparent "criminalization" of the mentally ill. She asserted that individuals who might have been treated in mental health facilities are instead arrested as an unintended consequence of deinstitutionalization and inadequate community mental health resources. This phenomenon has led to an increased number of men and women in jails and prisons who may have previously been in more long-term care in psychiatric facilities. Last, Covington (1998) has pointed to recent mandated sentencing laws for drug offenses resulting from the "war on drugs." While these laws were designed to rid society of dangerous drug dealers, Covington contends that they have inadvertently led to the sentencing of more women to prison than men, most of whom were convicted solely of drug possession charges.

Notwithstanding the various contributing factors underlying their increased presence in correctional systems, incarcerated women pose unique challenges to administrators of the criminal justice system. Jail and prison overcrowding is endemic. Moreover, inmate alcohol and substance abuse, homelessness, poverty, and unemployment are concomitant issues that impact incarceration and complicate release planning and community management of men and women inmates. Incarcerated women, however, have multifaceted health care needs that are different from those of men (Covington, 1998). Compared to incarcerated men, women inmates have an increased prevalence of sexually transmitted diseases (Covington, 1998), more frequent and severe abuse histories (McClellan, Farabee, & Crouch 1997), and an increased susceptibility to psychiatric illness in general (Teplin, Abrams, & McClelland, 1996). Incarcerated women have other unique health care issues such as pregnancy and childcare issues that have become pressing concerns to health care providers working in the criminal justice system. In the context of their increased presence in the criminal justice system and their unique health care needs, the present study of incarcerated women was conducted. The remainder of this chapter will be a literature review addressing issues of inmate mental health, criminality, and behavior during incarceration, especially among incarcerated women. The chapter will conclude with an outline of the proposed study and proposed research questions and hypotheses.

Incarcerated Women and Mental Health

The mental health of men and women inmates is of particular concern for policy makers, health care providers, and correctional staff. Several researchers, using

predominately incarcerated male samples, have documented the high prevalence of substance abuse disorders and antisocial personality disorder (ASPD) (see Teplin, 1994, and Widiger & Corbitt, 1995 for summary). In their surveys of the literature, Teplin, (1994) and Widiger & Corbitt, (1995) found that diagnoses of substance use disorders ranged from 60% to 80%, while rates of ASPD ranged from 49% to 80% among incarcerated individuals. The prevalence rates of other mental disorders in incarcerated individuals have only recently been investigated.

In one study, Teplin (1990) used a sample of male urban jail detainees and found the prevalence rate for inmates with major mental illness (schizophrenia and major affective disorders) to be approximately two to three times greater than rates for these disorders in the general population, even after controlling for differences between the jail sample and the general population. Teplin found that the most frequently occurring diagnoses were substance abuse disorders and affective disorders. She also assessed for ASPD, a personality disorder thought to be endemic in incarcerated individuals, and found a prevalence rate of 49%. In a related study, Abram & Teplin (1991) found that the rates of co-disorders (major mental illness, ASPD, and substance abuse) in a sample of urban male detainees were substantially higher than rates for the co-occurrence of these disorders in a community sample described in the Epidemiological Catchment Area (ECA) study of Robins & Regier (1991). These results are particularly striking given that the ECA data and those from the Abram & Teplin study were obtained in the same year and used the same diagnostic instruments. Together, these studies suggest that several

psychiatric disorders (severe mental illness, substance use disorders, and ASPD) occur more frequently in incarcerated men than in the general population.

Very few researchers, however, have investigated the prevalence of psychiatric disorders among *women* inmates. Those researchers who have studied women inmates have highlighted important differences between incarcerated men and women in diagnostic profiles, rates of mental illness, and developmental experiences. For instance, researchers have found that incarcerated women, compared to incarcerated men, have more extensive histories of early traumatic experiences of abuse and neglect (see Browne, Miller, & Maguin, 1999). Browne, Miller, & Maguin concluded that approximately 60% of women inmates reported some form of early sexual abuse, and over 80% reported having experienced either sexual *or* physical abuse. Some investigators (e.g., Chesney-Lind, 1997) have held that early experiences of victimization are related to women's later criminal behavior as well as to other difficulties, including proneness to psychiatric disorders (including personality disorders and substance-related disorders). Other investigators (e.g., Falkin & Strauss, 1997; Rosenbaum & O'Leary, 1981) have explored the relationship between early experiences of victimization and subsequent impaired parenting and increased likelihood of committing child abuse. Clearly, incarcerated women's early experiences of victimization and the sequelae of victimization are important issues for mental health and criminal justice workers working with these women.

Two recent large scale epidemiological studies (Jordan, Schlenger, Fairbank, & Caddell, 1996; Teplin et al., 1996) provide a broad perspective on the prevalence of

psychiatric disorders in incarcerated women and further our understanding of the relationship between crime and psychiatric disorder. These studies are important for they represent the first attempts to use standardized (and comparable) diagnostic procedures and matched community samples to assess psychiatric disorders.

Jordan, Schlenger, Fairbank, & Caddell (1996) used the Composite International Diagnostic Interview (CIDI), a modification of the Diagnostic Interview Schedule (DIS), with a sample of 805 convicted female felons. They found that about 66% of the sample met criteria for at least one lifetime psychiatric disorder. Incarcerated women were especially prone to diagnoses of alcohol and drug abuse and dependence, ASPD, mood disorders, and PTSD compared to a matched community sample. Drug abuse or dependence was the most prevalent diagnosis (44%), while alcohol abuse or dependence was the second most common diagnosis (39%). The lifetime prevalence of ASPD was 12%. Interestingly, the third most prevalent psychiatric diagnosis was borderline personality disorder (BPD) with a lifetime prevalence of 28%. Individuals with this disorder are prone to impulsive behavior, unmodulated anger, unstable self-image, and chaotic interpersonal relationships (American Psychiatric Association, 1994). A history of childhood physical or sexual abuse was thought to potentiate the development of these symptoms and BPD (Herman, Perry, & van der Kolk, 1989). Jordan et al. (1996) concluded by stating that the high rates of psychiatric disorders, specifically the rates of BPD, ASPD, substance abuse, and PTSD, may be related to a woman's exposure to trauma. Jordan et al. (1996) suggested that these individuals are in acute need of treatment; they asserted that a correctional setting might be a potential site for secondary

and tertiary preventative interventions in which a woman's traumatic past can be addressed.

In another large-scale epidemiological study of 1272 women detainees awaiting trial, Teplin et al. (1996) used diagnostic procedures similar to those used by Jordan et al. (1996) and found comparable rates of psychiatric disorders. They found that over 80% of the sample met diagnostic criteria for at least one lifetime disorder. Foremost among these disorders were drug abuse or dependence (64%), and alcohol abuse or dependence (32%). The rate of major mental illness (schizophrenia or major affective disorders) was 18.6%. Teplin et al. found a 34% lifetime prevalence of PTSD and a 14% lifetime prevalence rate of ASPD. They did not assess for any other personality disorder. These researchers then compared their data with a community sample in the ECA study. The women detainees had higher rates of all disorders assessed (except for schizophrenia and panic disorder) compared to those in the ECA study. Incarcerated women were especially prone to diagnoses of substance-related disorders and ASPD. Teplin, Abram, & McClelland (1996) then compared their data with a comparable sample of male detainees from an earlier study (Teplin, 1994). They found that incarcerated women in their sample were disproportionately more susceptible to psychiatric disorders than the men; nineteen percent of women exhibited major mental illness compared to 9% of men. The researchers concluded: "Women are more impoverished and underserved than men in jail. Although the courts have mandated that women prisoners must have services equivalent to males, in practice they have been deprived. Many detainees have more

than one psychiatric disorder and jails need treatment programs for persons with co-morbidity" (p. 511).

These studies point to several salient issues regarding women inmates and mental health. First, women have unique health care needs that impact their incarceration and criminal justice involvement. Second, incarcerated women are disproportionately more susceptible to many psychiatric disorders than non-incarcerated women and in some cases, more susceptible than incarcerated men. Third, the majority of women inmates have extensive histories of victimization that may be linked to future criminal activity and the development of psychiatric disorders (especially PTSD, personality disorders, and substance-related disorders).

Criminality and Psychological Disorders

The relationship between mental illness and criminal behavior has been a topic of speculation and debate for many years, with particular attention to the relationship between mental illness and violent crime. News headlines describe heinous acts of violence by individuals who are deemed mentally ill. Several high profile cases of mentally ill perpetrators of violence (e.g., John Hinkley and Jeffrey Dahmer) have contributed to a widespread belief that mental illness and violence go hand-in-hand.

The relationship between mental illness and crime, however, has only recently been subjected to methodologically rigorous study. Despite some notable exceptions (e.g., Porporino & Motiuk, 1995; Teplin et al., 1994; Torrey, 1994), there is a growing consensus among mental health and criminal justice researchers that mentally ill individuals are more prone to acting violently than those who are not mentally ill,

especially for those individuals who are not receiving any type of psychiatric treatment (for a review, see Marzuk, 1996). This relationship seemed most significant for those with a major mental illness (especially for those who experienced psychotic symptoms at the time of the offense), as well as for those who actively abused substances. A recent report by the Bureau of Justice Statistics (Ditton, 1999) substantiated this relationship. The report cited that 53% of mentally ill inmates are in state prison for a violent offense, compared to 46% of non-disordered inmates. Moreover, 33% of the mentally ill are incarcerated for a violent offense, compared to 13% of non-disordered inmates. While this method of analysis introduced a selection bias by focusing only on those who already have been deemed mentally ill, the report used a large-scale survey across all federal prisons to highlight the salience of mental illness in those who commit violent crime.

Understanding the relationship between mental illness and criminality has obvious ramifications for the prediction and prevention of crime. Is the presence of a mental disorder a reliable risk factor for repeat offenses? Do the criminal careers of mentally disordered offenders unfold in a way distinct from their non-disordered counterparts? There are other reasons why it is imperative to understand the relationship between psychiatric diagnosis and criminality. Tailored treatment strategies may be developed and recommended for mentally disordered offenders who have criminal involvement. Furthermore, the American Bar Association (1986) has recommended diversionary procedures for mentally disordered detainees who commit minor offenses. As pretrial decision-making is often determined by the severity of the alleged offence, it

becomes essential that psychiatric diagnosis and criminal history be used together to inform judicial decision-making.

Most researchers who study the relationship between psychiatric disorders and criminality have focused on violent criminals who are also mentally disordered. Few, however, have examined inmates who are dually diagnosed and how their psychiatric disorders may be linked with various types of criminal activity. Since many offenders are dually diagnosed, (Abram, 1989; Côté & Hodgins, 1990), and most mentally disordered offenders are dually diagnosed, (Abram & Teplin, 1991), investigating this relationship is logical and practically relevant.

Abram's (1989) study of male detainees awaiting trial is one exception. She examined the impact of an inmate's psychiatric disorder(s) on various facets of his criminal career. She studied 728 male detainees who were stratified by their arrest charge (violent felonies, non-violent felonies, and misdemeanors). Abram administered the Diagnostic Interview Schedule (DIS) to assess three common psychiatric disorders in incarcerated populations, ASPD, alcohol abuse, and substance abuse. She was interested in examining differences in criminal histories between singly and dually diagnosed offenders. Inmates were classified as having one of the seven possible permutations of drug, alcohol, and ASPD diagnoses, or no disorder. Abram found that current arrest charges were significantly related to diagnoses. Contrary to expectations, having an alcohol disorder per se was not associated with an increase in either violent or non-violent criminality. Drug abuse as a sole diagnosis, however, was associated with increased criminality for both felony property crimes and misdemeanor crimes. Finally,

a diagnosis of ASPD was related to felony property crimes, misdemeanors, and violent crimes. This relationship held for those who were singly diagnosed with ASPD or dually diagnosed with ASPD and drug or alcohol disorders. Antisocial drug abusers, in particular, were the most violent and had the greatest number of prior arrests.

Abram (1989) concludes by pointing out the implications of her results: "Criminal recidivism is associated with the least treatable detainees...It is precisely the antisocial substance abusers who are committing the most, and possibly the worst, crimes" (p. 144). Abram's study advanced our understanding of the psychopathological correlates of crime by employing a detailed analysis of psychiatric diagnoses, their co-occurrence, and their relationship to various types of criminal offenses. Abram concluded by suggesting that future researchers study other forms of personality pathology, their co-occurring disorders, and their relationship to criminal activity.

Diagnostic studies of women inmates that also examine a woman's criminal history are few. Two studies (Lamb & Grant, 1983; Robertson, Bankier, & Schwartz, 1987), however, represented early attempts at examining the role that psychiatric disorder plays in criminality in women. Lamb & Grant (1983) used non-standardized diagnostic procedures in their study of 101 incarcerated women who were referred for psychiatric treatment in a county jail. They found that 86% of the women had a history of psychiatric hospitalization and 58% met criteria for an Axis I diagnosis according to DSM-III criteria (American Psychiatric Association, 1980). Surprisingly, only two women were diagnosed with ASPD; no other personality disorder was assessed. Lamb & Grant also found that 94% of the women had prior arrest records and 37% had been

recently arrested for felonies, of which 46% were considered violent felonies. Although this study was an early attempt at examining psychiatric disorder and criminality in women inmates, it did not systematically examine this relationship.

In a Canadian study, Robertson, Bankier, & Schwartz, (1987), assessed 100 female offenders with respect to their psychiatric diagnosis and criminal histories. Using a non-standardized diagnostic interview, these researchers assessed for substance use disorders, ASPD, and psychosis according to DSM-III criteria (American Psychiatric Association, 1980). They found that 60% of the women met criteria for ASPD and 40% met criteria for either a drug or alcohol disorder. The women's criminal histories varied: 76% were convicted of non-violent offenses, with theft being the most common offense, and 24% were convicted of violent offenses. These researchers then examined those inmates who were convicted of violent offenses and found a significant relationship between a woman's illicit drug use, alcohol abuse, family history of crime, and her propensity to commit violent crime. These researchers concluded by suggesting that "the differences between the violent and non-violent female offenders appears to be more striking than the differences between male and female offenders since violent males also tend to have lower education, a family history of violence, and a history of alcohol abuse" (p. 754).

Finally, Teplin et al. (1996), in their large-scale epidemiological study of women detainees, examined the relationship between an inmate's arrest charge and her psychiatric diagnosis. These researchers grouped current charges into four categories: violent felony, nonviolent felony, violent misdemeanor, and nonviolent misdemeanor.

Psychiatric disorders were classified into schizophrenia and other psychoses, major depressive disorder, drug or alcohol disorder, and no disorder. ASPD (and other personality disorders) were not examined in this analysis. Teplin et al. used the most narrow recency criteria of the Diagnostic Interview Schedule (DIS) to examine the contemporaneous relationship between psychiatric disorder and arrest charge. They found no significant differences between any of the mentally disordered groups and the non-disordered group in either severity (misdemeanor or felony), or injuriousness (non-violent or violent) of current charge. There was a trend, however, for women with schizophrenia or other psychoses to be arrested more often for violent crime than non-disordered women.

In summary, results from the few studies that have examined the relationship between criminality and psychiatric diagnosis have pointed to equivocal conclusions. A diagnosis of ASPD in addition to a drug or alcohol diagnosis is associated with an increased likelihood of committing violent crime for male detainees. The propensity of women to commit violent crime, like that of men, seems to be influenced by substance use, history of violent crime, and family history of violence. Any relationship between particular psychiatric diagnosis (es) and type of criminal offense, however, has not been substantiated in studies of incarcerated women (Teplin et al., 1996). More research is needed to elucidate this relationship in incarcerated women.

Inmate Misbehavior and Psychological Disorders

Inmates who are persistent management problems pose numerous challenges for correctional staff. Escapes, assaults, possessions of contraband, rule infractions, and

general behavioral disturbances are commonplace in correctional facilities. Prison and jail staff must continually monitor and respond appropriately to inmates' problematic behaviors in order to insure the safety and protection of the inmates themselves, other inmates, and society at large.

One topical issue for both correctional staff and criminal justice researchers is predicting who will be a disruptive inmate. Some researchers have examined whether psychologically disordered inmates are more prone to disciplinary violations than their non-disordered counterparts. At the heart of this question is the adaptation to a life behind bars: Do mentally disordered inmates react differently to imprisonment than non-disordered inmates?

Cunningham & Reidy (1998) reviewed several studies of male inmates who were diagnosed as "psychopathic" and who showed an increased likelihood for various forms of disciplinary violations while incarcerated. These violations included engaging in threatening and violent acts. Psychopathy is a diagnostic construct based on the early conceptualizations of Cleckley (1941) and later revised by Hare and his colleagues in their versions of the Psychopathy Checklist (Hare, 1980; Hare, 1991; Hart, Cox, & Hare, 1995). Psychopathy, as measured by the Psychopathy Checklist, has been shown to be a reliable construct of maladaptive personality features and socially deviant behaviors. Research has suggested that psychopathic individuals are at increased risk for recidivism both in and out of institutional settings (Salekin, Rogers, & Sewell, 1996). Cunningham & Reidy (1998), however, detailed several methodological problems inherent in these

studies and emphasized that several other studies have shown no differences in incidents of disciplinary violations between psychopathic and non-psychopathic inmates.

In one study that did address the correlates of disciplinary violations, Toch & Adams (1989) investigated patterns of violations and found that male inmates who had been hospitalized for mental health difficulties while incarcerated had higher rates of rule infractions than did non-hospitalized inmates. These researchers then classified disciplinary violations into "episodes" which could include multiple incidents of problematic behaviors. They concluded that hospitalized inmates have longer episodes with more incidents. One major methodological flaw in this study, however, was that mental disorder was defined as "some involvement with mental health services" during incarceration. Presumably those incarcerated individuals who were referred for mental health services were actively symptomatic, and represented a particularly vulnerable subset of the entire population of mentally disordered inmates.

Porporino & Motiuk (1995) used a more methodologically sophisticated matched-subject design in their study of 36 incarcerated males who had diagnoses of major mental illness. All 36 inmates met stringent criteria for either a manic episode, schizophrenia, or schizophreniform disorder. Using a matched-sample of 36 non-disordered male inmates, they found no differences between the two groups on any type of disciplinary violation. Disordered offenders also showed no particular pattern of the types of violations that occurred while incarcerated.

Few researchers have examined incarcerated women's disciplinary behavior. In his 1996 summary of research, Maden compared rates of various forms of disciplinary

problems for men and women and found that women were disciplined more often than men. Women's violations, while more frequent, were generally comprised of less severe and less violent incidents than were those of male inmates. One researcher (Carlen, 1985) has suggested that these gender differences in misbehavior are due to prison regimes being more oppressive for women than for men.

Assessing Personality Pathology in Incarcerated Women

Many theorists (e.g., Millon, 1997; Vaillant, 1987) have hypothesized that disturbed interpersonal relationships are the core dysfunction of the personality disorders. Moreover, each personality disorder is thought to have a characteristic dysfunctional interpersonal style (Widiger & Frances, 1985). Given that incarceration poses significant interpersonal stress, it may be especially difficult and challenging for a personality-disordered inmate who struggles to adapt to an environment that restricts her freedom, limits her opportunities, and dictates her daily activities.

BPD and ASPD have been shown to be the most prevalent personality disorders in incarcerated women (Jordan et al., 1996; Teplin, Abram, and McClelland, 1996). Both disorders have also been theorized to be related to early developmental experiences of abuse and neglect (Zlotnick, 1997; 1999), experiences common to a disproportionate number of incarcerated women. ASPD, histrionic personality disorder (HIS), and narcissistic personality disorder (NAR) have been linked theoretically by several researchers (Lilienfeld, 1992; Lilienfeld, Van Valkenburg, Larntz, & Akiskal, 1986) to shared pathogenesis, negative emotionality, and impulsive behavior. DSM-IV (American Psychiatric Association, 1994) also recognizes a similarity among the four disorders and

categorizes these four personality disorders together under "Cluster B" due to their conceptual relationship within the dramatic-emotional dimension of personality pathology.

Assessing personality pathology is an especially important undertaking in a correctional setting. An assessment of adaptive and nonadaptive personality can inform decision-making regarding treatment and release planning. Identifying and managing women who may pose management problems may also be invaluable for correctional staff in the appropriate allocation of resources. As Maden (1996) put it bluntly: "No account of psychiatry in relation to female prisoners can be complete if it does not deal with personality disorders" (p. 106).

In summary, studies of psychopathic men suggest that these inmates are at increased risk for more severe and violent forms of disciplinary behavior. More data, however, are needed to substantiate this relationship as many of these studies have methodological limitations. Furthermore, it still remains unclear whether psychopathy is a valid, applicable construct to women (Salekin, Rogers, & Sewell, 1997). Results of studies of women inmates who are deemed mentally disordered have yielded inconsistent results and are also fraught with methodological limitations. The few studies that have examined incarcerated women's behavior have found that women are subject to more frequent, yet less severe, disciplinary violations than men. No researchers have examined a woman's disciplinary record and its relationship to her psychiatric diagnosis (es). Although researchers who study incarcerated women have found a high prevalence of personality disordered diagnoses (ASPD and BPD), none have examined the other,

related personality disorder diagnoses of HIS and NAR. Furthermore, no researchers have examined a woman's diagnosis of personality disorder in the context of her behavior while incarcerated. Given the ubiquitous problem of inmate misbehavior as well as the paucity of research in this area, the relationship between a woman's personality disorder diagnosis and her disciplinary record is a topic of practical and theoretical interest.

