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Kimberly Gillette
The Psychological and Emotional
Experiences of Pregnant and
Postpartum Incarcerated Women

ABSTRACT

This theoretical thesis explores the experiences of pregnant and postpartum incarcerated women, with particular emphasis on the impact of attachment insecurity, relational trauma, and forced separation from their infants. The majority of incarcerated women are dually diagnosed with substance abuse disorder and other clinical disorders on Axis I or II of the Diagnostic Statistic Manual IV. Often the symptoms displayed from Posttraumatic Stress Disorder are mistaken for personality disorders which prejudice staff and providers against these women. Thorough assessments need to be conducted using a compassionate lens to accurately interpret the psychological effects of interpersonal violence and other traumas and in the creation of a comprehensive treatment plan. Empirical evidence from research and case studies from my experience doing individual and group work with pregnant and postpartum inmates at a Northeast correctional center will be used to explore this phenomena. I use attachment theory to examine the unique stressors these women face and their response to profound hardships. Different treatment methods including gender-responsive, trauma-informed individual and group interpersonal psychotherapy are recommended to support healing and transformation in these women so that they can break the cycle of incarceration and decrease the transmission of their attachment insecurity onto their children.

**THE PSYCHOLOGICAL AND EMOTIONAL EXPERIENCES OF PREGNANT AND
POSTPARTUM INCARCERATED WOMEN**

A project based upon an independent investigation, submitted in partial fulfillment of the requirements for the degree of Master of Social Work.

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2011

Acknowledgements

This thesis is dedicated to the women I have encountered and been privileged to hear stories from, bearing witness to the pain, and seen the hope and possibility for transformation and growth. Survivors among you, keep going.

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CHAPTER I

Introduction

We have an image of mothers as superheroes; imperturbable and able to withstand adversity to do whatever task at hand needs doing. We imagine that a mother will do anything to protect her child, even if it means giving her life for her child. We cannot imagine any woman not putting her child's needs first, much less abandoning her child. We also have an image of drug users in this society and it does not equate with motherhood, yet most women in jail are mothers and drug addicts. As a society, we hold our greatest contempt for pregnant and parenting drug users because they are the antithesis of our images of good mothers. We look at drug use as a simple choice, as though quitting is just a matter of willpower. Our thinking is that if a parent loved her child enough, or even loved herself more, than she would stop using drugs. The phenomenon I will explore is the psychological and emotional experiences of pregnant and postpartum incarcerated women, many of whom are also substance users and have untreated mental illnesses. These are not women who decide after getting pregnant to start using drugs; they are women who are in active addiction who find themselves pregnant. They have faced unimaginable hardships beyond most of our comprehension which has led them to self-medicate with substances. Addiction has caused them to commit offenses for which they pay dearly by separation from their loved ones.

Approximately 8-10% of women in jail are pregnant (Chambers, 2009; Hutchinson, Moore, Propper, & Mariaskin, 2008) and give birth during the course of their sentence, and 50% of these women will remain separated from their children for the rest of their lives (p. 204).

Parenting stressors in incarcerated mothers are related to clinical levels of general psychological distress as incarceration and separation exacerbates pre-existing conditions. (Hutchinson, Moore, Propper, & Mariaskin, 2008, p. 441). Research reveals that women who give birth while incarcerated face a myriad of emotions ranging from isolation and grief to anger and hostility. They also struggle with lack of communication and contact visits with their infants and family members. This lack of support from fellow inmates, family, and staff often evokes previously existing attachment insecurities and feelings of sadness and anxiety. While there is an enormous impact on the children of incarcerated women, this will only briefly be mentioned as this thesis is intended to focus on the experiences of the mothers of these children. The purpose of this research is to use attachment theory to explore the path that led to their incarceration and to examine their emotional and psychological experiences while pregnant and postpartum during incarceration. I will then suggest different methods of treatment that can be used to help women heal and transform from substance use and mental illnesses or trauma.

Byrne's (2009) research from existing prison nursery programs indicates positive outcomes for mothers and children such as secure attachment, better parenting skills, and decreased recidivism rates (Chambers, 2009, p. 204). However, only nine states currently have prison nurseries: California, Illinois, Indiana, Ohio, Nebraska, New York, South Dakota, Washington, and West Virginia (p. 204). For the rest of these women, there is an immediate separation from their infants which is likely to cause insecure attachment in the children, complicated by the mothers' own histories of attachment insecurity. Poor attachment relationships have negative consequences including intergenerational transmission of attachment insecurity and mental health issues such as anxiety and depression for both mother and child (Makariev & Shaver, 2010, p. 316). For children, poor attachment can lead to behavioral

concerns, and sometimes, psychopathology requiring serious intervention. Children with an incarcerated parent have rates of engaging in antisocial and delinquent behavior that are three to four times higher than for children who do not have a parent that is incarcerated (p.312). This appears to be a reciprocal relationship; forced separation affects the mother, the child, and the mother-child dyad. If we can better understand the mother's history and presenting concerns, we can design gender-responsive and trauma-informed treatment methods to 1) help women recover 2) reconnect with their families and children 3) lower recidivism rates, and 4) decrease intergenerational transmission of attachment insecurity.

This study is relevant to social work practice in many areas referred to in the NASW Code of Ethics. One of the primary ethical principles in the code is that social workers must challenge social injustice and work to pursue social change for and with vulnerable and oppressed individuals and groups of people. The population of pregnant and postpartum incarcerated women is an extremely vulnerable group that has been marginalized and stigmatized by society and by the correctional staff that work with them. Evidence from Merten's (2000) research shows that it is not unusual for pregnant inmates to be dealt with more cruelly than their nonpregnant peers (Tapia and Vaughn, 2010, p. 419). Social workers, by nature of our education and profession, are trained to see the ways in which institutional racism, poverty, and inequity of resources impact these women. It is important that social workers see these women as whole people and the sum of their experiences rather than as criminals or bad people. In this way, we are upholding another important ethical principle: respecting the inherent dignity and worth of the person. If many of these women had their basic needs met as young children or young adults they would not have turned to drugs, committed crimes, and ended up incarcerated. By helping

them, we are also healing their children and future generations by preventing the transmission of attachment insecurity and trauma.

Because of the distinct pressures facing this population, it is likely many women already have affective and anxiety disorders, along with Posttraumatic Stress Disorder (PTSD). Most may also experience depressive symptoms which may evolve into full-blown Postpartum Depression (PPD). Social workers and other practitioners need to support pregnant women and mothers before, during, and after giving birth by advocating for access to quality mental health treatment and prenatal care. We also need to fight for their right to have contact with their infants, which will help foster a stronger bond between mother and child. We have an obligation to research best practices for mental health and substance abuse issues and advocate for a change in policy that promotes connection to their infants and families while incarcerated and upon release.

The main source of hope and propellant for change for many incarcerated women is their re-entry into the community which includes reconnecting with their children. Not allowing this connection while incarcerated, and upon release, may lead to increased recidivism. Taking away their identity as mothers leaves them to identify only as addicts, criminals, and prostitutes.

Covington (2007) uses one mother's comment to illustrate this point:

Many women that fall [back] into prison have the problem that their children have been taken away. When they go out to the street, they don't have anything, they have nothing inside. Because they say, "I don't have my children, what will I do? I'll go back to the drug again. I will go back to prostitution again. And I'll go back to prison again. Why fight? Why fight if I have nothing?" (Garcia et al., 1998, p. 266)

Murray and Murray (2010) write that there is vast evidence indicating that incarcerated adults have had disturbing childhoods themselves, including lack of adequate parenting, child abuse and/or neglect, and the absence of one or both parents (Makariev & Shaver, p.312). The developmental attachment trauma which stems from those conditions is often exacerbated by relational violence in adulthood and then transmitted by parents to their children. Attachment theory (Bowlby, 1982) proposes that children inherit their parent's internal representations of self, attachment figures, and attachment relationships (Makariev & Shaver, 2010, p. 316). Therefore, one can assume, and research backs this, that the attachment relationships between mother and child mirror each other. The insecure attachments of the mother to her own caregiver as a child may translate into affective disorders, substance use disorders, and psychopathological behavior as an adult (p. 317). The woman, herself now a mother, tends to be anxious or engrossed by her own troubles, causing her to ignore, neglect, or provide inconsistent care for her own children; this causes the children to develop their own insecure attachment pattern and have difficulty modulating their emotions. The reason I am using attachment theory to view this phenomenon is because many of the crimes which land a woman in jail or prison are a result of addiction which has resulted from self-medicating against the residual effects of relational violence in childhood, compounded by interpersonal violence as an adult.

Additionally, incarceration creates forced separations between mothers and children resulting in disrupted attachments, re-evoking traumatic memories causing clinical levels of psychological distress. Empirical evidence suggests that negative childhood encounters with their caregivers directly affects the current psychological functioning of incarcerated mothers. Grandmothers are most likely to provide care for children of incarcerated mothers (Hutchinson, Moore, Propper, & Mariaskin, 2008, p. 441) While there are obvious benefits to kin care over

foster care, such as prevention of termination of parental rights and more frequent visits with the child, it can be particularly stressful for mothers who received poor parenting and worry that their children will have the same experience. Furthermore, if attachment organization is connected to an individual's ability to control and modulate one's moods, emotions, and impulses, then it would make sense to see heightened emotional and psychological distress during periods of added stress, such as incarceration.

There has been a considerable amount of research conducted on the impact of forced separation on children, but less is known about its impact on mothers. There is also a gap in the literature around treatment methods for the attachment trauma these women have suffered. The goal of this paper is to reflect on attachment theory and how insecure attachment and attachment trauma in childhood and adulthood contributes to emotional dysregulation and addiction in incarcerated mothers and mothers-to-be, thereby threatening their attachment to their own children. Using this information, I will examine existing programs for pregnant and postpartum incarcerated women and suggest the importance of incorporating gender responsive, trauma informed programming into treatment so that women can heal and recover and prevent transmission of trauma and insecure attachment to their children. However, we are remiss if we think that the phenomenon of incarcerated pregnant and postpartum women is a simple problem with a quick solution. We are obligated to understand the complex causes of attachment insecurity and relational trauma so that we can offer appropriate treatment and interrupt the cycle of incarceration.

CHAPTER II

Conceptualization and Methodology

Studies on adult attachment show higher levels of insecure attachment found in samples of members of lower socioeconomic groups, clinical populations, and inmates. A mother's own history of abuse is a significant cause of insecure attachment. Over 50% of incarcerated women in this country say they experienced childhood abuse by their parents and/or adult partners (Makariev & Shaver, 2010, p. 318). Evidence also shows that the mother's state of mind regarding attachment determines her parenting ability and what paradigm of attachment she will transmit to her child. Women are becoming incarcerated at increasingly higher rates than men and this is particularly concerning because women are more likely to be caregivers for their children than men (p. 311). For pregnant and postpartum women there is an immediate separation after birth which hampers the maternal-child bond from developing, causing a plethora of devastating effects on the dyad as well as with mother and child. This forced separation may cause the mother to become despondent, emotionally withdrawn or flooded, and preoccupied with her own memories of inadequate care or abuse.

Incarcerated mothers are likely to have experienced complex and chronic trauma from childhood as well as adult interpersonal violence by their partners. This may increase their vulnerability and put them at risk for further victimization if they are prostituting themselves to support their addiction. These women are likely to display symptoms such as hypervigilance, hyperarousal, numbing, flooding, and emotional dysregulation. Other symptoms may include sleep disturbance, depressed mood, feelings of helplessness or hopelessness, catastrophic

thinking, and panic attacks. Many of these women self-medicate with substances in an attempt to regulate their emotions and numb their emotional and psychic pain. However, without the access to drugs in jail they are left with these heightened attachment needs and untreated mental illnesses.

