8-1-2019

REFORMING THE REHABILITATION PROCESS OF INCARCERATED FEMALES AFFECTED BY SEXUAL TRAUMA

Tamnika Walton

REFORMING THE REHABILITATION PROCESS OF INCARCERATED FEMALES AFFECTED BY SEXUAL TRAUMA

by

TAMNIKA WALTON

Presented to the Faculty of the Honors College of
The University of Texas at Arlington in Partial Fulfillment
of the Requirements
for the Degree of

HONORS BACHELOR OF SOCIAL WORK

THE UNIVERSITY OF TEXAS AT ARLINGTON

August 2019

ACKNOWLEDGMENTS

I would like to give all honor and glory to my Heavenly Father. He has made this process possible and has given me strength to persevere. I would like to thank my parents for their unwavering support in continuing my education and the endless assistance with my daughter as I reach for my dreams. I would like to commend my children for supporting me through this season of continuing my education and pushing me to strive for more. Thank you for giving me reasons to be better and to never quit. I commend you two for being selfless with your time with me and understanding my drive to be instrumental in creating a better future and world for you both. I last, but not least, want to extend a special gratitude to Dr. Regina Praetorius. You have been instrumental in my remaining sane throughout this process. You have taught, encouraged, and pushed me to push myself and the limits of gaining knowledge. Thank you for your time, patience, understanding, guidance, knowledge, leadership, and listening ear. For anyone who has been instrumental during my educational process, I am eternally grateful.

August 06, 2019

ABSTRACT

REFORMING THE REHABILITATION PROCESS
OF INCARCERATED WOMEN AFFECTED
BY SEXUAL TRAUMA

Tamnika Walton, BSW

The University of Texas at Arlington, 2019

Faculty Mentor: Regina Praetorius

Sexual trauma has been found to affect individuals across all socioeconomic lines. For some, recovery from the damages is a process that often includes bouts with the justice system that ends in one or more imprisonment terms. Often these prison sentences are caused by substance use and sex industry crimes. The study shows that the time these women are serving is often a result of the trauma they have faced either by childhood sexual abuse (CSA), domestic sex trafficking (DST), or sexual violence as an adult. The purpose of the study is to determine if incarcerated women who have suffered sexual trauma face a higher rate of imprisonment than women who have not experienced sexual trauma in the corrections system due to exclusion from specialized treatment of sexual trauma. The method utilized for this study was Qualitative Interpretive Meta-Synthesis (QIMS). For (QIMS) a research question must be formed. Then a sample of qualitative research is

chosen. Then begins analytic steps of extraction of the theme, theme synthesis, triangulation, and credibility reporting (Aguirre & Whitehill Bolton, 2013). The study proved that women who identified as sexual trauma victims had often not been benefactors of interventions that were specific to sexual trauma. Gender Responsive Treatment (GRT), which was modified with Cognitive behavioral Therapy (CBT) included guided imagery, mindfulness meditation, and art therapy being used in the study and concluded that the participants showed greater productivity psychologically. Refraining from substance use, provided evidence that trauma- informed intervention was most beneficial when the participants had themselves experienced trauma (Saxena et al., 2014).

TABLE OF CONTENTS

Appendix

CHAPTER 1

INTRODUCTION

Sexual abuse and sexual trauma are problems that affect more women than what is nationally accounted for. According to Breidling (2014), approximately one out of five women (an estimated 23 million) have been raped in their lifetime (p. 2). An estimated 64.1 percent of multiracial women, 55.0 percent of American Indian or Alaska Native women, 46.9 percent of White non-Hispanic women, 38.2 percent of Black non-Hispanic women, 35.6 of Hispanic women, and 31.9 percent of Asian or Pacific Islander women experienced at least one act of other sexual violence in their lifetime (Breidling, 2014, p. 2-3).

Lesser discussed acts of sexual violence include attempting or forcing the penetration of a victim, attempting or forcing the penetration of a victim while they are intoxicated by drugs or alcohol, forcing a victim to attempt or complete the penetration of someone while sober or inebriated by drugs or alcohol. It can also include non-physically forced penetration which occurs when a person is forced to submit or coerced, unwanted sexual contact, and non-contact unwanted sexual experiences (Basile, 2014). With such astounding numbers, it is probable that everyone knows at least one victim that has experienced some form of sexual trauma or violence. The probability increases when we consider those who do not report or acknowledge the sexual violence. According to reports, it is estimated that only 2 to 26% of rape victims will report the crime to authorities (Ahrens, 2007).

When the physical pain is long gone from these assaults, the psychological and emotional trauma women face is a daily battle. Research shows a large percentage of sexually assaulted individuals will deal with numerous psychological issues following the attacks. Depression and Post Traumatic Stress Disorder (PTSD) are among the most prevalent, but many of the victims will attempt or die by suicide; have increased risk for obesity, eating disorders, or substance use disorders; develop anxiety, anger issues; become overly or under sexualized; be at an increased risk for incarceration; and more prone to experience emotional detachment from the people and things they once loved (Kirkpatrick 2018). It is inevitable that there will be some aftermath that not only negatively impacts the victim, but also those around the victim as personal relationships with family, friends, and work suffer as a result of sexual trauma. For some women victimization is all they have known since childhood. According to research, close to 325,000 children are at risk each year of becoming victims in the child sex trade (Estes & Weiner, 2002). How these forms of abuse will affect each victim varies. In one study, the rate of lifetime depression among childhood rape survivors was 52% compared to 27% among nonvictims (Saunders 1999, p. 187-200).

In the state of dealing with the trauma of being victimized, some women will make choices that will affect their futures in some fashion. Women who have been victims of sexual assault, abuse, or trauma often choose to cope with the pain by using illicit substances; while many others develop mental illness. Often it is during a weakened state of psychological functioning due to substance use or mental illness maladaptive behaviors are incited. This may include prostitution, violence, criminal activity, neglect, or harm of their children, all of which can land them in jail or prison (Kirkpatrick, 2018). Although

the rate of sexual assault is high in the general population, it is proven to be even higher amongst incarcerated women. Specifically, the literature reveals that between 48% and 60% of women in prison reported a history of sexual assault or abuse prior to incarceration (Bloom, 2003). An important question to ask when dealing with these women is, are women who have suffered sexual trauma at a higher risk of incarceration than women who have not been affected by sexual trauma in the correctional system? Research done by self-report also shows that 20 percent of females can remember an incident of childhood sexual abuse or sexual assault (The National Center For Victims of Crimes, 2018). Research into this issue will help to identify the impact of sexual victimization on women's experiences and their status in the justice system. The purpose of this study is to use existing qualitative research to understand how to best design and implement interventions for victimized women.