The Present Study

The present study extended the work of previous investigators by examining incarcerated women with respect to their psychological symptoms, criminal histories, and disciplinary behavior while incarcerated. In a two-phase data collection procedure, I first administered two personality inventories, the Personality Assessment Inventory (PAI) and the Schedule for Nonadaptive and Adaptive Personality (SNAP), in a group setting to assess psychological symptoms and pathological personality traits. In phase two, I invited nine women to participate in a biographical interview in which I inquired about their developmental experiences, psychological symptoms, criminal histories, and behavior while incarcerated.

Using a combined quantitative and qualitative approach, I formulated four aims of the study:

(1) To provide diagnostic information on rates of depression, suicidality, anxiety, mania, schizophrenic symptoms, drug and alcohol problems, and traumatic stress.

(2) To examine the relationship between a participant's diagnosis of personality disorder, her disciplinary record while incarcerated, and the severity and violence of her current criminal charge.

(3) To examine the relationship between a participant's aggressiveness, her disciplinary record while incarcerated, and the severity and violence of her current criminal charge.

(4) To provide personal narratives of nine participants to give context to each woman's developmental experiences, psychological symptoms, criminal history, personality and interpersonal functioning, and behavior while incarcerated.

Women were assessed for personality pathology using the PAI and the SNAP. Four personality disorders were assessed: Borderline Personality Disorder (BPD), Antisocial Personality Disorder (ASPD), Histrionic Personality Disorder (HPD), and Narcissistic Personality Disorder (NPD). The PAI contains two scales that measure personality pathology: the borderline (BOR) scale, and the antisocial (ANT) scale. The SNAP contains two scales that measure histrionic and narcissistic personality pathology, (HIS) and (NAR). Scores on these four scales were used to assess personality pathology. Psychological symptoms were assessed by the clinical scales of the PAI.

Women were also assessed for aggressive tendencies by the aggression scale (AGG) of the PAI. Unmodulated anger and aggression are predominant behaviors in individuals with various forms of personality pathology (see Millon, 1997). In one recent study (Salekin, Rogers, Ustad, & Sewell, 1998), the PAI's aggression scale (AGG),

especially the verbal aggression (AGG-V) subscale was shown to be a good predictor of one-year recidivism post-release in a sample of incarcerated women. A woman's aggressive tendencies, therefore, may be an important variable to examine in context of her disciplinary record.

Women's current criminal charges were examined via the HCHC's computerized database and were coded with respect to the *severity* of offense (misdemeanor or felony) and *violence* of the offense (violent versus non-violent). Disciplinary violations were also examined via the HCHC's computerized database and were coded using a point system based on the severity of the offense; more serious disciplinary violations were allocated a greater number of points. A woman's total number of disciplinary violations was standardized over a given time period. A complete description of the coding procedures for both criminal charges and disciplinary violations will be discussed in Chapters 5 & 6.

Research Questions and Hypotheses

Four research questions were formulated for this study:

1. What is the relationship between jail disciplinary record and personality disorder among incarcerated women?
2. What is the relationship between criminal histories and personality disorder among incarcerated women?
3. What is the relationship between jail disciplinary record and aggressiveness among incarcerated women?

4. What is the relationship between criminal histories and aggressiveness among incarcerated women?

Based on these questions, two hypotheses were offered. First, women who are deemed personality disordered by their scores on the BOR and ANT scales of the PAI and on the NAR and HIS scales of the SNAP were hypothesized to have *more* disciplinary violations than non-personality disordered women (as obtained through their disciplinary records from HCHC's computerized database). Second, women who are deemed aggressive by their scores on the AGG scale of PAI were also hypothesized to have *more* disciplinary violations than non-aggressive women (as obtained through disciplinary records from HCHC's computerized database).

No directional hypotheses were made between personality disordered and non-disordered women with respect to the severity and violence of their most recent charge. Researchers who study the psychopathological correlates of crime (e.g., Abram, 1989; Robertson, Bankier, & Schwartz, 1987; Teplin, Abram, and McClelland, 1996) have found inconsistent results regarding the relationship between psychological diagnoses and type of criminal offense. Consequently, the present study will elucidate this relationship. For the same reason, no directional hypotheses were made between aggressive and non-aggressive women with respect to the severity and violence of their most recent charge.

CHAPTER 2

SETTING THE STAGE: PEOPLE AND PROCEDURES

The Setting

The study was conducted at the Hampden County House of Correction (HCHC), a medium to maximum-security county jail located in Ludlow, Massachusetts. The housing units at HCHC, called "pods," form a U-shaped area around a central walkway, called the "T." All inmates must walk through the "T" when going to meals, recreational activities, or work assignments. Inmates at HCHC are classified as "sentenced," "awaiting trial," or "pretrial" inmates. Members of each group are identified by the color of their institutional clothing; sentenced inmates are dressed in drab green while pretrial inmates are dressed in orange.

Women are housed separately from men. The women's pod is divided into three units, labeled C7, C9, and C10. Sentenced and pretrial women are housed in C10, while C7 is composed entirely of sentenced women. Between C7 and C10 is C9, informally referred to as "the hole," which contains a series of segregation units that are used to house women temporarily who are either at imminent risk of harming themselves, other inmates or staff, or the facilities at HCHC. Women who are in protective custody are also housed in C9.

Trina's Walk Through "the System" at HCHC

To illustrate the various facets of admission, booking, orientation, classification, and eventual release at HCHC, I will use the case of Trina (pseudonym). Trina was sentenced for six months after she had attacked another woman with a broken bottle

when she learned that this woman had had sexual relations with her boyfriend. Upon being admitted to HCHC, Trina's photograph was taken, she removed her personal property, received pat and strip searches, and took a shower. She was then given institutional clothing (in Trina's case, drab green), which she would wear for the remainder of her sentence at HCHC. Trina was then asked numerous questions, including those verifying her legal status, her current charges, and questions about any outstanding warrants and court dates. Trina was then escorted to the New Inmate Orientation Unit where she would stay for approximately three days. Within this time period, she learned about the facilities, rules, and operations. During this time period HCHC personnel obtain relevant information to assist in classifying Trina. During orientation, Trina also received a medical examination and information on smoking cessation and HIV/AIDS. Finally, Trina was administered psychiatric and substance use screenings as well as an educational assessment to assist in her classification.

After all the information was gathered, Trina was then classified and assigned to a pod where she lived for the remainder of her time at HCHC. Classification is the process of evaluating, separating, and housing inmates based on custody level, behavior, work assignments, or program participation. Most inmates, like Trina, are initially classified as maximum-security status, but may move to medium security status should they demonstrate good behavioral control. Some inmates, for either administrative, disciplinary, protective custody, medical, or mental health reasons, are classified as Special Management (SM) and may be removed from the general population and either placed in special units, or given limitations on their activities. For example, an inmate

who has had a number of serious disciplinary violations may be placed on Special Management-Discipline to help maintain institutional order and appropriate behavioral control. Inmates who have gang involvement, which is revealed through their court documents, known associations, or gang symbols or paraphernalia, are classified as Security Risk Group (SRG) status and may also have their privileges withheld. The classification of SM or SRG may be made on admission to HCHC, or may be "earned" during the stay at the HCHC. Inmates classified as either Special Management or Security Risk Group Status are reviewed separately for privileges on a weekly basis.

Trina was classified neither as SM or SRG and was promptly escorted to her new home on C7. Here she met her cellmate, the Correctional Officer (CO) on duty in her pod, and her Correctional Case Worker (CCW) who assisted her as she moved through the system at HCHC. As women like Trina approach the end of their sentences, several options are open to them. First, they may be eligible for parole, which in Massachusetts often occurs after half the sentence is served. This, of course, is contingent on agreement by a parole board, which makes this decision based on criminal history, severity of her current offense, and behavior while incarcerated. Second, she could serve her entire sentence and be directly released into the community. (She can be picked up at the facility or use public transportation.) Third, she may qualify for transfer in the final months of her sentence to the Pre-Release Center (PRC), located on the grounds of HCHC. In this setting, the women could live and prepare for re-integration into the community through various educational, family, and treatment services. Alternatively, she may qualify for Day Reporting (DAY), where she can live at home, but must "check

in" daily to the facility through visits, telephone calls, or electronic communication via a wristband. Last, if the individual has longstanding substance abuse problems, she may be selected to attend the Western Massachusetts Correctional Alcohol Center (WMCAC), where she can live and receive specialized substance abuse services for a specified period of time. Spots at WMCAC, however, are in short supply relative to demand; many more women seek these services than can be accommodated. Often there is a waiting list, and some women serve their entire sentences before there is an available bed at WMCAC.

The HCHC Women

Although the number of inmates fluctuates daily depending on releases and new admits, HCHC houses approximately 1,600 inmates, 10 % of whom are women. At the start of the current study, there were 145 women at HCHC, (120 who were sentenced and 25 who were awaiting trial). The women at HCHC are incarcerated for a variety of offenses, including misdemeanors and felonies, violent and non-violent offenses (see Haven et al., 1999). Some women who reside in Hampden County are sentenced through the county system and serve their sentences at HCHC. Other women are sentenced through court systems outside Hampden County, but are sentenced to HCHC for administrative or other reasons. Finally, there are some women who are sentenced by the state, and who have begun their sentences at the state women's prison in Framingham, MA before being transferred to HCHC.

Measures Used

Two measures were administered in the study: The Schedule for Nonadaptive and Adaptive Personality (SNAP), (Clark, 1996), and the Personality Assessment Inventory (PAI), (Morey, 1991).

The Personality Assessment Inventory

The Personality Assessment Inventory (PAI) is a 344-item multiscale inventory of adult psychopathology that includes four validity scales, 11 clinical scales, five treatment scales, and two interpersonal scales (Morey, 1991). The clinical scales are designed to cover a range of psychopathological symptoms including somatic complaints, anxiety, anxiety-related disorders, depression, mania, paranoia, schizophrenia, and alcohol and drug problems. Raw scores on the PAI's clinical, treatment, and interpersonal scales are transformed to T scores (mean-50; standard deviation-10) in order to provide interpretation relative to a standardization sample of 1,000 community dwelling adults. A T score of 70, which is two standard deviations above the mean, and termed "clinically significant," represents a marked deviation from the mean, such that 98% of *nonclinical* patients will have scores below a T score of 70. The PAI also includes T scores for clinical, treatment, and interpersonal scales that are referenced against a *clinical* sample of 1,246 patients. Interpretation can be accomplished in comparison to both clinical and nonclinical respondents.

The PAI was chosen for the current study for the several reasons. First, the PAI serves as a good screening measure for major forms of psychopathology. Second, two of its scales of personality dysfunction, the Antisocial scale (ANT) and the Borderline scale

(BOR) have contemporary theoretical bases and assess maladaptive personality features that are of theoretical interest in the current study. Second, the Aggression scales (AGG) provide a measure of attitudes related to anger, hostility, and aggression, characteristics also relevant to the current study. Third, the Anxiety-related scale (ARD) contains a subscale, traumatic stress (ARD-T), which is germane given the high prevalence of traumatic stress in incarcerated women. Last, the PAI has been shown to have good psychometric properties (Morey, 1991, 1996). In the following paragraphs I will discuss the scales of interest in the current study.

The ANT scale of the PAI is comprised of 24 items which make up three subscales tapping the construct of psychopathy. Psychopathy is a narrower construct than ASPD in that it encompasses both dysfunctional personality traits and behavioral disturbances. The DSM-IV (American Psychiatric Association, 1994) definitions of ASPD emphasize only the disruptive behavioral characteristics of the disorder. Two subscales of ANT, Egocentricity (ANT-E) and Stimulus Seeking (ANT-S), represent the personality aspects characteristic of the psychopath. The third subscale ANT, Antisocial Behaviors (ANT-B) represents the conduct problems characteristic of both ASPD and psychopathy.

The BOR is composed of 24 items that make up four subscales that characterize the borderline personality organization: Affect Instability (BOR-A), Identity Problems (BOR-I), Negative Relations (BOR-N), and Self-Harm (BOR-S). BOR-A includes items that tap emotional dysregulation. BOR-I includes items that assess for a fluctuating sense

of self. BOR-N contains items that reflect chaotic and disruptive interpersonal relationships. BOR-S includes items that assess for self-injurious behaviors.

The AGG scale of the PAI taps characteristics and attitudes related to anger, hostility, and aggression. This includes a history of physical or verbal aggression. The 18-item AGG scale is composed of three subscales: Aggressive Attitude (AGG-A), Verbal Aggression (AGG-V), and Physical Aggression (AGG-P). AGG-A includes items that address poor anger management and volatility. AGG-V includes items that describe situations of insulting or criticizing others and not backing down from confrontation. AGG-P includes items related to physical aggression, damaging property, and threats of violence.

The (ARD) scale of the PAI is comprised of three subscales assessing the anxiety-related symptoms of obsessions and compulsions (ARD-C), phobias (ARD-P), and traumatic stress (ARD-T). The ARD-T taps symptoms related to exposure to or witnessing a traumatic event, including guilt, disturbing memories, anxiety, and distressing experiences related to the event. ARD-T, however, is nonspecific and does not distinguish past from current traumatic experiences. Subjects who score high on this subscale generally feel that the event(s) has left them changed or damaged in some fundamental way.

The PAI contains four validity scales, each addressing a particular invalidity construct. Morey (1991) recognizes the gradations inherent in distinguishing valid from invalid protocols and designates elevations on validity indices as either "moderate" or "high." For the purposes of the current study, the "high" cutoff score was used to

differentiate an invalid from a valid protocol; a single "high" elevation on any one validity scale is sufficient to deem a protocol invalid.

The inconsistency (ICN) scale reflects the consistency by which respondents answer statements of similar content. A T score of 73 or above suggests that the respondent did not attend consistently to PAI item content. The infrequency (INF) scale contains items of extremely low endorsement rates and is useful in identifying protocols characterized by idiosyncratic, random, confused, or careless responding. A T score of 75 or above suggests that the respondent did not attend appropriately to PAI item content.

The negative impression management (NIM) scale is designed to assess the degree to which a respondent tries to portray herself in an overly negative light. It contains items that represent bizarre or unlikely symptoms. A T score of 92 or above suggests that the respondent is attempting to portray herself in an especially unfavorable manner.

Last, the PAI's positive impression management (PIM) scale contains items that assess a respondent's tendency to portray herself in an overly positive light. A T score of 68 or above suggests that the respondent attempted to portray herself entirely free of the shortcomings most individuals experience.

Schedule for Nonadaptive and Adaptive Personality

The Schedule for Nonadaptive and Adaptive Personality (SNAP) is a 375-item, factor analytically developed self-report instrument designed primarily to assess the trait dimensions within the domain of personality disorders (Clark, 1996). It contains 12 trait and three temperament scales designed to measure twelve specific traits and three more

general affective traits or temperaments, respectively. The SNAP also contains five validity scales as well as one overall validity index designed to identify invalid protocols owing to carelessness, defensiveness, social desirability, acquiescence, or excessive pathology. Finally, the SNAP contains 13 diagnostic scales using the personality disorder criteria used in DSM-III-R.

The SNAP was chosen for the current study for several reasons. First, the SNAP's scales are internally consistent, have acceptable test-retest reliabilities, and are appropriately independent (see Clark, 1996). Second, its diagnostic scales address two personality disorders, histrionic and narcissistic, which are not directly assessed in the PAI but are of interest to the current study. Third, the SNAP's unique dimensional approach to assessing personality dysfunction using trait and temperament scales is consistent with some contemporary theorists who conceptualize pathological personality as existing on a continuum of traits rather than as discrete disorders (for a review, see Frances & Widiger, 1986). A brief description of the SNAP's validity and diagnostic scales of interest in the current study follows.

The SNAP's diagnostic scales are composed of items reflecting DSM-III-R (APA, 1987) personality disorder criteria. At least two items were selected to represent most criteria. To be scored as meeting the criteria, a respondent must endorse both SNAP items. Clark (1996) describes two ways of scoring the diagnostic scales: (1) Determine whether the requisite number of criteria are met for any given personality disorder and score the personality disorder as being "present" or "absent," or (2) Score the diagnostic scores dimensionally by counting up the number of items for each personality disorder

scale. T scores are also available for the diagnostic scales and are based on a smaller, normative sample of college students, (216 males and 345 females). A T score of 65 or above reflects a marked deviation from the mean, such that 98% of the sample scores fall below that score. Clark recommends scoring the diagnostic scales dimensionally; her preliminary validity studies suggest dimensional scoring is the more reliable scoring method. Dimensional scoring of the Narcissistic (NAR) and Histrionic (HIS) scales were used for the current study.

The SNAP contains six validity scales: TRIN, DRIN, VRIN, Rare Virtues (RV), and Deviance (DEV), and an invalidity index (INVAL), which is an index of scores from the five other invalidity scales. INVAL provides a measure of overall invalidity. In Clark's (1996) analyses of the various invalidity indices, she concludes that all validity scales are adequate in predicting invalid protocols, but the INVAL is "an especially good indicator; it has consistently both a low False Positive rate and a high True Positive rate" (p. 32). Since the INVAL seems to encompass a wide range of protocol invalidity, and has good statistical properties, it was used in the current study as the measure of invalidity. In assessing all individual validity indices and INVAL, Clark recommends using a T score of 70 as a cutoff for delineating invalid from valid protocols. The other five validity scales are described below.

Like the PAI's ICN scale, the SNAP's VRIN scale taps a respondent's tendency for inconsistent responding by assessing the degree of similar responding among content-matched items. The TRIN scale assesses a respondent's tendency to respond either in a positive or negative manner regardless of item content; these response sets have often

been called "Yea-saying" or "Nay-saying." The DRIN scale assesses a respondent's tendency to choose either socially desirable or undesirable responses. Seventeen pairs of responses are included, one of which is socially desirable, another is socially undesirable. Responding based on social desirability occurs if the respondent consistently endorses the socially desirable response, while social undesirable responding occurs when the opposite response is consistently chosen.

RV, like the PIM scale of the PAI, taps a respondent's tendency to not admit to having common personal shortcomings most individuals experience. Finally, the DEV identifies respondents who present themselves as deviant; high scorers on the DEV may actually experience deviant thoughts, feelings, or behaviors, or may want to present themselves this way.

The Procedure: A Two-Phase Data Collection

Data were collected through a two-phase process. Phase One consisted of a group testing, and Phase Two consisted of an individual interview with nine participants. Participation in both phases of the study was limited to sentenced women. Sentenced women were chosen for two reasons: (1) there were many more sentenced than pretrial women; (2) Compared with pretrial women, sentenced women had already been convicted of their offenses. Women who had at least a working knowledge of English were invited to participate in both phases of the study. Women were also informed that they would receive a "gift," a multi-colored notepad, as a token of appreciation.

Phase 1: Group Testing

Participants were chosen through a recruitment procedure on C7 and C10. The study was announced on C7 and C10 to three large groups. The study was introduced as a project with an aim to "find out more about the women who come to HCHC." I explained my educational background and that the project was to be my dissertation.

The women were informed that there would be two phases to the study. Phase One would take place in a group setting and would involve completing two paper-and-pencil inventories. Participants would be asked to rate statements about their "personalities," or the way they "normally behave in the world." Women were then informed that for Phase Two, nine women would be selected with whom I would meet individually and inquire about developmental experiences, substance use histories, criminal histories, and overall adjustment to life at HCHC. During the individual interviews I would ask them to elaborate on some of their responses to the inventories they had completed earlier.

The women were told that, for both phases of the study, their participation was entirely voluntary, and that their involvement in the study would in no way influence their length of incarceration, classification status, or treatment while in jail. They were also informed that all data collected would be identified solely by their HCHC identification number, and that only their identification number would be used as an identifier for the data from the testings and interviews. All women read and signed a consent form prior to beginning the study (see Appendix A). Women were instructed to sign up with their identification number on a sign-up sheet at the Correctional Officer's

station. Both the group testing and individual interviews were conducted in two rooms located on C7 and C10. The testing time for the group testing was approximately two hours; the individual interview was also two hours.

In all, 49 women participated in the group portion of the study. At the start of the study, there were approximately 105 sentenced women housed on C7 and C10; thus 47% of the sentenced women on C7and C10 participated in Phase One. Group sizes ranged from two to nine women. Over the course of testing, it became apparent that most women found completing the two personality inventories, (the PAI and the SNAP) to be too arduous in one sitting. Thus, the group testings were restructured such that women were administered the two inventories on separate occasions, separated by a one-week interval.

Two women who were unable to complete the PAI or the SNAP inventories due to language difficulties were administered the Spanish-language version of the PAI. At the time of testing, there was no Spanish-language version of the SNAP. Thus, only PAI data are available for these two women. These women did not participate in Phase Two of the study. Four women were released from HCHC prior to completing both inventories. These four women completed the PAI, but none completed the SNAP. In total, all 49 women completed the PAI, while 43 completed the SNAP.