Because of the high probability that the majority of incarcerated pregnant and postpartum women have experienced some sort of attachment or relational trauma it seemed natural to use attachment theory to view this phenomenon. To demonstrate this phenomenon I have included a case example from the work I did while facilitating the Mothers Among Us (MAU) group for pregnant and postpartum incarcerated women at a Northeast Correctional Center. I will examine origins of attachment theory, beginning with John Bowlby, and expanded on by Mary Ainsworth and Mary Main. This will be followed by a brief overview of secure attachment and a more in depth exploration of insecure attachment. I will explore the concept of an Internal Working Model (IWM), also known as a mental representation, and show how it influences and shapes future interactions and relationships. Mental representations are defined as enduring cognitive-affective psychological structures that provide templates for processing and organizing information so that new experiences are assimilated to existing mental structures (Blatt & Levy, 2003, p. 120). These representations direct an individual's behavior, particularly in interpersonal relationships.

I will attempt to explain how attachment insecurity and attachment trauma leads to clinical disorders and substance abuse disorder in pregnant and postpartum incarcerated women. After doing a brief overview of attachment related disorders and the psychological impact of relational trauma, I will look at the specific experience and impact of being forcibly separated from their infants while incarcerated. I will only briefly mention the impact on their infants and

later development, as the primary focus of this thesis is the experiences of the mothers. This will be followed by treatment suggestions, mainly individual and group interpersonal therapy for attachment related trauma and disorders so that we can help these women heal their emotional and psychological wounds; through this healing, we can hopefully break the cycle of repeated incarceration and decrease the transmission of attachment insecurity to their children.

I will not suggest that healing can take place in the short time that many of these women are incarcerated; it may take years of work in therapy to recover. My interest in this topic for my thesis came from my work as an intern in the Forensics department of a correctional center, where I did individual therapy but also facilitated the MAU group for five weeks. I witnessed these women struggle to repair their damaged psyches in a hostile environment in which minimal support or assistance was offered. They were only seen once a month, unless they were fortunate enough to get assigned an intern; then they were seen weekly. The rest of the time they had to rely on group therapy which was offered by indifferent, minimally trained or skilled, counselors and staff.

My initial hope was to conduct a qualitative study exploring their subjective emotional and psychological experiences, as well as mitigating factors such as participation in MAU. I was connected to a person of considerable influence which helped me gain entry way to begin the research process. I made it as far as obtaining approval for my proposal from the Human Subjects Review Committee at my institution. However, a series of unforeseen events occurred that prevented me from accessing the subjects; therefore, I was forced to switch to a theoretical thesis. While this has been a rewarding process, reading and writing using secondhand data is not as compelling or meaningful as hearing the stories firsthand from this marginalized and largely ignored population. I had a good idea from working with them what themes would emerge and

what issues they faced, but I lacked a framework or theory from which to view it. At my adviser's suggestion I began to look into attachment theory. I quickly learned that this theory was highly applicable to this phenomenon as it is prevalent with attachment insecurity and disruption.

Erik Erikson (1964) has suggested that workers in the social sciences should consider what personal factors and life stage conflict have contributed to their interest in a particular area of research. It is important for us to know what our personal biases are; Freud would refer to this as countertransference, so that we do not project our unhealed areas or weaknesses onto our clients. I will give an example of how not acknowledging one's blind spot can hamper effective therapy or negatively influence the therapeutic relationship. Many years ago I got pregnant with twins and due to an undiagnosed illness I went into preterm labor. One of my daughters died two days after giving birth and the other is a healthy 12-year-old girl. Because of the pressure and extra care she needed due to prematurity related issues and the events that came after I never really got to mourn her loss. I moved on, so to speak, and raised my family, worked, and eventually went back to graduate school for this program.

While working at the jail my first client was a young mother who stood accused of killing her baby. We spent many sessions speaking of her family, her disappointment that they had stopped visiting, her past, and her hopes for the future. We rarely spoke about her child or her grief around losing this baby. After discussing an impasse with this client with my faculty field adviser said something that deeply resonated with me. "You cannot take a client where you have not gone," he told me. How could I expect her to process something that I had unconsciously denied myself permission to feel? Another way in which this created a blind spot for me became evident when my client was telling me the list of programs she was enrolled in; one of which was Anger management (for violent offenders or those facing charges of violent offenses). I thought

it was so bizarre and I had to ask a staff member to see if there had been a mistake. It completely escaped my notice that she stood accused of a violent offense in that moment---so convinced was I that a mother is not capable of committing such a crime. We never did reach a deeper therapeutic rapport and I strongly suspect my countertransference was the reason for the impasse.

What I came to realize while doing this research, is that I have also been affected personally by experiencing attachment insecurity and relational trauma. Professionally, I have been affected by witnessing my clients facing the same issues. I am adopted and have struggled most of my life to have healthy relationships and attach myself to others without fear of abandonment or engulfment. I have enacted this pattern of pushing others away and then desperately chasing them to keep them close. This came to a head in my adult life when I became involved in a very violent relationship which lasted for almost three years. This was preceded by other relationships of various levels of neglect or abuse but none as detrimental as this one. I have made many of the mistakes these women have, which almost cost me custody of my children, job, housing, sanity, and even my life. That is why when I work with these women I follow the philosophy, "There but for the grace of God, go I." I do not place myself above them or attempt to exert my power or control; however, I recognize that education and privilege from resources available to me sets up an innate power differential. Still, I am careful not to exploit it; I simply seek to ally myself with them and understand their experiences and desire to recover.

CHAPTER III

Phenomenon

Twenty-five years ago it was an anomaly to find many women, let alone mothers, in the criminal justice system. However, the number of women in prison has skyrocketed since the introduction of federal mandatory sentencing for drug offenses in the mid-1980s. The laws for drug sentencing have disproportionately affected women and there are now more women incarcerated for drug offenses than men. While the crimes males commit are typically more violent in nature, the majority of women are non-violent, first time offenders and would benefit from judicial changes that would mandate them into substance abuse and mental health treatment over incarceration. Over the past two decades the number of parents incarcerated within the state and federal prison system has increased by a staggering 79% (Makariev & Shaver, 2010, p. 311). Citing Glaze and Maruschak (2008) this translates to approximately 1.7 million children having an incarcerated parent in a state or federal prison in the United States while millions more have a parent in a local jail (Western & Wildeman, 2009) (Makariev & Shaver 2010). Women are more likely to be the primary caretaker for their children, thus are disproportionately affected by the separation. Women are also more likely to be survivors of trauma who are seeking relief from their symptoms by self-medicating with alcohol, prescription, and illicit drugs.

Given that substance use and trauma are closely intertwined, particularly in pregnant and postpartum incarcerated women, it makes sense to treat for substance use and mental illness to optimize healing and recovery. In the general population only 8% of people have Post-Traumatic Stress Disorder, as compared to 36-50% of people diagnosed with Substance Abuse Disorder

(McDermott, 2009). It is believed that opiates act upon the cluster of PTSD symptoms involving numbing and avoidance whereas cocaine use affects the symptoms of hyper arousal and hyper vigilance. This attempt to regulate affect leads to the phenomenon referred to as self-medicating. Treatment for substance use and trauma cannot occur separate from each other; effective treatment requires both areas need to be addressed. In one study, individuals receiving treatment for PTSD in addition to substance abuse treatment were 3.7 times more likely to be substance free at a 5-year follow-up than individuals who received substance abuse counseling alone, (Russo, 2007).

Psychological Needs

As children both boys and girls are both at risk of sexual abuse from family members and people they know. Statistics from the Bureau of Justice (2000) however, indicate that adult victims of violence are overwhelmingly female. The other striking aspect is that while men are more likely to be harmed by strangers, from gang violence or random acts of violence, women are more likely to be harmed by loved ones such as boyfriends or partners (Covington, 2008, p. 380). Because of the nature of intentional interpersonal cruelty, as opposed to random acts of impersonal violence (such as a car accident or tornado) the symptoms and outcome may differ. Many women suffer complex and chronic PTSD because of developmental attachment trauma, which is abuse or neglect at the hands of their caretakers that changes the natural sequence of identity development. The initial trauma from childhood may then be compounded by their lovers or partners. In both cases, it is the person charged with protecting her that claims to love her and have her best interests at heart that is the one inflicting harm either by extreme neglect and/or abuse. A woman may often feel a conflicted loyalty to her loved one and rather than act out towards the perpetrator(s) or speak negatively, she may internalize the abuse and feel as

though she has deserved it. This is especially likely when one has been the victim of repeated abuse at the hands of multiple known perpetrators.

Prison Conditions

Often the harsh conditions of prisons, jails, and correctional centers create or exacerbate existing trauma. As noted before many women are incarcerated for minor property crimes, drug use charges, and “moral” offenses such as prostitution. Very few women are incarcerated for violent crimes as compared to male offenders. Drug related crimes such as possession and use and solicitation for sex increase the propensity that a woman will be subjected to sexual or physical violence by her partner and the person she is soliciting drugs or sex from. This just compounds the trauma she has already incurred and jeopardizes her physical, emotional, and mental health. Pregnant and postpartum women are likely to suffer as there are few prison-based programs specifically designed for them and existing pre-trial diversion, alternative to incarceration, or re-entry programs are inadequate. While *Estelle v. Gamble* (1976) established that prisoners have a constitutional right to adequate medical care, this is consistently not enforced in this country. For individuals seeking legal retribution for poor medical care resulting in fetal death or risk to self, it is not enough to prove negligence or medical malpractice; deliberate indifference has to also be proved.

Less than 50% of state prisons have written policies specifically detailing or mandating the treatment of pregnant women or medical care and only 48% offer prenatal services (Tapiá & Vaughn, 2010, p. 420). While the most painful aspect of incarceration may be the impending separation between mother and child there are numerous other struggles a woman faces such as: lack of quality to prenatal care, delayed access to medical care, being shackled during and after childbirth, and complications from difficult pregnancies. Pregnant inmates also experience high

stress and possible complications such as poor nutrition, bleeding, high-risk pregnancies, sexually transmitted diseases, and drug withdrawal (p. 421). Amnesty International released a damning report in 2010 on the conditions of pregnant women incarcerated in the United States detailing the cruel and unusual treatment of pregnant women including cases of rape and coercive sex by prison staff. If a woman is brave enough to report it she is usually subject to victim blaming where she is accused of being hypersexual and luring the guards in. When the complaint is investigated or brought to court, a victim's social status and criminal history are used to discredit her character and allegations, which result in her claim being delegitimized as seen in *Newsome v. Lee County* (2006). All of these conditions serve to heighten a pregnant inmate's anxiety, exacerbate pre-existing trauma, and cause risk of complications to both mother and baby.

Policy Implications

Social welfare policy was not created specifically to facilitate or preserve relationships and it can often unintentionally have a detrimental impact on attachment relationships. Often, policy is shaped by how a phenomenon, or problem, such as the reason why women are incarcerated, is defined. For example, as a society if we have a standard definition of what it means to be a good mother who does not leave room for deviation or alternative models, then we are likely to design policy which will impact incarcerated women unfavorably. The Federal Adoption Assistance and Child Welfare Act of 1980 established permanence as a goal of foster care. This mandate states to enact practices which kept children in the home, except in cases of extreme risk of harm or neglect, or reunite with family shortly. The primary focus was preservation of the family. However, there was a shift away from this idea of permanence with a

later piece of legislation known as the Federal Adoption and Safe Families Act of 1997 (ASFA). This legislation was reaffirmed in 2003 by the Keeping Families and Children Safe Act.