CHAPTER 2

LITERATURE REVIEW

While studies on the possible effects that sexual trauma has on women in the prison system are minimal, the relevance of its impact on the victims, their families, and society are being researched in other countries. There is a common theme across the spectrum of women who have endured sexual abuse whether they have been in carceral settings or not. Posttraumatic Stress Disorder (PTSD) affects many survivors and has proven to have an elevated rate amongst women in the correctional system (Moloney et al., 2009). According to a study of incarcerated females that were experiencing PTSD or had a lifetime occurrence, 68.2% had experienced sexual abuse or physical abuse as a child. The results also indicated that these women had a higher emotional and physical distress compared to their female counterparts who were not reported to have PTSD (Moloney et al., 2009). While it is known that sexual trauma reaches all races, genders, and socioeconomic statuses, it is often impoverished and minority women who lack the proper resources to obtain help to work through victimization. Without help, research shows many turn to substance use, risky sexual behavior such as prostitution and other crimes. According to one study, numbers showed that in 2013 there were over 1.25 million women in the US correctional system. The majority were arrested for non-violent drug related crimes (Carson, 2014). Therefore, reforming the rehabilitation process and using adulthood to have the opportunity to heal the emotional wounds they have endured at the hand of their perpetrators can be done by developing a proper protocol to screen individuals who are

being held for crimes that are common tendencies for sexual assault victims. Studies show that without proper rehabilitation, 4 out of 10 juvenile offenders who have been sexually assaulted by the age of 18 will become perpetrators (Page & Murphy, 2017). It is the duty of society to provide ways to identify this vulnerable population who may not always be vocal and assist them through the aftereffects that will arise. Sexual abuse and sexual trauma knows no boundaries, but we know that minorities are incarcerated at a higher rate for crimes; these crimes include prostitution, theft, drug use and possession, and other criminal activity. “In 2014, the imprisonment rate for African American women (109 per 100,000) was more than twice the rate of imprisonment for white women (53 per 100,000) (Carson E. 2014, p.15).” “Hispanic women were incarcerated at 1.2 times the rate of white women (64 vs. 53 per 100,000)” (Carson, 2012, p.11).

There are various reasons that play a role in women becoming inmates through the correctional system. A study conducted with 521 women 18 years and older in 2016 from 2 North Carolina prisons self-reported in the 18-question survey Adverse Childhood Experiences (ACE) revealed an alarming rate of Childhood Sexual Abuse (CSA). Women who were verified as experiencing their first time for incarceration reported a rate of CSA at 31.1% compared to women who were verified to have two or more incarcerations at 40.4% (Herbst et al., 2016). In this research sexual trauma included being forced to have sex without protection, being physically assaulted during intercourse, fear of refusing sex, having sex while incoherent, forced to have sex against their will, and rape (Herbst, et al., 2016). The results in each of these areas was significantly higher for those who had previously been in carceral settings in comparison to first time offenders. Of 521 women,

58.5% of first-time inmates and 70.5% of inmates reported sexual trauma in adulthood (Herbst et al., 2016).

According to the reviews by (Herbst et al., 2016), inmates who had recurring incarcerations proved to have significantly higher occurrences of CSA than first time incarcerates, and women with multiple incidents of incarceration had increased rates of violence and victimization across. This study concludes that the findings determine a specific need to address societal risk factors that include the use of substances, sexual risk, victimization, and symptoms of depression prior to reentry into the community and that social and health services should work together to identify and address the issues that create behavior risk and recidivism for these women (Herbst et al., 2016).

Gray and Rarick (2018) states in their study on gender and racial/ethnic differences in the effects of CSA found that CSA frequency is higher with girls than boys, and that most victims know the perpetrator who is commonly male (Olafson, 2011). In a report conducted by the U.S. Department of Health and Human Services (2013), stated that in 2012, "CSA showed (21%) to be African American, (1.2%) American Indian/Alaskan Native, (0.8%) Asian, (21.8%) Hispanic, (4.7%) Pacific Islander, (8.2%) Caucasian, and (10.8%) multiracial adolescents." Gray and Rarick (2018), also mention that as they have found on many other discoveries with CSA, the racial differences have been based on adult examinations and that percentages may be higher as a result of underreporting due to the stigma in some ethnic groups CSA carries. From the studies, it has been determined that adolescents who are survivors of CSA are at an elevated probability for psychiatric issues long-term (as cited in Shapiro et al., 2012) that including revictimization, abuse of substances, depression, and hypersexuality (Olafson, 2011).

One of the common results of CSA has been determined to be emotional dysregulation, which is defined as the inability for an individual to control their emotional response or behavior. It can carry well over into adulthood and increase negative coping mechanisms such as abuse of substances, hazardous sexual behavior, and self-harm (Messman-Moore et al., 2010). Findings show a substantial correlation with trauma in childhood and disorders dealing with depression, specifically major depressive disorder, and PTSD (as cited in Gray and Rarick, 2018). Dependent upon the severity of the abuse, it is symptomatic of chronic indications that enhance the probability of harm in functioning because of PTSD, dissociative disorders, abuse of substances, anxiety, and behavioral problems (Bedi et al. 2011).

According to Roe-Sepowitz, Bedard, and Pate (2008), research has proven in children who have been sexually victimized, that it can adversely affect their adult behavior, and this is said to have long-term psychological consequences. Over the years the population for people who are incarcerated has been on the increase not only for males, but particularly the female prison population and looking deeper into what has caused the influx starts by probing into the past of their youth and experiences (Roe-Sepowitz et al., 2008). As cited in Roe-Sepowitz et al. (2008), the research done in regard to female prison population shows a correlation linking their incarceration to physical or sexual abuse (Brunschot and Brannigan, 2002; Chesney-Lind, and Sheldon, 2004). While the majority of those who have been incarcerated are not apprehended for violent crimes, many of the arrest are results of the victimization they have endured. The scenario for this trauma has significant correlation to the social learning theory as cited in Roe-Sepowitz, Bedard, and Pate (2008), and these women who have been exploited and abused sexually will develop

a complex that grooms them into viewing and believing that as an adult or adolescent in order to function they must adhere to the sexual degradation of themselves, and it is also known as a sexually deviant identity (Brunschot & Brannigan, 2002). Through the studies they have found that dissociation is common with survivors of CSA and that it is a coping mechanism that has been developed as an effort to distance themselves from the trauma that is taking place.

2.1 Treatment of Effects of Sexual Trauma

Gender Responsive Treatment (GRT) is a modality that is new in the therapeutic treatment of women inmates. As it has been noted in studies regarding the topic, women who have experienced trauma either sexual or physical, it is often a precursor to their substance use (Saxena et al., 2014). According to some studies, (as cited in Saxena et al., 2014) it is beneficial for those women who have suffered abuse to receive specialized treatment. Historically inmates who have been sexually victimized and have substance abuse issues are sent to Therapeutic Communites (TC) which are more often male oriented (Messina et al., 2010) and focus on eliminating illicit substance use and utilize group sessions that can be confrontational. According to research by Lipsey, (1995) also shows that women suffereing from these disparities need multiple types of interventions that focus on several issues concurrently as (cited in Saxena et al., 2015)

GRT is designed for women and addresses the many facets of life that women encounter. Through this process that emphasizes being well mentally and developing same sex platonic relationships they utillize a specific curriculum and employ facilitators who are often in recovery themselves (Saxena et al., 2014). The primary focus points of GRT include substance abuse, trauma, and mental health issues due to the prevalence of

women's causal introduction to crime consisting of a history of prior abuse, poverty, and absence of proper resources to care for their children (as cited in Belknap & Holsinger, 2006; Daly, 1992, 1994; Steffensmeier & Allan,1998). Another major component of GRT is relational-cultural theory. This theory examines the mental growth of these women in their interpersonal and social relationships, as well as behaviors. GRT promotes fostering healthy relationships, specifically with interpersonal relationships with immediate family such as children and significant others.

