

SURVIVAL STORIES: RELATIONSHIPS OF JUSTICE-INVOLVED WOMEN
WITH HISTORY OF TRAUMA

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ABSTRACT

Over one million women are incarcerated in local and county jails or placed under community supervision of the criminal justice system in the U.S. each year. Women with history of incarceration have higher rates of many chronic and infectious diseases, and their access to health care is often complicated by mental illness, drug addiction, and significant lifetime history of trauma. Systemic barriers, including cost, restricted availability, and confusing fragmentation of services and care make access difficult for justice-involved women. Little is known about how women navigate support after and between incarcerations to survive. In this study, I explored justice-involved women's perceptions and management of informal sources of social support through narratives of interpersonal relationship.

Minimally structured, story-eliciting interviews were conducted with 10 jail-incarcerated and recently released women with history of lifetime trauma. Interviews were analyzed using thematic and structural narrative inquiry techniques, and two explanatory models were derived. The first model described women's use of opportunizing talk and fatalizing talk in embedded trauma stories as a reflection of their perception of self-and-other in the process of support-seeking. The second model focused on empowerment and entanglement, prominent themes through which women organized perceptions of the outcomes of support-seeking through social bonds, specifically in stories of housing need.

For nurses and other care and service providers who work with justice-involved women, the models for understanding women's perceptions of support provide insight into how effective and ineffective practices take shape and may point to better targeted care planning, program design, and policy advocacy.

APPROVAL PAGE

The faculty listed below, appointed by the Dean of the School of Nursing and Health Studies, have examined a dissertation titled “Survival Stories: Relationships of Justice-involved Women with History of Trauma,” presented by Amanda Marie Emerson, candidate for the Doctor of Philosophy degree, and certify that in their opinion it is worthy of acceptance.

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CONTENTS

ABSTRACT	iii
LIST OF TABLES	ix
LIST OF ILLUSTRATIONS	x
ACKNOWLEDGMENTS	xi
Chapter	
1. INTRODUCTION	1
Study Purpose and Specific Aim	1
Research Questions	2
Definition of Terms	2
Theoretical Basis	5
Conceptual Framework and Assumptions	6
Reflexivity: Positioning and Power	9
Significance and Rationale	12
Chapter Overview	14
2. REVIEW OF THE LITERATURE	16
Literature Review, Part 1: Three Facets	16
Literature Review, Part 2: Theories Relevant to Trauma-informed Interventions with Jail-incarcerated Women	27
To Advance the Field	46
3. METHODS	48
Study Design	48
Procedures	51
Analysis and Interpretation	54
Evaluation: Trustworthiness	56
Summary	58

4. OPPORTUNIZING AND FATALIZING: SELF AND OTHER	
IN THE TRAUMA NARRATIVES OF JUSTICE-INVOLVED WOMEN	60
Abstract	60
Introduction	61
Methods	67
Findings	71
Discussion	98
Implications and Recommendations	100
Limitations	102
Conclusion	103
5. HOUSING FOR THE JUSTICE INVOLVED: EMPOWERMENT AND	
ENTANGLEMENT IN NARRATIVES OF SHELTER SUPPORT	105
Abstract	105
Introduction	107
Methods	114
Findings	118
Discussion	133
Implications and Recommendations	136
Limitations	138
Conclusion	139
6. CONCLUSION	141
The Unheard Stories of an Overlooked Population	142
Learning from Women’s Narratives	143
Limitations of the Dissertation Study	146
Conclusion	148

Appendix

A. PARTICIPANT CHARACTERISTICS.....	150
B. UNIVERSITY OF KANSAS MEDICAL CENTER IRB APPROVAL	151
C. APPROVED REQUEST TO RELY AGREEMENT.....	152
D. HUMAN SUBJECTS (CITI PROGRAM) TRAINING	155
E. INTERVIEW PROTOCOL.....	156
F. CODE LIST.....	158
REFERENCES.....	163
VITA.....	187

ILLUSTRATIONS

Figure	Page
4.1 Spectrum of self-efficacy in approaches to management of relationships in narratives of trauma.....	97

TABLES

Table	Page
2.1 Interventional Research: Treatments for Incarcerated Women with Trauma, 2003-2013	31
4.1 Opportunizing and Fatalizing Modes of Talk	104

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smoothed my way with the participants. Joi kept track of women once they signed on, scheduled interviews, and coordinated compensation. She was present for most of my interviews and field encounters, read all the interview transcriptions, and contributed to the focusing of my analysis of data and development of themes. Joi provided an ear when I was struggling and was always ready with her world-brightening smile and laugh—elements of what the SHE team affectionately calls “The Joi Effect.”

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CHAPTER 1

INTRODUCTION

On any given day, over one million women are under supervision in a U.S. jail, prison, or community corrections (The Sentencing Project, 2015). Justice-involved women form a marginalized population that carries a disproportionate disease and injury burden (Binswanger, Krueger, & Steiner, 2009; Centers for Disease Control and Prevention, 2011; Maruschak, Berzofsky, & Unangst, 2015). Few studies investigate justice-involved women's health care needs after release from incarceration, and even fewer seek to understand women's own perceptions of health and supportive services. This dissertation focused on stories told by justice-involved women with significant lifetime trauma about personal relationships in the context of managing health and safety risk. The goal of the research was to draw on justice-involved women's personal narratives to understand how they perceive and manage health and safety through social connections. The project works from the assumption that unpacking justice-involved women's stories about relationships can provide researchers and practitioners with otherwise inaccessible but essential information in caring for and creating health interventions to improve health and safety in a historically underserved and often overlooked population.

Study Purpose and Specific Aim

The purpose of the dissertation was to explore how women with significant lifetime trauma and criminal justice involvement perceive, manage, and assign purpose to social relationships under highly constrained material and psychic circumstances. Existing cross-sectional research has improved our understanding of the magnitude of health and safety threats and associated factors, but surveys do not lend much insight into how justice marginalized women—situated within social structures that render some options more visible than others—make choices that impact their safety and health. The specific aim of this project is to use story-eliciting interviews and narrative inquiry methods in an in-depth

examination of the relationship narratives of women with justice involvement and significant lifetime trauma exposure in order to discover how women so positioned perceive and manage interpersonal connections to mediate health and safety risk.

Research Questions

The research question posed in this dissertation was, “What do the relationship narratives of women with criminal justice involvement and history of interpersonal trauma tell us about their experiences of social support-seeking to manage health risk and prevent violence?” During data collection and analysis, the question was refined into subordinate queries: (a) what structural, thematic, and performative patterns emerged in narratives of interpersonal relationship as told by justice-involved women with trauma; (b) how did women’s constructions of interpersonal relationships intersect with beliefs, attitudes, and behaviors relevant to health problems; and (c) how did women’s relationship stories reflect on or respond to dominant cultural discourses around individualism and personal responsibility in the context of health.

Definition of Terms

The dissertation brings together concepts and methodologies from several disciplines. Here, I offer introductory definitions of key terms that will be encountered frequently along with some that require special note.

- *Justice-involved*: being or having been incarcerated in a jail or prison or living under formal correctional supervision in the community (i.e., parole, probation, house arrest). All the women in this study were selected from a larger study sample of women who were recruited during incarceration in an urban, county jail. Jails may be administered by cities, counties, states, the federal government, private entities, or some combination and generally hold persons sentenced to short-term (up to a year) detention, including persons held pending trial and/or sentencing and persons in violation of terms of a release (Phelps, 2002). Prisons

are run by county, state, or federal agencies and typically hold inmates convicted of felony sentences—usually entailing one year or more of incarceration (Phelps, 2002). Community corrections take a variety of forms, mostly supervised and unsupervised probation in this study. Probation is a conditional release that may mean required weekly meetings with a court-appointed probation officer, periodic and random drug testing, and/or the simple stipulation that any further legal entanglement reverts an offender back to incarceration (Kaeble & Glaze, 2016). Court-ordered drug treatment is another form of community correction reported by women in this study.

- *Narrative and story*: a narrative is a discursive construction made up of a series of temporally bounded events or conditions—a telling that includes a beginning, a middle (usually featuring some form of change or complication), and an end or resolution (Mishler, 1995). The delivery of narrative is flexible in that the narrator(s) may relate the parts of a narrative in other than chronological order. As distinct from narrative, a story refers to a teller's more purposeful crafting of setting, character, dramatic form, and purpose—the performative exposition of events or conditions that gives shape, flavor, and meaning to a narrative (Maynard-Moody & Musheno, 2009). These differences are often blurry in the literature (Riessman, 2008), and, except when specified, I have used story and narrative interchangeably in this dissertation.
- *Prostitution*: the exchange of sex acts for food, drugs, shelter, or other resources. The choice of prostitution as a term—rather than sex work, sex exchange, or commercial sex—has political implications. Farley and Kelly (2008), for example, argue for using the term prostitution instead of commercial sex or sex exchange, since the latter may obscure the extent to which prostitution is not a simple act of agency by a rational actor in a free market but a complex form of

exploitation in a market that is structured by an often gender-specific and oppressive lack of options (Höigård & Finstad, 1986). I use prostitution except where individual women used another term or stated another preference.

- *Social capital, social support, social networks*: social capital refers to the resources embedded within a network that can be mobilized by members (individually or collectively) to access institutional goods (Hawkins & Maurer, 2011); social support refers to resources exchanged within a network for the purpose of survival, making ends meet, or getting by (Briggs, 1998); and social network refers to the web of social ties that connect people to one another, through which social support flows and in which social capital resides (Hawkins & Maurer, 2011).
- *Trauma*: the psychic wounding that results from an event (also used metonymically to refer to the precipitating event itself) that a person experiences as likely to produce serious injury or loss of life, or the result of witnessing the same in someone close to them (Herman, 1992). Unresolved or non-integrated trauma may lead to symptoms of avoidance, numbing, increased startle response, flashbacks, and dissociation, which make it difficult for survivors to relate to others (Brewin & Holmes, 2003; S. J. Weiss, 2007). Complex post-traumatic stress refers to a more pervasive symptomology affecting self concept—often including self-blame and alienation—and results from events of violence that are sustained over an extended period, as in cases of abuse or captivity (Nickerson et al., 2016).
- *Vulnerable population*: a group that faces increased risk to health or well-being due to social marginalization (Flaskerud & Winslow, 1998).

Theoretical Basis

The research questions, data collection, and analysis methods for the study were based on constructivist and narratological foundations. These hold that people are active shapers of the raw material of experience, continually forming events and situations into personal narrative—sequentially ordered, spoken or written accounts of experience—that subsequently influence thought and behavior (Frank, 2010; Patton, 2015; Polkinghorne, 1988; Sandelowski, 1991). The process of narration depends on social context, including the storyteller’s socioeconomic, cultural, and historical standpoints as well as the interview situation itself (Gubrium & Holstein, 2009; Maruna, 2001; Riessman, 2008). That is, the various coordinates of the world in which a person forms a story help determine the themes and limit the terms in which the narrative is fashioned (Gubrium & Holstein, 2009; McAdams, 2006). Narrative inquiry techniques may not be scientific in a probabilistic or experimental sense, since they do not provide means to establish generalizations about a population. What they do make possible is access to perception and experience in form as well as content (Maynard-Moody & Musheno, 2014; Stake, 2003). In telling stories, research participants paint character, setting, action, and meaning and thus call out complexities of thought, feeling, and behavior that are less available in aggregated cross-sectional and experimental methods (Clandinin & Connelly, 2000). Additionally, because narrators work within—adapting and individualizing—existing narrative forms that they share with others in their sociohistorical moment, the stories they tell carry within them a rich sense of social and cultural context (Riessman, 2008). Finally, the underlying tendency of narrative inquiry is uniquely humanistic, for the approach assumes that everyone has a story to tell and that everyone’s story is worthy of being heard (Frank, 2010). This is especially key in health disparities research that seeks to discover useable health knowledge about a group for whom disenfranchisement and invalidation are too often dominant themes.

Conceptual Framework and Assumptions

A conceptual framework combines concepts from multiple theories to guide research questions and help explain phenomena (Imenda, 2014). In that way, a conceptual framework accords with what Denzin and Lincoln (1998) have described as the *bricolage* or “pieced-together” (p. 3) character of qualitative inquiry, in which investigators make choices based on emergent aspects of a research situation, the data it yields, and the tools at hand rather than working to prove or disprove a single pre-selected theory (Creswell, 2014). The conceptual framework that guided this study was assembled during the processes of interviewing and analysis of data, although I was also influenced from the outset by substantive concepts from nursing and public health, the literature on trauma and social support, and methodological concepts from the literature on narrative inquiry.

Nursing

A number of assumptions shaped this study. Broadly, I assumed that investigating the perceptions and narrative constructions of a vulnerable population in order to guide improved interventions to reduce risk of illness and violence constituted a legitimate and much needed endeavor within the compass of nursing research. Nursing is a diverse discipline of theory and practice unified by its concern with promoting the holistic well-being of persons and populations (American Nurses Association, 2010). I assumed that (a) personal narratives give otherwise difficult to access insight into emotional and social realities relevant to the nursing metaparadigm of person, environment, health, and nursing (Fawcett, 1984); and that (b) understanding these realities may yield information that is translatable into services and care that are better designed to reach women where they are at, that is, to help them maintain health and stay safe using strengths they already have (Lee, Fawcett, & DeMarco, 2016).

A related assumption is ethical. Namely, because of the professional mandate to advocate for equity and social justice (American Nurses Association, 2010), nursing and nursing research are charged with a particular obligation to pursue better ways to meet the

health needs of vulnerable populations (Schim, Benkert, Bell, Walker, & Danford, 2006). Nursing extends care to all who need it, and in cases of special need, nurses have a special mandate to assist (American Nurses Association, 2010). The population of women on whom my research focuses makes up a vulnerable population and thus a case of special need. Flaskerud and Winslow (1998) mapped three mutually reinforcing conditions as defining of vulnerable populations: limited access to resources, increased relative exposure to risk factors, and decreased health status. All three apply to justice-involved women, who as a group find themselves excluded from social and political power due to race, gender, class, and status (Reynolds, 2008).

Public Health and Health Promotion

While the dissertation works within the nursing metaparadigm, it is based as well on a public health orientation with health promotion objectives. My work is ultimately concerned with addressing challenges to the health and safety of a population. In keeping with public health assumptions, I hold that health challenges or impediments are multifaceted and dynamic, determined by social, economic, and political factors as well as individual behaviors (McEwen & Nies, 2011). I draw on principles of health promotion rather than those of biomedical and preventive medicine, which tend (though the labels are not exclusive) to target curative treatment of specific diseases through top-down actions initiated by health professionals (Povlsen & Borup, 2015). A health promotion perspective, as outlined in the World Health Organization's Ottawa Charter, emphasizes maintaining and facilitating health rather than curing disease, encouraging participation of individuals at all levels and sites of care, accomplishing equity of health and health care within societies, and enacting multiple strategies to better address multifactorial causes of health risk (Bunton, Nettleton, & Burrows, 2005; Povlsen & Borup, 2015; Thorlindsson, 2011; World Health Organization, 1986). A health promotion orientation assumes that the personal and interpersonal aspects of health behavior and behavior change are partly determined by

broader social and economic determinants, such as education, social economic status, and built environment (Pullis & Nies, 2011). Because this dissertation study was explorative, my purpose was to learn more from women themselves about how they conceptualize and manage relationships in their social environments. Its larger goal, however, was to add to our knowledge in order to improve the ability of nurses, other health and service providers, program designers, and policy makers to support women in answering the challenges of achieving or maintaining health and safety—ultimately through population-specific, health promoting services and programs. Meeting women where they are at with programs that derive from and speak to their own conceptualizations of health risk is the definition of a health promoting, public health stance, and the basis for patient-centered public health nursing.

Feminism

Feminist standpoint theory and its emphasis on relationality informed the study. Feminist standpoint theory reaffirms the centrality of ways of seeing, knowing, and experiencing the world to which women have been and to a large degree are still socialized (Hartsock, 1987). Central among these ways of being in the world for many women is relationality, the prioritization of ideals of connection, continuity, and cooperation over autonomy, disjunction, and competition (Freedberg, 2015). Relationality informs versions of feminist epistemology (Haraway, 2014) and is reflected both in approaches to scientific inquiry and to moral decision making in the feminist standpoint tradition (Gilligan, 1982; Harding, 2004; Miller, 1986; D. E. Smith, 1990). The relationalist aspect of feminist theory is particularly well aligned with the emphasis in this study on justice-involved women’s trauma experience, since trauma can be very much about disruption and injury to a person’s sense of coherency and connection (Comstock et al., 2008; Herman, 1992; Porter, 2015). Feminist standpoint and relational theory underlay the project as a whole and influenced my selection of methods, including the use of minimally structured, conversational interviewing, in which

I joined women in their environments and encouraged them to tell their stories as they chose, engaging with them in a relationship, not as interrogator but as discussant and advocate (Devault, 2004). Through the story-based analytical technique, I addressed women's experiences holistically, respecting their ways of selecting, framing, and conveying experience as well as extracting meaning from the content (Draucker & Martsof, 2010; Porter, 2015; Riessman & Quinney, 2005).

Reflexivity: Positioning and Power

I brought to this research identifications, values, experiences, and assumptions that derived from my own eclectic academic background and a comparatively privileged socio-economic position. These are part of who I am and had bearing on the questions, methods, and interpretations that made up this work. I am a White woman of middle age, no children, twice-divorced, with three prior degrees in English, including a PhD in American literature, and a more recent Bachelor's of Science degree in nursing. I have been a university professor of English and women's studies, a registered nurse, an advocate in a domestic violence shelter, and most recently a health disparities researcher. I come from a two-parent home in a middle-class, suburban community. I have never been abused, raped, or violently attacked in any way. No one in my immediate family has been the victim of a violent crime. I have never been sentenced to jail or prison or arrested or questioned by law enforcement for anything. I have no major chronic conditions and have only ever been operated on for removal of my gall bladder. I lived a little over half my life in the Midwest and half on the east coast. I am heterosexual, nontheistic, and non-religious. I am a progressive in my politics. I am a feminist.

In some ways, my life could not be more different from most of the women who were interviewed in this study. By virtue of socioeconomic and situational status, my position in most of the interviews was that of comparatively greater power. I tried to remain conscious of the potential for implicit class and racial biases on my part to affect interactions between

the women and myself and worked hard to establish trust by expressing openness and empathy. As is explained in Chapter 3, most of the women and I were already acquainted through their participation in the intervention portion of the parent study, which I helped to implement in the jails. I was further aided in establishing trust through the assistance Joi Wickliffe, MPH, project director for the parent study. Ms. Wickliffe is a gifted communicator with skills in cultural competence and trust-building. Because of her frequent contact with the women as part of the ethnographic arm of the larger study, Ms. Wickliffe provided entrée, helping to coordinate interviews for this study and attending many of them, where her presence often helped to put women at ease. The interview dynamic was affected by several other factors. One was that, in the moment of interviewing, a woman with a story to tell wields her own power. The largely open-ended, story-eliciting interviewing method used in the encounters meant that each woman controlled what she told and how she told it. Participants in the study gave shape to the interviews, determining the direction they took in answering questions. Indeed, at times, participants ignored the protocol questions altogether, reworded them, or got to them in their own time. Participants generally controlled the amount of time they spent on any one story or topic and often offered evaluation about how best to interpret their responses.

The analytical approach provided for some leveling of my influence as well, in that the narrative analytic approach calls for preserving stories *as* stories, as extensive segments of participant talk that urge attention to performative and structural choices as well as situational, cultural, and other contexts—instead of just mining for and extracting for themes or ideas that fit a thesis (Riessman & Quinney, 2005). By focusing on larger segments of text from transcriptions, narrative inquiry gives readers of the research more opportunity to judge the extent to which a researcher has convincingly interpreted a woman's narrative. Further, from my perspective, working with these more complete renderings of life events meant

having to reckon with differences between the women's ways of assigning meaning and value to situations and my own, since the narratives often included those evaluations.

To further sensitize myself to how my perspective might encroach on interpretations, I memoed reflectively on my responses to interviews and encounters in field notes and process memos, monitoring my perceptions and their potential to skew understanding of the women's stories. The process of building awareness around the impact of subjectivity was similar to but not the same as *bracketing*, commonly used in phenomenological and grounded theory studies, which endeavors not just to recognize but to more completely set aside or cancel out suppositions arising from researcher values and/or external knowledge about a phenomenon (Gearing, 2004). Instead of bracketing, I engaged subjectivity by using a sensitization and naming approach closer to what Manias and Street (2001) describe as common in critical ethnography, where “a researcher acknowledg[es] the subjective contribution of the researcher and [seeks] to reveal the power relations inherent within the research process” (p. 236). Such reflexivity is most apparent in places where I acknowledged my viewpoints or reactions to women's stories and where I indicated my more active contributions to the formation of narratives as they emerged during interviewing.

Power is a multidimensional concept that has been defined as embodied and relational, working at micro and macro levels in ways that are oppressive but also productive, especially of techniques of knowledge (Foucault, 1980). The project of sociological-ethnographic research—the tracking through phone and text and Facebook, the questioning and recording, the careful watching, the note taking and interpreting—all this rendering of life into knowledge is surely an exercise in micro techniques of power (D. Wilson & Neville, 2009). But power is also never total, and aspects of the data collection process, though on some level chosen by me, put participants in a position of influencing the pace, direction, and outcomes of our encounters. Interviews were often conducted at locations named by the participants, in their homes and neighborhoods, many of which were comfortable or at least

familiar to them but not to me. The women determined the length of the interviews, occasionally breaking off suddenly to let me know they were done. Such elements only lessen but do not eliminate the power differential that the research interview situation entails, for the fact remains that I performed data analysis and interpretation as well as the broader contextualization of the interviews with limited assistance from the women. It has been my charge to remain sensitive to and up front about how my choices in small and large ways impacted findings.

Significance and Rationale

The rates at which women enter and leave U.S. jails and prisons are higher than in any other country in the world and have been increasing, outpacing increases in men's imprisonment rates by 2.8% in 2013 (Carson, 2014; Minton & Golinelli, 2014; Walmsley, 2015). As a group, incarcerated women tend to be poor, young, unmarried, have children, and have low educational attainment (DeHart, Lynch, Belknap, Dass-Brailsford, & Green, 2014). Race plays a role in that women of color are incarcerated at more than two times the rates of white women (Sabol, West, & Cooper, 2009; The Sentencing Project, 2015). In general, women offenders tend to be sentenced more often for property crimes; status offenses and terms violations; and minor drug possession, sales, and use infractions than for violent offenses like murder or armed robbery (Belknap, 2007; Swavola, Riley, & Subramaniam, 2016). Women with criminal justice involvement are disadvantaged in health terms, experiencing higher rates of some chronic and infectious diseases and higher rates of mental health problems than either incarcerated men or women in the general population (Maruschak et al., 2015; Wildeman, 2016). On leaving incarceration, many justice-involved women have little choice but to return to home environments that are characterized by poverty and violence, where they run increased risk of injury, illness, and death (Binswanger et al., 2007; Freudenberg, Daniels, Crum, Perkins, & Richie, 2005; Massoglia, Pare, Schnittker, & Gagnon, 2014). Justice-involved women may receive help from formal social

services after release, but such support tends to be fragmented and uneven (Binswanger, Nowels, et al., 2011; Lorvick, Comfort, Krebs, & Kral, 2015; Mallik-Kane & Visher, 2008). Given the limited availability of formal support for women in and after jail incarceration, this study sought to capture—through perceptions, sense-making, and management of informal, interpersonal relationships in narrative—how justice-involved women act as their own health risk managers.

Although not a hypothesis-testing study, this research builds from the underlying proposition that women imaginatively construct and manage interpersonal relationships in ways that impact their attitudes and behaviors around safety and health. The significance of such work is that, despite their numbers and the seriousness of the challenges they face, and despite the high costs to women, their families, and their communities of overlooking or failing to help them meet their needs, justice-involved women tend to have few institutional champions. After being released from incarceration, their struggles become largely invisible, with the services and resources that are available to them too often underfunded and poorly administered. Aggregated data from surveys may capture the broad outlines of what women need post incarceration, but numbers cannot convey the texture of women's lives or how women perceive and emotionally manage their choices. Program design and administration of services for women during and after incarceration would benefit from a fuller and more nuanced understanding how women in this population variously build and maintain relationships for social support. Especially for nurses and others whose practice is in health care, health promotion, or the design and implementation of community health services, there is particular value in knowing how members of a socially and economically marginalized population construct narratives of interpersonal relationships that inform their risk attitudes and prevention behaviors. Better tailored social services programming and better targeted health messaging built on such understandings may prevent illness and save lives.

Chapter Overview

The dissertation is organized as a single study that includes this introduction, a review of literature, explication of methods, two findings chapters presented as article manuscripts, and a conclusion.

Chapter one introduces the study, including the theoretical and conceptual background, definitions of terms, research questions, and significance of and rationale for the inquiry as a whole.

Chapter two presents a two-part literature review. In the first section, I review (a) published research on the physical and mental health challenges of and the health services environments in which justice-involved women navigate health care and (b) relevant social support, social capital, and social network studies that document how underresourced populations meet their needs when formal systems are lacking. The second part of chapter two presents a published review of theory—relational-feminist, trauma, and addiction—as it is applied in interventional research with jail-incarcerated women.

In chapter three, I present methods of the study, including description of the narrative inquiry study design and the relationship between the interview study and the interventional parent study. I describe the rationale for the selection and recruitment of participants, measures taken to ensure human subjects protection, detailed descriptions of data collection and analysis procedures, and I offer discussion of evaluation criteria.

Chapter four comprises an article manuscript in which I derived a model of women's presentation of self-other in embedded trauma stories from the interviews. Opportunizing and fatalizing talk map a continuum of agency in women's constructions of support-seeking. The model contributes to our understanding of how justice-involved women with history of trauma perceive and manage self-in-representation in high stress situations where support seeking is complicated by scarcity of resources.

Chapter five presents a second article manuscript, in which I derived a model from justice-involved women's stories of shelter seeking post-incarceration. In this model, intertwined themes of empowerment and entanglement characterized women's perceptions and constructions of obtaining housing assistance and revealed the unhealthy, unsafe side of accessing social network connections for basic resources. The model pointed to the importance of advocating for greater access to post-incarceration public support, especially shelter, and provided a framework within which nurses and other care providers working in the community might begin to help justice-involved women struggling to meet the challenge of housing recognize and minimize entangling situations while developing those that promise more empowerment.

The final chapter sets forth the conclusions of the project and the research gaps it sought to fill and reaffirms the importance of using women's perceptions and women's stories to gain insight into challenges they face and potential ways of meeting them.

CHAPTER 2

REVIEW OF THE LITERATURE

This chapter is organized into two major sections. In the first, I present a review of the literature that addresses three primary facets of the dissertation as they pertain to justice-involved women. I address (a) the literature on health and health care for women with justice involvement; (b) the literature on trauma among justice-involved women; and (c) research concerning social capital, social support, and social networks with a special focus on research investigating how women in low socio-economic situations mobilize informal access to resources. In the second main section of this chapter, I present a published review in which I critiqued the application of three theories in interventional research for trauma exposed, incarcerated women: trauma theory, relational theory, and addiction theory (A. M. Emerson & Ramaswamy, 2015).

Literature Review, Part 1: Three Facets

Health and Health Care for Justice-Involved Women

Spending time behind bars has been associated with a variety of risks to women's health and the health of the communities in which they live (Clear, 2007; Freudenberg, 2001, 2002; Freudenberg et al., 2005). Bureau of Justice statistical reports document higher rates of diseases such as arthritis, asthma, hypertension, hepatitis, and heart problems among female than male prisoner populations (Maruschak, 2006) and higher overall rates of chronic medical problems in jail-incarcerated women (66%) than jail-incarcerated men (48%) (Maruschak et al., 2015). Rates of some infectious diseases are also higher among correctional populations, especially sexually transmitted infections (Centers for Disease Control and Prevention, 2011; Clarke et al., 2006). Human immunodeficiency virus (HIV) and hepatitis C (HCV) affect incarcerated women at higher rates than women in the general population, with HCV rates for women estimated to be 35-50% among prison releasees (Altice & Bruce, 2004; Maruschak, 2006). That women who spend time in jail and prison

suffer more as a group from alterations in health than women without histories of incarceration was the conclusion reached by a recent latent-class analysis of secondary data from a national drug and health survey (Vaughn, Salas-Wright, Delisi, & Piquero, 2014). In that study, researchers detected a latent group of justice-involved women who experienced significantly higher rates of asthma, hepatitis, lung cancer, and sexually-transmitted disease than female respondents in a normative (not drug- and not justice-involved) group (Vaughn et al., 2014). Incarceration has been independently linked to increased mortality for justice-involved women (but not men) in the U.S. (but not other developed nations), even after controlling for factors such as criminal activity before incarceration, health status, health insurance, and demographic characteristics such as race and education (Massoglia et al., 2014; Wildeman, 2016). And high incarceration rates have wider effects as well, with associations suggesting negative impacts on families—especially children (Wildeman & Turney, 2014)—and on the health of urban communities where returns are heavily concentrated (Freudenberg, 2001).

During incarceration, prisoners experience difficulty gaining access to health services (Wilper et al., 2009). Secondary data analysis of Bureau of Justice national surveys of jails and prisons has shown, for instance, that out of the one in five inmates who were taking a prescribed medication for a chronic condition upon admission, 64% were no longer taking the medication by release (Wilper et al., 2009). For many who do receive medication or treatment for physical, mental health, and substance abuse conditions while in jail or prison, release often means an interruption in that care (Dumont, Brockmann, Dickman, Alexander, & Rich, 2012; Fox et al., 2014; Mallik-Kane & Visser, 2008). Wang et al. (2008), reporting on after-care health service access for persons discharged from the San Francisco County Jail, found that 42% experienced disruptions in care during the transition back into the community, and this percentage included an oversampled HIV+ group (52%) who received mandated discharge planning. Though some have argued that involvement with the criminal

justice system improves the chances of health care for the uninsured and underinsured, research has not borne this out for women (Wildeman, 2016). Nor does health care access improve as a result of contact with the criminal justice system in the form of probation and parole. Lorvick et al. (2015) found drug using, justice-involved women in the community had higher odds of health disparities, lacked health insurance, and were less likely to receive basic health care than drug abusing women who were not justice-involved. The only difference between the two groups in terms of health services was that the women on probation and parole received HIV testing at higher rates (Lorvick et al., 2015). Research specific to women's experience has shown that, in the tumultuous period of reentry, women prioritize children, housing, employment, and transportation, leaving non-emergent health care needs for a more stable time (Freudenberg et al., 2005; Ramaswamy, Upadhyayula, Chan, Rhodes, & Leonardo, 2015).

The reproductive health of women with justice involvement merits particular note since Bureau of Justice Statistics data indicate that women in U.S. jails suffer from STDs at a rate of about 6.1%, a full 2.6 percentage points higher than women in the general population (Maruschak et al., 2015). Chlamydia, gonorrhea, and syphilis, and hepatitis C are more common among women with incarceration histories than women with none, according to one meta-analysis of prevalence studies (Kouyoumdjian, Leto, John, Henein, & Bondy, 2012). Importantly, women with STDs are at higher risk for more serious conditions including increased susceptibility to HIV infection, infertility, life-threatening ectopic pregnancy, liver disease, and cervical cancer (Centers for Disease Control and Prevention, 2011). Indeed, women in jails and prisons suffer from cervical cancer at rates four times higher rates than women without histories of incarceration (Binswanger et al., 2009). Like HIV, cervical cancer can be deadly, but it is also a preventable and treatable disease that occurs more often in justice-involved women for numerous reasons, including higher rates of associated risks such as substance use, interpersonal violence and abuse, prostitution, and lack of screening

and follow up after screening (Binswanger, Mueller, Clark, & Cropsey, 2011; Clarke et al., 2007; Hindin, Btoush, Brown, & Munet-Vilaro, 2015). As with other aspects of health care for justice-involved women, unmet reproductive health care needs are a problem for women and their families, and missed opportunities for prevention mean costs to the community (Hammett, Harmon, & Rhodes, 2002).

Mental Health: Substance Abuse and Trauma in Justice-involved Women

Mental health care for women in the criminal justice system is also poor. In the decade or so following President Reagan's de-institutionalization of state-run mental hospitals in the 1980s, a number of studies investigated rising prevalence of mental illness among imprisoned women (Teplin, Abram, & McClelland, 1996). These included in particular a focus on posttraumatic stress disorder (Zlotnick, 1997) and severe psychological distress from signal life events (Keaveny & Zauszniewski, 1999). More recent studies have supported earlier claims that incarcerated women as a group suffer from posttraumatic stress disorder (PTSD) and somatic and anxiety disorder symptoms at higher rates than women in the general population, including one systematic review of research from 1998 to 2013 that found methodologically strong studies generally indicated higher rates of PTSD and major depression for women inmates than women in the general population (Prins, 2014). Incarcerated women fare worse than incarcerated men when it comes to mental illness, showing higher PTSD rates than men (Drapalski, Youman, Stuewig, & Tangney, 2009), and, for other serious mental illnesses like bipolar disorder, double the rates (Steadman, Osher, Clark Robbins, Case, & Samuels, 2009). Bureau of Justice statistical reports have consistently supported similar findings (James & Glaze, 2006; Maruschak, 2006; Noonan, 2010), as have life history studies like DeHart et al.'s (2014) in which interviews with 115 incarcerated women indicated that 51% suffered from PTSD at some point in their lives, while 57% met criteria for a serious mental illness.