ASFA policies had negatively and disproportionately affected incarcerated mothers and mothers-to-be by effectively shifting the focus away from family preservation. Instead of looking at the needs of the family unit, policy began to look only at the child's needs to determine what is reasonable for a timely permanent placement. The reasonable effort requirement could be waived under the following circumstances: 1) if a parent commits a felony assault causing serious bodily injury to the child or sibling, 2) if the parent commits or attempts the murder of a sibling or voluntary manslaughter, or 3) there exists aggravating circumstances including *abandonment*, torture, chronic abuse, or sexual abuse or if the parental rights to a sibling had been voluntarily terminated. Most logical people, including myself, would not argue the first two circumstances or parts of the third including torture, chronic abuse or sexual abuse. However, I would argue that including abandonment as a reason to speed up termination of parental rights resulting in permanent placement unfairly targets pregnant and postpartum women. Part of the nature of addiction often involves the individual leaving his or her home/job/family in search of the next fix. It is a symptom of the disease of addiction that women are being punished for. Also, terminating rights based on a previous voluntary termination of parental rights for another sibling is not appropriate in every case. Often a woman may have lost custody of a previous child during active addiction but later cleaned herself up and created a stable life and then has another child. She is immediately flagged by the state Department of Children and Families (DCF) and is in danger of losing her subsequent children, despite the fact that she is in a much better place financially, emotionally, and physically.

The idea of permanence is not clearly defined by statute or by attachment relationships but is determined by the “best interests of the child,” (Everett, 2010, p. 199). However, there is no universal or operational definition of the best interest standard. Family courts have wide discretion to define this concept which is often used to determine the *de facto* parent. Generally, the psychological parent is considered the *de facto* parent. The psychological parent is the one who the child associates feelings of love, security, and identity with. The *de facto* parent is the one who assumes the typical daily parenting tasks of providing emotional support, materials, and physical needs of affection. Part of the problem lies therein; who can evaluate and determine an internal construct relative to a young child’s perceptions of emotional support and love? Furthermore, there is no way of predicting how a child will connect to a *de facto* parent over the biological parent over time. In addition, these laws were designed to protect against neglect and abuse, not parents who are separated because of incarceration.

Incarcerated pregnant and postpartum women are at risk losing permanent custody of their children for several reasons. ASFA requires states to file for termination of parental rights for children whom have been in an out-of-home placement for 15 of the past 22 months. Again, the idea of permanence is challenged. Many court cases are prolonged because of inadequate or inability to access legal representation because of social and economic inequalities. I have seen pretrial women wait years to be tried and released, or convicted; meanwhile the clock is ticking on their parental rights. They are also in jeopardy of losing their rights because incarceration keeps them from being able to comply with the service plan instituted by DCF. For example, a service plan might require custody contingent upon a women receiving mental health and substance abuse treatment, parenting classes, secure employment and housing. However, not all facilities include parenting classes and many do not offer treatment. Furthermore, if a woman

returns to the community without the necessary resources and with a criminal record she is unlikely to be able to secure employment to be able to obtain housing. Therefore, she is unlikely to meet the demands of the service plan and be unable to retain custody of her child.

I will attempt to use a case example to illustrate the inequity of AFSA policies and the implications for incarcerated women. At the correctional center I began working with a woman in her mid-30s named Desiree. Desiree had a long history of substance use with crack-cocaine and alcohol resulting in fairly serious charges including possession with intent to distribute and attempted murder. She explained that it was a case of self-defense and that the person was released from the hospital with minor injuries. She found out she was about 12 weeks pregnant when she was incarcerated. Desiree was already a mom to an older child and a five-year-old son. She had been clean since his birth but had relapsed a few months before being arrested. During this time her family had taken her son in and was now insisting that she sign custody over to them. During visitations her counselor observed the close bond that Desiree shared with her son and the tenderness with which she interacted with him. Desiree took full responsibility for her actions but felt it was unfair for her to lose permanent custody of the child she had raised for almost five years.

She was in a precarious position; first she qualified under the expedited process to seek a permanent home for him because she had “abandoned” him in the eyes the law. Second, if she conceded to her family’s wishes and voluntarily terminated her rights then she automatically qualified to lose rights to her unborn child upon its birth. Another piece that complicated the situation is that for a brief period she felt hopeful upon being accepted into a residential treatment program that would allow her to have her son. The District Attorney (DA) in the case

of attempted murder even agreed to the plan but the DA in the second case involving the charge of intent with possession opposed it; thus, her hopes of being reunited with her son were dashed.

Desi ree felt helpless and hopeless to alter the course of events and reluctantly she agreed to allow her son to be adopted by her aunt. Her hope was that if she was agreeable then she would retain some ability to have contact with him in the future. She was under so much pressure that she appeared withdrawn, sullen, and hostile to most staff and inmates. However, to me it was a clear indication of the grief and anger she felt towards her family and the system. Adding to her distress was the untreated PTSD and major depressive disorder and probable Bipolar disorder along with the fact that she was not prescribed any psychotropic medications while pregnant, as per policy. She did not have any ability or method to self-medicate or self-regulate but she was fortunate enough to work with another master's level intern weekly, attend group therapy, receive monthly sessions with a forensics staff member, and attend the MAU group. Still, with all the support, she was unable to rally from the loss of her son completely.

Impact of Separation from Child

Upon giving birth while incarcerated the women are transported to a local hospital, unless the prison is already attached to a medical facility equipped to handle childbirth. Policies and procedures allow for little bonding time with their infants as they are often whisked away for observation and treatment, and are usually only returned for a final goodbye visit after two or three days. At this time, babies are usually prepared to be sent home with their caretakers, who may be a father or grandmother, or to foster care placements or adoption agencies. The mother is only given a few days to recuperate and to adjust to a sizeable loss after having grown attached to this little being that she has carried for nine months before being thrown back into the daily grind of incarceration. This event may even distort the initial bond between mother and baby

even upon being reunited (Hutchinson, Moore, Propper, & Mariaskin, 2008, p. 441). If she has already been diagnosed with an affective disorder such as depression or anxiety, has PTSD, or attachment trauma it is likely that these conditions will worsen and she may decompensate.

Many women suffer from feelings of isolation and uncertainty while pregnant and after giving birth. The degree of severity differs, from mild discomfort to full-fledged PPD, and many factors influence a woman's predisposition to depression and willingness or ability to seek treatment. Research has highlighted the additional needs of incarcerated women such as severe trauma and addiction histories, untreated mental illnesses, poverty, and difficult family relations. They are trying to navigate the harsh physical conditions and limitations of the facility with minimal contact from loved ones or support systems. There is a stigma placed on mothers in prison, by the general public, which further exacerbates their anxiety about their homecoming, (Williams & Schulte-Day, 2006, p. 80). Many of these women will return to the community and resume their roles as mothers and they need treatment for a variety of issues as well as to improve their parenting skills, competency, and understanding of the expectations placed on them. By instituting programmatic interventions while incarcerated we can improve their mental health and relationships with their children.

Case Study of Tina

The following is a case study from my experience working in forensics at a small correctional center in the Northeast. I met Tina, a White female in her mid to late thirties, when I first conducted her intake for forensics and completed a biopsychosocial assessment and mental status exam on her. Tina had an extensive trauma history including several sexual assaults from her teenage years. She presented with a variety of symptoms including: mood dysregulation, hypervigilance, a hyperarousal response, feelings of hopelessness, emotional lability, severe

anxiety, and suicidal ideation with past attempts. She also carried a diagnosis of opioid dependence disorder in partial remission with agonist therapy (methadone) and polysubstance abuse disorder. Tina had just been violated on her probation for use and possession of a controlled substance after relapsing several months ago. Tina was about 5 months pregnant and had not been receiving any prenatal care but was immediately put on methadone to help with her withdrawal symptoms and to prevent fetal distress.

Tina had 4 other children and was married although her husband only cared for the younger two while her mother had custody of the two older children. Tina explained that she was clean and sober for a significant period after getting out of state prison but became severely depressed and overwhelmed after the birth of her youngest child, to whom she gave birth to unassisted on her kitchen floor. She described seeking support and mental health counseling but her insurance lapsed and she felt as though she continued to slip through the cracks, leading her to relapse and return to jail. I met with Tina weekly to provide additional support as her anxiety was very high and she was not able to receive psychopharmacological support because of her high-risk pregnancy. Tina described her highly controlling mother whom she alternately feared and loved and who she relied on to care for her oldest two children while she was previously incarcerated for almost 10 years. Tina describes being so anxious herself as a child that she would often pretend to go to school but then sneak back home to be with her mother, much to her mother's annoyance. Tina reported that as a child, her mother seemed to withhold affection and praise towards Tina, while she displayed a yearning for her mother's approval. Tina reported that her mother would accuse Tina of abandoning her children while she was using but then if she attempted to see her children her mother would sabotage Tina by reporting her for a probation violation.

When Tina was about 7 months pregnant I was offered an opportunity to facilitate a group called Mothers Among Us (MAU), which was run by two doulas from the Prison Birth Project, who had taken a 5 week hiatus. My role facilitating this group gave me an insight into the lives and minds of these women that would normally be hesitant and not open to sharing their feelings, fears, and hopes for their unborn children. What I consistently saw and heard was that these women were very much attached to their children and loved them as deeply as any non-incarcerated mother would. Sometimes they loved their children so much that they realized it was in their best interest to let them be adopted, rather than weave in and out of addiction and their child's life. It was their addiction and inability to manage their past and current experiences of trauma that led them to become incarcerated, not intention to cause harm to themselves or others. They needed validation, empathy, information, and resources and a safe space to speak openly without fear of retribution or termination of parental rights. It was this group that inspired me to inquire more deeply into the experiences of pregnant and postpartum women in effort to understand the events that led up to incarceration. The following is a description of MAU.

The objective of this group is to provide a transformational space where incarcerated mothers can explore issues of motherhood, identity and parenting. This safe space includes a non-judgmental, supportive opportunity to share information, resources and gain skills in self-efficacy. A goal of this group is to encourage mothers to maintain a relationship with their children and to continue mothering even while incarcerated. We discuss that mothering may look different for everyone. There is a large focus on self care with the understanding that if a mother does not care for herself, it is that much more difficult to care for one's child. In this it is important to find positive ways to nurture oneself while at the same time nurturing the children. MAU group has a nutrition

component. Every group will be the same in structure, with guidelines, check in and activity. Some topics discussed in our groups are: Identity of motherhood, strengths and resiliency, personal narrative, tools to navigate difficult moments in parenting and life. This group is for all pregnant woman and mothers with children under 3. Also open to any mother who feels the group topics relate to her current experiences of mothers guilt, delayed postpartum depression, etc (The Prison Birth Project).