As proven in the preliminary research of GRT a random controlled study showed that GRT resulted in harm reduction with drug use, maximizing the utilization of aftercare services, and a lower rate of recidivism compared to those who received treatment as usual with the standard TC groups (as cited in Messina et al., 2010) for comprehensive results. The sample for this pilot study consisted of women inmates from a California state prison and took place over a period of 2 years from 2006 to 2008. There were a 115 women participants with 60 having the GRT, and 55 having treatment as usual with a TC. Their eligibility for the study was determined by their history which was retrieved through inmate central files composed of their past use with substances, and the length they had remaining on their sentence (Saxena et al., 2014).

During the longitudal study and GRT intervention a modified curriculum specific to women in the criminal justice system focusing on Cognitive Behavioral Therapy (CBT) approaches, mindfulness meditation and experiential therapies such as art therapy, guided imagery,etc. was used, Helping Women Recover: A Program for Treating Substance Abuse and Beyond Trauma: A Healing Journey for Women (as cited in Covington, 2000, 2002, 2003). Each person received 20 hrs of therapy per 5 day week, and were followed up after

release at 6 and 12 months. The results from GRT treatment reported that participants in the study who are survivors of sexual abuse or physical abuse showed greater productivity psychologically and in refraining from substance use providing evidence that trauma-informed intervention was most beneficial when the participants had themselves experienced trauma (Saxena et al., 2014).

According to Ford, Chang, Levine, and Zhang, (2013) victims of traumatic events and issues correlating with PTSD can experience affect dysregulation which are defined as abnormally strong emotions that can range from fear to anger. Many incarcerated individuals suffer from comorbid psychiatric problems and many institutions utilize group therapies to treat these issues, when in fact, individuals who have suffered trauma need something more effective that focuses on multiple stressors. Trauma Affect Regulation Guide for Education and Therapy (TARGET) is a therapy that teaches participants succeedent affect regulaton skill sets (as cited in Ford & Russo, 2006). It is taught to strengthen affect regulation by identifying and balancing negative emotional states and permeate positive emotional well-being (Ford, Chang, Levine, & Zhang, 2013). The study has shown to be effective in group sessions with juvenille offenders in confinement as well as inpatient settings (as cited in Ford & Hawke, 2012; Marrow, Knudsen, Olafson, and Bucher, 2012). As noted by Ford, Steinberg, and Zhang (2011), TARGET has also shown promising results with women in poverty suffering from PTSD and girls in the juvenile detention system during individual therapy.

During this study, TARGET was used to determine the efficacy of focusing on affect regultion with incarcerated women suffering from PTSD (Ford et al., 2013). A secondary focus of TARGET was to assess it and Supportive Group Thearpies (SGT)

efficiency in the reduction of mental health indications and psychosocial problems that are often present along with PTSD and relative to affect dysregulation (Ford et al., 2013). Out of 197 screened women 80 met the criteira to be included in the study and showed that those who were diagnosed with full or partial PTSD had reduced severity of symptoms and improved on psychiatic symptoms and psychosocial functioning outcomes (Ford et al., 2013). However, full remission from PTSD occurred for only 12% to 23% of participants (Ford et al., 2013).

2.2 Method

The method that was utilized was Qualitative Interpretive Meta-Synthesis (QIMS). For this methodology to be most effective required gathering qualitative research on the topic of CSA, PTSD, Sexual Trauma, and Incarceration. QIMS is the process of compiling a collaboration of qualitative studies while avoiding the use of clusters of quantitative data. In doing so making sure to notate any changes that come about on the position or condition of the topic (Aguirre & Whitehill Bolton, 2013). The end result is to combine the relevant information into a coherent whole in order to create a theory, system, or intervention (Aguirre & Whitehill Bolton, 2013). This method is in the infancy stages of utilization, but as it was designed to cater to the field of social work it is becoming more relevant to the profession and the way studies are conducted. To begin QIMS a research question must be formed. Then a sample of qualitative research must be chosen (Appendix A). From there begins analytic steps of extraction of the theme, theme synthesis, triangulation, and credibility reporting (Appendix B) (Aguirre & Whitehill Bolton, 2013).

.

CHAPTER 3

RESULTS

Analysis of the five articles resulted in the emergence of five themes. These themes capture the impact of sexual victimization on multiple female participants varying in ages. Some studies included the perspective of caseworkers as well, in relation to the discord that can impede one's life as a victim of sexual trauma. The seven themes were; Trading Myself, Help Resembles Past Abuse, Substance Use as a Coping Mechanism, Relapse Versus Relationships, Childhood Abuse, Abuse as an Adult, and Recovery (Appendix C).

3.1 Trading Myself

Several participants throughout the articles detail the hurt and pain from trading themselves whether sexually, emotionally, mentally, or physically for perceived love, drugs or alcohol, and basic needs. As stated by a 15-year-old individual who was a victim of Domestic Minor Sex Trafficking (DMST): "Yes, I did it but it was not necessarily my intention. I slept with men for drugs and money for other things. Some were boyfriends and some were other men" (Perkins & Ruiz 2016, p. 177). Another participant reported how the fear of being alone influenced her decision to use: "I don't want to lose him. So I felt, I'm going to do the drugs with him… I don't want to be left alone again" (Rivaux, S., et al 2008, p. 966). One teenager details how her friends use their bodies in a negative way: I never have… But my friend has sex to get things she wants. It is the only way she feels loved and get what she wants (Perkins & Ruiz 2016, p. 177). Also, a victim of DMST states: "Yes, I gave sex four times to two different people for heroin. But then one time I

went to get some heroin from these people and they forced me to give oral sex, anal sex…they physically forced me and threatened me. I knew these people, they were like family. Thankfully some other friends came to get me" (Perkins and Ruiz 2016, p. 177). And finally, another participant tells a horrific tale of her breaking point; "I had laid awake the night before with all three children on the couch, trying not to fall asleep. I had to keep myself up…Because he had threatened my life and the children and his…I was lying there thinking, 'Wow. I never thought this would be me having to do this'…and I just knew that was my boundary" (Rivaux,. et al 2008, p. 966).