Phase 2: The Biographical Interview

Participants

Nine participants were invited to participate in the interview portion of the study. These women were chosen based on several factors. Participants were chosen in an effort to

maintain: (1) ethnic and age diversity, (2) a diversity of current criminal charges, and (3) a range of personality profiles. Participants were approached individually and asked to join Phase Two of the study, and all women agreed.

Interview

Interviews were semi-structured and included questions on childhood experiences (e.g., "What is your earliest memory of your mother?"), personality and interpersonal functioning (e.g., "Tell me about the most disturbing relationship in your life."), life at HCHC (e.g., "What are your relationships like with others here?"), drug and alcohol use (e.g., "Have you ever received drug or alcohol treatment?"), and criminal history (e.g., "How did you end up in Ludlow?"). Finally, approximately seven statements were taken from either the PAI or the SNAP that were either (a) listed as "critical items" on the PAI (items of either low endorsement rates or those potentially indicative of a clinical crisis, or (b) seemed to typify the participant's personality make-up. For example, a subject whose Borderline Scale on the PAI was significantly elevated would be asked to elaborate on statements taken from that scale, (e.g., "My relationships have been stormy—Very True"). Consequently, all interview participants were asked the same questions with the exception of those statements taken from the SNAP and PAI. In general, interview questions were designed to cover a wide range of areas related to personality development and functioning as well as topics of interest to the current study (i.e., criminal history and behavior while incarcerated). (See Appendix B for a list of questions posed to all participants and representative PAI items.)

Access to Disciplinary Records and Current Criminal Charges

Disciplinary records and current criminal charges were examined via HCHC's jail management system (JMS). The author was trained to use JMS by the correctional staff at HCHC. Disciplinary violations were coded by the author according to severity on a three-point scale. Each woman's total disciplinary score was then divided by her length of incarceration, producing a ratio of disciplinary violations over length of incarceration. A full description of HCHC's disciplinary system and the coding of discipline violations is provided in Chapter 4.

Women's current arrest charges were classified in accordance with procedures described in the study by Teplin et al. (1996). A woman's most violent current arrest charge was used as her current charge. (Some women are multiply charged.) Using the guidelines of Teplin et al., arrest charges were classified as either violent or non-violent. (See Chapter 5 for a complete description of the coding of women's current criminal offenses.)

CHAPTER 3

WHO ARE THE WOMEN AT HCHC?

Demographic Statistics

The average age of the participants was 33.8, with a standard deviation of 8.7 years. The median age was 35. A woman, on average, received 12 years of education, which was also the median level of education. The average length of incarceration was 268.7 days, with a standard deviation of 297.2 days. The median length of incarceration was 198 days; some women had been at HCHC for lengthy time periods, inflating the overall mean length of incarceration. The ethnic composition of participants was as follows: 26% Hispanic, 24% African-American, and 49% Caucasian.

Validity of PAI and SNAP Inventories

Validity analyses were done separately for the PAI and the SNAP. Since analyses were done separately, it was possible for a woman who completed both inventories to produce one valid and one invalid protocol. Recommended cutoff scores for distinguishing valid from invalid protocols were obtained from the test manuals (Clark, 1996; Morey, 1991), and are more fully discussed in Chapter 2. One modification was made to the recommended guidelines. According to the author, (Morey, personal communication, March 2001), the recommended T score cutoff of the Negative Impression Management (NIM) scale was extended to 100. Morey suggested extending the cutoff score due to the stress inherent in incarceration, which may translate to higher NIM scores. Using these reformulated guidelines, 14 PAI protocols were considered invalid, leaving 35 valid protocols. Five SNAP protocols were considered invalid,

leaving a total of 39 valid protocols. Some protocols were considered invalid across more than one validity index.

Psychopathology in the HCHC Women

The Average Woman at HCHC

Mean scores on all PAI scales for all participants are listed in Figure 1. Figure 1 represents the PAI profile of the "average woman" at HCHC. While a more individualized analysis of a woman's PAI profile in the context of her life history will be undertaken in Chapter 6, an aggregate analysis of all women's clinical symptoms can identify common areas of clinical concern and attention. On average, these participants attended consistently and appropriately to PAI item content, (Inconsistency < 60 & Infrequency < 65). They did, however, have a slight tendency to portray themselves negatively, suggesting a slight degree of exaggeration of clinical symptoms (NIM = 75).

Upon examining the profile of the "average woman," several clinical features are apparent. First, participant's average PAI scores were elevated (at or above a T score of 70) across several clinical scales, suggesting the possibility of numerous complaints and multiple diagnoses. Mean scores on the following scales were clinically significant: Borderline (BOR), Antisocial (ANT), Drug problems (DRG), and the Traumatic stress (ARD-T) subscale. Together, these data suggest that the majority of women struggle with impulsivity, emotional lability, and identity and life goal confusion. Not surprisingly, these women also frequently engage in antisocial acts and hostile and tenuous interpersonal relationships. The majority of women are also likely to have suffered a traumatic event(s) in the past which has continued to distress them and causes

reoccurring bouts of anxiety. Finally, the overwhelming majority of women have had reoccurring drug problems at a level of severity consistent with those commonly seen in drug treatment programs.

Scores on several other clinical scales were also elevated, but fell just below the T score cutoff. Scores within this range reflect problem areas and areas of concern for women. Women's scores on the following scales were within this moderately elevated range: Anxiety-Related Disorders (ARD), Depression (DEP), Paranoia (PAI), Schizophrenia (SCZ), Alcohol problems (ALC), Aggression (AGG), and Stress (STR). Clearly, the women at HCHC report a multitude of clinical concerns, including complaints of overwhelming stress, alcohol problems, anxiety-related symptoms, and depression. Women also had a tendency to pronounced fears of others, uncontrolled aggression, and experiences of social detachment, mental confusion, and audio or visual hallucinations common to schizophrenia.

A Closer Look at the Clinical Symptoms of HCHC Women

As discussed in Chapter 1, the study of incarcerated women and psychopathology has only recently been undertaken by researchers. Only two large-scale recent studies (i.e., Jordan et al. (1996) & Teplin et al. (1996) have been conducted, which assess psychopathology using standardized instruments and matched community samples. Data from the current study are examined in the context of findings from these two studies, and of a smaller study of incarcerated women (Zlotnick, 1999), in which standardized diagnostic interviews were also used. Due to its similarity in scope, theme, and participants, comparisons will also be drawn to findings from the study by Haven et al.

(1999) of women involved in Hampden County's criminal justice system. This study comprised sentenced, pretrial, and community residing women.

Numerous researchers have commented on the high prevalence of traumatic stress in incarcerated women (see Brown et al. 1999). Data from the current study are no exception: 74% of women reported symptoms suggestive of experiencing a traumatic event in the past that continues to bring distress and episodes of anxiety and guilt. While self-report instruments can yield a greater degree of psychopathology than standardized interviews (Groth-Marnat, 1996), women's reported symptoms of traumatic stress were comparable to those found in other studies. In their study of women detainees, Teplin et al. (1996) found a lifetime prevalence rate of 34% for PTSD, while Zlotnick (1999) found 20% of her sample met criteria for lifetime PTSD, while 48% of women met criteria for current PTSD. Zlotnick also inquired about specific forms of abuse, and found that 40% of women reported childhood sexual abuse, while 55% reported childhood physical abuse. Haven et al. (1999), using unstandardized instruments, found that 71% of women had histories of sexual or physical abuse, while 88% reported some type of abuse as a child, including verbal, emotional, physical, or sexual abuse. Haven et al. (1999), however, used only one question to assess each abuse category and used vague examples for each category of abuse (e.g., "repeatedly ignored or told I was bad," as an example of emotional abuse). Their methodology may have confounded actual prevalence rates of abuse.

Participants' symptoms of affective illness and suicidality were generally higher than those found by other researchers who have studied incarcerated women. Forty

percent of the women reported clinically significant symptoms of depression, including affective, cognitive, and physiological signs of depression, while 35% reported a clinically significant degree of suicidal ideation. Jordan et al. (1996) found a 13% lifetime prevalence rate for major depressive disorder, while Teplin et al. (1996) found a 17% prevalence rate in her sample. These researchers did not assess suicidality. Finally, Haven et al. (1999) found 68% of the women in their sample reported feeling depressed at the time of the study, and 22% reported currently feeling suicidal. Thirty-eight percent of the women also reported a history of at least one suicide attempt. The results from Haven et al. are tempered by the same study limitations discussed earlier, (i.e., one question was used to assess current suicidality and past suicide attempts).

Interestingly, incarcerated women report fewer clinical symptoms related to anxiety than to depression. Twenty-nine percent of women report clinically significant symptoms of anxiety, worry, and tension, while 40% report clinically significant symptoms of depression. Both Teplin et al. (1996) and Jordan et al. (1996) also found low prevalence rates for specific anxiety disorders. These researchers found that 4.1% and 8.5% respectively, met criteria for a lifetime prevalence of panic disorder (PD) *or* generalized anxiety disorder (GAD). The PAI's ANX scale is non-specific and taps feelings of anxiety and apprehension that are inherent in anxiety disorders more generally, as well as in other disorders, which may explain, in part, the greater number of women who report clinical symptoms of anxiety.

As expected, the majority of women had histories of drug and alcohol abuse. 69% of the women scored at or above the average score of those in treatment for drug

dependence, while 29% of women scored at or above the average score of those in treatment for alcohol dependence. These results are consistent with those found by both Jordan et al. (1996) and Teplin et al. (1996) in their epidemiological studies. Jordan et al. (1996) found that 44% of their sample met criteria for drug abuse or dependence and 38% of their sample met criteria for alcohol abuse or dependence, while Teplin et al. (1996) found 52% met criteria for drug abuse or dependence, and 24% met criteria for alcohol abuse or dependence. Zlotnik (1999) assessed substance use more generally, without reference to severity, and found that 83% had substance use prior to incarceration. Haven et al. (1999) did not assess substance abuse directly, but found a high percentage (73%) had at one time been involved in a 12-step program for substance use.

Few women reported symptoms of major mental illness characterized by psychotic symptoms. While 40% of women scored moderately high (at or above T score of 70) on SCZ, none scored very high (at or above T score of 90). Morey (1991) suggests that scores within this higher range are indicative of an active episode of psychotic symptomatology. Moreover, only 9% of women scored at or above a T score of 75 on PAI's mania (MAN) scale, a range typically associated with the disorders of mania, hypomania, and cyclothymia. Teplin et al. (1996) also found a low lifetime prevalence rate of 5% for either schizophrenia, schizophreniform disorder, or a manic episode. In their self-report study, Haven et al. (1999) found that 10% of women reported a history of "hearing voices" or "seeing things," but the investigators did not more systematically assess psychotic symptoms.

Personality Pathology in the HCHC Women

Results from the PAI

Women were assessed for pathological personality traits and behaviors using two scales of the PAI: the Borderline (BOR) scale, and the Antisocial (ANT) scale. Using Morey's (1991) guidelines, a T score of 70 or higher is considered to reflect maladaptive personality traits. Women's mean scores and standard deviations on the these two scales were as follows: BOR: M= 76, SD= 12, ANT: M= 72, SD= 14. As an aggregate, HCHC women report a constellation of maladaptive personality traits, including impulsivity, hostility, egocentricity, strained interpersonal relationships, and emotional lability. Not surprisingly, these women show a disregard for conventional rules and have histories of committing antisocial acts.

Eighty percent of women scored at or above T score of 70 on BOR, while 60% scored at or above a T score of 70 on ANT. Sixty percent of women scored at or above T score of 70 on *both* BOR and ANT. Morey (1991) recommends using a higher T score to designate those respondents who would most likely meet criteria for the diagnoses of either BOR or ANT. Scores at or above T score of 92 on BOR and at or above 84 on ANT are thought to be "typically associated with personality functioning within the borderline range" or with "prominent features of antisocial personality disorder" (p. 18). Using these more stringent guidelines, 31% of women would carry a diagnosis of Antisocial Personality Disorder (ASPD), one woman would carry a diagnosis of Borderline Personality Disorder (BPD), and three women (9%) would carry (an) ASPD *and* BPD diagnosis.

The number of women with a probable ASPD diagnosis was higher than that found by other researchers. Teplin et al. (1996) found that 14 % of their sample met criteria for ASPD, while Jordan et al. (1996) found that 12% of their remanded women met criteria for ASPD. In their construct validity study of psychopathy in incarcerated women, Salekin, Rogers, & Sewell (1997) reported the ANT scale scores of their sample. They found only 33% of women had "psychopathic traits" (T score of 70 or above), while only 14% scored above a T score of 80. It is unclear why more women seem to exhibit antisocial personality pathology in the current study. One possibility is that the women at HCHC represented a particularly intransigent group of antisocial women with more extensive criminal histories. Salekin et al. (1997) only broadly described their women's representative charges as "theft, delivery of a controlled substance with intent to sell, and to a lesser extent assault and violent acts." Given this amount of information, it is difficult to ascertain whether his sample was comprised of women who had more serious criminal charges than those of women in the current study.

Although many women reported maladaptive personality traits common to borderline pathology, *few* women had a probable BPD diagnosis according to Morey's (1991) guidelines. These results contrast with those of other researchers who assessed for BPD. Jordan et al. (1996) found that 44% met criteria for Borderline Personality Disorder, while Zlotkin (1999) found that 49% of her sample met criteria for BPD. Teplin et al. (1996) did not assess for BPD. It is unclear whether differences in prevalence of BPD are a result of real differences in prevalence rates, or to methodological factors related to the arbitrary cutoff score suggested by Morey.

Results from the SNAP

Results from the SNAP's two diagnostic scales, narcissistic (NAR) and histrionic (HIS), are of interest in the current study. Unfortunately, the SNAP has no clinical comparison groups, so elevated scores can only be interpreted by their degree of deviation from the reference group, which is a large sample of female college students. Clark, (1996) recommends using a T score of 65 to designate maladaptive traits. A T score of 65 or higher will be used as a cutoff score to designate personality disordered from non-disordered participants on NAR and HIS.

Women's mean scores and their standard deviations for these two diagnostic scales are as follows: HIS: $\underline{M} = 48$, $\underline{SD}$ 9.2, and NAR: $\underline{M} = 58$, $\underline{SD} = 9.4$. Women's average scores on NAR and HIS do not meet the T score of 65 cutoff. Eighteen percent of women report narcissistic traits, while only two women (5%) report pathological histrionic traits. Interestingly, these results suggest that the majority of women at HCHC do not report symptoms common to histrionic personality disorder, including attention-seeking, suggestibility, and rapidly shifting and shallow expressions of emotion. Early theorists (e.g., Cloninger & Guze, 1970) postulated an etiological relationship between hysteria and sociopathic behavior. Cloninger & Guze (1970) found that 41% of their sample of incarcerated women met criteria for a diagnosis of hysteria. The concept of hysteria has gone out of fashion among researchers and clinicians and has not been included in the past three revisions of DSM (American Psychiatric Press, 1980; 1987; 1994). Nonetheless, some researchers (Lilienfeld, 1992) have studied the familial link between histrionic behaviors, somatization, and ASPD.

In general, results from the current study fit in broadly with those obtained in others studies of incarcerated women. Together, the picture of the psychological make-up of the incarcerated woman is becoming clearer; she has a history of substance abuse, and has likely suffered some type of abuse, most commonly childhood abuse. She likely suffers from a range of clinical symptoms, most notably depression and is especially prone to suicidal thoughts and behavior. She is also prone to develop a constellation of maladaptive personality traits characterized by affect instability, stimulus seeking, and acts of self-harm. Finally, she has a tendency to be egocentric and to engage in antisocial behaviors. These traits and behaviors increase the likelihood of a diagnosis of either Borderline and/or Antisocial personality disorders.

Classification of Personality Disordered Women

Classification of women in personality disordered and non-disordered categories involved a two-step process. First, women were classified as either personality disordered or non-disordered based on their scores on SNAP's two diagnostic scales, NAR and HIS. Women who scored at the cut-off score of 65 or above on *either* NAR *or* HIS were designated as personality disordered. Using this criteria, seven women (18%) carried this designation, with five women scoring high on NAR elevations, while two women scored high on both NAR and HIS. None scored high solely on HIS.

Second, women whose T scores were 92 or above on BOR *or* 84 or above on ANT on the PAI were designated as personality disordered. Using this criterion, 15 (43%) of women scored high on ANT, one scored high on BOR, and three women scored high on both BOR and ANT. Combining scores from both the PAI and SNAP, two

women scored high on both ANT and NAR, while one woman scored high on BOR, ANT, and NAR. In total, 16 women (33%) were designated as personality disordered using the above criteria. Interestingly, when lowering the cutoff score on BOR to T of 84, six more women were now included, but five of the six women had already been designated as personality disordered, suggesting a shared pathogenesis among these personality disorders.

Classification of Aggressive Women

Scores on the PAI's AGG scale were also used to classify Aggressive (AGG) from Non-aggressive (NAGG) participants. A T score cut off of 70 was used to designate aggressive from non-aggressive participants. In total, 12 (37%) of women were classified as aggressive. Of the participants who were classified as aggressive, 8 (67%) were also classified as personality disordered.

CHAPTER 4

WOMEN DESCRIBE THEIR PSYCHOLOGICAL SYMPTOMS

Nine women participated in the biographical interview: Charlotte, Jacqueline, Karyn, Kit, Marissa, Maryanne, Rasa, Toni, and Yolanda. Using their own words, I will have these women speak of their psychological symptoms. While I will discuss relevant information from their histories, I will focus my discussion on their experience of psychological symptoms. In this context, I will also make reference to their scores on the PAI, and the SNAP. Please see Figures 2 & 3 for a graphical representation of all nine women's scores on select PAI clinical scales, and scores on the SNAP and PAI personality disorder scales. A more thorough biographical chronology will be provided in Chapter 7, where I will select a subset of three women and explore the interplay of their developmental experiences, psychological symptoms, criminal histories, and behavior at HCHC.

Although the women interviewed were incarcerated for different reasons and came from various ethnic and socioeconomic backgrounds, they shared many psychological symptoms. Most revealed harrowing experiences of abuse, drug addiction, relapse and recovery, and depression and suicide. Many spoke of longstanding difficulties in relationships, as well as conflictual relationships with partners, friends, family, and the legal system. Many of these relationships had been severed or damaged beyond repair. Some, however, still endured through the vagaries of these women's lives

in and out of jail. I will begin by discussing the almost ubiquitous experience of substance abuse.

Substance Abuse

All but one of the nine women reported continued struggles with substance abuse. It was not uncommon for a woman to report first using drugs in her early teens. Yolanda's score on the Drug scale was significantly elevated, even compared to a clinical sample in drug treatment. She began using drugs when she was 12. Serving a six-month sentence for the combined charges of breaking and entering with intent to commit a misdemeanor, resisting arrest, and shoplifting, Yolanda first smoked marijuana and "popped" amphetamines. At 15, she graduated to speed balling, a procedure in which she injected herself with a mixture of heroin and cocaine. At 31, Yolanda is a self-professed heroin addict, who has used drugs close to half her life. She described how she first learned of drugs through her mother's friend, whom she called a "junky." In an example of perverse role modeling, her mother's friend, instead of baby-sitting Yolanda and her sisters, taught them how to use drugs.

Yolanda pointed to her drug use as the culprit in her incarceration. "My use got me here. If I wasn't a heroin addict, I wouldn't be in jail." With a sly grin on her face, she proclaimed: "I live and love to get high." Many of her criminal activities, she claimed, were done to support her drug habit. "I sold myself, stole stuff, and did whatever it took to keep high." Yolanda said her drug use had caused her recently to lose custody of her three-year-old son. Her mother has custody of her two other children, ages 11 and 12. Her three-year-old son is now living in foster care. Yolanda tearfully

described how she has only seen her son once over the course of her 219 days of incarceration at HCHC. At the time of the interview, she had just heard from her mother that he was ill with a stomach virus, but she could only hope that he was being well taken care of.

Yolanda spoke of her desire to attend the drug treatment program at Howard Street; she feels this is the only way for her to conquer her addiction and regain custody of her son. "I didn't care about anything when I was out there [on the streets]," she said. She spoke of her need to "prove" herself to DSS and to her mother that she is a fit parent. "My mom thinks that I'm a coward to have gotten into drugs." "I want to show her I can do it," she said. As we will see in Chapter 7, Yolanda would sabotage her chance for recovery at HCJ by receiving a 10-day in-house suspension and eventual expulsion from HCJ for serious offense. She would return to HCHC to serve out the remainder of her sentence.

Kit, whose score on the Drug scale was also elevated, is serving a two-year sentence for possession of heroin with intent to distribute. Kit, who is 42, charts her drug use back to age 8 when her mother would sedate her and her sister with Percodan in order to give herself "a break" from them. Kit began smoking cigarettes to "emulate" her mother at age 9. She described herself as a "junky" who has been a heroin addict for over twenty years and has abused alcohol since she was a teenager. As a tall woman of five feet nine inches, Kit was an emaciated 93 pounds upon arrest. The judge had reportedly told her that he was "doing [her] a favor" by sending her to jail where she would get adequate food, medical care, and abstinence.