Implicated with trauma, substance abuse disorder is among the most common mental health issues experienced by justice-involved women and represents a formidable barrier to both health and desistance from crime following incarceration (Mallik-Kane & Visser, 2008). In a systematic review involving 13 studies and 3,270 female prisoners, estimated prevalence rates for substance abuse disorder among women ranged from 30% to 60% (Fazel, Bains, & Doll, 2006). Binswanger et al.'s (2010) secondary analysis study of national survey data found similarly that justice-involved women's rates of substance dependence reached 59.2%. Alcoholism and drug addiction have been specifically associated with history of trauma in qualitative inquiries like those of DeHart et al. (2014), Fedock, Fries, and Kubiak (2013), and Fuentes (2014), all of which related that women who suffered from trauma symptoms often reported that they abused alcohol and illegal drugs as a way to cope with the effects of lifetime abuse and violence. Substance abuse may dull the perceived effects of lifetime trauma, but, for women who may be additionally disadvantaged by lack of resources, addiction can also lead to re-traumatizing involvement in illicit economies, including the drug and/or prostitution trades (Logan, Walker, Cole, & Leukefeld, 2002).

The most recent national general population surveys of violence against women reported 1.9 million physical assaults against women annually (Tjaden & Thoennes, 2000). Lifetime rates of completed rape against women were 18%, with 54% of those attacks having occurred before victims were 18 years of age (Tjaden & Thoennes, 2000). Trauma resulting from interpersonal violence is even more prevalent in justice-involved samples and represents a continuing physical and mental health risk for many women who have been incarcerated (Lynch et al., 2014). Psychosocial trauma among incarcerated women often results from childhood sexual and/or physical abuse, adult assault and chronic abuse, rape, and/or threats of serious injury or death (Grella, Lovinger, & Warda, 2013). One large cross-sectional study ($n = 806$) of women released from a jail substance abuse program in a large urban jail system found 53% reported greater than five lifetime traumatic events (Scott,

Coleman-Cowger, & Funk, 2014). In research to test an integrated treatment for trauma and substance abuse among women in a California prison, Sacks et al. (2008) learned that in their sample of 314 women prisoners 98% had had at least one life-time traumatic experience, with 75% of those events involving sexual violence. B. L. Green (2005) documented a 90% trauma prevalence rate in a sample of 100 justice-involved women, including 50% who reported childhood sexual abuse. In another study, Cusack, Herring, and Steadman (2013) examined the role of PTSD as a mediator for drug use in jail diversion participants with a history of sexual assault. Using a clinician administered diagnostic tool, 60% of the women in the study met criteria for PTSD, with lifetime rates of sexual assault at 67% (Cusack et al., 2013). To contextualize these findings, consider that Briere and Elliott (2003) reported a still remarkable 32% prevalence of childhood sexual abuse in a large general population survey, and Grella et al. (2013) cited 15% childhood sexual abuse prevalence among women in the general population using data from the 2004-2005 National Epidemiological Survey on Alcohol and Related Conditions. Rates for traumatic sexual violence in the lives of justice-involved may thus be roughly two to four times higher than the non-involved population. During incarceration, moreover, women with history of trauma face potential retraumatization in a corrections environment that emphasizes control, security, isolation, and punishment over rehabilitation, restoration, and connection (Gadow, 2003; Harner & Burgess, 2011). And on release, the cycle continues, since women meet with few options during transition back into the community and often have few options but to return to persons and situations that make them vulnerable to further violence (Kellett & Willging, 2011; Leverentz, 2010; Richie, 2001).

The high prevalence of lifetime trauma among incarcerated women, along with the general lack of professional, individualized psychological care for all but those with dangerous mental disturbances, means a large population with unmet, chronic, life-disrupting physical and mental health care needs (Hegadoren, Lasiuk, & Coupland, 2006). A majority

of jail inmates return to the community within weeks (Potter, Lin, Maze, & Bjoring, 2011; Spaulding et al., 2011), so that what might be an easy-to-access population for services and treatment quickly becomes dispersed. Once discharged, justice-involved women with significant trauma history are no more likely to receive the support they need after release than they were while incarcerated, and—withstanding the many weaknesses of carceral health care systems—some have argued that they may be even less so (Colbert, Sekula, Zoucha, & Cohen, 2013; Dumont et al., 2012; Lorvick et al., 2015).

What the literature shows is a substantial population of women, vulnerable to mental and physical illness, compounded or in some cases caused by multiple lifetime experiences of interpersonal abuse and violence. The women, often with poor coping skills and few accessible institutional resources, find scant assistance from official systems of support. Yet many women survive, even in contexts of extreme instability and scarcity. Some of what enables survival must have to do with management of informal social resources, but there is little research addressing how that happens, specifically among members of a population of repeat offenders with high trauma exposure. Studies that do address the needs of justice-involved women either explore the situation of women while incarcerated or they assess women's needs post release only using survey tools. As for more in-depth views from women's own perspective, Richie's (2001) landmark study on women's needs after incarceration, now over 15 years old, remains, with a few exceptions (Colbert et al., 2013), one of the only in-depth looks at how women themselves conceive of their needs. It was the purpose of this dissertation to inquire more deeply into how women manage their support networks and how they conceive of their relationships as intersecting with health and safety. My purpose was not at all to suggest that informal social support might replace institutional support. Rather the point was to discover whether what women themselves understand about their ways of managing relationships can ultimately be leveraged by nurses and other care providers to create—or advocate for—more accessible, better targeted, formalized support.

Social Support, Social Capital, and Social Networks

The literature on the shape, value, and uses of social connections by individuals in moments of crisis or enduring need is both voluminous and amorphous. In this section, I briefly define social capital, social support, and social network theory and discuss some ways the concepts have been combined in research with economically marginalized women.

Very broadly, *social capital* describes resources that an individual or group has by virtue of social relationships that are governed by norms of reciprocity or exchange (Szreter & Woolcock, 2004). Hawkins and Maurer (2011) defined social capital as a “by-product” (p. 356) enjoyed by individuals, communities, and institutions as a result of formal and informal social interactions. Such definitions combine (and possibly obscure differences between) the three classic versions of social capital developed by Bourdieu (1986), Coleman (1988), and Putnam (2000), which placed the locus of capital diversely, in the individual versus the network, and defined the nature of social capital diversely, as reinforcing the outcomes of actions (i.e., by facilitating transmission of information, exerting influence, certifying social credentials, and legitimizing claims) (Lin, 1999). From a social network perspective, social capital may derive from *bonding* (close, strong connections among members of a homogeneous, socially equal group), *bridging* (weaker connections between members of heterogeneous but socially equal groups), or *linking* (connections between members of heterogeneous groups with different levels of access to institutional power) network ties (Briggs, 1998; Szreter & Woolcock, 2004).

Social support refers to a particular kind of social capital, namely received or perceived access to resources that enable an actor to cope with stressors (Lourel, Hartmann, Closon, Mouda, & Petric-Tatu, 2013). Social support has functional (i.e., providing intimacy, reciprocity, and contact) and structural (i.e., social integration, involvement, connection) dimensions (Lourel et al., 2013; Uchino, 2004) and may have either direct or indirect/buffering effects on a person’s ability to adapt to circumstances (Uchino, 2004).

Social networks are the webs of relationship in which social capital in the form of social support reside (Hawkins & Maurer, 2011). Social networks are composed of ties to others which may be weak or strong, near or distant, active or latent (Uehara, 1990). In social network theory, the shape, density, and extent of ties have much to do with the resources and options that are available to those within a network and can influence behaviors (Savage & Russell, 2005; Uehara, 1990). Key concepts in social network theory include reciprocity, density, intensity, and encapsulation, the last three being variable features of ties and the first describing a characteristic principle by which resources are exchanged in social networks in general (Uehara, 1990). Finally, network connections have variable valence, with positive and negative outcomes not necessarily mapping respectively onto strong and weak ties as might be expected (Granovetter, 1973).

For women and men who have been incarcerated, social and economic adjustment at all points can be tremendously difficult: during the upheaval attending arrest and impoundment; the commotion following release; and later, when the stigma of a criminal record may impede a justice-involved person's ability to get a job, housing, or social benefits (Uggen, Manza, & Behrens, 2013; Western, Braga, Davis, & Sirois, 2015; Western & Pettit, 2005). Leverentz's (2010) research with women living in a transitional group home following discharge from prison indicated that, even in a transitional programs in which housing was provided, women struggled to overcome stigma and to organize support for transportation, employment, and health care. While institutional social support services exist for women, they are rarely (except in some cases for persons who are HIV+ or involved with drug court) coordinated or sustained (Green, 2005). Informal sources of support from family, friends, and other interpersonal ties may be available in such situations but they vary significantly. Mallik-Kane and Visser (2008) documented, for instance, that informal social support after release from prison may be offered more readily to men than women, especially support in the form of housing. This is concerning, since not only are women often seeking to

resume care of children after discharge, but findings suggest that women are particularly prone to substance abuse relapse and lessening interest in health maintenance when housing is uncertain post release (Ahmed, Angel, Martell, Pyne, & Keenan, 2016).

Social capital has been defined as “what we draw on when we get others, whether acquaintances, friends, or kin, to help us solve problems, seize opportunities, and accomplish other aims that matter to us” (Briggs, 1998, p. 178). The social capital of individuals may come in the form of social support, which can be used to “get by” or survive, or in the form of social leverage, which helps a person “get ahead” or improve their lot (Briggs, 1998). These categories are roughly coincident with Putnam’s (2000) notions of bonding capital, which refers to social capital that is available laterally within a network, usually through strong ties within a socially homogeneous group (i.e., family, close friends), and bridging capital, also mostly lateral, but based on less proximate ties, for instance with members of another social group (i.e., neighborhood, ethnicity, religion). Less common but arguably more useful for advancement out of a condition of poverty are vertical relationships that connect persons from different social levels in a social hierarchy (i.e., employer/employee, philanthropist/beneficiary) (Szreter & Woolcock, 2004). These form what Szreter and Woolcock (2004) call linking capital. For frequently incarcerated women with trauma exposure, social leverage occurs occasionally and social linking rarely: much more prominent is social capital in the form of bonding or social support (Domínguez & Watkins, 2003). Yet evidence suggests that even when persons in circumstances of persistent poverty, drug abuse, and/or mental illness receive social support from friends and family, that support may be complicated by a recipient’s inability to reciprocate or by exhaustion of connections due to expectations that are too burdensome for one side or the other (Nelson, 2000; Ray, 2015). For these and other reasons, the value of social support as a buffer against the negative health effects of stress may be decreased among the very poor (Moskowitz, Vittinghoff, & Schmidt, 2013).

In recent years, researchers have interrogated established understandings of how social support operates across networks in socioeconomically vulnerable populations by taking a second look at, among other things, the influential thesis developed in Stack's (1974) urban ethnography, *All Our Kin*. Stack's study of social networks found that among the impoverished, Black women she studied, informal (i.e., non-institutional) assistance came mainly from an intricate exchange system among family members and extended and fictive kin connections. These supportive relationships were organized around the concept of reciprocity or exchange. The form of reciprocity that Stack described fell within the compass of Uehara's (1990) "generalized exchange" (p. 526). In a network characterized by generalized exchange, return for support given may not be immediate or in-kind, but the generalized or assumed availability of support among members within a network produces a diffuse or systemic reciprocity. That is, social support resides in the network, not in ties between specific individuals. Revisions to Stack's thesis have come from a variety of directions in recent years. Some arguments hold that changes in the economy and social fabric of late capitalism have led to changes in expectations around reciprocity and the nature of social ties in low resource environments (W. J. Wilson, 1996), evaporating generalized exchange and leaving in its place more fragmented, contentious, transactional (Offer, 2012; Ray, 2015), or "restricted exchange" forms (Uehara, 1990, p. 526).

The current study set out to learn what light trauma stories told by justice-involved women with significant history of trauma might cast on women's perceptions and management of social support for health and safety. In this specifically constrained environment, what do women's stories have to tell us about the ways they perceive agency and relationship in the context of social support seeking; do their perceptions and the behaviors they narrate fit a pattern of durable bonding ties, or do they look more like fractured and disposable connections (Desmond, 2012; Offer, 2012), or what Menjivar (2000), writing of social support networks among Salvadoran immigrants to the U.S., has

referred to as the “fragmented ties” that stand in place of family bonds under repressive socioeconomic and political conditions? How do women frame and manage the possibility of social support in the context of trauma and around specific needs related to health and safety in the months following release from an incarceration? Such questions have rarely been explored in depth by researchers working with the justice involved, though they have clear implications for how public health, nursing, and social services are designed and administered for them.

Women’s incarceration in the U.S. has continued to number less than men’s, lingering at around 10-14% of overall incarceration, although women’s rates have increased more rapidly than men’s in recent decades (Guerino, Harrison, & Sabol, 2011). The experiences of women in incarceration and the pathways that lead them to and from entanglement with the criminal justice system differ in key ways from men’s (Fuentes, 2014; Kelly, Cheng, Spencer-Carver, & Ramaswamy, 2014; Simpson, Yahner, & Dugan, 2008). The prominence of trauma and abuse in the life histories of justice-involved women means that their experience of crime, punishment, rehabilitation, and especially the perilous period of reintegration back into families and communities deserve study in its own right. In the following section, I interrogated research on trauma-informed programs for incarcerated women to parse out three underlying theoretical orientations that, while not always identified in the research, help shape the field in which the present study seeks to intervene.

Literature Review, Part 2: Theories Relevant to Trauma-informed Interventions with Jail-incarcerated Women

Abstract

Purpose. The field of interventional outcomes research in programs designed to treat trauma in correctionally involved women involves contributions from researchers in a variety of disciplines.

Methods. In this review, we asked how recent interventional studies addressed 3 theoretical touchstones—relational cultural theory, trauma theory, and addiction theory.

Results. We found that few outcomes studies engaged theory directly on any of these points and concluded that the opportunity for field-defining debate may risk getting lost in a quest for numbers or outcomes.

Implications. We recommended that researchers more explicitly position their work, especially with respect to key theories and points of debate.

Key words: corrections, interventions, theory, trauma, women

Introduction

One million women are under correctional supervision in the U.S on any given day (The Sentencing Project, 2015). Women with criminal justice involvement bear a disproportionate burden of substance use, mental health problems, and personal trauma histories (Binswanger et al., 2009; Grella et al., 2013). Finding ways to address the needs of incarcerated women who suffer from psychological trauma poses a profound challenge that is shared by the criminal justice system, the public health and mental health care systems, and social support services. It is not one that has gone ignored, but because of the complexity of the issues and the diversity of sectors involved, effective coordination of efforts has been difficult to achieve. In this paper, we reviewed the theoretical arguments or assumptions of published interventional studies that test trauma-specific programs designed to assist women incarcerated in U.S. jails and prisons.

These programs target trauma directly by including the reduction of trauma symptoms as an objective (Covington, 2008; Tripodi, Bledsoe, Kim, & Bender, 2009). In all cases, researchers responded to a current trend to make criminal justice and the programs offered to women in jails and prisons more gender-responsive and trauma-informed. Since efforts to design gender-based, trauma-informed programs for incarcerated women come from different academic and practice-area sectors—as befits the multifactorial nature of the

problem—having some kind of stage-setting theoretical conversation, one that takes account of the different voices and theories that come together on the subject of women, trauma, and criminal justice, seems timely and requisite. The overall objective of the present analysis was to highlight common strands of theoretical emphasis—or the *absence* of theoretical drivers—in current, published interventional research that addresses trauma in incarcerated women.

Specifically, this review took a closer look at the theory and assumptions that researchers cited in the outcomes literature on trauma-informed, gender-based services for women in prison. We reviewed interventional studies to ask whether, how, and what kind of theory informs the ways in which this research is conducted and reported. We were especially interested to learn whether interventional research in trauma-informed women’s corrections gave more than superficial consideration to the implications of theory when discussing the purpose, methods, and outcomes of the interventions they trialed. Motivating this analysis is the supposition that without a cohering theoretical conversation, the pilot studies, programs, and controlled trials for treatment efficacy that researchers undertake will fail to impact the criminal justice system or its inmates in any meaningful way. Without theory to guide objectives and methodology, to provide, that is, a common ground for disagreement and growth, researchers risk losing track of *why* such emphases are necessary and fail to allow those emphases to guide what we actually do in the research.

Methods

The studies reviewed in this article were all published between 2003 and 2013. We reviewed only studies that tested experimental group-format treatments in carceral settings. The review focused on studies that themselves required significant (by the study’s measures) trauma history, symptomology, or post-traumatic stress disorder (PTSD) diagnosis in their inclusion criteria, and included trauma symptoms and/or PTSD diagnostic measures among outcomes. Using EBSCO, ProQuest, Scopus, and Medline indexes and reviewing abstracts

and then the articles themselves, we narrowed the search to 11 studies that met the review criteria.

The interventions reported in the studies were divided broadly into two categories: integrated services and trauma-only services. Integrated services referred to treatments that simultaneously addressed substance abuse disorders and trauma. Trauma-only services, as the name indicates, targeted trauma. Most of the studies were conducted as random-controlled trials, one used a wait-listed control design, several were quasi-experimental, and one was a program evaluation that included criteria and results that met the review criteria. In the comparison studies, most included random assignment to groups, although in some cases, because of the carceral setting, samples were assigned on the basis of prospective release or transfer dates.

All interventions took place in women's prisons and were conducted in a small-group format. The interventional curricula included skills-based, strengths-based, and risk-based treatment modalities. All interventions trialed in the studies reviewed here were cognitive-behavioral in their objectives and multi-modal in technique, combining psychoeducational, narrative, and role-playing methods among others. The interventions were all gender-responsive in their methodologies (Table 1).

Table 2.1. Interventional Research: Treatments for Incarcerated Women with Trauma, 2003-2013

<i>Study authors (date)</i>	<i>Type of study</i>	<i>Method</i>	<i>Theoretical Underpinnings</i>
Bradley & Follingstad (2003)	RCT	DBT and writing therapy	social learning theory staged recovery theory
Cole, Sarlund-Heinrich, & Brown (2007)	Quasi-experimental	SGT/psychoeducation/writing therapy	feminist theory relational theory trauma theory social learning theory staged recovery theory
DeHart (2010)	Descriptive/Evaluation	GRT and dream	cognitive self theory dream therapy logic model of group process social learning theory
Ford, Chang, Levine, & Zhang (2013)	RCT	TARGET	social learning theory
Kubiak, Kim, Fedock, & Bybee (2012)	Pretest/Posttest	Helping Women Recover & Beyond Violence	addiction/integrated treatment theory ecological theory psychoneurobiological theory social learning theory trauma theory
Lynch, Heath, Mathews, & Cepeda (2012)	Pretest/Posttest	Seeking Safety	addiction/integrated treatment theory social learning theory
Messina, Grella, Cartier, & Torres (2010)*	RCT	Helping Women Recover & Beyond Trauma	trauma theory social learning theory
Sacks, Sacks, McKendrick, Banks, Schoenberger, Hamilton . . . & Shoemaker (2008)*	RCT	GRT/Therapeutic community	addiction/integrated treatment theory social learning theory
Ward & Roe-Sepowitz (2009)	Quasi-experimental	Esuba	relational theory social learning theory staged recovery theory
Wolff, Shi, Frueh, & Schumann (2012)*	Pretest/Posttest	Seeking Safety	addiction/integrated treatment theory social learning theory
Zlotnick, Najavits, Rohsenow, & Johnson (2003)*	Pretest/Posttest	Seeking Safety	addiction/integrated treatment theory relational theory social learning theory
Zlotnick, Johnson, & Najavits (2009)*	RCT	Seeking Safety	addiction/integrated treatment theory social learning theory

Note. DBT = dialectical behavior therapy; GRT = gender responsive treatment; SGT = small-group therapy; *Integrated treatment.

Findings

In the following sections, we give accounts of the main theoretical arguments guiding the call for gender-responsive and trauma-informed services for women as articulated in a white paper that was published in 2002 by the Department of Justice. Authored by Barbara Bloom, Barbara Owen, and Stephanie Covington, the 140-page *Gender-responsive strategies: Research practice, and guiding principles for female offenders* mapped the theoretical grounds for gender-based changes in U.S. jails and prisons. For each of the three theoretical approaches—relational, trauma, and addiction theory—we described how authors of interventional literature engaged with theory in the consideration of program attributes as well as in the articulation of their own methodologies. We end by briefly calling out a tension that threads through a number of articles unannounced and that, were it more explicitly developed, would provide a productive arena for further discussion and debate.

Relational Cultural Theory. Bloom et al. (2002) traced relational theory back to the work of feminists of the mid-1970s and particularly to Carol Gilligan (1982) and Jean Baker Miller (1986). Relational cultural theory posits that women—whether as an essential expression of their womanhood, or as a result of socio-economic forces or social and cultural lessons specific to gender—tend to make choices based on the impact they will have on others (Miller, 1986; Bloom et al., 2002; Covington, 2008). This orientation toward connection with others stands in contrast to historically prominent constructions of the moral development of white men, which as research of Lawrence Kohlberg and others has suggested involves construction of a largely autonomous self situated in hierarchies of power, where moral decisions are made based on abstract principles of justice (Gilligan, 1982). Women, according to relational cultural theory, are more likely to base their self-concepts and moral identities on responsibilities undertaken within a web of relationships, where maintaining connections and cultivating group cohesion are of central concern (Miller, 1986; Gilligan, 1982). Relational cultural theory in the context of women and incarceration

underscores that gender-based experiences of violence and abuse, often beginning with one or multiple episodes of childhood sexual abuse and exacerbated by jail and prison stays, disrupt or distort women's ability to build and maintain relationships and thus impact women in especially devastating and gender-specific ways (Covington, 2008). These effects are also inflected by race. As sociologists and feminist theorists from Carol Stack (1974) to Patricia Hill Collins (2000) have pointed out, African American women have long found meaning, support, and even means for survival through networks of caring connection and reciprocity with one another and with men in their families, neighborhoods, and friendships. As Collins writes, "Historically, survival depended on sticking together" (p. 102). Collins acknowledges that such cohesion could at times suppress differences among black women, and thus stand in the way of self-expression, but she also emphasizes that safe spaces for self-expression for many black women have often existed in women's relationships with one another and in "friendships and family interactions" (p. 102). In combination with large-scale political and socio-economic trends, racially targeted incarceration has done much to disrupt and distort these connections (Alexander, 2010; W. J. Wilson, 1996). Bloom et al. (2002) and others have emphasized that a criminal justice system attuned to women's needs from a relational-cultural perspective will develop policies and procedures that foster rather than destroy connections and will implement treatment programs that build and strengthen relationships rather than isolating women and re-enacting the situations of control, intimidation, and abuse that often led them to become correctionally involved in the first place (Covington, 2008; Harner & Riley, 2013; Harris & Falot, 2001).

Discussion of relational cultural theory in the interventional studies was rare; however, we found the influence of relational cultural theory threaded throughout descriptions of program curricula and embedded in quoted responses from participant evaluations. The most pointed references to relational cultural theory appeared in Messina, Grella, Cartier, and Torres's (2010) pilot trial of *Helping Women Recover and Beyond*

Trauma, where the authors followed program designer Stephanie Covington's (2008) lead in stressing the influence of relationships in the lives of women and the role such relationships play in healing from trauma. Jean Baker Miller's foundational work from 1976 was cited by Messina et al. (2010), and specific characteristics of the Beyond Trauma treatment, including "same-gender environments, nonconfrontational and nonhierarchical programming" (p. 99) were ascribed to the objective of cultivating positive relationships. Sacks et al. (2008) similarly though less explicitly associated their adapted therapeutic communities approach with a gender- and relational-theory, encouraging "mutual respect rather than authoritarianism" in order to "avoid repeating past abusive relationships" (p. 242). Outcomes reported by Sacks et al. included incidences of trauma experienced in relationships posttest and at six months but included no contextualization of the results in relation to the curricula or other possible approaches. Messina et al. (2010) did not include outcome data relevant to relationships in the article reviewed here, but the authors referred to a separately published qualitative study (Calhoun, Messina, Cartier, & Torres, 2010) based on the pilot which reported that women who participated in the Beyond Trauma program felt supported by the group in exploring issues related to trauma and substance abuse.

In other interventional studies, relational cultural theory informed prefatory references made by researchers to the key role of relationships in the lives of women and in their responses to treatment. For example, Ward and Roe-Sepowitz (2009) described their experimental trial of the psychoeducational program Esuba, for incarcerated women who have a history of prostituting, as one that "emphasizes relational connections" (p. 298) by fostering connections between group members and group leaders and among the members themselves. Other similarly brief, indirect references to the underlying role of relational cultural theory were evident among the interventional studies. In DeHart's (2010) evaluation of a small-group therapy that focused on group analysis of participants' dreams, the author designated one of the overarching goals of the therapy: "creating a sense of community,

commonality, and connection” (p. 24). Women in this program, administered in a maximum security prison, agreed that the relational goal had been met, giving their highest marks in program evaluations to “Safe place to share thoughts” (DeHart, 2010, p. 28). In the qualitative portion of that study, DeHart also referred to comments in which participants praised the treatment for “help[ing] them connect to others” (p. 34). None of the four Seeking Safety studies reviewed here discussed relational theory directly, but Wolff, Frueh, Shi, and Schumann (2012) reported that Seeking Safety participant evaluation comments included references to the importance of sharing feelings with others, learning that they were not alone in their experiences, and forming “a bond with each other and with our leader” (p. 706).

Relational cultural theory stresses women’s prioritizing of ties with others. The theory may help explain why certain aspects of the treatments—the small-group format, non-confrontational techniques, non-hierarchical structures—were so appealing to women. Clearly some of the treatments incorporated gender-based, relational-cultural principles into the study designs, especially in curricular emphases on skills building for interpersonal relations. Most of the researchers who trialed the programs seemed interested to learn in evaluations whether participants felt their relational needs for safety were met. However, relationship-building and maintaining rarely factored into methodological discussions in the interventional studies, and even less often were they measured as study outcomes. This is surprising, especially in relation to the four Seeking Safety intervention studies, since the program literature for Seeking Safety emphasized the importance of building a trusting relationship between trauma survivors and the therapist/counselors who facilitate the groups (Najavits, 2006, 2009). Efforts to conceptualize women’s needs for connection and to discuss even briefly how the trialed programs are positioned in a larger, shared theoretical construct based on relationships might go some way toward creating coherency for the field and may help guide future program development or adaptation. In the next section, we reviewed

evidence for the impact of trauma theory on the interventional literature, where we saw a fuller engagement of theory.

Trauma Theory. Trauma theory has a long history and comprises a complex, multi-faceted body of work branching out from a variety of disciplines. In the interventional literature reviewed here, Judith Herman's (1992) definitions of trauma and model for recovery were cited frequently. Herman defined trauma as a terrifying often violent event to which a person responds with powerlessness, horror, and a sense of possible annihilation, and, later, with feelings of secretiveness and shame. Herman described how trauma interferes with the ways in which an individual makes sense of life events, often leading a survivor to feel as if s/he has lost "control, connection, and meaning" (p. 33). Herman (1992) also articulated a three-stage recovery model, which reasserts phases of recovery first established by Pierre Janet in the 1890s: (a) stabilization of symptoms and preparation for remembering; (b) identification, exploration, and modification of memories of past traumatic experiences; and (c) reintegration of trauma memories into personality with measures to achieve relief from symptoms and prevent relapse (van der Hart & van der Kolk, 1989).

The most purposeful use of the three-stage recovery model appeared in Ward and Roe-Sepowitz's (2009) study of Esuba, in which the authors comparison-tested the Esuba treatment with a group of women in a medium-security prison and a group of women in a community-based center. Esuba ("abuse" backwards) was delivered in once weekly, 2-hour sessions over 12 weeks and included psychoeducational activities focused on trauma identification, anger management, and communication skills, as well as activities designed to prompt discussion and sharing of experiences. The authors referred to Herman's work when they characterized prostituted women's traumatic experiences as both "difficult to understand and [. . .] difficult to treat" (Ward & Roe-Sepowitz, 2009, p. 296) and they covered all three stages of Herman's model, discussing (a) the use of grounding techniques to promote safety,

(b) the narration of experiences to promote remembering, and (c) the encouragement of group feedback to help rebuild a sense of connectedness through community and cohesion.

Similar to the Ward and Roe-Sepowitz (2009) study, both of the articles that reported on Covington programs (*Beyond Trauma* and *Beyond Violence*), those by Messina et al. (2010) and Kubiak, Kim, Fedock, and Bybee (2012), respectively, made explicit references to Herman's trauma theory and recovery model. Both studies alluded to stage-one and stage-two priorities of establishing safety and exploring the impact of abuse and trauma in women's lives as key elements in the therapies. Kubiak et al.'s (2012) discussion of *Helping Women Recover/Beyond Violence* also briefly made reference to a related category of trauma theory, psychoneurobiology, to explain one way in which scientists have linked histories of abuse to women's commission of violent offenses. Kubiak et al. did not make a connection between psychoneurobiology and Herman's recovery work as complementary theoretical approaches to trauma theory, but Herman (1992) and others have reported on the impacts of trauma on memory and the neurohormonal system, and Herman has published with one of the leading explicators of stress and psychoneurobiology, Bessel van der Kolk (Cloitre et al., 2009; van der kolk, Perry, & Herman, 1991).

Cole, Sarlund-Heinrich, and Brown (2007) trialed their own trauma-focused group-therapy intervention for incarcerated women with histories of childhood sexual abuse. The authors called on Herman's work to support a multi-faceted symptom profile for complex PTSD, a different form of posttraumatic stress disorder that has yet to be integrated into the DSM as a separate entry, despite efforts by experts extending back decades (Cloitre et al., 2012; Herman, 1992). Complex PTSD refers to a pathological trauma response specific to situations of trauma enacted over extended periods of time—a pattern that often describes childhood sexual abuse and intimate partner abuse (Cloitre et al., 2009). Cole et al. (2007) explained that inadequacies in the diagnostic criteria for PTSD in the DSM have led to its failure to capture symptom combinations associated with chronic trauma or complex PTSD

and thus may have rendered some women unable to access treatment. Although the DSM was revised in 2013, calls for the need to distinguish the complex form of PTSD continue (Cloitre et al., 2012; Elklit, Hyland, & Shevlin, 2014). Cole et al. also referred to work by John Briere (1996), whose self-trauma theory highlighted links between childhood sexual abuse, impairments in childhood developmental task completion, and deficits in affect regulation and coping skills in adult survivors. Following Briere, Cole et al. stressed that sequelae of childhood sexual abuse will differ in individuals depending on a host of life-time moderators, and as a result—and in keeping with the three-staged format of Herman’s model—Cole et al. endorsed accessing and working through the original trauma as a centrally important step in treating adult survivors of childhood sexual abuse.

All 11 of the studies referred to aspects of trauma theory at least in passing. Bradley and Follingstad (2003) noted that the combined dialectical behavioral therapy/writing therapy program trialed in their study drew on Brown, Schefflin, and Hammond’s (1998) stage-based approach. In Ford, Chang, Levine, and Zhang’s (2013) study of TARGET, the authors described TARGET as a treatment that narrowly focuses on one aspect of traumatic stress, affect dysregulation, but the study included outcomes measures for forgiveness and hope, which the authors associated with recovery and resilience, elements of stage three in Herman’s (1992) model. Theoretical landmarks or influences remained largely unspecified by Ford et al. (2013), with the authors situating the TARGET program on a practice level and emphasizing comparisons with other recent trials. Perhaps most reticent on the topic of trauma theory were the Seeking Safety studies (Lynch, Heath, Mathews, & Cepeda, 2012; Wolff et al., 2012; Zlotnick, Johnson, & Najavits, 2009; Zlotnick, Najavits, Rohsenow, & Johnson, 2003). The one exception was Zlotnick et al.’s 2003 trial of Seeking Safety in which the authors referred briefly to Herman’s trauma theory in summarizing the tradition on which the Seeking Safety treatment draws, listing Herman’s (1992) book among influences for “PTSD treatment” (Zlotnick et al., 2003, p. 100). In a later Seeking Safety trial, Zlotnick,

et al. (2009) omitted mention of Herman and the three-stage trauma recovery model. The Lynch et al. (2012) and Wolff et al. (2012) studies did not allude to trauma theory at all. The four Seeking Safety studies named but did not elaborate on key characteristics of Seeking Safety, noting that the therapy is present-focused; integrated (designed simultaneously to treat PTSD and substance abuse disorders); and based on cognitive behavioralism, using skills- and strengths-based psychoeducational methods. Seeking Safety has been theoretically positioned in multiple program descriptions and literature reviews published by the treatment author Lisa Najavits (2006, 2009). It bears reiterating that while every interventional study included in this review recited several paragraphs of empirical evidence for women's crime, women's trauma, women's poverty, and women's mental illness, few provided theoretical contextualization for the methodological choices in the programs, considerations that would seem key to understanding what is useful, what is not, and what is still needed.