3.2 Help Resembles Past Abuse

As many of these women have some type of involvement with the justice system, some have been exposed to male authoritative figures in the system who mimicked the trauma these women had previously endured. Many found that it was a hindrance to their healing as stated by a woman female substance user who was entered into Alcohol and other Drug Treatment (AOD): "I'm glad that this service is all women because it is the only way I could talk about my past experiences; if services are mixed, women are inhibited and all sorts of sexual dynamics are set up" (Salter and Breckenridge, 2013, p. 170). One worker of a program imposed by the justice system stated: "Some services even seem to perpetuate feelings of abuse" as there is a "hierarchical structure of people who can sanction and punish you for the things that you do" (Salter & Breckenridge 2013, p. 167). One participant in a court ordered program realized the effectiveness of gender responsive treatment in stating: "There is definitely something to be said about the emotional energy that exist in a women – only service. Women are thinking of that same perspective – not that a man couldn't, but if a man were here it would trigger a whole bunch of new stuff that

we'd have to cope with. That we don't want to, because there is an element of safety being around women" (Salter and Breckenridge, 2013, p. 171).

3.3 Substance Use as a Coping Mechanism

Without a foundation of therapy to process past and current traumas in life, many women choose to utilize drugs and alcohol to numb the pain and cope with the feeling of being violated as given in examples by study participants: "I found out he was with his ex-girlfriend the night before. This is the cause of a lot of my problems. The drinking is because he blows me off, so I started drinkin" (Johnson et al., 2013, p. 7). Another study participant stated: "That is my coping skill is to drink and drug when I am feeling insecure about myself." (Johnson et al., 2013, p. 7). A lady reported her reasonings for drinking as; "I didn't want to feel depressed anymore and I know if I drink I won't feel anything" (Johnson et al., 2013, p. 7). Many of the participants felt as this one individual did about her usage: "It just helped me cope with my situation" (Johnson et al., 2013, p. 7). As circumstances spiraled out of control the following participant notated this: "First, I'm homeless. I had no place. I had no job. So I was just drinking" (Johnson et al., 2013, p. 8). One individual knew she needed help with the abuse but the help she found was but found this out as she sought help for it: "I was steered toward drug and alcohol services even though I wasn't seeking help for the pot. I wasn't allowed help for the abuse until I dealt with the pot" (Salter and Breckenridge, 2013, p. 171).

More often than not, trauma has had influence in decisions to use as reported by one participant: "The majority of women using drugs would've had some sort of trauma. Most have had a shit upbringing. You don't hear very often 'I don't know why I use. I've had a great upbringing" (Salter & Breckenridge 2013, p. 168). This woman realized that

there was something beyond the surface as she details: “Crack was an escape…a symptom of the problem…I was molested by my biological father from age four to sixteen” (Rivaux et al., 2008, p. 963). One woman discusses how she felt substance use helped her: “It blocked a lot of stuff out. Everything I was going through, the hurt or the pain or anything…it just wasn’t there when I was using” (Rivaux et al., 2008, p. 964).

3.4 Relapse Versus Relationships

It is commonly found in some unhealthy relationships that substances are used as a “bonding tool” and can bring about a false sense of happiness and hope for change in an otherwise toxic situation. It perpetuates a cycle of co-dependency as shown by some research participants past relationship interactions: “I started using because…I wanted to fit in with what he was” (Rivaux et al., 2008, p. 965). This participant states what she feels happens when she denies herself: “It’s not a coincidence that he came into my life and I relapsed. Anytime I trade myself… that’s not being true [to myself]…so I have to drink” (Rivaux et al., 2008, p. 963). Some, such as this participant discuss boundaries they have learned to set: “If he can’t support [my recovery] and he can’t change life with me, then there’s no relationship for us” (Rivaux et al., 2008, p. 969). One woman details her struggle to refuse drugs around her intimate partner: “I mean, at first, I was like, ‘no no no no’. Then he did it, and I smelled it, I just had to have it. I couldn’t; I said oh, hell with it, gimme some” (Johnson et al., 2013, p. 8).

This participant tells how she links trauma to her substance use: “Probably since the time I was 30, I had problems with my drinking…I’ve had very difficult relationships with men… The drinking has always been, just kind of gone hand-in-hand with the abuse, and I don’t know if its that I’m trying to repress the anger or not believe that its bothering

me as much. I have problems dealing with, um, emotions and so this helps me not have to feel the pain as much" (Nehls and Sallman 2005, p. 371).

3.5 Childhood Abuse

So many women experience traumatic childhoods that are inundated with stories of abuse. At such a young age, their minds are not fully capable of processing what they are enduring, and substances introduced soon become ways to block the pain as detailed by study participants:

"I think the first time I got drunk I was 8 years old and me and my dad sat down and drank a case of Leinies longnecks [beer]. And he was certainly never abusive with me but his whole attitude was he was partying and if you wanted to party that was okay with him… At age 10 I could drink my dad's poker buddies under the table. And so, um pretty much from the time I was 10, I was partying with my older stepsister smoking weed, taking pills…I'd pretty much do anything I could get my hands on…I mean I would drink everything I could lay my hands on and take every kind of pill I could get a hold of and I was pretty much continually stoned on weed. And, ah, well, and that all made it easier to deal with what was going on at home. When I was about 11 my stepfather started sneaking into my room at night and feeling me up and stuff. I never said anything for a variety of reasons. One of them was I remember how poor we had been before my mother married him. I was just hugely terrified of him [stepfather]. Neither of my parents ever hit us – ever. And I had never seen a parent beat a child until they [stepfamily] moved in with us and ya know stepdad got pissed off at the boy one day, and went after him with a bullwhip. And I mean, beat him, beat him till the kid was bleeding. He had welts for a week. And just that terrified, that just terrified me. I, I was in terror of this guy and my mother had promised

us that [name] would never be able to hit us like that. But ya know, well mom wasn't always home" (Nehls and Sallman 2005, p. 370).

This young teenager discusses her run ins with older men that led to mental health issues, poor boundaries, and substance use: "When I was 14 I started dating a man 10 years older who beat me…I always thought that, I don't know if I got this from my folks or what, but it made me feel like he must really love me if he gets that jealous" (Nehls and Sallman 2005, p. 370). This young lady associates relationships with abuse and drug use starting with her parents: "I was married into it. Every relationship I got into was more abuse, more drugs. That was the only relationship I knew – being slammed up against the wall and having a black eye that was love – from Mom and Dad that was the way of life" (Nehls and Sallman 2005, p. 371). Finally, this young lady details how abuse at a young age affected her well-being: "I attempted suicide at fifteen. The suicidality became more pressing and I became more emotionally tumultuous over the pot. I was hospitalized for a few days or a week and I disclosed [sexual] abuse there. They didn't help much" (Salter and Breckenridge 2013, p. 168).