Kit had a long history of prostitution and has been charged numerous times for prostitution and common night walking. Interestingly, Kit describes her engagement in prostitution as an "addiction," much like her drug use. "It's all the same; drugs, food, sex, anything that feels good takes me over the edge," she declared.

Prostitution brings Kit not only money for drugs, but also perceived power over her clientele. Kit describes how she is "so good" at pleasing men that they are "hooked," and they can't help but come back to her for pleasure. Her clients also buy her things, such as clothing, furniture, or drugs. In an odd switch of roles, Kit describes how she becomes the "dope dealer," dealing intoxicating sex to her clients.

Traumatic Stress: The Experience of Abuse

Experiences of traumatic stress were ever-present among the women; it was rare to find a woman who did not reveal appalling experiences of various forms of abuse. Karyn, whose score on the Traumatic Stress subscale was very high, is serving a 45-day sentence for the combined charges of sex for fee, possession of crack cocaine, and assault and battery on a police officer. She described how she was raped twice because of "[her] drugs and putting [herself] in situations [she] shouldn't." In another horrific event that occurred two years ago, a client had choked her during intercourse until she lost consciousness. Karyn woke to find herself alone in the bedroom, and without the drugs she had been promised as payment.

Toni, another high scorer on the Traumatic Stress subscale, suffered multiple abuse experiences from different family members. She is serving a one-year mandatory sentence for possession and intent to distribute heroin. Toni described living with chaos

and uncertainty in a place she called "not really a home, not really a foundation" where she was never sure how her alcoholic father would react toward her. Toni, who has one older sister and four brothers, described how her mother left the family when Toni was nine. Her mother had developed a drinking problem of her own, and would have all-night parties where "people [she] didn't know would be lying around in the house in the morning." Her father, in an effort to shield the children from her mother's drinking and excessive behaviors, divorced her mother and attempted to raise the five children himself. Upon the divorce, her father began to drink more heavily, which translated to more physical abuse. Toni described one particularly violent incident when her father repeatedly kicked her ribs while she was on the ground after she had skipped school and had been out "partying" the night before.

In addition to the physical abuse by her father, Toni told of being sexually abused by her brother for six years. As is oftentimes the case with sexual abuse (Terr, 1994), the abuse took place in secrecy with no family awareness and stopped when her brother "gave up on it." Although she said she "blocked out" much of the experiences with her father and brother, Toni had recently begun to sort through the feelings of these abuse experiences with a counselor at HCHC. In an effort at reconciliation and coming to terms with her past, Toni recently confronted her brother about the abuse. In a manner remarkable for its insensitivity and ignorance, her brother told her, "I thought it [the abuse] was something people sometimes do when they're drunk. I didn't think it would affect you."

Yolanda, previously mentioned, told of horrendous abuse experiences. Her score on the Traumatic Stress subscale was one of the highest. In an adolescence absent of any discipline or control, she described how she had a careless, "don't-give-a-fuck-about-anything" attitude. She lived at various friends' houses, continued using drugs, dropped out of school, and prostituted and stole to support her habit. In a gesture reflecting the ultimate lack of care and responsibility, Yolanda got pregnant at 18 and abandoned her child at the hospital. Yolanda's mother, with whom she has an ongoing conflictual relationship, eventually picked the child up at the hospital and gained custody. One year later, her mother also gained custody of her daughter. Yolanda's mother, however, refused to accept custody of her third child because "he was black." DSS now has custody of her son.

In an appalling story of sexual trauma, Yolanda tearfully described a date she had planned with her boyfriend on his 32nd birthday. She planned to offer him her virginity as his birthday present. Instead, she arrived at his house to discover 12 of his friends playing cards. According to Yolanda, one-by-one, all 12 men raped her. Yolanda feared that if she protested, she would be killed. The evening of horror ended when her boyfriend gave her "a kiss goodnight" after the gang rape.

Yolanda reported the rapes to her mother. Her mother made sense of the horror by claiming divine retribution. "God was punishing you for disobeying me," she told Yolanda. Eventually, Yolanda and her mother reported the rapes to the police. Five of the 12 men were eventually convicted and incarcerated.

Depression and Suicide

Because depression is common among substance abusers, abuse victims, and inmates (Jaffe, 1995; Stucker, 1994), one would expect to find depressed women at HCHC. This proved to be true; many women reported depressive experiences, including thoughts of worthlessness, sadness, anhedonia, and guilt. Many women also reported suicidal thoughts and behaviors. Of the 49 participants, over one third (37%) had suicide attempt histories according to HCHC's JMS database.

Kit was one of several women whose high Depression score was indicative of the physiological, affective, and cognitive manifestations of a clinical depression. Kit spoke of the depression that accompanied her drug addiction. She also spoke about the depression that accompanied taking care of an abusive and drug-addicted husband through a fatal illness. Ten months prior Kit suffered what she termed a "nervous breakdown." At the time, Kit was taking care of her ailing husband, Steve. Steve was also a substance abuser and was dying of cirrhosis of the liver and Hepatitis C. During their marriage, Steve had been physically abusive toward Kit, before he succumbed to his illness and became dependent on Kit for his daily functioning. Kit had tried to sustain both her marriage and Steve's health through her own drug addiction. "If only I could keep him alive long enough, the marriage will be good," she had thought. Caring for Steve and sustaining her addiction became too much to bear. "He was living off my strength, and I had nothing left for myself," she claimed. Kit became increasingly depressed, getting out of bed only to feed, clothe, and bathe Steve. She lost weight, cried much of the day, and continued to isolate herself. It was only when Kit's son called his

biological father to tell him that his mother was "dying" that she eventually received treatment for her depression through psychiatric hospitalization.

Marissa, a 36-year-old, is serving a two-year sentence for possession of crack cocaine and intent to distribute in a school zone. She produced an invalid PAI due to a tendency to portray herself negatively and an exaggeration of clinical symptoms. Her behavior at HCHC, however, suggests that she suffers from depression. As we shall see, Marissa has also been suicidal and prone to act on her impulses. Marissa describes her first year at HCHC as "Hell," characterized by "ups and downs; with more downs than ups." As a result of this, her first incarceration, Marissa lost custody of her 15-year-old. She became animated talking about her son, whom she considers the most important person in her life. She describes having a "special relationship with no secrets" with her son and that she "broke that bond" by being away from him while in jail.

Marissa also has a rare medical condition called Reflexive Sympathetic Dystrophy Syndrome that produces chronic pain, usually on one side of the body. Marissa had been diagnosed with the syndrome while in jail; she spoke hopefully about ways to treat the syndrome. One treatment would involve the surgical implantation of a medical apparatus in her stomach, with wires attached to her spine to regulate nerve conduction. HCHC will not pay for the surgery, which costs $8,000. Even if she were to finance the surgery, she would not be able to have it done for another four months because of the remaining time of her incarceration.

Approximately six months ago, Marissa was sent to the hole after getting into a physical fight with her roommate. Earlier that same day she had heard that she had lost

custody of her 15-year-old son due to her ongoing drug problems and current incarceration. Earlier that week, she had also learned that she would have to finance the surgery herself and could not have it for another four months. With these external stressors on her mind, Marissa entered the hole. Uncustomarily, the Correctional Officers did not remove her shoes upon entrance to the hole. In an act of despair and determination, Marissa used her shoes and her jail shirt to attach one end of her makeshift noose to a vent on the ceiling and the other end around her neck. She hanged herself during the evening after "count." Marissa was unconscious when the Sergeant went on her rounds and found Marissa. In a stroke of fortune, the Sergeant had brought a jackknife to work that day and used it to cut the noose around Marissa's neck. Upon her rescue, Marissa was transferred to a local psychiatric hospital where she received more intensive evaluation, management, and treatment. After one month, she returned to HCHC to serve out the rest of her sentence.

When Marissa reflected on this experience, she talked in spiritual terms of her exclusive relationship with that Sergeant. She said there was a "reason" that the Sergeant happened to bring her jackknife to work that day and that she was the one who had rescued her. "I would be dead if it weren't for her," she emphasized. In a way reflecting her belief in the Sergeant's ability to be attuned to her distress, Marissa described how she would turn to the Sergeant, rather than to any counselor, when she really needed someone to talk to.

Personality Disorders

Four personality disorders were assessed by the PAI and the SNAP. The majority of women who scored high on one personality disorder scale also scored high on at least one other personality disorder scale. Antisocial Personality Disorder and Borderline Personality Disorder were the two most common personality disorders in the women. In fact, 60% of women scored above 70 on *both* the Borderline and Antisocial scales of the PAI. These data are further evidence in support of the high degree of comorbidity of the personality disorders. (For a review of this issue, see Frances & Widiger, 1986.)

Of the nine women interviewed, four were classified as personality disordered using the stringent criteria discussed earlier: Yolanda (Antisocial Personality Disorder), Toni (Antisocial Personality Disorder), Maryanne (Borderline Personality Disorder), and Marissa (Borderline Personality Disorder). In the following sections, I will discuss three of these women, Yolanda, Maryanne, and Marissa, with respect to their thoughts, feelings, and behaviors that best reflect their personality disorders. Having each woman described under only one personality disorder is, in one sense, artificial; most of these women had maladaptive personality traits that overlapped with more than one personality disorder. Each woman, however, is listed under the personality disorder that most accurately reflected her personality organization.

As a footnote, Marissa produced an invalid PAI protocol, thus eliminating the possibility that this instrument could be used to confirm a diagnosis. Although scores on the Borderline and Antisocial scales of the SNAP were *not* used for classification purposes, Marissa's scores on these two scales were examined in combination with

observations by correctional staff and clinical evidence from the biographical interview that suggested that she had prominent features of both Borderline and Antisocial Personality Disorders.

Antisocial Personality Disorder

As stated in Chapter 3, many women at HCHC would likely be diagnosed as having Antisocial Personality (ASPD) according to DSM-IV criteria (American Psychiatric Association, 1994). While many women would meet the behavioral criteria of antisocial behaviors, few women would also manifest the interpersonal/emotional aspects of the disorder. These interpersonal aspects are thought to fundamental in the narrower concept of psychopathy (Hare, 1991). These interpersonal/emotional components of the disorder include a shallow expression of emotion, egocentricity, interpersonal exploitation, and a tendency toward stimulus seeking. Many of these psychopathic characteristics were strikingly apparent in Yolanda.

Yolanda

Yolanda, as discussed, suffered horrendous sexual abuse and has an extensive drug history. She would also most likely be diagnosed as psychopathic. Her score on the Antisocial scale of the PAI was the highest of all women tested. Her story of criminal history and interpersonal history is replete with examples of self-serving interpersonal exploits and manipulation.

Yolanda began the interview by talking about her relationship with her "boyfriend" of six years, Frank. Frank is physically impaired and regularly sends Yolanda money, which is kept in her HCHC bank account until release. Frank is on

disability and has collected a settlement for a work accident that resulted in a permanent disability. Although she said "He's no good for me," and "I'm no good for him," she states he is "the only family I have" and he was her "first love." She claimed that they are often physically abusive toward one another. When asked if she was intending to stay with him upon release from HCHC, she had a telling slip-of-the-tongue, "I shouldn't, but I need to take advantage of him." Realizing what she had said, Yolanda rephrased her statement by saying how she needed the "love" he gives her and how she must be "open and available" to it.

Yolanda's description of herself and how she thought others perceived her was also remarkable for its artificial display of emotion. She described herself as "nice, strong, intelligent, faithful to friends, and caring." She thought that others, however, tended to see her as "mean and cold-hearted," with a "hate-me look." Yolanda felt undeserving of these perceptions and said she is "more afraid of them" than they are of her. She stated that she had "just learned" this information about herself. These explanations, however, seemed contrived and were a scripted portrayal of what others would *expect* her to feel in a given situation.

Yolanda's stories were also marked by themes of interpersonal exploitation. Later in the interview, she boasted that she was a "chameleon," that she could "be whatever others want [her] to be. I can play the game." In elucidating this point, Yolanda spoke about one inmate who she felt was trying to elicit sympathy, money, and provisions from others for her dire financial straits. Yolanda said of this woman: "She thinks she's playing with me, but I'm playing with her by going along with it. I let her

think that I feel sorry for her, but I know that she's full of shit." In Yolanda's world, one can be either the victor or the sucker in the interpersonal game of exploitation; it's either exploit or be exploited.

Finally, Yolanda described the events of one of her most recent arrests, which demonstrated both her penchant for thrill seeking and exploitation. She told how she went to Florida to visit some relatives soon after Hurricane Andrew. Yolanda was traveling back from Florida with a "friend" she had met while there. The two women had reportedly stolen the pocketbook of an older woman. They were pleasantly surprised to find a Platinum Visa card in the pocket book. Her friend "dared" Yolanda to use the credit card. Yolanda proudly described how she used the credit card to buy herself clothes in order to "dress [herself] up" and "look expensive" like the owner of the credit card. Yolanda then traveled up the East Coast buying "pots, pans, vacuum cleaners, baby clothes, drugs, or whatever" much to her amusement and chagrin. Yolanda described how she would "bullshit" the shopkeepers into letting her use the credit card without identification by claiming that the rest of her identification was "lost" in the aftermath of Hurricane Andrew. With a hint of victory that her charade had lasted so long, Yolanda had "maxed" out the credit card to $25,000, before finally being arrested in Massachusetts.

Borderline Personality Disorder

As discussed in Chapter 3, many women at HCHC showed borderline personality traits of affect instability, identity problems, negative relationships, and self-harmful behaviors. I will use the case of two women, Marissa and Maryanne, to exemplify

borderline pathology. Both these women represent extreme cases of Borderline Personality Disorder; they were among the highest scorers on both the Borderline and Antisocial scales of the PAI and SNAP.

Maryanne

Maryanne is a 44-year-old divorced, African-American who is serving a 21-month sentence for the combined charges of possession of crack cocaine, writing bad checks, possession of stolen property, and attempting to commit a crime. Maryanne has an extensive criminal history dating back to when she was an adolescent, which included convictions of robbery, assault, conspiracy, and attempted murder. She also boasted having nine escapes from correctional facilities. Maryanne has one living daughter, age 26, and a son who died two years ago at age 19 while he was incarcerated. A fellow inmate at HCHC murdered her son. Maryanne is also HIV-positive and a self-identified gang member of NETA. After one month of her current incarceration, Maryanne was involved in what she referred to as a gang-related "turf fight." This fight was to be the first of a series of fights in which she was involved. Maryanne spent more than half of the first three months of incarceration in solitary confinement. Soon after being incarcerated, she was placed on Special Management-Discipline and Security Risk Group status because of her admitted gang involvement. Although Maryanne would most likely have several DSM-IV (American Psychiatric Association, 1994) diagnoses, the extent of her borderline pathology reflected in her interpersonal rage and rapidly shifting emotional states was remarkable.

Maryanne's score on the Borderline scale was the highest of any woman; her score on the Traumatic Stress subscale was also one of the highest.

Maryanne described a past filled with ritualized abuse at an early age by her father, including being physically tortured almost daily by various implements and tools. She also reported being made to sit on a lit stove. Maryanne summed up her early experiences this way: "There's nothing that a human being can do to me that hasn't already been done."

Maryanne describes how feelings of disrespect from her childhood are a trigger to her rage. Throughout the interview, Maryanne made connections between her past abuse experiences and the anger and rage provoked in the present by the slightest interpersonal hurt. In a way that seemed to reflect her history of mental health treatment, she stated "I don't see them disrespecting me; I see my father disrespecting me." She stated that she would prefer that [they] "slap or hit me than disrespect me." "I know how to heal a cut or a bruise, but I don't know how to heal the hurt," she claimed. Although her language was infused with psychological jargon and intellectualized concepts, one could sense the raw emotions, inspired by her traumatic past, which are ready to erupt when triggered.

Maryanne told of how she can react to disrespect with retribution and vengeance. "If I'm hurt, I'll take a life if I have to. One way or another, I'll get you." She stated how her moods can "turn on a dime," and how she can aggress toward anyone who either disrespects or violates her. Maryanne also discussed how she has difficulty controlling her anger. In an interpersonal conflict that was continuing at the time of the interview, Maryanne described how she saw herself "going to the hole soon," because of the

provocation of another woman. In a mother-child connection group set up by the jail staff to reacquaint mothers with their children, Maryanne described how she was "this close to hitting" another woman in the group. The woman had reportedly made comments toward Maryanne that were perceived as insulting to her deceased son. Maryanne said that for the previous day she had "prayed not to go off on her."

Maryanne's relationships with men have been marked by abuse, conflict, and retribution. She was reportedly married to a man with whom she engaged in reciprocal abuse. She described one incident 15 years ago that led to a lengthy incarceration. Maryanne had had a particularly heinous argument and physical exchange with her husband the day earlier. Maryanne had devised a plan to have her husband come home and sit down next to her on a chair after work. Her plan was then to douse him with lighter fluid and ignite the flames with a match. Things had gone according to plan. In an ironic act of safety, Maryanne had helped her husband put out the fire before the police came and eventually arrested her. She served a ten-year sentence for attempted murder. She said that her husband, to whom she is still married, avoids her at all costs and refuses to have any contact with her.

On a positive note, Maryanne described how she is trying to learn how to accept affection and love from her daughter. She claims that it's "hard to give something you never had." "I was never held or hugged." "Every time I was held it was wrong," she stated. Maryanne described how she is beginning to learn how to hug her daughter without "jumping back" out of fear.

Marissa

When asked to describe her relationships with other women at HCHC, Marissa replied succinctly, "Not good." Marissa accurately described her relationships: In 472 days of incarceration, she has been sent to the hole five times for fighting with other women. Recently, she became Special Management-Discipline due to her frequent fights with other women. Marissa, who was discussed earlier, manifested one of the hallmarks of borderline personality pathology: intense, conflictual relationships. Over the course of the interview, it was also apparent that she showed other signs suggestive of borderline pathology. Notwithstanding her demonstrated tendency toward self-harm, Marissa's life stories were also filled with displays of unmodulated anger and identity confusion.

Although her PAI was invalid due to an elevated Negative Impression Management score, her SNAP profile was valid. She had elevated scores on three of the four personality disorder scales assessed by the SNAP: narcissistic, borderline, and antisocial personality. Her score on the Borderline scale was most noteworthy; she scored the highest of all women.

Like Maryanne, Marissa had a traumatic past. She spent much of her childhood in various foster placements. In her late teen years, she lived at various halfway houses where she attempted to treat her already fully developed drug addiction. Prior to being placed under DSS custody, Marissa lived with her mother, whom she described as a shining light in an otherwise dark and bleak childhood. Her father, whom she would see when not with her mother, physically abused her. She was also made to perform oral sex on her brother, and was raped by her uncle. When asked to describe her earliest memory

of her father, Marissa said: "I think about him hurting me and then I start to feel like killing him." "That's what I'm now working on with my psychiatrist." Marissa then instructed me: "Don't speak of him anymore." This exchange, which was startling and arresting in its intensity and immediacy, demonstrated the tenuous hold Marissa has on separating the past from the present. Moderately intrusive explorations into the past elicit unmodulated rage and aggression.

Marissa described having a "trust issue" with people. She spoke of "never hanging with women on the outside," and talked about her difficulty trusting and forming any relationships with the women in jail. In one breath she told me "you won't see me getting close to any of these people," yet in another she spoke positively of her relationship with the Sergeant, who had saved her life, and with "two or three other friends" at HCHC. In a manner that seemed to reflect her ambivalent feelings of relationships, Marissa said: "Every time I get close to someone, they leave. One friend left today. I know she had to leave sometime, but..." To Marissa, the price of an attachment seemed to come at an exorbitant cost.

Last, Marissa demonstrated a confused sense of identity that often characterizes individuals with Borderline Personality Disorder. During the follow-up questions, Marissa was asked to elaborate on a response she gave to a PAI statement. She responded "Very True" to the statement: "Sometimes I can't remember who I am." Marissa laughed when she was read her response. "I would give the same answer now," she said. "Everyone has always told me why don't you be like Johnny, [her brother] or like Jennifer' [her sister]." "I've tried to live as they wanted me to, but you stop being

who you are. Even people here expect you to be someone else, but it's not who I am." With a poorly developed sense of herself and her needs, one can imagine the confusion and uncertainty Marissa experiences when she tries to distinguish herself from the persona she feels others expect of her.

CHAPTER 5

LIVES INCARCERATED: HOW DO THE WOMEN AT HCHC BEHAVE IN JAIL?

Adjusting to a Life Behind Bars

Women began the biographical interview by answering the question: "How has your adjustment been here at HCHC?" Many talked of the complex interpersonal web of power and influence among inmates and the correctional staff. Some women openly flaunted what they perceived as their power and influence. Maryanne, an identified gang member, described a situation several months prior when there had been a rash of fights in C10 among women who had reportedly been rival gang members. This situation had escalated to a point at which correctional staff officers were concerned about future fights and wide-scale insurrection. Several Correctional Officers had come to Maryanne for assistance, imploring "Maryanne, if anyone can stop it you can. The girls respect you."