I invited Tina to join the group and she readily accepted. I watched as Tina opened up to the other women in the group and began to share her hopes, dreams, and fears for her unborn child. They were not much different from any mother you might ask about her love for her child. Between individual psychotherapy and the support this group provided Tina's symptoms began to stabilize and she began to hope for the future. Tina enjoyed the camaraderie of the other women in the group and the exchange of resources as well as the validation of her concerns, stresses, and celebrations of her achievements, such as visits with her other children. Tina was hoping that the judge would be lenient on her and release her to probation or a program so that she could continue parenting her children, including the new baby. She was realistic that with her long history with this particular judge that she may face a stiff sentence and she began to talk about the supports she might need after giving birth, such as a single cell, psychopharmacological support, and weekly therapy. She knew that she was prone to postpartum depression and high levels of anxiety, so a plan was created to have her seen by the psychiatrist as soon as possible after birth. Tina continued to participate in the Mothers Among Us group and weekly psychotherapy right up until giving birth. While in the hospital Tina received assistance from the Doulas from the Prison Birth Project and spent a few days with her daughter in close

contact, took pictures, and bonded the way any new mother would. Her daughter remained there while they titrated her off methadone and observed her progress.

I saw Tina shortly after she was discharged from the hospital. Her affect was flat and her mood was depressed. She was quiet, withdrawn, and soft-spoken and a shadow of the vibrant, loquacious woman I had come to know. She looked and felt lost as she tried to adjust to life incarcerated without the presence of her daughter in-utero. She did her best to keep in contact with her daughter's nurses in the Neonatal Intensive Care Unit, though her calls and inquiries were often rebuffed. She often felt stigmatized by the nurses and correctional staff for her daughter being born addicted. Tina continued to attend MAU and the women tried their best to support and mirror her experience of celebration at the birth, which was also tinged with grief and loss. The last session that I facilitated I noticed Tina had about four red jagged straight lines on her wrist. It seemed as though she had succumbed to the guilt, anxiety, depression---her own private demons. Those four lines seemed to represent to me the effects of incarceration and forced separation on mothers. I later heard she was sentenced to 2-5 years upstate, with little possibility of seeing and bonding with her daughter. I can only imagine what this does to the future relationship between Tina and her daughter.

Literature Review

The literature on the experiences of pregnant incarcerated women is minimal and studies of their postpartum experiences of motherhood are scant. Chamber's (2009) study on an existing prison nursery program demonstrates positive outcomes for mothers and babies and decreased recidivism rates (Byrne, 2009). This qualitative study was conducted with 12 mothers in a Texas prison hospital. The mean age of the sample was 25 years of age and 58% of the sample were women of color while 42% were White women (p. 206). Chambers (2009) found that there was

no difference in attachment to their babies between incarcerated and non-incarcerated mothers (p. 209), findings that contrast with the Williams and Schulte-Day study (2006) in which the researchers described the mothers as “matter-of-fact” during the interviews and showed no shame or remorse about being separated from their newborns, (p.86). One woman described her emptiness upon being separated from her baby after delivery as missing a part of her (p.208).

Another woman describes her experience in this way:

“It just hurts, it really does, and something I have got to deal with slowly but surely, you know. I can’t really overwhelm myself with all the pressure and the stress; if I do then I get stressed out, and then I don’t get better, but it is really a hard situation” (p. 209).

Williams and Schulte-Day (2006) conducted an exploratory study of 120 female inmates who had just given birth at a California prison, which holds the world’s largest population of pregnant inmates, (p. 80). Researchers hypothesized that rates of depression would be higher in incarcerated women after giving birth than in non-incarcerated women who had recently given birth but found that none of the participants were clinically depressed upon giving birth (p.85). Williams & Schulte-Day (2006) and Jesse et al. (2010) used the Beck Depression Inventory, which is not specifically tailored to measure postpartum depression. While it was a diverse sample in many ways, none of the women were diagnosed with a serious mental disorder and thus were determined not to need mental health services before birth. None of the women were assessed to need psychotropic medications post-birth either. Regarding the appearance of being unconcerned with separation from their children, the researchers acknowledge the women could have been in denial of the experience of their situation or used dissociation as a defense mechanism. The researchers also acknowledge that their findings could also be due to the lack of rapport established and the women’s unwillingness to discuss their feelings with persons they do

not feel close or safe with. There could also be a sampling bias because the women that were selected to participate are the ones who want to talk about their experience. The findings from this study do not match the prevailing literature which describes women as much attached to their unborn children and dramatically affected by the forced separation. This is also my shared observation from working with the women in MAU.

The stressors facing incarcerated mothers and mothers-to-be such as attachment trauma, affective disorders, addiction histories, and difficult family relations make it necessary to focus on their psychological well-being, cope with impending separation from their infants, and access quality mental health care and treatment options. While interpersonal psychotherapy and substance abuse counseling are invaluable tools for recovery, given the limitations with staffing, budget, and inequities in mental health care in many facilities, women are likely to receive limited individual services. Therefore, more emphasis needs to be placed on the benefits of interpersonal group therapy or support groups for these women. In this treatment modality the women can look to each other for mirroring experiences, psychological and emotional support, and networking around available resources. With both individual and group treatment women can begin to address the past that is encroaching upon their ability to lead happy, productive, and violence-free lives. As providers we need to understand the behavior before we can address it and this begins with an understanding of attachment trauma.

CHAPTER IV

Attachment Theory

John Bowlby

John Bowlby was originally a psychoanalyst who studied under Melanie Klein in London in the 1930s and 40s. He began to diverge from the Kleinian camp when Klein discounted the role of the actual parent in developing the child's representations and overall development and welfare in preference to innate drives. Bowlby felt that the child could not be studied in isolation and that the child was indeed affected by his surroundings and quality of care giving. Traditional psychoanalytic thought posits that humans develop static representations based on internalized others; however, attachment theory believes that development is based on internalized relationships. Psychoanalytic theory states that development of the self and interrelatedness occurs within the framework of mental representations. For example, Kernberg states that development occurs as one's image of self and others becomes further differentiated and integrated. Mature representations allow for integration of good and bad and the ability to tolerate uncertainty and opposing feelings about oneself and others.

Attachment theory considers the development of the self and relationships within a paradigm known as Internal Working Models (IWM). Despite its roots in object relations theory attachment theory pulls more from ethology than from psychoanalysis. Ethology is the scientific study of animal behavior, as it compares to and explains human behavior. Bowlby first examined attachment theory based on a biological model of evolution beginning with the observation of the behavior of young animals with their mothers. Leaving their mothers' sides meant certain death

from predators or starvation, so it was in their best survival interest to keep close contact with their caretakers. Bowlby then applied this concept to the human infant while observing that infants rely on their mothers as a “secure base” to get their basic needs met, including attunement and communication, and then to explore their surroundings. In Bowlby’s view, the quality of attachment between infant and caregiver leads to development of the IWM. These paradigms represent how we view ourselves and others, and we use them to model future relationships on. There are many different types of internal working models based on the attachment style one develops from having one’s needs met or ignored. For example, extreme neglect or abuse may lead one to become fearful of attachment for fear of abandonment or mistreatment. Bowlby argued that early attachment experiences had far-reaching effect throughout the lifespan and are the major determinates of personality structure and psychological disorders (Blatt & Levy, 2003, p. 107).

Bowlby’s research showed that babies rely on their mothers for emotion regulation and distress tolerance skills. With adequate attunement and mirroring, a secure attachment is developed as well as the capacity to self-regulate and modulate emotions. In the absence of attunement, a child may develop an insecure attachment and an inability to modulate or control his emotions. Emotional attunement also fosters “mentalization” which allows us to stand inside and outside of our experience and imagine the experiences of others. This makes us able to describe events, our response, and see others’ perspectives of the event as well as our own subjective sense of it. It allows us to develop our true selves. Conversely, the objectification that occurs with trauma, such as sexual abuse, creates an experience of a non-self. One experiences a disassociation from the body and does not develop her own likes and dislikes because one tends to merge into another and only feels real in connection with others.

Allen speaks of a developmental concept of self-worth which is deeply damaged by interpersonal trauma, especially childhood sexual abuse, but also by interpersonal violence in adulthood. For example, when a child is violated she may develop an internalized sense of badness, rather than direct her rage towards the perpetrator. By directing her hatred inward, the child preserves the attachment to her caretaker, which feels safer. Allen says that deliberate interpersonal trauma undercuts the development of the belief that one is good and whole and worthy of having healthy, loving relationships. Bowlby observed that in times of threat, we reach out to loved ones. To reiterate, threats, whether real or imagined, heighten our needs for attachment and connection. What, then, happens to infants for whom the parent is both a source of security and fear? Bowlby (1977) spoke of how childhood attachment lies beneath “the later capacity to make affectional bonds, as well as a whole range of adult dysfunctions,” including psychopathology and personality disorders (Blatt & Levy, p. 107). He wrote about the impact of insecure attachment on children and adolescents who had lost their mothers in *44 Juvenile Thieves: Their Characters and Home-life* (1944) but he did not have the empirical research to delve further into insecure attachments that Mary Ainsworth was to later provide.

Mary Ainsworth

Mary Ainsworth collaborated with Bowlby for the better part of 40 years; she expanded on his theory to include research on insecure attachments and formulated the classification system to describe infant’s attachment styles that we still refer to today. Ainsworth conducted the Strange situation first in Uganda and later in Baltimore, with 26 families observed over countless hours and home visits to determine the nature of attachments, secure or insecure. She further determined that the key to insecure versus secure attachments lies in the patterns of communication between infants and their caregivers which were revealed when introduced to a

stranger and the mothers' departure and return. The first description was of a secure attachment, where a mother was attuned to her child and able to anticipate his or her wants and respond appropriately to them. This was more likely to enable the child to be able to leave the secure base of his mother and explore his surroundings. He may become disregulated when his mother left but was able to become quickly consoled upon her return and resume playing. Later research was to expand upon their theory that secure children equal secure adults, barring any trauma along the way. However, Ainsworth discovered puzzling responses from those children whom she determined to have insecure attachments.

While observing the actions of the children with insecure attachments in the Strange Situations, Ainsworth created two different categories of attachment styles: Ambivalent and Avoidant. The first set of children, labeled Ambivalent, showed a preoccupation with their mothers' whereabouts and tended to hover by their mothers instead of exploring the toys. Upon the mothers' departure and subsequent return, they became angry and inconsolable. These children may have developed this response based on their mothers being responsive to their cries and needs at times, while at other times, ignoring them. Ambivalent children are also referred to as anxious, resistant, enmeshed, or preoccupied. Bowlby described their tendency to make undue requests of others and to be anxious when the requests are not met, which he observed in the phenomenon of borderline, dependent, and histrionic personality disorders (Blatt & Levy, 2003, p. 137).

The other set of children, labeled Avoidant, displayed a preference for exploration over connection and appeared to be averse to physical contact and seemed to show no emotional response to the mothers' departure or return. While they looked detached, their heart rates were elevated during the separation and the stress hormone, cortisol, was at an elevated level post-

procedure (Wallin, 2007, p.21). This led Ainsworth to conclude that the children were acutely distressed, but it was not evident from outside appearances because these children had adapted to their mothers' dismissive parenting styles. This was considered a defense mechanism for these infants, a way of coping by protecting themselves from being rebuffed. Bowlby and Ainsworth observed that avoidant attachment was related to an inability to empathize and make deep connections, which is present in affectionless and psychopathic personalities such as narcissistic, antisocial, and paranoid personality disorders (p. 107). There was yet a third category of puzzling and concerning responses within the insecure attachments that was to be discovered and researched by Mary Main.