Addiction Theory and Integrated Treatment. Addiction theory was the third main theoretical concern mapped in Bloom et al.'s (2002) blueprint for gender-based corrections, along with relational cultural theory and trauma theory. Bloom et al. (2002) cast addiction through the twin prisms of trauma theory and relational theory to characterize substance abuse as itself a kind of unhealthy relationship that forms between a woman and the substances and to which she turns to as a way to cope with abuse and the memory of abuse. Addiction was, the authors explained, citing Covington, a caring about substances instead of caring about the self, a form of "chronic self neglect" (Covington, 2008, p. 338). Bloom et al. argued that the complexity of addiction among women offenders with trauma histories requires a holistic approach, one that understands substance abuse not just as a medical and genetic or biological problem but also an issue of spiritual and sociopolitical etiology and significance. A mere medical or disease model, in other words, would miss the ways in which addiction compensates for the "nonmutual, nonempathetic, and even violent

relationships” that define the self-other dyad for many women living with trauma (Bloom et al., 2002, p. 74).

Theoretical underpinnings for a holistic or integrated perspective in women’s corrections emerged at least in part from Jean Baker Miller’s work in the 1970s and 80s (Bloom et al., 2002, p. 66). But the current emphasis on development and testing of integrated therapies emerged in the 1990s and early 2000s with the congressional establishment of the Substance Abuse and Mental Health Services Administration (SAMHSA); six years later, the National Institute of Corrections partnered with Cincinnati University to explore a gender-based risk-needs assessment tool for female offenders; and SAMHSA sponsored a multi-site Women and Co-occurring Disorders and Violence Study (WCDVS) that was conducted from 1998-2003 (McHugo et al., 2005; Salasin, 2005; Wright, Van Voorhis, Salisbury, & Bauman, 2012). Integrated treatments formed a core concern for each of these developments, which in turn provided institutional support and sources for secondary data in subsequent interventional research.

Of the 11 recent interventional studies in this review, 4 were primarily trauma focused while 7 also included significant substance abuse components in the program curricula and referred to substance abuse measures in their outcomes. The integrated treatment studies included 4 trials of Seeking Safety and 2 trials of Covington-authored therapies, Messina et al.’s (2010) study of Helping Women Recover and Beyond Trauma and Kubiak et al.’s (2012) trial of Helping Women Recover and Beyond Violence, both of which latter trials were embedded in and run concurrently with pre-existing prison-based therapeutic communities for substance abuse disorder. Similarly Sacks et al.’s (2008) trial of The Challenge to Change was set in an existing prison-based residential therapeutic community program for women offenders with substance abuse disorders. Sacks et al. described The Challenge to Change as a “comprehensive” (p. 236) treatment program that integrated “trauma and abuse, relationships, education, employment, and parenting issues”

(p. 242) into an established substance abuse treatment. Designed as an integrated therapy, the Seeking Safety program is explicit about its combined focus and, as Wolff et al. (2012) noted, is “the only effective treatment intervention for co-occurring PTSD and SUD identified by the International Society for Traumatic Stress Studies Practice Guidelines” (p. 704).

All the studies in this review, even those that trialed programs that were not strictly “integrated,” referred to connections between trauma and addiction or noted elements of their curricula that combined addiction and trauma therapy. Cole et al. (2007) cited addiction as a factor that contributes to and results from trauma in women’s lives and observed that one of the 16 weekly treatment modules in their program focused on addiction and trauma. DeHart (2010) quoted participants who were grateful to be free from drugs and alcohol and to learn ways of coping that would not lead to dependency. Ford et al. (2013) included substance use among the measures of efficacy in their study, which compared the TARGET affect regulation therapy to a supportive group therapy treatment. Only in brief moments of identification and attribution—as in Ward and Roe-Sepowitz’s observation that untreated trauma disorders can be an obstacle to recovery from substance abuse—however, did study authors engage with addiction theory itself to ask how it illuminated results, responses, or aspects of the programs they tested. As a result, points of divergence that may have emerged between treatment approaches were mostly muted, including the one with which we will close.

Discussion

A point of contestation that runs unobtrusively through the 11 articles is whether or not trauma-informed treatments with female offenders should encourage women to explore their traumatic pasts in group therapy sessions or not. The divergence of approach on this point bobs in and out of view in the interventional literature, never quite surfacing at the level of debate, while in other kinds of literature—in qualitative studies and descriptive

literature—the question of exposure or memory processing receives more focused attention. In a study of data from the multi-site WCDVS, for example, Cusack, Morrissey, and Ellis (2008) noted that women with different patterns of co-occurring disorders (e.g., drug abuse with PTSD *versus* alcohol abuse with PTSD) appeared to develop different symptom profiles, and further, that women with different symptom profiles tended to respond differently to interventions. Cusack et al.'s findings in this regard accorded with those of Rauch and Foa (2006), who identified divergent patterns of response among PTSD patients to clinician-delivered, prolonged exposure (PE) therapies. The conclusion Cusack et al. drew from their research was that, if administered without proper assessment of individual need, well-meant trauma interventions could prove harmful by interfering with a woman's own recovery process. The question of whether exposure therapy or memory processing can be safely administered in a small-group format is a mostly unspoken but generally present issue in the 11 interventional studies reviewed here.

As trauma survivors recover from episodes of abuse and violence, they are thought to integrate trauma experiences into the schemata or systems by which they make sense of self, other, and the world in general (Harris & Fallot, 2001; Herman, 1992). Some survivors are able on their own to accommodate traumatic episodes into existing schemata; many are not. When a survivor cannot integrate trauma, cognitive-behavioral and exposure treatments offer two of the most popular methods for helping patients recover. Most interventions for incarcerated women, whether trauma-specific or integrated with substance abuse treatments, use a cognitive-behavioral approach. Therapies based on cognitive behavioralism hold that thinking influences behavior, and that by correcting errors in thought, individuals can develop healthier, more positive behaviors (Gonzalez-Prendes & Resko, 2012). Many manualized cognitive-behavioral treatments do not require clinician-facilitators; some do not require training at all and can be implemented in small-group formats that span short periods, ranging from a few weeks to a few months (Najavits, 2009). For women with unresolved

trauma, cognitive behavioral treatments help with identification of perceptual distortions that lead to trauma symptoms—dissociation, intrusive thoughts, avoidance behaviors. Trauma survivors learn to recognize damaging patterns of cognition or memory, distortions in the conclusions they draw from words, gestures, events, and situations that trigger fear reactions, not because they are dangerous in themselves but because they are linked in the survivor’s mind with the traumatic experience(s) (Ehlers & Clark, 2000). Cognitive behavioral therapies promote awareness, mindful restructuring of thought and response, and the acquisition of grounding and relaxation skills to enable better affect regulation. The intended result is more emotional control and healthier connections or relationships with self and others (Gonzalez-Prendes & Resko, 2012).

Many of the cognitive-behavioral approaches in the programs for incarcerated women in this review were “present-based” in that they emphasized teaching women here-and-now strategies to replace unhelpful modes of thinking and reacting with ones that would more accurately and less harmfully account for events and behaviors of others. The TARGET program, for example, was designed specifically to address trauma-based responses in the “*current day-to-day lives*” of women (Ford et al., p. 273, italics in original). In keeping with the TARGET emphasis on affect regulation, Ford et al. ended their study by warning explicitly against trauma memory processing with women who have severe affect dysregulation and thus are often unable to tolerate the therapy.

Memory processing or prolonged exposure approaches require participants to reaccess trauma in order to habituate to the memories, a process that can involve intense triggering of emotions and that may be better suited to individual than group therapy settings (Courtois & Ford, 2013; Gonzalez-Prendes & Resko, 2012). This, at least, is the position implied by Ford et al. (2013) and more explicitly developed by Seeking Safety author Lisa Najavits (Najavits & Hien, 2013) in a recent systematic review. In other program literature, Najavits (2009) has clarified that while the Seeking Safety program welcomes some

discussion of individual trauma, participants are directed away from narration of detailed traumatic memories that may overwhelm others in the group. Lynch et al. (2012), referring to their trial of Seeking Safety among women with comorbid trauma, depression, and substance abuse disorder in a state prison, noted that “[p]articipants are actively discouraged from describing traumatic experiences in detail” (p. 89) and Zlotnick et al. (2009) highlighted the present-based orientation of Seeking Safety alongside its abstinence emphasis and compassionate approach. In her evaluation of a dream therapy program, DeHart (2010) indicated along similar lines that one advantage of a therapy built around dream analysis rather than trauma memory processing was that dreams are only obliquely related to the past so that women found them less painful to probe than exposure or memory processing, but still therapeutic.

In contrast with present-based treatments (i.e., dream analysis therapy, TARGET, and Seeking Safety), other programs we reviewed embodied a trauma-specific approach with a strong remembrance component, including structured opportunities for women to revisit, narrate, and attempt to reintegrate trauma from their pasts. The trauma-specific programs attended more pointedly than the present-based treatments to what Herman (1992) identified as the second stage of recovery, “remembrance and mourning” (p. 175), where recalling and revisiting the past functions as an important step in healing. Four of the studies in this review trialed programs in which remembrance of past trauma was a central theme. In the Beyond Trauma and Beyond Violence studies, for instance, researchers explained that the women embarked on “a process of understanding what has occurred in their past” (Messina et al., 2010, p. 100), a process that included remembrance of experiences of sexual and physical violence. Similarly, the DBT/writing therapy that Bradley and Follingstad (2003) trialed was organized around structured writing assignments in which women were asked to narrate their life stories and incorporate experiences of interpersonal victimization. To prepare for the recollection of trauma memories, the program trialed by Bradley and Follingstad featured a

dialectical behavior therapy component that gave participants “psychological skills for the regulation of emotions” (p. 337). Notably, the protocol for the writing therapy was itself revised during the pilot stage—away from a more exclusive trauma focus and toward a life history approach—because pilot participants expressed concern about being overwhelmed by emotion if asked to recount their experiences of interpersonal violence directly (Bradley & Follingstad, 2003). The authors suggested in the conclusion of their study that attrition rates might have been less in their trial if the treatment had provided more skills work for affect regulation prior to the memory writing activities.

Ward and Roe-Sepowitz (2009) and Cole et al. (2007) also referred to the necessity of trauma-specific treatments in which women could bear witness to past experiences: Cole et al. noted that the sharing of memories enabled feelings of connection by “normalizing experiences of shame” (p. 113), and Ward and Roe-Sepowitz cited remembrance of the past as a means of repairing relationships (308). Among the trials of programs that placed an emphasis on remembrance and mourning, some, like these, made passing reference to the need for guided exposure but elaborated no further. The interventional research on present-based approaches, such as the four Seeking Safety studies, were equally brief in observing their programs’ present-minded orientations and gingerly engagement of trauma memories. The here-and-now focus was described as preferable (Lynch et al., 2012; Wolff et al., 2012; Zlotnick et al., 2009; Zlotnick et al., 2003), and only Ford et al. (2013) and to a minor extent Bradley and Follingstad (2003) spelled out what seemed to be a theoretically-informed divergence with potentially important implications for practice.

Conclusion

The interventional studies reviewed here indicated that gender-based, trauma-informed care for women in carceral settings is a topic of high priority for researchers, care providers, and corrections administrators. Many of the authors of articles surveyed here are researchers who have spent many years helping to construct a field in which designing

effective, trauma-focused therapies for women in jails and prisons has been a primary concern. The therapies themselves include a rich variety of treatment modalities that arise from theoretical orientations that span multiple fields, including corrections, trauma studies, behavioral and social psychology, public health, and social work, to name the most obvious. Our intention in this review was to point up what we feel to be a missed but recuperable opportunity. When researchers elide discussion of the central theoretical orientations, principles, and debates that give shape to the treatments they trial, they bypass an opportunity to engage conversation not just about *what* works but also *why*. Such discussions need not be exhaustive to be illuminative. We are reminded of Cole et al.'s (2007) decision not to include attendance requirements for participants in their trial; the authors named their “feminist orientation” (p. 106) and linked the emancipatory principles of feminism to the choice to avoid using any coercive or disempowering means to obtain or keep participants. In a couple sentences, the authors “placed” their method and the underlying methodology, giving readers a sense of the guiding principles for the treatment and the choices made in designing the study of the treatment.

Interventional trials are charged with establishing evidence of feasibility and efficacy (or its lack). This is important work. Our review, we hope, may spark researchers to more explicit articulation of the theoretical drivers that also matter to that work. Discussion of points of divergence and identification of theoretical stances or positionings within the field of women’s corrections and trauma studies ultimately can make outcomes studies more *connect-able* to one another and perhaps light the way toward more effective means of helping the women we endeavor to help.

To Advance the Field

Research indicates a growing number of women whose justice involvement and history of trauma position them such that survival, namely, the maintenance of health and safety, is an ongoing, hazardous project. Their access to official sources of assistance in the

community is often limited and fragmentary, and sometimes perceived as not available at all. Women survive nonetheless, navigating their way in situations where institutional resources for health, housing, and other necessary supports may be severely lacking (Lorvick et al., 2015). How women manage informal social resources in the absence of coordinated safety nets and programs is unclear, especially in the context of repeat offending and high interpersonal trauma exposure. Research to assess the needs of justice-involved women tends to address services available to women during incarceration or survey women's health and service needs post-incarceration. Only a very few studies delve into how justice-involved women view their needs and how they construct strategies to meet them (Richie, 2001). This dissertation seeks to inquire more deeply into how justice-involved women themselves understand their support networks and how they conceive of their relationships as intersecting with health and safety. The dissertation uncovers women's ways of perceiving and managing relationships, offering new insights that can lead to creation of more accessible, better targeted social systems to support them in preventing disease and injury.

CHAPTER 3

METHODS

This dissertation study was nested within a larger cervical cancer study (National Cancer Institute, R01CA181047), Sexual Health Empowerment (SHE) for Cervical Health Literacy and Cancer Prevention, on which I served as research associate (Ramaswamy, Simmons, & Kelly, 2015; Ramsawamy, Lee, Wickliffe, Allison, Emerson, & Kelly, 2017). SHE was led by Dr. Megha Ramaswamy (Principal Investigator) of the University of Kansas Medical Center (KUMC) and Dr. Patricia Kelly (Co-Investigator) of the University of Missouri-Kansas City. SHE was a mixed methods, longitudinal study involving a quasi-experimental, wait-list control design to assess knowledge, belief, self-efficacy, and behavior outcomes of a brief cervical health literacy intervention with women incarcerated in jail. SHE included the intervention arm, delivered in three area jails, and an ethnographic arm, conducted with a subsample of participants in the community after release. Implementation of the jail intervention lasted from September 2014 to March 2016, with follow-up surveys and ethnographic fieldwork scheduled to continue to 2019 (the grant was in Year 3 during the writing of this dissertation). I was actively involved in both segments of the study since initial implementation in 2014.

Study Design

Recruitment and Eligibility

The recruitment goal for the dissertation study was between 10 and 15 participants. These were selected purposefully from the parent study (SHE) sample, which comprised a convenience sample of 184 women recruited from one suburban and two urban jails in a Midwestern metropolitan area from fall 2014 to spring 2016 (Ramaswamy et al., 2017). Participants were recruited to SHE through posted notice in common areas of the jails, word-of-mouth by jail staff and other study participants, and brief informational talks delivered by SHE study team members at the jails. Eligibility criteria for SHE included being 18 years of

age or older and ability to understand spoken English (Ramaswamy et al., 2017). Each week, interested women attended a meeting in which the study purpose was discussed and benefits and possible harms of the study described. The consent document was read, either by the women themselves or, if requested, by study staff; women were encouraged to ask questions throughout the consent process. In keeping with concerns about the potential exploitation and coercion of prisoners in research (Quina et al., 2007), the voluntary nature of participation of the study was emphasized, and women were informed that they would be free to discontinue their involvement at any time with no repercussions. Persons were excluded from the SHE study if they showed signs of overt distress during consent (Ramaswamy et al., 2017). Only one woman from the parent study was excluded based on these criteria. The consent for the parent study included permission to contact participants for post-intervention surveys, ethnographic encounters, and interviews—all on a continuing voluntary basis.

The cases for the dissertation study interviews were selected, with the assistance of Ms. Wickliffe, the SHE project director, from the original 184 SHE participants who completed the intervention. Over the two years of implementation in the jails, women were invited face-to-face, through text messaging, or Facebook messaging to participate in the dissertation substudy, which was described as interviews to explore how women manage interpersonal relationships. We identified potential participants based on their allusions to trauma and complicated relationship histories during the jail sessions and field encounters. Retention of participants in the dissertation study was accomplished, as through the SHE study itself, by the project director, who used mailed letters, phone calls, texting, Facebook messaging, and word-of-mouth to locate participants who did not themselves maintain contact with the team.

Case Selection

Eligibility for the dissertation sample included being 21 years of age or older, showing no signs of disruptive personality disorder or psychopathy, and being or having been

incarcerated in a local jail for at least one week during the period of September 2014 to March 2016. Because my goal was to reach a deeper understanding of a specific experience in a specific population through extended narrative accounts, I made purposeful selection of women for the dissertation study interviews based on the complexity of personal history related during jail sessions and SHE ethnographic encounters. I tried to include cases that reflected variety in age, education level, and socio-economic status, as well as racial identification, though for the last I was only able to recruit Black and White women as very few Hispanic and even fewer Asian women took part in the SHE study. (For participant characteristics for the dissertation study, see Appendix A.) I set out to include interviews with 10-15 women, but further selection of cases was discontinued after 10 women were interviewed, when ongoing analysis indicated that I had stories sufficiently rich in a range of interpersonal support relationships as understood and managed around concerns of health and safety to answer my research questions (Patton, 2015; Small, 2009).

Human Protections

The study had risks for participants, including psychological distress arising from discussion of difficult subjects and events; perceived coercion to participate due to criminal justice status; perceived legal jeopardy from discussing involvement in illegal activities; and perceived sense of invasion into social space or privacy. Measures taken to reduce risk of harm included informed consent; repeating informed assent in interviews; restating the voluntariness of participation and the participant's absolute freedom to withdraw or simply decline to answer any question at any time; use of pseudonyms and obfuscation of participants' identities in research dissemination; secure storage of data; and protection of all study materials and records from legal seizure through a National Institutes of Health Certificate of Confidentiality. By these measures, in place in the parent study and in the dissertation project, risks of harm to the participants were minimized. Institutional Review Board approval was obtained to conduct the interviews and perform participant observation

from the University of Kansas Medical Center (Human Subjects Committee Protocol #13559) (Appendix B), with a UMKC-approved Request to Rely on a CTSA Partner External IRB (Appendix C). I completed and maintained the required CITI training in human subjects research with special modules in working with prisoners (Appendix D).

Procedures

Data Collection

Interview data were collected in audio-recorded, face-to-face encounters, with the exception of one interview that I conducted over Skype. Audio recordings were temporarily downloaded to a password protected drive on a home computer and then to a secured server within the KUMC network. Audio files on the recorder were deleted after downloading. I transcribed about one-fourth of the interviews verbatim, while the remainder were transcribed by a transcription service, the confidentiality of which was ensured by non-disclosure agreement. After completion of each transcription, I checked copy against the recording for accuracy and removed verbal filler where it was especially excessive (i.e., “like”; “uh”; “you know what I’m saying”). All transcribed interviews were encrypted and stored—along with electronic copies of field notes—in Dedoose, a password protected, web-based, qualitative and mixed methods research application. Only the three-member SHE ethnography team had access to the Dedoose database.

Setting. The interviews were conducted at various sites chosen by or agreed to by the participants. In many cases, the women themselves proposed a site for our meetings, typically near where they lived or worked. Those sites included McDonald’s restaurants, coffee shops, public libraries, a choir changing room in a church, cars, and participants’ residences. Sessions with the two women who were still in jail took place in the Jackson County Adult Detention Center, in Kansas City, Missouri. During these interviews, I met with participants in a locked-door classroom with a guard nearby but out of hearing range. Safety and privacy, both for the participants and for myself, was a concern at all times. The

two main rules of the ethnography arm of the parent study applied to the dissertation study as well: (a) do nothing illegal; and (b) immediately leave a situation in which you feel unsafe. In all but a few cases, I was accompanied by Ms. Wickliffe, the parent study project director, on community encounters. Privacy was also a concern, and I preferred not to interview in restaurants and coffee shops, but participants often requested these. In a few instances, we were induced to leave one site for another due to noise or other interruption. During the interview encounters, it was never necessary to leave for safety reasons.

Interviews. A total of 20 interviews comprising 110 hours of audio recording were collected. Interviews averaged just over 60 minutes and ranged from 32 to 91 minutes in length. All interviews were arranged by the SHE project director and scheduled at times convenient to the participant and myself. I interviewed each of the 10 women twice, once in an initial or “story interview” and again in a follow-up interview. All interviews were face-to-face and semi-structured, and all were conducted in the field, except for the three interviews that were performed in the jail and one that was performed over Skype. Most interviews were also attended by the SHE project director who contributed questions and provided emotional support to participants when appropriate.

In the initial or “story” interviews, I used methods adapted from Maynard-Moody and Musheno’s (2009) work on street-level service providers and McAdams’s (2008) life story interviewing technique (for my interview protocol, see Appendix E). In the story interviews, after describing the procedures, obtaining assent, and inviting participants to create a pseudonym, I asked them to imagine life as a book, divided into chapters, with each chapter designating a major relationship. Women were encouraged to begin their story and order their chapters in any way they liked. Within each chapter, I prompted participants: “What happens in this relationship?” “What is the story of this chapter?” The approach was intended to elicit extended discourse in story segments—more or less sequenced narratives that would capture a participant’s formulation and navigation of significant relationships. I probed

further occasionally—”Who are the main characters?” “If this were occurring in a book, what would you tell the reader about the setting, about what things looked like, sounded like, felt like?” Or, when a participant was moving too fast, I might ask her to go back and “tell the story” of some undeveloped aspect. For storytellers whose narration style was especially episodic or event-based, I mined for impressions and feelings to get a better sense of how the participant evaluated or assigned meaning to a relationship. Supplemental questions used during the initial story interviews included asking which chapter a participant would choose to edit out of her overall story, and what she would add into her story if she could. At the end of each interview, I asked the participant to think back over her chapters and come up with a book title. The purpose of the story interview was to set a stage on which the participant had freedom to discourse on interpersonal relationships as social support—to give her opportunity to express in her own way, through choices of ordering, emphasis, and expression of people and events, how she perceived the role of social bonds in managing health and safety risk.

At least one follow-up interview was conducted with each participant. Time elapsed between initial and follow-up interviews averaged five and a half months, with a range of 3 weeks to 12 months, and depended primarily on participants’ availability. In the first two follow-up interviews that I conducted, I simply read back quotes or pointed to details from the chapters that were narrated in the initial interviews to elicit further storytelling. Based on review of this approach and the themes that emerged when memoing about the interviews, the follow-up protocol was revised to include three new components. First, I brought to each subsequent follow-up interview an outline that I constructed based on the participant’s initial interview. These “book outlines” included the participant’s chosen title and enumerated chapter titles which usually included short, representative quotes from the interview. Key events or impressions were listed under the chapter headings. With each participant, I read

through the outline, which acted as a framework within which gaps could be filled and further discourse elicited.

Second, I developed a very simple visual timeline that extended from birth to the present and asked women to mark the five most significant health or physical events in their lives along the line. Again, the timeline served as a tool to prompt further exploration of key relationships specifically in conjunction with health and safety. Third, analysis indicated that emergent themes clustered around types of support and interestingly around the women's own contributions of support to others. This led me to ask for three specific stories at the end of follow-up interviews: (a) tell me a story about a time when you asked for help from someone and they helped you; (b) tell me a story about a time when you asked for help from someone and they denied you; and (c) tell me a story about a time when someone else in your life needed help and you provided it.

Participant Observation. In addition to the semi-structured participant interviews, I also spent a limited time in the field with participants, approximately 10 hours, meeting and accompanying women as they went about their day-to-day lives. I had access moreover—through the ethnography arm of the SHE project—to the project director's field notes on her community encounters with women, including many of those in the interview group. The SHE encounters focused on navigation of social and service environments, including but not limited to health appointments, urine drops, social service system navigation, and group support interactions. Similar to my interviews, descriptive field notes were written after each field encounter, and often recorded and transcribed. All field notes and transcriptions were stored in Dedoose and on the secure server at KUMC.

Analysis and Interpretation.

Analysis of data was iterative and collaborative, with discussion and memoing performed concurrent with interviewing by me and the other two members of the SHE ethnography team, the SHE principal investigator and project director. I used a variety of

methods in data analysis, including open, line-by-line coding in Dedoose to identify overall impressions, emphases, and repetition of thematic, structural, and performative elements within the interviews. The code list (Appendix F) for this study, formulated by me in discussions with the SHE ethnography team over the entire period of data collection, included three broad groups that emerged as prominent in the women's interviews: relationships, trauma, and support. Coding in turn guided memoing and formed the basis from which themes were derived and developed.

Analytical memos were composed during the process of data collection and analysis, once the coding began to show repetitions and patterns. Two types of memos were written: (a) project memos, in which I periodically recorded reflections on the project as a whole and included questions that arose about study goals, ethical issues, and aspects of the research process; and (b) analytic memos, in which specific patterns were defined and elaborated as they were identified (R. M. Emerson, Fretz, & Shaw, 2011; Saldaña, 2016). Analytic memos included micro or "emic" elements that highlighted how women perceived and portrayed their experiences as well as macro or "etic" aspects that cast the stories comparatively against existing theory and larger cultural narratives (Spradley, 1979, p. 231-232). As data collection and analysis proceeded, further refinements were made to these analytical tools.

The unit of analysis was two-part and involved life-story narratives constructed by the women and embedded narratives that occurred within the chapters that constituted the life-stories. In theory, *narrative* specifically refers to the ordering of a temporally bounded series of events or conditions by a subject (Gubrium & Holstein, 2009; Polkinghorne, 1988), while *story* refers to a more purposeful performance, involving attention to the act of storying, including, for example, more attention to scene-setting and evaluation of meaning than narration (Maynard-Moody & Musheno, 2009; Mishler, 1995). Notwithstanding distinctions made between story and narrative, in social sciences research the two are often used interchangeably, as I use them in this study. For my purposes, both story and narrative will

refer to segments of talk that form a plotted, though not necessarily chronologically ordered, sequences constructed around a complication in situation or environment that calls for a response or correspondent change in the subject (Labov & Waletzky, 1967; Riessman, 2008). Identifying the boundaries of a narrative was a matter of interpretation, since stories do not always have clear beginnings and endings and are often nested one within another (Riessman, 2008).

One assumption of narrative inquiry is that aspects of meaning reside not just in thematic repetitions but also in the organization of elements (i.e., structure) within stories and in the positioning of stories vis-à-vis larger cultural narratives or discourses (i.e., intertextuality) (Gubrium & Holstein, 2009; Riessman, 2008). Analytically then, narrative inquiry requires something more than the extraction and aggregation of thematically representative fragments across interviews (Riessman & Quinney, 2005). The findings in a narrative inquiry will generally take a different appearance on the page from other qualitatively analytic investigations, such as grounded theory or qualitative descriptive studies, since more extended segments of text may be necessary in an analysis to explicate theme, structure, and performance of narrative wholes. In the two manuscripts in which I report my findings, reporting longer segments allowed me to convey thematic cross-case analysis as well as a more holistic consideration of individual cases.

Evaluation: Trustworthiness

Methods for achieving rigor in qualitative or naturalistic inquiry have been discussed extensively in the literature (Anney, 2014; Clark, 2008; D. J. Cohen & Crabtree, 2008; Cope, 2014; Emden & Sandelowski, 1998; Hammarberg, Kirkman, & de Lacey, 2016; Miles & Huberman, 1994; Patton, 2015; Pope, Ziebland, & Mays, 2000; Tracy, 2010). Unlike research performed under controlled conditions, where specific variables are delineated from the start and then measured and analyzed using well-established statistical methods, naturalistic research takes place in the field, where variables are not only in flux but are also

often overdetermined, too numerable and too overlapping to parse out with certainty (Danermark, Ekström, Jakobson, & Karlsson, 2002). Questions of causation and generalization look different under these conditions, causing the goals shift from making predictions and verifying hypotheses on the basis of aggregated information (i.e., induction or deduction) to reaching revised understandings on the basis of reasonable inferences made from careful analysis of individual cases (i.e., abduction) (Danermark et al., 2002; Small, 2009).

Much of the methodological writing about evaluation of person- or case-based study for the social sciences improvises on Guba and Lincoln's (1985) argument that trustworthiness is the appropriate measure for rigor in naturalistic inquiry. Trustworthiness serves as a rough proxy for validity and reliability criteria of clinical research and includes what Guba and Lincoln (1985) termed credibility, transferability, dependability, and confirmability. To produce credible findings or results in which others may invest confidence, researchers use a variety of techniques in qualitative inquiry. The most common of these is triangulation (Bowen, 2009). The current study achieved credibility through triangulation, using two of the types discussed by Guba and Lincoln (1985, p. 305-306). Members of the analytic team and members of the author's dissertation committee accomplished triangulation of investigators through biweekly meetings to debrief and review memoing. Triangulation of methods took place through serial interviewing and participant observation. Because narratives offer highly situated and interpretive data, transferability or applicability refers to the idea that a reader ought be able to make a reasonable surmise that the study could be reproduced elsewhere; transferability is accomplished through thick description and purposeful sampling (Anney, 2014; Guba & Lincoln, 1985). I enhanced transferability and applicability by including substantial text from the transcripts and my field notes in the findings. By these means, another inquirer should be able to make a reasonable determination about whether my findings are applicable in (i.e., transferable to) another

context (Tracy, 2010). Finally, to support dependability and confirmability, I preserved raw data, process notes, emails, meeting agendas, coding documents, and project and analytic memos. In these, I documented study design decisions, the processual development of codes and themes, and my own process of drawing interpretive conclusions from data. Miles and Huberman (1994) and Bowen (2009) both point out that, even while an actual audit is rarely produced as part of the publication of a study, keeping an audit trail can contribute to the researcher's confidence in her process and findings—and the materials remain available for later review.

Summary

Using a narrative inquiry study design, I interviewed 10 justice-involved women over one year, soliciting life stories and embedded narratives that focused on women's relationships with others in their social networks. My purpose was to explore how women, with history of incarceration and trauma, living in unstable and underresourced situations, perceive and manage interpersonal relationships to access support for health and safety. I used coding and memoing to identify themes and narrative analytical methods to parse out meaning as it was expressed through what was said, how it was said, and women's implied purposes in saying. Since narrative functions as a primary way in which humans order experience and give it meaning—and thus can inform behavior—there is much to be gained by nurses and other care and social services providers in attending to justice-involved women's narratives. These can illuminate how women perceive self, other, and the availability of support. Stories can give important information about the health and safety goals of women with history of incarceration and trauma and the strengths and weaknesses in the strategies by which they currently navigate barriers to reach them.

The rationale for this study design is that in-depth, person-based approaches can contribute uniquely to the science of health disparities research and population health by providing insight into the ways in which relationships are organized and understood as

socially supportive (or not) in a hard-to-reach but high-risk population. Current methodological approaches—primarily surveys—have failed to provide clarity or account for the complexity in how justice-involved women manage interpersonal and other support relationships in ways that influence risk of violence and disease in their lives. The narrative inquiry methods used here were chosen because they offer a richly contextualized, unusually detailed means of advancing understandings that may be useful to nurses and others working with justice-involved women in carceral and rehabilitation institutions and in the community. We lack a nuanced understanding of justice-involved women’s unique risks and ways in which they attempt to meet them. Given the many barriers of incarceration, release, and traumatic life experiences, without such efforts of understanding, health disparities and unnecessary suffering will persist.

CHAPTER 4
OPPORTUNIZING AND FATALIZING: SELF AND OTHER
IN THE TRAUMA NARRATIVES OF JUSTICE-INVOLVED WOMEN

Abstract

Nearly one million women cycle in and out of jail each year on low-level drug and property crimes. For many of these, access to formal systems of support after release from incarceration can be quite limited. Jobs paying enough to house, feed, and obtain medical care have become difficult to find in many poorer communities in general, and much more so for the justice-involved, many of whom struggle with substance abuse disorders and lifetime trauma in addition to the stigma of a criminal record. Many justice-involved women turn to informal economies and social support from family, friends, and sometimes strangers to survive.