Women also talked about the psychological impact of incarceration. They spoke of the restrictive disciplinary system in which they were not allowed any conversations with male inmates, were only to communicate with other women in the "common areas," and had to remain "locked" in their cells every evening and at "count time." Count time took place when women had to return to their locked cells for a head count. Jacqueline, who was incarcerated for the first time for passing marijuana to a brother's friend in jail, spoke of the paradoxical effect of losing her freedom and independence, which she had achieved at an early age. "I've been on my own since 15. Now I can't even talk to a boy, look out the window, or do anything."

Women who had been sent to solitary confinement, the "hole," spoke of their experiences. They spoke of living in the confinement of a smaller cell, where only one hour out of twenty-four was permitted outside the cell for "recreation." Boredom was a common experience with which to contend. They spoke of the magnified feelings of depression and isolation they felt living in a cell measuring 12 feet by 12 feet.

Ironically, a few women welcomed their stay at the hole, seeing it as a "break" from the interpersonal stress and dynamics of their pod. Marisa was a woman who recently became Special Management--Discipline after a multitude of disciplinary infractions and a near-fatal suicide attempt. She described behaving in a manner that seemed a willing effort to gain entrance to the solitary confinement. "I knew I was going to the hole if I did it [physically assault another woman who stole two sugar packets from her], but I did it anyway." I don't mind going to the hole. The last time I was there it was very spiritual for me. I found God again. It was very peaceful and quiet there." Maryanne also echoed a similar sentiment, suggesting that solitary confinement provided a sanctuary. She described how she spent half of her first fifty days of incarceration in solitary confinement after she was involved in three separate fights. "C9 is a vacation for me. It's an escape from the madness where I can get some peace of mind. If they let me, I sometimes crochet in the dark there. I see better in the dark." Although they may have spoken with bluster about HCHC's most serious form of punishment, both Maryanne and Marissa talked of the hole as providing something that neither was able to do on her own. Solitary confinement offered a safe haven and containment from the interpersonal dynamics of the unit and an escape from their own destructive tendencies.

Aggression

Many women talked of the ethic of "claiming your place" at HCHC and actively defending one's place "in the mix" of the women's unit. Cliques abounded; women formed alliances that served to protect themselves in jail and later "on the streets." Some of these affiliations were gang-related, but many were not. Some women had troubled and conflictual histories with particular women who were also incarcerated. Others renewed friendships at HCHC. Either as enemies or allies, many women knew one another by living in geographic proximity, interacting with the same people, and sharing involvement in the criminal justice system.

Intimidation is a part of living at HCHC. As women jockeyed for positions of power, influence, and affiliation, there were frequent interchanges of verbal aggression. Although the consequences for intimidation and aggressive behavior are clear, women frequently exchanged threats, insults, and propositions. Many of these threats and propositions, however, went unheeded. Bravado was a way of deflating potential conflict and maintaining pride and stature. As Jacqueline described it, "The girls here are all talking and no fighting. I've never seen anything like it. The way I see it, don't talk about it, be about it."

Some of these threats and propositions, however, were acted upon. Maryanne, who had been involved in five fights during her incarceration, told her intimidators, "Go ahead. If you feel froggy leap!" Most did not follow through on her command.

The relationships of women with other women were always a lively topic during the interview; the women tended to have polarized views on the importance they placed

on relationships. Some women seemed to thrive on their affiliations with other women, affectionately referring to them as "my homeboys," or "my girls." Sometimes they made plans to live with each other or to attend a program together upon release. Others tried to avoid the interpersonal dynamics of relationships altogether, and wanted to "do their time" alone. Jacqueline, who spoke negatively about all women except her cellmate, described her fellow inmates this way: "The bitches are grimy. They'll be your friend and then they'll talk about you to others." You really don't have a friend here. I didn't come here to make friends. I don't care to know any of them when I leave." While seeming to disavow any interest in jail relationships, Jacqueline then began talking about how much she would miss her cellmate following her release five days hence.

Rasa, who was serving a 10-year sentence for trafficking cocaine, also spoke negatively about her relationships with others and her desire to isolate. Rasa had been at HCHC since 1996, after serving three years at the state women's prison in Framingham, Massachusetts. Although she was classified as SM for a brief period in 1996 for continual conversations and inappropriate contact with a male inmate, she had been a model inmate since that time. She held several jobs, had maximum privileges, and rarely received even a verbal warning. When asked about her relationships with others, she responded: "They hate me. They think I'm better than they are." "I don't click with nobody here. I keep to myself." Her isolation, however, had at times led to more intimidation by others. Rasa had to be "strong" and not back down to the threats of others. "I'm not scared of them, though. If they hit me, I'll hit them back," she emphatically stated. Some of these women had propositioned Rasa several times to go to

a specified place to "have it out" with them. Rasa had thus far not taken them up on their offer. Even a model inmate like Rasa, however, has to contend with the aggressive posturing that occurs "in the mix" of the unit.

Inmate Management at HCHC

Upon being admitted to HCHC, all women are given the "Jail and House of Correction Inmate Handbook" (Hampden County Sheriff's Department & Correctional Center, January 2000), which describes the policies and procedures for all aspects of incarceration. Included is information related to admission, housing, bail, legal counsel, health, security, programs, work assignment, and parole and release options. Two aspects most relevant to the current study are the policies on classification, conduct, and discipline. Each is described below.

Classification

Classification is the process of evaluating, separating, and housing women based on custody level, behavior, work assignments, and program participation. There are two types of classification at HCHC: (1) Unit, and (2) Central. Each has its own appointed board members. The Unit Classification board is responsible for classifying living quarters, work assignments, program participation, and work assignments. The Central Classification board is responsible for classifying women on their level of security status. The Central Classification board is also involved in identifying and reviewing women who pose a safety risk to themselves, others, or the safe running of HCHC. Women who are considered safety risks may be classified as Security Risk Group Status (SRG) and/or Special Management (SM).

Special Management Classification

Women who are classified as SM are "inmates who are threatening the secure running of the facility. For their own well-being, they may be removed voluntarily or otherwise from the general population and placed in special units and/or have limitations placed on their privileges or activities (p.10)". Women may be classified as SM for a variety of reasons. There are four SM classifications: (1) SM-- Discipline, (2) SM--Forensics, (3) SM--Medical, and (4) SM--Protective Custody. SM--Discipline classified women are behavioral management problems. SM--Forensics classified women have significant mental health issues that warrant closer monitoring. SM--Medical classified women have significant medical issues that warrant closer observation and treatment. Finally, SM--Protective Custody classified women need more isolation and containment due to their high-profile status or risk of attack by others. As an example, Kristen Gilbert, the former nurse found guilty in 2001 of killing four patients at the Northampton Veterans Administration in 1997, was classified as SM--Protective Custody while she was incarcerated at HCHC prior to her trial.

The Central Classification board reviews reports and records of the SM classified women weekly. Sanctions may be given to those who do not maintain appropriate levels of conduct and behavior. Special Management classified women who behave according to expectations are granted "All Privileges." Women who are behaving below expectations may be given "Unit Privileges Only," a status in which they are relegated to their units and are not allowed to have meals in the cafeteria, or attend recreation off the unit. Women who are even more restricted may be given "Pod Privileges Only," a status

in which they are only allowed out of their pods (cells) for limited time periods. Women who are returning to the general population from solitary confinement may first be granted Pod or Unit Privileges and then progress to a higher level of privileges as they show improved behavioral control.

Security Risk Group Classification

Women who are classified as SRG are deemed safety risks due to their gang involvement. HCHC evaluates potential gang involvement through a systematic procedure called the Objective Gang Classification and Tracking System. Certain gang-related activities and behaviors are given point values. Higher point values indicate an increased likelihood of active gang involvement. For example, contact with known gang members garners two points, while use or possession of gang symbols brings eight points. Information from law enforcement agencies of a woman's gang membership brings eight points. Each woman's point values are totaled; those who have point totals between five and nine points are considered SRG "suspected", while those with at least 10 points are considered an SRG "member." Like Special Management classified women, SRG classified women are reviewed weekly by a special SRG classification board for conduct and behavior. If an SRG classified woman is sent to solitary confinement, she also has to follow certain rules and regulations before she can be sent back to the general population. Certain women who have known gang involvement *and* are classified as SM have the dual classification of SRG *and* SM.

Conduct and Discipline at HCHC

Staff Involved in the Disciplinary Process

Conduct at HCHC is maintained by a systematized disciplinary system composed of Disciplinary Officers (DO), Correctional Officers (CO), Unit Supervisors (US), and Disciplinary Boards ("D-Boards"). The inmate handbook lists all rules and regulations of the facility as well as the steps in the disciplinary sanction process.

A Disciplinary Officer (DO) investigates all Major A violations (which are described below) and is the liaison with the disciplinary board. The DO also has the authority to eliminate, adjust, and clarify violations and complaints in a Major A violation case. D-Boards investigate all Major A violations through a disciplinary hearing and make decisions on guilt and appropriate sanctions. The US or DO may also conduct a Minor Rule Violation Hearing for a Minor B Violation (also described below) which is being disputed by a woman.

The Disciplinary Process

In general, there are three types of disciplinary sanctions, each distinguished by the severity of offense. A woman may be given an Informal Alternative Sanction, which is the least severe violation. This sanction is given for small rule violations, and does not require that the CO write a disciplinary "ticket" as is the case for Minor B or Major A Violation. After the behavior occurs, the CO writes down the problem behavior and allots consequences for the behavior. For an informal sanction, a CO may impose either a loss of privileges, removal from work detail, or confinement in one's cell for a period no more than two hours. A woman may also be given a "verbal warning" by the CO.

Verbal warnings have no associated consequences, but may accumulate so that three verbal warnings during a 30-day period constitute a more serious Minor B Violation. Examples of behaviors that warrant an informal sanction include making inappropriate comments to staff, being slow to mealtime, or minimally communicating with male inmates. A woman is given the opportunity to agree with the informal sanction or can protest the sanction at which time the sanction becomes "formal," is "ticketed," and is elevated to a Minor B violation. A D-Board then conducts a disciplinary hearing.

Minor B violations are given for behaviors that are more serious, but not considered an immediate threat to the security of the facility. Generally, Minor B violations warrant "locked time," or Disciplinary Detention (DTTN), a status in which one is "locked" in a deadlocked cell on the unit. Locked time for B Violations can vary from 24 hours to 72 hours. When a Minor B Violation occurs, the CO maintains safety and order on the unit, and writes an incident report with recommended sanctions for the behavior. The DO receives the report and then has 24 hours to review the case and decide if the recommendations are appropriate. If they are deemed appropriate, the DO imposes the recommended sanction the next day. If the DO is not in agreement with the recommended sanction, he or she may conduct a D-Board hearing to investigate the offense.

Upon receiving a B violation, a woman may either agree with the violation, serve the recommended "locked time," or appeal the violation at which time a D-Board is conducted. The interval between the time of the violation and the recommended sanction by the DO or the D-Board is considered PHD, or Pre-hearing detention. Inmates

in PHD are locked in the deadlocked cells on the unit as they wait for the decision by the DO or D-Board, or else in holding cells on the unit. Examples of B violations are: (1) creating a disturbance, (2) foul and abusive language to staff, and (3) gambling. As is the case for Major A violations, time spent in PHD is counted as time served toward the sanction. For instance, if a woman spends 24 hours in PHD, and then receives 48 hours of locked time, she has only 24 more hours to serve. If a woman is given three B violations within a 30 day period, her last violation becomes elevated to a Major A violation.

A Major A violation is the most serious violation and constitutes a threat to the security and safety of HCHC, its staff, inmates, or visitors. All Major A violations go through a formal investigation process conducted by a D-Board. Once a Major A violation occurs, the CO imposes order on the unit, which involves placing those involved on PHD and in deadlocked cells on the unit. Most often, violating inmates are sent to solitary confinement in C9. The CO then writes an incident report. The DO then begins an investigation of the offense within a 24-hour period and completes the investigation within 72 hours. The DO makes recommendations to the D-Board prior to the hearing. A D-Board hearing is conducted not before 24 hours and not after 72 hours of the incident. The maximum sanction cannot be more than ten days for one offense or thirty days of locked time for all violations arising out of an incident. Violations that constitute Major A Violations include fighting, escape, possession of drugs or contraband, or inciting a riot. Informal Alternative Sanctions, Minor B violations, and Major A violations are all inputted into the JMS database. Verbal warnings, though theoretically inputted, are in practice not consistently entered.

The Case of Toni

The case of Toni illustrates the various aspects of the disciplinary process. Toni, had accumulated a number of disciplinary violations, including talking to males, loitering in the "T," and making inappropriate comments to staff. She was a persistent management problem for HCHC staff. Most of her behaviors, however, were relatively minor and constituted informal sanctions, or Minor B violations. She did, however, receive one Major A violation, described below.

Toni had just been given an informal sanction, a two-hour lock, for creating a disturbance on the unit. She had reportedly gone over to a woman, Marie, and told her what another woman, Jeanne, had said about her. The conversation then erupted into angry words between Toni and Marie, at which point the CO gave Toni and Marie an informal, two-hour lock. After serving the two hours lock time, Toni went with several other women to the recreation hall. She had her Walkman on and was playing basketball when an acquaintance of Marie lifted up Toni's headphones and grabbed her basketball. Toni then went after the woman and was in the process of fighting for the basketball when a CO intervened. Special Operations officers were called and they escorted the women back to their respective units.

Toni was placed in the deadlocked cell on her unit and was told she was given a B violation (a 48-hour lock) for her disruptive behavior at recreation. Toni then protested the sanction and swore at the officer. The officer then threatened to place Toni in solitary confinement if her language continued. At that time, Toni responded, "Go ahead, and send me there, you bitch." Special Operations officers were called again and

Toni was moved to solitary confinement. Toni was placed on PHD while she awaited an investigation of her behavior in recreation and on the unit. Toni was given a B violation for her "foul, abusive, and threatening language" toward staff. After 24 hours, the DO completed his investigation and gave his recommendations to the D-Board--10 days of locked time. As it happened, Toni had been given a B violation the previous day for talking with males in the "T." She was now considered a "multiple and persistent" violator because she had more than three B violations in a 30-day period. Consequently, her most recent B violation turned into a Major A violation. Forty-eight hours after the incident, the D-Board met and agreed with the DO's recommendations. They had reasoned that, since this was to be Toni's first time in solitary confinement, serving all her locked time there might deter her from future misbehaviors. Since she had already served two days, Toni was released eight days later from solitary confinement to the general population.

Disciplinary Violation Coding

The disciplinary records of participants were accessed via the HCHC's computerized jail management system (JMS). Each inmate's disciplinary record was retrieved, printed, and coded. All women were incarcerated at HCHC for at least 30 days to allow enough time for a disciplinary violation.

Each participant's behavior was coded for disciplinary violations beginning at the time of booking and ending on the day of release. During their incarceration, some participants were reclassified and transferred to other services of HCHC, such as the Western Massachusetts Correctional Alcohol Center (WMCAC), the Pre-Release Center

(PRC), or Day Reporting (DAY). Participants who were classified as WMCAC or PRC are still housed on HCHC-owned facilities. Consequently, they are subject to the same disciplinary procedures. Participants who are classified as DAY, however, live independently and must "check in," either via telephone or in person at the HCHC Pre-Release Center. Participants who were classified as DAY were assessed for disciplinary violations *up to* the point at which their classification status changed to DAY. Some participants returned to HCHC after DAY for misbehavior; coding for these participants resumed at the point they returned to HCHC.

Eleven of the 49 women (22%) had at one time during their incarceration been designated as Special Management (SM). Seven women (14%) were active SM cases at the time of the study. One woman was classified as SM and Security Risk Group Status (SRG). One woman was classified as a Suspected Security Risk Group Status (SSRG), but was not classified as SM. Coding of Special Management Women and SRG/SSRG women are discussed separately.

General Coding Procedures

Coding procedures were formulated with the collaboration of the Disciplinary Officer of the Women's Unit, Dan Cavannah. The existing disciplinary system at HCHC, comprising Alternative Sanctions, Minor B violations, and Major A violations was translated to a disciplinary point system. Violations were allocated points depending on the severity of the offense; a more serious offense was allocated a higher point value. Coding was conducted by the author. Disciplinary violation data were objective data that

required little coder inference. Nonetheless, to assure validity coding checks were done periodically with the Disciplinary Officer.

Women committed a range of disciplinary violations, ranging from possessing contraband (cookies), to inciting a riot. The following point system was used to code various infractions. "Locks" occur in the deadlocked cell on the unit or in solitary. With a few exceptions, time served for Informal and Minor B violations is served in the deadlocked cell, while time served for Major A sanctions is served in solitary confinement.

1 point: Two hour lock, "verbal warning," or loss of privileges or work detail

2 points: 24 hour to 72 hour lock

3 points: Four to six day lock

4 points: seven to nine day "lock"

5 points: Ten days or longer lock

In summary, a one-point infraction constitutes an Informal Alternative Sanction. Two point infractions constitute Minor B violations, and three to five point violations are Major A violations.

Each participant had a point total of disciplinary infractions. This sum was then divided by a participant's total number of days incarcerated. The result is a Disciplinary Infraction Score (DIS). When coding participants' disciplinary violations, it became apparent that a number of participants committed serious disciplinary offenses warranting lengthy periods spent in solitary confinement. The DIS seemed better able to

capture multiple and persistent minor violators rather than severe disciplinary offenders. As an alternative measure of disciplinary misbehavior, a Hole Infraction Score (HIS) was calculated by dividing the total number of days spent in solitary confinement by the total number of days incarcerated. These two measures of disciplinary misbehaviors, the DIS and HIS, were used in all analyses.

Disciplinary Coding of Special Management Women

As discussed earlier, a Central Classification board reviews women who are classified as SM. Women who are SM also have different disciplinary procedures than non-SM women. Verbal warnings, two-hour locks, loss of pod or unit privileges, and solitary confinement are the consequences used to maintain control of SM women. SM classified women cannot be given an A or B violation; they can, however, be given verbal warnings or can be locked in a deadlocked cell for up to two hours. If an SM woman suffers a disciplinary violation that the CO believes warrants more than a two-hour lock, she is usually held in a locked cell on the unit or else sent to solitary confinement until her weekly hearing occurs. At that point, the Central Classification board decides upon guilt and appropriate punishment. Punishment is usually a reduction in privileges for less severe violations, or a continued stay in solitary confinement for more serious violations.

After consultations with the DO, the following coding guidelines are used for SM women. These coding procedures are designed to closely approximate the disciplinary coding for non-SM women. First, verbal warnings and two-hour locks are coded as 1 point, as they are for non-SM women. Women whose records reflect a reduction in privileges are coded one point for each decrease in privileges. For example, a woman

who began with "All Privileges" and then is reduced to "Unit Privileges" would be allotted two points. A woman who began with full privileges and then is reduced to "pod privileges" would be allotted three points. Time spent in solitary confinement is coded as a Major A violation and is allotted points based on the total time spent in solitary confinement.

Coding Oddities and Exceptions

Due to the complexity of recording different degrees of disciplinary misbehavior in a multi-layered system like HCHC, several coding oddities were encountered. First, cell moves were frequent, but it was impossible to know the reason for the move. As an example, "Cell move per Sergeant Boss" was a common entry in the JMS. This cell move could have been due to disciplinary misbehavior or for administrative reasons. Second, some COs would enter "problems with roommate," or "inmate moved due to excessive noise" in JMS, but there was no indication of a verbal warning, two-hour lock, or other disciplinary sanction having been given. Third, a few women left their units for a "respite" at the Crisis Stabilization Unit (CSU), a unit at HCHC that functions like an inpatient unit for acute psychiatric treatment and evaluation. These visits were listed in JMS as "CSU respite." From the entry into JMS, it was impossible to know if these respites were part of a regular plan for continued psychiatric treatment, or were elicited by an acute behavioral and/or psychiatric problem. Together, these entries were *not* coded for any disciplinary violations. Finally, Marissa was sent to two local psychiatric hospitals after her suicide attempt. She was away from HCHC for a total of two months. This time was subtracted from her total time of incarceration.

Statistical Analyses

Relationship Between Personality Disorder and Disciplinary Violations

For all analyses, the two dependent variables, disciplinary ratio (DISRAT) and the hole ratio (HOLRAT), were converted from decimals to whole numbers by multiplying by 100. It was hypothesized that personality-disordered (PD) women would have more disciplinary problems than non-disordered (NPD) women. This hypothesis was not supported. PD and NPD women did not differ in the number of disciplinary violations committed ($M_{pd} = 9.7$; $M_{npd} = 6.2$), $t(46) = -1.8$, $p = .07$.

It was also hypothesized that PD women would spend more time in solitary confinement than NPD women. Levene's Test for Equality of Variances indicated a statistically significant difference between the variances of PD and NPD women with respect to time spent in solitary confinement, thus violating the assumption of equal variances between the two groups ($F = 5.3$, $p = .03$). After adjusting analyses to account for unequal variances between the two groups, PD and NPD women did not differ in the amount of time spent in solitary confinement ($M_{pd} = 7.4$; $M_{npd} = 3.3$), $t(21.7) = -1.6$, $p = .12$.