Mary Main

Mary Main joined the conversation in the 1970s while working at the University of California at Berkley where she observed the responses of a group of infants that was not easily categorized into ambivalent or avoidant responses. These children showed fright and apprehension around their mothers and the trained observer. At points they froze or held their hands up to their faces in what Main considered a dissociative state. Main considered these children to be Disorganized and noticed that their mothers also displayed similar symptoms of unresolved trauma. The fearful response to their mothers seemed to stem from one of two conditions: either the mother was frightening through abuse, extreme discipline, or unpredictability, or she approached the child in a tentative, frightened manner. The latter could be due to her childhood history of abuse, particularly sexual abuse, which made her hesitant to approach her own child, perhaps out of fear of perpetrating the same abuse. Citing Main (1995) "It has long been presumed that the parent's representation of his or her own life history shapes the way in which the infant is conceptualized, and concomitantly, the way the infant is treated,"

(Allen, 2001, p.65). From observing the infants' attachment styles and their mothers' responses Main created the Adult Attachment Interview to be administered to the mothers in an effort to learn more about their own upbringing and style of attachment.

Preoccupied Mothers

Main found that Preoccupied mothers were likely to have children with Ambivalent attachments although that link is the weakest in the research as there were fewer participants who met the criteria for ambivalent attachment. It is believed that the mother is so preoccupied with her own experiences and feelings that she is unable to be present and attuned to her child's needs, wants, and cues. The key part that creates the ambivalence is that she is consistently inconsistent. She is able to notice her child's needs at times and at other times is too distracted to tend to her child adequately. These mothers appeared engrossed with their own needs causing their children to react to them with ambivalence and uncertainty. "Resistant attachment involves an intense preoccupation with maintaining contact with the need-gratifying figure and is accompanied by considerable anxiety in response to separation and loss" (Blatt & Levy, 2003, p. 108). These children then develop into adults who embody ambivalence in their adult relationships; they simultaneously desire attachment and fear abandonment and engulfment, which is characteristic of Borderline Personality Disorder.

Dismissive Mothers

Main created the label Dismissive to describe mothers who were inattentive to their children causing their children to be cut off from their own emotions, creating the Avoidant attachment style. In the interviews Main saw a trend of Dismissive mothers who idealized their own parents and childhood but were unable to give specific examples of good parenting or had very vague recollections of their childhoods. Main then theorized that as adults perhaps the

child's cries triggered a mother's recollection of her own childhood which may be characterized by abuse or neglect. This realization of her own unmet needs may have been too painful that in effort to discount the impact of this and preserve the image of the idealized parent---she ignores her child's cries. The child then learns not to turn to her parents for comfort and displays self-sufficiency to mask her desperation. While secure attachments are ideal, the first two categories of attachment styles, Ambivalent and Avoidant, are considered to be the result of "good enough" parenting, borrowing from Donald Winnicott's object relations theory. The third category, Disorganized children may result in more serious psychopathology unless serious intervention occurs.

Unresolved Mothers

Main notes that it is not the parent's history of trauma or loss that predicts the child's insecure attachment style but the unresolved aspect of trauma that is likely to predict the child's attachment. Main believed that it was the mother's own experience with her caretaker as unpredictable or frightening but needing to rely on this caretaker that provoked such emotional instability and disregulation that upon recall the mother lapsed into silence, babbling, long and protracted explanations, or abrupt shifts in discourse. It is this reactivity that prevents metacognitive monitoring, which is the ability to have an experience and reflect on it. It also hampers their ability to mentalize; instead, these mothers seemed to re-experience the trauma when interviewed. These mothers seemed unresolved in their trauma, likely the result of abuse or extreme neglect, causing them to be unable to reconcile the fact that "the one that I need is also the one that scares me." It is this absence of resolution that causes mothers to transmit this disorganization of attachment to their infants. This pattern of alternately fearing and loving one's

caretaker is often seen in abusive relationships in adulthood, in what is referred to as a reenactment by attachment theorists.

For example, one can imagine a woman who has grown up witnessing her alcoholic father abuse her mother and has developed an insecure attachment style. She then looks for a mate who is strong and protective to rescue her and provide stability where it was absent. He may start out as loving and attentive and then after they marry or she gives birth, he turns more controlling and abusive. Perhaps by then he has isolated her from family and friends. Using Bowlby's biological explanation, when an animal feels frightened or alarmed, it turns to one's caretaker as a source of strength and protection. So as the abuse escalates a woman's attachment needs are evoked and she is drawn closer, much like the original ambivalent attachment style from infancy. The reconciliation which occurs in the honeymoon phase then regulates arousal and the cycle begins again. This response is referred to as traumatic bonding in the cycle of violence.

Avoidant attachment may include passive-aggressive hostility and critical behavior driven by fear of intimacy. High levels of attachment avoidance contribute to men's psychological abuse. Women typically use attachment avoidance when they are defensive; in other words, not as a tool to control their partner's behavior and elicit a response. Controlling behaviors are seen as a way to regulate the self by keeping others at bay. Such strategies may include putdowns or insults, intended to create emotional distance from the partners. Also, well-controlled acts of violence may be used to keep the partner in line and when confronted, the perpetrator tends to deny or minimize the violence. Roberts and Noller (1998) found that women were more likely to use mild violence such as throwing objects, hitting, or threatening; whereas, men were more likely to use severe violence such as beating and using weapons (p. 790).

Incarcerated women are at high risk for IPV. The abuser relentlessly seeks for his victim's vulnerabilities; in a woman with a history of attachment issues, he has found a bonanza to exploit. This does not make her more vulnerable to victimization, as though she calls him forth to reenact; it is he who is hunting for vulnerability to exert control. It does, however, make the damage he inflicts more profound. This makes it difficult for the victim to muster the vast energies needed to center herself in decisions that come from an integrated place (pre-frontal cortex) and supported by protective connections. Since the batterer systematically works to break those external connections while simultaneously attacking her internal sense of security, it is a wonder she can take any safe steps forward at all. Therefore, it is not surprising to see women stuck in the cycle of domestic violence and incarceration.

It is important to mention that Main noted a category of responses in mothers who had “earned secure” attachment indicating that internal working models can be restructured. Secure relationships, whether in the therapeutic arena, romance or friendships, foster reflection, stability, and a wholeness of experience. These women had worked through their trauma, providing them with the ability to create secure attachments with their infants, and allowing them to break the cycle of transmission. Given the relational nature of attachments, with appropriate treatment, including psychoeducational information, and parenting skills, there is the possibility of decreasing attachment insecurity. While Bowlby, Ainsworth, and Main agreed that the mental representations formed in childhood are somewhat static, they left room for hope that such models were not completely fixed by suggesting that these models can be upgraded in light of treatment and new, reparative relationships.

Without the necessary interventions, there is a high risk of revictimization in adulthood as defenses may be lowered, self-esteem affected, and ability to detect unsafe people or situations

can be compromised. Attachment trauma also affects a person's ability to see a situation in a new light, causing one to react to a perceived threat based on his or her IWM. This makes it hard for one to trust a person in relationship as one carries forward the original paradigm for relationships which is built on mistrust, violation, and neglect and/or abuse. This is especially evident within the population of incarcerated women. There is a neurobiological explanation as well as a relational component. The amygdala is believed to hold our pre-verbal emotional memories and is the part of the brain that is responsible for the fight, flight, or freeze response. While this part of the brain may not be able to register early experiences in descriptive or verbal terms it can register as body memories and sensations. Clinically speaking, the key factor is that the hippocampus only develops around age two or three, which is why learning registers in the amygdala as over generalized and disproportionately influential memories (Wallin, 2007, p.73). Secure relationships allow the hippocampus to develop fully and regulate and temper the amygdala's response while insecure relationships, particularly attachment trauma, can shut it down or inhibit the development of the hippocampus. Thus, the amygdala is left to operate uncontrolled and unmodulated. These emotional memories may be contained within the individual forever but the conditioned fear response can be altered within a safe and contained therapeutic relationship.

The orbitofrontal cortex registers cues from facial expressions, sounds, and noises and then activates the sympathetic nervous system which instantly tells us how to respond to perceived danger. This is related to hair-triggered reactions so the hippocampus is needed to weed through the signals and information to act as a brake while alerting the parasympathetic nervous system to slow our responses down and differentiate between real and perceived danger. An example of this would be a war veteran who hears a car backfire and perceiving danger---

immediately drops to the ground. In traumatized women, particularly those who have encountered early childhood sexual abuse, their ability to differentiate real threat and perceived threat may be hampered. Being yelled at by a correctional officer or having a strip search can trigger the same feelings of threat, vulnerability and helplessness as the original assault, causing her to have a flashback or be rendered immobile.

While there have been numerous studies looking at attachment styles in the general population, there are only two empirical studies examining the attachment organization of pregnant and postpartum incarcerated women and a handful of qualitative exploratory studies. In existing research, the data from Adult Attachment Interviews conducted with participants from lower socioeconomic backgrounds and clinical samples have been used to hypothesize about the rates of attachment insecurity in incarcerated pregnant and postpartum women. This is due to the fact that, as noted before, extreme periods of stress or difficult conditions elicit attachment needs and responses which may closely mimic those of incarcerated women. Bakermans-Kranenburg and van Ijzendoorn (2009) conducted a meta-analysis of studies examining the link between insecure attachment and clinical disorders of over 10, 500 individuals who completed the AAI showed 73% of adults diagnosed with a clinical disorder also were classified as insecure (Makariev and Shaver, 2010, p. 317). Although insecure attachment does not in itself qualify as psychopathology, individuals who suffer from it are more likely to develop clinical disorders because of their decreased coping skills and capacity to handle stress. Therefore, it would stand to reason that pregnant incarcerated women would be particularly at risk given the stressors from their experiences pre-incarceration as well as during incarceration.

Primm, Osher, and Gomez (2005) write that only 62% of facilities offer psychological or psychiatric counseling for pregnant and postpartum women (McGee, 2010, p. 337). This is

extremely concerning given the stressors and clinical disorders found in this population. Given that there are so little requirements and regulations regarding medical care the absence of quality mental health care is not surprising. In one study by Fogel and Belyea (2001) out of 63 pregnant inmates interviewed, many of the women were at risk for poor parenting and perpetuation of abuse and over 70% reported symptoms considered to be clinical depression (p. 10). Of this sample, the women who admitted to substance abuse also reported childhood histories of sexual abuse whereas the non-substance abusers did not. Citing Mumolat & Karberg (2006) substance abuse is prevalent in the majority of incarcerated women (Borelli, Goshin, Joestl, Clark, and Byrne, 2009, p. 357).

In one of two empirical studies on this phenomenon, Borelli et al. used the AAI and a number of other tools to examine the intersection between maternal attachment style and substance use. With regards to drug use and drug-related crimes, it was discovered that drug use was correlated more with Dismissive and Unresolved attachment styles. The researchers also examined the relationship between Unresolved and Preoccupied classifications and depressive symptoms, perceptions of parenting competency, and perceived social support. 69 pregnant women incarcerated in a New York State prison were studied upon completion of a prison nursery program. It is important to note that these findings may be generalizable to women in other prison nursery programs, (which exist in only 8 other states) but not necessarily to incarcerated mothers who are separated from their children.