In this study, I sought to learn more about how justice-involved women with history of trauma in low resource conditions perceive and manage social ties to protect health and safety. Participants were purposefully selected from the convenience sample of an ongoing, longitudinal cervical health literacy intervention study. In-depth, semi-structured, story-eliciting interviews were conducted with 10 participants over 12 months. Trauma narratives were selected from the interviews as the primary unit of analysis due to their detail and focus on support-seeking.

Justice-involved women crafted trauma narratives that registered along a continuum of agency, anchored at one end by opportunizing talk and at the other by fatalizing talk. Understanding how women strategically perceive and construct self and other in moments of trauma or crisis, when accessing support is crucial, can provide a beginning framework around which health care and social service providers may find means to develop effective ways to help justice-involved women meet the challenges they face after incarceration.

Keywords: *Incarcerated women, trauma, social support, narrative inquiry*

Introduction

Jail admissions in the U.S. total over 11 million per year, with daily population censuses for jails numbering about two million (Minton & Zeng, 2015). Women make up about 15% of those totals, their rates increasing 18% between 2010 and 2014, while men's rates of jail incarceration decreased 3.2% (Minton & Zeng, 2015). Much has been written about the distinctive pathways that lead women to incarceration, and it is well-documented that rising rates are tied less to changes in the rates of actual criminal offending than to changes in the policing and sentencing of drug and property crime in underresourced, often racially targeted communities (Alexander, 2010; Wacquant, 2010). Justice-involved women, including both those who are incarcerated and those under criminal justice supervision in the community, thus often come from and return to underresourced areas, where jobs and social capital that might be used to improve socioeconomic status are lacking (Sered & Norton-Hawk, 2014; Western & Pettit, 2010). The justice-involved often struggle with substance abuse disorders, mental illness, and severe personal trauma at higher rates than women in the general population, including experiences of childhood sexual abuse, intimate partner abuse, and adult rape (Grella et al., 2013; Lynch, Dehart, Belknap, & Green, 2012). Seeking to gain control over a cycle of incarceration, women with a history of incarceration face multiple barriers that affect their health and safety (Lorvick et al., 2015; Swavola et al., 2016).

In this exploratory study of narratives about interpersonal relationships in moments of trauma, as told by recently incarcerated women, I sought to develop a fuller, more nuanced understanding of how justice marginalized women perceive and manage interpersonal social ties for health and safety. For nurses and other care and service providers, recognizing how justice-involved women understand themselves in relation to others as they attempt to manage resources for survival can be an important initial step in changing how women are supported in the community. Of the stories women shared, the most focused, coherent, and frequently-told narratives were trauma narratives. In stories of trauma, women's

constructions of self-in-representation registered along a spectrum of agency that was distinguished by two modes, opportunizing talk and fatalizing talk. These forms of talk encompassed both what was told and the women's ways of telling and characterized the women's presentation of roles, actions, and motivations. The typology is not meant to categorize women themselves but to highlight patterns in their notional management of self, other, and support as they accessed informal social support through relationship with others. Indeed, women rarely adhered exclusively to opportunizing or fatalizing talk but told stories in which both modes were featured, at times switching between modes from one story to another.

Trauma and Trauma Narratives

The high rates of lifetime trauma from interpersonal violence among women with history of incarceration are well documented (Browne, Miller, & Maguin, 1999; Chesney-Lind & Pasko, 2004; Grella et al., 2013; Lynch et al., 2014). Reports of childhood sexual abuse (CSA) and adult sexual violence are prevalent in incarcerated populations, with studies finding CSA rates for incarcerated women between 32% and 68%, and sexual violence as high as 86% (J. Briere, 1996; Cusack et al., 2013; DeHart et al., 2014). Justice-involved women who have experienced traumatic life events often adopt coping strategies such as drug and alcohol abuse that lead to revictimization and additional health risks (Cusack et al., 2013; Fuentes, 2014; Logan et al., 2002). Symptoms from unresolved trauma responses take a toll on physical health and are associated with dysregulation of stress responses (Cloitre et al., 2012; van der Kolk, 2006) leading to digestive, endocrinal, cardiac, and immunologic conditions (S. J. Weiss, 2007).

Trauma has special significance for a study that focuses on how women narrate relationships. In her landmark text *Trauma and Recovery*, Herman (1992) explained that trauma, a psychic injury or wounding, refers to the profound disruption in a survivor's understanding of self in relation to the world, a loss of perceived "control, connection, and

meaning” (p. 33). Caruth (1996) has stressed that the key aspect of trauma is the difficulty with which survivors understand and make meaning of negative experience owing to the peculiar way trauma is recorded in memory, its tendency to be unanchored contextually—not part of the flow of experience but separated and locked out. Survivors often can only incorporate the meaning of traumatic experience into their lives indirectly and belatedly. Janoff-Bulman (1992) has argued that trauma entails such a shattering of a person’s basic assumptions about the self in its connection with others that it may require construction of a whole new self narrative or schema. In the work of Gordon and Szymanski (2014), in which women themselves were asked what made experiences traumatic for them, respondents emphasized rupture in their understanding of how the world operates. Disruption of one’s worldview can mean loss of trust in others and difficulty integrating new experiences into one’s existing self-story, the identity construction by which one defines oneself and, importantly, by which one forms connections with others (Gordon & Szymanski, 2014). The process of recovery from trauma for many is an extended and uneven process marked by maladaptive symptoms such as re-experiencing, avoidance, and dissociation (Bromberg, 2003; Janoff-Bulman, 2004; Tedeschi, 1999) that interfere with a survivor’s ability to make sense of, form, and manage relationships (Golin et al., 2016; Herman, 1992; Levers, 2012).

Because women with significant lifetime trauma may suffer retraumatization through unintended triggering of their symptoms, trauma-informed movements in corrections have been a focus of research in recent decades (Harner & Burgess, 2011; Machtinger, Cuca, Khanna, Rose, & Kimberg, 2015). Attention to the need for targeted, trauma-informed support for women while incarcerated rarely extends beyond their release, however, after which many are on their own, receiving only minimal social assistance or mental and physical health attention (Belknap, Lynch, & DeHart, 2015; Mallik-Kane & Visher, 2008; Richie, 2001). To change how women are supported in the community after release, we can begin by hearing what women are already doing, taking stock of the particular ways in which

justice-involved women with history of trauma perceive self and other in manage health and safety risk through informal social support.

Research Question

“What do trauma narratives of justice-involved women reveal about how they perceive and manage social ties to access support for health and safety?”

Conceptual Framework

I worked with a conceptual framework for this study that incorporated aspects of feminist standpoint and relationality theories as well as narrative inquiry methodology. Additionally, concepts from social network, support, and capital theories helped to situate the findings within literature on how women cope in situations of high resource scarcity. Brief accounts of feminist standpoint, relationality, and narrative inquiry methodology are presented below, with the social theory concepts introduced here and more fully explicated in the subsequent discussion.

Feminist Standpoint and Relationality. Feminist standpoint theory and its emphasis on relationality informed the overall objective of the current study, to learn from justice-involved women’s own accounts of experience how they manage social ties to support health and safety. Feminist standpoint theory holds that women share certain ways of viewing and understanding the world as a result of being socialized *as* women in a specific social structure at a specific time. Subject to a good deal of variation and modification—due partly to the fact that other factors like socioeconomic status, race, religion also impact experience—standpoint theory argues that relationality represents a primary way in which women tend to know and experience the world (Freedberg, 2015). Connectedness and transaction rather than autonomy and detachment thus become key motifs around which feminist epistemology (Haraway, 2014) and feminist approaches to philosophic and scientific inquiry take shape (Gilligan, 1982; Harding, 2004; Miller, 1986; D. E. Smith, 1990). The relational aspect of feminist theory supports a focus on stories about trauma, since trauma is

often defined as the rupturing of connection (Comstock et al., 2008; Herman, 1992). Feminist relational theory guided the interviewing technique in this study, which was conversational and minimally structured. I joined women in their environments, giving them room to narrate stories as they chose and encouraging an atmosphere of supportive conversation (Devault, 2004). The narrative analytic method that I used additionally honored women's voices by attending to their ways of crafting and performing stories in addition to the experiences thus narrated (Riessman & Quinney, 2005).

Narrative Inquiry. Story-based or narrative research assumes that narrative is a basic means by which humans make sense of and communicate experience (Bruner, 1990; Polkinghorne, 1988). Narrative specifically refers to the temporal ordering of a series of events or conditions by a speaking (or writing) subject (Mishler, 1995), while story refers to a more purposeful performance that may involve more attention to scene-setting and evaluation of meaning than is found in the mere narration of events (Maynard-Moody & Musheno, 2009; Mishler, 1995). Notwithstanding distinctions made between story and narrative, in the social sciences literature the two are often used interchangeably to refer to segments of talk that form a plotted sequence, though it may not be chronologically ordered in the telling (Riessman, 2008). I use the terms narrative and story interchangeably in this article. Narrative inquiry has been developed for social science research by Clandinin and Connelly (2000), Gubrium and Holstein (2009), (Hall, 2011), Maynard-Moody and Musheno (2014), Riessman (2008), who argue that personal narratives provide rich, detailed information about how people infuse experience with meaning and emotional valence, which in turn inform attitudes and behaviors (see also, Sandelowski, 1991).

The narrative analytical methods used in this study were specifically adapted from Riessman (2008), who demonstrates how narratives convey meaning through thematic, structural, and performative dimensions, as well as through intertextual connections or the way stories told in one context converse with stories told in another, including broad cultural

narratives. Inquiry based on personal narratives has had special significance for health science (Priest, 2000), where stories and storytelling are employed as a mode of intervention (M. J. Smith & Liehr, 2013) and as a method to build knowledge about the subjective experiences and needs of patient populations (Draucker & Martsof, 2010; Polzer, Mancuso, & Rudman, 2014). For nursing and other health researchers, storied data can render visible the emotional and perceptual patterns that organize the ways in which people manage health and safety risk in their worlds (Bally et al., 2014; Lee et al., 2016).

Social Network, Social Support, Social Capital. The study focused on justice-involved women’s stories about relationships in order to understand how they perceive self and other in mobilizing social support. According to social network and social support theories, the webs of social relationship that bind persons to one another in a community often serve as a conduit for social support (Berkman, Glass, Brissette, & Seeman, 2000). Social support in a network may take form as emotional, material, instrumental, and informational resources exchanged across specific ties or relationships and, in low resource situations, may be necessary for survival or “getting by” (S. Cohen, 2004; Uchino, Bowen, Carlisle, & Birmingham, 2012). Social support generally operates according to a principle of reciprocity, the achievement or promise of some form of give and take (Uehara, 1990). Social capital describes resources that are held within network relationships and become available to a person or a group through interactions with others in the network (Hawkins & Maurer, 2011; Lin, 1999). Although social capital may include aspects of social support, it is more typically used to describe resources (i.e., credit, entrée, cultural knowledge, access to power brokers) that improve one’s position in a social field or facilitate “getting ahead” in a realm of activity (Bourdieu, 1986; Lin, 1999).

The central tendency in the conceptual framework for this study—including the three social theory concepts, feminist standpoint theory, and narrative inquiry methodology—is relational and as such is well-suited to support investigation into the question of what trauma

stories of women with justice involvement have to tell us about how women perceive and manage social ties to access the social support they need to protect health and safety.

Methods

Case Selection and Recruitment

Women were invited to interview from a larger, ongoing interventional and ethnographic study (Ramaswamy et al., 2017). The convenience sample ($n = 184$) for the parent study included English-speaking women who were recruited during incarceration in three county jails in a Midwestern metropolitan area from September 2014 to March 2016 (Ramaswamy et al., 2017). The only exclusion criterion for the parent study was indication of severe psychological disturbance or extreme emotional volatility that might affect a woman's ability to participate in the intervention (Ramaswamy et al., 2017). For the interview-based substudy, a purposeful selection of 10 cases was made based on the complexity of women's social networks and experiences of trauma as expressed during the interactive group sessions of the parent study. Invitations to interview for the present study were made by phone or in person between December 2015 and July 2016 by the parent study project director. Recruitment of participants for the interviews ended in July 2016, when it was determined that story data collected from the 10 existing cases was yielding stories of sufficient complexity and diversity about women's interpersonal relationships to answer the research question (Patton, 2015).

No one who was invited to participate in the interviews declined, and none of the participants were lost to follow up during the 12-months of interviewing. All participants gave informed, written consent to voluntary ethnographic interviews and observation as part of the consent process in the parent study. Prior to the interviews, I reviewed the purpose, benefits, and possible risks of the substudy, and verbal assent to continue participation and be audio recorded was obtained.

Data Collection

Two in-depth, semi-structured interviews were conducted with each of the 10 participants. All interviews were audio recorded. Recordings and transcriptions were stored in Dedoose (a password-protected online data management system) and on a secure server at the University of Kansas Medical Center. Interviews in both the initial and follow-up series averaged 60 minutes and ranged from 31 to 91 minutes. The average passage of time between each woman's initial and follow-up interview was five months, with a minimum of three weeks and a maximum of 12 months.

Initial interviews employed a life-story trope in which the participant was invited to imagine her life as a book, similar to what McAdams (2008) describes but with each chapter specifically dedicated to the story of one or more key relationships. The relationships could be with family, friends, intimates, or acquaintances. Participants were encouraged to order their chapters and the stories within them however they liked and were not held to the book format if they seemed resistant to it. After a woman narrated her last chapter, she was asked which (if any) of the chapters she would remove from the story and why; what she would make up and add in as a chapter; and finally what title she would give her overall story. In follow-up interviews, I presented a typed outline or a verbal description of the book's chapters and their key contents to participants for verification and invited additional storytelling prompted by that frame. A visual analog timeline was completed with most participants during follow up to chronologically map events of significance to physical well-being or health.

All interviews were conducted in person, with the exception of one, which took place over Skype after the participant moved out of state. All interviews were coordinated by the project director for the parent study, and most interviews occurred in the community, at sites that included participants' residences, researchers' cars, coffee shops, a public library, a

church-choir changing room, and various McDonald's restaurants. Three interviews (two initial interviews and one follow up) were conducted in a meeting room in the jail.

Data Analysis

Recorded interviews were transcribed verbatim, and I reviewed and cleaned each against the original recording before loading it into Dedoose, a data management program for qualitative inquiry. I and another member of a three-member analytic team coded transcriptions in Dedoose independently, using two sets of codes, one that I developed for this study and another developed for the ethnographic arm of the parent study. Throughout the 12-month period of data collection, the three members of the analytic team—including, in addition to myself, the principal investigator and the project director for the parent study—met biweekly and then weekly to compare emergent themes from field notes, coding, and analytical memos (R. M. Emerson et al., 2011). Through an iterative process of coding, memoing, and discussion with the team, I discerned the presence and main attributes of a framework of opportunizing and fatalizing talk in the management of relationships for support.

The unit of analysis in this study was two-part and included the overall life stories constructed by the women over the course of their interviews and the more restricted, embedded trauma stories within them. The larger, life stories were constructed from the chapters outlined by the women; field notes, in which I recorded impressions of interactions and setting; and the time line reviews, which were completed with some women in the follow-up interviews to map events chronologically. Embedded stories were delineated for analysis based on a narrated trauma event series with a discernible abstract or beginning (often instigated by a question or prompt posed by me) and an ending, in which, after recounting the shifts in action or condition, a participant gave some form of resolution and provided a “coda,” usually a sentence or two bringing the account into the present perspective (Labov & Waletzky, 1967, p. 39). Embedded stories of trauma could extend over

a few lines or a few pages; some were peppered through with my probing questions, while others issued forth as an unbroken flow of narration. The trauma stories cited in the findings were selected on the basis of detail, complexity, and completeness.

Ethical Issues

Participants in this study were initially encountered during an incarceration, and most continued to be subject to criminal justice supervision, some returning to incarceration during the course of the study. As such, they were deemed vulnerable and merited special protections as human subjects. Amplifying their potential for harm and exploitation was the continuing involvement of many of the women in drug use, drug sales, and prostitution—illegal activities that participants discussed freely in the interviews. I met the confidentiality requirements related to human protections by storing data in password protected computers and on a secured university server. Initials and pseudonyms were used to identify the women in notes and transcripts and were not linked to women’s actual names outside documents from the parent study. I protected women from coercion by reemphasizing that the participants were under no obligation to continue with the study as a whole, the interview portion, or any particular line of discussion within an interview. I did this in each encounter. I took care to stress to participants that the project would probably not benefit participants in any direct way, but I also let them know that their contributions may help care providers and program designers improve conditions for women in like positions by designing better services. I warned women that our discussions may cause unwanted memories or emotions, and I reminded them that our team was available and could provide referrals for mental health support if needed.

Women were remunerated \$10 for each interview in acknowledgement of their time in addition to being compensated for participation in the parent study. The amounts were applied to debit cards held by the women as part of their ongoing participation in the larger study. A National Institutes of Health Certificate of Confidentiality was obtained to protect

recordings and other materials in this research from seizure or discovery by law enforcement. The substudy was approved under the parent study protocol by the institutional review board at the sponsoring university medical center with an agreement to rely on partner IRB memorandum approved by my university.

Findings

Participant Characteristics

My objective was to achieve depth and detail of data in a range of specifically selected cases rather than representativeness or probabilistic generalizability (Miles & Huberman, 1994; Patton, 2015). Even so, demographic information in a qualitative study can provide a snapshot of a group of cases and give some idea where diversity of experience may have been achieved or lacking (Sandelowski, 2001). The 10 participants in the interview group all identified as *cis*-women and reported Black (60%) and White (40%) racial identification. One participant additionally reported maternal grandparents with American Indian tribal membership. Ages ranged from 27 to 52, the average age being 38.5. Five of the women graduated from high school or earned its equivalent through General Education Development (GED) examination, four had some college attendance, and two of those held bachelor's degrees. Other participants described dropping out of school before the twelfth grade, with one reporting that she had had no formal schooling past the ninth grade. Nine of the women experienced pregnancy at or before age 17, and eight had three or more living children. Two of the women were grandmothers. Of the eight mothers, all had lost parental rights or temporarily or permanently lost custody of one or more children who were placed in the care of a family member or assigned to state administered guardianship.

Three of the women in the study, all of them white, were incarcerated for the first time during the parent study, whereas the rest had been jailed at least five times before that, with half of the women claiming to have been incarcerated over 10 times. Two of the first timers in jail were sent up to prison during the study, so that, at the end of 12 months, all but

one person in the group had served prison time. Prison differs from jail in that the former usually means a felony charge with a longer than one-year sentence. Jail stays may be for misdemeanor offenses and other charges carrying less than a year's sentence, detainment pending trial, or remand due to violation of probation or parole. The longest prison stint among the women was 16 years, served for drug trafficking. Only two of the women were employed in the official economy for short periods during the study. Four of the women exchanged sex for food, shelter, money, or drugs either regularly or intermittently during the 12 months, and two others had done so in the past. All of the women reported history of controlled substance use, most frequently (other than alcohol and marijuana) crack cocaine (typically smoked among this group), methamphetamine (women reported smoking, snorting, eating, and injecting meth), and PCP (or "wet"; i.e., cigarettes soaked in PCP, dried, and smoked). In either the initial or follow-up interview, all but two of the women acknowledged drug use during the period of the study, including the two incarcerated women who described using while in jail.

Finally, various combinations of drug abuse, sex exchange, interpersonal violence, and insecure housing put these women at elevated risk of infectious and chronic disease and injury (Kelly et al., 2014). Judging by their own descriptions, the most pressing risk related to health and safety in the women's day-to-day life, the one that often motivated the frequent shifts in relationships, was the threat of injury or death due to violence. Six women described being raped as adults, often multiple times. Seven were beaten by boyfriends, husbands, or johns severely enough to require hospitalization. Three described abductions by abusive partners that involved being held captive for a period of time. Two reported having been hospitalized with gun shot wounds. Three of the women described death or severe injury of an infant in the home. Of chronic diseases, one woman in the group was diagnosed with hypertension, two others had arthritic conditions that affected their mobility, and one was HIV positive.

Opportunizing Talk and Fatalizing Talk in Narration of Trauma

The initial interviewing and analysis of data in this study was guided by the broad question, “What do trauma narratives of recently incarcerated women reveal about how they perceive and manage social ties to access support for health and safety?” Trauma stories represented comparatively extreme moments of health and safety risk in the women’s lives, and, as Janoff-Bulman (1992) has argued about research based on extreme events, because of that they may provide particular insight into “basic aspects of human thought and behavior” (p. 3). The narratives I collected indicated that justice-involved women in volatile environments with compromised access to resources perceived relationships of support and their own capacity to engage them along a continuum extending from greater (opportunizing) to lesser (fatalizing) ascriptions of agency. Where opportunizing talk appeared in the narratives, storytellers often filtered experience through a cultural discourse of self-help and personal responsibility. They presented themselves as planners and goal-setters, actively attempting to negotiate social ties to obtain support from friends, family, and social institutions. In fatalizing talk, narrators of trauma tended to adopt equally prevalent cultural discourses of inevitability or unpredictability, where events and outcomes unfolded according to forces beyond their control. Though the former is generally a privileged narrative in twenty-first century North American culture, in this analysis both types of talk served important purposes for the women in reconstructing responses to crisis, and both may prove enlightening to those who seek to find better ways to provide supportive care or design better targeted programs.

Opportunizing. Justice-involved women with history of interpersonal trauma struggle to achieve economic and social stability and are challenged by risks to health and safety. In the life stories narrated in this study, women often presented themselves as injured but not immobilized, as agents who, despite persistent disappointment and even disaster, strived to manipulate social ties to achieve objectives related to reducing risk or improving

health and safety status. In embedded trauma stories with an opportunizing emphasis, women focused attention on their roles as agents—often as mothers—attempting to direct the shape and outcome of crisis. These accounts traced women’s actions but also highlighted their analysis of cause and effect, cost and benefit, facilitators and barriers. Women who used opportunizing talk described decision-making or planning and often ascribed circumstances that affected their health and safety to their own actions and/or claimed to control responses and outcomes.

Natalie. Natalie, a 35-year-old Black woman, was a college graduate and mother of four (all, middle- and high-school-aged), who spent four years in prison and reported having been jailed more than 10 times, mostly for drug-related crimes and violations. Chapters in Natalie’s life story described relationships with her mother, the fathers of her children, two same-sex prison relationships, and the man she married during the year of this study. Key events in Natalie’s life story included rape by an acquaintance at age 14, the birth of her children, the loss of her parental rights, and the sudden death of her mother. Natalie identified herself as an alcoholic and reported using methamphetamine and abusing prescription opioids.

I interviewed Natalie once in a colleague’s car and once, at the participant’s request, at a McDonald’s, located on a busy thoroughfare in an area of the city known for high unemployment and crime rates. In the first interview, on a very cold, gray day in late January 2016, Natalie told me that she and her fiancé, Paul, a meth user, had recently been kicked out of a house in which they were squatting following a previous short residence in someone’s car. In our second interview, 11 months later, Natalie recounted how she was recently arrested and extradited on a warrant from a small town in a neighboring state, where she and Paul, now her husband, had gone to live temporarily with Paul’s mother. During arrest and extradition, Natalie miscarried a pregnancy. While free pending trial, she and Paul were subsequently evicted from one apartment; squatted in what Natalie described as a shed for a

time; and, when we met for our second interview, she was subleasing a bedroom with Paul in a tiny, dilapidated house in a very run-down neighborhood. As I recorded in a field note, the house featured a front door that was either constructed of or covered by particle-board across which was handwritten in big red letters, “NO DISTILLERS” (underlined). We learned from Natalie that this was a reminder to all who entered that, due to increasingly severe liver disease, the 25-year-old woman with whom Natalie and her husband shared the house was not to be given distilled alcohol under any circumstances.

Natalie’s life-story narrative was shaped by her almost constant maneuvering to secure sanctuary, both physical and emotional, for herself and formerly for her children. She told several embedded trauma stories that exemplified opportunizing talk in managing relationships to obtain support. In her first chapter, Natalie described leaving her mother’s home at age 15 (not, she specified, because of abuse, but because Natalie felt “abandoned” due to what she perceived to be her mother’s preference for a younger sister) to live with a 14-year-old boyfriend, Darren, in his mother’s house. Natalie spent nearly seven years and had two daughters with this partner in a relationship characterized by severe physical and emotional violence. The extended, disjointed account of this first opposite-sex relationship included allusions to being punched, kicked down stairs, and raped. Importantly though, despite the recitation of chronic, severe abuse, Natalie framed herself as an opportunist, first narrating a predicament over which she perceived that she had little control and following, despite that lack of control, with descriptions of strategizing: variously establishing intent, assessing options, making plans, taking action.

The tale of liberation from Darren’s abuse, for instance, began with a program of resistance in which, “after, like, six and a half years of bein’ tired of it, it got old. I started fightin’ him back my last year. I stopped having sex with him completely [...]. I’d just lie about having headaches.” Prior to this, Natalie related that while she never disclosed the violence to her family she had begged her mother to let her come home, a request that was

denied. Natalie finally hit upon the means to escape the relationship with Darren and gain permission from her mother to move herself and her two young daughters into her mother's house:

Natalie: I got a day job, okay? I snuck and got a day job. Put my kids in day care while he worked at nights. See, he would work the graveyard shift, so he'll be gettin' off work, I'll be going in. And he'll be thinking that I'm just gone, you know what I'm sayin', but I'll be really at work. [**Amanda:** Yeah.] I was trying to save my money so I could get me a car, so one day he'll come and all our stuff will be packed and we'd be gone.

Amanda: Was anybody helping you during that?

Natalie: Nope.

Amanda: Wow. Huh. And then, and then you finally did it?

Natalie: Well, this is—I finally did it. This is what happened, me and him had gotten into an argument, and his mama—no, me and his mama had gotten into an argument, and she—

Amanda: What were you arguing about?

Natalie: Oh, something stupid, I really can't remember. But the man she was messing around with, Samuel—he was—she thought—he lied and told her that he had cancer and was going through chemo.

Amanda: Oh, for goodness sake—that's terrible.

Natalie: No, me, I looked at it as something different. The changes—he was HIV-positive, [**Amanda:** mm] and, uh, by this time I think it had blown to AIDS, and he didn't tell her and she was still having sex with him, and I told her—we got into an argument, and she swung at me, and I didn't want her to scratch me—I mean, you know what I'm saying. And I was like, "You need to go and get checked, cause that ain't cancer Samuel is going through. He got AIDS." And she was like, "*What?*" I was like, "Yeah, he got AIDS, you can't tell?" She was like, "How do you know?" I said, "Just look at him." He went from being a heal—I mean a big, healthy man to like, in a ye—in like 5 years—to bones. Skin and bones. Like his face was pale and everything. So, after me and her got into the argument and she tried to fight me, I called my mama, cause my mama stayed right down the street—I could walk down the street to my mama house—and I was like, "Mama, I need to come home, I need to get out of this house. I think Bernice and them is up here with this package, you know, with HIV and stuff, and I can't have my kids around this." So, she was like, "Come on home." And she let me come home.

Natalie set two plots into motion in this account, an elaborately planned one that involved a secret job and savings but required time to come to fruition, and a second, the fight, enacted on the fly, its results put to immediate use. The structure of the story highlighted Natalie's tactical aptitude as she abruptly pivoted from the first approach to seize on and develop the

circumstances surrounding the second. In the second, she transformed the “something stupid” of a minor fight with Darren’s mother into a narrative of imminent danger. Opportunizing was made even more apparent in the final lines, when Natalie pointed to her strategically reasoned assumption that, even though her mother had not responded to previous requests for sanctuary, appealing to her fear of HIV and the safety of her granddaughters would prove more successful.

Natalie’s opportunizing talk took form through her presentation of self, which focused on the depiction of a woman isolated and yet continually plotting to rebuild connections. From the beginning of her life story, Natalie stressed her perception that the primary outcome of most relationships was abandonment. Heading off or responding to abandonment motivated numerous embedded stories in Natalie’s interviews. In one such story, Natalie narrated the crisis surrounding the permanent loss of custody of her children. After Natalie left Darren, the father of her two daughters, she had a son with a second man and then moved in with and had another son with a third man. This third man and Darren were in frequent conflict, which culminated one night in an exchange of gunfire outside Natalie’s apartment. Neighbors called the police, and all of Natalie’s children were removed from the home. In recollecting 10 years later the chaotic period that ensued, Natalie designated a new chapter that she said she would not associate with any relationship. Instead, this was a chapter in which she described herself as situated against everyone. Natalie’s focus is on strategizing—with little help and much hindrance from others—to secure her own and her children’s safety. With her use of present tense to narrate parts of the story (which confused me at first, as is evident from the dialogue), Natalie underscored how painfully near the loss remained to her, even a decade later:

Natalie: Yeah, it [the court removal of her children] ended that chapter and started a new chapter. Cause now it’s me against [pause], I feel like, against everybody, trying to get back my babies. And nobody else is working on this with me. Like, where my brothers and sisters at? Where my mama? Where’s my support group at? Nobody’s

trying to support me. Everybody's talking about "You need to get a—just do this and do that." How much more do I need to do? I mean it's just me now, I feel like. Cause every time we go to court, my baby daddy arguing with the judge. And she seem like she still equated him, giving him all the, giving him all more rights than she, than they, giving me. I'm like "What the *hell* is going on?" That's why I feel like, "What the?"

Amanda: So, they've taken all your kids away? And the kids are all in foster care—they're not with family?

Natalie: They were. Uh-uh. They was— Okay, my mom told my brother to get her grandkids *out* of foster care. Okay, so he still trying to talk about, "I need to talk to my wife about how we going to do." So then Darren's uncle stood up and took my two oldest girls. His uncle did, okay? [**Amanda:** mm-hm] My boys—John went with my little sister, and David with his grandma on his daddy side, okay. So I'm like, "Alright." I feel like everything was—they not in foster care, so maybe now I could do a little bit more, you know what I'm saying, with the visitations and stuff without even going through the courts, cause they were with family, you know what I'm saying? [**Amanda:** Yeah.]

[Long pause.]

Natalie: Well, my daughters ended up being molested while they was over there, by members of the family. [Pause] [Starts crying softly.] And so, so my babies, when they end up getting molested— My daughter used to scream, "Mama, please don't take me back over there," and she wouldn't—they wouldn't ever *tell* me. And I told them they could always tell me anything. [...] But they ended up getting molested by they own cousin. So that's when my brother finally stepped up to the plate. Because I was going on a murder spree. I really was. I was ready to kill everything in that house. Because I was like, "I trusted you with my girls," and I started thinking about it—I *never* wanted men around my girls. But the wife was there, and she end up dying. [**Amanda:** mm?] I didn't even know the wife had died, you know what I'm saying. They didn't even tell me the wife had died. So Darren's grandma end up going there, and I was like, the grandma's there and the wife is there, and there's only one son—I didn't think the son would be doing what he was doing to his own—you know. Anyway, so my brother stepped in and he gets my girls, and he gets my boy, he gets my oldest boy.

This pained account traced Natalie's unanswered need for support as she sought to regain control over the disposition—interpreted correctly by her as the safety—of her children, and it highlighted Natalie's perception of abandonment and isolation, of being alone against the world. The fathers of her children caused her to lose them, her own family let her down by failing to act, and Darren's family allowed the unthinkable to happen to their own kin. Finally, the system made demands that, as she said, no matter how hard she tried she could

not seem to satisfy. The image Natalie painted was one of embattlement and isolation, yet, crucially for this analysis, it was not one of helplessness or passivity.

Similar to other trauma stories that featured opportunizing talk, in this one the presentation of a self in isolation, lacking either formal or informal social supports, tended paradoxically to be parlayed into the portrayal of a hard-bought agency. Natalie recounted how her mother, her brother, her family, Darren's family, the judge, and Darren himself failed to act—or acted directly to the detriment of her children's well-being. Natalie perceived that she had scant actual power, her agency highly constrained. The entire first passage is dominated by expressions of helplessness and bewilderment, exemplified by her anguished wondering: "Where's my support group? [...] What the *hell* is going on?" These moments resembled in many ways the fatalizing talk found in other participants' narratives as discussed below. But in Natalie's storytelling, alienation did not lead her to submit to circumstance but to reassert agency: though utterly alone, she was "working on this"; once the children are in the care of family members, she would be able to "do a little bit more" to achieve time with her kids; and, in narrating what occurred after the sexual molestation of her daughters by their cousin, she underscored—with a single, important "[b]ecause"—that it was her own murderous rage that impelled her brother finally to step up. Though not always successful and certainly fraught with heartache, frustration, and sometimes recklessness, Natalie's narrative constructions of her own efforts to achieve safety highlighted opportunizing talk, wherein plans were laid and goals for safety pursued by an individual who evaluated motivations in order to manipulate social ties and assert agency over events. Natalie chose as the title for her overall story "Don't Throw me No Pity Party"—sounding a kind of credo against being defined by others as powerless.