Relationship Between Aggressiveness and Disciplinary Violations

It was hypothesized that aggressive women (AGG) would have more disciplinary problems than non-aggressive (NAGG) women. This hypothesis was supported. AGG women committed more disciplinary violations than NAGG women ($M_{agg} = 11.9$; $M_{nagg} = 6.3$), $t(37) = -2.5$, $p = .02$. It was also hypothesized that AGG women would spend more time in solitary confinement than NAGG. This hypothesis was also supported.

AGG women spent more time in solitary confinement than NAGG women (M_{agg} = 9.7; M_{nagg} = 6.6), $t(37) = -2.4$, $p = .02$. Please refer to Table 1 for a listing of means and standard deviations between groups on all analyses.

CHAPTER 6

THE CRIMINAL CAREERS OF THE WOMEN AT HCHC

Many women described a complex and multi-faceted involvement in the criminal justice system. Some talked of the perceived injustice of the system. Rasa, who is serving a mandatory ten-year sentence for trafficking cocaine, described her plight this way: "They got the wrong person. I may have made some mistakes, but I didn't do what they said I did, and I'm losing 10 years of my life because of it." Many who were incarcerated for drug-related offenses made the distinction between being a drug addict and a "criminal." These women saw themselves as being different from those who had assaulted, robbed, stolen, or otherwise violated others. "I've never done anything to hurt anyone," some pleaded. They saw themselves as more deserving of drug treatment than locked confinement. Charlotte, who reflected this view, spoke of her beliefs about the current mandated sentencing laws for drug-related offenses. "It's a way for them to keep addicts off the street. It's illogical. They don't need jail; they need drug treatment," she said.

Other women viewed their incarceration as an event that brought them to a realization of their vulnerabilities, and toward an understanding of experiences they long struggled to comprehend. "Until I got into jail and spoke to a counselor, I never knew how those experiences [of abuse] affected me," Charlotte reflected on her childhood when her brother sexually abused her at an early age. Charlotte saw her incarceration as a vehicle for self-exploration and change. Being jailed gave her time to think about the

choices she made, the paths she had forged, the relationships she had created, and the future on which she had yet to embark.

Coding of Criminal Charges

Criminal charges were examined using HCHC's JMS database. The JMS database system lists a participant's *most recent charge(s)*, or the charge(s) that led her to her current incarceration. A printout provided by the Bureau of Probation, called a "BOP," listed *all* previous adult charges. BOPs, however, were not available for all women; as a result, only a participant's *current* charge was used for analyses. Charges are coded by their *severity* and their *violence*. The criminal records of three women listed their current charge as either "violation of probation," or "violation of parole." These charges could not be coded for violence, but could be coded for severity by the imposed sentence length.

Using a procedure common in the criminal justice system (see Senna & Siegel, 1998), the severity of an offense was determined by the length of the imposed sentence. Charges are classified as either misdemeanors or felonies. A charge is considered a felony if the participant is sentenced to one year or longer; those charges for which participants are sentenced to less than a year are considered misdemeanors. Charges are also coded for degree of violence. Charges were classified as either violent or non-violent using the guidelines described by Teplin et al. (1994). The following arrest charges are classified as violent: assault and battery, assault with a dangerous weapon, assault and battery with a dangerous weapon, assault and battery on a police officer, and assault and battery on a child with injury. All other charges are coded as non-violent.

Charges were grouped as: (a) either violent or non-violent, and (b) either misdemeanor or felony. Many women, however, had more than one current charge. If any of the current charges was violent, that participant's charge was coded as "violent." A participant's most serious charge was used as the measure of severity. Thus, the charges that were the most severe and the most violent were coded. Interestingly, some women charged with the same crime had varied sentences. Consequently, one charge could be coded as a felony for one woman, but coded as a misdemeanor for another. As an example, one woman was sentenced for an assault and battery charge for nine months, while another woman was sentenced for five to seven years for the same offense.

Descriptive Statistics of Criminal Charges

A list of participants' criminal charges and their frequency is provided in Tables 2 & 3. Felonies and misdemeanors are listed together. Included are all participants' current charges; participants' "double charges" (being charged twice for the same offense) were only counted once. Many (44%) women were incarcerated for drug-related offenses. This, of course, does not take into account charges that were indirectly drug-related, such as stealing to obtain drug money. Forty-one percent of participants committed at least one felony, while 59% committed only misdemeanors. Twenty-four percent were charged for at least one violent offense, while 76% were not charged with a violent offense. Interestingly, these results parallel those of Haven et al. (1999), who found that 24% of their sample had committed a violent crime, while 76% had not. They also found that 69% were arrested for drug-related offenses (i.e., drug possession, sales, and drug-related motor vehicle charges).

Relationship Between Aggressiveness and Criminal Charges

Two Chi-Square analyses were conducted to investigate the relationship between aggressive (AGG) and non-aggressive (NAGG) women with respect to the severity and violence of their current charge. There was no difference between AGG and NAGG women with respect to the violence of their current criminal charge, $\chi^2(1, N = 37) = 1.1$, $p = ns$. There was also no difference between AGG and NAGG women with respect to the severity of their current criminal charge, $\chi^2(1, N = 39) = .04$, $p = ns$.

Relationship Between Personality Disorder and Criminal Charges

Two Chi-Square analyses were conducted to investigate the relationship between personality disorder (PD) and non-disordered (NPD) women with respect to the severity and violence of their current charge. There was no difference between PD and NPD women with respect to the violence of their current criminal charge, $\chi^2(1, N = 48) = .04$, $p = ns$. There was also no difference between PD and NPD women with respect to the severity of their current criminal charge, $\chi^2(1, N = 46) = .29$, $p = ns$.

Three Women Tell of Their Involvement in the Criminal Justice System

Karyn

Karyn was a 41-year-old, unmarried, African-American woman serving a 60-day sentence for the combined charges of assault and battery on a police officer, (coded as a violent offense), illegal possession of class B drugs (crack cocaine), and sex for fee (prostitution). In the interview, Karyn described the events leading to her current incarceration. According to Karyn, she had just smoked crack cocaine and was "on [her]

way to get some more," when she was stopped by a policeman in a patrol car and was questioned about having an "open container" of beer. The policeman strip-searched her and found two vials of crack cocaine in her possession. As she was preparing to get into the patrol car, Karyn overheard a voice on the police radio report that she had three default warrants. Karyn then struggled from the grasp of the police officer and attempted to run away. The officer ran after her and attempted to subdue her. Karyn, a heavy-set woman, put up a fight; the officer had difficulty restraining her and called in other police officers for help. Later, Karyn described how the officer became the "butt of jokes" at the precinct because he "couldn't handle a woman." Karyn was charged with assault and battery on a police officer, possession of crack cocaine, and prostitution, a charge resulting from one of her outstanding warrants.

Karyn, who was classified neither as personality disordered nor aggressive, believed her involvement in the criminal justice system was due either directly or indirectly to her drug addiction. She described a 30-year history of drug use and a 15-year history of crack cocaine use. This was her second incarceration; she had been at HCHC eighteen months ago after being charged with assault with a dangerous weapon, unarmed robbery, and distribution of crack cocaine. Karyn said that these charges were also connected to her drug use. Karyn also described having been arrested numerous times in the past for shoplifting to support her drug habit. Shoplifting meat items and baby formula brought the greatest funds on the black market. Karyn said she was an expert shoplifter, and described various ways she concealed ten-pound meats. "I know it's outside the norm, but you have to have skill to do this," she explained. Karyn had

prostituted "off and on" for 15 years. She made a distinction between prostituting for money and prostituting directly for drugs. "I usually don't exchange sex directly for drugs. This way I'm in control," she explained.

Karyn made a point of saying that she was not a violent person and rarely became involved in physical fights. She admitted that she does get "dope crazy" while using crack cocaine, in that she can become aggressive and "do things [she] ordinarily wouldn't do." When talking to Karyn, it was difficult to imagine her involvement in these behaviors. Her soft voice, subtly applied make-up, and easy-going demeanor belied a criminal history of violent acts and aggressive behavior.

Karyn spoke philosophically about her drug use and involvement in crime. "No doubt I would never have landed in jail if I wasn't a drug addict. I come from a very good background," she stated. "I've always been close to both my mother and father; they have been married for 38 years," Karyn told me. "Where did I go wrong?" she wondered aloud. She also spoke about her experiences being part of "the family of the streets," which she likened to an extended family in which similarly drug-addicted women can "look out for one another." Although she described her biological family as "incredibly supportive," she also said they were the "biggest enablers" of her drug use. She described moving in and out of her parents' home numerous times as a result of the ebb and flow of her addiction. Her parents' support, however, was not without its complications. She described a year-long period, approximately five years ago, during which she was homeless and did not want to return to her parents' house out of guilt and shame for breaking her promise of sobriety.

The interview ended when Karyn talked about her future plans to work in health care. She was involved in an organization that works with incarcerated women to provide job placements. Karyn explained that she had a job prospect working with chronic mentally-ill adults; she had an interview scheduled two days after her anticipated release from HCHC.

Marissa

Marissa was a 36-year-old, unmarried, Caucasian woman who was arrested for distribution and possession of crack cocaine and possession and intent to distribute drugs in a drug-free school. She was serving a mandatory two-year sentence. This was her first incarceration. Marissa could not be classified as either aggressive or non-aggressive due to her invalid PAI profile; her Negative Impression Management (NIM) scale was elevated beyond an acceptable level. Marissa was classified as personality disordered, however, due to an elevated narcissism score on the SNAP. Her scores on two other personality disorder scales of the SNAP (borderline and antisocial) were also elevated. Marissa, who tried to hang herself at HCHC, also claimed to have "multiple personalities," and claimed that she is sometimes unaware of her other "personalities" and their actions.

In a confusing and roundabout way, Marissa described the details of her current charge. She began by stating emphatically: "My boyfriend got me thrown in jail." She described a long, conflictual history of mutual physical abuse with her boyfriend, Jimmy. On the day of the arrest, she and Jimmy had gone to a bar together after smoking crack, and began to drink heavily. Marissa had a cast on her leg at the time, and Jimmy wanted

to hide several vials of crack cocaine in her cast. Marissa refused. Jimmy then left Marissa at the bar to go outside. The bar owners were "long time friends of Jimmy." The bar owners told Marissa that they had been told by Jimmy to tell her to go pick him up at a friend's house with his car. The bar owner then gave Marissa the car keys. Marissa attempted to drive away, but she was stopped by the police. Unknowingly, Marissa was in a stolen car and inside the glove box police found three vials of crack cocaine. In an act of revenge and retribution, Jimmy had set up Marissa. Marissa remembered going into the squad car and seeing Jimmy "laughing, pissing drunk" at her. Marissa was arrested for possession of crack cocaine, attempting to drive a car with a leg cast, and possession of stolen property. The last charge was later dropped. Marissa did not say how she had received the charge of intent to distribute drugs in a drug-free school zone.

Marissa's story of her past criminal involvement was similarly confusing and inconsistent. Although she said this was her first incarceration, Marissa had been arrested several times before. Most of these charges, she said, were drug-related. She did acknowledge a penchant for "stealing," which she said she has done since she was young. Stealing continues to give her a "thrill," she stated. She said she was arrested as a teenager twice; one charge was breaking and entering and another was grand auto theft. Interestingly, a printout of all her adult charges provided by the Bureau of Probation (BOP) revealed a more extensive criminal history. Marissa's charges, which dated back to 1980, included several assault and battery charges, and one charge of assault with a dangerous weapon. Her other charges included larceny, stealing a car, shoplifting, as

well as various charges involving drug possession and intent to distribute. Did Marissa "forget" about those other charges? Was her story of her criminal involvement more palatable when it was framed to herself (and to others) as either "drug-related," or "stealing-related?" Might her psychological symptoms contribute to her spotty and inconsistent memory?

Although Jimmy was "at fault" for her incarceration, Marissa acknowledged her guilt. "I did something wrong and I have to pay for it. I learned my lesson" she said. Marissa even went so far as to thank the correctional system for "saving [her] life." "I would be dead today...drug overdose, shot, stabbed, killed, whatever." She described how her drug addiction and alcoholism were "out-of-control" at the time of her offense. In jail, Marissa began to attend AA meetings regularly, and was able to see how she had no control over her drug and alcohol abuse. Being incarcerated gave Marissa a time of sobriety, self-reflection, and re-evaluation. "I pray that I don't end up in jail again," she stated.

Jacqueline

Jacqueline is a 21-year-old single, white, female who was classified neither as personality disordered nor aggressive. She was serving a two-year sentence for attempting to deliver a controlled substance to an inmate. During a visit to her brother at jail, she had unsuccessfully attempted to pass marijuana to him. He was incarcerated at another county jail for assault and battery and breaking and entering. A Correctional Officer who had observed them on closed-circuit television caught the two in the act of exchange. According to Jacqueline, she had passed "half an ounce" of marijuana just

two weeks earlier to her brother's friend, who was also incarcerated at the same jail. Correctional Officers had found the marijuana; her brother's friend then confessed to them how he had received the drugs. The Correctional Officers, according to Jacqueline, had "their eyes on" her. In reflecting on this event, Jacqueline claimed she didn't think she would get caught. "That jail is nothing like this one (HCHC). There they smoke cigarettes, smoke weed. I used to bring in quarter pounds (of marijuana) there."

Although this was her first "adult" charge, Jacqueline had often been delinquent as a youth and seemed to inhabit a world where criminal involvement was common. Both her brother and her boyfriend of seven years are currently incarcerated. She described having numerous charges as a juvenile, including selling drugs, larceny, writing bad checks, assault and battery, and breaking and entering. To top it off, Jacqueline said jokingly that she even "mooned" the principal once when she was 15.

When asked to describe her involvement in crime, Jacqueline stated: "I guess I have a bad attitude. I don't like people fucking with me. I just can't walk away from people disrespecting me." In one particularly telling example of this tendency, Jacqueline described how she had been "disrespected" by another girl who had begun to see her boyfriend behind her back. Jacqueline, 17 at the time, and her friends who had been drinking began to talk about the incident. As she continued to drink and talk, Jacqueline became more enraged. With her friends "egging [her] on," Jacqueline took a kitchen knife from her house and, along with her friends, went over to the girl's house with the intention of "messing her up." Jacqueline was yelling at the woman through the door and was attempting to break the door down when the police came. Amazingly, the

police did not find the knife; Jacqueline was arrested for attempted assault and battery and malicious destruction of property.

Jacqueline tried to normalize her involvement in crime. "It was the crowd I was running with. Drinking, smoking weed. To me it was normal." She also spoke fatalistically about her turn toward crime. She spoke about how a lack of parental discipline was not the culprit in her criminal behavior. "Nothing they (her parents) could have done would have made me change. I didn't listen, it didn't bother me if I was grounded."

Jacqueline described herself as different from other women at HCHC. She emphatically stated that she is not a drug addict. "I don't have a drug problem," she claimed. Although she had smoked marijuana for eight years, beginning at age 12, she had stopped three years ago because she was getting "panic attacks." Jacqueline admitted to "getting in trouble" when she drinks, but denied having an alcohol problem. "I'll drink when I get out of here…I've never been arrested while drunk. Actually, I did that one time I mentioned." There is no way to know whether this, her first "adult charge," was to be her last. Her inability to see the detrimental effects of her alcohol abuse, her longstanding and normalized criminal history, and her tendency toward impulsive, aggressive are predictors of future criminal involvement.

CHAPTER 7

THE INTIMATE LIVES OF THREE WOMEN AT HCHC

Of the nine women interviewed, I decided to tell the stories of three women who embody the most compelling characteristics of the many women interviewed. The stories of these women capture the impact of personality disorder, drug history, aggressiveness, and trauma. The structure of the narratives is thematically focused and follows the structure of the biographical interview. I will discuss relevant details of each woman's assessment data, childhood experiences, early memories, relationships, criminal involvement, and life at HCHC.

Rasa

Rasa eagerly awaited our interview. "I'd like to tell my story and help you out in any way I can" she said while smiling. Although she was dressed in the required pale-green prison garb, Rasa did not look like a prisoner. Her long, shiny, hair was pulled back neatly in a ponytail. She wore heavy lipstick and makeup and had on vibrant white sneakers. Fanning her long hair back with her hand, she began by talking about her childhood.

"They spoiled me...my childhood was good," Rasa began. Her parents divorced when she was 10 years old; she grew up with her mother, seven siblings, and her aunt. She saw her father on weekends. Her father was originally from Puerto Rico, and her mother's relatives were from the Dominican Republic. "I would always get what I wanted: clothes, candy, whatever," she said. Her father seemed to be the "spoiler" who

often brought home "bags full" of candy and clothing from his frequent trips to Puerto Rico.

The theme of her earliest memory of her father was of a benevolent figure who protected her from harm. When Rasa was five, her father brought home chocolate from Puerto Rico. Although they were expected to wait to look into the "goody bag" until after dinner, Rasa and her sister raided the bag, split a large chocolate bar, and hid under their aunt's bed. With chocolate on their mouths, their behavior was easily detected. Their aunt wanted to physically punish the children, but Rasa's father intervened. "Look at them; they look so pretty and cute," her father had said, a statement which diffused the threat of physical punishment.

While Rasa and her siblings saw their father as generous and loving, their mother saw him as a selfish philanderer, a man who had had several extramarital affairs. As a young girl, Rasa had often heard her mother cry when her father's numerous affairs were discussed. "He likes every woman," Rasa said. "He's always with different women." Her father, 58 years old, is now married to a woman who is 27. In a defensive maneuver to avoid tarnishing her image of him, Rasa made a distinction between her father's adultery and his responsibility as a father. "He screws around and cheats, but he's responsible," she said. "He has always taken care of us kids. He always buys us stuff," she stated.

Rasa's first memory of her mother, however, involved a frightening situation for her mother and her. Rasa was six when she was trying to sleep on a mattress on the floor

in her mother's new home, which was infested with rats. Rasa and her mother were equally petrified and cried the entire night, fearful of the rats.

During adolescence relationships with boys and fighting went hand-in-hand. Fights were common on the streets of East Brooklyn, New York. Rasa described numerous times when she fought on the streets to "defend" herself against the advances of women who were often angry over some type of love triangle. Accusations of cheating were hurled, and threats were made. Fights began if one was willing to fight to defend one's name or one's relationship with a boy. As mentioned in Chapter 5, Rasa was not the first to initiate a fight, but was willing to fight if someone violated or assaulted her first.

Rasa struggled in her adolescence and young adulthood to form relationships with boys. These relationships, however, were fraught with conflict, violence, and intense fears of abandonment. When asked to describe the worst thing that has happened to her, Rasa described a traumatic event that occurred with her "first boyfriend." Rasa was 13 and her boyfriend was 16. Rasa had discovered that her boyfriend was cheating on her; she wanted to break-up with him, but he refused to let her leave him. Her boyfriend, a "drug dealer," threatened to kill her if she left him. Placing a restraining order on his contact with her didn't help.

The intense feelings in the relationship with her boyfriend culminated in an act of mutual violence. Her boyfriend had gone to school drunk carrying a knife. He found Rasa and coaxed her to go home with him. At the house, he wanted to have sex with her, but Rasa protested his advances. They then became engaged in a struggle; Rasa grabbed

the knife and inadvertently cut him in the leg. Her boyfriend then fell to the floor and did not move for ten minutes. Describing herself as "stupidly crying," Rasa remained by his side, concerned that he was badly hurt. After ten minutes, her boyfriend got to his feet, grabbed the knife, and stabbed her in the stomach, telling her "you're not going to leave me." In an ironic act of care taking, her boyfriend took Rasa to the hospital, where she received 24 stitches on her stomach. Her boyfriend was also admitted to the hospital for treatment. Both of them then "ran away from the hospital" before being formally released. Her boyfriend, caught leaving the hospital, was arrested for assaulting Rasa.

Rasa is currently serving a 10-year mandatory sentence for cocaine trafficking. The circumstances around this charge, too, involved an intense, conflictual relationship with a boyfriend. In much the same language she used to describe her father, Rasa told how her ex-boyfriend, her "co-defendant" in her case, was "nice" and "kind" to her and "made sure [she] had everything [she] wanted—cars, furniture, anything." Although Rasa said that she knew he dealt drugs, she had never seen him use drugs and did not use drugs herself. On the night of her arrest, Rasa was with her boyfriend at a club. Rasa said they were fighting at the time due to her allegations that he was cheating on her. Her boyfriend was drunk and wanted Rasa to take him to "pick up some money." Rasa's boyfriend had sweet-talked her by calling her his "wife" to try to get her to drive his car to pick up the money. Rasa drove his car to a spot where he sold five ounces of cocaine to an undercover agent. The two were arrested on the spot.

Rasa said she didn't know there were drugs in the car. She said the operation was a "sting" that was geared toward arresting a former girlfriend of her boyfriend. Maria,

the former girlfriend, was the one who had sold large quantities of cocaine with Rasa's boyfriend. After the arrest, Rasa's boyfriend had unexpectedly disappeared from her life. "He just left me and didn't care about me anymore," she said. Only later did Rasa find out that she didn't even know her boyfriend's real name. In fact, Rasa later learned that her "boyfriend" had been an integral part of the sting operation, which was arranged as a plea bargain in his arrest. "I was set up with a stinger," Rasa reflected. Rasa was sentenced to 10 years in prison for trafficking cocaine. "Justice wasn't served," Rasa concluded. Rasa talked about the depression and suicidal thoughts she had upon first being incarcerated, when she felt betrayed and wrongly sentenced. In an ironic twist of fate, Rasa learned in prison that she was pregnant with her boyfriend's child. Rasa decided to have the child, who is now living with Rasa's mother.