Findings supported the researchers' hypothesis that Preoccupied mothers would be at increased risk for maladjustment and have the hardest time managing their affect and emotions and struggled with separations. These women are particularly susceptible because their internalized representations of loved ones are skewed. It is difficult to sustain the image of a

loved one when separated. They also scored the lowest on the scale of perceived competency in parenting and perceptions of or dissatisfaction with social support. Given these findings, the researchers suggest that Preoccupied mothers are at greatest risk during their first year of incarceration; however, they note that these findings were based on subjective self-reported answers of symptoms and beliefs, so objective measures and indicators would be helpful in future research. Unresolved mothers with respect to trauma also reported greater increases in depressive symptoms over time, which is consistent with theory that incarceration in itself is a traumatizing experience. When confronted with this threat, attachment needs and trauma/depressive symptoms are heightened. One mother recalls her emptiness in this statement, “I don’t feel her every day. I don’t have her right here with me, and I mean, after you have her, you want your child there with you every day, and when you don’t have them there, it is a separation anxiety that you go through, (Chambers, 2009, p. 208).”

Poor emotion regulation is said to be a result of insecure attachments which supports the theory that substances are often used to self-medicate distress or to regulate moods. Opioids mimic the soothing experience of attachment whereas withdrawal is analogous to separation; thus attachment, especially traumatic attachment, is reinforced at the neurobiological level as well as through mental representations (Allen, 2001, p.45). Women are often first introduced to drugs by their partners and continuously supplied by them. When women make attempts at sobriety, they are often sucked back in by their partners who use them to prostitute as a way of providing income or by selling drugs for them. However, most women are stuck in the cycle of addiction because of their untreated/unresolved issues of mental illness and/or trauma.

Converging research on attachment studies indicate that many of the personality disorders described in Axis II of the DSM are interrelated and fall into the two dimensions of self

and interpersonal relations. Narcissistic personality disorder appears to develop in effort to preserve the self by dismissing the importance of others and meaningful relationships; whereas, borderline personality disorder develops in attempt to preserve the self in context of meaningful interpersonal interactions and connection with others, albeit in a maladaptive manner. While personality disorders amongst incarcerated pregnant and postpartum women certainly exist I would add that there are many other Axis I disorders that apply first and foremost to these women. This would include Substance Dependence Disorders, Posttraumatic Stress Disorder, Generalized Anxiety Disorder, and Major Depressive Disorder.

I would also argue that many, if not the majority, of these women have suffered attachment or relational trauma which has shaped their personalities. I believe that what appears to be manipulation, splitting, or excessive demands on staff is not necessarily classic symptoms of Borderline Personality Disorder, but rather, an attempt to adapt to their environment based on years of having to navigate unbearable stress and trauma. Careful assessments need to be done to distinguish true personality disorders from Axis I disorders such as PTSD. The outcome or diagnosis will determine the course of treatment which must include treatment for mental illness and substance abuse when applicable.

CHAPTER V

Treatment

Psychological needs of women

As previously mentioned, attachment organization is particularly significant in incarcerated pregnant and postpartum women as they are more likely to suffer from clinical disorders. Given the complex nature of previous abuses, the prison environment may appear harsh and unyielding and actually increase their symptoms of trauma. For these reasons, programs and treatments need to be gender responsive and trauma informed as women have different needs than men and most prison programs were designed for men. Erik Erikson (1950) spoke about the need for children to separate from their mothers and develop an identity based on industrious action and achievement. This theory of individuation is based on a Western cultural value system that also speaks more to how boys grow into men than how girls grow into women. Gilligan contends that psychologists and others in the mental health field have expected women to fit the traditional developmental models created by and for men and then pathologize women when they fail to fit in them or be explained by them.

Perhaps more useful to understanding the unique needs of women, particularly incarcerated women, is Relational Cultural Theory (RCT), which posits that people grow through and toward relationships throughout the lifespan. RCT was developed at the Stone Center for Development Services and Studies at the Wellesley Centers for Women (WCW). The Stone Center was dedicated in 1981 at Wellesley College to the prevention of psychological problems, the enhancement of psychological well-being, and the search for a more comprehensive

understanding of human development. Particular attention was paid to the experiences of women, children, and families across culturally diverse populations. Over the years, innovative theoretical work on women's psychological development and model programs for the prevention of psychological problems were developed. Jean Baker Miller, M.D. served as the founding director of the Stone Center and was a practicing psychiatrist and psychoanalyst for over 40 years. Miller wrote *Toward a New Psychology of Women* arguing that a woman's path toward adulthood differs than a man's because women are primarily driven by a sense of connection to others: children, family, and community over individuation.

The relational model from the Stone Center defines a "connection" as "an interaction that engenders a sense of being in tune with self and others, of being understood and valued," (Covington, 2007, p.4). Miller describes the outcome of disconnection as a "depressive spiral", which is reflective of the literature that has been generated from studies of the psychological experiences of pregnant and postpartum incarcerated women. Connection is based on the principles of mutuality and empathy. Mutuality empowers an individual in a relationship to be able to express herself fully and authentically while being able to be moved by and influenced by the thoughts and feelings of the other. Empathy is the mechanism or tool in which she can understand the experience of the other without needing to go through it herself. Together these two concepts empower women to join and share power with others instead to dominate or be dominated, a concept drastically opposite of what actually happens in the penal system. Mutuality and empathy need to be channeled by the staff that work in these institutions and are two key ingredients that need to be involved in the creation of treatments and programs for pregnant and postpartum women in jail. It is not enough to simply make the programs equal to those of men but to take the unique needs of women and inform policies and procedures for

treatment. Simply interchanging the word she for he in written policies or adding a basketball hoop because a men's jail has one is inadequate. An effort towards parity, instead of equality, should be strived for so that not only women, but especially pregnant and postpartum women, can receive the treatment they so desperately need without being re-traumatized.

Treatment methods

Group Interpersonal Psychotherapy

Recognizing the need women have for connection, mutuality, and empathy should be the guiding principles in the creation of two types of interventions: individual therapy with a therapist using a relational approach and group interpersonal therapy or a support group. The rationale behind group therapy is explained in terms of reducing social isolation and feelings of loneliness amongst mothers. Sharing feelings in this setting helps to normalize women's experiences and provide opportunities for modeling and peer support. The Abriola study (1990) was informed by Mercer and Rubin's theoretical framework that "maternal behavior is very much dependent on the feedback the mother receives from people in her own social network" (p. 116). While the following studies included a sample of non-incarcerated women these women still shared some of the same experiences as new incarcerated mothers, such as postpartum depression.

Elliott, Leverton, Sanjack, Turner, Cowmeadow, Hopkins & Bushnell (2000), McCarthy-McMahon (2008) and Abriola (1990) conducted studies of postpartum mothers' experiences in the community using qualitative data: the former study was conducted in New Zealand and the latter in Southwestern Pennsylvania. They found that many women do not seek help because they are unsure of the nature of the symptoms they experience. There was often recognition amongst the participants that "something was wrong" but they were unable to identify whether

they were having “normal” feelings and reactions related to first-time mothering and fatigue or something more insidious such as postnatal depression. One participant noted, “I was really desperate and I knew something was not quite right and I thought it was because I was so tired and because she wasn’t settling, (p.624). Another reason the participants gave for not seeking help is the stigma of being perceived as a “bad mother”.

Often this stigma is created and perpetuated by societal and media messages of the myths of motherhood and the ease and effortless skills that are expected of new mothers. Another woman shared that “the intense emotions were really overwhelming. I couldn’t understand and I wasn’t handling it. You know, being a mother comes naturally. I always thought before having children it was going to come naturally” (p.624). While some mothers described feeling shame upon being told they suffered from postnatal depression, many also expressed relief at finally having a name or diagnosis to put with the feelings (p.627). One mother commented, “I often thought in those beginning weeks that something was wrong with me. But it wasn’t me at all. I think you gain solace in knowing other mothers have survived” (p.129).

While this research was done with non-incarcerated women, the findings can be extrapolated to work with incarcerated postpartum women. The feeling of being a bad mother is especially evident in pregnant inmates. To be with others with shared values and experience can provide the sense of belonging, the need for mirroring and twinship that women need. It can also be a way for women to share resources and network around their parental rights, legal charges, and re-entry programs. The skill or knowledge of one member may be the limitation of another member, thus everyone can derive maximum benefits. Being incarcerated is a solitary and degrading enough experience, let alone the shame that is generated from being pregnant or postpartum while incarcerated. Not only have they likely missed opportunities as youth to be

mirrored and idealized by their caretakers but they now have the larger society reflecting back to them a sense of disdain and judgment on their capacity as women and mothers. This not only affects their self-esteem but allows shame to create a self-fulfilling prophecy which creates more of the same. There is no healing, only suffering, transgression, and punishment.

Inmates can benefit from the mutuality and mirroring that were missing in childhood through the connections with the facilitator and the other group members. Schiller (1995) suggests using the Relational Model for women's groups to account for the needs for connection and affiliation. The traditional group therapy model proposed by Garland, Jones, and Kolodny tends to map out the stages of group development based on the individual needs that men have to jockey and compete for power and individuate from each other. The traditional model of group processes proposes that groups move through the following developmental stages: 1) pre-affiliation 2) power and control 3) intimacy 4) differentiation and 5) termination. I propose using the Relational Model for creating groups to work with incarcerated pregnant and postpartum women with some adjustments due to the limitations that exist within the current framework. The following are the stages of the Relational Model: 1) pre-affiliation 2) establishing a relational base 3) mutuality and interpersonal empathy 4) challenge and change and 5) termination. Men use the pre-affiliation period to begin jockeying for power and control; whereas Schiller believes that women need to immediately upon entry into a group find affiliations and common ground, that will withstand later conflict that is almost certain to happen. Because the first and last stages of group development are the same in both models I will focus on the three middle stages.

During the second stage of this model women are working towards establishing a relational base. The facilitator can help promote this by encouraging women to find points of

connection and by working to establish a safe space. The need to create an atmosphere of safety cannot be underscored enough, for these women have a history of general disempowerment by the institution and legal system. They also have personal histories of violence and neglect making it vital that they feel contained and protected while in group. In establishing commonalities women may feel joined by the shared theme of losing their children abruptly and forcefully or in unified anger directed at the prison policies or Department of Children and Families, with whom most of the cases are monitored by. Schiller seems to believe that “deep empathic connection” is not a growth edge for most women. She quotes McWilliams and Stein (1987) as saying, “Women generally come into a group with some skills and experience regarding intimacy. They fall short of being ultimately therapeutic for the simple reason that confiding in each other, giving support, and being open about emotion are not problems for (many) women to begin with,” (Schiller, 1997, p. 5). While women may possess these skills it does not mean they have a lot of experience using them. Also, just because they have these skills does not mean that the group will not be beneficial. I would argue that unlike the women Schiller refers to, incarcerated women may not “come” with these skills of empathic connection because of their attachment insecurity. It takes time and effort to cultivate an atmosphere of connection; however, I still believe the stages of the relational model to be helpful.

The third stage of mutuality includes aspects of both intimacy and differentiation, which contrasts with the traditional model which separates intimacy and differentiation. This space typically allows for women to begin exploring both connection and difference amongst each other. However, as noted with attachment insecurity mutuality is not necessarily a skill that women have attained. Typically during this stage women are practicing trust and disclosure. I would argue however, that the prison environment does not cultivate feelings of trust or

disclosure because women have so few privileges that they are afraid to be reported or retaliated against and lose what little freedom they have. This can be overcome with a good facilitator who is able to be empathically attuned to the women and display mutuality, which is the ability to show emotional authenticity. This means the facilitator acknowledges when she is moved or touched by what is occurring during the group session, that she is not stoic and removed, but appears human and relatable. So often these women have experienced ruptures and disconnections in relationships and do not feel as if they or their actions have impacted others. By providing feedback on something that has been shared the facilitator is saying, “You matter to me. What you have done has impacted and (perhaps) changed me.” This can also be achieved by the other members of the group reflecting back to each other how they are moved by the content that is shared.