Jennifer. Jennifer, a White woman, aged 40, also emphasized opportunizing talk in her approach to managing support in a trauma narrative about losing child custody. Jennifer's opportunizing talk underscored rather differently the ways a woman with criminal justice

involvement might find herself having to navigate around rather than through relationships to get help. Our first interview took place in Jennifer's temporary home—a bright, clean, two-bedroom apartment, cluttered with potted plants, books, baby toys—in a residential transitional program, where she was completing substance abuse treatment as ordered by the county-administered drug court after leaving jail. Five months later, our second interview was conducted over Skype, after Jennifer moved to a distant state for a job. The jail incarceration in which I initially encountered Jennifer was her first, and Jennifer had no prison experience at all. Her life story was further distinguished from the others in this study by a middle-class upbringing, attendance at a private high school, professional career history, and the absence of reported physical and/or sexual trauma. Despite these differences, Jennifer's life story shared elements with the other participants', most prominently an unplanned first pregnancy before age 17, history of cocaine and meth use, and loss of the custody of a child due to substance abuse.

Jennifer recounted a chronologically ordered life story, proceeding from childhood to her incarceration, through release and recovery, and finally to the present. She organized chapters loosely around key relationships and events, with early segments centering on her family, including a sympathetic, supportive father and a distracted, alcoholic mother; her three siblings; a couple high school and college boyfriends; a few female friends; and the man she married after college. Key health events she identified on her time line and in her life-story narrative included first sex at age 15, an elective abortion soon after, and a more recent diagnosis and successful treatment of cervical cancer. Jennifer's overall story featured a prominent use of opportunizing talk that took the form of evaluation and assessment, indeed, a running analysis of the causes behind her actions, feelings, and attitudes. For instance, while she began her life story by relating an idyllic-sounding childhood and adolescence, that narration of early life was followed almost immediately with premonitory ruminations on what Jennifer identified in hindsight as sources of future trouble. She

explained that what she once considered to be a “normal,” carefree childhood she now recognized as lacking in emotional connection, steeped in the heavy drinking of her parents’ social circle and the superficiality of bonds among her own friends. Early social experiences, she argued, left her with inadequate skills for building strong, reciprocally supportive relationships in adulthood. As a form of opportunizing talk, Jennifer’s analysis functioned to control interpretation of her story by making explicit the connections between causes and effects, between her early history and the later perceptions, choices, and actions that comprised the particular, embedded trauma story in which she lost custody of her middle child.

The trauma story occurred after a “downward spiraling” series of events. Jennifer married right after college and had a child. Eventually, Jennifer divorced her husband (he was granted custody of the child) and then, weary of the frequent travel associated with her career, she accepted a less challenging and, as it turned out, less fulfilling position that left her idle much of the time. She explained that this led to boredom, which led to vulnerability to substance abuse:

What happened—oh, I—okay, I moved back, I got this job, got a little apartment, started dating him—Chris. Everything was going good. Everything was fine. We were doing good, you know. But I was unfulfilled with my job—totally unfulfilled. And that was starting to show, because I was waking up not—just didn’t care. I didn’t have to work a lot. Then kind of just started spiraling downward, because I was bored.

Jennifer’s narration of this period grew more haphazard as she progressed into the telling of crisis. Just before becoming pregnant with her third daughter, she returned a positive drug test. Then, in what she denominated the one real trauma in her life, Jennifer lost custody of her second daughter. Jennifer was subsequently arrested and incarcerated, events that Jennifer interpreted in fortunate-fall terms, both because “they kind of got me at a really good [time]—you know, I, I was *able* to come back,” and because living through the crisis that followed enabled personal growth that might not have been possible otherwise.

Taken as a whole, Jennifer's life story fits the shape of a redemption narrative (Maruna, 2001; McAdams, 2006) in which a comparatively untroubled early life is disrupted by a series of complicating events or errors that intensify with life transitions, until a crisis or what in their influential formulation Sampson and Laub would have called a redirection of life course—a "turning point" (1993, p. 8). The turning point ushers in a new life, often one that allows the agent to make up for (or redeem) the errors of the old in some fashion (Maruna, 2001). For Jennifer, declension, the downward spiraling of events, proceeded through the traumatic loss of her daughter and her arrest. Her subsequent decision to enroll in drug court and participate in rehabilitative treatment was the turning point that produced, in Jennifer's own estimation, a stronger, more emotionally centered Jennifer than was possible before the crisis. As she said, relationships in her life prior to the crisis were "just skimming the surface of relationships." Incarceration, sobriety, and self re-definition through small-group therapy with other women reversed a downward trajectory, so that in the second interview an employed, drug-free Jennifer was able to claim that—notwithstanding the continuing absence of her second daughter in her home—she had never in her life been happier. Although Jennifer framed her life's turning point in the fatalizing terms of fortunate-fall (they "got me at a good time"), the narration of the trauma story emphasized something more akin to opportunizing talk.

In the embedded narrative of trauma, Jennifer's focus (unique among the participants) was almost exclusively limited to relationships with formal systems or agencies. Jennifer depicted her family as present but uninvolved, her intimate partners mainly absent. Overall, Jennifer presented herself as an autonomous actor, independently formulating plans and weighing costs, much like Natalie. Jennifer also described feeling alienated from others, in her case not so much abandoned by them as separate from and unable to connect emotionally. Both Jennifer and Natalie portrayed families that were accessible but seemingly indifferent to their plights. But whereas Natalie narrated attempts to extract support from

family members whose emotional legibility made it eventually possible for her to manage those relationships for shelter and sanctuary, Jennifer painted a picture in which interpersonal relationships were simply not part of the array of support options she recognized or sought to activate. Instead, she narrated an anxious dance with state agencies, an attempt to manage a relationship with a system that was decidedly less comprehensible to her than family members were to Natalie and around which it was far more difficult for her to form and execute plans. Opportunizing talk in Jennifer's trauma narrative centered on the interpretive task of assessing intentions and weighing costs. In this exchange, Jennifer narrated the events—the decisions she made—leading up to her loss of custody:

Jennifer: One, it's very—the system is set up—in my opinion, and I'm saying in my opinion—that you may need support, but it's not very easily found. And, um, like no one loves to talk about, “Oh my god, I'm addicted to drugs. I'm using every day with my kids here”—to anybody, because reality is, you say that and then it's like they come to get the kids “duh-ti-duh.” And then you're more distraught. So, asking for help [sigh] was like, it's—you don't want to, because you don't want to lose your kid.

Amanda: Yeah.

Jennifer: You know what I mean?

Amanda: No, you're making a lot of sense, yeah.

Jennifer: You don't want to lose your home, you don't want to—you know, so if you let [them get] wind [of it] and then it's on your health record—

Amanda: Mm-hmm.

Jennifer: Like, I have people looking at me and like, “Oh, you used to be a u—” and I'm like, “Wait a minute! how—where did this come from?” And so then you're labeled like this. They treat you differently. It's like people don't *mean* to. You know, they go through all these trainings that say, “You don't treat these people differently. They need the same care.” But people are people and they treat people differently.

Amanda: Yeah.

Jennifer: You know, people have their own opinion sometimes. You don't know what they do when they go home—if they're totally anti-drug, they don't understand, they're not an addict, they don't get it, you know. And so, like, that makes it difficult. So it's really hard.

Amanda: I'm sorry.

Jennifer: And from where I was coming from, it was extremely hard to ask for help because I don't—I didn't—trust anybody, and I was brought up to get through it on my own. I was to a point where I had nowhere else to go. And these were the last strings. And they're like, “Here, you can either grab it or you're gone.”

In this segment, leading up to the trauma story, Jennifer's opportunizing talk highlighted a process of risk assessment, outlining the factors that she, as a drug user and a mother, considered in determining whether to initiate a relationship with the state's Department of Family Services (DFS). First, she was challenged to identify the right source of help, the entity with which to form a relationship—whom to entrust with her predicament. The right assistance, she said, was “not very easily found.” She then reviewed the costs of disclosing drug use and asking for help, which included potential loss of a child, breaking up the family, and feeling marked as a drug user. Jennifer's opportunizing talk highlighted the extent to which a perfectly rational perception of a punitive function (the power to remove children) might impede viability of support functions (getting help for substance use) for a help seeker. There was also a slightly different cost of losing face (E. Goffman, 1967), since, as Jennifer pointed out, asking for help at all was opposed to the bootstraps view of herself with which she was accustomed: “I was brought up to get through it on my own.” Jennifer's trauma narrative stressed that, if opportunizing is the mode in which a woman imagines herself to manage relationships, a lack of legibility or transparency around support—in this case for drug-abusing women with children—may prove prohibitive. To Jennifer's exasperation, nothing about the process of seeking support before or getting formal help after losing her child was “straightforward,” except the threat about what Foucault (1990) might have called an imperative to confess: “grab it or you're gone.” Jennifer recognized the dilemma, namely that “grab it *and* you're gone” was equally likely, since confessing drug use and getting help for it could very well be disastrous.

Jennifer: Well, I think we run and hide at that point. I was in hiding mode. I didn't want anybody to know. And, and, and, eventually, you know, that's why I lost her, you know.

Amanda: Yeah.

Jennifer: I wasn't, I wasn't—I didn't reach out for help. But I was so scared of the inevitable that the inevitable happened. Nobody—no one sits you down and says: “If you don't do this, this will happen.” No one's very straightforward. Everyone kind of

sugarcoats it, like, “Okay, well, you know, this is only going to happen for a couple of weeks.” The weeks turn into the months, the months turn into a year. And then you turn around and you’ve lost your child.

Amanda: I’m sure there’s a lot of denial going on there, too—the “I can stop at any point”?

Jennifer: You know, they’re trying—the goals of DFS is to make sure—for the child. They could really give a shit less—I mean, this is how I felt—they don’t really care about me. They don’t care about the dad. They care about the child, and they should. But then they want us to meld together. But they’re not—they don’t ever come across very serious. They’re like, “Oh, you’ll have your visits,” and their intention makes it seem like you—just seem so scared to be open and honest with them because they use everything to keep the child.

When Jennifer recounted what she named “the biggest trauma” she had experienced, what she described was the apparently permanent disruption of a relationship with her second child. Jennifer chose to narrate her crisis as an extended, emplotted process of assessing and weighing likely choices and anticipated outcomes. At the center of the story was Jennifer’s emphasis on how troubling she found it not to be able to make an accurate reading of the other’s (the state’s) intentions and thus form reasonable predictions about what would happen next. This trauma account was opportunizing in its list-like form, in its thematic content of frustrated strategizing, and in Jennifer’s presentation of a self-examining, goal-setting persona. Jennifer’s life story highlighted her role as one who struggled to negotiate a relationship with a state agency that represented “the last strings,” the only means she could envision to promote her rehabilitation and prevent harm to her child. Unfortunately, that relationship also, in Jennifer’s view, threatened to and in fact did sever the mother-child bond.

Despite failing to head off disaster, Jennifer resumed opportunizing—goal-setting, assessing, planning—in stories about relationships after her loss. In the period following arrest, Jennifer explained, she learned to identify and navigate the services that would facilitate her own and her partner Chris’s journeys through recovery. In her words, “I really used all my resources. No one tells you what resources to use.” Jennifer also described learning finally to build and maintain supportive interpersonal relationships, particularly

friendships with other women, through recovery groups. When asked what she would entitle her life story, Jennifer proposed “What Not to Do,” a clause that implies a scene of learning, where persons who encounter her story might equip themselves with lessons based on her experience to improve their own capacity to make choices and achieve desired outcomes.

Fatalizing. As trauma stories like Natalie’s and Jennifer’s indicated, some stories told by justice-involved women featured opportunizing talk, which included planning and decision making in a highly constrained environment based on assessments of costs and benefits. Opportunizing talk reflected the storytellers’ declared or implied trust in their own capacity to pursue health and safety goals, despite varying degrees of structural marginalization due to race, poverty, and criminal justice involvement. By contrast, in stories dominated by a fatalizing approach, storytellers stressed a displacement of control or agency. Fatalizing talk was dominant when women expressed a sense of compromised self efficacy around marshaling support for health and safety. In these accounts, women represented crisis and their own roles in it as either foreordained or as radically unpredictable and incomprehensible. In fatalizing talk, women ascribed situations and outcomes to fate, God, or chance and identified themselves as detached, confused, surrendering, and often dazed observers.

Cicely. The first time I met with Cicely to interview, we used a tiny study cubby at a local public library. It was a hot day for June, nearly 90 degrees by 10:00 a.m., and the study room—though it was uncomfortably humid and we were practically sitting on top of one another—proved to be comparatively cool and private. For the second interview, in October, a colleague and I went to a house that Cicely rented with her boyfriend. Like many other houses on Cicely’s street, this one appeared uninhabitable, a broken pane in a front window, the yard and driveway littered and overgrown with weeds. Cicely was 31 years old, African American, quick-thinking and fast-talking, self-confident, very intense. She had four school-aged children, two living with Cicely’s maternal grandmother, one adopted into a family in

another state, and the fourth under guardianship of that child's paternal grandmother. Cicely reported over 10 incarcerations and one prison stay. In June and again in October, Cicely acknowledged recent use of coke, meth, and PCP. When I saw her in a field encounter a month after the second interview, she claimed to be in hiding, saying that a local dealer had a "hit" out on her.

In her life story, Cicely made frequent declarations of self in which she seemed intent on establishing a general kind of agency: no-nonsense, goal-driven, someone who gets stuff done. In the chapter she created around her relationship with the father of her first three children, for instance, Cicely outlined her role as the family supporter, "the breadwinner," and "a go-getter," working two or three jobs at once to provide for the household. In a formulation that she repeated in almost identical terms in the two interviews, Cicely stressed her attitude about roles in her relationships: "if you ain't about to go get it, then get out of my face, so I can go get it myself." Based on such self-defining moments in the larger story of her life, one would expect Cicely's trauma narratives to be dominated by opportunizing talk as well. But what emerged in the embedded trauma stories was far more aligned with a second cluster of story attributes, those of fatalizing talk.

The central embedded trauma narrative in Cicely's life story had a reactive, chaotic quality to it, a dreamy disjointedness. The disorder echoed a general pattern in Cicely's recounting of her early life, when she was moved from mother's and grandmother's homes in one part of the country; to father's, aunt's, and paternal grandmother's homes in another; to foster homes; to a state-run children's home; to an uncle's home; to being on the run; to living at 16 with a much older male partner. Cicely's embedded trauma narratives featured similar disorder and randomness, often displaying lots of movement but not much focused direction. Events appeared to occur at random or as inevitable, and other people's motivations were elided altogether or depicted as inscrutable. Exemplary of fatalizing talk around management of relationships in Cicely's narration of trauma was the extended and

circumlocutory account she gave of her relationship with Ángel, a long-term partner with whom she had two children. At the center of that relationship, and arguably an organizing force in her life story as a whole, was the embedded account of the death of Cicely's second child, James.

While Cicely volunteered James's story, she clearly found it difficult to narrate. She wove her way to the newborn's death gradually. She told first of Ángel's strange writing in a secret journal that he called his "manifesto," a detailed, daily chronicle of everything he and she said and did. Then, in what might in a work of fiction be called foreshadowing, Cicely described how a social worker or public health nurse visited their home and told Cicely that her newborn son lagged developmentally, that "when he was about six months, he was probably about maybe four, you know, his level." In the same segment of narration, Cicely recounted having a mysterious premonition or "prevision," in which, overcome by a sudden conviction that her child would not be with her much longer, Cicely told her mother, a month before his passing, "I don't think he's going to make it." Finally, immediately before the story presented below, Cicely shared that she believed she had previously witnessed Ángel trying to smother her older child (by another man), when that child was six months old. By these means, Cicely created a context of inevitability in the narrative, retrospectively constructing the infant's death as an event destined or foretold. Cicely deployed fatalizing talk in the narrative, portraying herself as baffled and helpless, moving as if in a dream, unable to control and struggling to piece together meaning in the events she narrated:

Cicely: Because I woke up, like I usually would, you know, going to school, but I slept in the living room, because, like I said, I was doing online classes too, so my computer was in the living—so, when I would sleep, I would sleep on the couch. And, I remember seeing [Ángel] come in with the baby, with [James], and he was on the couch with him. [...] And, um, I remember waking up, and when I woke up I was about to go to the bathroom, and [Ángel] kinda like picked [James] up and took him in the room. So, you know, I'm thinking he's doing what he's supposed to be doing, changing his diaper or whatever for the day. But, when I went back there [Ángel] had [James] on the bed, and I was like, "Why's he on the bed and not his crib?" And then

I looked at [James], and I was like, “Well, why’s his color look like it—” because he kinda looked like he was pale. But, my baby daddy [Ángel] he, um, was white Filipino, so he looked like he was white, you know, [Ángel] looked like he was white—he looked like, actually, maybe whiter than you. And, it was crazy because [James] was way lighter than *that*, and that’s what kinda make me look at him like [shakes head], “Mmm-mm, why does he kinda look like that?” And, I ended up picking him up and I was like, “Why is he kinda—look like he might be sick or something.” And, [Ángel] was like, “I think he might be sick,” and I was like, “Why didn’t you tell me that he was sick?” and I seen [Ángel] in the closet doing something, and after about maybe a couple of years I started thinking maybe it was the bottle or something that he might have used in the whole incident. I end up picking [James] up, you know, looking at him and realized that he kinda wasn’t breathing. I kinda looked at his hands and feet and they were turning blue and they were turning purple and I didn’t have a phone at the time because I guess I really didn’t need one. But, I didn’t have a phone, and I had to end up going to my neighbor’s house to use the phone to call the ambulance. And, [Ángel’s] stepdad being a police officer he heard the address and he was the first one that was there, and he started trying to perform CPR. But, I kinda already knew that he probably passed away in my house, because just me seeing him and me trying to give him CPR myself—because when we left [the NICU] they were teaching us how to do CPR—and, he was just throwing up all his bodily fluid, like. And he was eating so little. He was like five pounds when I brought him home, because of course he had to be five pounds to bring him home, and at least five of that came out of him. And I was just kinda like, “What’s all this stuff that’s coming out of him? He is so little, like, what? I don’t understand.” ‘Til today I still don’t understand what all that was.

Amanda: Yeah.

Cicely: And, I don’t think I even found his bottle either. And, um—but we went to the hospital and that’s when they told me that he had passed away. And, the whole time that I was there with him his dad wasn’t there, and I was wondering, “Well, where’s the dad at, and where’s my [older] son at?” Like, I’m not understanding. And then the next thing you know his friend, who worked with us, came. I was like, “Where’s [Ángel] at?” and he was like, “He’s at the house.” And, he had brought my [older] son up there, and I’m like “Okay, well, don’t nobody tell him [James] passed away. I want to be the one to tell him he passed away.” But, there were detectives there, obviously because they think that [Ángel] did it. They couldn’t—I don’t think they had enough proof to prove that he did it—but it was something in there that made them think that he did it. And they didn’t actually tell me exactly what it was, but if you, being a detective, think he did it, then obviously, he must have did it. And there’s only me, him, and our [two-year-old] kid in the house. And our son was asleep, you know, and I remember seeing [Ángel] with [James] on the couch. So . . . um, that was kinda hard, a little bit. And I stayed with [Ángel], you know, because I didn’t—I was torn. I didn’t know whether he did or didn’t, until the next incident, which made me be like, “Am I crazy?”

Cicely introduced this story unexpectedly within a chapter in which she had been describing her partnership with Ángel, and specifically in response to a probe from me about the relationship's low point. Despite the rush of language, a dream-like passivity reigned over her narration, marked in the delivery by a liberal use of the coordinating “and,” the use of pronouns (“he,” “him”) instead of names, and rhetorical cushioning through repetition of the qualifier “kinda.” The account was structured not through a replay of its teller's actions as much as through a series of unanswered questions, bookended by the twin suspicions that Ángel tried once to smother her older son and now may be responsible for the death of her younger one. Within the story, Cicely's questions flowed unanswered from one to the next as she queried what Ángel was doing with James on the bed and what he was doing afterward with the bottle in the closet; why her child was pale and motionless; why the child vomited so much during CPR; where Ángel was while she was at the hospital; and what the police and/or courts eventually determined to be true about James's death and Ángel's role in it. Even eight years after the event, Cicely constructed an account of trauma in which the self she narrated moved through events as a perplexed observer—detached, alone, full of wondering horror, noting without comprehension the gaps left unfilled. Cicely's fatalizing talk exemplified vagueness and passivity, qualities that were nowhere so clear as in her final, aggrieved admission of inaction due to uncertainty: “I stayed with him . . . I was torn. I didn't know.”

Cicely's fatalizing talk was unexpected, at odds with repeated and explicit references to herself in opportunizing terms (“And I'm a go-getter, and I will make it fuckin' happen, and we ain't got something, we about to go get it”). In her embedded trauma narrative, however, she created a mood of helplessness and detachment and deployed formal elements such as questions, gaps, digressions, and foreshadowing to call into relief her diminished role as an agent able to manage social ties to get support to protect her own and her children's safety. When Cicely acknowledged relationships—the nurse/social worker, her mother—they

were perceived not as opportunities for support, even failed ones, but instead functioned as part of the story's machinery of inevitability. Through fatalizing talk, Cicely created what may have been an emotionally necessary detachment from a memory that continued to be too painful to bear. She could recollect and narrate the scene of crisis but only through the observer's lens of detached bewilderment. The exception to fatalizing talk in Cicely's narrative lay in the perspective of judgment that also threads through the narrative. That is, though confused and questioning, Cicely's depiction also echoes the style of a true-crime television show, employing dramatic innuendo to organize suspicion around Ángel's actions. She thus works to control her listener's interpretation of the event. In the next example of fatalizing talk from the interviews, many of the same aspects came into play, only the construction of self more completely illuminated a notion of surrender that often lay at the core of fatalizing talk.

Renée. The youngest woman among those interviewed for this study was a talkative, bright, anxious 27-year-old White woman, serving her first incarceration. Renée was also the first person I interviewed for the project and the only participant who did not leave incarceration during the study; she went to trial and was sentenced to prison shortly after our second interview. Both interviews with Renée were conducted in meeting rooms in the jail, the first occurring just after Renée returned from two days in the hospital, having had a bad reaction to a cocktail of illicit drugs that were smuggled into and passed around in the jail. She was mother to three children, all of whom had been placed in the custody of her fiancé's mother. Renée gave birth to her third child only weeks before turning herself into police on a warrant. Renée described smoking weed and meth since early adolescence, including use of the latter during her third pregnancy. She dropped out of school in 12th grade to care for her first son, who was born with a serious congenital condition. The primary relationships that Renée described in our interviews were with her long-time partner and fiancé, Lance; his parents; her mother; and her grandparents.

In conformity with the interview prompt, Renée recounted her life in chapters representing a series of relationships. The overall shape or trajectory of Renée’s life story was declensional, a downward slide. It began with what she characterized as a mostly happy early childhood in which she enjoyed a series of close girlhood friendships. That early picture was marred by sexual abuse at the hands of an uncle and by her mother’s uneven parenting: in and out of jail; arranging for Renée’s first sexual experience at age 13; and initiating Renée in the use of marijuana and methamphetamine. These events were partly counterbalanced in Renée’s telling by descriptions of emotionally supportive relationships with her grandparents, the parents of a particular girlfriend, and—for most of her late adolescent years—her fiancé.

Renée’s overall life story took a decisive downward turn prior to her incarceration when she lost the grandfather on whom she particularly relied for emotional support. By her telling, the grandfather’s death triggered a cascade in which Renée began using drugs again; lost custody of the child she had just delivered; and was arrested, charged, and eventually convicted and sentenced to prison for felony offenses. Leading up to the events of the trauma account, Renée’s first child was hospitalized and she became pregnant with her third. Though she depicted herself as being under considerable strain, Renée also noted that she was working and that she and Lance lived in his parents’ home, where they received help with child care. Significantly, Renée was desisting from use of meth. All that changed suddenly.

The fatalizing mode in which Renée told her embedded trauma story underscored how vulnerable Renée perceived herself to be in this crisis and how subsumed in the actions and motivations of those around her she became. She did not manage relationships in order to obtain help but was swept along and pulled into greater risk by them. Even Renée’s repetition of the assertive-sounding formula, “I will [do]” (in bold type) in the self-defining first few lines below highlighted the translation of support-seeking into terms of helplessness and surrender.

Renée: Then I got pregnant again, and my grandpa died, and that's when everything kind of went downhill without him. I have always been the one who—if I don't have someone there—I have no coping skills. [...] But, uh, **I'll** self-destruct. **I'll do** something as a cry-out-for-help kind of thing [**Amanda:** Mm-hm], whether it be start doin' drugs again, start some something—**I'll** do something—**I'll** quit my job— [**Amanda:** Mm-hm] **I'll** do something to where it's kind of like, “help me, I'm drowning,” kind of thing.

Amanda: Can you tell me a time where you did that?

Renée: Right after I had my son.

Amanda: Okay. What happened?

Renée: My grandpa died, and [long pause]

Amanda: Was it unexpected?

Renée: Uh, very, very unexpected. Like he was fine one day. His last steps were to go see my son in the hospital. [**Amanda:** Really.] Very unexpected. Me and my grandpa were always very, very, very, very close growing up, because my mom was in and out of jail. And, I don't know, she was so young, so she was always off doin' something else. So my grandparents pretty much took care of me. When he died, it was just a real shock to me. I was working. I'd get off work, first thing I'd do was go over to his house. Another really kind of underlying thing that was going on was that my ex-boyfriend—me and my fiancé [Lance] broke up in 2011, right before I had my other son [**Amanda:** mm-hm]—uhhh, but my ex-boyfriend [Scott] came back in my life. He'd just got out of prison, so me and him were kind of talkin' on the side. Just, you know, not doin' nothing, but just talking. [...] Well, while my grandpa was dying—my mom and [Scott] have always been really close, so, like I said, he comes from way back, from my chi—from my little sister and stuff. So my mom and him have always been real close. His mom died while he was in prison, so they were just really close. Um, whenever my grandpa was dying, my mom lived with my grandparents at the time, so [Scott] was always over there. [...] So, anyways, the day my grandpa died, my fiancé comes—he wouldn't wake up to take me over there—they're like “He's dying, he's dying—you need to be over here, now!” I was having a panic attack, and [Lance] wouldn't wake up to drive me over there. So I had to go ask my neighbor to drive me to my grandparents' house. Well, when we get there, my grandpa's obviously dying. I'm holding his hand. Scott's there, getting his brakes changed outside on the driveway. Well, an hour later, my fiancé pulls up. My grandpa had just passed away, just passed away. He comes in the room—Scott comes in—gives me a hug “Everything's gonna be all right.” My fiancé walks in at the same time. They start fighting, right over my grandpa's dead body. [**Amanda:** Oh, no.] Yeah. Horrible, horrible experience. They start fighting over his dead body. I go downstairs, my mom's in the bathroom. That's when she handed me the meth pipe. She's like, “Here, just hit this.” So I'm freakin' out. So, that's when I started doin' drugs again, which obviously led all the way up to this point.

Renée narrated a story abounding with relationships in which those to whom she might have applied for support passed away, got in the way, stayed too much out of the way, or pushed her along a disastrous path that “led all the way up to this point,” namely, incarceration awaiting trial and potentially a 25-year prison sentence. Fatalizing talk in Renée’s trauma story was evident in the presentation of a self shaped by submission to external influences and forces. The recitation was structured not as gaps and questions, as in Cicely’s story, but through the serial citation of non-managed relationships, all of which exemplified a thematic of impotence or surrender: a fiancé whose support she could not rouse; an inconveniently comforting ex-boyfriend whose ill-timed embrace triggered a blow up; and a mother who unhelpfully ushered Renée back into a drug habit—all of it hanging together, as if in a Faulkner story, with repeated variations on the refrain, “while my grandpa was dying.”

In other stories in which fatalizing talk formed a dominant approach to narrating the management of relationships for support, justice-involved women with significant history of trauma expressed the unpredictability or unfathomability of events and the inscrutable motivations of others. One 40-year-old participant, a white woman who asked to be called Cat, described how, at age 16, after the stepfather—who first molested her at age 12—administered her home pregnancy test, she then had to inform her mother of the positive result: “I bawled and bawled and bawled and bawled. And she just said—she was reading the Bible when I told her [...] My mom was very emotional most of the time [...] but didn’t have no emotion about it [...]—just said I had to deal with it.” Cat dealt with it by having her much older boyfriend sleep in her bed during the pregnancy to keep her stepdad out of it. I asked Cat to describe what happened when she initially broached the subject of her pregnancy with this boyfriend, curious to know how the adult Cat might explain or frame what sounded a lot like safety planning in her 16-year-old self. She responded: “Um, you know, with everything that was going on with me—you know, I just lived. I wasn’t really there. I just was there, but I wasn’t there. You know, I just lived.” Cat’s narration stressed not the planning or strategy-

deployment of opportunizing talk but, understandably enough, “just living,” a numb, swept-along response embodied in fatalizing talk, which may have seemed to her like the safest strategy of all.

Elsewhere in the interviews, mixed applications of opportunizing talk and fatalizing talk occurred. Three participants narrated stories about captivity in which intimate partners emotionally and/or physically abused and then held them against their will for a period of time, until the women escaped. In one story, Neta, a 45-year-old African American woman with gold teeth, gold hair, and irresistible laugh, described moving 500 miles from her home and extended family to live with a partner who beat her viciously over the next several months, policing her every move and at one point pushing her out a third-story window. For Neta, this was not a random, unpredictable, inscrutable, or fated event. She began the narrative: “Tried to get clean again. Went to treatment. I did the big no-no, which, you know, is to go with anyone that’s in treatment with you that’s trying to get clean also. I end up doin’ that.” Neta thus begins with a form of opportunizing talk, citing her agency: it was her transgression of a well-known rule that caused her predicament. Over the course of the brief, focused story that followed, however, Neta switches from the agentic approach adopted to explain her abuse (“my mistake”) to a fatalizing approach to narrate her escape:

Amanda: How’d you get away from him?

Neta: His sister. She took me to go get my check this time. I told her I was ready to go. She took me to the airport. I came back here. [**Amanda:** Wow.] She helped me. I couldn’t even talk to her and I was stayin’ in her home.

Amanda: How did you manage that? Did you set it up beforehand, or it was just “boom”?

Neta: It was just “boom.” She asked me what I wanted to do. [...] “If you gonna leave, it’s time to go now.” Cause he was at work. So I cashed my check, and she put me on the first plane back.

In this portion of the story, Neta neatly elided any management of relationships on her part. Most of the action, as she framed it, was performed by the sister: “she asked me,” “she put me”; the sister issued the imperative and gave it urgency: “If you gonna leave, it’s time to go

now.” As did many of the women, Neta performed a combination of opportunizing talk and fatalizing talk in her storytelling about crisis. In Neta’s case the pattern may have been reminiscent of a logic followed by some recovery discourse, with Neta simultaneously owning responsibility for the problem—the abuse—but then surrendering power at the point of narrating the solution. She shifted from opportunizing talk to fatalizing talk, along a continuum of agency, when she moved from blunder (self attribution) to correction (other attribution). Hence, the use of opportunizing talk, while possibly reflecting a useful guideline (i.e., avoid hooking up with others in recovery), also signaled a kind of victim blaming, in which Neta brought herself up short for the abuser’s lack of regard for her human rights. Neta’s account suggests that there is probably little that is straightforwardly positive about opportunizing talk or inherently negative about fatalizing talk.

Patterns that emerged in the narratives showed opportunizing talk and fatalizing talk to be primary modes through which women represented their experiences of negotiating support in moments of trauma. When participants engaged in opportunizing talk, they emphasized agency and an implied self efficacy, sharing in some form the goals, plans, and actions that made up a process of mobilizing social support. Opportunizing talk was apparent in the women’s self-presentations as beleaguered yet strategizing fighters who made or at least tried to make accurate assessments about how, when, and from whom to seek support. Opportunizing talk took form in the way women gave account: ticking off causes and effects, costs and benefits, assessments, plans, and courses of action. Though marked by distress, pain, and frustration, trauma stories that were dominated by opportunizing talk tended to be focused on social support goals and the means by which their narrators attempted to meet them.

In contrast, in stories where fatalizing talk dominated, the women’s self presentation highlighted helplessness, with narrators depicting themselves as overwhelmed and passive, moving through events as observers rather than actors. Events unfolded thematically in ways

that pointed to randomness and the unfathomable, unpredictable will of others—or, alternatively, to destiny, the unfolding of something pre-ordained and inevitable. Relationships that might have provided openings for support in opportunizing narratives went unremarked or were portrayed as unreachable in stories where fatalizing talk was dominant. Formally, stories that featured fatalizing talk were marked by disorder, gaps, silences, unanswered questions, and at times a meandering and highly digressive presentation of events and thoughts. Fatalizing talk may have reflected the need of storytellers to buffer unbearable memories—possibly functioning to protect tellers from painful feelings of re-experiencing, regret, guilt, or abandonment—or as a stop-gap for the perceived lack of coherence and connection in event, intent, and outcome that can occur in the recall of trauma (Bromberg, 2003; Janoff-Bulman, 1992).