3.6 Recovery

For many, more often than not, recovery came through a court order from the justice system or child protective services to regain custody of their children. Some also may be coerced by family into treatment. Unfortunately, being forced into rehabilitation is not always a viable option, particularly when the program providing the help is flawed:

"[In the service I attended] other patients were either paroled or had been in jail and didn't want to be there. Other addicts had responsibility for running the service which seemed to be 'slave labour called therapy' – even the food was out of date…lots of bullying and

coercion and lots of intrusion from staff stopping or controlling contact with family and other professionals. Other clients had behaviour problems, and there were no segregation of genders. There were four male clients verbally attacking me in the group meeting which made me feel like going and having a drink. I decided to leave when I realized I was pregnant and the staff would not let me see a doctor" (Salter and Breckenridge, 2013, p. 168).

A service worker described how the program was not beneficial in recovery: "In AOD services, treatment positioned the female 'addict' in contradictory ways: held responsible for their AOD use on the one hand, while being considered incapable of exercising agency and choice on the other due to 'addiction'. Treatment frequently included the goal (and sometimes the requirement) of abstinence, despite the fact that the cessation of AOD use for abuse survivors can have catastrophic implications. AOD can provide sexually abused girls and women with a way of regulating the psychological and emotional impacts of abuse and experience feelings of confidence and belonging in interpersonal relations that might otherwise elude them. At worse, AOD treatment may deprive sexual abuse victims of a vital coping strategy, exposing the victim to intolerable memories or feelings that may prompt self-harm and/or suicidality" (Salter and Breckenridge, 2013, p. 168).

Another service worker commented: 'We reject clients of the basis of their destructive behaviour, problems with other clients. I guess if they had the inability to tolerate difficult emotions, because our programme does bring up a lot of emotions for women who have used substances to push those emotions aside. If they don't have stable accommodation to return to – that's another exclusionary criterion I guess, when they have

absolutely no supports in the community, we would exclude them as well. You wouldn't want to open up all this stuff for them, only to have them return to a community where they have no support. I mean, that is a problem. There is a lack of resources out there for these women, and the majority doesn't have the financial means to seek therapy on an ongoing basis" (Salter and Breckenridge, 2013, p. 168).

A service worker of a program that allows children to be with the mothers during recovery stated: "In our services, the woman is our client and her recovery is our focus. This can mean she forsakes her children if obligations or worry regarding her children seem to compromise her recovery. Making decisions regarding care of children – for example 'putting up with' a poor relationship, accepting financial support, even fighting to get children back – can be framed as 'selfish' and not in keeping with recovery. In one case recently, it was thought that doing things to care for a grown child was not in her interests, that is, in the interest of her recovery" (Salter and Breckenridge, 2013, p. 169).

For many women an opportunity to get help and have their children with them is welcomed, but this female participant details how a flawed system made it a hindrance to the mother and children to heal: "They say they're child friendly but it's not. Mothers here are more stressed. There is nothing for them (the kids), no TV, they're stuck in the house unless they go to school. There's no programme for them. They go into a playroom when the mothers are in groups but they're bored. One mother took off 'cos her 7- year old was bored witless. One boy has hungered for attention. He is better now that another kid is here. But they are desperate to watch TV. Staff put pressure on mothers to keep kids occupied and be a good parent, while the parent is sick and that's why she's here. They have to do chores, like they're in the kitchen but the kids are in there too screaming and the parent

will be in trouble if dinner is not done. It is really unfair for parents and children. Others are not allowed to give help 'cos it's their responsibility. Parents are really stressing and others are upset by it. I miss my kids. I hear a girl is coming in. There were boys before and that was ok. I don't know if I can handle being here without my daughter. I feel like leaving" (Salter & Breckenridge, 2013, p. 169).

A young teen mother tells how a department meant to help but missed the opportunity: "I'm thinking even with DoCS [child protection services], when they intervened with my son…I didn't get pointed in any direction. It was all about dirty urines and court. I was 16 when I had my son and just didn't know. Not all mothers that use are bad mothers. They need guidance unless the child is in immediate threat of harm. If service had worked with me, I'd have been really willing to break the cycle then. I pretty much gave up hope. It was a really big opportunity missed" (Salter & Breckenridge, 2013, p. 170).

Another mother tells her encounters with Department of Children Services during her addiction: "I have a son, and DoCS intervened saying I needed clean urines to keep him. They didn't give me no help, no counseling, no welfare. I couldn't stop using and we went to court and he was taken out of my care. All I was told was 'stop using' but I couldn't. I had a DoCS worker but no counsellor…They wanted me to go to parenting classes but the parenting wasn't even related to the drug use. They said do A, B, C, then I did that and there was more to do. I just ended up using. Now he is with his grandparents permanently and I have a relationship with him thank god. I thought he was better off without me. I suffered at mum's hands and I didn't want that for him. But him being taken away enabled me to use more" (Salter & Breckenridge, 2013, p. 170).

One young woman tells the objections she received about utilizing counseling during recovery: “The way it was explained to me was that funding didn’t allow us to look at the abuse and that counselling would be complicated due to the pot use. I was steered towards drug and alcohol services even though I wasn’t seeking help for the pot. I wasn’t allowed help for the abuse until I dealt with the pot. I went to a private hospital and walked out after a few days as they refused to talk about the abuse without me giving up the pot. Where I’m going with this is that I have continued to seek help and I can’t find someone who understands the needs of both issues” (Salter & Breckenridge, 2013, p. 171).

This participant realized the effectiveness of genuine help for her healing: My counselor at [place] is, like I said, the first person who really got to know me. She really and truly listened as to how I felt and not how everybody else felt or what everybody else thought was right. And my treatment was really personalized. I set my own goals…and I think that that was one of the things that made me feel so incredibly comfortable was that everything was about me. It wasn’t about anybody else. It wasn’t about her making a hundred dollars an hour or anything. It was all about me…And the fact that she would talk a little bit about her own life made me feel more comfortable about mine. I’m not the only one…She was incredible. I felt really, really comfortable with her…Um, and of all the doctors that I talked to when I was in school and all the different counselors, she was by far the only person who I think really and truly got to know me for who I was…She really, really helped me become my own person and see the strength that I had inside of me versus what I thought I needed to have…just daily activities I couldn’t do…She was very nonjudgmental and really made me feel like I mattered” (Nehls and Sallman, 2005, p. 375).

Another participant gives her account on mental health and substance use: “I mean the trauma and the substance abuse cause your mental health to be weakened…it’s a triangle, or you can see it as three circles inner, inner connecting so that they’re connected and they influence each other. I like the three-circle idea. I have to draw it to be able to talk about it. So let’s put mental health in the middle and substance abuse over here, and, ah, trauma here. Mental health alone would be wellness but with trauma and substance abuse, mental health is, you’ve got illness then. So you need treatment. You need the treatment for your substance abuse. You need the treatment for trauma, you need treatment for the mental health…they’re intertwined…you start out as a seed and you grow and you look like a very strong tree, but some people have or some trees have a disease, they’re diseased. And on the outside they look perfectly well, but on the inside there’s this rot. And it’s getting them. And so if the wind comes along, a strong enough wind, it will knock them over and you’ll see on the inside of the tree that there’s been this rotting away of the soul of the tree so to speak. Um, the trunk of the tree is indeed diseased. The disease is mental illness, the trauma, the substance abuse and how it’s affected me. If the disease isn’t treated, it’s going to kill me. It will do great harm and probably cause my death someday” (Nehls and Sallman, 2005, p. 375).