Rasa's characteristic way of relating to others, particularly with men, appeared in her first relationships. She fell in love with a Correctional Officer. Rasa had been sentenced to the Women's Prison in Framingham, Massachusetts, where she met a Correctional Officer who worked on another unit. They first exchanged glances, then notes, and then made plans for a secret rendezvous. On one occasion, Rasa was caught "kissing" the officer and was sentenced to 10 days in solitary confinement The officer was disciplined, but still remained in his post. Amazingly, they continued to have secret meetings and were caught on other occasions ostensibly talking to one another. As a result of the second incident, Rasa was sent to HCHC to serve the remainder of her sentence. The officer was summarily dismissed from his post.

Rasa continued to have problematic contacts with men when she arrived at HCHC. She was given numerous disciplinary violations for Minor B offenses, such as "talking to males" and "unacceptable contact with males." For a brief period of time, Rasa was placed on Special Management-Discipline for her numerous disciplinary violations. During her last four years of incarceration, however, Rasa has been a model inmate. She has avoided potential conflicts with women and eschewed contact with men. This has not been easy for Rasa. "I know I look good; guys are always asking me for my number when I'm in child-care taking care of kids," she told me. She has also had to face disparaging comments by other women. In a double-entendre, Rasa has heard others say about her: "Don't worry about her, she only *fucks* with COs." Despite these struggles, Rasa has earned many jobs at HCHC and has achieved the highest privilege level.

In part, Rasa's change in behavior seems to be due to her realization that she wants to maintain a close relationship with her children upon release. Misbehavior may earn her more jail time, keeping her apart from her children even longer. Rasa, who has three children, talked of her past behavior at Framingham this way: "I'd lose what I have for a stupid kiss. I'm now more open-minded than that." Her behavior at HCHC has won accolades from correctional staff. Many correctional staff have called her a "role model." One correctional officer told Rasa: "If I could open these doors right now and let you be with your kids and your family, I'd do it."

Despite these changes, however, Rasa still recognizes her vulnerabilities and relationship insecurities. "I'm very insecure. Everything makes me jealous. It's always

been that way. I'm always assuming someone's doing me wrong." In a way, Rasa has chosen partners whose fidelity is questionable, and whose behaviors reinforce her fears and anxieties. Hopefully, this realization will bring about new relationships that are not dominated by jealousy, betrayal, and violence.

Charlotte

At 53 years old, Charlotte was the oldest incarcerated woman at HCHC. She was affectionately referred to as "grandma" due to her age, maturity, and "mother role" she fulfilled with many women on the unit. Charlotte was the first to participate in the study. "I think that hearing of my experiences can be helpful to other women," she told me. Charlotte is a small, heavy-set, Caucasian woman with gray hair. During phase one, (the group testing portion of the study), Charlotte was characteristically mother-like. "Shh, come on now girls," she told a few boisterous women who were snickering after reading a question on the PAI. "We don't want him to get a bad impression of us," she told them. Amazingly enough, the women listened, at least temporarily, until the next outburst, and then came the next admonition.

Charlotte began the interview by describing herself growing up in a family in which women were second-class citizens. A woman's role was to attend to men and to withstand abuse when she did not fulfill these responsibilities. Growing up with two brothers and one sister in western Massachusetts, Charlotte described how she was told to "keep your brothers out of trouble." Her alcoholic father physically abused her when she did not fulfill this role. To compound matters, one of her brothers had sexually

abused her from age four to nine, experiences that Charlotte had "put away for a long time," and was now discussing with her correctional caseworker at HCHC.

Through these dire experiences of her childhood, Charlotte learned how to do one thing very well: care take. Charlotte care took her two brothers and her younger sister; she even helped to ease her mother's distress when "Dad was awful" to her. "I've always been nurturing. I had three siblings to take care of," Charlotte reasoned.

Charlotte's tendency to care take appeared in her first marriage, which ended in divorce after several years. In the first of a series of relationships with alcoholic or drug-addicted men, Charlotte described herself as a "submissive, perfect wife." "I'd wake him up for breakfast, wash his clothes, shop for food, all the things a wife is *supposed* to do," she explained. Although her husband was not abusive toward her, Charlotte called him a "toy alcoholic," characterizing a relationship in which they both were nurturing each other's developing alcoholism.

Care taking also had its downside. In her relationships, Charlotte sacrificed her own needs and her sense of personal safety at the expense of taking care of sick, ailing, or addicted men. In her second marriage, Charlotte again married a "wonderful alcoholic." The relationship ended after five months when Charlotte realized he was not "father material." During the relationship, Charlotte gave birth to a daughter, one of her two children. Soon after getting married, her second husband began to drink more heavily. Charlotte, on the other hand, had cut down on her drinking. Much like her father had done, Charlotte's second husband would become physically abusive toward her when he was drinking and criticizing her. In one particularly telling incident,

Charlotte was kicked in the head with steel-toed boots after she was "rolling a cigarette the wrong way." Charlotte felt her head and said she still has "lumps" from the beating. Fortunately, Charlotte left this relationship after only five months of marriage.

Although Charlotte was away from an abusive marriage, she was having problems functioning independently. She had become increasingly debilitated by her alcoholism; she could not keep a job and lost her apartment due to non-payment. She began to sleep at friends' houses, and crash in "abandoned buildings" after a day (and night) of drinking. In an effort to "get money for booze," Charlotte developed a relationship with an older man with polio and a drinking problem. Charlotte would informally "help him out" by taking care of his everyday needs. For the first time in her life, Charlotte began using crack cocaine and began to become more financially dependent on this man to support her two addictions.

Charlotte arrived one day at his apartment to find his wheelchair tipped over and the man lying dead on the floor. Charlotte was suddenly confronted by another woman who came out of an adjoining room. The woman, who was unknown to Charlotte, threatened her with a knife and kept her at bay in the room. After eight hours in the room, Charlotte tried to make an escape, but the woman headed her off. They began fighting and Charlotte suffered a broken nose. Eventually, Charlotte managed to escape and call the police. The woman fled the apartment, but was later arrested.

This event led Charlotte to much soul-searching. She tried to channel her energy and use her experiences to help others with similar problems. Realizing that she had developed a drinking and drug problem, Charlotte began to attend Alcoholics

Anonymous (AA) regularly. Soon she started working in the administration for the main office in western Massachusetts. She also became chairman of a Christian organization's efforts to curb alcoholism and drug addiction through education and outreach. Charlotte states that she also developed a personal relationship with God and began reading books on spirituality, addiction, and recovery.

In a relationship in which she "tried to do the right thing the wrong way," Charlotte became involved with another alcoholic drug-addicted man. The circumstances surrounding her involvement with this man led to her current criminal charge of possession and distribution of class B drugs (crack cocaine). Charlotte had known the man, a "friend," for 10 years and had periodic contact with him. Charlotte had asked her friend over to her house to celebrate her birthday. Charlotte was shocked to find her friend haggard and emaciated. Her friend had developed Hepatitis C, and was not receiving adequate medical care. Charlotte, in her need to "fix him," began to help him get to his doctor's appointments and maintain daily functioning. Her friend was addicted to crack cocaine, and soon Charlotte began using crack because of the "stress of taking care of him." Her friend was also a drug dealer, and soon Charlotte became intimately involved in the day-to-day operations of the drug business.

Charlotte described creating an elaborate system of buying and selling cocaine, using beepers, payphones, secret rooms, and code words. This system remained in full operation for four years, until an undercover policeman "stumbled upon" her operation. Charlotte and her friend were arrested in the act of selling crack cocaine to the undercover policeman. Charlotte received a mandatory two-year sentence. After the

arrest and prior to incarceration, Charlotte did "anything to self-destruct," including drug and alcohol binges and two suicide attempts.

Charlotte's incarceration at HCHC was a welcome retreat from her out-of-control, self-destructive behaviors. At HCHC, Charlotte seemed to develop a care-taking role with other women as she had done in her family and relationships. This time, however, Charlotte did not want to neglect herself in the process. "I try to set a good example for the girls, by saying 'please' and 'thank you,'" Charlotte said. Charlotte was always available to listen to other women's problems, and she helped women write letters to different treatment programs they could enter upon release. She also tried to set an example for the women. "I don't get in the mix with their problems," she said. "A lot of women have problems with men; I try to discourage them, and tell them that jail is a time to work on yourself, not to be in a relationship." "It's amazing. Some of these women talk to other men through the vents in their cells and *actually* talk about getting married. They haven't even seen each other yet," she exclaimed.

Charlotte has had little difficulty adhering to the rules and regulations at HCHC; she's had few disciplinary violations. Once, however, she was sent to solitary confinement for eight hours. Her solitary confinement was triggered by a disturbing phone call and an empathic failure. Charlotte had just received news that her best friend was in the hospital receiving angioplasty for a heart condition. Charlotte was upset. As she tended to do when upset, Charlotte became anxious and began to have suicidal thoughts. She told her correctional caseworker that she was struggling and in distress. The correctional caseworker, whom Charlotte referred to as "young and not experienced

in therapy," did not consider Charlotte to be in imminent crisis. When the correctional caseworker did not call Forensic Services for an immediate psychiatric evaluation and possible transfer, Charlotte escalated and became more upset. "I wasn't listened to. The counselor didn't realize that I wasn't equipped to handle it on my own. I didn't feel comfortable," she reflected. After she "flipped out and cried hysterically," Charlotte was put in solitary confinement, where she stayed for eight hours before returning to her unit.

When asked to describe how others would describe her, Charlotte revealed her vulnerabilities. "I am a really good person, but I get really walked on, and easily used. It's like I have a neon sign on my back saying 'sucker,'" she said. "Sure I'm the good ole grandma, but sometimes I wonder when it's going to be my time when I can sit back, relax, and be waited on."

Charlotte talked with enthusiasm about her activities at HCHC. Charlotte was the librarian of the small library room on the women's unit. She organized all donated books, and recommended books to other women. She also made requests for certain types of books. "Women here like biology, women's self-help, spirituality, and books about angels. Mysteries are also pretty popular," she said. Charlotte loved to talk with other women about books. "It's great to be able to talk on a different level, and on a 'clean' topic with other women," she said. Charlotte found the joys of reading late in life; she now enjoys both reading and writing. Charlotte had written some poetry on spirituality and addiction for women's prison journals. She is now in the process of writing a mystery novel.

Charlotte concluded the interview by talking about her hopes and aspirations upon release. She talked about how she felt better prepared and more equipped to face the challenges and temptations "in the outside world." Her relationship with God is a constant source of support. "I've always had a powerful contact with God that has only become stronger since I've been here," Charlotte explained. "He keeps me alive; he talks to me every day." Charlotte also spoke about how she needed to rely more on herself, and less on others, for support, nurturance, and guidance.

When looking back on the events that led to her incarceration, Charlotte saw her behavior as a failed attempt to "do the wrong thing right." Unlike other women who saw their incarceration as a consequence of their drug addiction, Charlotte saw her incarceration as a consequence of her personal shortcomings. Through recognizing her vulnerabilities, Charlotte believed she could surpass them. Charlotte had refused parole, pre-release, or day reporting. She had even refused referrals to halfway houses for drug and alcohol treatment. Preferring to "do it on [her] own," Charlotte wanted to be able to start anew with her own resources and her relationship to God as her bedrock. "This way no one's looking over my shoulder," she explained. "One baby step at a time."

Yolanda

During the group testing, Yolanda was a force to be reckoned with. A heavy-set, Hispanic woman, Yolanda had a loud and deep voice. She came to the group testing session listening to a Walkman. The music was so loud that the sounds of Bob Seger could be heard 10 feet away. She continually swore at other women in the testing room, telling them "Shut the fuck up, I trying to do this stupid test." "These questions are so

stupid. Did you write these?" she asked me. Yolanda made a diagnostic comment to one particular statement on the SNAP: "I enjoy a good brawl." "Of course I do," she laughed, egging on others to respond similarly to the statement. Several attempts were made to quiet Yolanda down, and encourage her to complete the testing. "All right, I'll finish, but only because I'm getting something out of it," she fumed. In a final act consistent with her antisocial character, Yolanda stole a pencil and binder clip given to her as part of the testing packet. Afraid that certain women (specifically Yolanda) may not be allowed sharp pencils, or anything metal, the Correctional Officer was approached and told that Yolanda had "mistakenly taken" the pencil and clip. After her name was called over the intercom, Yolanda came out of her cell with the clip and pencil. Smiling, she said, "Oh, here you go. I forgot to give them back."

Yolanda's behavior at the start of the interview was in sharp contrast to that in the group testing. She was unassuming and deferent, having no audience but myself. She initially stated: "Count me out, I just want the colored notepad," when asked about the possibility of participating in the individual interview. She had changed her mind. "Now I want to do it. I think it's good. I'm getting a lot off my chest," she said.

Yolanda was interviewed the day before her release from HCHC, after serving nine months of a one-year sentence for the combined charges of resisting arrest, improper use of a credit card, breaking and entering, and shoplifting. She was scheduled to go to Howard Street, an HCHC-run facility where women lived and received residential alcohol and drug treatment prior to release into the community. Howard Street was a sought-after treatment option. Many women who wanted substance treatment found

Howard Street offered an effective treatment program with a community emphasis. Being transferred to Howard Street was also a way of serving the remainder of one's sentence in a less restrictive setting. Yolanda was looking forward to Howard Street. She believed she had to get "clean" before anything "good" could happen to her.

Yolanda began the interview by talking about her childhood. As we mentioned in Chapter 4, Yolanda grew up fatherless, with a domineering mother whom she continually rebelled against. Growing up in the South Bronx, New York, Yolanda had never met her mother's expectations that she be a "princess" by "cooking, cleaning, and being perfect at it." Her earliest memory of her mother involved a scenario in which she and her sister were criticized by their mother for eating too many hot dogs on a trip to Manhattan. Yolanda was nine and her sister eleven when her mother sent the two off to meet a "male friend" of hers. The friend took them by subway and they stopped at a street vendor. Both sisters had one hot dog each, but were not satisfied. They went back two times and ate four hot dogs each. Arriving home, they each had stomachaches and became physically sick. Yolanda and her sister were scolded for eating too much, and were told that they "broke [their] mother's heart."

Yolanda's mother's response to her sexual abuse was similarly damning and shaming. After the rape, which was discussed in Chapter 4, Yolanda had gone to tell her mother what had happened. Her mother hit her, calling her a "slut" and a "whore." "You're never going to be your mother's daughter again," she said. Yolanda's mother had even invoked divine retribution against her daughter. "Mom thinks that God punished me that way [by being raped] for going against her," Yolanda said.

For much of her adolescence and young adulthood, Yolanda seemed to be engaged in a struggle with her mother around issues of enmeshment and identity. Ironically, Yolanda used the same words to describe her mother that she thought others would use to describe her. At one point she described her mother as having a "heart of steel." While describing herself as "loving" and "caring," Yolanda thought others would incorrectly describe her as a "cold-hearted bitch." Yolanda's father, whom she met for the first time when she was 29, claimed that Yolanda and her mother were "just the same: bitchy and manipulative."

As far back as adolescence, Yolanda's past was replete with criminal activity. Yolanda was, however, non-chalant when describing her past criminal charges. "Mainly all assault and batteries, menial stuff," she said. She also made light of her extensive disciplinary record at HCHC, and even boasted of it. Yolanda received eighty disciplinary "tickets" on her previous incarceration at HCHC. Now, her stomach is "in knots" for days after she gets ticketed. Most of these tickets have been for "talking back to COs," "refusing to lock in," and "saying fuck you" to COs." Interestingly, Yolanda's disciplinary record was full of violations, but none serious enough to warrant solitary confinement.

The circumstances around Yolanda's current criminal charge also reflected her impulsivity, aggression, and exploitative tendencies. One of Yolanda's friends had bought a Nintendo 64 video game. Yolanda wanted the game herself, and wanted to get her friend's receipt for the game so that she could "try to get one for [herself] without paying." The woman agreed to give her the receipt, but did not follow through on her

offer. Yolanda became inpatient. After the woman did not return her phone calls, Yolanda decided to go to her friend's house directly and take the game herself. Picking the lock to the door, she entered her friend's house and took the game.

Did Yolanda feel guilty about stealing her friend's Nintendo? After having the game for some time, Yolanda said she felt "bad" that she had taken it from a "friend." Claiming to her friend that she was "dope sick" when she took the game, Yolanda wanted to "return" the game. Yolanda knocked on the door to return the game, but the police were waiting to arrest her. Yolanda tried to run away, but was forcibly taken to the ground by the police who added "resisting arrest" to her growing list of current criminal charges.

Despite her long history of criminal behavior and drug addiction, Yolanda claimed she has been trying to change her ways. "Who wants to tell their friends that their mother is a junky," Yolanda spoke from the perspective of her three children. "I've got to show the kids that I love them. I didn't love them in the past, but now I do."(As discussed in Chapter 4, Yolanda abandoned her first child after her birth at the hospital, only to have her mother later gain custody.) "My mom thinks that I chose drugs over my kids. I want to prove to her that I can be a Mom." In an act that reflected her mother's manipulativeness, secrecy, and shame about Yolanda, her mother told Yolanda's two children that Yolanda was her "sister." "They just found out I was their mother," Yolanda sadly stated.

Unlike Charlotte, Yolanda put the responsibility for her incarceration on her drug use. For Yolanda, the way out of criminality is drug abstinence. In fact, Yolanda thinks

she could have avoided all incarcerations if she were only drug free. Yolanda sees little in herself that needs to change or that contributes to her criminal behavior. Yolanda, in one sense, has externalized her difficulties by faulting her drug addiction. It is true that Yolanda was substance-dependent, needed treatment, and engaged in drug-related criminal activities. Her penchant for stealing, exploitation, and thrill-seeking, antisocial acts, however, reflected an ingrained, maladaptive, personality style.

In an act that seems to symbolize Yolanda's "success" and finally achieving her mother's approval, Yolanda concluded the interview by talking about her "dream" of opening a Spanish restaurant. She wanted to "retire" by opening up a "family-owned" restaurant so she could "live well off like [her] mother." Despite proudly claiming that she has never had a job in her life, Yolanda beamed when talking about her plans for a restaurant. Running the restaurant, she said, "couldn't be that hard." The restaurant seemed to symbolize a familial, easy-going life she has never had. Expressing her desire for a surrogate "family" with a hint of grandiosity, Yolanda said she would be "famous" because she would appear on television advertisements for her restaurant with herself as the main spokesperson.

While Yolanda thought about a life of sobriety, she described a recurring nightmare. Her dream seemed to symbolize her anxieties about her ability to remain sober, and her fears of losing custody of her three-year-old son. In the dream, Yolanda, her son, and his godmother were together traveling in a car. With a quick and unexpected turn, they veered off the road and decided to go to Yolanda's brother's house. When they arrived, everyone in the room was smoking crack and shooting heroin. Soon

Yolanda became lost in the crowd of people. Trying to regain her orientation, Yolanda looked around the room, but couldn't find her son and his godmother. She felt that they had disappeared forever in the crowd.

CHAPTER 8

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

The present study was conducted as an evaluation of incarcerated women in a county jail. Using a combined qualitative and quantitative approach, the study had four aims: (1) to provide diagnostic information on psychological symptoms; (2) to examine the relationship between a woman's diagnosis of personality disorder, her disciplinary record while incarcerated, and the severity and violence of her current criminal charge; (3) to examine the relationship between a woman's aggressiveness, her disciplinary record while incarcerated, and the severity and violence of her current criminal charge; and (4) to provide personal narratives of selected participants.

In a two-phase data collection procedure, 49 women were administered two personality instruments, and nine women were interviewed regarding their developmental experiences, psychological symptoms, criminal histories, and behavior while incarcerated. The stories of three of these women were discussed in greater depth in this dissertation.

Many of the women who participated in this study suffered from a range of clinical complaints, most commonly alcohol and drug dependence, traumatic stress, depression, and suicidality. Although there was little evidence of major mental illness, many of the participants had borderline and/or antisocial personality traits. Phenomena associated with antisocial personality disorder (ASPD) were more prominent than features associated with borderline personality disorder (BPD). Contrary to expectations, few women showed evidence of narcissistic or histrionic personality traits.

In this sample, women who were classified as personality disordered, as assessed by the SNAP and PAI, did not differ from non-disordered women with respect to number of disciplinary violations or time spent in solitary confinement. Aggressive women, as assessed by the PAI, however, had a greater number of disciplinary violations and spent more time in solitary confinement than non-aggressive women. Neither aggressiveness nor the presence of a personality disorder was related to the seriousness of current criminal charges, or to the level of violence associated with those charges.

In light of the fact that only 49 women participated in the group testing, and nine women participated in the biographical interview, caution is warranted when making generalizations to other incarcerated women. The stories of these women, however, provide interesting and important insights regarding the relationship between personality disorder and criminal history or disciplinary behavior.