In summary, a model of opportunizing talk and fatalizing talk was derived from (a) presentations of self, (b) recurring emphases in theme, and (c) patterned structural elements (Table 1). Though in the abstract, modes of opportunizing and fatalizing may occupy two poles, they also overlap and alternate in practice, mapping a continuum of perceived agency in the women’s accounts, often co-occurring in individual stories, and certainly not characteristic of all the stories of trauma told by any one woman (Figure 1).

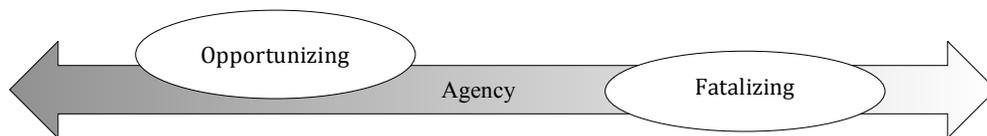


Figure 4.1. Spectrum of self efficacy in approaches to management of relationships in narratives of trauma

Discussion

Feminist Standpoint and Relationality

Analysis of interviews in this study illuminated how women in a justice-involved group applied opportunizing and fatalizing talk in narrating the struggle to access social support for health and safety in moments of trauma. A central premise of feminist-relational theory is that women tend to prioritize connectedness over autonomy in understanding self and exercising moral judgment (Comstock et al., 2008; Miller, 1986). Such tendencies are no doubt true of individuals from any gender group, but according to some feminist-relationalist perspectives, women's historical socialization may lead them to be more apt to organize identity, action, and ethics around mutuality over autonomy, cooperation over competition, and collaboration over conflict (Gilligan, 1982; Mackenzie & Stoljar, 2000; Miller, 1986; Miller & Stiver, 1997). The disruption, absence, or denial of social bonds that occurs in trauma (and, for that matter, in incarceration) may thus be especially difficult for women to cope with. This has been the argument of Covington (1998; 2007) and others involved in the gender-responsive corrections movement, which stresses the need for the criminal justice system to adopt policies and procedures that take into account women's pathways to criminal offending, including the frequent experience of trauma and susceptibility to retraumatization (Bloom, Owen, & Covington, 2002; Harner & Burgess, 2011; Wright, Van Voorhis, Salisbury, & Bauman, 2012). Whether during or after incarceration, for many justice-involved women, the aftermath of complex trauma may produce combined fear of and need for connection (Herman, 1992; Janoff-Bulman, 1992). This study illuminated some of the particular and variable ways in which justice-involved women with significant lifetime experience of interpersonal trauma position themselves as agents in quest of support.

Managing Social Relationships for Support in a Context of Trauma

Justice-involved women used opportunizing talk and fatalizing talk to manage self and other in stories that depicted their seeking, receiving, and in some cases giving social

support. Social support includes emotional, material, instrumental, and informational resources that enable people to maintain a social position, get by, or survive (S. Cohen, 2004; Lourel et al., 2013; Szreter & Woolcock, 2004). Social capital, a slightly different concept, has been defined as an umbrella term that includes social support as one of its functions (Carpiano, 2008) but is also distinguished from social support as access to resources in a network that confer a competitive edge on holders by facilitating social mobility (Bourdieu, 1986; Burt, 2000). At an individual level, social capital may function by bonding, bridging, and linking (Brisson, 2009), where bonding most resembles exchanges of social support between close friends and relations; bridging social capital describes resources accessible through lateral exchanges between more distant connections; and linking refers to vertical exchanges between members of different socioeconomic classes that can be leveraged into social advancement (Baum & Ziersch, 2003). At a group level, social capital in a network has been associated with intra-group trust, cohesion, shared norms, and collective self efficacy, so that social capital in a group typically functions to position that group (i.e., neighborhood, region, political party, work faction) advantageously within a social field (Coleman, 1988; Putnam, 2000). This is important, because women most often cited seeking social support in the form of shelter and emotional reinforcement through bonding ties of family and close friends. Rarely did the women acknowledge having any access to resources through network connections that would facilitate the kinds of improved positioning that social capital imparts.

Social support and social capital are both governed by principles of direct and generalized exchange undergirded by trust. Members in a network assume that everyone gives and everyone takes; a kind of balance is maintained across relationships (Domínguez & Watkins, 2003; Lourel et al., 2013; Plickert, Côté, & Wellman, 2007; Uehara, 1990). For women with overtapped material and psychological resources like most of those in this study, the requirement of exchange means that even support accessed through family and close

friends may be perceived as highly restricted, hedged in with caveats and hazards (Hawkins, 2010; Offer, 2012; Offer, Sambol, & Benjamin, 2010; Radey, 2015). Close social bonds may be subject to exhaustion when social networks lack socioeconomic diversity and demands are too frequent or too great (conditions that are especially likely in a population in which drug abuse, violence, homelessness, and frequent incarceration are prevalent) (A. Goffman, 2014; Harknett & Hartnett, 2011). Supporting connections that are exhausted under such circumstances can become a source of guilt, resentment, manipulation, and social isolation (Offer, 2012; Ray, 2015). Too much reliance on bonding connections among persons in the same network with access to the same minimal social capital may also restrict and entangle members in ways that prevent them from forming new ties outside the network, where social capital for leveraging—getting ahead rather than getting by—may be more available (Domínguez & Watkins, 2003; Henly, Danziger, & Offer, 2005). Researchers have learned that interventions to strengthen social support and social capital in low resource situations are most helpful when they are tailored to the particular needs and dynamics of existing social relationships and networks (Brisson, 2009; S. Cohen, 2004). The goal of this study was to establish a beginning from which we may build better understanding of the positionings and tactics used by a marginalized and growing group of justice-involved women as they seek to protect their health and safety. The use of opportunizing and fatalizing talk may serve as a beginning point from which to craft better targeted approaches to assisting them.

Implications and Recommendations

Justice-involved women in this group struggled with drug abuse, poverty, and unstable housing. Many suffered from physical and mental health problems. Though racism was rarely referred to overtly in the interviews, more than half the women identified as Black, and the conversations I had with them about their histories indicated that most of the women's families hailed from formerly slave-owning Midwestern or southern states. All lived, at the time of the interviews, in a medium-sized, Midwestern city where *de facto* racial

segregation continues to characterize neighborhoods, schools, and churches (Gotham, 2002; Reece, Olinger, & Hammock, 2011). Finally, like other women with history of incarceration, all the women in this group carried a disproportionate share of traumatic loss or injury, much of it involving recurrent interpersonal violence.

Given the dearth of public assistance available to most of the women and the high unlikelihood of increased programmatic focus on their needs in the near future, it is urgent for health care and service providers to learn from women's own perceptions and strategies for accessing informal ties for social support. Women's practices may provide lessons for more effectively supporting them in what works and helping them find alternatives for what does not. Nurses and care and service providers who practice in a health promoting capacity in community and clinical settings need to learn to give trauma-informed care and understand that health and safety challenges among women in this group are met within a limited horizon of real and perceived choices of agency and relationship. Bourdieu's (1980; 1992) concept of *habitus* is useful here, since Bourdieu explained how the perceptions that shape action (for him, "practice," 1980, p. 54) occur within contexts that are already structured by socioeconomic determinants. What may look like poor personal decisions from the outside, may not have the look of decisions *at all* from the women's perspectives. To recognize the operations of a continuum model of opportunizing and fatalizing talk in women's trauma stories is to acknowledge the dialectic of structure and agency in women's attempts to cope (Rutten & Gelius, 2011; Sweetman, 2003). As an organizing tool, the opportunizing talk and fatalizing talk model can focus our understanding on how women manage agency and relationship, self and other, in accessing social support.

Nurses and other service providers who meet with women during or after an incarceration and who hear their stories in the course of giving care, need to be aware of both modes of talk and the perceptions about agency and relationship that these modes imply. Simply listening for and supporting women in recognizing the ways in which opportunizing

can facilitate and fatalizing can obstruct the management of social ties may not be enough. In some cases, opportunist talk may mean asserting unwarranted and immobilizing personal responsibility when structural contingencies or other people should be held accountable for a situation. Similarly, fatalizing entails inaction, detachment, and displacement of self, but those may be strategies for survival as well as avoidance, and in certain cases they may represent the best strategies for staying safe. Assisting women in meeting their health and safety needs will require something more than administering an instrument—and probably more than careful listening and dialogue at an individual level. Because this is a population with distinctive shared needs, nurse advocates, lawmakers, service administrators, and program designers should have familiarity with how justice-involved women perceive the structurally constrained choices before them. Opportunist and fatalizing talk provide a preliminary framework within which to begin pushing for programs and policy changes that create coordinated services and more supportive environments and opportunities to help women recast their stories, learn to reconceive options, and, in particular, ensure that access to resources exists to move women beyond simply getting by.

Limitations

In this study I derived theory through thematic and structural analysis of narrative data from in-depth interviews with 10 women. I sought to achieve credibility and trustworthiness for the model by sharing sizable segments from the data and a fairly detailed demonstration of interpretive process in the findings, thereby giving readers means to judge the applicability of interpretations to other, similar situations. To further strengthen trustworthiness, I used repeat interviews and worked with two other researchers who iteratively and independently memoed on the interviews and with whom I regularly discussed interpretations over a year-long period. Regardless, judged by standards of probabilistic research that seeks to make statistically generalizable claims about populations based on the manipulation of controlled variables, this study will appear limited due to the small number

of cases. This is not so much of a limitation from an interpretive, case-based perspective, in which social science knowledge is assumed to be as legitimately generated through detailed, languaged analysis of a few cases as it is through inferential analysis of aggregated variables abstracted from many cases (Danermark et al., 2002; Small, 2009). The small number of selected cases will still be of concern to some. Additionally, deriving an opportunizing-fatalizing model does not on its own give much specific guidance as to use. This limitation may be expected in an exploratory study, where the next steps may take several directions, including the further refinement of constructs and the operationalizing and validation of the model for use in interventions.

Conclusion

I sought to build understanding about how justice-involved women perceived and managed interpersonal relationships in their lives for health and safety. Opportunizing talk and fatalizing talk emerged from narrative analysis of women's trauma stories as two ends of a continuum that mapped perceived agency to access support. The ten women who participated in the interviews were complex individuals, every one of them navigating her own set of highly challenging circumstances. In the community and in clinical situations, in their interactions with justice-involved women with history of trauma, recognition of patterns of self-other management by nurses and other health service providers may foster appreciation for knowledges and aptitudes that women already evince in accessing support through interpersonal ties. Alternatively, where ways of managing social ties are leading to greater health and safety risk for women, better understanding of those on the part of nursing and social service providers may suggest openings where new interventions can be targeted. Of course, the framework presented in this analysis will only be useful if providers cultivate the ability to listen closely and respectfully for the nuanced ways in which women in their stories express strengths and weaknesses

Table 4.1: Opportunizing and Fatalizing Modes of Talk

	<i>Opportunizing Talk</i>	<i>Fatalizing Talk</i>
Self-presentation	<ul style="list-style-type: none"> • goal-setter and planner • independent or oppositional • maneuvering 	<ul style="list-style-type: none"> • erasure of self, surrender of power • overwhelmed, swept up
Formal elements	<ul style="list-style-type: none"> • outlines, plans, lists • action interspersed with focused analysis • focused, straightforward descriptions • event-based 	<ul style="list-style-type: none"> • dreamy voice • questions • declarations of confusion, being overwhelmed • digression • emotion-based
Thematic emphases	<ul style="list-style-type: none"> • agency: getting things done, power over events • self-improvement, turning things around • assessing of situations, others' intentions, likely outcomes 	<ul style="list-style-type: none"> • religion, God's will • inscrutability of others' motivations • unpredictability of events • playing a part in a design (teleology) • short-termism: foreshortened horizons • resignation: taking things as they come
Intertextual & theoretic connections	<ul style="list-style-type: none"> • AA talk (Leverentz, Maruna) • Turning points & redemption (Laub & Sampson; Maruna) 	<ul style="list-style-type: none"> • Learned helplessness (Seligman) • Troubled narration (Bromberg, Janoff-Bulman, Caruth) • Women as victims of social circumstance

CHAPTER 5
HOUSING FOR THE JUSTICE INVOLVED: EMPOWERMENT AND
ENTANGLEMENT IN NARRATIVES OF SHELTER SUPPORT

Abstract

An estimated 11.4 million admissions to U.S. jails take place each year, and on any given day, over one million women are incarcerated or under correctional supervision. Many who cycle through U.S. jails are trapped in conditions of poverty, and many suffer from cumulative lifetime trauma. Frequent incarcerations and lack of material and psychic resources threaten women's health and safety and the health, safety, and stability of their families and communities.

The objective of this exploratory study was to increase understanding of how justice-involved women who struggle with history of interpersonal trauma perceive social relationships as a means of support in the months following a jail incarceration.

Ten women were selected from an existing longitudinal study ($n = 184$) in an urban jail on the basis of the detail and complexity of the personal histories they recounted in the parent study. Repeat, semi-structured, story-eliciting interviews were conducted with the women over one year. Transcribed interviews were then analyzed using thematic narrative inquiry techniques.

In the context of inadequate public support, women organized stories of survival and support-seeking around patterns of empowerment and entanglement. Housing access was empowering when it facilitated survival, buffered women from high-risk environments and relationships, and opened paths for future thriving; shelter support became entangling when it exposed women to situations that increased their risk of illness, injury, or reincarceration.

Care and service providers sensitized to these patterns can help justice-involved women recognize and capitalize on the empowering aspects of their housing options and explore with women strategies for avoiding or transforming those that threaten entanglement.

Policies and programs are needed to increase the availability of low-cost housing and jobs to give women access to tools beyond the social ties that permit mainly survival and tend to keep women trapped in unhealthy social niches.

Keywords: Health disparities, homelessness, women's health, reentry

Introduction

Of the over 100,000 women held in U.S. jails on any day and the over one million who are incarcerated or under community correctional supervision, most are situated at the low end of the socioeconomic spectrum (Minton & Zeng, 2015; Swavola et al., 2016; Western, 2006; The Sentencing Project, 2015). According to analysis of Bureau of Justice Statistics data from 2004, in the year before an incarceration, the median earnings for prison incarcerated women of all races, 27-42 years old, were 42% lower than non-incarcerated women in the same age group (Rabuy & Kopf, 2015). Both men and women with criminal records pay what researchers call an “incarceration penalty” (Wakefield & Uggen, 2010, p. 395), a kind of tax in the form of lower wages, lost experience, and increased difficulty securing employment following incarceration (Travis, Western, & Redburn, 2014; Walter, Caudy, & Ray, 2016). The majority of those sentenced to jail return to their communities in less than three weeks (Spaulding et al., 2011). Many employers are reluctant to hire ex-offenders (Holzer, Raphael, & Stoll, 2006), and that tends to be true even when programs encourage such hiring (Walter et al., 2016). Depending on state rules, having a criminal record can additionally complicate or preclude an ex-offender’s eligibility for public assistance, such as food stamps or government subsidized housing, although many of these rules were loosened by states between 1996 and 2017 (Hager, 2016). In general, the justice-involved are underresourced before incarceration and meet with formidable barriers to getting back on their feet afterward (Comfort, 2016). The structural narrowing of prospects or foreclos[ing] of opportunity (Western & Pettit, 2010) in combination with the heavy policing of selected areas sets the stage for what some have identified as the emergence of a “permanent underclass” (Dumont et al., 2012).

Many women entering and leaving local jails are not just underresourced but suffer as well from cumulative lifetime trauma, beginning with childhood abuse and neglect and continuing into adulthood as intimate partner abuse, rape, and loss of loved ones through

violence (Fuentes, 2014; Grella et al., 2013). Not surprisingly, women in jail report mental conditions at high rates, especially posttraumatic stress disorder and anxiety disorder (DeHart et al., 2014; Drapalski et al., 2009). Both women and men in jails report higher prevalence of some physical health problems than persons without history of incarceration, including hypertension, cardiac conditions, diabetes, HPV, hepatitis B and C, tuberculosis, and HIV (Altice & Bruce, 2004; Binswanger et al., 2009; Maruschak et al., 2015; Weinbaum, Sabin, & Santibanez, 2005). Incarcerated women more so than incarcerated men report ever having had a chronic health condition (Maruschak et al., 2015). Both going into and coming out of an incarceration can mean disruption of care, and many women find that coordinating services to meet their mental and physical health needs in the community requires more time, energy, and know-how than they have: women can easily slip through the cracks (Mallik-Kane & Visser, 2008; Sered & Norton-Hawk, 2008; Wilper et al., 2009).

Even when justice-involved women are in reasonably good physical and mental condition, the scarcity of affordable, safe housing and difficulties finding employment sufficient to maintain it threaten women's well-being. Housing insecurity has been associated with poor health, risk of violence, drug use, and, for the justice involved, recidivism (Dickson-Gomez, McAuliffe, Convey, Weeks, & Owczarzak, 2011; Freudenberg et al., 2005; Robinson & Adams, 2008; Stahre, VanEenwyk, Siegel, & Njai, 2015). The last of these makes finding secure shelter an especially important goal for those transitioning back to the community after an incarceration (Ahmed et al., 2016; Western et al., 2015). As will be explored in detail below, for most of the women in this study, lack of secure shelter posed a primary challenge to health and safety. Learning more about justice-involved women's perceptions of the availability of and ways to access social support to obtain shelter formed the major objective of this analysis.

Research Question

In this study, I ask, “What do relationship narratives told by justice-involved women with history of interpersonal trauma reveal about their perceptions and management of social support to access housing resources after a short incarceration?”

Social Support

Social support refers at its most basic to resources that are available to individuals through social connections and that function to prevent or alleviate stress (S. Cohen, 2004). Resources for social support may be instrumental and financial, informational, appraisal-oriented, or emotional, and social support may influence the impact of stressors either directly or through buffering (Berkman et al., 2000; S. Cohen, 2004). A rich literature in sociology, psychology, anthropology, nursing, and other health sciences documents efforts of researchers to establish cognitive and structural functions of social support and the effects on physical and mental health (Lourel et al., 2013). Evidence of associations between perceived social support and morbidity and mortality are well-established in recent meta-analyses (Gilbert, Quinn, Goodman, Butler, & Wallace, 2013; Holt-Lunstad, Smith, & Layton, 2010). The emphasis on social support in this study emerged from the interviews themselves. With limited access to income or formal benefits, women with history of trauma and frequent justice involvement reported turning to friends, family, and strangers for the basic resources necessary to maintain health and safety. It was the purpose of this study to build a better understanding of how social support, specifically for housing, was perceived and managed from the women’s perspectives, in order to find better ways to help them avoid disease and prevent injury.

Homelessness and the Justice-involved

Homelessness prior to incarceration among jail inmates is estimated to be 7.5 to 11.3 times higher than in the general population (Greenberg & Rosenheck, 2008). Women and men with a criminal records, and particularly those ever having had a felony drug conviction,

face multiple structural barriers to housing assistance, including screening procedures and specific and blanket exclusions related to drug use, drug manufacture, and other convictions (E. Weiss, 2016). By these means, public housing agencies can make determinations about availability of benefits and rental units to low-income applicants based on history of justice involvement. There are in fact a number of federal laws, agency rules, and court findings that facilitate public housing agencies and federally funded projects in imposing discretionary burdens on housing applicants with past incarceration (E. Weiss, 2016). In 2016, the United States Department of Housing and Urban Development (HUD) issued guidelines based on the Fair Housing Act of 1968 to address the use of criminal records as a basis for housing determinations. The Fair Housing Act prohibits discrimination based on membership in a protected class—that is, status specifically defined by race, color, religion, sex, disability, familial status, or national origin—and the HUD recommendations addressed the link between the specific protected class of race and the use of criminal records as a means to exclude (U.S. Department of Housing and Urban Development, 2016). Importantly, having a criminal record in itself does not legally constitute a protected category, and as long as rules and requirements about criminal justice history do not also impose “disparate impact” in relation to an applicant’s protected class status, local agencies and authorities have broad discretion about interpretation of the law (Equal Rights Center, 2016; U.S. Department of Housing and Urban Development, 2016; E. Weiss, 2016). Consequently, while the HUD guidelines clearly discourage discrimination against persons with a criminal record, they are limited by the scope of the Fair Housing Act and by the fact that they are, in the end, only recommendations.

Empowerment and Entanglement

The justice-involved women in this study constructed their support-seeking in various ways. In a companion analysis of this interview data, for instance, I examined the women’s narration of trauma stories in order to explore how they constructed and navigated

relationships for support *in extremis*, in moments of crisis. I discovered that women's trauma stories could be mapped along a continuum of agency that ranged between poles of opportunizing and fatalizing. Opportunizing talk and fatalizing talk exemplified understandings of self-in-relation, how women identified themselves as subjects in the act of support-seeking. In the present analysis, I moved away from trauma stories and women's notions of self/other as formulated in crisis to investigate how justice-involved women perceived outcomes of social support seeking in daily dealings with others. I discovered that, around the ubiquitously cited problem of finding shelter, women's stories developed dual themes of empowerment and entanglement, which usefully highlighted the catch-22 quality of justice-involved women's broader quest for health and safety after an incarceration.

For the purposes of this study, to be empowered is to have the power or ability to do something (Kuokkanen & Leino-Kilpi, 2000). The *Oxford English Dictionary* (OED) ("Empowerment," 2017) defines empowerment as "the fact or action of acquiring more control over one's life or circumstances through increased civil rights, independence, self-esteem, etc." Empowerment in this study refers to a woman's ability to control or manage access to the resources necessary to satisfy basic needs of survival and safety. While empowerment may include more—i.e., access to tools to advance well being, socioeconomically or otherwise—such was rarely the case in these data. Entanglement is defined in the OED as "a circumstance which complicates or confuses a matter" ("Entanglement," 2017) and is used in this analysis to refer to the patterned ways in which social relationships often functioned in an obverse relationship with empowerment—ensnaring a woman in situations of risk and complicating her ability to access the shelter and other resources necessary for health and safety.

From the interview data, I derived a descriptive model elucidating how underresourced women construe support-seeking through relationships with others as both empowering and entangling. Understanding the mixed nature of the social support that

justice-involved women with history of trauma perceive as accessible represents an important step toward more responsive care and better targeted design and implementation of supportive, post-incarceration interventions.

Methodological Framework: Narrative Inquiry

This was a narrative-based inquiry, the findings derived from stories that I invited women to tell about their relationships. As Riessman (2008) argues, not every reporting of experience is a narrative, and definitions of narrative range broadly. Nor are all narratives stories. Maynard-Moody and Musheno (2009) argue that while narrative is a capacious term that refers to a subject or narrator's relation of events or conditions as temporally constellated—i.e., occurring in time—story involves something more particular, involving a sense of context, shape, and purpose. Even so, in much of the literature on narrative and story, the terms are used interchangeably, as I use them here, with both terms referring to ways in which a speaker orders experience and uses language and the performance of telling to imbue an account with purpose and significance (Bruner, 1990; Gubrium & Holstein, 2009). An advantage of using narrative as a unit of analysis in social science research is that narrative provides access to information as it is embedded in the social world of a storyteller (Clandinin & Connelly, 2000). Narrative inquiry begins with people's constructions and meanings in a particular time and place, rather than abstracted categories and theories established by researchers. Stories may thus give a more holistic picture, preserving information that gets lost when variables are selected out beforehand and conditions of collection closely controlled (Gubrium & Holstein, 2009; Maynard-Moody & Musheno, 2014). Narrative inquiry discloses elements of voice and persona, giving play to the unique while also enabling comparison of patterns (of theme, of form, of interaction, of performance) across a group of stories (Riessman, 2008). That stories insist on our attention to the human fullness of research participants may be especially important for studies like

this one that involve groups who are apt to be ignored in research, reminding us that behind numbers lie persons (Frank, 2004).

Transformative perspective: Feminism

In this study, feminism functioned as a transformative perspective (Creswell, 2014). Transformative perspectives are broad critical frameworks that position researchers in relation to institutions and structures in which power is inequitably distributed (Creswell, 2014). Feminism is a system of thinking that critically questions the ways in which gender gets used to organize relations within social relationships and structures. As a transformative perspective in research, feminism—or critical race theory or queer theory or disability theory—guides choices about which questions are posed and informs the selection of methods to answer them (Creswell, 2014). Feminism entails focus on women’s issues, voices, and perspectives; attention to power imbalances and inequities along gender lines; and a commitment to political change to correct inequities (Hall & Stevens, 1991; Hesse-Biber & Nagy, 2014). I worked as well from a feminist perspective that acknowledges the influence of intersectionality, recognizing that justice-involved women experience the world through multiple lenses, not just gendered but also dynamically raced, classed, and sexually oriented, among other things (Cho, Crenshaw, & McCall, 2013). This was especially important in a study for which one of the goals was to understand relationships and social support from the perspectives of justice-involved persons, since policing and incarceration disproportionately affect women of color and women with few material resources (Clear, 2007; Swavola et al., 2016). Finally, in keeping with a transformative feminist perspective, the present study sought knowledge about women’s experiences ultimately as means to argue for the need to change oppressive systems that make health and well-being structurally and persistently more available to some than others.

Methods

Case Selection and Recruitment

Ten participants were invited to interview from a larger, ongoing sexual health education and intervention study (Ramaswamy et al., 2017). The parent study enrolled 184 women in three county jails located in a Midwestern metropolitan area. Eligible participants were adult (over 21), English-speaking women who entered the jails between September 2014 and March 2016, with exclusions occurring only when indication of severe psychological disturbance or emotional volatility was observed (Ramaswamy et al., 2017). Because my overarching objective was to explore justice-involved women's perceptions about and experiences in navigating relationships, my selection criteria were the complexity and richness of detail in the stories the women told during the original intervention. Within that broad parameter, I also sought to include women from the older and younger ranges of the larger sample, both White and Black women, and at least one case that was socioeconomically divergent. Women were invited to interview with me by the project director of the parent study, a sexual health educator and MPH holder who formed a uniquely warm, supportive bond with participants during the jail intervention. Her assistance contributed significantly to successful recruitment, scheduling, and retention. Purposeful recruitment of cases ended after initial interviews with 10 women, when, through ongoing review of the data, I determined that the group was yielding sufficient detail, diversity, and complexity of experience and insight to answer my research question (Patton, 2015). Retention of participants was 100% over the 12-month period of data collection.

Data Collection

Each woman completed an initial and then a follow-up, face-to-face, semi-structured, story-eliciting interview with me. During initial interviews, I invited women to imagine their lives as a book and to narrate chapters around important relationships. In follow-up interviews, I solicited additional narrative and queried for missing detail. Participants were

presented with a typed “story outline,” built from their initial interviews, showing the results of the initial interview divided into chapters with key incidents and quotes. Together, we also constructed a simple time line on which women located the five most important health events in their lives. On average, five months passed between the initial and follow-up interviews, the interval ranging between three weeks and 12 months. Both initial and follow-up interviews averaged 60 minutes in duration, and all were audio recorded on a small handheld device. Most recordings were transcribed verbatim by a service, after which I reviewed transcriptions against original recordings and my field notes.

Interviews were conducted face-to-face, mainly in the community, mostly at sites that were proposed by the participants. These included women’s residences, cars, coffee shops, fast-food restaurants, a public library, and a church-choir changing room. Three interviews (two initial interviews and a follow up) took place in meeting rooms at one of the jails, and one follow-up interview took place over Skype after a participant moved to a distant state.

Data Analysis

Beginning shortly after transcription of the first interview, I followed a course of iterative analysis, reading and rereading the transcriptions in light of each new interview. I built a list of descriptive codes (Saldaña, 2016) related to relationships, trauma, and health care as they were alluded to by women in their stories, and I coded transcriptions based on this evolving list. As themes began to emerge based on the descriptive codes, I memoed analytically (R. M. Emerson et al., 2011), comparing themes across interviews and in relation to the social support literature. In addition to themes, I systematically reviewed for other aspects of narrative, including how participants created character, setting, mood, and conflict in recounting episodes from their experience (Clandinin & Connelly, 2000). Over the course of data collection and analysis, I met biweekly and then weekly with two colleagues from the parent study, who independently read and memoed on my transcriptions and field notes. Our dialogue continued through the 12 months of data collection and beyond and provided a

forum in which to critically examine the emerging themes of empowerment and entanglement and to consider alternative interpretations.

Methodological Rigor

Narrative inquiry does not aim to draw probabilistic, generalizable conclusions about a population but to derive or adapt an underlying theory or model (i.e., interpret) or discern and unpack complexities of a subjective process or phenomenon (i.e., describe) (Clandinin & Connelly, 2000). Narrative inquiry draws its conclusions not from frequency and variability around an average but from the illumination of a complex situation through the depth and detail of individual cases. Rigor in narrative inquiry refers to (a) the *trustworthiness* of methods and findings; (b) the *credibility* or believability of the truth of its interpretations; (c) the potential *applicability*, or meaningfulness of findings to researchers working in cognate situations; and (d) the demonstrated *consistency* of presented evidence with interpretation (Hammarberg et al., 2016). In the research report, a researcher performing narrative inquiry creates rigor through clarity about how cases were chosen, how data were gathered, and how meaning within data was derived. This means another researcher can gain confidence in the interpretations and their transferability by following along with the research process and interpretive reasoning (Riessman, 2008). I sought to achieve trustworthiness, credibility, applicability, and consistency mainly through transparency about methods, presentation of substantial quotes from the data, and through triangulation of investigator and source (Guba & Lincoln, 1985; Miles & Huberman, 1994). The latter was accomplished through frequent review and discussion of interpretations with two independent readers, review of life story outlines and portions of the interpretations with the women themselves, and the inclusion of data from a second source (i.e., observation data from field encounters by myself and a colleague). Finally, through iterative coding, process and participant memos, and notes from analytical meetings, I built self-awareness about the impact of my own subjectivity on the

study, and I created an audit trail or record of how data were gathered and interpretations formed.

Ethical Issues

Participants in this study were initially encountered during a jail incarceration, and most continued to be subject to some form of community criminal justice supervision over the course of the study, with several returning to jail for short periods. The women thus constituted a vulnerable population requiring additional human subjects protection (Institute of Medicine, 2007). All participants gave written, informed consent to be interviewed as part of the original consent process. Additionally, before each interview I reminded participating women of the voluntary nature, purpose, benefits, and possible risks of the substudy, and gained verbal assent from the women to continue participation and to be recorded. Women were reminded during the interviews that they could choose not to answer any question and that their participation in the interviews was not connected in any way to their legal disposition or to their continued inclusion in the parent study.

To keep names and stories confidential, I stored data in secured, encrypted, and password-protected files on a secured university server and an encrypted and password protected online data management service, Dedoose. The women themselves chose pseudonyms, and these were used in place of the women's names in documents. A National Institutes of Health Certificate of Confidentiality was obtained to safeguard recordings and other materials related to the study from seizure or discovery by law enforcement. To further protect women from harms arising from participation, I reminded them that we could provide referrals for mental health support if distress occurred as a result of the interviews. Finally, women were remunerated \$10 for each interview in acknowledgement of their time. The institutional review board at the academic institution that sponsored the parent study approved the procedures and interview protocol.

Findings

Participants

The ten women in this study averaged 39 years of age, and all identified as *cis*-women. The racial make up of the group was six women who identified as Black and four as White, with one woman also reporting a grandparent of Native American ancestry. Eight of the women were mothers; and all of those who were mothers had permanently lost or relinquished custody of at least one child. The women's experiences with incarceration were diverse: three of the participants were jailed for the first time during our initial encounter in the parent study, while five of the women reported at least 10 prior incarcerations. By the end of data collection, all but one of the women had also served time in prison, which typically involves sentences longer than one year and thus usually refers to felony convictions. All of the women had been drug-involved, reporting either former or current use of illegal substances, most often crack cocaine, methamphetamine, and PCP (i.e., "wet": cigarettes soaked in PCP, dried, and smoked).

Aside from incarceration, what most distinguished the women in this group from women in other studies of social support in underresourced communities was the cumulative lifetime burden of interpersonal trauma that they reported. All but one of the women had multiple experiences of childhood sexual and other physical abuse; adult rape, physical assault, and chronic intimate partner violence; stalking and abduction; and sudden loss of children, siblings, and parents. Women also reported mental health conditions, mainly PTSD but also schizoaffective disorder and behaviors like cutting. Finally, they described numerous, mostly managed physical health conditions, including sexually transmitted infections, hypertension, diabetes, arthritic disorder, cervical cancer (treated), HCV, and HIV.

The latter challenges notwithstanding, the women in this study were in reasonably good physical health. Their needs were met either through low-cost services offered through

local hospitals and health clinics or through emergency department visits. Several of the women had case workers through local social service agencies who helped them patch together health services. What women described struggling with most consistently was the challenge of finding housing, a fundamental requirement for well-being. Baseline survey results in the parent study sample indicated that at least 24% of the group were homeless or staying place-to-place before the incarceration in which we met them, and 71% felt they had barely enough or not enough money to live on each month (Ramaswamy et al., 2017). At the time of the interviews, among the 10 women in the present study, half had moved at least three times since release. Although we were ultimately able to stay in contact with all 10 over the 12-month period of the interview substudy, during those 12 months, all but two participants went missing for weeks or months—unlocatable by phone, text, mail, email, Facebook, or street contacts.