Another participant in the study tells how sexual abuse has affected her and her decision about recovery: “I’ve got so much to lose at this point in my life and I don’t know if I am capable of hanging on to it. I think everybody should have mental help…everybody should see a psychiatrist or a psychologist or some sort of person like that. I think they work wonders, but sexual abuse is something. I think, yes it happened to me. Yes, I’m a victim, but I’m not being a victim right now. And look at me…I think I’m doing okay now,

maybe when I'm 45 and something happens. I watch a program and I just can't take it anymore and then I need to go into therapy, then let me. But right now, don't make me" (Nehls and Sallman, 2005, p. 376).

CHAPTER 4

DISCUSSIONS

The intent of this study was to highlight the importance of programs that can effectively identify victims of sexual trauma and provide adequate care that will greatly reduce recidivism amongst this population that is often incarcerated for drugs and alcohol or participating in the sex industry crimes. When penalized instead of rehabilitated, women are again revictimized through the justice system and treatment programs for situations that were results of their sexual trauma.

Based on the results of this study survivors are often left to deal with the aftermath on their own. This often often leads to criminal records for drugs, alcohol and sex industry crimes, as many have adopted these ways as a means to cope and survive. “The majority of women using drugs would’ve had some sort of trauma. Most have had a shit upbringing. You don’t hear very often ‘I don’t know why I use. I’ve had a great upbringing” (Salter & Breckenridge 2013, p. 168).

4.1 Conclusions

As stated by participants and workers in the treatment programs, an increased rate of success was found for the participant when they were placed in gender-based settings. These findings propose that creating and implementing gender-based treatment will provide the best opportunity for participants to work through the traumatic events they have faced. “There is definitely something to be said about the emotional energy that exist in a women – only service. Women are thinking of that same perspective – not that a man

couldn't, but if a man were here it would trigger a whole bunch of new stuff that we'd have to cope with. That we don't want to, because there is an element of safety being around women" (Salter & Breckenridge 2013, p. 171).

Women who participated in various treatments which were either court mandated or conditions of getting their children back from Child Protective Services spoke the same disapproval of the way they were treated and that the curriculum promoted did not foster the change for true rehabilitation. Some decided that the way they were treated resembled past abuse they had experienced, and the risk of being revictimized was greater than the reward. This further validates treatment protocol for sexual trauma victims should be re-evaluated and treatment should be specifically tailored to the issues developed from the effects of sexual victimization and reformed to produce effective outcomes.

A service worker stated, "In AOD services, treatment positioned the female 'addict' in contradictory ways held responsible for their AOD use on the one hand, while being considered incapable of exercising agency and choice on the other due to 'addiction'. Treatment frequently included the goal (and sometimes the requirement) of abstinence, despite the fact that the cessation of AOD use for abuse survivors can have catastrophic implications. AOD can provide sexually abused girls and women with a way of regulating the psychological and emotional impacts of abuse and experience feelings of confidence and belonging in interpersonal relations that might otherwise elude them. At worse, AOD treatment may deprive sexual abuse victims of a vital coping strategy, exposing the victim to intolerable memories or feelings that may prompt self-harm and/or suicidality" (Salter & Breckenridge 2013, p. 168).

As research stated previously, gender focused treatment that involved female participants proved to be more successful than that which was co-ed. When formulating a program that works with survivors of sexual trauma it is important to realize that there is always the possible threat of sexual tension between clients in the program or between the client and the therapist. Some of this can perpetuate from those who have experienced sexual trauma, especially at a young age have been taught that sex can be a way to manipulate. If this is not recognized when developing interventions, it can prove to lead back to old harmful habits for those survivors. “I’m glad that this service is all women because it is the only way I could talk about my past experiences – if services are mixed, women are inhibited and all sorts of sexual dynamics are set up” (Salter & Breckenridge 2013, p. 170).

Childhood abuse is a heinous crime committed against those who are not capable of defending themselves. The research correlates that childhood abuse poses a higher risk of the victims being involved later in adulthood in drug or alcohol abuse, intimate partner violence, as well as in the sex industry either by force, coercion, or self-will. In order for change to occur, the issues at hand must be identified and addressed. “I was married into it. Every relationship I got into was more abuse, more drugs. That was the only relationship I knew – being slammed up against the wall and having a black eye that was love – from Mom and Dad that was the way of life” (Nehls and Sallman, 2005, p. 371).

When an individual has faced trauma in their life, they often turn to self-medication and in some cases it is whether they have received professional counseling or not. This form of self-treatment is what many victims of sexual trauma use in effort to forget or not feel the physical and emotional pain that comes with what they have endured. And as it

shows, many who have endured sexual trauma may continue to use even when they have been removed from the situation or have been presented with help, this has become their current coping mechanism. “It blocked a lot of stuff out. Everything I was going through, the hurt or the pain or anything…it just wasn’t there when I was using” (Rivaux et al., 2008, p. 964).

Trauma bonds can be formed when an individual remains in an abusive relationship despite the danger and becomes conditioned and addicted to the highs and lows. Research shows abuse is not always physical, it can be emotional, psychological, sexual, and neglect. For many, the scars developed will be around long after the physical ones have healed, creating dysfunction in other areas of their lives if the proper behavior modification therapy is not introduced. In many of these traumatic situations drugs or alcohol have been involved and are a part of the trauma bonding: “Probably since the time I was 30, I had problems with my drinking…I’ve had very difficult relationships with men…The drinking has always been, just kind of gone hand-in-hand with the abuse, and I don’t know if its that I’m trying to repress the anger or not believe that its bothering me as much. I have problems dealing with, um, emotions and so this helps me not have to feel the pain as much” (Nehls and Sallman, 2005, p. 371).

Successful recovery in life can only be successful if there is awareness of what you are needing to recover from. This is detrimental for a productive recovery process for those who have experienced sexual victimization and substance abuse. To treat a sexual trauma victim for substance abuse only in most cases would be equivalent to putting a band-aid on a gun wound. The individual is still going to be in pain, they will continue to bleed, and the wound could get infected, and at worse they could die. It is the same with substance

abuse, if the root of the choice to use is not discovered, processed, and worked through the individual cannot heal, and this too can lead to death. "I mean the trauma and the substance abuse cause your mental health to be weakened…it's a triangle, or you can see it as three circles inner, inner connecting so that they're connected and they influence each other. I like the three-circle idea. I have to draw it to be able to talk about it. So let's put mental health in the middle and substance abuse over here, and, ah, trauma here. Mental health alone would be wellness but with trauma and substance abuse, mental health is, you've got illness then. So you need treatment. You need the treatment for your substance abuse. You need the treatment for trauma, You need treatment for the mental health…they're intertwined…you start out as a seed and you grow and you look like a very strong tree, but some people have or some trees have a disease, they're diseased. And on the outside they look perfectly well, but on the inside there's this rot. And it's getting them. And so if the wind comes along, a strong enough wind, it will knock them over and you'll see on the inside of the tree that there's been this rotting away of the soul of the tree so to speak. Um, the trunk of the tree is indeed diseased. The disease is mental illness, the trauma, the substance abuse and how it's affected me. If the disease isn't treated, it's going to kill me. It will do great harm and probably cause my death someday" (Nehls & Sallman 2005, p. 375).