For some women, the criminal justice system provides a context of authority and containment--experiences most had never known in their families of origin or in other relationships. In much the way solitary confinement has provided sanctuary and containment for Marissa and Maryanne, the criminal justice system became the final authority, the last entity that could say "no" to their engaging in problematic, illegal behaviors.

In the descriptions that these women provided about their lives, interesting themes emerged regarding the relationship between personality disorder and criminal history. One prominent theme that emerged was of conflicted relationships with men in which drug addiction, drug sales, and criminal behavior are interwoven. These women

became so entangled with their partners that their sobriety, safety, and sense of morality were suspect. "I know I shouldn't be with him, but..." was a common acknowledgement. For Charlotte, her relationship with her male "friend" satisfied her need to take care of someone--a carried over need that was unmet within her family of origin. While she was not deemed personality disordered by the SNAP or PAI, Charlotte's personality and predisposition to addiction may have influenced her choice to take care of a drug-addicted man. Maintaining her interpersonal connection to him through drug dealing eventually led to her incarceration.

Rasa's criminal behavior was also interwoven with her relationship with a man. Beginning with her relationship with her father, Rasa's relationship history suggested that she desperately sought the attention, care, and protection of men. She fought against, but would excuse infidelity and other transgressions, and engage in illegal activities to maintain this connection. Her criminal involvement seemed in part to be an outgrowth of her need to maintain a connection to men. Each new relationship with a man seemed to be a reenactment of previous relationships in which jealousy, betrayal, and fears of infidelity provided the fuel to the relationship. Although she produced an invalid PAI, making a diagnosis of personality disorder difficult, Rasa's behavior in relationships in and out of jail reflects an ingrained pattern of maladaptive relationships.

Criminal behavior, like most behavior, is multi-determined. Explaining why someone commits a crime then becomes a difficult, if not impossible task. One can look, however, for factors that seem to influence the likelihood that a woman will engage in criminal behavior. Men were intimately involved in the criminal lives of both Charlotte

and Rasa. While these men did not "cause" these women to use drugs or engage in criminal activity, their relationships with the women provided a fertile ground within which unmet longings from childhood, relationship dynamics, and predispositions to addiction coalesced to influence criminal behavior.

For other women, criminal behavior seemed to occur in a number of contexts and involved different relationships. Not surprisingly, growing up in a world of criminal behavior seemed to predispose women to future criminal acts. This seemed to be especially true for Yolanda. Yolanda's penchant for antisocial acts was widespread and developed from an early age. For Yolanda her connection to her boyfriend (and others) seemed to be based on the potential for personal gain. Yolanda did very well committing antisocial acts apart from her boyfriend, although her boyfriend may have provided some resource, such as money, to assist these behaviors. In Yolanda's case, her relationships were the tools by which she engaged in criminal activity.

Narrative data also provided a window into the connection between personality disorder and disciplinary violations. Aggressive women, as assessed by the PAI, had the most difficult time adjusting to a life behind bars. Aggression, which was displayed through aggressive acts and hostile posturing, was a major theme in the interpersonal world of the jail. The stature and the pride of women were constantly threatened, and many retaliated with aggressive threats and behaviors. Other women chose not to engage in this dynamic. Yolanda was a good example of someone who not only retaliated with aggression when provoked, but also initiated it. Her frequent disciplinary violations were

a consequence of both her aggressive attitude and her willingness to "follow through" on her threats.

What can this study tell us about incarcerated women? One conclusion is that women with antisocial personalities are especially prone to continued criminal behavior. Other women who are not so predominantly antisocial, but have traits of pathological personalities, are likely to engage in criminal behavior in the context of conflictual, enmeshed relationships with romantic partners. Women who have aggressive tendencies as a predominant aspect of their psychological make-up are especially prone to misbehavior in jail.

This study points to the need for the development of a screening tool for correctional staff to aid in the identification of women who are prone to disciplinary problems. A screening tool including items assessing verbal, physical, and aggressive attitudes is recommended. Items assessing the antisocial personality traits of manipulativeness, exploitative tendencies, and shallow expression of emotions should be included.

If there is to be any hope of reducing the number of women who become incarcerated, several societal changes are in order. First, drug treatment programs are recommended for those women with only drug convictions. These women could avoid incarceration if their addiction were treated. Second, a relationship-based treatment program, such as Dialectical Behavior Therapy (DBT; Linehan, 1992) is recommended for those women with histories of severe relationship conflict and affect instability. Women can participate in this program when they are incarcerated, and such treatment

may help their adjustment and functioning upon release. Third, special containing procedures for women who have predominately antisocial personalities may help limit jail misbehavior. Therapeutic interventions are recommended, like those suggested by Millon (1996), in which women are instructed about ways, other than criminal or exploitative behaviors, to attain their desired goals.

Over the course of the study, several limitations were apparent. First, the study was conducted under the unique circumstances of a secure correctional facility, which had the potential to prejudice participant's stories in the biographical interview and their responses on the personality measures. Due to various forms of self-presentation bias, women may have told personal narratives that misrepresented their actual biographies. As an example, during the interview some women may have been motivated to exaggerate their aggressiveness in an effort to avoid being portrayed as "weak." Second, the interplay between a male interviewer and a female interviewee may have affected what women revealed through their personal narratives. Given that many women's stories were replete with incidences of conflictual relationships, particularly with male partners, it is not presumptuous to assume that the content and form of the narrative data may have been affected. Third, women's personality profiles and self-report of psychopathology obtained through the PAI and SNAP may *reflect* the fact that these women were incarcerated rather than assess the "true" extent of their psychological symptoms pre -incarceration. Reports of depression and suicidality, as well as of aggression and paranoia, may have represented the environmental effects of incarceration. Last, this study did not directly address the lively debate surrounding the

dimensional and categorical approaches to the study of personality disorders. Although the SNAP can be used to assess personality disorders dimensionally, in the current study it was used as a tool to make categorical statements of personality pathology. The PAI was also used to make categorical statements regarding personality pathology as well as about pathological personality traits, (e.g., aggressiveness). The statistical and theoretical limitations of using categorical approaches to personality pathology are more thoroughly discussed elsewhere (see Frances & Widiger, 1986).

EPILOGUE

In a biographical study such as this, one is always curious about the fate of the participants. Through some sleuthing and a chance encounter, I was able to find out how the lives of two women whom I had interviewed had progressed.

After conducting the individual interviews, some time elapsed before I entered the jail's database system to examine the criminal and disciplinary records of the women. I was able to determine how the women behaved after I had interviewed them. Yolanda's disciplinary record was particularly telling. She had gone to Howard Street residential treatment facility and was there two-and-a-half months before she was involved in a gang-related fight in which she punched another woman in the face. Yolanda was transferred from Howard Street back to C10 of HCHC. At the time of this writing, she was still housed at C10 with a month of her sentence remaining.

About two months after my last interview at the jail, I was leaving the jail after having met with Dan Cavannah, the Disciplinary Officer. While walking out of the administrative building I heard: "Hey, Doug!" I turned and saw an African-American woman standing at the bus station with an older, African-American man. Both were well dressed. The woman had on a cotton dress and casual sandals. The man wore a brown suit, vest, tie, and felt hat. Walking toward her, I could not recognize who it was. As she came near, the woman smiled, revealing a big gap between her two front teeth. It was Karyn! I hadn't recognized her without her drab-green jail uniform. She looked so different in "normal" clothing. She told me that she had been offered and accepted the job as a counselor that we had discussed in the interview. I was so happy for her! She

introduced me to the well-dressed man who was her father (I recalled discussing her "close family"). She was at the jail visiting some of the other women. She told me she was in the process of moving to Boston, where her job was. Ironically, I was also moving to Boston in a few months to begin my internship. We talked for a few moments; I congratulated her again and walked away. I sat in my car and reflected on the chance encounter. I was struck by how "normal" she looked, wearing a dress and make-up. One would never know that she had had numerous incarcerations, for changes ranging from prostitution to assault and battery. She was also a recovering substance abuser. I began to think how I had previously viewed her as an "inmate" and a "drug addict." Seeing her with her "new life" was in stark contrast with my earlier, circumscribed image of her. That a woman can move from being an "inmate" to a life with goals and accomplishments is a lesson Karyn taught me.

Table 1: Mean Levels of Disciplinary Violations and Time Spent in Solitary Confinement by Personality Disorder and Aggressiveness

		Disciplinary Violations		Time Spent in Solitary Confinement	
Personality		M	SD	M	SD
Disorder					
	PD[a]	9.7	6.4	7.4	9.3
	NPD[b]	6.2	6.6	3.3	6.1
Aggressiveness					
	AGG[c]	11.9	5.5	9.7	9.2
	NAGG[d]	6.3	7.0	3.5	6.6

Note. [a]$n = 16$. [b]$n = 32$. [c]$n = 12$. [d]$n = 27$.

Table 2: Number of Participants with Convictions: Drug-Related Charges

Possession class A	4	Possession class A w/intent to dist.	4
Possession class B w/intent to dist.	7	Possession class B	12
Possession of drug paraphernalia	5	Possession class D w/intent to dist.	2
Drug free school zone	5	Trafficking cocaine	1
Attempted delivery of controlled substance to inmate	1	Operating under influence of liquor	2
		Operating under influence of drugs	1

Table 3: Number of Participants with Convictions: Non-Drug Related Charges

Assault and battery: 5

Assault and battery w/dang. weapon: 3

Assault and battery on a police officer: 2

Assault and Battery on a child: 1

Larceny $250 +: 10

Larceny from a person: 1

Larceny by check: 2

Forgery: 3

Shoplifting by concealment: 4

Shoplifting by apportion: 3

Uttering a forged institution: 7

Uttering a false person: 1

Using a false name: 1

Improper use of credit card: 1

Violation of protection order: 1

Violation of parole: 3

Common night walker: 2

Minor exporting: 1

Operating MV w/ suspended lic: 4

Leave scene after damage: 1

Receiving stolen property: 3

Receiving stolen MV: 1

Unauthorized use of MV: 1

Resisting arrest: 3

Intimidation of a witness

Attempting to commit a crime: 3

Escape from correctional facility: 1

Breaking and entering: 3

Threatening to commit a crime: 1

Disorderly person: 1

Malicious destruction of property: 3

Possession of unlicensed firearm: 1

Burning a building: 1

Causing a false fire: 1

Violation of probation: 1

Sex for fee: 3

Sell/deliver alcohol to minor: 1

Attach plates to MV: 1

Operating MV w/suspended reg: 2

Figure 1: Mean Scores on PAI Clinical Scales

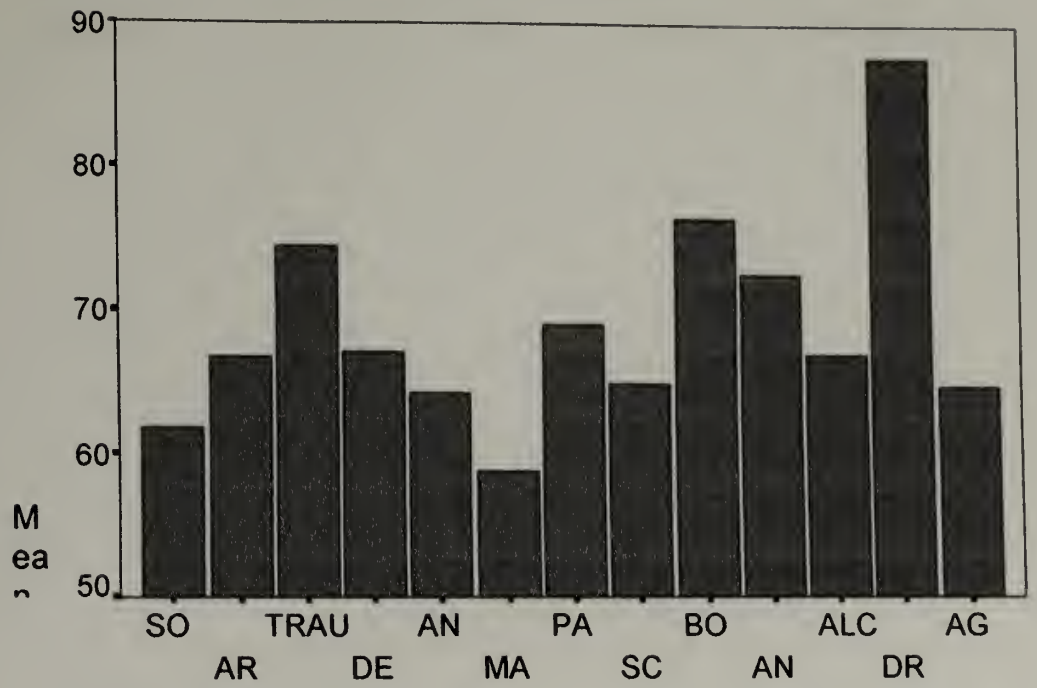


Figure 2: Interview Participant's Scores on Select PAI Scales

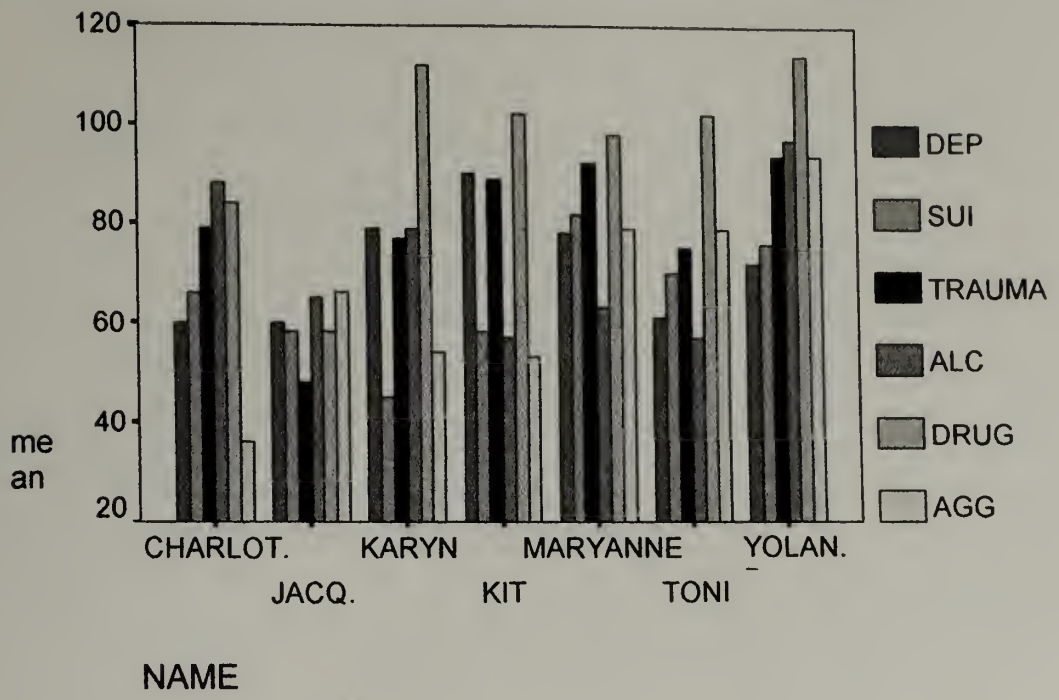
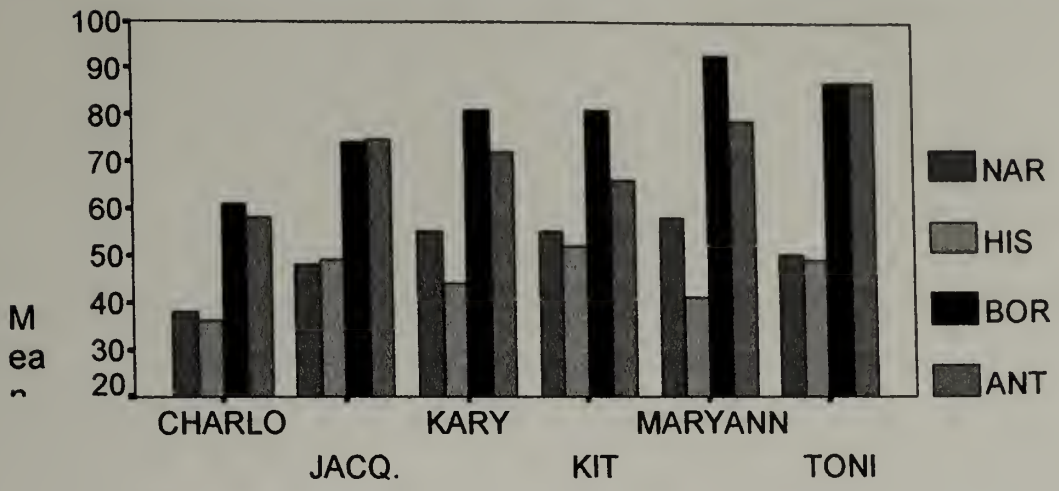


Figure 3: Interview Participants' Scores on Personality Disorder Scales



NAME

Note: Marissa: NAR=70, HIS=59; Rasa: NAR=60,

Yolanda: BOR=91,

APPENDIX A

INFORMED CONSENT

1. I agree to participate in the study entitled "The Personalities and Life Experiences of Women in Jail."

2. This study involves answering paper-and-pencil and interview questions about one's personality—or how one usually feels or behaves in situations. Interview questions will also be about one's personality as well as one's early developmental experiences.

3. I understand that there are no known discomforts or risks involved in participating in this study. This judgment is based on a large body of experience with the same or similar procedures with people of similar ages and gender.

4. I understand that I have the right to decline to answer any questions, as well as to withdraw from the study at any time.

5. As part of the study, I agree to let the experimenter examine my jail file—including my most recent legal charge and any disciplinary infractions I incurred while in jail.

6. I have been assured that the subject specific information gathered in this study will, unless compelled otherwise by law, be disclosed only to the investigator and his collaborators, and not to anyone else.

7. I have been told that I will use my personal ID number for identification purposes in the study. The information I disclose during the experiment will be identifiable only through my personal ID number and not through any other means.

8. Information revealed during the study will in no way affect jail status, including parole or release dates, or other pending case-related issues.

9. I consent to the publication of the study results so long as the information is anonymous and disguised so that no identification of individual participants can be made.

10. The investigator will be glad to answer any questions in regard to the procedures used in the study.

11. I have read and understand the above explanations and voluntarily consent to participate in this study.

Date_____ Signature_____

APPENDIX B

BIOGRAPHICAL INTERVIEW

CRIMINAL HISTORY

1. I'll begin by asking you how did you end up at HCHC

2. Other criminal charges? (seriousness and interpersonal nature)

3. How do you understand your involvement in crime? Why are you here?

LIFE AT HCHC

I want to ask you a little about your life here at HCHC.

1. How long have you been here? How has been the adjustment here?

2. What are your relationships like with others here?

3. Have you ever gotten into fights, squabbles with others here?

4. Have you ever suffered disciplinary violations here? For what? How do you understand them?

5. Tell me about other women who seem to constantly get in trouble here.

DRUG AND ALCOHOL USE

Now I'm going to ask you about your drug and alcohol use.

1. When did you first start using drugs?

2. What kind? For how long?

3. Any treatment?

4. How do you think drugs/alcohol have affected your life?

PERSONALITY AND INTERPERSONAL FUNCTIONING

Now I'm going to ask you some questions about how you usually as a person.

1. How would you describe yourself?

2. How would the people who really know you describe you?

3. Who are the most important people in your life?

4. Tell me about the most disturbing relationship in your life?

5. Tell me about your romantic or intimate relationships.

6. Ever been married, or been with a partner for extended period of time?

7. Do you have children?

CHILDHOOD EXPERIENCES

Now I'm going to ask you some questions about some of your earlier experiences and upbringing.

1. How would you describe your childhood?

2. What is your earliest memory of your father or mother?

3. . Criminal history as a young woman (Fights, stealing, drugs, and early relationships)

4. Tell me about what you consider the worst things that has happened to you.

5. How do you support yourself? What jobs have you had?

FOLLOW-UP QUESTIONS
(QUESTIONS TAKEN FROM THE PAI AND THE SNAP)

Now I'm going to ask you to elaborate on some of the questions about some of the responses you gave on some of the inventories you did earlier.

Sometimes I can't remember who I am—very true. Tell me about that. Give examples.

People are afraid of my temper—very true. Tell me about that. Give examples.

I'll take advantage of others if they leave themselves open to it—very true. Tell me about that. Give examples.

I've heard voices that no one else can hear—very true. Tell me about that. Give examples.

There are people who want to control my thoughts—very true. Tell me about that. Give examples.

My mood goes up and down—true.

I get a kick out of doing dangerous things—moderately true.

Sometimes I feel terribly empty inside—very true.

I do a lot of wild things just for the thrill of it—very true. Tell me about that. Give examples.

It bothers me when other people are too slow to understand my ideas—very true. Tell me about that. Give examples.

At times my thoughts move very quickly—very true. Tell me about that. Give examples.

I have many qualities that others wish they had—true. Tell me about that. Give examples.

I like to show off—true. Tell me about that. Give examples.

I worry a lot about people leaving me—true. Tell me about that. Give examples.

I have severe psychological problems that began very suddenly. Tell me about that. Give examples.

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