In the context of criminal justice involvement, cumulative lifetime trauma, drug use, and mental and physical health burdens, the women interviewed for this study experienced complex barriers in their navigation of relationships for social support, mainly in the form of shelter-seeking. Their efforts and understandings deserve our close attention. As researchers, policy makers, and care and service providers, we can begin to help justice-involved women achieve social integration and something like flourishing only if we first understand the world they experience as they perceive it. That requires hearing their stories and being able to recognize in those stories core frameworks that structure possibility and its foreclosure.

Empowerment and Entanglement in Social Networks

The justice-involved women in this study described multiple instances when, during the months after returning to their communities following an incarceration, they appealed to family, friends, acquaintances, and even strangers for assistance. Their stories revealed patterns of empowerment and entanglement as central to the experience of seeking and receiving support through social connections. Of all the support to which women sought

access through non-institutional or informal ties, shelter was by far the most prominent. From the perspective of Maslow's (1943) theory of human motivation, this makes sense. None of the women I interviewed had a place of her own to which to return, so a main priority after leaving jail was to establish a safe place to stay. That need was not, in most cases, summarily satisfied; it continued to dominate attention and energy. Attaining shelter assistance was depicted in the women's accounts as empowering primarily because it enabled survival; it brought a minimal physical security—although other kinds of support, such as emotional support or instrumental and information aid sometimes came to be available through housing as well. The important point, however, was that for most of the women using social connections to get housing was very often also entangling—both restrictive and risky: first, housing support could be constrained or complicated by overall scarcity in underresourced networks. That is, especially when obtained through close social connections, support often came with rules or conditions that women found demeaning or impossible to follow. Housing support could also entail obligations that reduced women's access to the kinds of external resources—connections outside one's immediate network—that would have more potential for leveraging into improved social position. Perhaps most troubling, in over half the cases, women described shelter accessed through social ties as directly threatening to health, safety, and their ability to avoid reincarceration.

For justice-involved women with significant histories of trauma who attempted to meet housing needs after incarceration through informal social ties, the persistently entangling quality of those ties represented threats to health and safety. Those of us who provide care or design and implement transition programs need to be able to recognize the shifting, intertwined patterns of empowerment and entanglement that justice-involved women encounter in accepting help from others in low-resource contexts. It is the assumption of this study that we can best start to build understanding by asking the women themselves how they experience the navigation of social ties for shelter.

Accessing Shelter through Family Bonds: “I have four sisters and two brothers, okay? Why am I out here in the cold?”

Four of the women who interviewed with me told stories about seeking and receiving housing support from family after release from jail. Among the most empowering and least entangling occurred in an account narrated by Susan, a 38-year-old Black woman who reported having served one term in prison but estimated that she had been jailed 5-10 times for drug sales and assorted misdemeanors. Susan had no children but was herself one of seven siblings, including five brothers and a sister. Over the years, she periodically declined shelter with several of her siblings, because, as she said, “I was a female on my own since 13. You don’t want to depend on nobody. You don’t want to ask nobody for nothing, you feel like you—you can do it on your own.” This citation of a culturally dominant script of self-reliance occurred frequently in the interviews. Susan, however, went on to say that despite her continuing desire to be self-sufficient, after her most recent incarceration she was “tired of going from house to house, and this and that,” so she broke down and accepted shelter with family.

Susan: My brother.

Amanda: Okay.

Susan: [My family] knows I don’t depend on no nobody, and I don’t like to live with nobody—He was like really shocked of me, you know what I’m saying, to come to him like that.

Amanda: Mm-hmm.

Susan: Cause they know I’m gonna stick on the street before I’ll go— [...] before I asked one of them. I would go, you know what I mean [shakes head]—it was kind of like hard for him. And then me and him and his ex had problems and stuff. So it was kind of like, he was shocked that I was coming to him. [...] I lived with my sister before, and didn’t even like it. I didn’t even stay there for two days—I was out of there. And she was mad about it. But I’m not used to it. I don’t like to be under nobody’s rules, I don’t like to—you know what I mean?

Amanda: Mm-hm. How did you feel when he said, “Of course, come on in,” you know? How did that feel inside?

Susan: It felt good, it felt good. But it took me about a week to do it. He kept calling my phone—“When you coming? I put your key in the mailbox—when you gonna come and move in?” He kept—he was anxious. He was excited too. We had the best time, do you hear me—the best time. We went out, ate, we did brothers and sisters

stuff. Just me and him doin' brothers and sisters stuff. And then we had my nephews and nieces on the weekend and stuff. It was cool, do you hear me. I love my oldest brother. I love all of them, but I'm just saying, I love them. Because I never asked none of them, you know. Like my sister, I only stayed there two days. It was a wrap—pshoom. But I maintained it with him. I think he was trying, too. He kept me cause he don't like to see me in the streets. [...] He was like a brother's supposed to be, you know what I mean?

Amanda: Mm-hmm, I do.

Susan: And it's just, it was me pushing him away from me, because I was just, you know, so used to being out there on my own and stuff.

Five months earlier, in her first interview, Susan had described living with her brother more concisely: “[H]e don't drug or nothing like that. He goes to work every day [...] he's very positive. We do a lot of positive stuff.” In Susan's case, positive stuff involved activities with family, sequestered from drug activity and street violence. What the longer account from the second interview highlighted was how getting to the place where positive stuff occurred was perceived by Susan as itself a process worthy of remark. Narratively, it took Susan some time to get us to what I was wanting to see as the core event of living with her brother. She circled around her stay, spending much time before and after making sure that I knew how unusual the acceptance of such help was for her and setting the positive experience with her brother against the previous, less amenable situation with her sister. But once she got to the story, Susan's account of housing support was unusually free of entanglement. The outcome was more than just a roof and four walls; it was an experience that enabled Susan to reconnect with family and to discover that accepting informal support did not have to signal weakness. Susan still preferred to have her own place, and at the time of the second interview she had moved on to other arrangements. But Susan spoke fondly of her stay with her brother and expressed awareness of the heightened sense of family belonging to which it led. For Susan, the experience of receiving aid from family was not simple, but it did prove to be relatively free of entanglement. In this respect, Susan's narrative of accessing shelter represented an exception. Most of the other women in this study who narrated stories about seeking housing resources through family ties reported more mixed results.

Natalie was a 36-year-old Black woman and mother of four, a bright, funny woman and a natural storyteller, who reported that she had earned GED equivalency and later a college degree. Natalie was also a self-described heavy drinker and occasional user of opioid narcotics who had lost custody of all four of her children when she was sentenced to several years in prison 10 years earlier. She had been in and out of jail since. Following release from the jail incarceration in which we met, Natalie lived temporarily with her father and his wife. Natalie noted three details about staying in her father's home: the frequent criticism she received about weight she gained in jail, her stepmother's padlocking the kitchen cabinets and prohibiting her from using the kitchen, and a strict curfew according to which Natalie was barred from re-entering the premises after 10 p.m. Although shelter with her father was physically safe and drug-free, Natalie found the rules and demeaning treatment uncongenial and soon moved out. Over the 12 ensuing months of this study, Natalie lived in an abandoned building, a car, a shed, in a rented bedroom, and briefly out of state with her new husband's mother. In mid-winter, city officials confiscated her things and locked Natalie and her fiancé out of the abandoned house in which they were illegally squatting. Natalie narrated a subsequent episode in which she went to her brother for help:

Natalie: My brother, I called him, and I'm like, "Bro, it's cold—can you help me out on the room or whatever? Terence's at work, at the part-time job up here." [Aside, to Amanda: They don't pay him much, but still. It's still a job.] "Can you help me out with at least \$30?"

[Pause] [Brother's voice:] "I need to check with my wife and see."

"Why you need to check with your wife? I'm your sister, tellin' you I'm in the cold and I just told you what happened—we got to get out of this house. What's so hard for you? I ain't askin' you to come to your house. I'm just askin' you to help me out."

I had to hear 30 minute, 45 minute about how I need to get my life together, and he—this, that, and all this crap—and then [he] throws me \$20. [**Amanda:** Mm-hm] I have four sisters and two brothers, okay? Why am I out here in the cold?

[**Amanda:** Yeah] Couldn't none of my sisters and brothers ever be out in the cold and I have my own place.

In some ways, Natalie's story represented the inverse of Susan's. While Susan described having held herself apart while her family attempted to draw her in, Natalie described a

recurring narrative of exclusion in her interviews. In situation after situation, she reported seeing herself left out, abandoned, or betrayed by family. Natalie assured me, following the account of this appeal to her brother, “I don’t *have* no family, I never had no support. But if my little sister called one of them—ahh, they breaks they neck.” Underlying the focus on exclusion was Natalie’s perception of a moral claim on her family, its logic encapsulated in “I have four sisters and two brothers, okay? Why am I out here in the cold?” The assumption is that families have an obligation to support members in trouble. The brother’s response—“about how I need to get my life together”—represented a counter claim, one based on the reciprocity principle in social support, namely that social assistance takes place in a system of exchange to which all parties are expected to contribute something. It is not difficult to infer that, while Natalie felt excluded, her family felt overburdened by the persistence and magnitude of her needs. Indeed, it is worth noting that the same brother and his wife had been raising three of Natalie’s children—for the past decade.

Natalie’s story highlighted several of the primary sticking points of relying on close bonds for housing: the difficulty that a justice-involved woman with significant lifetime trauma would have meeting conditions of reciprocity; the likelihood that a justice-involved woman’s needs, especially if long-lasting, would at some point exhaust or overstrain her network’s ability or willingness to meet them; and the possibility that the woman in need might fail or refuse to comprehend why she was being denied help. For Natalie, the story was simple: “I don’t know what’s wrong with my family. It’s just I don’t *have* no family.” These perceptions are important, regardless of how seemingly at odds they are with some of the experiences Natalie described. They are what eventually drove her to seek shelter in much less safe situations. In Marie’s story, which I discuss next, we see something different. For Marie, shelter with family also ended up being entangling or threatening to health and impeding of social advancement. But in her case the entangling outcome unfolded *because* Marie was meeting the demands of reciprocity.

Marie was a White woman, aged 31, also mother of four, all of whom, similar to Natalie's children, were in the custody of relatives. Prior to her incarceration, Marie made money stealing cars and dealing methamphetamine for about two years and described herself as one of the central local purveyors of meth. When we met, Marie was in jail for the first time. She shortly after went to trial, was charged with four felony offenses, and ended up taking a deal that involved residential drug treatment and a concurrent, reduced prison sentence. On release, Marie went to live with an uncle and the grandmother who raised her. Similar to the housing support that Susan received from her brother and that Natalie received from her father, the shelter to which Marie gained access through family following incarceration enabled basic safety and some degree of buffering from former drug-dealing associates. But Marie's situation was complicated by conflicts between the demands placed on her by the criminal justice system and those she was expected meet in exchange for accepting shelter with family.

The latter revolved around the understanding that Marie would provide full-time care to her grandmother who suffered from Alzheimer's and dementia and her uncle who was mentally competent but physically disabled. Marie confessed that she felt overburdened by the arrangement, which made her anxious and sleep deprived. She described overeating, increased cigarette smoking, and sex (unprotected) with an acquaintance as primary ways in which she coped. Additionally, Marie's situation at home complicated her ability to comply with probation requirements. These included weekly visits with her probation officer, involving a several hour round-trip journey by bus from the suburb where Marie lived. She was required to pay a \$30 "intervention fee" per visit with her probation officer and another fee for random urine drug tests.

Marie: Right. And like right now, I was on city probation, and I went to court and the lady was like, "Okay, we're gonna not do the drug classes. You did treatment and you did drug classes in jail," and then all this and that. But they sent me a paper to do a drop, and I needed \$20 for it. Okay, well, um, I don't work. I don't know where you think I'm gonna pull \$20 out of. And then I just got another letter in the mail saying

that I had a violation for that probation down there. I'm like, for real? Like the judge is gonna drop the whole fucking thing, so why do I have a—I mean I don't understand, like why—do you think I'm gonna pull money out of my ass?

Amanda: Right.

Marie: You tell me not to go out and sell drugs, but then you tell me to go out and make up \$20? It's kind of like tellin' me to do it but not do it. Handing it to me and telling me "Don't touch it," but you're telling me to take it. You want me to touch it, or do you want me not to touch it? [Laughs] So I don't know. I have to talk to my probation officer about that tomorrow—*if* there's not already—I don't know how that works, I don't know, hopefully there is not like a warrant or anything for that.

In this account of her predicament, Marie depicted herself in Kafka-like opposition to a system that seemed to taunt or toy with her, making demands that she was structurally denied the possibility of meeting. She had no income and, as she emphasized to me, no way to take a job outside the home, since she was needed there nearly all the time. She also had no source of transportation other than the bus with its limited commuter schedule. For Marie, gaining shelter through close bonds enabled her immediate survival. The situation even provided her opportunity, as she said, "to give back" to her grandma and uncle, who "stuck with me during jail." And, at least initially, the arrangement seemed to help Marie maintain distance from a drug-involved social network. But the combination of unrealistic community supervision requirements and expectations that arose from living in her grandmother's home entangled Marie in obligations that she experienced as overwhelming, increasing her risk for stress-related health problems, unplanned pregnancy, probation violations, and, as she saw it, urging her along a path to reoffending. Finally, the need to be at home nearly all the time had opportunity costs in that it all but precluded the formation of ties outside her close network that might have been used to access resources with more potential to advance Marie's socioeconomic position.

For the women like Marie who found housing assistance through close family bonds, the experience of gaining shelter meant relief from the immediate dangers of living on the street or moving constantly from place to place. Though it was doubtless not always the case, the descriptions provided by the justice-involved women in this study suggested that family assistance enabled women to put distance between themselves and criminogenic social

environments. The women's accounts also indicated however that shelter accessed through family connections could involve rules and conditions, expectations and obligations that women variously perceived as antithetical to their self-image, demeaning, overwhelming, and at times impossible. Although Susan's example suggested that under the right conditions receiving social support from family members could promote personal growth and enhanced relationships as well as survival, Natalie's and Marie's examples underscored that housing with family could also be harmful to health and an impediment to leveraging out of a socioeconomic position through external ties.

Finding shelter with friends and acquaintances—"They wasn't sending me out for me to be free. They were sending me out to be in hell"

Several of the justice-involved women in this study did *not* find shelter through strong, close ties in a bonding network. These women, similar to Natalie after she left her father's home, moved about frequently, staying with casual friends and acquaintances in situations that entangled them, posing threats to their health and rendering them vulnerable to violence and reoffending. Neta, a Black woman, 46 years old, reported a long history of incarceration, including 16 years in prison for drug trafficking. She had prostituted for many years and was highly networked in the urban community that formed around one of the main strolls, or areas where street prostitution is common, on the east side of Kansas City. Neta's extended story of shelter-seeking after jail is best understood through the lens of recurrent interpersonal trauma. Sexually molested by her father from age eight to nine, Neta experienced further sexual abuse in foster homes; multiple incidents of brutalization by adult partners; the sudden death of a newborn in the home; and her own near-death experience after being raped, shot in the abdomen, and left bleeding in a bus stop. Following the jail incarceration in which we met, Neta first went to live with her husband, a man to whom she was recently married. When the marriage began to replicate violent patterns of her past, Neta was forced out:

Neta: After awhile, I didn't even want him to touch me. I moved my bed into another room and let him stay in there. [...] Then the violence started, he wants to try to fight me. I didn't get married to get beat on. It was really crazy.

Amanda: Did you fight back at all?

Neta: Course. That's why it didn't work. I tore his ass up. I ain't gonna lie. You not going to beat me—I'm not going through that. And, you know, of course it clicked [...]—the first thing I clicked back to was my mom bein' beat. [...] He would wait till I turned my back and try to hit me in the head with something. Or if I would fall asleep—God is good, though, I'm telling you—the first time he tried it, I was asleep. He hollered out, “Bitch, I'm tired of you!” By the grace of God, God moved me a little ways, swayed me a little way, because, I mean, had I not moved, my head would have been busted. I probably would have been dead, cause he was trying to hit me in my head with a bat.

[...]

I left. More or less he put me out for someone else. When I got out of jail this last time, he told me I was too fat and I was ugly and he was tired of looking at me. And he wanted me out.

Neta's interviews were replete with violence and loss, trauma an ever-present factor in her efforts to navigate the challenges of survival after incarceration. In this brief account of sheltering with her husband, his violence “clicked” Neta back to memories of her mother's being brutalized by her father. Elsewhere Neta attributed her revulsion to sex to having been raped by her father as a child. For Neta, housing with her spouse meant finding herself entangled in increasing intimate partner violence that triggered trauma memories of her childhood and put her at heightened risk of injury, death, and extreme mental strain. Blocked thus from safe shelter in what should have been her home, Neta turned to other network connections.

During the next several months, Neta received shelter in exchange for providing personal care to a male acquaintance with diabetes who recently underwent an above-the-knee amputation. The man owned the dilapidated house in which they lived and was renovating it before he lost his leg, which is why, Neta told me, it had no plumbing and ran lights from a generator. In our first interview, Neta pointed to the metal can in the front yard where she disposed of the man's medical and their personal waste in plastic trash bags each day. We sat on chairs on the front porch during that interview because Neta said raccoons had gotten in and peed on the furniture inside the house. Seven months later when I met up

with Neta for our follow-up interview at a nearby McDonald's, the house had been shut up by the city, and Neta had moved into an apartment with four men she knew, two of whom were unemployed and all of whom drank and smoked crack. Things were getting uncomfortably strained between Neta and one of the men, with whom she said she had made the mistake of having sex. "He's done turned fatal," Neta told me, referencing the man's increasing surveillance of her activities. It seemed likely that this living arrangement would end poorly, and a couple months after that interview we found Neta's phone was disconnected, and letters sent to her at that address were returned undelivered.

While each new shelter kept Neta temporarily off the street, none offered much security or any opportunity to improve her status. Worse, each subsequent situation posed new threats to her health and put her in danger of violence. A similar story, though one perhaps more hopeful, was told by Cat, who also reported experiences of sexual abuse as a child, a decades-long history of incarceration, and, in her case, mental institutionalization. Cat was a 38-year-old White woman who was HIV-positive and trying to exit prostitution and recover from a crack cocaine habit. She described years of having to cobble together shelter any way she could:

I was homeless for a long, long time. I used to sleep on the house—down there [gestures toward the street] on the porch. Which somebody *else* is sleepin' on the porch now. Yeah, they can have it [chuckles]—I won't evict them. But um, yeah, I slept underneath bridges, I have slept in parks, I've been in abusive relationships.

At the time of our first interview, Cat had just begun receiving Social Security Insurance (SSI) for her mental illness in an amount that was sufficient to rent a studio apartment. She lived in one room in a small, squat brick building, one block from the street where she had spent much time prostituting and using drugs. She lived with her boyfriend, who was also her Medicaid-reimbursed caregiver. This partner, Cat told me, "can be abusive when he's pushed [...]. He, um, he does—his drug of choice is PCP. I don't like PCP, but I don't wanna be by myself. So, maybe I accept things that I shouldn't accept." When I caught up with her for the

second interview five months later, Cat described how she had replaced the PCP-using roommate with a former associate to whom she had just gotten married:

[W]e were homeless together, we used together, we hustled together—and [pause]—you know, I, I left—came back when I was clean, and he was nowhere to be found when I came back. So I, um, got my apartment, let my boyfriend move in—a new boyfriend I had, which he smoked PCP, which I did not know ‘til after—yeah. And that was an abusive relationship and stuff, and somebody told me that my boyfriend, which is my husband now, came back around. So I went down there lookin’ for him, and I asked him, I said, “Are you ready to come home yet?” [Laughs] And he said, “Yeah.” I said, “Okay, but we have a situation.” [Laughs] I said, “There’s somebody else at my house.” He says, “As soon as you tell me I can come in, there’s nothing he can do.”

The passage was noteworthy for its intertwining of relationships and housing—the nodal points of “homeless together,” “got my apartment,” “let my boyfriend move in,” “ready to come home,” “somebody at my house.” Such points of articulation or thematic jointing emphasized Cat’s underlying consciousness of homelessness as something relational, as something more than a roof over her head. Much of this for Cat was about safety, her sense of home as physical and psychic security. And, despite her husband’s meth habit, he was in Cat’s estimation comparatively safe. When I asked outright why she married, Cat gave three reasons: belief in the Bible, no longer having to disclose HIV status (since her husband already knew), and “I got tired of being beat by other men.” For Cat, while actual access to housing was gained through social services not informal social connections, her perception of that shelter as safe and stable paradoxically depended on the presence of male partners, who, though she saw them as protecting her, often also seemed to expose her to further harm.

Among the women I interviewed in the community, Cat was among the more securely sheltered. In fact, Cat herself provided shelter and income not only to the men, like her husband, whom she set up as her Medicaid-reimbursed personal caregivers, but also to a series of homeless women who struggled with drug addiction. Several of these she housed temporarily over the year of this study. With a ninth grade education, no formal work experience, a long history of serial incarceration, a background marked by sexual and

physical victimization, and health conditions including schizoaffective disorder, HIV, and diabetes, Cat faced serious barriers to thriving. And, though she appeared to have attained a comparatively stable housing situation, her status remained tenuous. In a field encounter that took place three months after the second interview, Cat related that she might lose her housing benefit due to difficulties procuring her husband's out-of-state birth certificate. For women in this study, finding housing often meant a shifting mix of empowerment and entanglement, including, as was true for Cat, continued, daily, intimate proximity to alcohol and drugs and vulnerability to interpersonal violence that threatened both injury and the triggering of emotional wounds.

Most of the situations in which women found shelter did little more in terms of empowerment than shield the women from the immediate dangers of sleeping on the street. Shelter support accessed through social ties put women at risk of not just several kinds of harm but of reincarceration as well. Another participant, Sarah, a 52-year-old woman with over 30 years experience as a professional sex worker (her designation), was assaulted and permanently disabled after being released from the incarceration in which we met. When I interviewed Sarah, she reported that approval of her victim's compensation and Social Security insurance benefits was pending. She was temporarily sheltered by a male acquaintance who "takes meds for hepatitis C and tuberculosis. And he smokes crack, and he drinks liquor, and it alternates him, and he changes." Between our first and second interviews, this person "jumped on" her, Sarah defended herself, the police were called, and the man was taken into custody on domestic assault charges. Counter claims were made, and, while all charges were dropped, the police involvement triggered a probation violation for Sarah. She spent another 30 days in jail.

In the year following a jail incarceration, only a few of the justice-involved women in this study had access to community services or public benefits that provided shelter while they attempted to get their lives on track. The exceptions included Sarah and Cat and the one

socioeconomically divergent participant, Jennifer, who was a White woman with a middle-class background, a college degree, and professional experience. Jennifer was placed in Drug Court and provided with shelter in transitional housing after release. Cat's serious mental illness gave her access to benefits that enabled her to pay for housing. Sarah was on the verge of receiving benefits. The others made do. They found shelter, as Susan said, "from house to house, and this and that," through family, friends, and acquaintances. Perhaps the most striking testament to the difficulty of securing a safe and stable place to sleep for women with significant history of incarceration and trauma was given by Neta, who told me that even jail seemed at times preferable to the constant, exhausting, punishing quest for shelter:

Each time I went back to jail and came out, it got worse. I mean, I didn't care. Couple times I asked them to keep me. They thought it was funny, but I was serious as hell.

"We're gonna send you back out."

I said, "Why?" I said, "My feet still hurt. I'm tired."

They wasn't sending me out for me to be free. They were sending me out to be in hell.

Shelter meant getting off the street, off porches and park benches, and out of cars. But for women struggling with history of trauma and often cyclical incarceration, getting shelter through social network connections also led to a host of difficulties. Women depicted shelter through close family relationships as entailing obligations that were difficult to meet or as requiring endurance of demeaning treatment or abuse. When shelter support was obtained from mere acquaintances, women indicated that the drug habits and mental conditions of those on whom they depended put them in direct line for disease and further violence, and in two cases among those I interviewed, leading directly to reincarceration. Shelter arrangements through social connections of any kind did not last long and only very rarely did they facilitate the women's access to more than survival. Instead, finding help through social ties too often meant being subject to stressful, volatile, unsafe, and, at best, socioeconomically stagnant situations.

Discussion

Empowerment and entanglement were conflicting and simultaneously occurring themes that shaped the narratives that justice-involved women told of their experiences seeking and receiving shelter support through social relationships. Much of what was divulged by women in stories about supporting relationships pointed to patterns that are congruent with existing research about other low-resource populations struggling to get by. For women in particular, achieving affordable, safe shelter during transition after incarceration has been identified as a priority (Freudenberg et al., 2005; Ramaswamy, Upadhyayula, et al., 2015), yet, for reasons that remain unclear, women are less likely than men to be offered housing assistance from friends and family (Mallik-Kane & Visher, 2008). While one might speculate that the additional burden of providing shelter for a woman's children would affect the willingness of close ties to offer housing to justice-involved women, many of whom are mothers, that seems an unlikely explanation in this case, since only one of the women in this study still had any of her children in her custody.

Several women in the current study did survive in the months following a jail incarceration by accessing shelter through the close family networks that social capital and social network theorists describe as bonding networks (Brisson, 2009; Domínguez & Watkins, 2003). In bonding networks, social connections usually consist of strong, long-term ties among members who see themselves as similar to one another; these networks tend to provide access to modest forms of social support (Hawkins & Maurer, 2011). For women in the current study, sheltering arrangements gained through strong ties within bonding networks were not entanglement-free, but in the women's accounts they did seem to offer more safety than those situations in which women gained housing through weaker ties in bonding networks, that is, through less proximally related family and friends or acquaintances. In a study of women returning to homes in rural communities following completion of prison-based drug programs, Kellett and Willging (2011) presented findings

that indicated how entangling a lack of options around housing could be for justice-involved women in highly circumscribed social networks. Women in the Kellett and Willing interviews reported having no choice but to return to living situations in which drug use and interpersonal violence were key parts of the environment. The stories recounted by women in the current study, though they took place in an urban setting—in which we might expect to see more choices—seemed to document equally constrained and imperiling options.

Marie, Natalie, and especially Susan were among the more empowering of the cases I analyzed, but even their accounts underscored how access to housing assistance through strong ties in bonding social networks could be restricted by a general unavailability of resources in overburdened structures. Natalie's perception of her siblings' failure to extend support when she faced homelessness was in keeping with studies finding that in low-resource networks benefactor members tend to be stricter about enforcing reciprocity rules with members who are especially or very frequently in need (Domínguez & Watkins, 2003; Harknett & Hartnett, 2011; Hawkins, 2010; Henly et al., 2005). In some cases, like Marie's, obtaining shelter support from family may have had an additional effect of precluding involvement in "linking" (Domínguez & Arford, 2010, p. 118) social relationships that she might have formed through employment or college classes. The social network literature characterizes resources gained through "linking social capital" as means to advance social status or get ahead rather than just survive (Freeman & Dodson, 2014; Henly et al., 2005; Nelson, 2000). Lastly, researchers have found that when women in low resource situations received support through close social network ties, such assistance could lead to shame and in some cases withdrawal and social isolation (Offer, 2012). Though none in the study group disclosed shame directly, several spoke of their related unwillingness to become dependent on others, claiming, as Susan did, that "you don't want to ask nobody for nothing or you don't want to, you feel like you—you can do it on your own."

In addition to shelter that was obtained through close bonding networks that mainly involved family, justice-involved women frequently related accounts of brief periods of sheltering with weaker bonding network connections, acquaintances whom they described as drug-involved and/or suffering from poorly controlled mental health conditions. In this study, such arrangements seemed to threaten more in the way of entanglement than those involving family members. Neta's experience with the four men or Sarah's sheltering with an acquaintance whose violence toward her led to her reincarceration, for instance, fit the parameters of a disposable ties concept developed by Desmond (2012) to account for the intense, short-lived relationships formed between near-strangers to meet shelter needs after an eviction. The idea of disposable ties (Desmond, 2012) neatly captures the experiences narrated by several justice-involved women in this study, where, to avoid homeless shelters or the street, women like Neta relied on intense, quickly formed and quickly dissolved ties that came with high potential costs to health and desistance.

The women I interviewed were not just women living on low-incomes trying to put together the means to keep a roof over their heads, as have been the subject of research by Lein and Edin (1997), Harknett and Hartnett (2011), Lavee and Offer (2012), and Nelson (2000). Nor do their needs correspond neatly with those related in Leverentz's (2010) study of women living in a transitional home in Chicago following release from several or more years of a prison incarceration. Though a number of the women in this study served prison time in the past, all but two were interviewed after a short incarceration, and most reentered the community with no access to transitional shelter services. The challenges faced by women cycling in and out of jail and frequently on probation, what Taxman, Byrne, and Pattavina (2005) call "churning" (p. 65), can be uniquely challenging, different from those commonly encountered by persons coming out of longer terms in prison. Women and men who are frequently incarcerated for short periods in jail and are released on probatory conditions, occupy a "unique social nexus," between the demands of a surveilling and

stigmatizing criminal justice system “and community influences, which involve them in the risks and rewards of daily life in predominantly socially and economically disadvantaged communities” (Lorvick et al., 2015, p. 1). Those community influences, in many instances, may also be women’s sole source of housing and other resources for survival.

The present study adds nuance and context to our knowledge about how women with history of trauma and incarceration struggle to meet their health and safety needs under materially constrained and highly stressful conditions: the women’s interviews called into relief, first, the intertwining experiences of empowerment and entanglement and how the women’s perceptions and constructions of these markers for survival, risk, and opportunity informed their navigation of social relationships. Second, the analysis provided insight into where things tend to go wrong—and where they seem to have most potential for going right. Finally, the women’s stories underscored the crucial need for publicly provided support for women during jail-to-community transitions. Shelter accessed through social ties represented for these women a stop-gap to enable survival. Unfortunately, for most of the women the stop-gap strategy appeared to be an only option and a trap, miring them in situations for which there seemed to be little chance of extrication.

Implications and Recommendations

The women in this study were intensely networked. They came from neighborhoods, had families and friends, and interacted in the community in all sorts of ways. Despite the many barriers they faced, justice-involved women with history of trauma told stories about relationships that highlighted persistence and resourcefulness in cobbling together shelter. What their narratives of shelter seeking made evident was the need for better scaffolding, a coordinated system of public support, initially in the form of housing, but designed overall to provide coordinated, non-judgmental access to the resources and services upon which justice-involved women can begin to craft healthier ways to live.

Nurses and other providers working directly with individuals in the community can learn to identify empowerment and entanglement in women's stories. They can help women recognize and cultivate the healthy or empowering sources of shelter support and avoid or extricate themselves from those that pose increased health and safety risk. Care providers, including nurses and physicians, can make an effort to cultivate agency contacts and have accurate, up-to-date information about area resources, including non-profit, religious, and other community organizations that are available to help women avoid housing situations where entanglement seems most threatening. Other recommendations would involve finding ways to extend care to families who are dealing with the strains of sheltering justice-involved women as they attempt to reintegrate. It is possible that providing low-cost, community-based classes and retreats for re-entering women and family members to help alleviate stress through meditation and mindfulness exercises or to give assistance in managing expectations may also be helpful.

The empowerment/entanglement model may also be useful in informing the development of housing policies and programs. Publicly supported, community-based transition programs are needed to enable women to establish independent or semi-independent households and avoid the entanglements of relying on either strong or weak social connections—which seemed with few exceptions to embroil the women in this study in situations of abuse and injury, relapse to drug use, and reincarceration. Some work in this direction has been attempted. New York City; Oakland, CA; and Cook County, Illinois, with their very large jail systems have developed innovative transition and housing programs in recent years that show encouraging outcomes on health and recidivism indicators (Bae, diZerega, Kang-Brown, Shanahan, & Subramanian, 2016; Teixeira, Jordan, Zaller, Shah, & Venters, 2016). The Housing First movement that underlies several such ventures posits that stable, safe, independent housing comes first—without requirements that clients complete rehabilitation programs or sign abstinence or behavioral contracts (Pleace & Quilgars, 2013).

Proponents argue that compared with traditional “staircase” (p. 8) approaches housing first projects may be more effective in achieving both harms reduction and social integration (Pleace & Quilgars, 2013).

It is likely that, in many parts of the U.S., health and service providers and their professional organizations will find legislatures resistant to funding the development and implementation of such programs. Where funding and programmatic support are lacking, communities, organizations, and individuals providing care and services to women must organize to increase pressure while also exerting efforts in more embedded and sporadic form to help those who confront the difficult task of securing shelter after an incarceration. The frustrating and unfortunate fact is that, without any material change in the circumstances that make homelessness a threat—i.e., the current high cost of housing and the difficulty of accessing housing benefits for women with a criminal record—such efforts are likely to run aground on the shore of inadequate real options.