The central tenet of group therapy, particularly during this stage, is movement and change. This happens because the client can be encouraged by the facilitator and the facilitator can be encouraged by the client. Citing Miller and Stiver (1991) “This movement occurs through empathy. If the therapist can feel with the patient and be with the patient’s experience, she will be moved. The patient will be moved when she can ‘feel with the therapist feeling with her,’ or can feel with the therapist’s experience” (Schiller, 1997, p. 12). It is the task of the facilitator to manage the twin tasks of authority and intimacy and in my experience if incarcerated women did not feel that they could relate to me then they did not disclose. It was important that I matched their stories with appropriate affect and emotion when the occasion arose during group and really personal details were revealed. It is important for the women to show mutual aid and empathy towards each other as women that have traveled their own paths

but have all arrived at the same destination. Regardless of the crimes or charges that brought them to jail or the myriad of reasons they lost their children they still share the same heartbreak.

The fourth stage of the Relational model is challenge and change, which has the potential to be the most growth inducing stage, but also the most complex. Women are generally conditioned to make nice and be people pleasers, making conflict and confrontation less desirable. I would argue that conflict is even less desirable for women who have experienced relational trauma as this can evoke the same fears and uncertainties they have previously faced, such as fear of abandonment or withdrawal of love and support. The role of the facilitator in this stage is to help the women maintain their connection and simultaneously express a whole host of emotions, including anger and disagreement. An example of this in a group for battered women may be if a woman returns to her abuser, eliciting a wide range of responses and emotions from the other women, including anger, betrayal, disgust, maybe even wistfulness or longing. The challenge will be for the facilitator and the other group members to express this in a constructive way and to be able to maintain the relationships that have been formed in the face of conflict. The group must develop the capacity to withstand conflict and understand that conflict does not have to equal violence, rejection, and termination. The facilitator may have her own feelings of countertransference or judgment to manage and hold so as not to push the member further into the margins of the group.

Ideally, by this stage of the development the group almost functions by itself; this was certainly my experience as the facilitator of the MAU group and I was more of a passive guide while they set the tone and the pace. However, the group was not without conflict. One example of the stage of challenge and change came when one of the members announced that she was terminating her rights and allowing her child to be adopted. The other members tried to dissuade

her from adoption and encourage her to fight the Department of Children and Families system. The woman tried to explain that she was an addict and could not be certain that she would not relapse and felt that it was in her daughter's best interest to pursue adoption. The challenge was for the other women to be able to hold a space for her in the group, in spite of disagreeing with her decision. It was also my responsibility as a facilitator, to keep the space free of judgment and condemnation and honor her choice, though it may not be one that I or any of the other women, would make.

Ferszt and Erickson-Owens (2008) created a six-session, 90 minute biweekly pilot educational/support group for pregnant women in a Northeast correctional facility. This was designed with specific goals of improving the physical and psychosocial well-being of the women through education and support by providing an atmosphere where the women were comfortable discussing fears and questions. Another aim for the facilitators was to create a support system where the women could encourage each other during pregnancy and after delivery upon termination of the group. This is vital given the flurry of emotions that occur upon forced separation from their children and lack of access to outside support. Even after the termination of the pilot group, the members continued to meet citing the benefits of receiving and giving support to one another and feeling less alone (Ferst and Erickson-Owens, 2008, p. 57). The structure was adapted to include introductions, questions and answers, and then a topic discussion initiated by the women themselves. Over time, the facilitators saw a need for a nurse midwife, a woman with experience to provide accurate information and answers to the more complex medical questions and included one. They also saw a need for a Doula, to offer individual support beginning in the early stages of labor, throughout labor, and after the woman has given birth. The conclusion was that while the facilitators played an influential role it was the

women themselves who offered the greatest amount of insight, strategies for coping, and support for each other women. While sharing and finding support in a group setting is invaluable one caveat is that many issues are triggering for other group members. A woman might also feel inhibited to share her most private or personal details in a larger forum. For these reasons there is a need to offer these women individual therapy too.

Individual psychotherapy

I will use another case example to illustrate the importance of individual psychotherapy. This is from my forensic work with a postpartum incarcerated bilingual Latina female in her late 20s incarcerated on charges of sex for fee. Maria was of average weight and good hygiene and appeared younger than her stated age. She was married to an older man but had a boyfriend of 10 years with whom she had 3 children. Her daughter was 12 and in the custody of a family member. Maria had a 5- year-old son who had been adopted in a closed adoption and a one-year-old son who was formally adopted during our work together. Maria had two sisters and alternated between living with her partner and living with her mother. She was referred to forensics because she had a recent history of suicide attempts and had been treated for depression and anxiety in the past and was on Vistaril. This was her second incarceration.

Initially, it was very difficult for me to conduct an assessment because Maria was emotionally labile and complained she felt ill and could not answer my questions. After a few attempts over several days I completed the biopsychosocial assessment. The client was cooperative and very quiet. Maria was eating and sleeping poorly and stated her mood was extremely anxious and depressed; her mood and affect were congruent. Maria did not present as paranoid, delusional, psychotic, or manic. Her thought process was logical and coherent and the content displayed some passive suicidal ideation. After the initial assessment if a client is opened

the policy is to see her for a follow-up two weeks later. Then she is only seen once a month, however; this client struck me as very fragile and at risk for another suicide attempt so I requested to see this client weekly for approximately 30-45 minutes each time.

Maria was previously diagnosed during her first incarceration with anxiety, major depressive disorder, and polysubstance dependence disorder in early full remission in a controlled environment (because she was incarcerated). I later added a diagnosis of PTSD. The client has a history of using 30 bags of heroin intravenously daily. She also smoked an unknown quantity of crack/cocaine a few times a week. Maria had a period of sobriety in 2005, shortly after the birth of her second child, which lasted for 3 years. The client had entered a program, graduated and secured housing, and employment as a phlebotomist. While working at a nursing home, her criminal record check came back and her employment was terminated. After that she felt like she lost her bearings and began to sleep more and feel depressed. Soon she picked up using again and before long got involved in an unhealthy relationship. One day she called the cops to get assistance with getting the man out of the house and they showed up with a DCF worker. Since there was drug paraphernalia in the house they immediately removed her son. She went into a full blown binge and describes coming to awareness that her rights were terminated entirely. After her suicide attempt, Maria was hospitalized inpatient for a month. Upon release she immediately relapsed and has been unable to maintain a period of sobriety since. She has supported her habit through prostitution and theft.

A few days after I conducted the assessment Maria requested to read a copy of it. I gave it to her and the next time we met Maria handed me a few pages of what appeared to be her biography, written on her life events from age 2-13. She said it was easier to write than to tell me what happened and asked if I could incorporate that into her assessment which I agreed to do.

Maria appeared to have witnessed severe domestic violence between her mom and dad up until age four when her dad left. After that she described her mom as partying very hard and always having strangers in the house. Many of them molested Maria but she cannot recall who or how many. Eventually, her mom then got involved with another man whom she refers to as her stepdad. Around age 12, Maria discovered her stepfather was raping her sister and they reported it to the guidance counselor at school. At this point, Maria entered the foster care system, ran away, and had a CHINS order placed against her. Shortly after, at age 13 she began to use drugs. She started with sniffing coke and heroin and moved to IV use around age 19.

We focused on her experience as a victim of repeated acts of sexual abuse, first from childhood, and later from prostitution. I saw this as an example of repetition compulsion, or an attempt at mastery, which continued to put her at risk. We were able to have conversations about how the abuse affected her and led to her drug use and dependence.

C: I've been trying to keep myself occupied so I can turn off the noise.

T: What is the noise for you?

C: It's the thoughts about things I've done. It's the men. I can see their hands and smell them. The ones that touched me while I was a little girl and things that I want to block out. It's the prostitution and the things I've done to support my habit.

T: How do you numb yourself in here since you can't use drugs?

C: I just grab whatever I have and read and my thoughts go away. Sometimes my heart starts beating really hard and my palms get sweaty and I start looking at my veins and see the needle about to go in but then I can change my thoughts and the needle doesn't go in.

Maria's experience of early relational trauma and addiction validates the research discussed earlier in this paper.

We also spoke of her experience of becoming a mother and woman. Both of these experiences brought unimaginable pain into Maria's life. Motherhood is traditionally celebrated in our society; however, drug-addicted and incarcerated mothers are stigmatized and

marginalized. Drug addiction is seen as a moral failure, especially in light of the expectation that a mother protect her child from the time he is in utero, until he is fully grown. To have her child removed is seen as the ultimate failure and caused Maria to question her identity sans children. Maria often described the pain and guilt around losing her son which caused her to feel that life was not worth living without him.

- T: I cannot imagine the pain you are going through. I can't imagine how I'd feel if I lost my child.
- C: You have a child?
- T: I do but I'm saying that I imagine how hard it must be for you. But I also believe you can learn to live with that loss. You had three years with your son. He is who he is because of you. He carries you with him in every part of him---in his cells, in his memory, in his thoughts. He is still a part of you and you of him. (We both start to cry).
- C: I'm sorry.
- T: Don't be sorry, you didn't do anything wrong.
- C: Thank you. That means so much to me. I never thought of it that way.
- T: I really believe it is possible that maybe one day you will reconnect and maybe it will be when he's older but if he comes to find you where will you be? A child never forgets his mother and a mother never forgets her child.
- T: Somehow we need to get you to be able to hold the pain of this loss but learn how to live and be happy in spite of it. You are not any less of a person because you don't have your children.

If I had not inadvertently disclosed that I was a mother, the course of our treatment may have changed trajectory. Initially, I thought I was triggered by countertransference issues around difficulties I was having with my own son. After discussing this case with another therapist I realized that countertransference resulted from my experience of having almost placed my son for adoption and my experience of being adopted. I believe, when I told her that "a child never forgets his mother and a mother never forgets her child" that I was referring to an unspoken hope and belief I have that I had not resolved in my own heart and mind. Seeing this in my client also made me hopeful that somewhere my own mother feels a sense of loss when she thinks of me. While it may have shut her down to know that I still had my children while she mourned the loss

of her own, I really believe that it made me real for Maria. I hope she knew that they were tears of empathy, not pity; they were also tears of gratitude.

My work was to be able to hear these stories and to display empathy and mutuality which O'Rourke (2008) defines as the work. To "welcome without judgment the stories of having endured---or inflicted---horrible suffering powerfully conveys to or clients that just as we can hear these stories and not turn away, so too, can they now face their histories of pain and know that these histories cannot destroy them" (p. 454). We spent part of each session talking about her older son and her grief of losing her parental rights. Shortly before she was released she was called into court to terminate her parental rights for her 1-year-old son. In anticipation of a crisis I saw her twice that week and we spoke about safety planning around the court date. I was afraid that it might provoke her to attempt suicide again. While this was an emotional experience Maria pulled through it with grace and courage. She chose an open adoption and was able to recognize the joy in her son. Maria had a termination visit at the jail during which time she took photos of the two of them. She was able to infuse the experience with some meaning by recognizing that if she had not gone to jail when she did, than her rights would have been terminated and she would not have had the chance for any visits or contact in the future.

O'Rourke speaks of therapy in terms of liberating those who are held captive by their pain. "Are you willing to descend with them into their hell and stay with them there for as long as they need you?" (O'Rourke, 2008, p. 453). This is what Winnicott refers to as the holding environment and the concept of empathy which is central to attachment, self-psychology, and relational theories. This is what I felt continually compelled to do and it was emotionally draining at times. In our work together after my self-disclosure I believe Maria unconsciously

recognized suffering in me and helped me as I attempted to hold and help her. While he referred to the client feeling mirrored by the therapist, I believe in this instance, it worked both ways.