CHAPTER 5

IMPLICATIONS FOR FUTURE PRACTICE

The research gathered in this paper shows implications for practice that will be summarized in this section. While substance abuse is a serious issue that spans across all races, ethnicities, genders, and socioeconomic statuses, the correlation of how sexual trauma plays a large factor with those being incarcerated for substance use and sex industry crimes has far too long been ignored. The data from women who have been revictimized either through rehabilitation facilities contracted by the criminal justice system or child protective services has shown there are critical flaws in the current available programs.

The research from survivors, as well as workers in the system highlight many of the same issues that should be addressed and used to develop an effective program that will assist these women in recovery. The literature details the lasting effect that sexual trauma from any stage in life can have on its victim and the benefits of gender specific treatment while focusing on the trauma primarily before integrating substance use counseling into treatment.

Many of the study participants who have children discussed how though they may have strained relationships due to the trauma in their lives, they still wish to be involved with their children or regain custody. Finding a way to rehabilitate the women while including their children into some part of the therapy would beneficial in helping the women to complete the program. And utilizing age appropriate therapy with the children

to identify any issues they may have developed stemming from the mother's trauma could be effective to the family healing as a whole.

5.1 Future Research

It is still undetermined within the prison system how many women who have been incarcerated once or more and endured sexual trauma, could have avoided imprisonment if they were properly identified as victims and treated as such. Finding a way to identify these women at an early stage of the destructive behavior could lead to a reduction in overcrowded prisons, recidivism, crime, neglect of children and further destruction of family systems. The recognition of the problems associated with sexual trauma could break through many barriers that affect future generations and their well-being. Further research on sexual trauma and the mental and emotional repercussions it produces to not only the victim, but the family will open avenues to discuss, and develop highly effective programs to rectify the damage inflicted on often innocent individuals through the effects of this heinous crime.

APPENDIX A

STUDIES

Study	Author/Year	Method	Sample	Setting	Sexual Victimization	Addiction
Women, trauma, and substance abuse: Understanding the experiences of female survivors of childhood abuse in alcohol and drug treatment	Salter & Breckenridge, 2013	Qualitative Interview	13 women 3 men	Rehabilitative Services	CSA	Alcohol and Drug Addiction
A Group learning intervention into how women learn empathy in prison	Kilgore, 2001	Qualitative life history interview/ Qualitative and action research approach	24 women	Texas State Penitentiary	Physical Abuse, Sexual Abuse, Severe Neglect	Drug and Alcohol Use
"I know if I drink I won't feel anything": Substance use relapse among depressed women leaving prison	Johnson, J. et al 2013	Qualitative analysis	15 women	Northeastern State Prison	Major depressive disorder	Co-occurring substance use
Women's early recovery: Managing the dilemma of substance and IPV Relationships	Rivaux, S. et al 2008	Qualitative study	17 women	Residential substance abuse treatment center	Intimate Partner Violence	Co-occurring substance use
Women living with a history of Physical and/or Sexual Abuse, Substance Abuse, and Mental Health Problems	Nehls & Sallman 2005	Qualitative Interview, Heremeneutics	30 women Ages 19-65	In or near a midwestern city in the US	Physical Abuse, Sexual Abuse,	Co-occurring substance use
Domestic Minor Sex Trafficking in a Rural State: Interviews with Adjudicated Female Juvenile	Perkins & Ruiz 2016	Qualitative Interviews	40 Juvenile Females Age 14-19	Residential facility for adjudicated females	Sex trafficking	Co-occurring substance abuse problems

APPENDIX B

ORIGINALTHEMES

Authors (Year)	Original Themes
Salter & Breckenridge, 2013	• Independence and Responsibility: children as a form of dependency • Treatment in context: gender and intersubjectivity
Kilgore, D 2001	• Empathy as a Logic of Practice • The Prison as a field of Learning Empathy • Intimacy with Authority • Arbitrary Application of Discipline and Punishment • A Lack of Trust Among Inmates • Challenging Prison Logic with Group Learning

Johnson, J., et al 2013	• **RELAPSE TRIGGERS**
	  • Difficulty in romantic relationships
	  • Uncomfortable emotions
	  • Mental Health problems
	  • Substance illness
	  • Lack of housing and employment
	• **RECOVERY FACILITATORS**
	  • Support
	  • Avoiding relapse triggers
	  • Clean time from prison or fear of future legal sanctions
	  • Treatment
	  • Motivation and confidence to make changes in substance use
	  • Increased self-awareness and self-care
	  • Housing and employment
	• **RECOVERY BARRIERS**
	  • Barriers to accessing support
	  • Challenge with treatment
	• **DESIRED TREATMENT**
	  • Addressing comprehensive needs
	  • Provision of transition supports
	  • Not wanting to be in a locked environment

Rivaux, S., et al 2008	• Damaged Goods • Paying the Price • Trading Myself • Walking from the Nightmare • Hoping but Not Quite Believing • Who's In Charge Of My Life

Nehls & Sallman
 	
2005
	• **Being Thrown**
	  • The cycle of Abuse
	  • Being Thrown as a Child
	  • Being Thrown as an Adolescent
	  • Being Thrown as an Adult
	• **Living Life Fearfully:** A Restricted World
	• **Helping:** Hearing my Story

Perkins & Ruiz 2016	• Non-Self -Trafficked Youth • Survival Sex • The Need to Feel Loved