Limitations

This study was limited by the nature of the data and the study design. The women’s stories of housing support, though intelligible, were often also quite loosely bounded. Piecing together a coherent story of shelter-seeking as it was told by a participant often meant pulling together bits scattered across a single or across both interviews. This required more paraphrasing and extraction of small quotes than would be ideal. A second and related limitation was inherent in the design and the epistemology that underlay it. Narrative inquiry does not lend itself to the discovery of statistically generalizable knowledge, in part because narrative data are interpreted for meaning, not measured or counted for distribution and frequency. Though my goal was not generalizability in a probabilistic sense, I did seek what Maynes, Pierce, and Laslett (2012) call “sociologically generalizable knowledge” (p. 128), which refers to the illumination of social roles or processes through convincing interpretation of personal narrative evidence, a process that can be accomplished through detailed analysis

of as few as one case. Something akin to generalizability is achieved through a reader's persuasion that the interpretive reasoning is transferable to other, similar situations (Tracy, 2010). The overall choice of narrative inquiry will be deemed a limitation by those seeking a greater degree of inferential certainty. Third, some readers may also question my readings on the grounds of my subjectivism as interpreter of the texts. That the interpretation was subjective can be assumed, given the constructivist underpinnings of the methodology, but it was also negotiated (Gubrium & Holstein, 2009), in that both the participants themselves and my research team collaborated with me in the reasoning by which transcriptions were rendered meaningful as research. The latter, what Patton (2015) following Guba and Lincoln (1985) call investigator triangulation, involved two MPH holders—one also a sociologist—as independent readers and discussants in the process of deriving the model of empowerment and entanglement. By offering large segments of the text in this report, I additionally give the reader opportunity to judge the logic that links data to interpretation.

A last potential limitation is that, similar to a survey study, the source of data in this study is mainly self report. Unlike a survey study, however, respondent subjectivity in narrative inquiry must also be considered a strength, since the participants' contextualized, detailed renderings of perception and experience are part of what gives such work its ability to provide additional perspective and insight to the understanding of a phenomenon.

Conclusion

I sought to learn from justice-involved women with significant lifetime trauma more about how social support was accessed after a jail stay and how its outcomes were experienced. My data were the stories women told, and my methods were interpretive, mainly focused on discovering thematic and structural patterns in the perceptions of women about what happens after a jail incarceration. My objective was scientific, to discover knowledge, and political, to address with an eye to change a disparity in health.

Aside from trauma, in the interviews that I conducted, no aspect of reintegration seemed to demand more energy and attention from the women than the challenge of finding safe housing. The stories that justice-involved women told about obtaining access to shelter through social connections reflected two opposed though not mutually exclusive motifs, empowerment and entanglement. Empowerment manifested when women described access to housing resources that facilitated survival and, in a few cases, a semblance of growth or advancement. Entanglement occurred when women were pulled into situations of increased risk to their health, safety, or desistance from reoffending. The stories told by women in this study pointed to the conclusion that, without readily accessible, safe shelter, women with justice involvement and history of victimization through interpersonal trauma will find ways to survive post-incarceration, but only just barely, and they will be unlikely to thrive. Post-release, justice-involved women will continue to be exposed to injury, disease, and reincarceration, with communities, neighborhoods, and families sharing with them the costs in morbidity and mortality. Funding for effective programs to provide safe housing for persons as they seek to stabilize their situation after a brief incarceration needs to be a priority. In its absence, nurses, physicians, public health and social workers can collaborate with women to help them identify and promote empowering housing options and minimize the harms of those that are more entangling.

CHAPTER 6

CONCLUSION

The stories collected and analyzed in this dissertation highlighted justice-involved women's perceptions and management of relationships to manage health risk and maintain safety. By their own telling, when women made choices—about work, parenting, shelter, partnering, substance use, etc.—their horizon of options and understandings was influenced by experiences of lifetime trauma, the effects of criminal justice involvement, compromised access to social support, and little or no access to social capital. Women understood and reconstructed events around highly stressful situations through opportunizing and fatalizing talk, through which they performed their variable notions of personal agency around accessing social support. The social relationships through which women sought access to key aspects of assistance, such as housing, were often cast as empowering but also entangling, leading to heightened risk, with few linking opportunities that would allow women access to connections beyond family and existing social ties.

Yet, even with formidable obstacles and limited horizons of possibility, the women storytellers in this study called into relief more nuanced and thus more instructive visions of how survival is achieved by justice-involved women in underresourced situations with high health and safety-risk. The women provided pictures both of strength and strategy as well as struggle. The two models derived from the narratives may (a) provide starting points for assessing and responding to justice-involved women by nurses and other care providers in community and clinical practice, (b) serve as a basis for further research around the operationalization of variables and development of constructs, (c) inform programming and intervention design that is more in touch with the complexity of women's own perceptions and experiences, and (d) provide means to argue for resource allocation and policy that can address women's needs in more comprehensive and coordinated ways.

The Unheard Stories of an Overlooked Population

This research addresses a gap in the literature by examining the health and safety needs and experiences of women. Research concerning justice-involved populations has historically been dominated by investigations into men's incarceration. This continues to be true, even though women's incarceration rates have been rising in the past decade, while men's rates have fallen (Minton & Zeng, 2015). When women do constitute a population of interest for studies concerning the health and welfare of the justice involved, that research has typically addressed women's pathways to offending or the experiences and needs of or interventions with women who are currently incarcerated (Tripodi, Bledsoe, Kim, & Bender, 2011). The hundreds of thousands of women who transition in and out of short-term incarceration each year—many of whom continue to live under criminal justice supervision or surveillance in the community—have received some but far less attention from the health research community despite their significant health needs (Comfort, 2016; Freudenberg et al., 2005; Lorvick et al., 2015; Ramaswamy, Upadhyayula, et al., 2015). What we know from the pathways literature is that many justice-involved women suffer from substance abuse disorders and mental health problems; many occupy a socioeconomic position defined by scarcity of material resources and social capital, low education, and employment options that are mostly limited to work in the low-paying service industries (Kelly et al., 2014; Roos et al., 2016; Simpson et al., 2008; Western & Pettit, 2010). And we know that justice-involved women are disproportionately burdened with lifetime interpersonal trauma that can affect their ability to form and maintain relationships (Fuentes, 2014; Grella et al., 2013). What we lack is understanding of how justice-involved women, in the context of few resources and frequent interpersonal tumult, perceive opportunity and risk, and how those constructions influence their navigation of social networks to get what they need. In a continual scaling back of public benefits and reduced opportunities for employment, most justice-involved

women do manage to scabble together resources to survive. In this project, I sought to learn more about how that happens—specifically from the women’s own perspectives.

Learning from Women’s Narratives

The aim of this dissertation was to explore what the relationship narratives of women with criminal justice involvement and history of interpersonal trauma revealed about their perceptions and experience of seeking social support to manage health risk and prevent violence. Drawing on narrative data from in-depth interviews with 10 recently incarcerated and/or released women, I derived two models to add to our understanding of how justice-involved women understand and manage social support. My aim and purpose were influenced by a feminist and transformative perspective. My two findings chapters, chapter 4 and chapter 5, demonstrated how justice-involved women’s stories of survival provide access to knowledge that nurses, other care providers, and program and intervention designers may find useful in organizing efforts to reduce health disparities and advance social justice in their practice, research, and political advocacy.

Feminism and Transformativity

The study was designed according to transformative and feminist perspectives. Feminism guided the study’s focus on women, one of its overarching concerns being to contribute to the corrective task of filling historical gaps in knowledge by putting women at the center of inquiry. Women have long occupied an adjunct category in social scientific investigations of carceral groups in general (Belknap, 2007; Pollock, 2014). Feminism guided formulation of my research purpose, to learn more about the perceptions and experiences of social support on the part of justice-involved women, and its methodology—which was based not on querying ideas *about* women but on investigating the crafted or narrated ideations *of* women. Feminism guided the data collection methods, which involved minimally structured, conversational interviews rather than rigid questionnaires or surveys, and encounters that were conducted in spaces of the women’s choosing. Feminism

influenced the choice of analytical approach. The narrative inquiry methodology with which I worked was congruent with feminism in that it encouraged taking into account whole stories, honoring meaning in women's ways of structuring and performing storytelling in addition to distilling meaning from content alone (Porter, 2015). Finally, the study, though exploratory and descriptive, bore a transformative intention, the critical and activist goal of explicating disparities of health risks in an overlooked population in order to press for better targeted efforts to eliminate them.

Opportunizing and Fatalizing Talk in Narratives of Trauma

The findings of the dissertation focused, in chapter 4, on justice-involved women's perceptions of self and other as constructed around support-seeking, specifically in trauma stories that the women embedded in their larger life-story interviews. The justice-involved women in this study narrated accounts of traumatic violence and loss in which they rhetorically situated themselves along a continuum of agency that ranged from a predominance of opportunizing talk at one end to fatalizing talk at the other. When women reconstructed experience through a primarily opportunizing lens, they presented selves as active agents who assessed situations, set goals, and enacted strategies to obtain assistance in moments of crisis. In opportunizing talk, justice-involved women claimed control over relationships and outcomes. Narratives told in an opportunizing mode were structurally focused, featuring lists and plans and articulating objectives. These narratives tended to push back against broader cultural scripts in which women with few material and social resources become passive victims to violence and abuse.

In contrast, when women reconstructed trauma accounts through fatalizing talk, they presented selves that were detached and self-effacing, often narrating events of traumatic violence and loss from an observer's standpoint. Fatalizing accounts were digressive, dreamy, or confused in tone, often assigning cause to random chance on the one hand or a larger sense of telos or destiny on the other. Importantly, both opportunizing and fatalizing

talk referred to orientations in women's narratives rather than defining characteristics of the women themselves; most women told stories that exhibited a mixture of both opportunizing and fatalizing, and neither perspective was sufficient to type or classify the women. As a model, the spectrum of agency with its two forms of "talk" illuminated divergent modes of perceiving and managing self to obtain support for health and safety. As such, opportunizing and fatalizing talk may point nurses and other care providers to useful means of recognizing and responding when a tendency toward one or the other seems counterproductive. The results suggested that one direction for future research based on the findings may be to operationalize opportunizing and fatalizing for measurement in assessing justice-involved women's ways of drawing meaning from and responding to memory of trauma experiences. Interventions based on building women's purposeful use of opportunizing and fatalizing talk in recrafting stories around trauma may be useful as a means to increase self-regulation and control symptoms of trauma in everyday life.

Women's Post-incarceration Stories of Housing Support: Empowerment and Entanglement

The second model was derived from justice-involved women's narration of stories that addressed their efforts to access housing support through social networks during the months following release from short-term incarceration. The focus on housing or shelter support came from its ubiquity in the interviews. Shelter support was accessed through close, strong bonding connections of family and friends and through the weaker network ties of casual friends, acquaintances, and strangers. Women organized descriptions of obtaining housing on both counts around the two intertwined themes of empowerment and entanglement. Empowerment occurred only in a very limited form in these narratives, mainly manifesting as access to basic survival, a place to stay. In this way, empowerment was perhaps most meaningful in its being so limited, in its lack. Housing accessed through close bonding ties with family enabled survival and occasionally a measure of stability and safety.

Women's narratives of housing support did not, however, facilitate—and often impeded—development of connections that might have led to further improvement in their socioeconomic status, such as employment in the formal economy, job training, or education. When justice-involved women narrated stories about accessing housing through distal or weaker social connections, those accounts tended to involve still more description of entanglement. Entanglement characterized situations in which women expressed increased susceptibility to disease, injury, and reincarceration.

For justice-involved women with trauma history, the challenge of securing housing post-incarceration was formidable and was met most often through social connections that threatened women with exposure to unhealthy, unsafe situations. Care and service providers in clinical and community situations, and specifically nurses working closely with justice-involved women, can learn to identify the intertwining aspects of empowerment and entanglement in women's accounts of shelter seeking. By collaborating with women post-incarceration, nurses and other providers whose charge it is to facilitate health can provide information about community resources and strategize with women to make the most of empowering possibilities while minimizing the more entangling aspects of their housing situations. Ultimately, nurses and other care providers need to find ways to use their collective professional voice to advocate for funding to develop and implement comprehensive transition programs that will not force women to choose between the street and situations that compromise their health, safety, and desistance.

Limitations of the Dissertation Study

The limitations of this study included the narrative inquiry methodology, which entailed that the conclusions drawn would not be predictive or generalizable to a population or point very directly to concrete practice recommendations. Narrative data do not lend themselves to measuring or counting, so making claims about central tendency and variability—claims that would allow statistical generalizations or predictions—was not

possible. The methodology thus limited the results and their uses—as would be true, one way or another, of any study design. For a narrative inquiry, instead of being limited to the broad outlines of statistical generalizability, an investigator is limited to “sociologically generalizable knowledge” (Maynes, Pierce, & Laslett, 2012, p. 128), in this case the identification of underlying social roles, types, or processes through interpretation of detailed, personal narrative evidence.

Arguably, another limitation arising from the choice of narrative methodology and interpretive analysis is that the findings entail a fair degree of investigator subjectivity. In chapter 3 and in both of the findings chapters, I noted my reliance in this study on reflexive memoing, triangulation of investigators and data sources, and participant review of configured narratives to minimize or account for the effects that my values, attitudes, beliefs, and experiences might have had on the findings. Even with those precautions, the methodology itself involves more investigator subjectivity than would be true of a study in which inferences were analytically drawn from averages, distributions, and variances. Both approaches are limited, though differently so.

Beyond the inherently restrictive features of narrative inquiry, this study was also limited by setting and time. Regardless of how detailed and complex the selected cases and stories may have been and how sensitively they were analyzed for underlying realities, all were drawn from a single jail, in a single city, in the Midwest U.S. Many of the women in this study knew each other from the urban neighborhoods of this racially and economically segregated Midwestern city. The findings would likely gain from additional interviews with women from different geographic contexts and demographic profiles. The absence of Latina voices in the study is particularly regrettable and in part reflected the small number of Latina women who were recruited in the parent study (Ramaswamy et al., 2016). Researchers have explored support seeking by underresourced Latinas as well as fatalistic assumptions around disease risk, their work suggesting that cultural experiences may occur in patterned ways of

interest to this dissertation (Florez et al., 2009). The weakness in case selection might have been corrected with more time.

The time frame in which the study was conducted was fairly tight for field-based or naturalistic inquiry and limited the amount of participant observation I could perform. Although I took careful, detailed field notes and had access to notes from another researcher's more frequent field encounters with members of the study group, additional time spent interacting with participants in their daily activities would have enriched the data and added to the triangulation of source and thus the overall trustworthiness of findings.

Conclusion

Justice involvement and traumatic life events often feed off one another, creating a situation in which persistent poverty, insecure housing, interpersonal violence, drug use, and mental illness conspire to trap women in situations that threaten mental and physical health and safety. The systems and services available to justice-involved women post-incarceration are often fragmented or difficult to access. Studies have assessed the pathways to incarceration and the social and health service needs of women leaving incarceration. Other relevant research has investigated informal social support in the lives of women who face economic insecurity without the added burdens of justice involvement and trauma. There is not much if any research that can help nurses and other care and service providers understand in detailed, highly contextualized ways how women with complex trauma exposure and justice involvement perceive and manage informal social support around health and safety in the community. It was the goal of this dissertation to use analysis of in-depth, story focused interviews to contribute to what is known about how justice-involved women understand their own navigation of barriers in low resource, high stress situations. Findings from this study add to the knowledge available to nurses and other health and social service providers who give care to justice-involved women on release as well as in custody. The results of this work may additionally inform the efforts of those who design studies and interventions,

administer transition programs, and advocate politically to legislate more equitable and supportive public assistance systems. Underlying the dissertation is the conviction that, by starting with the women's own versions of how support operates through social ties, and by noting their ways of managing those relationships within personal narratives, we can work together to improve health and well-being and save lives.

APPENDIX A
PARTICIPANT CHARACTERISTICS

<i>Characteristics</i> (<i>n</i> = 10)	<i>Percentage</i> (# or average)
Age	(38.5 years)
Race	
Black	60%
White	40%
Education	
Less than high school diploma/GED	50%
High school diploma/GED only	10%
Some college	20%
Graduated college	20%
Employment (at some point during data collection)	
Formal economy	10%
Informal economy, legal	30%
Informal economy, illegal	50%
Housing (more than one applied; during data collection)	
In own apartment/rented room	40%
With family	40%
With friends/acquaintances	50%
Place to place	60%
Homeless (car, shelter)	10%
Children, living	(3 children)
Number of participants with one or more children in their custody during study period	(1 participant)
Ever exchanged sex for money, drugs, or other goods or resources	60%
Using illicit drugs during period of study	70%
Ever used illicit drugs	100%
Number jail incarcerations	
< 5 incarcerations	30%
more than 5, less than 10 incarcerations	20%
> 10 incarcerations	50%
Ever served prison time	90%
Named interpersonal trauma	100%
Childhood sexual abuse	50%
Childhood physical abuse	40%
Rape	60%
Intimate partner violence	70%
Violent assault by acquaintance or stranger	80%
Sudden death of child	20%
Sudden serious injury, illness, or loss of parent or other loved one	50%

APPENDIX B

UNIVERSITY OF KANSAS MEDICAL CENTER IRB APPROVAL

Sexual Health Empowerment study (SHE) IRB

The University of Kansas Medical Center

Human Research Protection Program

APPROVAL OF PROTOCOL

February 1, 2016

Megha Ramaswamy
mramaswamy@kumc.edu

Dear Megha Ramaswamy:

On 1/26/2016, the IRB reviewed the following submission:

Type of Review:	Modification and Continuing Review
Reviewing IRB:	KUMC
IRB#:	13559
Title:	Sexual Health Empowerment for Cervical Health Literacy and Cancer Prevention
Investigator:	Megha Ramaswamy
IRB ID:	MODCR00002139
Funding:	Name: National Institute of Health
Documents submitted for the above review:	<ul style="list-style-type: none">• Notice of grant award from NIH• Cont Rev Supp• Tracked changes protocol• Johnson County LOS (email - read from bottom up)• Clean protocol• Application to NIH• Tracked changes consent• Clean consent• Withdrawals
Personnel removed:	Anne Nzuki Kimberly Engelman Kaleigh Doke Lisa Silverman Tity Kpandeyenge
Special Determinations:	<ul style="list-style-type: none">• Prisoners

The IRB approved the study from 2/1/2016 to 1/25/2017 inclusive. Before 1/25/2017 or within 30 days of study closure, whichever is earlier, you are to submit a continuing

Mail-Stop 1032, 3901 Rainbow Blvd., Kansas City, KS 66160
Phone: (913) 588-1240 Fax: (913) 588-5771 humansubjects@kumc.edu

APPENDIX C
 APPROVED REQUEST TO RELY AGREEMENT
 UMKC – University Of Kansas Medical Center

University of Missouri Kansas City
 Research Compliance Office • Institutional Review Board
umkcirb@umkc.edu
 816 235-5927

UMKC Request to Rely on a CTSA Partner External IRB

Instructions: Submit this form to request the UMKC IRB to Rely on a Partner Institution IRB. As the Reviewing Institution, an Institution is responsible for IRB review and continuing oversight. As the Relying Institution, an Institution cedes IRB review and continuing oversight to the Reviewing Institution. The Principal Investigator is responsible for providing the Relying Institution with copies of all official documentation (approvals, etc.) from the Reviewing Institution's IRB. This document must be kept and available to the Office of Human Research Protections upon request.

Protocol Title:

Determining the IRB of Record

The following algorithm will determine which IRB should be the Reviewing IRB/IRB of Record

Participating Site with Highest Magnitude of Risk*:
 *Risk level to participants in the conduct of this research
 NA if study qualifies for Expedited Review

CMH KCUMB KUMC St. Lukes UMKC/TMC NA or Equal among sites

Participating Site of Majority of Research Procedures:

CMH KCUMB KUMC St. Lukes UMKC/TMC NA or Equal among sites

Site of Majority of Potential Human Subjects:

CMH KCUMB KUMC St. Lukes UMKC/TMC NA or Equal among sites

Affiliation of the Principal Investigator:

CMH KCUMB KUMC St. Lukes UMKC/TMC NA or Equal among sites

Recipient Institution of Grant:

CMH KCUMB KUMC St. Lukes UMKC/TMC NA or Equal among sites

The first clearly defined distinction in the algorithm above dictates which IRB should be the reviewing IRB.

If the algorithm determines that UMKC should be the Reviewing IRB you must proceed to the [UMKC eProtocol](#) application and submit for review to the UMKC IRB.

Has this study been reviewed and approved by one of the partner institutions?
 Yes No

If yes, please identify the reviewing institution.
 CMH KCUMB KUMC St. Lukes UMKC/TMC

Investigators

Please identify and provide contact information for Investigators involved in this study at all Partner institutions

CMH:	<input type="text"/>	Contact Person Information: <small>(provide name, E-mail & phone #)</small>	<input type="text"/>
KCUMB:	<input type="text"/>	Contact Person Information: <small>(provide name, E-mail & phone #)</small>	<input type="text"/>
KUMC:	Megha Ramaswamy, PhD, MPH, mramaswamy@kumc.edu	Contact Person Information: <small>(provide name, E-mail & phone #)</small>	<input type="text"/>
St. Lukes:	<input type="text"/>	Contact Person Information: <small>(provide name, E-mail & phone #)</small>	<input type="text"/>

UMKC/TMC Investigator Information

UMKC/TMC Investigator Name:	Patricia J. Kelly		
Phone #:	235-2617	E-mail Address:	kellypj@umkc.edu
Additional Contact Person Information: <small>(provide name, E-mail & phone #)</small>	Megha Ramaswamy; mramaswamey@kumc.edu; 913-588-2780		
As the UMCKC/TMC Investigator please describe your role/responsibilities in this research:	Co-Investigator : Dr. Kelly will assist Dr. Ramaswamy in all aspects of study design, implementation, analysis, and dissemination.		

Training

Conflict of Interest

For all Partner Institutions you must show completion of [CITI](#) Training Course "Conflict of Interest"

COI Training Certificate Attached

Human Subjects Research

For all Partner Institutions you must show completion of [CITI](#) training Course "Group 1 Biomedical Investigator"

Human Subjects Research Training Certificate Attached

Protocol Materials

Please provide the following pieces of information, as applicable:

<input type="checkbox"/>	Copy of IRB Application
<input type="checkbox"/>	Copy of Protocol
<input type="checkbox"/>	Copy of Grant
<input type="checkbox"/>	TMC Research Administration Approval This would include any applicable application to the TMC Privacy Board
<input type="checkbox"/>	Copy of IRB Approval
<input type="checkbox"/>	Conflict of Interest Disclosure <small>For studies relying on the IRB from CMH, KCUMB or St. Lukes, completion of the UMKC Financial Disclosure Form is acceptable. For studies relying on the IRB from KUMC you must contact KUMC to determine the necessary steps to comply with their COI disclosure.</small>

Will any human subjects activities, including subject recruitment, enrollment, and/or study interventions/interactions, occur on UMKC/TMC property?

If yes, please explain the activities in detail here:

UMKC/TMC Investigator Signature:

UMKC IRB Office

UMKC Agrees to cede IRB review to the following CTSA Partner institutional IRB:

CMH

KCUMB

KUMC

St. Lukes

UMKC IRB Representative Signature:

APPENDIX D

HUMAN SUBJECTS (CITI PROGRAM) TRAINING

Group: Human Research: Social and Behavioral Investigator Passed – 8/24/2016
(UMKC, Stage 2, Refresher Course) Report ID – 19678487

Group: Human Subjects Research: Behavioral Research with Prisoners – Advanced
(University of Kansas Medical Center, Stage 1, Basic Course) Passed – 5/26/2016
Report ID 15020675

APPENDIX E

INTERVIEW PROTOCOL

Initial, Story-eliciting Interviews

Introduction

“I am studying how women’s relationships and intimate partnerships affect their ability to be safe and keep healthy. I am interested in a whole range of relationships—family relationships, partnerships that are casual as well as those that are intimate and emotionally close—even sex hook-ups with strangers. The focus of the research is on what role relationships play in women’s attempts to maintain health and stay safe after incarceration. Mostly, right now, I just want to hear your stories, the stories you want to share about what your life is like in terms of the people you have close relationships with. In the first interview, we will concentrate on stories about your life.”

Assent and Permission

Discuss assent and request permission to record. Include reason for recording (accuracy, your story/your words), confidentiality (data safety), privacy (pseudonym), benefits and harms.

Questions

1. Imagine you are writing a book based on your life’s relationships. Let’s go through each chapter and you can tell me the story of each.

[Proceed chapter by chapter]

[Probe if necessary]

What is the story of how you met?

Tell me about what happened in this relationship

Sounds like in this chapter . . .

How have you changed in what you do in relationships/who you get in relationships with because of [that experience/that person]?

2. If you could cut or edit out a relationship in your life book of relationships, what would it be?

What happened that makes you want to leave this chapter out?

3. Say you decide to make up a chapter about a relationship—to make up something really wonderful or something you feel is missing—what would be the story in that chapter?

What characters would be there and what would happen to you / to them?

Why would you . . . ?

4. Looking back, what title would you give this life story of relationships? [Follow up: why?]

APPENDIX F

CODE LIST

Alcohol & Drugs

- Alcohol & Drugs: Coping
- Alcohol & Drugs Initiation
- Alcohol & Drugs: IV Drug Use
- Alcohol & Drugs: Overdose
- Alcohol & Drugs: Dealing
- Alcohol & Drugs: Rehab/Detox/Desistance/Relapse

Childhood

- Foster care & Institutionalization
- School
 - School expulsion

Health & Health Care

- Abortion
- Birth control
- Child loss or serious illness
- Environmental conditions
- Facilitated or Impeded by Others
- HC: Deciding to seek or not seek
- HIV
- Miscarriage
- Pap
- Pregnancy & Childbirth
 - Pregnancy & Childbirth: Drug use during
 - Pregnancy: Teenage
- Quality of care-community
- STDs
- Unplanned pregnancy

Incarceration

Incarceration: Carceral Self
Incarceration: Drugs Behind Bars
Incarceration: Disposition of Children
Incarceration: Health & Health Care
Incarceration: Reentry
Incarceration: Relationships
Incarceration: Treatment
Incarceration: Violence

Management of Persona for Others

Drug Use
Appearance & Weight

Material concerns

Consumer Goods/Material Possessions
Housing
Transportation Concerns
Food Concerns

Men—thoughts about, attitudes toward

Relationships

Children
 Child raising
 Frustration of absent parent
Fathers
Friends
Lovers/Intimate Friends/Spouses
 Same-Sex & Sexual Fluidity
 Spouses/Boyfriends
 Disrespect
Mothers
Other family

Self-Improvement / Education

Sex

Social Prejudice—Experienced or Expressed

Social Prejudice: Carceral stigma

Social Prejudice: Homophobia

Social Prejudice: Racism

Spiritual, Psychological & Mental

Abandonment/Betrayal/Trust issues

Alternative Imagined Future/Past

Astrology

Depression & Suicide

Other Mental Illness

Pride

PTSD signs

Shame

Spiritual/Religious

Staying Apart

Supernatural

Telos

Unpredictability/Chance/Randomness

Stories

Stories: Arrest

Stories: Abuse

Stories: First sex

Stories: Complex Networks

Stories: How Things End

Stories: How We Met

Stories: Sex Work Initiation

Stories: Title of Story

Support

Support: Participant supports

Support: Support denied

Support: Support given

Surveillance

Surveillance: Law Enforcement

Surveillance: Non-law-enforcement/Courts

Surveillance: Social Services

Technology Use**Trauma/Abuse/Violence**

Tr/Ab/Vi: Childhood physical abuse

Tr/Ab/Vi: Childhood Sexual Abuse

Tr/Ab/Vi: CSA: Incest

Tr/Ab/Vi: Event

Tr/Ab/Vi: Intimate Partner Physical or Emotional

Tr/Ab/Vi: Loss

Tr/Ab/Vi: Loss: Death or near-death of child

Tr/Ab/Vi: Loss: Loss of custody

Tr/Ab/Vi: Participant as Abuser/Perpetrator

Tr/Ab/Vi: Rape/Sexual Assault

Tr/Ab/Vi: Secondary Trauma & Witnessed

Tr/Ab/Vi: Self-Protection/Self-Defense

Tr/Ab/Vi: Violent Attack (Non-Intimate)

Objects**Work**

Drug Sales

Formal Economy

Other Informal Economy

Sex Work/Exploitation

Sex work: Facilitators

Sex work: Fear

Sex work: Safety rules

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VITA

Amanda Marie Emerson was born in Kansas City, Missouri, in 1969, and grew up in Prairie Village, Kansas, and Lee's Summit, Missouri. After graduating from Lee's Summit Senior High School in 1988, Amanda attended George Washington University (GW) in Washington, D.C., for two years on a partial soccer scholarship. At GW, Amanda followed a course of study in the Elliott School of International Affairs and, from 1988 to 1990, was enrolled in the first- and second-year residential honors program in the Classics, Roots of Western Civilization. In 1990, Amanda transferred to the University of Kansas (KU) in Lawrence, Kansas, where she earned degrees in English: a Bachelor of Arts in 1992 and a Master of Arts (Honors) in 1996. As a Graduate Teaching Assistant for the English Department at KU, Amanda taught first- and second-year composition and literature courses from 1993 to 1996.

From 1996 to 2003, Amanda studied in the Ph.D. program in English at Brown University in Providence, Rhode Island, earning another M.A. in 1998 and the Ph.D. in English in 2004. Amanda's doctoral dissertation, entitled *From Equivalence to Equity: Management of Myths of Equality in Early American Letters*, argued that early American writers contributed to the creation of a unifying national identity through manipulation of an inwardly conflicted myth of equality. While at Brown, Amanda was mentored by Dr. Nancy Armstrong, Dr. Philip Gould, and Dr. Mari Jo Buhle. During these years, she taught writing, literature, and feminist critical theory courses as a Graduate Teaching Fellow in the undergraduate program at Brown; taught American literature courses at Rhode Island School of Design; and, under Dr. Armstrong's editorship, held positions as Subscriptions Manager and then Assistant Editor for *Novel: A Forum on Fiction*. In 2003, Amanda published an article on the unequal permutations of an early American myth of equality in *differences: A Journal of Feminist Cultural Studies*.

From 2003 to 2004, Amanda was Visiting Instructor in the English Department at Wesleyan University in Middletown, Connecticut. On leaving Wesleyan at the end of her

appointment, Amanda accepted a tenure-track assistant professor position in the English Department at the University of South Dakota (USD) in Vermillion, South Dakota. At USD from 2004 to 2009, Amanda taught undergraduate, honors, and graduate courses in literature; administered the women's studies program; revised her dissertation into a book manuscript; published articles in *NOVEL* and *Legacy: A Journal of American Women Writers*; and presented her scholarship at national conferences in Boston, Massachusetts; San Francisco, California; and Oxford, England..

In 2009, Amanda set out to explore new applications for her interests, in health disparities and women's issues. She attended nursing school at Saint Luke's College of Nursing and Health Studies in Kansas City, Missouri, from 2010 to 2012. While completing her Bachelor of Science in nursing, Amanda worked as an advocate in a domestic violence shelter and as a nurse intern in the Mid-America Heart Institute at Saint Luke's Hospital of Kansas City, Missouri.

Following graduation from nursing school in 2012, Amanda worked as an RN on an intermediate post-surgical cardiac care unit at Saint Luke's Hospital for two years. In 2013, Amanda was selected by the Saint Luke's Hospital Foundation and the SPEAS Foundation to participate in a clinical research scholars program. Her proposal for a study on sleep practices of night shift nurses was presented to Magnet evaluators and at a Nurse Executives conference in Kansas City.

Also in 2013, Amanda was admitted to the Ph.D. program in nursing at the University of Missouri-Kansas City (UMKC), where her primary mentor was Dr. Patricia Kelly. Amanda worked as Assistant Editor at *Public Health Nursing*, under Dr. Kelly's editorship from 2013 to 2017. In the summer of 2014, Amanda began serving as research assistant and then research associate on Dr. Megha Ramaswamy's (Department of Preventive Medicine and Public Health at The University of Kansas Medical Center) National Institutes of Health-funded cervical cancer health literacy study with women during incarceration and reentry. In 2015, with Dr. Ramaswamy, Amanda co-authored a review of the uses of theory in trauma-

informed, jail-based interventional studies with women that was published in *Family & Community Health*. She is also a co-author on an article in *Preventive Medicine Reports*, published in 2017, presenting one-year outcomes of the cervical health literacy intervention study with incarcerated women. During her time at UMKC, Amanda gave oral presentations of research at the American Society of Criminology, American Public Health Association, and American Female and Juvenile Offenders conferences and presented a poster at the International Symposium on the Implementation of Social Media in Population and Community Health Initiatives.

Amanda maintains her nursing license and is currently a member of the American Public Health Association, Sigma Tau International League for Nursing (UMKC, Lambda Chapter), and Phi Beta Kappa (KU, Alpha Chapter). Her research interests are in social determinants of health and health disparities; health and health access in justice-involved populations; sexual and reproductive health interventions in high-risk settings; critical theory; narrative and other qualitative inquiry theory; storytelling research methods; and collaborative action research.