Winnicott places the onus on the mother to create a holding environment for her baby, which Maria's mother clearly failed to do. Winnicott says that the mother does not have to be perfect, but needs to be empathically attuned to her child and just has to be "good enough." For healthy development to occur the mother needs to create omnipotence in the baby first, and later, a sense of optimal frustration, so that the child learns that her mother is not perfect, and neither is she. If a child's needs are not impinged upon she will develop a true self and learn to be spontaneous and comfortable in solitude and in separateness. O'Rourke (2008) says that "part of that descent into hell, psychodynamically speaking, involves holding hope for our clients even when they cannot feel hope for themselves" (p. 454). We are called on to mirror our client, show empathy for that which has never been validated or healed, and to help our client find his or her true self. This involves re-learning her interests and values, and being able to integrate the good and bad parts of the self and other.

As therapists we are called on to behold and take in the wholeness of another person in all their fullness. In this way I hope that I became some sort of a self-object, representing hope for my client that she could internalize and draw upon in the struggles ahead. Attachment theorists would refer to this as "the self-regulating other." While the importance of both group and interpersonal psychotherapy cannot be underscored enough, it is my opinion that treatment for attachment trauma needs to occur in other realms using other modalities. The amygdala is believed to hold our pre-verbal emotional memories which are unable to be accessed verbally. This makes it hard to address these problems with cognitive behavioral therapy or traditional psychotherapy, whether in groups or individually. One such avenue of healing is dance therapy

which was used by Carl Jung to treat his patients because he recognized the need to make the contents of the unconscious conscious. Mary Whitehouse, who was an avid dancer, student and teacher of Jungian theory created a form of dance therapy in the 1950s called Authentic Movement.

The American Dance Therapy Association defines dance-movement therapy as *the psychotherapeutic use of movement* to further the emotional, mental, social, physical and spiritual integration of an individual or group. There are many ways dance and movement can be used to accomplish this goal and one of these ways is Authentic Movement. Ground work in this method involves at least two people who are referred to as the *Mover* and the *Witness*. The *mover* closes her eyes and focuses inward, holding what Jung referred to as “the good attitude” towards her psyche and body, remaining open to any sensation, thought, feeling, emotion or impulse that arises. When the urge or interest to move arises she may make a gesture or posture or remain silent and unmoving, open to surrendering what happens in her body and psyche. The goal is to trust that the body knows and to follow it to find the body’s own wisdom. It is possible to access memories, feeling, and healing and experience new depths of understanding through mindful experiences of bodily sensations. This is so vital to women that have experienced trauma, particularly incarcerated women, who have been so disconnected to their body and the mind-body connection.

While she is moving, the *witness* is watching her and observing what comes up in her own internal process and witnessing the *mover*. Healing and growth are facilitated through seeing and being seen as one is in the presence of a witness. The *witness* is, in a sense, creating a holding environment, a safe space, in which to observe the *mover* in all her fullness. When the witness signals to the mover that the movement is to end they reconvene to discuss what has

transpired, whether through talk, journaling, or drawing. The intention here is to capture what has been gleaned from the unconscious (personal or transpersonal) and to ground it in memory and daily life. This is a place where one can witness one's body awakening and being able to hold the self without judgment in a positive light. Personal history that has been stored in the body can be released and lovingly held, transforming and integrating all the facets of one's experience. There are variations on this ground form, which, for example, would be somewhat different if the mover/witness dyad is engaged in a psychotherapeutic relationship, or if Authentic Movement is being done as a group practice.

Incarcerated pregnant and postpartum women have most likely experienced severe attachment related trauma causing them to become cut off from and distanced from their own body and truth and from connecting to others in healthy, mutually satisfying ways. In Authentic Movement, mover and witness together can achieve a level of perception of self and other that evokes deep respect and empathy. In this modality, as with group and interpersonal psychotherapy, the goals are very similar: to provide mirroring, empathy, and attunement where it has never existed before. While this modality has not been offered in correctional settings to my knowledge, it is entirely conducive to the setting and could offer tremendous progress towards a complete and integrated treatment curriculum for this vulnerable population.

CHAPTER VI

Discussion

Beginning with Bowlby's theory of insecure attachment, which was built upon by Mary Ainsworth, Mary Main and others, attachment theory is used to explain the phenomenon of the psychological and emotional experiences of pregnant and postpartum incarcerated women. The identities of these women were shaped from birth by the developmental trauma of attachment insecurity from their own mothers' attachment styles and/or abuse and neglect. They grew into women who then faced relational trauma of domestic abuse, sexual assault, or stranger violence. Often, there is no recognition that something is wrong within their interpersonal relations because violence or mistreatment is the norm; it can therefore be strangely familiar and comforting versus the uncertainty of the unknown. At this point, their psyches and spirits have been damaged from witnessing and being the target of unspeakable acts of violence. The trauma incurred in adulthood compounds the initial attachment trauma, often leading them to self-medicate through the use of substances or to get involved in relationships with drug users or dealers, putting them at risk of incarceration. By the time they become involved with the legal system many have identifiable but untreated mental illnesses. In addition, they may have also developed untreated physical illnesses, which together require serious attention.

When they come to jail while pregnant or soon after giving birth, they are forcibly separated from their children, causing extreme emotional and psychological distress. This evokes their original attachment insecurities and also causes another generation to be subject to attachment disruption. The literature generally indicates the importance of maintaining contact

with their children to preserve the mother-child dyad, propel the mothers towards self-improvement, healing, and reduce recidivism. This is evident in a longitudinal study of a prison nursery in Nebraska where mothers were able to reside with their babies while taking parenting classes and getting hands-on parental skills for up to 18 months postpartum. Carlson found that the recidivism rate for pregnant women who had participated in the program was 16.8%, as compared to 50% for the women that did not partake in the nursery program (Makariev and Shaver, 2010, p. 324).

There is a number of intervention programs designed to improve attachment security between the mother and child dyad. These year-long programs include Child-Parent Psychotherapy, the UCLA Family Development Project, and Minding the Baby. There are two other programs: Circle of Security and Attachment and Biobehavioral Catch-up, which are 10 or 20 weeks long. The goals of these programs are: 1) target parents' internal working models and attachment styles, 2) teach parenting skills, and 3) establish supportive relationships between parents and interveners. Prison nurseries are rare so these programs cannot be tested with incarcerated mothers and their infants; rather, the interventions can only be used while working with the child and the alternate caregiver. The mother can benefit from participation in parenting programs while incarcerated but would have to wait until release to participate in the above programs.

In these programs the intervener is used to comment on the child's behavior and reframe it so the parent can understand how to meet the child's needs. This is especially important because if a mother's own needs were not met as a child she may not know how to appropriately meet her child's cries for help. Another important role of the intervener is to serve as an attachment figure for the mother. She can be a secure base from which the mother can mentally

explore herself and her relationship with her child. A relationship can develop which embodies mutuality, empathy, and caring, qualities which may not have been present in any previous relationships the mother had.

To address the needs of incarcerated pregnant and postpartum women and set the stage for healing to begin, we need to create gender responsive and trauma informed programming that includes treatment for mental illness as well as substance abuse disorder. At the heart of this disruption in development and need to self medicate is attachment insecurity and relational trauma. They need coping skills and tools to learn how to regulate their emotions without the use of drugs and alcohol. Psychopharmacology may be helpful in managing the most acute symptoms but often these medications are addictive, costly, and should not be long-term solutions separate from therapy. These women have learned to disconnect and disassociate from their bodies as a survival technique. They may never have learned to trust themselves or others as no one ever stood to witness or mirror their unbelievable anguish and suffering. This is why individual psychotherapy using a relational approach is so important.

Therapists can provide the empathy and mirroring that was minimally offered or absent from their caretakers and partners. We can serve as the self-regulating others and let our clients draw from our strengths and internalize them, until they can develop their own.

Everyone experiences assaults on his or her sense of self-worth and self-cohesion. However, everyone does not experience the same opportunities for self-enhancing self-object experiences. Assaults on the self often occur selectively, according to sociological categories of gender, race, ethnicity, class, age and sexual preference clinical social workers must ask how the larger society contributes to or interferes with opportunities for growth-producing mirroring and idealization. (Mattei, 2008, p.63)

It is our duty as social workers to inform ourselves on the root causes of social, economic, and legal inequities that lead to the high rates of incarceration amongst pregnant and postpartum

women. We need to be equally informed on what treatment modalities are most effective and how we can be part of the solution, not the problem.

It is my opinion that individual psychotherapy should not stand alone; it should be offered in addition to group interpersonal therapy. In this modality, women can find twinship and mirroring from each other, instead of relying only on one individual (the therapist or facilitator). The facilitator is only there part of the time but these women are with each other 24 hours a day. Women can learn to lean on each other for sharing of resources and support in ways that cannot be achieved in individual therapy alone. There is tremendous power in women seeing aspects of their own struggles reflected in their peers.

As mentioned before, the amygdala is believed to store our pre-verbal memories which are inaccessible to us using traditional modes of psychotherapy, including cognitive behavioral therapy. It is a long road to healing and transformation and I am convinced that only treatment using different modalities can best integrate the soul that has been shattered into a thousand pieces or has never fully been formed to begin with. For myself, this has meant a combination of Twelve-step meetings, a domestic violence support group, therapeutic massage, yoga, swimming, CBT, Authentic Movement, and other more alternative techniques. However, I recognize that the most vulnerable and in need of help, the incarcerated, will not have the resources or ability to access these costly forms of treatment. Instead of incarcerating pregnant and postpartum women we could offer substance abuse and mental health treatment, when appropriate. By offering diversion to treatment we are saving money which can then be used to fund different modalities of treatment.

Diversion from incarceration to treatment programs has a significant savings and should strongly be considered for nonviolent offenders struggling with substance use. It costs about

\$39,000 to house an inmate in a House of Corrections in Massachusetts. The Substance Abuse and Mental Health Services Administration (SAMSA) conducted a national survey and found the range of available treatment costs to range from \$1,433 for outpatient services to \$3,840 for nonhospital residential treatment to \$7,415 for outpatient methadone treatment. An average of these costs puts the average treatment episode at \$4,229.33. This is a savings of about \$30,000 per individual (NEPA, 2008, p. 8). Society as a whole reaps the benefits from decreased overall crime rates, reduced recidivism, and help for those with substance abuse problems.

The majority of incarcerated mothers and mothers-to-be are not violent criminals; rather, they are victims of severe and unrelenting trauma. This has caused them to become involved in a vicious cycle of poverty, substance use, and petty crime to support this habit, landing them in jail and separated from their support systems and loved ones. If we do not offer comprehensive treatment during and after incarceration we are ensuring that they become ensnared in the system they are so desperate to escape. In the short time I interned at the correctional center I saw the benefits to offering both individual and group therapy. The fact that they accepted me into their space and shared their most intimate thoughts, fears, and hopes for the future left me deeply impacted. O'Rourke (2008) discusses the mutuality that occurs in the therapeutic relationship, in which both patient and therapist benefit. "There is, I would argue, something incredibly intimate about beholding-and finding oneself held- in the compassionate gaze of another" (p. 455). It is my firm belief that I was profoundly changed in some palpable, but inexplicable way, as much, if not more, than the women I was privileged to work with.

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