APPENDIX C

NEW OVERARCHING THEME

New, overarching themes	Extracted Themes and subthemes with citations
Trading myself	• Trading Myself (Rivaux., et al, 2008) • Survival Sex (Perkins & Ruiz, 2016) • The Need to Feel Loved (Perkins and Ruiz, 2016)
Help resembles past abuse	• Treatment in context: gender and intersubjectivity (Salter and Breckenridge, 2013) • 'Surrender to treatment': agency, passivity and the female 'addict' (Salter and Breckenridge, 2013)
Substance use as a coping mechanism	• Difficulty in romantic relationships (Johnson, J., et al, 2013) • Uncomfortable emotions (Johnson, J., et al, 2013) • Mental health problems (Johnson, J., et al, 2013) • Substance Illness (Johnson, J., et al, 2013) • Lack of housing and employment (Johnson, J., et al, 2013) • Treatment in context: gender and intersubjectivity (Salter & Breckenridge, 2013) • 'Surrender to treatment'; agency, passivity and the female addict' (Salter & Breckenridge, 2013) • Damaged Goods (Rivaux, S., et al, 2008) • Paying The Price (Rivaux, S., et al, 2008)
Relapse versus Relationships	• Paying The Price (Rivaux, S., et al, 2008) • Trading Myself (Rivaux, S., et al, 2008) • Hoping But Not Quite Believing (Rivaux, S., et al, 2008) • Realapse Triggers; Substance Illness (Jonhsnon, J. et al, 2013 p. 7) • Recovery Facilitators; Support (Jonhsnon, J. et al, 2013 p. 9) • Being Thrown as an Adult (Nehls & Sallman, 2005 p. 371)
Childhood Abuse	• Being Thrown as a Child (Nehls & Sallman, 2005) • Being Thrown as an Adolescent (Nehls & Sallman, 2005) • Being Thrown as an Adult (Nehls & Sallman, 2005) • Treatment in context: gender and intersubjectivity
Abuse as an Adult	• Who's in Charge of My Life? (Rivaux, S., et al, 2008) • Being Thrown as an Adult (Nehls & Sallman 2005
Recovery	• 'Surrender to treatment': agency, passivity and the female 'addict' (Salter & Breckenridge 2013, p. 168 • Independence and responsibility: children as a form of dependency (Salter & Breckenridge 2013, p. 169) • Independence and responsibility: children as a form of dependency (Salter & Breckenridge 2013, p. .169) • Treatment in context: gender and intersubjectivity (Salter & Breckenridge 2013, p. 171) • Helping: Hearing My Story (Nehls & Sallman 2005, p. 375) • Waking From The Nightmare ((Rivaux, S., et al, 2008 p. 968)

REFERENCES

Ahrens, C. C.-T. (2007). Deciding whom to tell: Expectations and outcomes of rape survivors' first disclosures. *Psychology of Women Quarterly, 31*, 28-49.

Basile KC, S. S. (2014). Center For Disease Contro*l.* Retrieved from cdc.gov: https://www.cdc.gov/violenceprevention/sexualviolence/definitions.html

Bloom, B. O. (2003). Gender-responsive strategies: Research, practice, and guiding principals for women offenders. Retrieved from National Institution of Corrections: https://nicic.gov/gender-responsive-strategies-research-practice-and-guiding-principles-women-offenders

Breidling, M. J. (2014). Prevalence and Characteristics of Sexual Violence, Stalking, and Intimate Partner Violence Victimization. *Atlanta: Center for Disease Control* .

Carson, E. (2014). Prisoners in 2014. Washington, D.C.: *Bureau of Justice of Statistics*.

Carson, E. a. (2012). Prisoners in 2011. Washington, D.C.: *Bureau of Justice Statistics*.

Dutton, M. A., James, L., Langhorne, A., & Kelley, M. (2015*). Coordinated Public Health Initiatives to Address Violence Against Women and Adolescents. Journal Of Women's Health*, 80-85.

Estes, R., & Weiner, N. (2002). National Plan to Prevent the Sexual Abuse and Exploitation of Children. Retrieved from Prevent Together .Org: http://www.preventtogether.org/Resources/Documents/NationalPlan2012FINAL.pdf

Ford, J., Chang, R., Levine, J., & Zhang, W. (2013). Randomized Clinical Trial Comparing Affect Regulation and Supportive Group Therapiesfor Victimization-Related PTSD With Incarcerated Women. Behavior Therapy,p. 262-276.

Gray, S., & Rarick, S. (2018). Exploring Gender and Racial/Ethnic Diffrences in the Effects of Child Sexual Abuse. *Journal of Child Sexual Abuse*, p. 570-587.

Heath, N. L. (2011). Silent Survivors: Rape Myth Acceptance in Incarcerated Women's Narratives of Disclosure and Reporting Rape. *Psychology of Women Quarterly,* p. 596-610.

Herbst, J. H., Branscomb-Burgess, O., Gelaude, D. J., Seth, P., Parker, S., & Fogel, C. I. (2016). Risk Profiles Of Women Expereincing Initial And Repeat Incarcerations: Implications For Prevention Programs. Atlanta: The Guilford Press.

Kirkpatrick, D. G. (2018, November 3). The Mental Health Impact of Rape. Retrieved from *National Violence Against Women Prevention Research*: https://mainweb-v.musc.edu/vawprevention/Mental%20Health%20Impact%20of%20Rape.html

Messman-Moore, T.L., Walsh, K.L., DiLillo, D.K. (2010). Emotional Dysregulationand Risky Sexual Behavior in Revictimization. Faculty Publications, *Department of Psychology*.582., p. 968

Moloney, K., van den Bergh, B., & Moller, L. (2009). Women in prison: The central issue of gender characteristics and trauma history. *ElSEVEIR Health*, p. 426-430.

NASW Delegate Assembly. (2018, November 3). *National Association of Social Workers.* Retrieved from socialworkers.org: https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

Page, J., & Murphy, W. D. (2017). The Safer Society Handbook of Assessments and Treatment of Adolescents who have Sexually Offended. Safer Society Press.

Roe-Sepowitz, D., Bedard, L. E., & Pate, K. (2008). *The* Impact of Child Abuse on Dissociative Symptoms: A Study of Inccarcerated Women. *Journal of Trauma & Dissociation*, p. 7-26.

Saunders, B. E., Kilpatrick, D. G., Hanson, R. F., Resnick, H. S., & Walker, M. E. (1999). "Prevalence, case characteristics, and long-term psychological correlates of child rape among women"*: A national survey. Child Maltreatment*, *4*(3), 187-200.

Saxena, P., Messina, N., & Grella, C. (2014). "Who Benefits from gender-Responsive Treatment. Criminal Justice and Behavior" p. 417-432.

The National Center For Victims of Crimes. (2018, September 14). Retrieved from Victims of Crime: http://www.victimsofcrime.org/media/reporting-on-child-sexual-abuse/child-sexual-abuse-statistics

Yuan, N. K. (2006, March). *National Online Research Center on Violence Against Women*. Retrieved from VAWnet.org: https://vawnet.org/sites/default/files/materials/files/2016-09/AR_PsychConsequences.pdf

BIOGRAPHICAL INFORMATION

Tamnika Walton earned her first degree of an Associates of Applied Science in Mental Health and Substance Abuse at a local community college. She chose to further her education by pursuing an Honors Bachelor of Social Work at the University of Texas at Arlington so that she can help others. Tamnika has chosen to dedicate her career to helping vulnerable populations, but has a special interest in researching the effects of sexual trauma in the development of individuals from childhood into adulthood in the criminal justice system. Tamnika plans to continue on with her studies and attain a dual Master's degree in social work and criminal justice. Upon completion she will then work towards becoming a Licensed Clinical Social Worker and developing a curriculum for therapeutic interventions for sexual trauma victims to be utilized in the corrections system. It is Tamnika's plan to continue research on this subject and to branch out to determine how parenting skills of incarcerated women are affected by sexual trauma and the development of the children to those parents in the corrections system.